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HEALTHY WOMEN, HEALTHY ECONOMIES LITERATURE REVIEW

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CONTENTS

Acknowledgments	iii
Acronyms	iv
Executive Summary	v
Introduction	I
1. Workplace Health and Safety	3
Risk Factors for Women in the Workplace	4
Diagnosis, Compensation and Rehabilitation of Women’s Occupational Injuries and Illnesses	7
2. Health Awareness and Access	9
Noncommunicable Diseases in Women: Prevalence, Risk Factors, and Awareness	9
Women’s Access to Health Care Services	13
3. Sexual and Reproductive Health	19
Awareness and Access to Sexual and Reproductive Health Services	19
Women’s Access to Family Planning Services	22
4. Gender-Based Violence	27
Sexual Harassment in the Workplace	27
Vulnerable Female Migrant and Mobile Workers	29
Intimate Partner Violence	29
5. Work/Life Balance	33
Pregnancy Discrimination in the Workplace	33
Sick Leave and Paid Time Off	34
Maternity, Paternity, and Parental Leave	35
Supportive Policies for Breastfeeding	37
Flexible Schedules	38
6. Conclusion and Way Forward	41
References	45
Appendix A. Women’s Labor Force Participation in the APEC Economies	
Appendix B. Mortality from Noncommunicable Diseases	
Appendix C. Prevalence of Daily Tobacco Use	

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ACRONYMS

APEC	Asia-Pacific Economic Cooperation
ASEAN-OSHNet	Association of Southeast Asian Nations Occupational Safety and Health Network
CEDAW	United Nation's Convention on the Elimination of Discrimination Against All Women
COPD	Chronic obstructive pulmonary disease
GDP	Gross Domestic Product
GP	General practitioners
ILO	International Labour Organization
IPV	Intimate Partner Violence
NCD	Noncommunicable disease
NGO	Nongovernmental organization
OSH	Occupational safety and health
OECD	Organization for Economic Cooperation and Development
OSHC	Occupational Safety and Health Center of the Philippines
SME	Small and medium enterprises
UN	United Nations
USAID	United States Agency for International Development
US-ATAARI	U.S.-APEC Technical Assistance to Advance Regional Integration
WHO	World Health Organization

EXECUTIVE SUMMARY

Women remain underrepresented in the workforce in all APEC economies despite progress in recent decades. Women continue to face barriers in entering, remaining in, and advancing in the labor market. Barriers include gender discrimination, harassment, culturally entrenched views of gender roles, and a lack of family-friendly policies in the workplace. As a result, women are still an untapped source of capacity and productivity for fully realizing economic growth. According to a Booz & Company study cited by the International Monetary Fund, increasing women's workforce participation in the United States and Japan to the equivalent level of male workforce participation would increase GDP by 5 percent and 9 percent respectively (IMF 2013).

APEC's Healthy Women, Healthy Economies initiative aims to address these issues, and this literature review aims to inform and validate a policy toolkit for APEC government officials, policymakers, NGOs, and the private sector with recommendations for addressing issues affecting women's health. The document examines five issues: workplace health and safety, health access and awareness, reproductive health, gender violence and sexual harassment, and work/life balance.

Occupational injury and illness. Occupational injury and illness affect women and men differently. Women tend to work in less-hazardous professions than men, and rates of women's occupational mortality and morbidity are therefore lower. But rates for occupational injury and illness affecting women workers are underestimated because women typically sustain chronic injuries, such as musculoskeletal disorders, rather than acute injuries, which are harder to diagnose as work injuries. Moreover, a significant proportion of women in APEC economies work in the agricultural and informal sectors in unsafe and unhealthy working conditions with limited occupational health and safety regulations and controls. In these sectors, women are more vulnerable to certain occupational health illnesses and hazards than men.

Noncommunicable diseases. Women are at higher risk for certain noncommunicable diseases (NCD) than men and are more vulnerable to certain risk factors associated with the diseases, notably smoking. At the same time, women sometimes lack awareness of the prevalence and risk factors of common NCDs. The cost of NCDs is significant for individuals and families due to lost earnings and health care costs; for employers due to absenteeism, loss in productivity, and loss of trained labor; and for society as a whole due to greater health care expenditures and reduced economic output. Women suffer a two-fold financial burden from NCDs—as someone who suffers from an NCD and as the caregiver of a family member with an NCD. NCDs reduce women's ability to engage fully in the workforce.

Access to health care. Many structural, social, cultural, and financial barriers make it harder for women to access health care. One of the greatest barriers to health care is out-of-pocket expenditure, which is a higher burden for women than for men. As a result of cost, more women than men delay or forgo medical care. Additionally, women in the informal economy have limited medical coverage, and accessing health care can lead to catastrophic health care expenditures. Migrant workers are faced with additional barriers due to their irregular

immigration status and lack of health care coverage, language barriers and the threat or fear of wage or job loss.

Family planning services. There is a clear linkage between women's ability to delay childbirth and levels of women's education and participation in the workforce. Family planning services are crucial for women's ability to maintain their reproductive health and plan their childbearing. Studies have demonstrated that delaying childbirth and spacing births are associated with improved women's and children's health, as well as with higher levels of education, greater participation in paid employment, and higher earnings. Despite progress throughout the APEC region in the provision of family planning services, there is still a gap between women's decisions concerning family planning and women's access to and use of contraceptives. Adolescent women in the Asia-Pacific region have a lower use of contraception, poorer knowledge of family planning, and less access to information and services than adult women, although reliable statistics are lacking. Moreover, women from ethnic minorities who live in rural areas or are migrants, poor, unmarried, or teenagers are at a disadvantage in accessing family planning.

Sexual harassment. Sexual harassment, prevalent in both the informal and formal sectors, affects women's workforce performance and retention. Women who experience sexual harassment at work often experience physical and psychological effects. Sexual harassment can result in lower productivity and increased absenteeism, affecting both the worker and the company. Women face challenges in reporting workplace sexual harassment, due to taboo, fear, and lack of power in relation to the perpetrator. Even when company policies are in place to prevent or address sexual harassment in the workplace, women are not always aware of the policies or do not have an incentive to report the harassment. Certain groups of women, including migrant workers, whose employment is often insecure and isolated, are at greater risk of experiencing sexual harassment. Domestic violence is shown to have effects similar to those of sexual harassment in the workplace. Several studies have found that intimate-partner violence causes negative psychological effects, diminishing women's productivity in the workplace and increasing their absenteeism.

Paid leave and flexible schedules. Paid leave (including parental leave) and flexible schedules help women balance work, household, and family needs. Paid sick leave and paid holiday leave are also important for workers to stay healthy and productive. Many women in APEC economies, however, work part time and do not receive paid leave. Similarly, the industries dominated by female workers are the least likely to offer paid sick leave. Paid holiday time is also vital to the productivity of workers and to enable workers to spend time with their families. Finally, providing parental leave can affect female employment and advancement rates. Restrictive parental leave policies, inflexible working hours, unsupportive child care policies, and strong social norms about women's role as caregivers reduce women's workforce participation.

These issues affect women in different APEC economies and at different socioeconomic levels in different ways. Women in the informal sector face many of the same issues, and sometimes the effects are felt to an even higher degree. Jobs in the informal sector often pose safety challenges for women and offer less friendly benefits, affecting family life.

Policy recommendations. The literature reviewed reveals the need for the following changes in policy and practice to address the issues examined in this report:

- The implementation of gender-sensitive policies and programs regarding workplace health and safety can increase women's workforce participation.

- The delivery of health care services should be gender sensitive in ensuring that biological, social, and cultural factors are taken into consideration in the care and treatment of women.
- Programs should be put in place to disseminate information about family planning services and facilitate access to such services so that women can space their children in a way that allows them to continue to participate in the workforces.
- Workplace policies aiming to prevent violence in the workplace and at home can help women engage fully and perform at their best in their job.
- Policies and programs supporting women so they can balance work/life responsibilities can help women not only enter and stay in the workforce but also advance in their careers while raising a family.

The policy toolkit, developed under the Healthy Women, Healthy Economies initiative, provides policy recommendations validated by this research.

INTRODUCTION

Achieving the goal of sustainable economic growth is difficult if one-half of the potential workforce is unable to participate fully in the economy because of unmet health needs. APEC Leaders at their meeting in 2013 recognized that “the economic inclusion of women is critical for business performance and economic prosperity,” and committed to promoting integration of gender considerations into APEC activities. Consequently, in spring 2014, APEC Health Working Group (HWG), Human Resources Development Working Group (HRDWG), and the Policy Partnership on Women and the Economy (PPWE) started the multiyear Healthy Women, Healthy Economies initiative, led by the Philippines and the United States. Under this initiative, representatives from economy governments, industry, and NGOs gathered in August 2014 to examine how a lack of health care prevents women’s economic participation in the workforce.

The Healthy Women Healthy Economies initiative groups the barriers they found to health care in five categories:

- Workplace Health and Safety
- Health Access and Awareness
- Sexual and Reproductive Health
- Gender-based Violence
- Work/Life Balance.

The initiative is developing a policy toolkit that summarizes global good practices on how to improve women’s health for greater workforce participation. The toolkit was finalized at a two-day experts group meeting in Manila in August 2015. The policy toolkit will be shared with APEC economies and partners, and APEC member economies have committed to piloting elements of the toolkit by 2019.

By identifying issues and barriers to women’s health and women’s participation in the workforce, with a focus on APEC economies, this literature review supports the development of APEC’s Policy Toolkit. It aims to consolidate research on health-related barriers to women’s ability to join, remain in, and advance in the workforce. By quantifying the severity of these issues and how they affect women and the economy as a whole, the literature review aims to validate the identification of the barriers cited, demonstrate the need for investment in policy changes and practices, and support the recommendations outlined in the policy toolkit.

The literature review focuses on research on health-related issues that affect women’s workforce participation in APEC economies in the five identified issue areas. It examines not only resources on workforce participation rates, but also how the issues affect whether women drop out of the workforce and how they advance in their careers. Furthermore, it strives to quantify how these issues affect the economy and the workforce as a whole. The research draws from economy-level and regional studies as well as data from multilateral organizations such as the Organization for Economic Cooperation and Development (OECD) and the International Labour Organization (ILO). The findings in this literature review were collected from a thorough review of online health-related academic, peer-reviewed journals as well as studies and reports from governmental, international, civil society and research organizations.. A comprehensive review of recurring reports, such as the World Bank’s Women, Business, and

the Law report, uncovered much relevant information. The literature review has a broad focus, covering a wide spectrum of sectors, socioeconomic statuses, and phases of life. It encompasses young women, pregnant women, working mothers, and women in the agricultural and informal sectors, as well as migrant women.

The review also highlights successful policies and programs. These best practices, along with the other findings, will inform and validate the policy toolkit and call attention to the areas that the APEC economies (through governments or private sector firms) can learn from and act on.

The findings of the literature review were presented at the Healthy Women, Healthy Economies Experts Group Meeting in Manila in August 2015.

I. WORKPLACE HEALTH AND SAFETY

When both women and men fully participate in the labor market, economic growth is more sustainable and robust. Despite progress in recent decades, women remain underrepresented in the labor force across the world, and as shown in the graph in Appendix A, in all of the APEC economies. In Chile, Indonesia, Mexico, Malaysia and the Philippines, there is more than a 25 percent point difference in men's and women's labor force participation. Women workers constitute 40 percent of the world's workforce, yet they are underrepresented in many sectors, and less likely than men to be in a management position (IFC 2013).

Employment, when compared to joblessness, is good for physical and mental well-being. Employment is typically a person's main source of income, and greater income is associated with better health, while unemployment is associated with poorer physical and mental health and well-being (Kim and Waddell 2006). Nevertheless, work-related injury and illness are common. An estimated 2.3 million people die from work-related accidents and diseases around the world every year—close to 360,000 fatal accidents and 1.95 million fatal work-related diseases (ILO 2009a). These numbers are probably underestimated because of a lack of data, especially from low- and medium-income economies.

An occupational injury or disease can push a worker and his or her family into poverty. Not only the worker but also the employer suffers when an employee is injured or ill. The employer has direct costs for the injury; when an employee comes to work despite an injury or illness productivity declines; and absenteeism due to illness or injuries also imposes significant costs. It is estimated that workplace injuries in 2005 cost U.S. businesses US\$150 billion in direct and indirect costs—an amount exceeding the combined profits of the 16 largest Fortune 500 companies that year (Burton 2010). In Australia, the estimated cost for work-related injuries and diseases in 2005-2006 was AU\$57.5 billion, or close to 6 percent of Australia's gross domestic product (GDP) (Safe Work Australia 2009).

Women and men face different occupational health and safety challenges. Occupational health and safety regulations traditionally focus on controlling jobs involving obvious dangers such as construction, forestry, and mining, which are sectors dominated by male workers. Women tend to work in less hazardous professions than men, and the prevalence of occupational mortality and morbidity is therefore in absolute numbers lower for women than for men. But occupational safety and health (OSH) hazards affecting women workers have long been underestimated for two reasons.

First, OSH standards and limits on exposure to hazardous substances are based on male populations (ILO 2009a) and have not been updated to reflect new developments. Occupational health injuries or diseases in labor sectors where a greater share of women work, such as manufacturing, agriculture, health care, and other service sectors often develop over a longer period of time and are therefore harder to identify and diagnose as an occupational health injury or illness. Moreover, a significant proportion of women work in the informal sector where

unsafe and unhealthy working conditions are common. The informal sector is largely unregulated and is subject to limited OSH controls. Therefore women's occupational injuries and illnesses, such as work-related stress and chronic joint and muscle conditions have been underdiagnosed, under-reported and undercompensated (ILO 2013a). For instance, in the United States in 2013, 4,265 men and 319 women died from fatal work injuries (U.S. Bureau of Labor Statistics 2014a). The same year, 705,100 men and 453,010 women in the United States sustained occupational injuries that required days away from work (U.S. Bureau of Labor Statistics 2014b).

Counting occupational injuries and illnesses and data collection are complex, even in countries with robust reporting systems. Data collection is affected by employees' fear about reporting; lack of employer awareness of reporting requirements and willingness to report; complex definitions of workplace injuries; difficulty determining whether an injury actually occurred at work or is otherwise work related, and more (Wiatrowski 2014).¹ Hence, the number of occupational injuries and illnesses is believed to be greatly underestimated (World Health Organization [WHO] 2006). Although many economies have started to collect sex-disaggregated data for occupational illnesses and injuries, a majority of economies either do not collect or do not disaggregate the data. As a result, there is no global or APEC-specific dataset on how work-related health problems affect men and women (WHO 2011a).

Even when sex-disaggregated data are available, there is commonly a lack of analysis of the data. The number of injuries to women and to men is often reported and the type of injury or disease and the sector in which the injury or disease was sustained are also disaggregated by sex in some economies. But a deeper analysis would involve a comparison of the number of claims by the number of compensated claims to investigate if there are gender biases in the compensation system; this is less common. Moreover, a more complete picture of the distribution of occupational illnesses and injuries between women and men requires examining the total number of women and men working in a particular sector to determine the proportions of occupational injuries between men and women. This might shed light on where there is underreporting.

