A/CONF.94/9

WORLD CONFERENCE

of the

UNITED NATIONS DECADE FOR WOMEN:

Equality, Development and Peace

Copenhagen, Denmark

14-30 July 1980

REVIEW AND EVALUATION OF PROGRESS ACHIEVED IN THE IMPLEMENTATION OF THE WORLD PLAN OF ACTION: HEALTH

Agenda item 8 of the provisional agenda.

80-06437

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I. INTRODUCTION

1. The report of the Secretary-General has been prepared by the secretariat of the World Conference of the United Nations Decade for Women, 1980, in compliance with General Assembly resolution 3490 (XXX) of 12 December 1975 and with Economic and Social Council resolutions 2060 (LXII) of 12 May 1977 and 1978/28 of 5 May 1978. It reviews and evaluates efforts undertaken at the national level to implement the World Plan of Action for the Implementation of the Objectives of the International Women's Year, 1/ in particular the minimum objectives set forth in paragraph 46 thereof. This report is based primarily on the replies of 86 Governments to the questionnaire prepared and circulated by the Advancement of Women Branch in the Centre for Social Development and Humanitarian Affairs, and contains an analysis of the progress made and obstacles encountered in the field of health. Even among developed countries, data were not always available in the detail requested in the questionnaire, and there were at times discrepancies between the rates quoted by Governments themselves and those available from official United Nations sources. In some cases, the data from the countries were more recent than the latest available United Nations data. The usefulness of the data is in the indication of trends and inequalities in health status and health services, and in the changes which have occurred in the first half of the Decade for Women. In this respect, the findings have not been compromised by the discrepancies, although attempts have been made to ensure reasonable reliability. It has not been possible to describe the changes in all countries; examples have been chosen from each region, as points of illustration only, and should not be interpreted as being comprehensive.

A. Women, health and development

2. Health, an essential human right, is also the basic requirement for the development of human resources and is closely linked with education, employment and political participation. As a fundamental element in the full integration of women in development, health has implications for society as a whole and for future generations. Economic targets set by countries cannot be achieved without an understanding of the implications of the significance of women's health and their participation in the delivery of services.

3. With the exception of the specific resolutions of the World Plan of Action in the area of health, and seminars that have been organized by the World Health Organization (WHO) in recent years, 2/ issues relating to women's health and its

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1/ Report of the World Conference of the International Women's Year, Mexico City, 19 June-2 July 1975 (United Nations publication, Sales No. E.76.IV.1), chap. II, sect. A.

2/ A meeting on women and family health, held at Geneva from 20 to 30 November 1978, and a seminar on traditional practices affecting the health of women and children, held at Khartoum from 10 to 15 February 1979.

implications for development have received little attention at international conferences. The International Conference on Primary Health Care, held at Alma-Ata from 6 to 12 September 1978, emphasized a preventive and comprehensive rather than a curative and fragmented approach to health (see the Declaration of Alma-Ata 3/). Although the health problems of women were not specifically highlighted, this new emphasis, properly planned and implemented, could ensure women's full integration in health related activities as consumers, participants and decision-makers. In the light of the Declaration of Alma-Ata, the World Health Organization is now promoting the integration of the western and traditional health-care systems, to maximize the advantages of each in order to provide adequate health care for all by the year 2000.

B. Health and socio-economic disparities

4. Poor health is an important indicator of economic deprivation and marginalization. As a result of the economic disparities characteristic of most countries, good nutrition, environmental health, adequate housing and access to health care services are often unevenly distributed. Consequently, women in the low-income groups face greater risks to their health.

5. Social inequality between and within nations and sex discrimination underlie women's health problems. There is a correlation between poverty and low rates of life expectancy. 4/ The differences in life expectancy rates between and within countries reflect differences in living standards and the inequalities evident in and perpetuated by the present world economic system, which favours countries less dependent on agricultural and primary products as their major national resource.

6. Socio-economic, cultural, and environmental factors, operating at both the macro level (international and national environments) and the micro level (community, the family and the individual), create and maintain relations of inequality between nations and economic deprivation for particular groups, notably among women, which adversely affect their health. Health has become a central factor in the global imbalance and has important implications for the new international economic order (see General Assembly resolution 34/58 of 29 November 1979).

7. Global inequality is reflected in the control by developed countries over medical expertise and technology, the delivery of health services, and the philosophies, methods, and curricula followed in educating and training health professionals and health workers.

3/ See Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978, Jointly Sponsored by the World Health Organization and the United Nations Children's Fund (Geneva, World Health Organization, 1978), p. 2.

4/ S. Preston, "The changing relation between mortality and level of economic development", Population Studies, vol. 29 (2 July 1975), pp. 231-248.

8. This control is manifested in decisions made in the developed countries regarding the health problems of the developing countries, experimentation with new drugs, aggressive fertility regulation programmes and the irresponsible promotion of pharmacological products, manufactured foods, tobacco and alcohol.

9. Neither industrialization, improved medical technology nor fertility control can be expected to solve all the social and health problems of women. But the ways in which policies in these areas take into account the interests of women and the degree to which women participate in and influence policy decisions are critically important.

10. Development and industrialization may have both advantages and disadvantages for women. In all countries, national economies have come to rely on large numbers of women entering the industrial work-force. Little consideration has been given to the effects on women's health of the additional work-load and the exposure to specific occupational health hazards, or to the effects on the health and welfare of the women's families. Where capital-intensive industries have been set up, the mechanisms for collective bargaining, as well as adequate measures to ensure industrial safety, are often lacking: this lack has implications for women's health, for example, in Asia, the Caribbean and Central America, where female labour is being increasingly used in export-oriented industries. 5/

C. The importance of women's health

11. While women, like men, are subject to the entire spectrum of human disease, the demands of childbearing, the heavy work-load of women in both rural and urban areas and their generally lower status in society expose them to a wide range of additional health problems. Women are also exposed to domestic violence, sexual exploitation and assault.

12. There is a close relationship between malnutrition and infection. Nutritional and environmental diseases such as anaemia, goitre, metabolic diseases, and malnutrition have a much more severe effect on women, and can adversely affect the foetus during pregnancy. The pattern of women's work exposes them to infection in nursing the sick and makes them agents in the transmission of disease. Environmental pollution and exposure to radiation and toxic chemicals can be hazardous to women, especially during pregnancy. These factors, in addition to the role played by women in the socialization of children, impose a burden on women which may result in chronic ill-health, anxiety and other psychosocial problems, which have an impact on the family and society as a whole.

13. The approach to women's health should be comprehensive, dynamic, and sensitive to the changes in women's needs throughout the life-cycle, to changes in women's role both within and outside the family, and to socio-economic changes in society.

5/ See "Effective mobilization of women in development: report of the Secretary-General" (A/33/238 and Corr.1), paras. 94-96.

D. Traditional indicators of health status

14. In general, the levels of life expectancy for women are higher than those for men, a fact which may be due to genetic advantages and to a lesser likelihood of death from vehicular and industrial accidents, heart disease, lung disease and cancer, 6/ but women may have higher morbidity rates because of their reproductive role and their generally lower status in society. 7/

15. Levels of life expectancy and mortality rates do not permit a full appreciation of conditions of low-grade ill-health. Morbidity rates may be better indicators of the relative health status of men and women, in terms of their epidemiological implications and because they point to major health problems that require solution. Difficulties arise in the definition of thresholds of morbidity and in the collection of data. 8/

16. Trends towards declining infant and maternal mortality rates in developing countries may be due to increasing access to health-care facilities and to the extension of public health measures. Certain socio-economic processes injurious to health, and characteristic of underdevelopment, appear to be occurring simultaneously and can compromise any gains made in the area of health care. 9/ Such processes as rapid population growth, explosive rural-urban migration, unemployment and underemployment aggravate and accelerate public health problems, through the proliferation of slums, overcrowding, the spread of infectious diseases, prostitution, alcoholism and drug abuse. 10/

17. The planning and implementation of health programmes for women are hindered by cultural stereotypes about women on the one hand and failure to recognize differences in health patterns between men and women on the other. Actual programmes to meet the specific needs of women and to improve women's health are not reflected as a priority in the budgets and policies of most Governments. There is an urgent need to recognize the inherent interrelationship between women's health and social and economic development, which holds important implications for equality, and for peace.