Because more men in absolute numbers are at risk of occupational mortality or morbidity, research on women's occupational health is lacking, particularly in emerging and developing economies (WHO-Global Commission on Women and Health 1998). There is therefore a need for additional research on the risks and health problems women face, and how regulations concerning labor inspections and the diagnosis of, compensation for, and rehabilitation of occupational injuries and illnesses might affect women and men differently.

RISK FACTORS FOR WOMEN IN THE WORKPLACE

Women play a significant role in manufacturing, particularly in the food processing and garment industries. Women make up more than one-third of manufacturing labor in some economies, and almost one-half in some Asian economies. Women working in factories are exposed to high levels of dust, noise, chemicals, and repetitive and monotonous movements. Therefore, they are at high risks of lung diseases, impaired hearing, and repetitive strain injuries. Women are at least twice as likely as men to develop musculoskeletal disorders of the upper body, even in the same

¹ The U.S. Bureau of Labor Statistics is investigating the completeness of injury and illness counts to understand the extent of undercounting and the reasons for it. See <http://www.bls.gov/iif/undercount.htm>

job (Burr and Treaster 2004). A study from Australia found that women experience increased risk for musculoskeletal disorders due to the different demands they face at work and at home. At work, women spend more time using computers, do more repetitive movements, and use poorer and less-comfortable equipment. Outside work, women spend more time on household and parenting tasks and had less time for exercise and relaxation (Bammer and Strazdins 2004).

Agriculture is one of the largest sectors for female employment, particularly in Asia. It is also one of the most hazardous employment sectors. An estimated 170,000 agricultural workers around the world die every year from workplace accidents (Rockefeller Foundation 2013). Farmworkers endure strenuous work and excessive heat, are at risk for accidents handling animals and machinery and are exposed to agrochemicals. Particularly in emerging and developing economies, education on safety and safety standards are lacking, and the use of safety equipment is inadequate. Pesticide poisoning disproportionately affects women. One study in the United States found that acute pesticide poisoning was almost twice as common in women agricultural workers as in men agricultural workers (Calvert and Karnik et al. 2008). Women exposed to pesticides are at higher risk of having babies with birth defects (Lin and Kielb et al. 2011), are at higher risk for infertility (Arbuckle, Greenlee and Chou 2003), and risk transferring exposure to their babies through breast milk. For agricultural workers, physically heavy work can cause premature birth or stillbirth.

In addition, agricultural workers are at risk for other injuries and illnesses including fractures, respiratory disorders, infections and parasitic diseases, noise-induced hearing loss, and musculoskeletal disorders. Data from South Asian economies consistently show that malnutrition, anemia, and maternal mortality rates are higher among plantation workers than the general population (Rockefeller Foundation 2013). Although farming is one of the most dangerous sectors, agricultural workers are one of the least-protected occupational groups. The ILO's Safety and Health in Agriculture Convention (2001) and the ILO Code of Practice on Safety and Health in Agriculture have propelled the dialogue and improved safety training and awareness. When monitoring or market pressure is limited, however, implementation of safety regulations in the agricultural sector is often inadequate.

Many women are able to carry out their work as usual during pregnancy, but pregnant workers in jobs that require heavier physical activities, long periods of standing, and repetitive work can require job accommodations to protect the health of the mother and the unborn child. Pregnant workers might require accommodations such as assistance with heavy lifting, more frequent breaks, and the option to sit while working or to work different shifts. Studies have found that occupational lifting is associated with early and late miscarriage; the more lifts and the more total weight lifted per day, the higher the risk (Strandberg and Larsen K et al. 1989, 404-414). Shiftwork, which alters workers' sleep cycles, has negative effects on physical and mental health, including increased risk of breast cancer, irregular menstrual cycles, miscarriages, ulcers, insomnia, high blood pressure, and heart disease (Burton 2010).

The informal sector, which encompasses employment and self-employment in all sectors including trade, production, services, and agriculture, is dominated by women in many economies. Employment opportunities in the informal sector tend to be insecure, temporary, or seasonal, and workers are exposed to poor safety and health conditions. There is scarce information on occupational accidents and diseases arising from hazardous working conditions in the informal sector, and occupational health and safety standards and inspections do not reach the informal sector. For instance, the Occupational Safety and Health Center of the Philippines (OSHC) found significant occupational safety and health gaps for workers in the informal

economy. Occupational health and safety was weak in the informal economy because standards were mandatory only for formal businesses, and small and microenterprises were not inspected or required to report accidents and injuries. Moreover, employers and employees have limited awareness of occupational risks and preventive equipment and techniques. The report noted, “informal sector operators and workers admit that they have not really been thinking of OSH because their existence is hand-to-mouth” (Estrella-Gust 2008, 53).

Domestic and home-based employment is part of the informal sector dominated by women. Domestic jobs are a significant source of employment for women in the Asia-Pacific region. Many economies’ labor regulations stipulate exceptions for domestic workers, and domestic work is not generally subject to labor inspection (ILO 2005). Live-in arrangements and the long and irregular hours of their work isolate domestic workers and make them vulnerable to abusive working conditions and the associated adverse effects on their health and well-being (Holroyd, Molassiotis, and Taylor-Pilliae 2001; Joanna and Ujano-Batangan et al. 2014). Loneliness, stress, and exposure to physical, sexual, and psychological abuse by employers are considerable physical and mental health risks for domestic workers. Domestic workers are also at risk for other occupational illnesses and injuries, but they have less access to health services (Rockefeller Foundation 2013).

A certain kind and a certain amount of workplace stress are associated with decreased physical and mental health of workers, which affects both individual and organizational performance. A meta-analysis of 485 studies confirmed that job satisfaction is associated with improved health and that job dissatisfaction is strongly correlated with burnout, depression, anxiety, level of self-esteem, and general mental health (Cass, Faragher and Coope 2005).

Work that involves high demand and little control or opportunity to make decisions increased the risk of mental illnesses or disorders, including anxiety and depression. Because women tend to hold jobs with lower control than men, they are more adversely affected than men. For instance, women are over-represented in low-wage manufacturing jobs with high demands, monotonous tasks, and limited authority, which have been linked to fatigue, depression, and unhealthy behaviors (WHO 2011a).

Occupational health and safety is an excellent topic for collaboration and information sharing among APEC economies. In the ASEAN region, the Association of Southeast Asian Nations Occupational Safety and Health Network (ASEAN-OSHNet) shares lessons learned, promotes regional solutions, and helps develop national and regional standards. The network has carried out research on labor standards for small and medium enterprises; provided training on inspection practices, developed guidelines on classifications, labeling, and packaging of hazardous chemicals; and established a framework for developing national OSH policies.

A study of employees in France found that women are almost twice as likely as men to report stress in part due to differences in work conditions (WHO 2011a). A study of managers found that women’s stress levels remained high after work, particularly if they had children living at home. Men, however, generally unwind rapidly at the end of the working day (International Labour Organization 2013a). Intervention studies, primarily from Japan, have shown that employee-participatory approaches to improve the psychosocial work environment and individual stress management sessions were effective in reducing stress (Kawakami 2010).

As employers strive to increase worker productivity and rein in health care costs, they have begun providing preventive care services targeting obesity, tobacco use, alcohol abuse, and chronic illnesses (Schramm 2005). Workplace wellness programs may include nutrition classes and gym memberships or discounts. Some employers also give workers the option of

completing a health risk assessment as a preventive health measure. A study of U.S.-based firms found that 33 percent of companies that offer health benefits also offer health risk assessments (Bostick et al. 2014, 196-197). Such assessments touch on medical history, health status, and lifestyle. In the United States, large companies (with 200 or more employees) are more likely to offer wellness services and financial incentives for participation in these programs than small companies. A study of U.S.-based companies found that 36 percent of large companies and 18 percent of small companies that offer at least one type of wellness programs provide financial incentives for employees to participate (Bostick et al. 2014, 196-197).

Women are more likely to engage in workplace wellness programs than men (Burdorf et al. 2009). One workplace wellness program that has seen much success is offering onsite physical fitness activities, such as Tai Chi classes, which have been shown to be a cost-effective way of increasing productivity. Tai Chi can enhance mental and physical health, reduce work-related stress, and reduce absences from work. A study in the United States demonstrated a 3 percent increase in productivity in female nurses over the age of 45 participating in once-a-week Tai Chi classes. Their increased productivity allows them to perform better at in their jobs, and increases their chances at advancement (McIntosh et al. 2012). More information on preventive care is included in the section on access to health care services.

DIAGNOSIS, COMPENSATION AND REHABILITATION OF WOMEN'S OCCUPATIONAL INJURIES AND ILLNESSES

An important area for women's occupational health and safety is women's abilities to be diagnosed, compensated, and rehabilitated. It is important for the individual, but it is also important for the society to recognize legal, institutional, or social barriers for women's occupational health and safety, in order for potential inequalities to be addressed. This is an area that has obtained less attention.

Occupational health and safety inspections play an integral role in detecting and preventing occupational hazards. There is a gap in the literature on the role of gender sensitive occupational health inspections and best practices. Certain types of workers and jobs are excluded from occupational health and safety standards and workers' compensation. This includes for example domestic workers in many economies, which are overwhelmingly female. In a number of provinces in Canada other excluded categories of workers or type of work include people working from home, home care givers, temporary workers and self-employed workers (Cox and Lippel 2008, 9-30). There are all categories with a significant portion of female workers.

The injured worker must of course report an occupational injury or illness for it to be diagnosed. However, certain groups of workers, especially migrant workers and people with little job security are less likely to report work related injuries or illnesses. Studies from the United States, Canada, and Australia have found that temporary workers who report work-related injuries and illnesses may lose the chance of being called back for future or permanent jobs (Cox and Lippel 2008, 9-30) and therefore have less of an incentive to report injuries.

Doctors assessing injury may fail to recognize the work-related nature of chronic occupational injuries and illnesses, which is the majority of women's injuries or illnesses. Due to the type of work that women more typically engage in, they are more likely to present chronic injuries, such as musculoskeletal disorders, rather than acute injuries. However, it is harder to establish that a chronic injury or disease is related to an occupational hazard and fewer such claims are

accepted than for acute injuries. For example, in 2006 in Québec, Canada, the workers' compensation board accepted 89 percent of work accident claims compared to 48 percent of occupational disease claims (Cox and Lippel 2008, 9-30). Although women in manual occupations have more than twice the risk of musculoskeletal disorders than do men, another study from Québec found that women's claims for musculoskeletal disorders were accepted significantly less often than men, due to biases against women. The denial of women's claims that the injury was an occupational disorder were justified due to issues like age, menopause, pregnancy, work in the home, and simply being a woman. For men, however, personal conditions that disqualified claims were limited to arthrosis, diabetes, and rheumatism (Cox and Lippel 2008, 9-30). Similarly, a different study from Canada found that women's requests for compensation for psychological occupational disability related to stress were dismissed because the women's work was perceived as banal or unimportant (and therefore not stressful). Alternatively, women who worked in male-dominated jobs were dismissed because they were "not tough enough for the job" and it was a bad fit, even in situations where men were compensated (Lippel 1999, 79-89). Hence, women are more likely to have chronic injuries and illnesses, but even a seemingly gender-neutral system has discriminatory effects.

A study on gender, workplace injury, and rehabilitation from South Australia found that injured workers perceived the claim compensation system as very difficult and bureaucratic. There was a lack of understanding that the injury affected all parts of their life, not just their work life. Women reported that the expectation that housework and child care would continue as previously was common. In addition, management and coworkers' response to the injured worker was often negative and sometimes turned into workplace bullying (Auer, Cunningham and Jennings 2005).

2. HEALTH AWARENESS AND ACCESS

Awareness about how disease and illness affect women, and how the symptoms and risk factors, both biological and social, might be different for women than men, are poorly understood. Noncommunicable diseases (NCD) are the leading cause of death for women. Women are at a higher risk for certain NCD and are more susceptible to certain risk factors for NCD, notably smoking. NCD have considerable ramifications for the labor market because premature death, absenteeism, and reduced productivity have significant economic consequences. Women also face challenges in accessing medical care and treatment, especially affordable, gender-sensitive health care services. Women migrant workers and workers in the informal economy in particular lack access to services.

NONCOMMUNICABLE DISEASES IN WOMEN: PREVALENCE, RISK FACTORS, AND AWARENESS

NCD are a serious public health concern in the APEC economies and affect workforce participation for both women and men. Awareness of the prevalence of NCD in women and the risk factors associated with NCD is low. NCD is the leading cause of death for women and accounts for an estimated 65 percent of all female deaths worldwide (NCD Alliance 2011).² In recent years, there has been a rapid global increase in NCD; in 2012, NCD accounted for 68 percent of all deaths worldwide (World Health Organization 2014). In the 10 ASEAN countries, an estimated 2.6 million people died from NCD in 2005. With population growth and increased exposure to risk factors, the number is projected to increase to 4.2 million by 2030 (Dans, Ng et al. 2011). However, a study of six APEC economies found that there had been a modest reduction of NCD mortality rates in the last 30 years (Sheehan 2014).³ Although there is room for more careful analysis of NCD mortality trends in all APEC economies, it is clear that in APEC economies, deaths from NCD greatly outnumber deaths from infectious diseases.

The prevalence of NCD is difficult to measure, and as a result, there is a lack of data on the number of people in APEC economies living with an NCD. Nevertheless, NCD are serious concerns for the labor market because workers with an NCD may have reduced ability to work in the paid workforce and reduced productivity while at work. Moreover, a significant proportion of deaths occur in active and productive age groups: Globally, 42 percent of all NCD deaths occurred before the age of 70 (WHO 2014). One study found that in the 10 ASEAN countries, 30 percent of all deaths from NCD occurred in people aged 15–59 years (Dans, Ng

² In 2008, the four leading causes of death in women globally were cardiovascular diseases (33 percent), infectious and parasitic diseases (14 percent), cancer (13 percent), and respiratory diseases (7 percent). NCDs are also the leading cause of death for men globally (NCD Alliance 2011).

³ The six economies included in the study were the United States, China, Malaysia, Peru, Australia, and the Philippines. The Philippines had a slight increase in NCD mortality, while the other five economies had a small reduction (Sheehan 2014).

et al. 2011). The probability in APEC economies of dying between the ages of 30 and 70 from one of the four main NCDs ranges from 9 percent to 30 percent (see Appendix B).