6/ Some recent studies do, however, indicate that women are more susceptible to the "type A" behaviour pattern (that is, a hard-driving, aggressive and rushed life-style), to coronary disease and to hypertension; see Ingrid Waldron, "Coronary-prone behaviour patterns, blood pressure, employment and socio-economic status in women", Journal of Psychosomatic Research, vol. 22, pp. 79-87.

7/ See, for example, the section entitled "Women and health" in The International Journal of Health Services (1975).

8/ For example, WHO has established a cut-off point for anaemia in pregnancy (11 grams of haemoglobin per decilitre), but not all countries adhere to this limit.

9/ Asa Christina Laurell et al., "Disease and rural development: a sociological analysis of morbidity in two Mexican villages", The International Journal of Health Services, vol. 7, No. 3 (1977).

10/ Numerous studies document this trend; see, in particular, J. Gugler and W. G. Flanagan, Urbanization and Social Change in West Africa (Cambridge, Cambridge University Press, 1978); F. Sai, "Special nutritional considerations in the urban and peri-urban setting", in J. H. Beaton and J. M. Bengoa, eds., Nutrition in Preventive Medicine, Major Deficiency Syndromes, Epidemiology and Approaches to Control, World Health Organization Monograph Series No. 62 (Geneva, 1976).

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II. REVIEW OF THE PROGRESS MADE SINCE 1975: ANALYSIS OF COUNTRY RESPONSES

A. Trends in the status of women's health

1. Life expectancy, maternal and infant mortality rates

18. It is customary to measure a country's health status by infant mortality rates, but maternal mortality rates are equally important because they represent mortality in younger women of child-bearing age, and because of the major role women play in the nutrition and survival of their children, in subsistence production and in the socialization of the family. Maternal mortality also indicates the health status of women, since it reflects both the extent of the child-bearing role and adequacy of health care during childbirth. 11/

19. An improvement in infant mortality rates increases life expectancy. The age-structure of a population, however, can affect crude death rates. Estimates predict a rise in crude death rates from 9.2 (1970-1975) to 9.4 (1975-1980) for more developed countries, but a decline from 13.2 to 12.0 among less developed countries. 12/

20. Some countries did not submit information on life expectancy or on maternal and infant mortality and official estimates have been used to supplement the data. 13/ There was a marked variation between rural and urban areas and between different socio-economic and ethnic groups.

21. For the region covered by the Economic Commission for Africa, the following data were provided. Ghana quoted two estimates which showed a life expectancy of 46 years for women in 1974 and of 52 years in 1977. Zaire reported a higher life expectancy for women in urban areas and for women of the highest socio-economic status. Togo reported a life expectancy in 1975 of 56 for urban women and 48 for rural women and marked differences between urban and rural areas in maternal mortality rates (43 and 85 per 100,000 live births in 1975). Ghana reported a decline in infant mortality from 133 to 120 per 1,000 live births between 1969 and 1977. Throughout the region, infant and maternal mortality rates were

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11/ S. Preston and J. Weed, Causes of Death Responsible for International and Intertemporal Variation in Sex Mortality Difference; World Health Statistics Report, vol. 29, No. 3 (Geneva, 1976), pp. 144-163.

12/ World Population Trends and Prospects by Country, 1950-2000: Summary Report of the 1978 Assessment (ST/ESA/SER.R/33).

13/ The sources used include: World Population Trends and Prospects by Country ...; Demographic Year Book, 1977 (United Nations publication, Sales No. E/F.78.XIII.1); World Health Statistics Annual, 1978 vol. I, Vital Statistics and Causes of Death (Geneva, World Health Organization, 1978).

generally still very high; only Mauritius reported an infant mortality rate below 50 per 1,000 live births (48.7 in 1975 and 33.8 in 1978).

22. In the region covered by the Economic and Social Commission for Asia and the Pacific (ESCAP), responses indicated a wide variation in life expectancy, from 42 in Nepal in 1978 to 78 in Japan in 1977. An increase in total life expectancy was reported from Australia, India, Japan, Nepal, New Zealand, Philippines, and Singapore. The life expectancy for females was higher than for males except in the cases of India and Nepal. 14/ Urban/rural differences were also apparent. In Papua New Guinea, female life expectancy increased from 48.9 to 51.7 in the rural areas and from 58.7 to 60.8 in the urban areas.

23. New Zealand reported a life expectancy of 74.6 in 1978, but stated that the rate was about 10 years lower for Maori than for non-Maori women, and that while the infant mortality rate was declining among non-Maoris, there had been a slight increase among Maoris. Japan reported a decline in infant mortality from 10 to 9 per 1,000 live births between 1975 and 1977; India and Nepal reported rates over 120. India reported an estimate of 130 per 1,000 live births in 1972, ranging from 85 per 1,000 in urban areas to 150 per 1,000 in rural areas. Sri Lanka reported a maternal mortality rate in 1975 of 120 per 100,000 live births (United Nations statistics show a rate of 179.3 per 100,000 in 1968). 15/

24. Life expectancy from eight countries of the Economic Commission for Latin America (ECLA) was variable, ranging from 45 (Bolivia) to 76 (Cuba) in 1975. Socio-economic status reflected more variation than rural/urban distinctions. Honduras, for example, reported a difference of 11 years between rural and urban women (50 and 61) and 18 years difference between women of high and low economic status (66 and 48, respectively).

25. Cuba quoted a decline in the infant mortality rate of 22.3 per 1,000 live births; Argentina reported a differential decline in infant mortality between 1970 and 1976 (31 to 29 in urban areas and 129 to 83 in rural areas). Peru and Venezuela reported a decline in infant mortality, but figures from Paraguay indicated an increase. Generally maternal mortality had declined. 16/ Venezuela reported a decline of 22 per cent in maternal mortality between 1970 and 1974 (90 to 70 per 100,000 live births) due to declines in deaths from infection (60 per cent), toxaemia (22 per cent), abortion (21 per cent) and haemorrhage (15 per cent).

14/ Global estimates show that life expectancy for males is higher than for females in India, Pakistan and Sabah (Malaysia), and marginally higher or equal in Bangladesh, Iran, Papua New Guinea and the Upper Volta. Demographic Year Book. op.cit.

15/ This reflects a decrease when compared with figures for 1968; see Demographic Year Book, 1978 ... .

16/ Demographic Year Book, 1978 ... .

26. Data for the region covered by the Economic Commission for Western Asia (ECWA) were taken from official statistics. Life expectancy for women in the ECWA region has been estimated at 51.6 years for 1970-75 and is expected to reach 53.9 in 1975-1980 (medium variant). 17/ Estimates indicated that infant mortality had declined in Kuwait but had risen in Iraq. 16/

27. In the countries of the Economic Commission for Europe (ECE), life expectancy was higher for women than for men and in most cases was over 75 years. Turkey reported an increase in life expectancy for women from 59.9 to 62.8 over the period 1970-1975. Infant mortality rates in 1977-1978 varied from a low of 7.7 per 1,000 live births in Sweden to 31.2 in Romania. Seven countries had rates below 12 (Denmark, Finland, Iceland, Netherlands, Norway, Sweden, and the United States of America). Turkey reported higher infant mortality in rural than in urban areas (11.9 as against 16.1 per 1,000 live births).

28. The responses indicated declines in infant and maternal mortality rates, and improvement in life expectancy for women, which is consistent with world estimates. 18/ Such generalizations, however, disguise persisting or even worsening rates among some groups, and obscure conditions of low-grade ill-health among women. There is a wide discrepancy in life expectancy for women, ranging from 32 years in Sierra Leone to 79 years in Iceland, and wide variations in infant and maternal mortality rates, both between and within countries.

2. Relative health status of women and men

29. Some countries based their responses on the higher life expectancy of women, which may be a valid comparison in developed countries. Others, however, assumed that health status was related to the health care facilities available for women.