The four main NCD—cancer, cardiovascular diseases, chronic respiratory diseases and diabetes—are responsible for 82 percent of NCD mortality globally (WHO 2014). The number of deaths caused by the four main NCD in people under the age of 70 is higher for men than for women in all APEC economies. However, due to biological differences, women can experience NCDs differently than men (Clow, Pederson, et al. 2009).⁴ Moreover, women are at higher risk for certain noncommunicable diseases, notably thyroid disease, lupus, and osteoarthritis (U.S. Department of Health and Human Services Office on Women’s Health 2015).⁵ In addition, the global increase in cancer is severely affecting women. Cancer specific to women—breast cancer, uterine cancer, ovarian cancer, and cervical cancer—causes 1.5 million women’s death a year and is globally the second-leading cause of death from cancer after lung cancer. As *The Lancet* editorial recently pointed out, however, cancer specific to women is “neglected,” and there is a need to prioritize breast and gynecological cancer research, care, and treatment (The Lancet 2015).⁶

There is a lack of knowledge and awareness among women about the prevalence and risks of NCD in women, particularly in diseases that have traditionally been perceived as men’s disease. For instance, although cardiovascular disease is the leading cause of death for women, it has traditionally been perceived as a man’s disease, and there is a lack of knowledge among women about the prevalence and risks of cardiovascular diseases. For example, a study of women attending a rural health clinic in Australia found that only 13 percent of the participants identified heart disease as the most significant health problem for women, while the majority of women believed that breast cancer was the leading cause of death for women (Crouch 2008). Moreover, a recent study surveyed women aged 40-60 in U.S. metropolitan cities on their knowledge and awareness of gynecologic cancer. The study found that participants lacked the critical knowledge needed to understand their risk and seek appropriate care. The study uncovered limited knowledge of risk factors for gynecological cancers or gynecologic cancer symptoms (Cooper, Polonec and Gelb 2011).

A large cross-sectional survey of women in the United States carried from 2012 found that women’s awareness of only cardiovascular disease had improved over the last fifteen years, but that significant gaps for ethnic minorities persisted (Mosca et al. 2013). As shown in the graph below, in 1997, only 1 in 3 women correctly identified heart disease as their leading cause of death, and in response to these findings, the American Heart Association launched a national awareness campaign for women (Mosca et al. 2013).⁷ In 2012, 56 percent of women knew that cardiovascular disease was the leading cause of death for women. Although the level of

⁴ For instance, biological differences between men and women in the size of the coronary arteries, may explain women’s and men’s different experiences of heart diseases. Clow, Barbara, Ann Pedersen et al. 2009. *Rising to the Challenge: Sex and Gender Based Analysis for Health Planning, Policy and Research in Canada*. Atlantic Center of Excellence for Women’s Health.

⁵ Women are especially at a higher risk for thyroid disease right after a pregnancy and after menopause (U.S. Department of Health and Human Services Office on Women’s Health 2015)

⁶ Breast cancer (470,000), uterine cancer (67,000), ovarian cancer (160,000), and cervical cancer (24,000) combined is a total of 1.5 million. Lung cancer causes 1.63 million deaths a year (The Lancet 2015).

⁷ During the same time frame as the campaign, the death rate caused by cardiovascular disease declined nearly 50 percent for both men and women.

awareness had increased in all women, the level of awareness varied significantly among European American (65 percent), African American (36 percent) and Hispanic (34 percent). The data demonstrates the need to disaggregate and analyze the data as there is a great deal of variation among women. Moreover, the data highlights that traditional outreach methods may not be as effective in educating minority women, but outreach methods need to be tailored to meet the needs of different groups of women.⁸

While there are actual data or estimates for the number of deaths caused by NCD on a global and country level,⁹ global or national data for people living with a NCD is not as readily available. However, death and disability from NCD create significant financial burdens for workers and families due to increased medical costs, loss of income and time spent on caring for sick family members. In particular, in economies where the health insurance coverage is low, the combination of loss of income and sometimes catastrophic health care spending can drive households into poverty. Women are affected by the financial burden of NCD as a carrier of a NCD, but also when a spouse or family member has a NCD. Women, who spend time caring for their sick spouse/family member, will often forgo their own ability to work, which is a great strain on the family's finances as the family has less income and greater medical expenses.

As NCD has a relatively high frequency in the age group active in the labor market, NCD has significant macroeconomic effects due to loss of productivity, loss in trained labor supply and loss of savings. One study estimated conservatively that a total of seven billion US dollars would be lost between 2006 and 2015 because of chronic noncommunicable diseases in Myanmar, Indonesia, the Philippines, Thailand, and Vietnam (Dans, Ng et al. 2011). Another recent study found that loss in GDP due to death, absence and reduced productivity due to illness caused by NCDs between 2010 -20130 would be \$1.14 trillion(5.5 percent of GDP) for the United States and \$485 billion (4.3 percent of GDP) for China (Sheehan 2014). Hence, the financial burden of NCD is tremendous on individuals and families, businesses and the economy as a whole.

Primary risk factors for NCD include tobacco use, harmful alcohol consumption, unhealthy diet, and physical inactivity. While these are risk factors for both men and women, there are important biological and social differences which make women more vulnerable to these risk factors. For instance, women with diabetes have a higher risk of stroke than men with diabetes, and are more likely to die from a stroke (Sheehan 2014). Symptoms for NCD can also be different for women than men, but many NCD guidelines are gender neutral and based upon the symptoms and experiences of men, especially for NCD more common in men. This can lead to misdiagnoses and delayed treatments (Sheehan 2014). As women in general live longer than

Sex- and Gender-Based Analysis of Diabetes

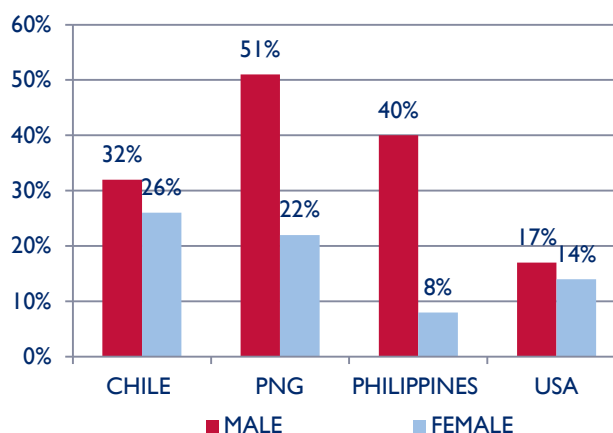
In Manitoba, Canada, the prevalence of diabetes was 5.2 percent for women and 4.9 percent for men. A closer look at the health data revealed that First Nation (aboriginal) women and men in Manitoba had a much greater burden of disease. In particular First Nation women had the highest rates of diabetes, compared to both First Nations men and other Canadian women and men. For First Nation women age 55 to 65 a staggering 35 percent had diabetes (compared with 17 percent of First Nation men). First Nation women were also more likely to experience medical complications from diabetes than other population groups. The prevalence of diabetes was also correlated with the level of income of the tribal council area (Clow, Pederson, et al. 2009).

⁸ The study notes that there is limited research on the effectiveness of intervention strategies for chronic diseases in different ethnic minority groups, but notes also that African American women in the survey reported that they were more likely to take preventative actions if they had been prompted and educated at their place of worship.

⁹ See e.g. www.who.int/nmh/countries/en/ and <http://www.healthdata.org/>

men, they live longer with a disability from chronic disease than men with NCD do. As shown in Appendix B, in absolute numbers, men in the APEC economies are to a higher degree exposed to key risk factors for NCD; alcohol consumption, tobacco use, high blood pressure and obesity, than women are. However, the harmful effects of certain risk factors for NCD, notably smoking, are higher for women than men. Moreover, many women have limited ability, power or awareness of how to mitigate risk factors.

Tobacco use is the single most important risk factor for NCD. There are specific increased health risks for women using tobacco including, cervical cancer, osteoporosis, poor pregnancy outcome and early menopause. Moreover, the harmful effects of smoking are higher for women than for men. For instance, women who smoke have a 25 percent increased risk for cardiovascular disease, even though the mean consumption of cigarettes is lower in women than men. Moreover, chronic obstructive pulmonary disease (COPD) occurs at lower levels of exposure to tobacco smoking in women than men, resulting in earlier development of respiratory diseases (Sheehan 2014). Moreover, reports from the United States find that women are also less likely to be diagnosed properly with COPD than are men who go to their doctors with the same histories and symptoms (American Lung Association 2013).



The prevalence of daily tobacco use (measured as smoking at least one cigarette per day) is lower, and in some APEC economies significantly lower among women than men (see Appendix C). Although tobacco use remains high in some economies, smoking is decreasing among women and men. Although there is a decrease in women smoking, there is a lag time between the start of smoking and the onset of disease. In the United States, the number of deaths caused by COPD in women has quadrupled since 1980, and since 2000 more women (53 percent) than men die from the disease. The rising death toll in women is closely linked to marketing directed at women (American Lung Association 2013). Moreover, some estimate that the proportion of female smokers will increase from 12 percent in 2010 to 20 percent by 2025 (NCD Alliance 2011). Tobacco companies are marketing tobacco to women, especially in emerging economies in Southeast Asia, where women's awareness of the health risks of tobacco varies greatly. Moreover, second-hand smoke is a significant problem for women in cultures where they do not have the power to negotiate smoke-free spaces in their home or workplace. For instance, in the Philippines, a survey found that 36 percent of women live in a household where someone smokes every day and 28 percent of women were exposed to smoking at their place of work (Department of Health 2009).

Physical inactivity, harmful use of alcohol and indoor air pollution are other important risk factors for NCD. Evidence suggests that there are lower levels of physical activities among girls/women than boys/men, especially during the school years. Mobility for women and girls can also be curtailed due to social, cultural or safety reasons. There might also be limited available opportunities for girls and women to participate in sports. Although alcohol consumption is much lower among women than men in APEC economies (see Appendix B), women are affected differently by alcohol than men. Women absorb more alcohol than men and are more vulnerable to alcohol's long-term effect on their health (Center for Disease Control 2014).

Pollution from burning solid fuels indoors for cooking is another important risk factor for NCD, which women are more exposed to. Indoor pollution from solid fuel is estimated to cause almost 2 million deaths throughout the world every year because indoor pollution contributes to chronic obstructive pulmonary disease, asthma, and lung cancer (USAID-ASSIST 2014).

There are significant differences in prevalence of NCD among women and men. Yet, especially in low- and medium-income economies, there is a lack of sex-disaggregated data on prevalence and treatment of NCD for men and women. In the APEC economies, the accuracy of reported causes of death varies, but the data is thought to provide a reasonably good estimate of the number of death disaggregated by disease and sex. Data on the prevalence of certain diseases is much more challenging to obtain, however, because data are not systematically maintained for most diseases in most economies (Sheehan 2014). Many reports on the prevalence and impact of NCD therefore focus on death caused by NCD rather than prevalence and treatment of NCD. To this effect, it is of great importance for economies to engage in systematic, gender-disaggregated data collection and analysis of NCD. Moreover, as discussed in more details below, it is important to recognize the strong evidence linking poverty, lack of education and other socio-economic issues to risk factors for NCD. These factors need also to be taken into consideration in the analysis of sex and gender differences. To better understand the specific challenges and risks faced by women in regard to NCD, it is important to undertake gender based and social determinants of health analysis.

Women and Mental Health

The prevalence of mental illnesses in both women and men globally is vast. Life expectancy among those who suffer from mental illness is significantly shorter (20 years for men; 15 years for women) than from the general population. Yet only a small minority of people with even severe mental disorders receives treatment in most economies and that even fewer receive high-quality treatment. Women represent 90 percent of all cases of eating disorders, are two to three times as likely as men to have anxiety disorders, including post-traumatic stress disorder. Women are nearly twice as likely as men to suffer from major depression, which is associated with problems such as lost productivity and more sickness. . Depression is also associated with riskier behavior such tobacco use, unsafe sex, abuse and poor adherence to medical regimens. Individuals with depression are of at greater risk of developing cancer and cardiovascular disease, and people with NCD have a higher rate of depression. Women of ethnic minorities, migrants and refugees, and women faced with poverty are less likely to access mental health services. There is a stigma associated with mental illness and a lack of awareness of mental health services. There is evidence that primary care providers are critical in helping to recognize and treat mental illnesses among women. For women the fear and stigma associated with mental illnesses can be reduced if the mental health services are provided in a primary care setting. However, the primary care setting might not have the expertise and resources to treat mental illnesses, but it is an important point of entry for diagnoses (US Department of Health and Human Services, Office of Women's Health 2012, 23-33).

WOMEN'S ACCESS TO HEALTH CARE SERVICES

Women's needs for and access to health care is different than for men. Women have greater needs for health care services at an earlier stage of their life than men, primarily due to women's reproductive health needs. There is also a growing need for women to access quality care and treatment for NCD. There are inequalities in women's access to comprehensive health care across their life course, due to a complex web of sources of inequality including poverty, poor education, lack of empowerment, weak health care systems and gender discrimination (Langer and Meleis et al. 2015). However, as women are often responsible for the health of their children, there are also opportunities through health care integration to encourage and allow

women to look after their own health while simultaneously seeking medical attention for their children.

Women are biologically more susceptible to certain diseases and may demonstrate or experience symptoms differently than men. There are also different social expectations of roles and responsibilities which expose men and women differently to health risks and their abilities to access health care and preventive services. However, there is also a great deal of variation of health risks and access to health care services among women, and among men. It is well known that social factors such as income and employment, level of education, age, living conditions, social safety networks, and ethnicity also play an important role in people's health status and access to health care services (World Health Organization 2011b). It has been found that unfavorable social conditions limit women's autonomy to seek health care, even when services are available. This is especially the case for migrant women, women living with disabilities and women from ethnic minorities due to discrimination, language barriers and provider bias, among other factors (Langer and Meleis et al. 2015). Hence, there is a great need to take these specific circumstances into considerations and ask explicit questions about women's and men's health situation and social conditions, in order to ensure that their health needs are being served (Clow, Pederson, et al. 2009).

There are a number of structural, social and financial health care barriers which makes it harder for women in need of care to obtain medical attention. The distance to the health care facility can delay or make access to care more difficult. Women's access to transportation and the cost of transportation are also factors effecting women's ability to seek health care. In many economies, women are less likely than men to have access to a private vehicle and more dependent on public transport. It might take longer time to access a clinic by public transportation, women might not have control of the financial means to cover the transportation and in some communities it might also be a safety and social concern for women to travel by themselves on public transportation (World Bank 2013). Services available closer to home or place of work at accessible at a time of day that is suitable to women's work schedule and family commitments are important factors to for women to seek timely diagnosis and treatment. When women have little control over their work schedule, it is more difficult to arrange medical appointments.

A study carried out by HERhealth in 34 export manufacturing factories in China, India, Indonesia, Mexico, the Philippines and Viet Nam found that more than 80 percent of the factory workers were women. The study found that when health care clinics were located away from the factory, women were less likely to take the time to visit the clinic, even if transportation was provided. In addition, if the line supervisors were not flexible in letting the factory workers take time to visit the clinic, workers were even less inclined to seek medical attention from the clinic. In particular, when the production pressure was high, women tended to miss routine medical check-ups, such as an antenatal visits during pregnancy (Business for Social Responsibility 2006). Hence, it is of great importance that employers supports and facilitates that employees can access care by allowing a certain degree of flexibility in the work schedule to accommodate medical visits.

According to some estimates, 70 percent to 90 percent of informal workers have no or few medical benefits or health insurance (Business for Social Responsibility 2006). As their employment is unregulated, some are not granted sick days, or they might be afraid of losing their job if they ask for sick leave. Accessing health care requires leaving work, which reduces the income of informal workers and adds health care expenses, which many have to pay out of

pocket for. This prevents many from accessing services, which exacerbates health conditions that could have been prevented, often at reduced costs, if services had been available.

Many migrant workers, from rural areas to cities, or from one economy to another are vulnerable and have health care needs that are not being met. Migrant workers experience deterioration of their health due to poor and dangerous working conditions, substandard living conditions, exploitation and high levels of stress and risk for injuries and diseases (World Health Organization 2010a). There is a high level of mobility, seasonality and work insecurity in the informal sector. The above mentioned HERhealth study found that a high proportion of the women working in the manufacturing factories in the six countries were young migrant workers. For example, in a garment factory in Viet Nam, 93 percent of the 5,600 workers were women, 80 percent of the women were migrant workers and 90 percent were between 20 and 26 years old. Due to the poor working and living conditions, and limited access to health care, the young, migrant women from across the six countries in the study were found to suffer from anemia, poor hygiene, inadequate pre- and post-natal care, sexual violence, and exposure to infections and illness, including HIV/AIDS, hepatitis B and C, and tuberculosis (Business for Social Responsibility 2006; Yeager 2011). Lower worker productivity due to these illnesses impacts the economy. The World Bank notes that globally, \$50 billion in GDP is lost due to iron deficiency anemia's effect on worker productivity. Additionally, the World Bank found that some economies see a four to seven percent drop in GDP due to the impacts of tuberculosis on workers.

Migrant workers are faced with additional barriers to access health care including their irregular immigration status and lack of health care coverage, their socio-economic status, limited social safety net, language barriers, the threat or fear of wage or job loss, and stigma and social marginalization. Illiteracy limits the appropriateness of written information as a mean to provide educational or preventive advice and information about how to access preventative health care (Donohoe and Hansen 2003). Studies from the United States have found that adult immigrants with limited English proficiency and their children are much less likely to have insurance and a usual source of care, have fewer physician visits, and receive less preventive care than immigrants from English speaking economies (Escarce, Derose and Lurie 2007). To mitigate health risk for migrant workers, some economies of migrant origin that heavily rely on remittances, such as the Philippines and Mexico have put in place insurance schemes for their departing migrant workers.

Cultural and religious norms can raise barriers to access to health care services. Social, cultural, or religious taboos can make medical care from male service providers inappropriate, which limits women's access to care, particularly in rural locations where few female health professionals might be available. If the health care provider does not speak the client's language or use an interpreter or is unaware of cultural differences, the quality of care can also be compromised (Anderson and Scrimshaw et al. 2003).

Although gender sensitivity training is an emerging field for health care professionals, a study from the Netherlands found that there was room for improvement. The study developed separate treatment guidelines for men and women for three common diseases or conditions found in women (depression, angina pectoris and urinary incontinence) and provided general practitioners (GP) with training and follow-up. However, the study found that the GPs were reluctant to ask questions in the treatment guides related to socioeconomic status, sexual history and abuse (Celik and Lagro-Janssen et al. 2008). The GPs found it difficult to bring up sexual or domestic violence issues with the patients, especially under time pressure. One study

participant said: “I was afraid of getting into a subject and stirring things up, knowing that I only had 10 minutes, which is not enough time to deal with it.” Some found the attention to gender issues as an additional burden to their already heavy workload, which could not easily be integrated into their already existing ways of caring for their patients. Another GP said: “In family practice doctors do what needs to be done and the other things get moved to the bottom of the pile. I think it is very normal that a family doctor always has to prioritize what to get done first”. Hence, the study found that there was a level of skepticism in integrating gender sensitivity into the interactions with their patients, but there were also structural issues which made it harder to implement the guidelines. The doctors knew that more time than the allotted 10 minute period was required for asking questions about sexual abuse and domestic violence. With a heavy workload, it could be difficult to make time to build rapport with patients to be able to engage in more sensitive, but gender relevant lines of conversations. However, without the additional time, there might be misdiagnoses and lower quality care.

One of the greatest barriers to access health care is out of pocket expenditure, which has been shown to be a higher burden for women than for men. Many women earn less money than men and women in many societies have less control over the family’s finances. With less financial resources at their disposal, access to affordable health care is a serious concern for women. Women who are employed and earn a salary have more say in how the money is spent than women who do not work (Head and Zweimueller 2014). It has also been shown that women who earn an income invest more in their family’s health, education and nutrition (McKinsey & Company 2012a).

Globally, there is a wage gap between men’s and women’s earnings, but the magnitude of the gap varies greatly between economies (International Labour Organization 2015). The wage gaps arise due to multiple factors including human capital and labor market characteristics, but also wage discrimination against women. Studies have found that women who are mothers earn less than women who are not mothers (International Labour Organization 2015). Migrant workers and workers in the informal economy earn also less than their national and formal economy counterparts.

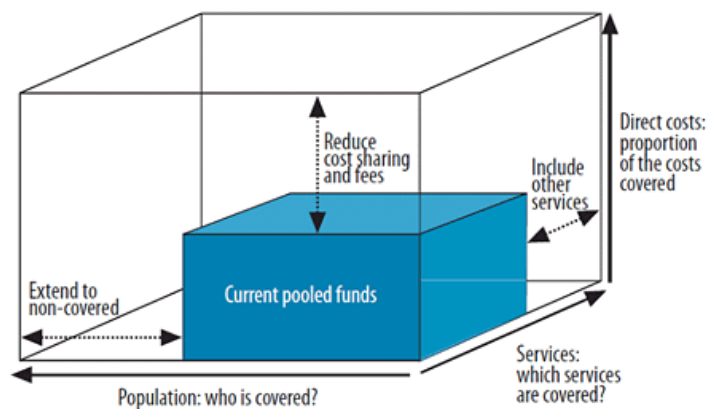
Most economies charge some form of user fees and out of pocket payments for health services. However, burdensome fees and payments reduce the access to care, particularly for women and the poor. Women’s out-of-pocket payments have been found to be systematically higher than that of men, in part due to the high financial burden of reproductive health services (Ravindran

The HERProject partners with factories and nongovernmental organizations to provide tailored training and support to improve the awareness and access to health care services for women factory workers in 13 economies in Asia, Latin America and Africa. The project provides training to female factory workers, line supervisors, clinic nurses, and human resources staff on relevant topics including sexual and reproductive health, sexual harassment and abuse, mental health and workplace safety. The program includes also efforts to improve access and awareness of health services either by improving factory-based clinics or by creating links with public or private hospitals and clinics. The program, which has served more than 250,000 low-income workers, many of them migrant workers, has increased health behaviors and enhanced access, awareness and uptake of health services for the women. For instance, there’s been a significant increase in the use of health care clinics (from 42 percent to 72 percent); use of family planning products (from 40 percent to 60 percent) and awareness that HIV is preventable (51 percent to 89 percent). The women have also reported a greater sense of empowerment over their own health and greater work satisfaction. In addition, businesses have found that when their female workers have greater health awareness and access, absenteeism, staff attrition and production errors have been reduced. The assessment of the return on the health investment in one factory found it to be as high as \$4:\$1 (Yeager 2011).

2011). Other contributing factor may be the higher prevalence of a number of chronic diseases and mental health problems among women. More women than men delay or forgo medical care due to financial obstacle of accessing care. For instance, studies from the USA have shown that women tend to earn less than men (American Association of University Women 2015); spend a greater proportion of their income on medical care, and are more likely to struggle to pay medical bills than men (Long, Stockley and Shulman 2011). Similarly, a study from New Zealand found that women were significantly more likely to defer their own primary health care, including doctor's visits, the purchase of medication or dental visits than men were because of cost (Crampton and Jatrana 2012). A comprehensive review of user-fees found that fees have a detrimental effect and decrease utilization of health services, unless there is a concurrent increase in the quality of the services offered (Lagarde 2011).

The lack of financial risk protection from health care costs drives millions into poverty as they struggle to pay for health care. In 2005, an estimated 80 million people in the Asia Pacific region faced catastrophic health expenses, and 50 million people were impoverished because of out-of-pocket payments associated with poor health status and use of health services. High health care costs drives millions away from needed health care due to inability to pay and fear of catastrophic expenditure. According to a WHO study from 2009, impoverishment due to health care costs in China and Viet Nam are among the highest in the world (World Health Organization 2009).

In 2010, the World Health Organization emphasized that user fees and other direct payments is the biggest obstacle for access to health care, especially for vulnerable population groups. Instead, the WHO strongly recommended that economies move towards universal coverage by financing their health systems primly through prepayments (mainly through taxes and health insurance schemes) (World Health Organization 2010b). Universal health coverage calls for the progress in three dimensions: (1) Provide financial



Three dimensions to consider when moving towards universal coverage

protection to the population by reducing out of pocket costs; (2) expansion of coverage to a wider population; (3) improvement of quality and quantity of care provided at no or a subsidized cost (World Health Organization 2010b). These are illustrated in the graphic above from the World Health Organization. For women's health it is important that the services provided include sexual and reproductive health, as well as noncommunicable diseases. Mexico, Thailand and Indonesia are example of economies that that more recently have moved towards greater universal coverage. These economies have seen an increase in available services, specifically reproductive health, and a reduction in catastrophic health expenditures and medical impoverishment.

In the delivery of health care services, there are professional, organizational and policy factors which affect the level of gender sensitivity in the health care practice. By applying a gender lens, health professionals are competent to perceive existing gender differences, including social and cultural differences, and to incorporate these into their medical decisions and actions (Celik and Lagro-Janssen et al. 2011). Clinical practice guides need to contain specific diagnoses and

treatment strategies for men and women when there is evidence that men and women have different symptoms or treatments needs. However, a study reviewing gender sensitivity in health care practices found that experts on gender and medicine were underrepresented on guideline committees (Celik and Lagro-Janssen et al. 2011). Moreover, several studies have found that developing and disseminating new treatment guidelines is not sufficient to bring about change in medical practice (Celik and Lagro-Janssen et al. 2009). Health care practitioners need to have an understanding and appreciation for gender sensitivity practice for the implementation of the guidelines to be effective. For instance, when there is certain level of gender awareness in the organizational culture of a care or treatment facility, practitioners become more aware of the issues and the step to also apply a gender lens in their work with their patients or clients is easier and appears more natural. For instance, in an organizational culture where there is a greater awareness and practice of creating a working work/life balance for the staff, the practitioner is more conscious of inquiring about family responsibilities which might affect a female client's recovery.

Although gender sensitivity training is an emerging field for health care professionals, a study from the Netherlands found that there was room for improvement. The study developed separate treatment guidelines for men and women for three common diseases or conditions found in women (depression, angina pectoris and urinary incontinence) and provided general practitioners (GP) with training and follow-up. However, the study found that the GPs were reluctant to ask questions in the treatment guides related to socioeconomic status, sexual history and abuse (Celik and Lagro-Janssen et al. 2008). The GPs found it difficult to bring up sexual or domestic violence issues with the patients, especially under time pressure. One study participant said: *"I was afraid of getting into a subject and stirring things up, knowing that I only had 10 minutes, which is not enough time to deal with it."* Some found the attention to gender issues as an additional burden to their already heavy workload, which could not easily be integrated into their already existing ways of caring for their patients. Another GP said: *"In family practice doctors do what needs to be done and the other things get moved to the bottom of the pile. I think it is very normal that a family doctor always has to prioritize what to get done first"*. Hence, the study found that there was a level of skepticism in integrating gender sensitivity into the interactions with their patients, but there were also structural issues which made it harder to implement the guidelines. The doctors new that more time than the allotted 10 minute period was required for asking questions about sexual abuse and domestic violence. With a heavy workload, it could be difficult to make time to build rapport with patients to be able to engage in more sensitive, but gender relevant lines of conversations. However, without the additional time, there might be misdiagnoses and lower quality care.

3. SEXUAL AND REPRODUCTIVE HEALTH

Women's access to and awareness about comprehensive sexual and reproductive health services are critical for women's health and their abilities to participate in the workforce. Access to affordable sexual and reproductive health services leads to greater educational and employment opportunities for women and create greater economic security for women and their families.

Women's ability to plan whether, when and how many children they wish to have is an important factor for women to pursue education and enter, remain and advance in the workforce. Preventative care for women's reproductive health is also important for women to make informed choices about their health and to stay healthy. Sexual and reproductive health rights refers to the right of all couples and individuals to access safe and non-discriminatory sexual and reproductive health care services; to freely and responsibly decide the number, spacing, and timing of their children and to have the information and means to access the services to support their decisions (Asian-Pacific Resource & Research Centre for Women 2014). The UN Convention on the Elimination of Discrimination against All Women (CEDAW) guarantees women and men equal access to health care services, including family planning (Article 12) and the same rights to decide freely and responsibly on the number and spacing of their children and equal access to the information, education and means to enable them to exercise these rights (Article 16). All the UN-member APEC economies are signatories to CEDAW, although the USA has not ratified the convention (UN Women).¹⁰ However, many economies fall short of their obligations under the CEDAW due to political, financial, logistical and organizational reasons, as well as their limited ability of meeting the needs of vulnerable groups of women.

AWARENESS AND ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

In more recent years, there has been an increased awareness in the health community about the multiple, inter-related aspects of women's health during the course of a woman's life. The emphasis on a comprehensive view on women's health has broadened the concept of women's health to include sexual and reproductive health, communicable diseases such as tuberculosis, HIV/AIDS and sexually transmitted infections and noncommunicable diseases including common diseases such as cardiovascular disease but also diseases exclusive to women such as breast and gynaecological cancers (discussed in more details in chapter 2). Additional important issues, including gender-based violence (discussed in more detail in chapter 4) and women's access to mental health services (discussed in chapter 2) are equally important components of women's

¹⁰ Malaysia and Singapore have reserved their right to not apply article 16. Chinese Taipei is not a U.N. member and is therefore unable to be a signatory to the document, however it has a law in place to implement CEDAW, making the Convention provisions effective as domestic law.

health. The many inter-related aspects of women's health call for an increased level of awareness and access to gender-sensitive, comprehensive and quality health services.

It is vital that women are aware of maternal, newborn, child health, nutrition and sexual and reproductive health services throughout their life course. Pregnant women and women with infants have additional needs of accessible and good quality healthcare to ensure good maternal and child health. In addition, pregnant women and working mothers require additional considerations and accommodations in the workplace. As discussed in the first chapter on Workplace Health and Safety, some pregnant women require accommodations, such as more frequent breaks or alternative tasks to avoid heavy lifting for example to ensure a safe pregnancy. Moreover, as discussed in chapter five on Work/Life Balance, lactating mothers need adequate workplace accommodations to be able to return to work and continue breastfeeding.

There is a need for additional research on the relationship between women with postpartum depression and their postpartum employment. A recent study from France found that women who experienced postpartum depression at 4 months were equally likely to be back at work one year after childbirth than those who were not depressed, However, the study noted that financial or social pressures may compel women to return to work while still burdened with postpartum depression, which has implications for her health as well as her productivity at work (Wallace and Saurel-Cubizolles 2013). In addition, as noted in chapter two on Health Awareness and Access, women are faced with stigma and there is a lack of awareness of mental health services.