30. Four of the countries from the ECA region stated that women's health status, particularly that of rural women, was lower than that of men because of their heavier work-load, inadequate health care facilities in rural areas, and a lack of technological assistance in their work. Sierra Leone, for example, indicated that women had a lower health status because they worked longer hours and as childbearers were more vulnerable; they lacked easy access to health facilities, were less educated and more bound by tradition.

31. From the ESCAP region, India reported that women's health status was lower than men's for the following reasons: a lack of awareness about the availability of medical services, early marriage and frequent pregnancies, hard manual labour, and inhibitions about seeking advice on family planning. Australia cited a morbidity survey in 1977-1978 which indicated higher rates among women than men, in musculo-skeletal, nutritional, metabolic and genito-urinary disorders (excluding pregnancy).

32. From the ECLA region, Cuba stated that women had a better health status because of the special attention they received. Honduras stated that, based on

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17/ World Population Trends and Prospects by Country ..., pp. 65 and 60.

18/ Ibid., pp. 62 and 57.

life expectancy, the health status for women was higher than for men. Other responses indicated that health conditions were lower for women than for men. Paraguay referred to nutritional deficiencies and childbirth as major problems for women. Peru stressed the lack of medical attention, while Colombia referred to the childbearing age (15-45 years) as the most vulnerable period for women. Argentina quoted figures for a number of illnesses which were more common among women than men, including arthritis, musculo-skeletal disorders, anaemia, diabetes, gall-bladder disease and cancer of the bowel.

33. The ECWA countries indicated, in general terms, that the health status of women was consistently low. Lebanon referred to the lower health status of women, particularly pregnant and nursing mothers in rural and peri-urban areas, due to frequent pregnancies, heavy domestic and agricultural work, nutritional anaemia and a lack of maternal health centres.

34. In the ECE region, the Eastern European countries emphasized equality in health care and health status for men and women. The Federal Republic of Germany referred to surveys in 1976 and 1977 which found that, in terms of specific illnesses, women had higher rates of asthma, musculo-skeletal, genito-urinary and psychological disorders. Cyprus, Romania and the United States of America considered that, based on life expectancy rates, women had a higher health status than men.

35. In assessing the differences in health status between men and women, a desirable approach would be to collect data and develop indicators that would reflect differences in morbidity rates as well as the relative access to health care services by men and women. A WHO study on the subject found that "in each country there exist two distinct subpopulations, men and women, each with its own morbidity and mortality patterns, which are often very different". 19/

36. The ECWA regional preparatory meeting for the World Conference of the United Nations Decade for Women, 1980 also reported the difficulties countries experienced in providing the data requested, and emphasized the need to involve the regions in the preparation of simplified questionnaires to secure up-to-date information on the special problems and needs of women and the programmes involving them (see E/ECWA/SHDS/CONF.4/7).

37. Simple indices should be developed that could be used at the village level. If there is a significant discrepancy between the sexes in terms of health status, other types of data on work-load, nutritional status, exposure to health hazards and the prevalence of sex-specific health problems might be necessary. More important is the earlier recognition of morbidity among vulnerable groups of women, the continued observation of the differences between rural and urban women and the trends in the patterns of disease in these areas.

38. The data available highlighted the need of women for special attention in health care, and the persisting wide disparities in rural and urban mortality rates between women of different social classes and between countries at different

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19/ E. Royston, "Statistical enquiry: on female mortality" (World Health Organization assignment report, 1977).

stages of development. These disparities persist despite an over-all improvement in the three indicators.

B. Specific health problems of women

1. Pregnancy and childbirth

39. The reproductive phase of a woman's life-cycle occupies a great part of her adult life. Menarche, childbearing and menopause are normal functions, but in suboptimal conditions raise special problems for women's health. Pregnancy is not only a burden on the mother's nutrition, but may be complicated by haemorrhage, toxaemia, infection, and abortion, which can result in morbidity or even death of the mother and/or infant. In some developing countries, death resulting from childbirth is a major cause of death among women in the reproductive age group.

40. Universal risk factors that increase the chances of a poor outcome of pregnancy have been identified as too frequent pregnancies, pregnancy at the extremes of the reproductive age, previous child loss, and malnutrition. 20/ Cultural practices such as Pharaonic circumcision can also lead to medical complications. Mortality from all causes rises with the number of children a woman has past her third child. 21/

41. With declines in fertility and increasing life expectancy, women tend to spend a diminishing part of their lives in actual childbearing, but many suffer chronic discomfort and ill-health from conditions such as prolapse, malnutrition, and anaemia. In both the developed and the developing countries, women tend to accept these symptoms as their lot and do not seek treatment, either because the facilities are not available except for the more acute illnesses, because they cannot give up work, or because they fear discrimination in employment. Much chronic illness therefore remains untreated.

42. Pregnancy among adolescents is an issue of social and medical concern in both the developed and the developing countries. 22/ Girls marry younger and start childbearing earlier in some countries. In Bangladesh, India and Nepal, over 70 per cent of the girls are married between 15 and 20 years of age. Unmarried adolescents facing unwanted pregnancies in some countries must make a choice between enforced marriage, abortion, adoption or raising a child alone. 23/ Adolescents are overrepresented in abortion statistics and are more likely to seek late abortion, with its high risks. 24/

20/ Risk Approach for Maternal and Child Health Care, World Health Organization Offset Publication No. 39 (Geneva, 1979).

21/ Kitagawa and Hauser, quoted in S. Preston and J. Weed, op. cit., pp. 144-163.

22/ A. Parkes, et al., eds., "Fertility in adolescence", Journal of Biosocial Science, Supplement No. 5 (1978).

23/ Health Needs of Adolescents, World Health Organization Technical Report Series No. 609 (Geneva, 1977).

24/ Pregnancy and Abortion in Adolescence, World Health Organization Technical Report Series No. 583 (Geneva, 1979).

2. Cultural practices affecting women's health

43. While recognizing the many positive effects of traditional practices relating to women's health, attention should be given to certain cultural practices that have negative effects. Food taboos imposed during pregnancy may result in a restriction of the foods essential to mother and infant. Traditional obstetrical practices, involving the use of unhygienic methods and the hastening of delivery, for example, can have an adverse effect on both mother and infant.

44. The milk produced in the first three or four days after delivery (colostrum) has been found to be a rich source of nutrients and antibodies for the young infant. In some societies, even where breast-feeding is a well-established practice, this vital food is considered to be harmful and is sometimes discarded. 25/

45. Female circumcision and infibulation can lead to complications during pregnancy. The Second Regional Conference on the Integration of Women in Development, held at Lusaka from 3 to 7 December 1979, condemned sexual mutilation practices, but was also critical of uninformed international campaigns against these practices, and called upon African Governments and women's organizations to seek solutions to the problem.

3. Environment and life-style

46. Poor environmental conditions, poor sanitation, unsafe or inadequate water supply, overcrowding and malnutrition are important causative factors in the prevalence of infectious diseases. Furthermore, women's role in the preparation of food, in the care of the sick, in the nursing of infants and as traditional birth attendants means that they can also become agents in the transmission of disease. The roles and health status of women have a direct bearing on such major causes of death among infants as diarrhoea and marasmus. 26/ Tetanus, which affects both mothers and infants, can be prevented by immunization of the mother before confinement. 27/

47. The disease pattern in industrialized societies shows a prevalence of chronic and degenerative diseases, as opposed to the infectious and epidemic diseases characteristic of developing countries. Ironically, the social changes taking place in developing countries, which include the aging of the population

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25/ Valerie Hull, "Women, doctors, and family health care: some lessons from rural Java", Studies in Family Planning, vol. 10, No. 11 (November 1979).

26/ Marasmus is an extreme form of malnutrition, often associated with the early cessation of breast-feeding in developing countries.

27/ Tetanus can be transmitted by unhygienic practices during delivery and when the umbilical cord is cut. See, for example, S. Chen, "Tetanus neo-natorum in West Malaysia", Journal of Tropical Medicine and Hygiene, vol. 77.

and changes in life-style, are likely to produce disease patterns that are at present more characteristic of developed countries, such as cardiovascular disease, cancer, diseases related to stress, the increasing use of drugs, alcohol and tobacco, and exposure to toxic environmental and industrial pollution. 28/

48. Problems of drug use are often considered only in terms of drug addiction and the abuse of narcotics, but major health problems arise from the over-use and misuse of therapeutic drugs and the socially acceptable drugs such as alcohol and tobacco. In developing countries, adequate legislative machinery has not yet been developed to control irresponsible sales promotion and the "dumping" of therapeutic drugs by international drug manufacturers. Alcohol, smoking and narcotic drugs have been linked with low birth weight and other effects on the foetus. 29/ Recent trends indicate that in some developed countries, as more women take up smoking, lung cancer rates have risen among women, in some cases even more rapidly than among men. 30/ Several developed countries cited problems of drug use and abuse. Canada referred to the "over-medicalization of women", and to attempts to influence young people against smoking, while some other countries, for example, Australia and the United States of America, referred to the need for health education to reduce smoking.

49. Large-scale migration and demographic imbalance can affect women's health. Inadequate resources and a lack of employment opportunities may force migration of families, or sometimes of males or females alone - depending on the society. The result in many cases is the disruption of family life, a break in traditional family support systems, and the need for women to assume the burden of sole support of the family, which imposes additional stress on their work-load and their health.

4. The impact of technology

50. While appropriate technology and labour-saving devices have positive benefits in relieving the work-load of women, rapid advances in industrial and medical technology on a global scale open up new problems in the field of health. There is a particular need for continuing research into the effects of new drugs and techniques used in medical treatment, and also into the chemical and physical effects of new industrial processes to which women are exposed in the home, the work-place, and the external environment. Contamination of air, food, and water supplies by chemical and radio-active wastes affects the population in general but because of their childbearing role women can be peculiarly vulnerable.

28/ A. R. Omran, "The epidemiological transition; a theory of the epidemiology of population change", Millbank Memorial Fund Quarterly, vol. XLIX, No. 4 (1971), part one, p. 509.

29/ There is some documentation on this subject, for example, P. Rothstein and J. B. Gould, "Born with a habit: infants of drug addicted mothers", Pediatric Clinics of North America, vol. 21 (1974), p. 307.

30/ F. Foster, Sex Differentials in Cancer Mortality and Morbidity, World Health Statistics Quarterly, vol. 31, No. 4 (Geneva, 1978).

51. In the absence of an adequate data base, it is difficult to determine the full extent to which the biological differences between men and women predispose women to greater risk when exposed to the same occupational hazards as men. This poses a dilemma, in that such differences might be used as a means of discrimination against women. Many of the jobs in which women are predominantly employed involve specific hazards, which therefore assume greater importance for women. In pregnant women, the greatest damage to the foetus occurs in the first three months - often before the diagnosis of pregnancy is made. It is also important to recognize that processes toxic to the foetus, or to women, may also be toxic to men. 31/

52. Where a working environment may have possible toxic effects on a woman's reproductive capabilities or on the foetus during pregnancy, the problem is not solved by discriminatory practices against women, such as the exclusion of women from the work-force. Social and industrial policies should be obliged to ensure a safe working environment for all.

5. Violence against women

53. In recent years, attention in both the developed and the developing countries has been focused on domestic violence and violence towards children. Most victims of rape and other sexual offences are female, and most victims of domestic violence are women. Many women have not sought help because of fear of publicity and exposure, the feeling of guilt that they have been responsible for the attack, and the feeling that police action would be futile. 32/ Children may be terrorized into not reporting offences unless obvious physical injury has occurred.

54. Research is needed to determine the basic causes of violence and the most effective ways of combating violence and sexual assault. Economic support for women is necessary to provide opportunities for escape from violent households. The stereotyping of males and females and the lower status of women in the family and in society create conditions which render women liable to violence; economic and social dependence prevents them from taking effective action. In many countries, women's groups have moved to help women and children who are victims of domestic violence. 33/ In the responses, two countries, Australia and India, referred

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31/ Exposure to anaesthetic gases has been investigated as a cause of increased incidence of miscarriage, congenital defects, and infertility among women working in operating theatres. For a recent report, see P. J. Tomlin, "Health problems of anaesthetists and the families in the West Midlands", British Medical Journal, No. 6166 (March 1979), pp. 779-784.

32/ J. R. Evrard and E. M. Gold, "Epidemiology of sexual assault victims", Obstetrics and Gynaecology, vol. 53, No. 3 (March 1979), pp. 381-387.

33/ E. Pizzey, Scream Quietly or the Neighbours will hear (Harmondsworth, Middlesex, Penguin Books, Ltd., 1974). See also "International self-help movements, women and health", Isis, vol. 8 (1978).

specifically to Government-sponsored centres to provide crisis care for women and their children in these circumstances.

C. Improvements in health service delivery

55. Approximately 80 per cent of the world's doctors are in the major urban areas but the majority of the world's population lives in rural areas. In the developing countries, less than 15 per cent of the population live within walking distance of any health facility. 34/ Between 60 and 80 per cent of all pregnant women in developing countries are attended in childbirth by a traditional midwife. 35/ The greater part of the countries' health budgets is spent on the sophisticated, high-technology treatment of illness, which has led to a widening gap between the facilities for health care available for the affluent and the poor. The utilization of professional staff may be limited by cost considerations. Health professionals are concentrated in the cities and tend to migrate from the less developed to the more developed countries. 35/

56. The International Conference on Primary Health Care at Alma-Ata sought ways to improve health care for all. In summary, the Declaration of Alma-Ata states that the "main social target of governments, international organizations and the whole world community ... should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development ... which includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs". 36/

57. The provision of maternal and child health services is an appropriate entry point for improvements in the delivery of health services and improvements in the health status of women. A multisectoral approach is required, involving health professionals, the community and government departments dealing with a variety of fields, including public health, welfare, education and agriculture.

58. Countries from all regions indicated that efforts had been made to intensify, expand and improve the delivery of health services, particularly in rural areas, with an emphasis on maternal and child health. The following is a general survey of some of the progress made since 1975.

34/ M. McHale and J. McHale, Children in the World Today (Houston, Houston University, 1979).

35/ Traditional Birth Attendants (Geneva, World Health Organization, 1978), p. 7.

36/ Primary Health Care ..., p. 3.

59. From the ECA region, Somalia reported activities to train more midwives, to extend maternal and child health and school medical services, to provide nursing breaks for working mothers and to protect pregnant women in industry. The Libyan Arab Jamahiriya stated that it had introduced free medical care, maternal and child health centres, which also provided compulsory immunization, and the monitoring of child development. Sierra Leone reported that clinic services had been expanded and a co-ordinated programme set up to provide primary health care in rural areas, which involved the Ministries of Health, Agriculture, Education and Rural Development. Women were being recruited to work at the village level and at all levels of health services.

60. Mauritius reported an improvement in its health infrastructure and the expansion of primary health care and maternal and child health services, as well as the in-service training of paramedical staff. Mobile services included dispensaries, vaccination, dental, ante-natal and family planning services. Botswana had expanded its basic health service programme by encouraging community participation in basic health services and establishing rural health clinics and health posts.

61. From the ESCAP region, Japan and Singapore indicated that health services were adequate and that good use was made of them. The Philippines and Sri Lanka referred to the heavy use of paramedical staff, mostly women, to improve health care in rural areas. Bangladesh and Pakistan encouraged the participation of women's organizations and women's rural co-operatives and the training of women at the village level. India had developed health programmes designed:

(a) To control and eradicate communicable diseases;

(b) To promote curative and preventive health services;

(c) To increase the training and retraining of medical and paramedical staff;

(d) To strengthen primary health care complexes in rural areas.

62. Australia and New Zealand expressed concern about the health status of indigenous peoples. Australia had introduced a community health programme to extend its outreach to rural areas and was training Aboriginals to become health workers; it had also provided funds for several women's health centres.

63. From the ECWA region, Lebanon reported the drilling of wells to improve the water supply in more villages, the further elaboration of a network of primary care centres in rural areas with assistance from the United Nations Children's Fund (UNICEF), and an increase in mobile services. Iraq hoped to provide 100 per cent health service coverage by 1985; Bahrain mentioned provisions made for the care of the elderly and protection for working women, especially during pregnancy and also referred to provisions made for women to be given time during working hours to continue breast-feeding.