There are great inequalities in access to skilled maternal and new-born care across socio-economic groups as well as geographical areas. Hence, women from minority groups, economically disadvantaged women, and women who live in poor rural communities are faced with additional challenges accessing prenatal and postnatal care. Mexico provides a good example of how a comprehensive approach to health care has a significant impact on women's and young children's health. When Mexico introduced its universal health insurance scheme *Seguro Popular*, the government decided that a comprehensive approach to address women's health would be one of the initiative's top priorities. Prior to the launch of a program specifically addressing maternal health and the health of children under five, the differences of maternal mortality within Mexico was huge; the southern state of Chiapas had more than six times as many maternal mortalities as the northern state of Nuevo León. The program included increased budget allocations to expand the health care network and the availability of medical supplies. To strengthen the availability of skilled health care workers, obstetric nurses and traditional birth attendants were trained, particularly in response to the needs of women in indigenous communities. As a result of these measures, maternal mortality declined from 72 in 2000 to 58 per 100,000 live births in 2006, which is one of the lowest figures in Latin America (Frenk , Gómez-Dantés and Langer 2012). In addition, the gap between the states in the north and south was decreased.

In malaria endemic countries, such as Papua New Guinea and Indonesia, the most vulnerable population groups have the highest risk of contracting malaria and the least access to effective services for prevention, diagnosis and treatment. Malaria infection during pregnancy increases the risk of maternal and fetal anemia, miscarriage, stillbirth, low birth weight and neonatal death. In high-transmission areas, children under five years of age are the most vulnerable group. In addition, people living with HIV/AIDS have an increased risk of malaria infection, and migrants and mobile workers are more vulnerable to acquire malaria due to their limited access to prevention, diagnostic testing and treatment services. However, malaria interventions, notably

insecticide-treated mosquito net, are effective and relatively affordable.¹¹ Pregnant women can receive a prophylaxis referred to as intermittent preventive treatment in pregnancy which has been shown to reduce severe maternal anemia, low birth weight and perinatal mortality (WHO 2014b). However, this is an intervention that needs to be scaled up to reach more women in vulnerable populations.

Employee HIV/AIDS Program

Levi Strauss & Co.'s Employee HIV/AIDS Program provides employees and their dependents access to HIV and AIDS prevention, education, and comprehensive treatment and support services. The Program is available in 44 economies, including eighteen of the APEC economies. The program includes a Worldwide HIV/AIDS Workplace Policy, workplace education and reimbursement of testing, treatment, and care services. The benefits of the program are available to all employees who have been on active payroll for a minimum of six consecutive months, and their legal dependents (<http://hivaids.levi.com/>).

With HIV infection rates falling, the Asia Pacific region has made significant progress in detection, care and treatment. In 2012, about five million people (1/3 of them women) in the region were living with HIV/AIDS and about half were under treatment (UNAIDS 2013). However, despite progress, stigma and discrimination are a continuing challenge across the region. Integrating HIV/AIDS prevention and treatment services with services focused on the health of mothers, infants and children, as well as on nutrition and family planning improve the health of mothers and children.

Reproductive, maternal, neonatal and child health services represent the primary point of women's and children's access to the health system and when these services are integrated with HIV/AIDS and

STI prevention, care and treatment – the reach and coverage of women and children is greatly expanded and women gain more easily access to a broader range of health services. In addition, integration of services reduces social stigma and barriers to care and treatment (Church and Mayhew 2009).

Integration of services might include:

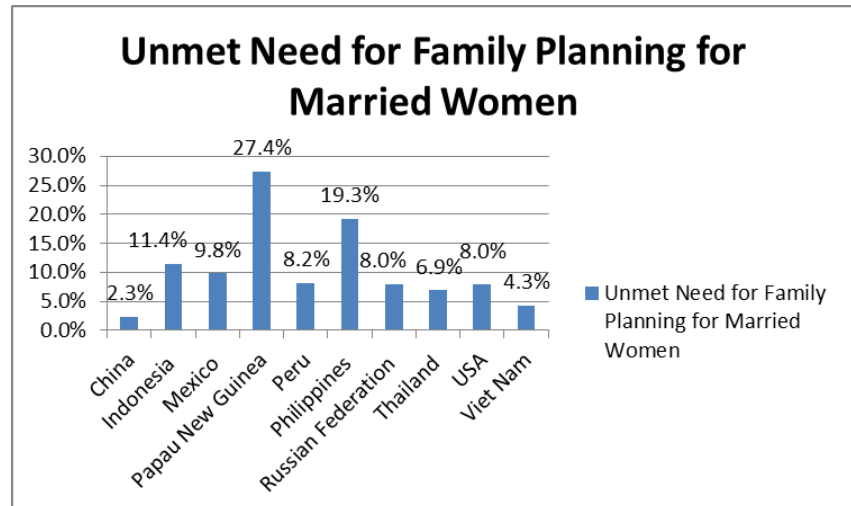
- **HIV Services:** Offer HIV awareness, counselling, testing, care and treatment services. Patient support groups to reduce stigma and support positive living strategies.
- **Family Planning Services:** Provide family planning awareness, counselling and services, post-abortion care as well as evaluations and treatments of sexually transmitted infections.
- **Antenatal Services:** Support pregnant women with antenatal care and assist in establishing birth delivery plans. Provide screening and treatment for anemia, STIs, tuberculosis, malaria. Offer nutritional assessments, counselling and support for women and deliver infant and child feeding counselling as well as water and sanitation counselling.
- **Childbirth Services:** Interventions to prevent maternal hemorrhage; the provision of skilled attendant at delivery and the availability of emergency obstetric care.
- **Postpartum Services:** Provide new-born care, breastfeeding support, new-born immunizations and postpartum services for women.
- **Infant/child services:** Offer immunization services, growth monitoring, management of common diseases and infections and nutritional assessment and support (Lindegren *et al.* 2012).

¹¹ International funding for malaria control has three folded in the last ten years globally, but the WHO estimates that funding still needs to be doubled to achieve global targets for malaria control.

WOMEN'S ACCESS TO FAMILY PLANNING SERVICES

Women's ability to plan whether and when to have children and access family planning services is connected to their own health; the health of their children; their abilities to pursue education, to increase their income and to participate in the workforce (Canning and Schultz 2012). Delayed childbirth and birth spacing is associated with an increase in women's and children's health, as well as women's education, earnings, and participation in paid employment. Access to family planning programs reduces the number of unintended pregnancies, and leads to more optimal birth spacing which improves maternal health and reduces the risk of premature deliveries and complications (UNFPA 2012).

One of the more rigorous and well-known studies on the effect of family planning and women's reproductive health and economic empowerment comes from a long-term, cluster controlled study from Matlab, Bangladesh. Over the course of almost 20 years, the maternal and child-health outreach program provided doorstep-delivery of contraceptives, pre-natal care, vaccinations, safe delivery kits and a variety of other health services to women in their homes. After almost 20 years of the intervention, child-to-woman ratios were 16 percent lower in villages with an outreach program than in the control villages which only had access to standard government family planning clinic services. The women in the villages with the outreach family planning program fared considerably better in a number of different aspects related to health, development and income than the women in the control villages. For instance, for the women in the family planning outreach villages the



under-age-five child mortality was considerably lower; the women's own physical well-being measured through their body-mass index was higher; access to water was better and they had more physical and financial assets than the women in the control villages (Canning and Schultz 2012). Moreover, women in villages with an outreach program reported monthly earnings that were 40 percent higher than were earnings in comparison villages, after controlling for age and schooling. In addition, wage earning women of childbearing age in these areas appeared to have been healthier and more productive than the wage earning women in the comparison area (Canning and Schultz 2012). Hence, easy access and control of reproductive health options enables women to improve her and her children's health and more productively engage in wage earning activities.

The relationship between the availability of family planning and women's participation in the workforce is rather complex and difficult to measure, and depends also on a host of related macro-economic and socio-economic factors including levels of education, opportunities for female employments, urbanization, industrialization and the cost of childcare. Nevertheless, for women, the ability to plan their pregnancies and stay in school longer to gain a formal education enables them greater career opportunities and long-term economic stability (Hasstedt and Sonfield, et al. 2013). Delayed childbearing, allows young women to pursue education and obtain

early work experience, which offers women a greater range of career opportunities. Adolescent motherhood has an impact on high school attendance. A study from Chile found that being a mother reduces girls' likelihood of attending and completing high school by between 24 and 37 percent (UNFPA 2012). Moreover, research from the US exploring historic data of the availability of the birth control pill found a 12 percent increase in the likelihood of college enrolment among young women who could obtain the pill, compared with those who could not. The same study found also that the dropout rate among women with access to the pill was 35 percent lower than among women without pill access (Hock 2008). In particular, women's ability to delay the birth of her first child has been found to contribute to her and her family's financial stability (Hasstedt and Sonfield, et al. 2013). Studies from the United States have shown that the narrowing of the gender gap in earnings is in part attributed to women delaying childbearing. Moreover, another study also from the US found that highly educated women in well-paying jobs experience the greatest economic benefit from delayed childbearing, as they often experience most wage growth early on in their career (Hasstedt and Sonfield, et al. 2013).

The availability and accessibility of family planning services and contraceptives is crucial for women to be able to determine if and when they want to have children, and to protect themselves from sexually transmitted infections. Despite progress throughout the APEC region in the provision of family planning services, there is still a gap between women's reproductive intentions and their access and use of contraceptives. Data from the World Health Organization's Global Health Observatory track the percentage of married women (or women in consensual unions) with unmet needs for family planning globally. Women with unmet need are those who are sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child (World Health Organization 2013b). The unmet needs for family planning for married women (or women in consensual unions) in the APEC economies with reported data in the Global Health Observatory are detailed in the graph above. As the graphs shows, there are over 10 percent unmet needs in Papua New Guinea (27.4 percent), the Philippines (19.3 percent) and Indonesia (11.4 percent).

Data on the unmet needs for family planning for women who are not married is not readily available. However, as discussed further below, the unmet need for unmarried women, in particular young women is estimated to be high (Sciortino 2010).

The availability and accessibility of contraceptives and family planning services is rather complex and is a function of a country's political commitment and convictions, regulatory and policy environment, financial and logistical capacity and the overall organization, coordination and integration of family planning in the health system. For instance, the decentralization of health services and procurements of drugs to local governments coupled with the scaling back of donor funding for family planning in the Philippines had negative effects on the procurement of contraceptives. A survey from 2007 found that a little bit less than half of the local governments considered family planning controversial or a low priority and did not use local funds to purchase oral contraceptives.¹² In the United States, most health insurance providers include contraceptives in their plans, but twenty of the fifty states allow religious or religious-affiliated employers to limit or refuse approved contraceptive drugs and devices as part of their coverage (Guttmacher Institute 2015). A large population-based analysis from the United States found that a significantly higher proportion of insured women than uninsured women used

¹² However, the situation is reported to have improved with among other things support from the UNFPA and the mobilization of local funds.

prescription contraceptives. Women without health insurance were 30 percent less likely to report using prescription contraceptive methods than women with health insurance (Culwell and Feinglass 2007). Interestingly, the study noted that being employed was significantly associated with increased levels of prescription contraceptive use. Although the study did not specify how the women obtained their health insurance, employer provided insurance is an important mean of obtaining health insurance in the United States.

Moreover, women from ethnic minorities, who live in rural areas, are migrants, poor, unmarried, or teenagers are at a disadvantage in accessing family planning. Women who are poor are less likely to use contraceptives. For instance, in the Philippines, 57 percent of women in poor households do not practice any family planning, while a little bit less than half (48.7 percent) of the women in nonpoor household do not use any birth control (Department of Health 2011). In Indonesia, which has a long history of effective population control and family planning, the public health care system's ability to target the poor is deemed insufficient. Family planning services have been found to be less accessible to the poor due to limited public resources, inadequate oversight over the procurement and distribution system, and the cost of accessing services (Sciortino 2010). In Peru, the government has initiated a number of laws, policies and programs over the last decades to enhance access to family planning services and commodities, especially for the poor. A review of the efforts found that increased availability of family planning service and the provision of free contraceptives increased contraceptive prevalence for all women in the short-term. Initially, there was an increased use of contraceptive among poor women and women in rural areas. However, after about five years, poor women's use of modern methods declined, while more women from wealthier socio-economic groups used the free family planning services. Poor women, especially in rural areas, decreased their use of modern contraceptives due to the reduction of accessible family planning facilities and contraceptive stockouts in rural Ministry of Health facilities and the levying of unofficial fees in public health centers. Even when services for the poor were available misinformation and public discrediting of modern methods affected women's interest in seeking family planning methods and services. To address the decline in modern method use among the poor and to improve access to accurate information, the Government instituted the use of conditional cash transfers and the expansion of a social insurance programs targeting the poor to increase access to modern family planning methods among the poor (Gribble, Menott and Sharma 2007).

A guiding principle for women's reproductive rights is women's choice and autonomy (Shalev 1998). In Indonesia, according to the Population Law, husband and wife have balanced and equal rights and responsibilities to decide the method of birth control (Harvard School of Public Health). It has been reported that this regulation is understood to mean that married women need their husband's consent before she obtains contraceptives. Moreover, a reproductive rights report found that some medical practitioners understood this provision as a prohibition on the provision of contraceptives to unmarried women (Amnesty International 2010; Center for Reproductive Rights 2012). Hence, this is an issue that needs further clarity as it appears like both married and unmarried women's reproductive rights are restricted.

There is less information about the unmet need for family planning for unmarried women. In part, this is a reflection of official norms and social beliefs that family planning is for married couples, and that contraceptives, especially condoms are for high risk groups for STIs such as sex-workers and men having sex with men (Sciortino 2010). However, as women are delaying marriage and the group of single women is growing, it is of great importance for women to have access to safe and reliable birth control methods and targeted reproductive health services. A study of eleven Asian Pacific economies including Indonesia, Papua New Guinea, the Philippines

and Viet Nam based upon data from the Demographic and Health Survey found that adolescent women age 15 to 19 have a high unmet need for contraception (Gray and Kennedy, et al. 2011). The study found that adolescent women in the region have lower use of contraception, poorer knowledge of family planning and less access to information and services than adult women. However, the study noted also that there was limited data on unmarried adolescent women and that further research is required to better understand the barriers married and unmarried young women face accessing reproductive health information and services.

4. GENDER-BASED VIOLENCE

Sexual violence both inside and outside of the workplace is detrimental to women's workforce participation. The affects are felt both immediately and overtime. Women in both the informal and formal sectors are affected by sexual harassment and intimate partner violence. Decreased productivity and increased absenteeism, as a result, affects the victims, companies, and economies.

SEXUAL HARASSMENT IN THE WORKPLACE

The term "sexual harassment" does not have a common definition agreed by all APEC economies although it has been defined by the International Labour Organization as a sex-based behavior that is unwelcome and offensive to its recipient.. It is believed to be widespread in both the formal and informal sector but the actual extent is hard to assess and assessments and studies report a wide range of incidents of sexual harassments. For example, 25 percent of women have been sexually harassed in their place of work (Australia Human Rights Commission 2014). There are several factors contributing to the challenges of assessing the prevalence of sexual harassment, including, different understandings and awareness of what constitutes sexual harassment and the applied research methods and quality of data. The methods of data collection and the design and content of the questionnaire affect the findings. Self-selection can show a higher numbers of reported incidents, while official larger data sets might suffer from under reporting. An accurate picture of workplace sexual harassment is therefore hard to gage, but majority of research find that sexual harassment in the workplace is a problem (International Labour Organization 2001).