64. From the ECE region, the countries of Eastern Europe emphasized that their constitutions guaranteed the right to a full range of health services, including rural networks linked with regional specialist centres. They stated that great attention was paid to protecting the health of women and that special benefits and assistance were available for pregnant women and mothers. For example, Poland outlined the policy adopted in 1970-1975, which covered the development of health care until 1990. The plan provided for comprehensive maternal and child health care and the supervision of children from infancy to 18 years of age, integrated into medical care at home and in school. Yugoslavia stated that the ratio of maternal health clinics was 1 for every 7,500 women over 15 years of age. The Scandinavian countries also reported a comprehensive network of services, with health surveillance from birth through adulthood.

65. In Israel, 90 per cent of the population was covered by health insurance in 1976, reflecting 97 per cent of the Jewish and 65 per cent of the non-Jewish population. Maternal and child health services were integrated into the general health services to provide health care at all levels, including care of the chronically ill, the disabled and the elderly. Turkey stated that legislation had been introduced in 1978 to bring all doctors into the public service and to phase out private clinics.

66. The United States of America described special programmes carried out by the different states to increase the number of skilled personnel, improve emergency transport and outreach in rural areas, and to reach high-risk women in urban and rural areas. Both Canada and the United States of America noted that some groups received inadequate health care, particularly the indigenous populations. In both countries, Indian and Eskimo health workers were being trained in an effort to improve health care.

67. There are many differences in the availability of health services at the urban and rural levels, at the socio-economic level, and at the racial and minority levels. Countries are attempting to reduce these differences by programmes directed towards minority and high-risk groups and rural areas and are using innovative approaches such as mobile clinics, and more traditional midwives, local health workers and indigenous health workers. Apart from maternal and child health programmes, few countries reported programmes directed specifically towards women.

D. Improvements in women's participation in the health services

68. Improvements in the participation of women in the delivery of health services must take into account the numbers of women involved, and also what opportunities they have to improve their skills, to expand the scope of their work, and to participate equally at all levels of the health professions.

69. Women have traditionally been the major providers of health care, within the family but also in the community as midwives and traditional healers. Most of the health professionals are women, but these women predominate in the lower status occupations. Positions of authority and decision-making are usually occupied by men.

70. The failure of the western medical model to meet health needs, particularly of people in the developing world, has led to a reappraisal of the important role played by traditional healers and the need to integrate modern and traditional medical systems. China is an example of successful integration, and alternative models are being developed in other countries, such as India, Indonesia, Sri Lanka, the Philippines and the United Republic of Cameroon. 37/ Traditional birth attendants have advantages in that they are part of the culture and the community in which they work, they occupy positions of trust, and are easily accessible.

71. The increasing integration of women traditional healers should not, however, be seen as a solution to the problem of ensuring equal participation of women in the provision of health care. It may merely legitimize the transfer of an increasing responsibility for primary health care to women who are already overburdened. Traditional health workers should have opportunities to learn new skills and techniques, to retain their position of status, to participate in planning and decision making, and also to advance to higher positions of responsibility.

72. Many countries were unable to give information on female participation in various categories for the period requested. Some categories - for example, paramedicals - were not clearly defined, and categories such as midwives were not included. In New Zealand, because of sex-discrimination legislation, it was not possible to record the sex of nurses. The data do, however, permit an over-all comparison of trends.

73. Nursing has been the traditional entry point for women into the health professions. In most developed countries, more than 95 per cent of the nurses are women. In some developing countries, particularly in the ECA region, cultural constraints and low levels of education among girls have restricted the number of women who enter the nursing profession although the situation is improving. Two of the lowest rates for nurses reported for 1975 and 1978 were in Togo (23 per cent and 22 per cent) and Lesotho (34 per cent and 40 per cent). Lesotho reported that 99 per cent of the student nurses were women and Sierra Leone noted that the level of female education was being improved in order to increase the participation of women as nurses.

74. With the rapid expansion of health services and an urgent demand for qualified staff, qualified women and men may obtain entry to positions which might have been difficult otherwise. This pattern was reflected in the response from Mauritius, which commented on the late entry of women but stated that women were preferred in hospital wards and family planning clinics and as peripheral staff. Females constituted 17 per cent of the senior personnel in 1975 and 22 per cent in 1978. In both years, 62 per cent of the nurses and 29 per cent of the paramedical staff were female but female gynaecologists had declined from 12 per cent to 8 per cent.

37/ See The Promotion and Development of Traditional Medicine, World Health Organization Technical Report Series No. 622 (Geneva, 1978).

75. From the ECWA region, Iraq gave figures for government institutions only, which showed that women comprised 32 per cent of the medical specialists, 30 per cent of the general practitioners, 48 per cent of the nurses, and 71 per cent of the pharmacists. Lebanon reported little change in female participation at the higher levels, but large increases in female paramedical workers (from 50 per cent in 1975 to 82 per cent in 1978), medical students (from 12 per cent to 16 per cent) and students of public hygiene (from 17 per cent to 50 per cent).

76. In the ESCAP region, Bangladesh was using women organizers in family planning programmes at the village level, usually under the supervision of male paramedical workers. India was paying stipends to women to increase the number in training. The fifth Five-Year Plan of India included the qualitative improvement of the education and training of health personnel and the increased use of community health workers, who would, in turn, transfer skills to selected workers at the village level. Women comprised 20 per cent of the doctors, 91 per cent of the nurses and 24 per cent of the medical students.

77. Sri Lanka reported an increase in the number of women as doctors, nurses, dental nurses, midwives and volunteer workers, and an expansion of the responsibility of dental nurses and midwives to cover field work, the care of pregnant women and infants (figures not available). In Papua New Guinea, 71 per cent of the nurses were female. The Philippines reported the training of hilots (traditional midwives) and the increased participation of women at the community level and among medical and health personnel. A programme of training was introduced to broaden nurses' responsibilities as part of a WHO-sponsored project to deliver family planning services in rural areas.

78. In Australia, over 80 per cent of the health work-force is female, including 96 per cent of the nurses, 85 per cent or more of the paramedical workers and 17 per cent of the general practitioners (other ranks not available). Female medical students increased from 31 per cent to 35 per cent over the period 1975-1978. In New Zealand, 22 per cent of those at the senior policy level were women, and female medical students had increased from 42 per cent to 46 per cent between 1977 and 1978.

79. In all ECLA countries where figures were available, women comprised over 95 per cent of the nurses and between 80 per cent and 95 per cent of the paramedicals. Female medical students had increased in Cuba from 30 per cent to 35 per cent, and in Peru from 15 per cent to 20 per cent over the period 1975 to 1978. Peru reported that 5 per cent of the senior administrators were women, and for Cuba the figure submitted was 20 per cent.

80. In the ECE region, Hungary, Poland and Romania gave figures documenting the high proportion of women in the medical field, and the different male/female distribution. Romania stated that in 1978 women comprised 25 per cent of the gynaecologists; 58 per cent of the general practitioners; 88 per cent of the nurses; 91 per cent of the paramedical workers and 68 per cent of the medical students.

81. Women constituted 4 per cent of the gynaecologists in Canada; 10 per cent in Denmark, and 15 per cent in the United Kingdom of Great Britain and Northern Ireland. Cyprus (67 per cent in 1978) and Turkey (23 per cent in 1975) had the lowest proportion of nurses. Sweden cited proposals to institute a quota system if the proportion of either sex was below 30 per cent. The United States of America cited a scheme to facilitate the entry of Hispanic women into the health-care delivery system so as to improve both bilingual and bicultural awareness in health care. All countries indicated lower rates of female than male gynaecologists.

82. The number of women entering the medical and allied health professions is increasing but is still concentrated in the service areas such as nursing, technology, social work and research. Most of the countries that stated they were encouraging women referred to those areas. Although there is no actual discrimination against women, it has been left to women themselves to break down the social constraints restricting their entry to the higher professional ranks. The increasing number of female medical students is likely to reduce the disparity in the medical profession over the next decade. Figures produced by the United States of America showed that 27 per cent of the male doctors were under the age of 35, while 39 per cent of the female doctors were under that age.