Case Study: China

A 2013 study on sexual harassment of women factory workers in Guangzhou revealed despite having laws in place, many women were still violated both inside and outside the workplace, causing, in some instances, women to drop out of the workforce. Roughly 70 percent of respondents reported having experienced sexual harassment during their career and 15 percent of respondents quit their jobs due to the harassment. In addition to the main work space, female respondents reported harassment in the canteen, hallways, restrooms, and via calls and text messages (Sunflower Women Workers Centre 2013).

Certain groups of women workers tend to be at greater risk of being subjected to sexual harassment, notably girls and young women, domestic workers, women with little job security, migrant women and women in male-dominated occupations, as well as women in work environments where a large number of women are supervised by a small number of men (International Labour Organization 2001). Women working in nontraditional sectors are also at greater risk of sexual harassment. Specifically, women working in male-dominated industries such as construction, law enforcement, and the military are at a higher risk of experiencing sexual harassment (Foster and Vince 2009; Lonsway and Paynich et al. 2013). Employment in the service sector is heavily dominated by women. In jobs in hospitality, education, health care, and retail, women experience greater risks of sexual violence from their clients, patients, and students (WHO 2011c).

Sexual harassment influences women's performance and overall experience in the workplace. Victims of sexual harassment commonly suffer a range of physical and emotional symptoms, including nausea, loss of appetite, anger, fear, headaches, fatigue and anxiety, a sense of humiliation and powerlessness, depression and loss of motivation. A study from Malaysia noted that 40 per cent of the victims reported feeling stressed at work, while a quarter of them reported being less productive and effective in their work (ILO 2001). A recent study in Singapore found that more than 13 percent of workers who experienced sexual harassment "felt it affected the way they did their job. Respondents also used words like 'disgusted', 'frustrated', 'embarrassed', 'humiliated', 'uncomfortable' and 'insecure' to describe how the incident of sexual harassment made them feel (AWARE 2008)." Employees subjected to workplace sexual harassment are less productive at work and are more absent. Additionally, sexual harassment leads to workplace tensions, which in turn may impede teamwork, collaboration and work performance.

In addition, sexual harassment can also pose a threat to women's job security and possibilities to job advancements. A recent study found that 11 percent of workers in Singapore reported receiving threats that they would be fired or not considered for a promotion if they did not fulfill requests for a date or sexual acts (AWARE 2008). Furthermore, the study found that 12 percent of the workers surveyed "were concerned that they would lose their job or not be promoted if they took action (AWARE 2008). This poses a major threat in economies where there are no formal mechanisms to redress sexual harassment.

There are multiple obstacles for women to report sexual harassment including taboo around sexual harassment, fear that the report will not result in actions against the perpetrator and the lack of power vis-à-vis the perpetrator. Women fear that if they report the violations they experience, they will be fired, not taken seriously, or that nothing will happen. Hence, in some workplaces there are no incentives to report sexual harassment and women are in many cases forced to deal with it or quit their jobs. It appears that even when policies are in place to prevent and address sexual harassment, female workers aren't always aware of the policies or how to get help. Just 23 percent of respondents were aware of existing company policies on sexual harassment and who they would report it to (AWARE 2008). Women subjected to sexual harassment by their supervisors often lack power when the perpetrator is in a more senior position. Furthermore, there is a fear of losing one's income and economic freedom. A 2008 study from Singapore found that there is a taboo around sexual harassment, which is reinforced by the limited policies and procedures to respond to sexual harassment in the workplace (AWARE 2008).

Models for Success: Examples from Singapore

One way companies encourage victims to report sexual harassment without fear is to ensure that retaliation from the harasser is not a concern. Some companies in Singapore have policies that protect both victims and witnesses from retaliation and assure confidentiality throughout the reporting process. For example, Singapore Airlines workers who experience sexual harassment can send an email or make a call to a special account, which is answered by staff who look into the complaints. The staff are appointed and are required to not be associated in any way with the victim or alleged harasser.

McKinsey & Company in Asia noted in a recent survey that they have an ombudsperson who is responsible for addressing gender, discrimination, and harassment issues. All employees are able to discuss these matters confidentially with the ombudsperson, who is currently a senior woman at the firm (AWARE 2008).

VULNERABLE FEMALE MIGRANT AND MOBILE WORKERS

Women are more likely than men to hold jobs in informal or untraditional sectors, including migrant jobs. Migrant workers tend to be at a higher risk of experiencing sexual harassment and violence. This is due to a variety of factors, such as the work space, language barriers, lack of job security, and others. The ILO explains that, “Women migrant workers’ concentration in private homes and other unregulated venues rather than public workplaces can represent more vulnerability in terms of discrimination on gender, racial, ethnic, occupational and nationality grounds. They may also find themselves victims of exploitation, hazardous work conditions and psychological, physical and sexual abuse (International Labour Organization).” Domestic workers are at a greater risk due to the isolation and long hours often involved in their jobs (Rockefeller Foundation 2013, 10). These effects are seen in Thailand, where one study found that 14 percent of migrant domestic workers surveyed experienced unsolicited physical contact from an employer (Kayalaan 2008). Furthermore, violations against female migrant workers are generally more hidden and go unnoticed in comparison to male migrant workers due to the work environments women tend to be in. Women are often in more “invisible” positions or industries that lack strong labor inspection services, such as domestic and caretaker positions (International Labour Organization).

Migrant Workers in Viet Nam

A qualitative research study conducted in 2006 on gender-based violence among 155 Vietnamese women who migrated to Ho Chi Minh City and the surrounding areas from other provinces in Viet Nam for factory jobs found that migrant women were more susceptible to violence and less able to defend themselves from violence. Many of the female respondents reported that their fear of or experience of violence was detrimental to their work and prevented them from being able to concentrate. In addition, victims of gender-based violence reported experiencing anxiety that disturbed both their sleep patterns and their motivation to work, leading to diminished work performance. Some respondents also mentioned missing work entirely due to violence-induced injuries, which resulted in missed pay. Some victims of domestic violence attempted to use sick leave, but were reprimanded by their supervisors for doing so (International Organization for Migration 2009).

While it appears evident that harassment against female migrant workers is prevalent, there is nonetheless a lack of awareness of about sexual harassment and what the venues for recourse might be. This is especially the case for overseas migrant workers and rural migrants whose primary language may be different from the one spoken at their workplace. In South and Southeast Asia, a significant proportion of women working on agricultural plantations where sexual harassment is prevalent experience these barriers to stopping it (International Labour Organization 2001).

Sexual harassment experienced by women in insecure jobs has implications for their status of employment. Since informal sector jobs tend to lack stability and security, they are targets of sexual harassment by supervisors responsible for renewing contracts (Rockefeller Foundation 2013, 10).

INTIMATE PARTNER VIOLENCE

The World Bank in the 2014 Women, Business, and the Law report defines domestic violence as “gender-specific violence commonly directed against women, occurring in the family and interpersonal relationships. Interpersonal relationships can include partners who do not live together or are not married. The violence can be in the form of physical, emotional or

psychological, sexual, or financial or economic abuse (World Bank 2014).” Roughly one of four women experience abuse by an intimate partner in their lifetime (Franklin and Kercher 2012).

The United Nations’ Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) defines “what constitutes discrimination against women and sets up an agenda for national action to end such discrimination (United Nations Women).” CEDAW defines discrimination against women as “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field” (United Nations Women). Since the adoption of CEDAW in 1979, 75 economies have passed legislation on domestic violence (Hallward-Driemeier, Hasan and Rusu 2013). Though many economies have legislation on domestic violence in place, domestic violence is still a major issue affecting women’s ability to participate and perform well in the workforce.

Domestic violence hurts women’s ability to work. There is substantial evidence that domestic violence has negative psychological impacts (World Health Organization 2013a), which diminishes women’s workplace performance. Women who experience domestic violence tend to be less productive at work (Chappell and Di Martino 2006). Firms suffer from this diminished productivity as well. In a recent study, Justice Canada reported that employers in Canada lose \$77.9 million annually as a result of domestic violence (Zhang et al. 2012). Despite the impact of domestic violence on companies, most do not make addressing domestic violence a high priority. A 2007 study by the Corporate Alliance to End Partner Violence found that just 13 percent of corporate leaders thought that firms should play a key role in this regard.

Workers who experience domestic violence also tend to be absent from work. Firms also take a hit when women workers are often absent, as demonstrated in Peru. A recent study found that absenteeism due to domestic violence amounted to an estimated aggregate national cost to firms in Peru equal to 3.7 percent of GDP (Horna 2012). Additionally, it is estimated that 2 percent of GDP in Chile is lost from reduced productivity as a result of domestic violence (Duvvury et al. 2013).

Furthermore, domestic violence at home can sometimes follow women into the workplace. The partners of female workers can enter their workplace uninvited for the purpose of hurting their partner physically or psychologically. This unwarranted entry and subsequent violation can affect both the women workers directly experiencing it and their coworkers (Chappell and Di Martino 2006, 63-64).

While there is ample literature demonstrating the immediate influence of domestic violence on women’s workforce participation, it is also important to note the long term affects. A study that surveyed women living in a low-income neighborhood in Chicago, Illinois found that domestic violence can diminish the physical and mental health of women that is needed to remain employed and perform well (Lloyd 2002). The study found that, “Those who reported severe aggression ever in life also reported work-limiting disabilities (Lloyd 2002).” The wage income of domestic violence victims can also be affected (Lloyd 2002).

Not only does domestic violence affect women’s ability to stay in the work place, but a recent study shows an additional relationship between violence and workforce participation. When women enter the workforce, the household power dynamic changes. Further, when women work, they undermine their partners through the development of their own power and

relationships outside of work, resulting in violence at home (Crime Victims' Institute 2012). Data from ten economies included in the WHO Study on Women's Health and Domestic Violence shows that, "Compared to couples in which both partners work, couples where just the man works appear to experience slightly lower levels of IPV [intimate partner violence] in some settings... In some settings women who work when their partners do not may be at increased risk of IPV (Abramsky et al. 2011)." Violence is a way for men to reaffirm their masculinity, especially if their wife is employed and they are not.

5. WORK/LIFE BALANCE

In many economies, women face challenges in balancing caregiving, household responsibilities, and employment. The provision of wellness programs, paid sick and holiday leave, pregnancy discrimination, parental leave, and flexible schedules affect women’s ability to participate in the workforce. Supportive programs and policies in these areas can not only help women stay in the workforce while they are raising a family, but also advance in their jobs.

PREGNANCY DISCRIMINATION IN THE WORKPLACE

In many APEC economies, women face pregnancy discrimination in the workplace. A 2014 ILO report noted that, “Of the 165 countries with available information, all but 20 had explicit prohibitions against discrimination during pregnancy, leave and/or an additional prescribed period.” (International Labour Organization 2014) Mexico and Brunei Darussalam were two of the 20 countries listed without any explicit prohibition against pregnancy discrimination.

Pregnancy discrimination can be largely driven by stereotypes. “Compared to other workers, pregnant employees are, on average, viewed as less competent and committed to their job, which is presumed to result in increased absenteeism and quitting.” (Bornstein 2011; Masser, Grass and Nestic 2007) It is not uncommon for employers in some economies to require female workers to take pregnancy tests. Just 47 of 141 economies (for which information is available) ban pregnancy testing in the workplace or have legislation in place that explicitly prohibits discrimination in access to employment based on pregnancy, maternity, family responsibilities or sex. The only APEC economies included in these 47 economies are Chile, Republic of Korea, Peru, and Russia (ILO 2014).

Examples of Pregnancy Discrimination in APEC Economies

United States	Pregnancy-related discrimination claims have increased by 35 percent in the last 10 years (ILO 2012a).
Republic of Korea	A poll given by the job portal Incruit showed that one-third of pregnant female employees did not take maternity leave due to fear of discrimination and seven percent were required to resign after utilizing maternity benefits (ILO 2014).
Australia	There are more pregnancy discrimination complaints than any other types of discrimination (Carter 2013).

Some pregnant women are able to work through to the last month of their pregnancy and many women need accommodation. The National Women’s Law Center in the United States notes that, “When a woman worker is already seen as an outsider, her pregnancy and any requests for changes in her job related to the pregnancy can be taken as further evidence that the job is inappropriate for a woman, leading employers to refuse to make accommodations (National Women’s Law Center 2013).” When these accommodations are not provided, pregnant women

often have to use their leave time, leaving little time for after childbirth want to spend time with their newborn (National Women's Law Center 2013).

SICK LEAVE AND PAID TIME OFF

The United States and Korea are the only economies of the 21 APEC economies where workers are not entitled to paid sick leave (World Policy Forum 2015a). In the United States, where provision of sick leave is not required, low-wage and part-time workers (who are predominantly women) are less likely to have paid sick time; indeed, a U.S. Congress Joint Economic Committee report in 2010 noted that two-thirds of low-income workers in the United States making \$10.63 per hour or less are not entitled to paid sick days. And the industries dominated by female workers, such as manufacturing and food service, are the least likely to offer paid sick leave. The same report noted that nearly three-quarters of child care workers (72 percent) and food service workers (73 percent) in the United States are not offered paid sick leave (U.S. Congress Joint Economic Committee 2010).

Throughout APEC economies where paid sick leave is mandated, however, it is still not available to the large segment of the workforce in the informal sector. In Asia, women account for 76 percent of all unpaid work and 43 percent of informal employment (ILO 2013b). Hence, though women are only a small portion of the workforce, they make up the majority of the workforce in types of employment where paid sick leave is less likely to be offered, creating a divide between men and women's access to sick leave.

The provision of paid sick leave (or lack thereof) can affect performance at work. Paid sick days are vital to the health of employees themselves—without them, employees may hesitate to stay home from work and not see a doctor when necessary, causing them to bring contagious illnesses to the workplace and reducing both the productivity of themselves and others. When an employee is sick, they cannot perform their best (Earle, Hayes and Heymann, 8). Therefore, it is important that women are able to access jobs that offer paid sick leave so that they are in their best possible health and can focus on excelling in their work.

Women use more sick leave than men and are likely to use the leave to take care of other family members (Morton 1995). This puts women in a difficult position of choosing between a paycheck and taking care of their sick children. Women often must forgo pay or even risk losing their job in order to stay home and tend to sick children. For women working in the informal sector or as migrant workers, who already experience less job security, the risk of losing their job is even greater.

Paid leave time is important for all workers. When workers have time off, they are more productive when at work. A study of U.S. employees found that those who use paid time off are more productive, focused, and dedicated. The use of paid time off reduces stress and allows employees to return to work feeling refreshed. In a survey of manager-level employees in the United States, 75 percent reported feeling recharged and 50 percent reported feeling more focused when returning to work from paid time off (Oxford Economics 2014, 14-16).

The provision of paid annual leave also affects employees' relationships. For workers with families, the length of allotted annual leave time can influence how much time a family can spend together (ILO 2012b). In a survey of U.S. employees, 59 percent of respondents reported that paid time off improved their family lives (Oxford Economics 2014, 15). Annual leave entitlement averages vary worldwide—137 economies mandate paid annual leave, and 121 of those

guarantee a minimum of two weeks annually (Earle, Hayes and Heymann, 3). Furthermore, a required day of rest per week is mandated in 126 economies (Earle, Hayes and Heymann, 3).