83. As the work pattern of women doctors tends to favour salaried, hospital-based and teaching positions, the nature of medical practice may also change. There has been some concern about the survival rate of women in the medical profession in some Western countries (for example, Australia, the United Kingdom and the United States of America), where it was feared that women might have a higher drop-out rate than men, and that their training might not be used. 38/ Suggestions have been made that the entry of female medical students should be restricted. Although no legal barriers exist, prejudices among appointing boards (male and female) and the attitudes of women themselves may influence the type of medical work accessible to women.

E. Nutrition

84. The relationship between nutrition and health is crucial for women. An adequate diet is necessary for the normal development of the pelvis during puberty, for the replacement of blood loss during menstruation and for the additional nutritional demands of pregnancy. Severe malnutrition may delay the onset of puberty, interfere with menstruation and be a causal factor in infertility. Traditional customs which interfere with the intake of adequate protein and vitamins and environmental factors such as a shortage of iodine can have serious effects on women, especially during pregnancy. Good maternal nutrition improves the pregnancy outcome for both mother and infant. A World

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38/ See, for example, I. Fett, "Australian medical graduates in 1972," Medical Journal of Australia, vol. I, 18 May 1974.

Health Organization study has shown a link between the increase in perinatal mortality rates and the socio-economic status of the mother. 39/

85. Women also play a strategic role in food production, processing, handling, distribution, preparation and consumption. It is therefore important that women should become involved at all levels of decision-making in food and nutrition programmes and in nutrition education.

86. In developing countries, breast-feeding and child-spacing are major factors in infant survival. A second peak of mortality in children occurs at the weaning stage. Breast-milk is the cheapest and best source of nutrition for the infant; it protects against gastro-enteritis and food allergies, provides antibodies from the mother and is a major factor in delaying the return of ovulation and fecundity. 40/ Babies who are weaned early have a higher rate of infection, malnutrition and death. Adequate nutrition of the mother who breast-feeds her baby is, therefore, of extreme importance for the infant as well as for the mother.

87. The promotional activities of the infant-food industry in developing countries are directly related to the declining trends in human lactation and have had disastrous nutritional and social consequences for both mother and infant. 40/ A recent joint WHO/UNICEF statement on Infant and Young-Child Feeding pledged a campaign to promote breast-feeding and called for the cessation of all promotion and advertising of infant foods. 41/

88. Nutritional anaemia has serious implications for women. In some areas, anaemia is so widespread as to be the norm, and women are particularly at risk. It is estimated that of the 500 million women living in developing countries (excluding China) about half the non-pregnant women and two thirds of the pregnant women are anaemic, making an estimated total of some 230 million anaemic women in these countries. Women in the reproductive years are at special risk in two ways: when not pregnant or lactating, regular menstrual blood loss constitutes a continuing drain of haemoglobin, which has to be replaced through adequate nutrition while pregnancy increases the iron requirements of the woman's body to meet the needs of the growing foetus.

89. Countries in all regions were concerned with nutrition and with the particular vulnerability of women and young children. Food deprivation and protein-energy

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39/ Main Findings of the Comparative Study of Social and Biological Effects of Perinatal Mortality, World Health Statistics Quarterly, vol. 31, No. 1 (Geneva, 1978).

40/ For a comprehensive coverage of the subject, see D. B. Jelliffe and E. F. P. Jelliffe, Human Milk in the Modern World (Oxford, Oxford University Press, 1978).

41/ The joint statement, issued on 12 October 1979, proclaimed, inter alia, that: "Breast-feeding should be initiated as soon after birth as possible ...". "For optimal breast-feeding, the use of supplementary bottle-feeding water and formula should be avoided ...". "Facilities of the health-care system should never be used for the promotion of artificial feeding."

malnutrition constituted serious problems in the ECA region. All countries recognized the need for programmes of nutrition surveillance, improved food intake and nutrition education. Mauritania had carried out sectoral inquiries on nutrition and had established a programme of family welfare covering health, nutrition and hygiene. Togo indicated plans for studying how to improve techniques of food preparation and storage. Sierra Leone stated that a nutrition survey had been conducted as well as a study of customs and beliefs relating to food.

90. All responding countries in the ESCAP region had carried out nutrition surveys and research to help in the formulation and implementation of food policy. For example, studies had been carried out in Australia on the food habits of several groups. The Ministry of Health in Nepal had carried out research on the nutritional value of locally available foods. In 1976-1977, Pakistan had carried out a micro-nutrient survey which showed that protein-energy malnutrition was the most serious problem in the country.

91. Special measures were reported by ccuntries in the ECLA region to integrate nutrition programmes into health education and agriculture, food supplementation programmes, and school and community education. The establishment of women's organizations and co-operatives for the production and distribution of food had been undertaken in many countries.

92. In the ECWA region, similar steps have been taken to identify nutritional problems, implement programmes and establish co-operatives. Iraq stated that it had studied the nutritional needs of pregnant and lactating women, older men and women and young children. Lebanon had a plan, involving the Ministry of Agriculture, academics and development agencies, for establishing food co-operatives and improving the quality of food distribution.

93. Although many ECE countries said they considered nutritional programmes generally adequate, emphasis was given to groups with special needs for whom food supplementation programmes had been introduced. The problems identified included unbalanced diets, an excess of fat and calories, the adverse effects of advertising, the need to improve the nutritional status of indigenous people and problems of alcohol and smoking.

94. Pregnant women, adolescents and infants are the groups most at risk in all regions, and many countries recognized the new problem of the growing number of elderly women. While most countries were concerned with problems of undernutrition, other countries referred to problems of overnutrition and obesity. Even within the developed countries there were areas of poverty and undernutrition. The use of the mass media to promote food of low nutritional value by large food manufacturing companies was a problem for both the developed and developing world.

95. Nutrition programmes cannot be effective if food and technology are unavailable, or if essential foods are financially beyond the reach of those most in need. Supplementary feeding programmes are only palliative and should not be considered permanent solutions.

F. Education in health and nutrition

96. Many programmes for health and nutrition education are based on the premise that health problems occur because people are ignorant and that behavioural change will automatically result from the transfer of information. 42/ These assumptions underestimate the reservoir of knowledge about health and nutrition that is to be found in many societies; in spite of some negative aspects, this has many positive effects on health and ensures community self-reliance and survival. Women have traditionally been important purveyors of this type of education

97. Most countries referred to programmes provided through the schools and health services and through the mass media. There was little indication of the content or effectiveness of the programmes.

98. The ECA countries stated that health education programmes had been intensified since 1975. As an example, the United Republic of Cameroon referred to a campaign to reduce calcium/protein deficiency, endemic goitre and nutritional anemia.

99. The ESCAP countries stated that they used mass media and community seminars and special social and community development projects. Australia referred to the discrepancy between expenditure on health education and the advertising of low-nutrition foods, tobacco and alcohol.

100. Bangladesh and Sri Lanka cited programmes directed through mothers' clubs, using trained and voluntary workers. India stated that nutrition education was included in the training of health workers to educate mothers during domiciliary visits. Among the ECLA countries, Cuba, Colombia, Honduras and Paraguay had health education programmes in schools and rural areas. All of the responding countries referred to special training programmes for health educators.

101. From the ECWA region, the Iraqi Federation of Women provided free meals in kindergarten and primary schools, and worked in health education programmes and centres to reduce illiteracy. In Lebanon, the Office of Social Development, voluntary women's groups and chruch organizations promoted health and nutrition education for women in rural and peri-urban areas.

102. All the ECE countries carried out health education through the schools, health services and training programmes and many of the Eastern European and Scandinavian countries considered the subject adequately covered. The United States of America and Canada emphasized the fact that the transfer of information was not enough unless accompanied by behavioural change. In Canada, a special campaign was directed towards achieving 100 per cent breast-feeding, and a special television campaign was aimed at children aged 9-12 years.

42/ "Who is ignorant? Rethinking food and nutrition education under changing socio-economic conditions" (report of the International Union of Nutritional Sciences, Committee on Nutrition Education Workshop, Tanzania Food and Nutrition Centre, Dar Es Salaam, 1978).