Annual leave entitlements differ greatly in part-time work. The U.S. Bureau of Labor Statistics found that nearly twice as many women as men worked part time in 2014. During that year, 9.8 million men worked part time in the United States, while 17.7 million women worked part time. Thirteen million of those women worked part time for “noneconomic” reasons such as to provide child or elder care and to perform household responsibilities (U.S. Department of Labor Bureau of Labor Statistics 2015). In economies such as the United States where there is a surplus of mothers needing flexible schedules to balance household and childcare duties, there is less of an incentive for employers to provide competitive wages and superior benefits. The supply of labor is high, so there are limited incentives for employers to provide excellent benefits to attract workers (Schulte 2015). The Families and Work Institute and the Society for Human Resource Management found that just one-third of 1,000 U.S. companies surveyed provided paid vacation days to part-time workers (Schulte 2015). And because part-time work is dominated by women, they are disproportionately affected by the lack of leave benefits.

Though there is some data available on sick and annual leave and its effects on women’s workforce participation, there is a lack of data across the APEC economies. There are ample opportunities for more targeted, economy-specific research in these areas.

MATERNITY, PATERNITY, AND PARENTAL LEAVE

Parental leave, both maternal and paternal, is a major factor in women’s ability to participate in the workforce. Of the 21 APEC economies, the United States and Papua New Guinea are the only economies that do not offer paid maternity leave (World Policy Forum 2015b). However, none of the APEC economies have ratified the ILO’s Maternity Protection Convention of 2000 (International Labour Organization 2000), which “sets out a number of protective policies, including 14 weeks of leave at a rate of pay at least two-thirds of previous earnings, paid by social security, public funds or in a manner determined by national law and practice where the employer is not solely responsible for payment (National Organization for Women 2014).” Additionally, a 2010 ILO study notes that the Asia-Pacific economies have especially low compliance with ILO standards on maternity leave, including the period of leave and the benefits provided. The report also noted that while provision of maternity leave is required in many economies of the Asia-Pacific, the actual enforcement is uncertain (International Labour Organization 2009b).

According to a 2003 OECD report, public expenditures on childcare averaged 0.7 percent of GDP in OECD countries. Public expenditure was relatively low in Japan (0.3 percent), Spain (0.4 percent), the United States (0.5 percent), and UK (0.5 percent), but was relatively high in countries where women’s employment rates tend to be higher, such as Denmark (2.7 percent), Sweden (1.9 percent), and France (1.3 percent) (Goldman Sachs 2010).

Parental leave can affect female employment rates, which are higher in economies where it is easier for women to work and have children. “Research shows that in countries where it is relatively easy for women to work and have children, female employment and fertility both tend to be higher (Daly 2007).” The OECD notes that there is a gap in employment rates for men and women both with and without a child. The gap is larger for women with one child and widens with each additional child (Daly 2007). Additionally, the presence of supportive parental leave policies is shown to have an effect on women’s workforce participation. This effect is evident in the United States, which lacks supportive policies for paid parental leave, part-time

work, and childcare, especially when compared to European countries. A study by Cornell University notes that the roughly one-third of the decline in female workforce participation in the United States from 1990 to 2010 can be attributed to this void in policy. They note that, had these policies been in place, the rate of women's workforce participation would have been approximately seven percentage points higher by 2010 (Flores 2014).

In 2006, in an effort to increase women's workforce participation in Chile, the government established the *Crece Contigo* program, "which provides free childcare for the most vulnerable 40 percent of the population." Between 2006 and 2009, 3,500 centers were opened, which provided free childcare for 70,000 infants (ILO 2012b).

Cultural norms and expectations in many economies can dictate or influence maternity and paternity policies for many employers. Employers sometimes dictate expectations around child care and leave, often providing benefits but discouraging men and women from utilizing the benefits, as evident in Japan (Dalton 2015). In addition, women are sometimes hesitant to utilize the maternity

leave when provided, as workplace culture and employer may place pressure or make them fear loss of their job. In response to this, many economies, such as Malaysia, have put in place national legislation to that prohibits female employees from being fired while on maternity leave (Boston College Global Workforce Roundtable 2007).

Weak or no childcare policies can force mothers to leave the workforce for a variety of reasons. First, some women transition from formal to informal employment, as seen in Mexico and Viet Nam (Earle, Hayes and Heymann). Second, if paid maternity leave is too short, mothers may drop out of the workforce instead of returning to work (OECD 2011, 129). Pamela Stone, a sociologist at Hunter College who studies gender and employment, has noted that in the United States, "For low- and middle-income families, it literally isn't worth going to work if the cost of child care exceeds what you'd bring in, and that calculus is exacerbated in an economic downturn" (Flores 2014).

The effects of women leaving the workforce when they have a child, whether due to lack of supportive maternity leave policies or other reasons, are apparent as women grow older and attempt to re-enter the workforce. When women go for leadership positions, they are often viewed as "past their peak" or "past their prime" and face difficulty in securing senior roles (Muhlbauer, Chrisler and Denmark 2015). Of 146 economies where information is available, just 64 have legislation in place giving women the right to return to the same position or an equivalent position paid at the same rate after maternity leave (ILO 2014).

But strong maternity and childcare policies retain female employees. Strong parental policies encourage women to work before they bear children so that they are eligible for maternity leave when they need it. Additionally, it encourages women to stay in the workforce rather than having to re-enter the workforce at a later age, which poses additional challenges as previously noted (Daly 2007). Further, women remain in the workforce uninterrupted, increasing their chances of attaining high paying jobs (Waldfoegel 1998).

Even if women participate in the workforce, parental leave policies can affect their ability to progress in the workplace. With supportive and strong policies for both parents, the childcare responsibility can be more equally split between them, which allows the mother a more equal chance at career progression as compared to her male counterparts (World Bank 2012, 20). Additionally, with supportive childcare policies, researchers argue that women in Asia would be better able to balance home and work responsibilities and therefore to rise through the ranks to middle- and senior-level jobs (Tuminez 2012, 57). Furthermore, when workers feel

supported, they have higher levels of job satisfaction that, in turn, increase their commitment to their company's success (Earle, Hayes and Heymann, 6)."

Mandating the provision of parental leave, however, can have adverse effects. If maternity leave programs are not publicly financed or subsidized, employers could be discouraged from hiring women. The People's Republic of China has made an effort to address this issue through social insurance-funded maternity leave. The method of implementation of parental leave and child care policies should be cautiously considered in each economy (Asian Development Bank 2015).

While maternity leave is crucial, paternity leave also affects women's workforce participation. "No international standards exist concerning paternity leave, but it is becoming increasingly common in national law and in enterprise practice." (ILO 2012b) None of the South Asian economies covered in the 2014 Women, Business, and the Law report provides paternity leave (World Bank 2014). Where paternity leave is not offered, many fathers are forced to use emergency leave or family leave. If paternity leave is provided, it is generally up to 15 days (ILO 2012b).

SUPPORTIVE POLICIES FOR BREASTFEEDING

Women may feel more comfortable returning to work after maternity leave if their employers have friendly nursing policies. The Work, Family, and Equity Index indicates that, "At least 107 countries protect working women's right to breastfeed; in at least 73 of these the breaks are paid." In 100 of these countries, women are entitled to a minimum of one hour for breastfeeding (Earle, Hayes and Heymann, 3). Women are less likely to start breastfeeding and continue to nurse once they re-enter the workplace: just 25 percent of working women with children under the age of one concurrently work and breastfeed for at least one month (Zinn 2000).

Breastfeeding has positive health effects on both mothers and children (U.S. Department of Health and Human Services 2011). When women breastfeed, their children are generally healthier and are receive stronger protection from infections. This allows mothers to remain in the workplace, taking less sick days and consequently reducing their absence from the office (Department of Health and Human Services, Office on Women's Health 2000). A study that looked at two U.S. corporations found that single-day absences to tend to sick children occurred more than twice as often for mothers of infants who were given formula, versus infants who were breastfed (Cohen, Mrtek and Mrtek 1995). Further, women employed in low-wage jobs experience a greater degree of difficulty in combining work and nursing (Kimbr 2006, 19-26). These workplaces tend to cater less to breastfeeding mothers (Cricco-Lizza 2005).

Are employers required to provide break time for nursing mothers?	
Yes	No
Chile China Indonesia Japan Korea Mexico New Zealand Papua New Guinea Peru Philippines Russia Chinese Taipei United States Viet Nam	Australia Canada Hong Kong Malaysia Singapore Thailand
2014 Women, Business, and the Law Report	

FLEXIBLE SCHEDULES

In many societies, women are expected to fulfill the caregiver role. They are expected to balance both household responsibilities, including looking after children and elderly family members, with employment (Asian Development Bank 2015). Flexible work schedules for working women are imperative to helping them achieve this balance. Without flexible hours, women face challenges retaining their jobs. Those who do stay in their jobs find that inflexible schedules hinder their performance and chances of being promoted.

A 2009 study on work-life conflict in Canada noted that workers who report high levels of conflict between their job and family responsibilities experiences up to 12 times as much burnout and two to three times as much depression as employees with better work-life balance (Goldman Sachs 2010), hindering their ability to do their best and excel in their position. A McKinsey & Company survey of business leaders worldwide asked participants to rank the challenges women face in moving into senior positions and the top response was the double burden of balancing work and domestic responsibilities. Furthermore, McKinsey notes that this double burden especially affects Asian women due to both strong cultural norms and shortage of government support in childcare. Finally, many company cultures favor and reward employees who are available at any time (ILO 2012b). Long hours are often viewed as a way for employees to prove their dedication. Even if employees can earn overtime pay, these hours may not necessarily be compatible with family schedules. Additionally, in many situations, overtime work is unexpected, and therefore mothers have a difficult time securing childcare with such little notice (Asian Development Bank 2015). In these environments, it is even more difficult for women balancing both work and domestic responsibilities to advance when up against their male counterparts (Asian Development Bank 2015).

In 2011, the Lee Kuan Yew School of Public Policy implemented two surveys¹³, each of 50 female leaders of diverse professional backgrounds throughout Asia, asking participants to select the three greatest challenges to women's ascension to leadership in Asia. In both surveys, the top-ranked challenge was constraints of family life, followed by organizational policies and practices favoring men over women. Balancing home life responsibilities and work remain a challenge in women's ability to rise in the workplace (Tuminez 2012, 51). Despite women's ability to balance work and family life, employers sometimes make hiring and promotion decisions based on the assumption that a woman's family will impose a burden on her work and consume her time and energy, preventing her from exceling and therefore moving up (ILO 2015).

Another factor contributing to decreased productivity and lessened chance of

Supportive Policies Benefit Everyone – not just Moms. A 2009 Cabinet Office survey in Japan concluded that companies with programs dedicated to supporting working mothers in their work/life balance, partnered with objective evaluation systems, saw higher profit margins than companies that lacked these programs. Of the companies surveyed, 57 percent with these policies in place experienced a 10 percent increase in their per-employee recurring profit margins during FY3/05-FY3/08, versus a 48 percent increase in firms without these programs (Goldman Sachs 2010).

¹³ These surveys took place February 23, 2011, at an NUS Women's Leadership luncheon and April 2, 2011, at the Asia Society Women Leaders of New Asia Summit in Singapore.

promotion is women's spare time. In many economies, women are expected to take care of most if not all household duties such as cooking, cleaning, and caring for children. This leaves women with even less free time for them. When they are racing around constantly, juggling many different responsibilities, they have less down time and aren't able to rest as much (Asian Development Bank 2015, 12). Additionally, they have less time to exercise, which can negatively affect their health and in turn, performance at work (Bammer and Strazdins 2004).

Due to lack of flexibility in many salaried jobs, mothers are choosing jobs that are more family-friendly, while men are remaining in the workforce (working full time) (World Bank 2012, 20). These jobs tend to be part-time and often lower-paying. To that effect, there is a motherhood wage gap, which measures the wage gap between mothers and nonmothers (ILO 2015). Additionally, part-time and flexible employment often offers less of a chance for promotions. Women working part-time tend to be less available for networking in professional settings, which hurts their chances of moving up. Additionally, the opportunities to transition from part-time back to full-time employment are limited. The 2012 World Development Report noted that, "While part-time and flexible employment should be available, part-time work should not be used in ways that reinforce existing employment segregation and ultimately reinforce gender roles for care responsibilities (World Bank 2011, 223-224)."

This shift to nonregular jobs is present in Japan and Korea. A current IMF working paper noted that "Currently, long and inflexible working hours associated with full-time employment prevent well-qualified Japanese and Korean women from taking up regular employment. The alternative is to take up nonregular low-skilled jobs with no security and benefits despite their high potential. In contrast, Nordic women and men are given the option of different working hours depending on their needs (e.g., Norway). What is more important is that a part-time employment in Nordic economies does not compromise the benefits and promotion prospects. Rather, a Nordic part-time work is a manifestation of flexicurity (flexibility and security) that gives women more options depending on the stage of the life cycle without career breaks (Guo and Kinoshita 2015, 18)."

Further, it is sometimes not an option whether women want to scale back their hours or not: Out of the 141 economies examined in the *2012 Women, Business, and the Law* report, 41 economies restrict the hours women are allowed to work. Hours at night are often restricted to protect their safety, but consequently limit the jobs they are eligible for (World Bank 2012, 3). The *2012 World Development Report* noted that, "In many countries, part-time work is not

Case Study: Shell Malaysia

The Boston College Global Workforce Roundtable conducted a study on flexible work arrangements in 2007 with seven companies in the Asia-Pacific region. The study interviewed Shell Malaysia, which offered a prime example of flexible work arrangements. Shell has a formal policy on this, which offers flextime, telecommuting, working beyond normal retirement age, part-time hours, and extended leave. More specifically, Shell Malaysia put in place a charter, which includes a framework for each employee and team to establish their own work arrangements. The charter encourages employees to talk openly with their supervisor about maintaining a strong balance between work and personal responsibilities. It goes as far as to specify that work/life balance should be maintained especially during times of long hours and large workloads as well as during and following business trips. The charter also states that employees should avoid scheduling meetings, workshops, and travel on weekends and holidays. It is important to note, however, that only some of Shell's flexible work arrangement policies are applicable to all employees (Boston College Global Workforce Roundtable 2007). While many companies have strong and supportive policies for mothers, it is important to ensure that these policies are reaching women at all levels of employment.

legally recognized. And even in countries where it is available, the vast majority of job openings in the formal sector are in full-time positions (World Bank 2011, 223).”

While some women cut back their working hours due to family responsibilities, many women drop out of the workforce entirely. In a McKinsey & Company survey of business leaders worldwide, 30 percent of respondents said “many or most women at mid-career or senior level leaving their jobs voluntarily did so because of family commitments (McKinsey & Company 2012b).” The survey revealed that cultural pressure for women to leave their jobs is was least present in Australia, China, Hong Kong, and Singapore.