103. All countries were conscious of the need to improve the nutritional status of the population, and particularly of the high-risk groups. Greater emphasis was given to nutrition education and better communication. Health and nutrition cannot, however, increase food production, ensure equitable income and food distribution or end problems of malnutrition, which require political and economic change.

G. Improvements in family planning

1. Family planning

104. The World Plan of Action for the Implementation of the Objectives of the International Women's Year reaffirms the right of individuals and couples to have the information and means to enable them to determine freely and responsibly the number and spacing of their children and to overcome infertility. Where the idea of restricting family size has been socially necessary or acceptable, couples have traditionally used such methods of birth control as prolonged breast-feeding, abstinence, coitus interruptus and abortion. Modernization has disturbed these traditional practices, particularly breast-feeding.

105. Infertility is an equally important problem for some couples and is a major social and demographic problem in the countries of sub-Saharan Africa, and in some areas up to 40 per cent of the women are reported to have completed their reproductive years without bearing a child. 43/ Infertility, once established, requires complicated investigation and treatment, and results may be disappointing. The emphasis on prevention and adequate treatment of such causes as malnutrition, trauma and infection following childbirth or abortion, and venereal infection in both males and females.

106. The responses from Governments indicated that the number of women using contraceptive measures had increased since 1975. 44/ In the ECA region, a number of countries reported increased access to services in both urban and rural areas (for example, Ghana, Kenya, Mauritius, Senegal, Sierra Leone and Togo). Low fertility was a problem in some countries. Mauritania and the Ivory Coast referred to their low population density and saw no need for family planning programmes promoting contraception. The Ivory Coast reported education programmes aimed at achieving the desired family size and at giving infants a better chance of survival.

43/ The Epidemiology of Infertility, World Health Organization Technical Report Series No. 582 (Geneva, 1975).

44/ For a more complete review of world family planning programmes, see D. Nortman and E. Hofstalter, Population and Family Planning Programmes, 9th ed. (New York, N.Y., Population Council, 1978).

107. All of the responding Governments from the ESCAP region had family planning programmes and indicated an increase in the use of family planning services by women. Pakistan referred to the wide use of paramedical field staff, local midwives, and teams of community motivators in the distribution of contraceptives and in education and motivation programmes. The programme was integrated into the health and development network to reduce infant and child mortality and to reduce fertility.

108. In Bangladesh, women's organizations were used to reach rural women through an integrated programme of income-generating activities and non-formal education, covering family planning, child care, nutrition and environmental hygiene. China referred to the success of its family planning policy in reducing population growth since 1971. The programme network extended throughout the country at the village level, and emphasized the use of contraceptives, late marriage and small families.

109. Many of the countries in the ECLA region reported that family planning was carried out mainly by the private sector. Cuba stated that 90 per cent of the urban women and 80 per cent of the rural women had access to information on family planning. The Dominican Republic and Peru reported an increase in access to family planning services.

110. Four ECWA countries reported that family planning education and services were largely functions of the private sector. Iraq commented that it was experiencing a shortage of manpower and that therefore the restriction of births was not encouraged; education with an emphasis on child-spacing was encouraged. In Lebanon, family planning services had been increased and information was available through several avenues. Work had begun on amendments to the penal code, which restricted the giving of contraceptive information.

111. Most ECE countries stated that access to family planning was widely available, although less so for adolescents. In Ireland, the sale of contraceptives was still illegal, but a law liberalizing family planning was in preparation. A number of ECE countries were seeking to promote fertility. A paper submitted by Hungary described the unsuccessful attempts to promote fertility by restricting abortion. The Netherlands was the only country of the ECE region that reported a need for population control.

112. The United States of America cited increased access to family planning services between 1975 and 1978, in urban areas from 56 per cent to 85 per cent and in rural areas from 35 per cent to 80 per cent. Special emphasis was given to extending access to all countries and to all groups, for example, by using Indian health workers to reach the Indian population.

113. There are still wide differences in the availability of family planning advice and services from one country to another, in the different socio-economic groups and between rural and urban areas.

2. Sterilization

114. Voluntary sterilization is being used increasingly in both developed and developing countries as a terminal method of contraception, especially because of reports that oral contraceptives may have more serious side effects on older women. 45/ A number of countries indicated the increasing availability of voluntary sterilization for women (for example, Denmark, Honduras, Norway, the Philippines and the United Kingdom).

115. There is always a danger that sterilization, if not properly managed, can be carried out on specific population groups without their informed consent. The United States of America stated that "the Department of Health, Education and Welfare has issued new regulations covering the sterilization of women which would be particularly important to poor and/or minority women who in the past have suffered disproportionately from indiscriminate sterilizations".

3. Abortion

116. Several countries also referred specifically to recent changes in abortion legislation. 46/ Historically, induced abortion has been the widespread use of sterilization and modern contraceptives, abortion appears to have become less important as a method of birth control. 47/ Illegal abortions, often performed by unskilled people in unhygienic surroundings, have been a major cause of maternal mortality and morbidity and subsequent infertility in many countries. 47/ Mortality and morbidity arising from abortion have declined when abortion has been legalized. 48/

117. The availability of legal abortion, even, may be limited by a lack of accessible facilities, cost, the persistence of religious attitudes and restrictive clauses. For example, Austria stated that it had introduced legislation on abortion in 1974-1975 but facilities were not yet available throughout the country. The Netherlands reported that legislation would be enacted in 1979 to formalize the legalization of abortion, which was already de facto, widely available.

45/ For an over-all analysis of global trends, see United Nations Fund for Population Activity, Survey of Laws on Fertility Control, Part I, Voluntary Sterilization (New York, N.Y., 1979).

46/ See United Nations Fund for Population Activity, Survey of Laws on Fertility Control, Part II, Termination of Pregnancy (New York, N.Y., 1979).

47/ The Epidemiology of Infertility, World Health Organization Technical Report Series No. 582 (Geneva, 1975).

48/ Induced Abortion, World Health Organization Technical Report Series No. 623 (Geneva, 1978), p. 15.

118. Other countries reporting legislation to make abortion available on wide medical and social grounds were Hungary (1973-1974); German Democratic Republic (1972-1976), and Israel (1977-1978). In contrast, the United States of America referred to a court ruling in 1977, which relieved the states from the obligation of paying for abortions that were not "medically necessary" in welfare programmes mainly benefiting indigent women.

119. The risks from abortion increase with the duration of pregnancy, and do so rapidly after the third month. 49/ Later abortions occur most often among women of a lower socio-economic status, and in the younger age groups. 50/ Concern about adolescent pregnancies was expressed by many countries.

120. In summary, women of all ages and in all groups in society must have more access to contraceptive information. Abortion data indicate the groups most at risk and also reflect the effectiveness of family planning programmes and practices. Thus a need for the development of simple, safe, effective methods of contraception, which will be inexpensive, easily available and culturally acceptable is clearly indicated. The evaluation and surveillance of methods to be used in developing countries should be carried out in the countries themsevles. 51/

121. Many factors are involved in the determination of family size. The adoption by Governments of favourable population policies can help to avoid problems and hasten solutions, and many Governments are becoming aware of the problems involved.

49/ Ibid., p. 19.

50/ Ibid., p. 28.

51/ Working Paper No. 4 of the International Conference of Parliamentarians on Population and Development, reproduced in Populi (a quarterly publication of the United Nations Fund for Population Activities), vol. 6, No. 3 (1979).

III. OBSTACLES AND PRIORITIES

A. Obstacles

1. Obstacles to improvements in the health status of women and health services

122. Countries in the ECA, ESCAP and ECWA regions referred to problems of access to the rural areas, the maldistribution of health-care services, and the lack of funds and of trained staff to meet the needs of the expanding health services. India and Bangladesh cited problems due to the sheer numbers of people involved and the fact that most of the population lived in rural areas. Ghana emphasized management problems and the poor distribution of resources, with a concentration of hospital-based services in the large towns, and poor co-ordination with other agencies.