Finally, flexible schedules are not only vital when women are at the childrearing age, but also when they are older. A study on employment retention and re-entry among older women from Curtin University in Australia found that a flexible work schedule and adequate benefits are factors in determining whether or not older women are staying in the workforce. Women with access to adequate sick leave are more likely to remain in the workforce at an older age than women whose jobs do not provide paid sick or recreational leave (Austen and Ong 2009).

6. CONCLUSION AND WAY FORWARD

The prevalence of health-related barriers to women's workforce participation requires major policy changes in APEC economies. These barriers affect both women and their workplaces. The literature demonstrates, for example, that the provision of paid sick and annual leave time improves worker productivity and absenteeism. Lower productivity can affect coworkers and the success of an entire firm. Examples from Australia, the United States, China, Peru, and Chile show that an entire economy's GDP can be reduced by some of these health-related issues influencing women.

Health-related barriers to women's workforce participation affect not only women's current workforce participation but also the entire course of women's lives. Short-term effects are apparent in retention and dropout rates, but the effects of domestic violence, for example, are seen throughout a woman's life. Victims of domestic violence experience work-limiting disabilities and mental health problems that diminish their ability to work and their income levels throughout their lives.

Our literature review found that a great deal of the barriers that women face cannot necessarily be addressed by policies alone but can be eliminated only by cultural change. Women face obstacles in reporting many problems because of fear or shame. Women in many economies fear that their claims of sexual harassment will not be taken seriously by their employer. Similarly, there is a common perception that companies will not take action to prevent or stop domestic violence or offer services to women who experience it. Often companies lack incentives to offer such services, or even services such as wellness programs. A shift in both company culture and the economy's culture may be needed to tackle some of these issues.

The literature brings to light how barriers affect women of different socioeconomic status, sectors, and economies in different ways. Women in the informal sector face unsafe and unhealthy working conditions. Domestic and home-based employment isolates female workers, making them especially vulnerable to abusive working conditions and associated adverse effects on their health and well-being. Informal workers have no or few medical benefits or health insurance. Receiving health care requires leaving work, which reduces their income and costs money out of pocket. And because informal sector jobs tend to lack stability and security, many women are vulnerable to sexual harassment and violence.

The Policy Toolkit offers opportunities for more detailed study of specific issues in a limited number of economies. Moreover, in areas where member states have expressed interest in carrying out further work, opportunities to gather and disseminate best practices can advance women's health and workforce participation.

Women tend to work in less hazardous professions than men. However, women's exposure to hazardous material is believed to be underdiagnosed because OSH standards and limits on exposure to hazardous substances are typically based on male populations. This is an area that needs further attention. But because developing exposure standards is such a complex endeavor, reviewing exposure limits requires significant resources. The United States is reviewing its exposure limits and provides a good example of what is involved in such a review.

A significant proportion of women work in the informal sector where there are unsafe and unhealthy working conditions. However, the sector is mostly unregulated, and there are limited OSH controls. ASEAN-OSHNet has done work in this regard, and the ILO has conducted research on the Asia-Pacific region, developed training manuals, and carried out training on OSH for migrant workers, farmers, small enterprises and homeworkers (ILO). For continued work on OSH concerns for the informal sector, there are opportunities for cooperation with both ASEAN-OSHNet and the ILO.

Greater focus on gender disaggregated data collection and analysis is needed. There are multiple factors hampering comprehensive data collection, including fear of reporting or unawareness of reporting requirements. Country-specific analysis can estimate the extent of under-reporting and pinpoint some of the main obstacles for reporting. Lack of accurate and gender-disaggregated data is an obstacle to identifying the occupational health and safety issues women face, and to designing interventions to address pressing issues.

In addition to gender-disaggregated data collection, there is a need for more rigorous and analytical research on occupational health and safety for women. Some APEC member economies report gender-disaggregated data on injuries and illnesses, and some also disaggregate by sector. But deeper analysis is needed of how processes and procedures for labor inspections, diagnoses, compensations and rehabilitations of occupational injuries and illnesses might affect women and men differently. This literature review has highlighted interesting research on gender differences in diagnosis, compensation, and rehabilitation in occupational health from Canada and Australia. In Canada, bias against women meant that women's claims for musculoskeletal disorders were accepted significantly less often than those of men. Moreover, this review highlighted the need for research on gender-sensitive labor inspections. Further research into these areas, and the collection of experiences and best practices from APEC economies would help advance occupational health and safety for women.

NCD reduce workers' ability to participate in the paid workforce and reduce their productivity while at work. Women's role as caregivers of family members with NCD further restricts their ability to engage in the workforce. A significant proportion of illnesses and deaths caused by NCD occur to people still active in the workforce. NCDs are the leading cause of death for women and men in APEC economies. However, a more detailed review is needed to determine economy-specific mortality and morbidity trends of the prevalence of specific NCDs. In addition, treatment guidelines, especially for those more common in men, are often based upon men's symptoms, which can lead to misdiagnoses and delayed treatment for women. A more detailed review, disaggregating by gender, would provide greater information on how the epidemic affects women, and highlight where there are gaps in the data, research and knowledge. Women's awareness of the prevalence and risk factors of NCDs varies greatly, and the suggested detailed review should also investigate at the country level what women's degree of awareness is for specific diseases.

Smoking is the greatest risk factor for NCDs. Although smoking is decreasing and women smoke less than men in the APEC economies, the harmful effects of smoking are higher for women. Moreover, due to the lag-period between the start of smoking and the onset of the disease itself, the United States for example has seen a sharp increase in women dying from respiratory diseases as more women used to smoke in the last couple of decades. It is important to sustain the decreasing trend of smoking among women in the APEC economies. To support decreased tobacco use in women and exposure to second hand smoke, it is important to further investigate advertising and marketing of tobacco use geared towards women; women's

awareness of the risks associated with smoking; as well as mechanism to limit women's exposure of second hand smoke, including in their place of work.

Women's access to health care is constrained by social, logistical, institutional, and financial barriers. To increase access to health care APEC economies Mexico, Thailand, and Indonesia have moved recently toward universal health coverage. Mexico has had positive experience in increasing access to health care services for the poor or otherwise underserved populations with conditional cash transfers programs, where women obtain funds for participating in preventive health care services (Dans, Ng et al. 2011).

The Philippines and India have taken innovative approaches to increasing the health care coverage for workers in the informal sector by working with governmental and nongovernmental agencies (Manansan 2011).¹⁴ Further research and a review of best practices from APEC member economies of approaches to reduce financial barriers to access health care, particularly for migrants, minorities, and poor women, would be beneficial. In addition, there is a need for a greater focus on gender and cultural sensitivity in the delivery of health care services. This literature review found limited research in the area, but a more focused review, possibly in certain medical disciplines or diseases could be more fruitful. This would be a particularly fruitful area for the APEC economies to share best practices as there is a need for greater awareness and training on gender sensitivity in the delivery of health care services for women.

For women to be able to join and advance in the workforce and plan their childbearing, they must have reproductive choices. The availability of contraceptives and family planning services varies among APEC economies and is a function of multiple factors, including a country's political commitment; financial and logistical capacity; and the organization, coordination, and integration of family planning in the health system. Hence, there is a need to look at each individual country context to understand the underlying challenges to availability and accessibility of contraceptives.

Young, unmarried women in the APEC region report less use of contraception, less knowledge of family planning, and less access to information and services than older, married women, but data on unmarried women's unmet needs for family planning are lacking. To identify the barriers to family planning services for young married and unmarried women, there is a need to identify the gaps in data and research at the country level. There is significant experience of best practices of family planning delivery in the APEC region. Thailand and Indonesia have been at the forefront of family planning and have established best practices in specific interventions and integration into the health care system that can be shared with other APEC member economies.

Another issue that would benefit from further research is wellness programs for employees. Although multiple studies have found that wellness programs enhance worker productivity and employer happiness, it is unclear how these programs affect men and women differently. Wellness programs are increasingly common, especially in the United States. As these programs become more prevalent, research might be conducted on their effect on women's workforce retention rates.

¹⁴ Rosario Manansan, *Extending Coverage to the Informal Sector*, Philippine Institute for Development Studies, 12 September 2011. Presentation in HRDWG/LSPN Social Protection Seminar in Manila. See for example *Self-Employed Women Association*, in Siddhartha Sarkar, *Health Insurance for the Poor in Informal Sector*, *Indus Journal of Management & Social Sciences*, Vol. 1, No. 2: 129-146 (Fall 2007)

Paid time off has clear effects on worker productivity and morale. Although the literature notes that women workers dominate in sectors that do not offer paid holiday time, and in part-time jobs, which also often do not provide paid holiday time, further research on the use of paid leave might shed light on why women are dropping out of the workforce. Do women take as much leave as men? Do they use it to care for their families while men use it for relaxation? Answering these questions may provide insight into the status of female workforce participation.

With further research in these areas and the implementation of policy recommendations featured in the Healthy Women, Healthy Economies policy toolkit, women's workforce participation can be strengthened, enabling further economic growth in APEC economies.

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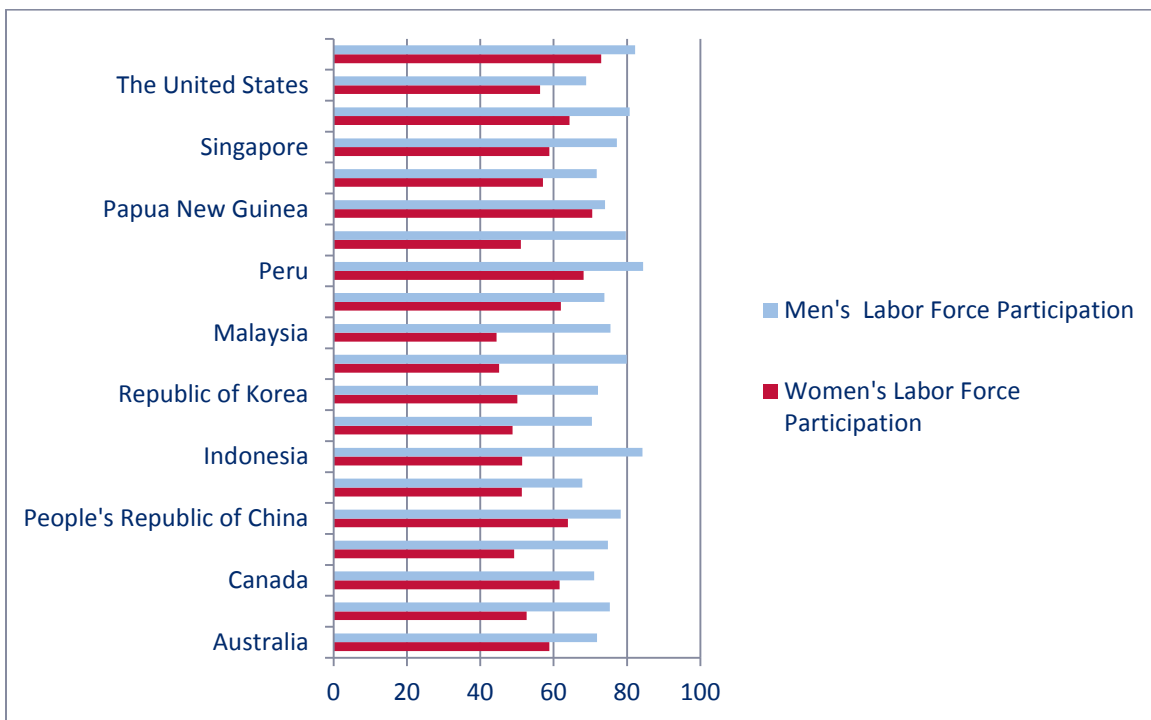
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APPENDIX A. WOMEN'S LABOR FORCE PARTICIPATION IN THE APEC ECONOMIES



Data source: ILO, 2013.

Labor force participation rate is the proportion of the population ages 15 and older that is economically active: all people who supply labor for the production of goods and services during a specified period.

APPENDIX B. MORTALITY FROM NONCOMMUNICABLE DISEASES

Probability of Dying Between 30 Years and 70 Years of Age from Four Main NCD, by Risk Factor (%)

Country	Overall Probability	No. of Deaths under Age 70 (in thousands)		Tobacco Smoking		Per capita Consumption of Pure Alcohol per Year		Raised Blood Pressure		Obesity	
		M	F	M	F	M	F	M	F	M	F
Australia	9	18	15	21	19	17	7	25	17	26	27
Brunei Darussalam	17	360	225	32	4	1.6	0.6	20	12	8	6
Canada	11	35	24	20	15	15	5	19	16	26	26
Chile	12	17	11	44	38	14	5	39	29	24	34
People's Republic of China	19	1,800	1,300	47	2	11	2	29	25	5	7
Hong Kong, China	N/A										
Indonesia	23	300	225	67	3	1	0.1	29	27	3	7
Japan	9	140	65	34	11	10	4	30	23	6	4
Republic of Korea	9	47	20	49	9	21	4	18	14	7	8
Malaysia	20	31	22	43	1	2.5	0.2	26	22	10	17
Mexico	16	120	100	27	8	12	2.6	26	20	26	37
New Zealand	11	3,800	2,900	21	19	16	6	25	18	27	29
Papua New Guinea	26	10	8	55	27	5	1	18	15	12	20
Peru	11	20	19	N/A	N/A	12	4	24	18	105	20
Philippines	28	150	88	44	10	9	2	25	20	5	8
Russia	30	450	240	59	25	24	8	37	38	18	33
Singapore	10	4.5	2.7	N/A	N/A	2.8	1.2	25	20	7	7
Chinese Taipei	N/A										
Thailand	16	90	60	46	3	14	0.8	24	21	5	12
United States	14	425	300	N/A	N/A	14	5	18	18	31	35
Viet Nam	17	110	50	46	2	12	0.2	26	20	1	2

N/A—Not Available

SOURCE: WHO Noncommunicable diseases country profiles 2014 www.who.int/nmh/countries/en/

APPENDIX C. PREVALENCE OF DAILY TOBACCO USE

Country	1996 (%)		2006 (%)		2012 (%)	
	Male	Female	Male	Female	Male	Female
Australia	26	23	21	17	18	15
Brunei Darussalam	14	8	14	8	14	8
Canada	27	25	18	14	17	13
Chile	39	34	31	26	32	26
People's Republic of China	53	4	44	2	45	2
Hong Kong, China	Data not available					
Indonesia	56	3	54	4	57	4
Japan	52	13	41	13	35	11
Republic of Korea	59	5	46	5	42	6
Malaysia	41	2	37	2	38	1
Mexico	29	10	16	5	16	5
New Zealand	26	26	21	20	18	17
Papua New Guinea	52	21	52	22	51	22
Peru	16	6	18	5	18	4.50
Philippines	50	11	41	8	40	8
Russia	55	15	49	16	51	17
Singapore	25	3.50	23	4	23	4
Chinese Taipei	42	4	34	4	31	3
Thailand	47	4	37	2	37	2
United States	23	20	20	16	17	14
Viet Nam	58	4	43	2	41	1.50

SOURCE: Smoking Prevalence and Cigarette Consumption in 187 Countries, 1980-2012. JAMA January 8, 2014, Vol 311, No. 2.