123. In the ECLA region, most countries identified financial constraints as the major obstacle to improving health services and there were difficulties in co-ordinating the activities of the various departments. Argentina stated that the lack of human resources and poor utilization of services by people who needed them were major obstacles. Colombia and Bolivia cited, in addition, the difficulties of co-ordinating the activities of various departments.

124. Many of the ECE countries considered their health systems were adequate to deal with any problems. The obstacles that were specified included the uneven distribution of information and services, limited finance and resources, and the lack of an adequate data base and methodology. Finland cited as problems the dominance of the medical model, and an overemphasis on medical care and hospitals. Canada referred to the paternalistic attitudes of male doctors and the male-oriented approach to illness, rather than the inadequacy of services for women.

2. Obstacles to the participation of women in the delivery of health services

125. Except in the Eastern European countries, women's participation in the health services was concentrated in lower-status occupations. Several countries identified no obstacles other than persistence of traditional attitudes and cultural inertia, which viewed women as unsuitable for certain jobs. Denmark commented on the small number of women candidates for jobs at policy-formulation levels; Norway found an important obstacle in prevailing attitudes, which confined women to a narrower range of occupations. In the ECWA and ECA regions, Bahrain referred to the cost of educating girls, given the legal and social constraints on women. Lebanon cited the persistence of the traditional idea that women were incapable of occupying positions of responsibility. The United Republic of Cameroon commented on the psychological barriers imposed by a six-year medical course, which deterred women from becoming doctors in favour of other professions, and on the lack of adequate nurse-training institutions.

3. Obstacles to the improvement of nutrition

126. Obstacles cited in this area included (a) low incomes, unemployment, inflation and high costs - particularly of essential foods; (b) low levels of production and

a lack of human and financial resources; (c) public indifference regarding the health and nutrition status of women and children; (d) a lack of community participation in nutrition programmes; (e) the inaccessibility of isolated populations, and (f) a lack of centralized decision-making and defined policies.

127. Both the disruption of traditional diet patterns by changes in food production, due to the development of a market economy and to modernization, and the persistence of unsound traditional practices relating to food contribute to poor nutrition.

128. Various ECA and ESCAP countries also referred to lack of finance and the inaccessibility and shortage of trained staff. Ghana commented that 70 per cent of the population was illiterate and lived in small villages. The Libyan Arab Jamahiriya referred to the failure to include nutrition in many health and medical training programmes. Papua New Guinea mentioned the following change in food production practices as an important obstacle: "decrease in domestic food production due to concentration of extension efforts on production of cash crops for export, a 3 per cent per annum population increase and a high rate of migration". The indiscriminate advertising of prestige foods and artificial foods on television and radio and in the press was cited by countries in several regions.

Obstacles to family planning

129. Many countries from the various regions referred to social, cultural, financial or legal constraints, which restricted the knowledge and use of family planning. The lack of trained personnel and facilities, the failure of Governments to acknowledge the need for family planning policies, the lack of an infrastructure and fear of the side-effects of contraceptives were also reported.

130. Botswana referred to the suspicion in which males, as heads of families, held "female" methods of contraception, and the feeling that family planning was a foreign idea, contradictory to the African tradition of family formation. Similar ideas were expressed by other countries in the ECA region. Ghana referred to the lack of finance and resources, the high degree of illiteracy, and the lack of motivation.

131. From the ESCAP region, Bangladesh stated that, with a high degree of illiteracy, women found it difficult to establish priorities when new skills, such as family planning, agriculture etc., were taught simultaneously. Singapore mentioned the marginal participation of males in sterilization programmes as an obstacle. Pakistan indicated that its programmes suffered from deficient organization, inadequate training, poor supervision and a lack of follow-up action.

132. Additional obstacles to continued progress reported from the ECLA region were the difficulty of changing attitudes towards family planning so as to make it a health programme (Paraguay); the efforts of outside agencies to insist on a population policy as a condition for financial support in the family planning field (Bolivia); political factionalism, tradition and culture (Colombia).

133. In the ECE region, major obstacles were also related to the persistence of restrictive cultural and religious attitudes, anxiety about abortion and sexual behaviour, and the limitation of finance and resources. There was a lack of priorities at policy levels, and a reluctance to recognize the needs of special groups, particularly the young and unmarried. Better communication strategies were needed to improve information and effect a change in attitudes.

134. Israel referred to the difficulty of integrating family planning into the health services within existing financial constraints. Canada referred to the need for information and for attitudinal change, to the delay in legislation, to political and religious resistance and the "de-emphasis on the preventive long-term orientation of family planning" because of overreaction to the abortion issue.

B. Priorities for 1979-1985

135. Countries in all regions stressed similar targets and priorities in the delivery of health, nutrition and family planning services, which emphasized both preventive and therapeutic aspects. In general these included increased training facilities for nurses, paramedical technical staff, midwives, nursing assistants and traditional birth attendants; the expansion of existing maternal, perinatal and child health services, the extension of public health and immunization programmes; and nutrition and health education.

136. Several countries cited specific targets. The Libyan Arab Jamahiriya planned to institute a campaign to combat contagious and endemic diseases, in particular, trachoma and malnutrition. Other priorities were regionalization and the extension of programmes to reach people in socially and geographically isolated areas, and to increase community participation.

137. India planned a preventive campaign against nutritional anaemia, to reach an additional million women per year; India and the Philippines outlined comprehensive programmes to improve sanitation and safe water supply in industrialized cities and rural villages; Botswana's highest priority was to improve primary health care and to increase ante-natal and post-natal services to reach 80 per cent of the target population by 1985.

138. Denmark stated as one of its priorities the investigation of the effects of industrial chemicals on the pregnant woman and her child. Some countries, for example, the Netherlands, mentioned the need for a reorientation of programmes in order to improve and expand the delivery services within the over-all budget restrictions.

139. A number of countries gave priority to increasing female participation at various levels of health sector occupations. Sierra Leone, in particular, indicated plans to expand the integration of traditional birth attendants into the health services. The Libyan Arab Jamahiriya reported incentive programmes for women to train as nurses, pharmacists and medical technicians.

140. Most countries indicated priorities and targets that would lead to a general improvement of the nutritional status of the population. The following response was made by Papua New Guinea: "The national food and nutrition policy is aimed at reducing nutritional problems and increasing domestic production so that there will be no further rise in the volume of food imports".

141. One priority mentioned by countries in several regions, for example, Canada and the Dominican Republic, was the need to change nutritional habits. Other priorities included plans to increase the coverage and impact of nutritional programmes, better food production and processing, and research into all aspects of women's health and nutrition. Brazil, Pakistan and other countries listed a number of priorities, including food supplementation programmes, the development and distribution of low-cost nutritional foods, the strengthening of the nutrition component in the health network, and the use of the media for nutritional education. Sri Lanka referred to a plan to integrate a community nutrition programme at the village level, to establish a school farm project in every electorate, to carry out a mass media campaign to increase community awareness, and to undertake programmes of nutritional surveillance to identify areas for nutrition intervention.

142. All countries gave high priority to health and nutrition education both in training of health educators, teachers, welfare workers and health professionals, and at the community level. Cyprus stated that scholarships were provided for post-graduate courses in health education. Australia referred to the need for education in nutrition to involve industry, the mass media and consumers, as well as the health professions. Through health education, Canada hoped, over a period of 15 years, to raise to adulthood as non-smokers a generation of children born in 1979.

143. Most countries attached priority to the promotion and expansion of family planning programmes, including the removal of legal constraints, to reach all groups in the community.

144. ECE countries such as the Netherlands, the United Kingdom and the United States of America emphasized the particular need of adolescents for better access to family planning information and services, and the development of a technology more suited to their needs. The United Kingdom also stated that one of its priorities was to extend the availability of sterilization as an alternative to oral contraceptives.

IV. CONCLUSIONS

145. This paper has presented a review and analysis of the progress made and obstacles encountered in the field of women's health in the first half of the United Nations Decade for Women. Using as indicators the increase in female life expectancy and declines in infant and maternal mortality rates, improvements have occurred in the health status of women. Such generalizations, however, obscure persistently high or increasing rates of maternal and infant mortality among particular groups and do not give a complete picture of morbidity among women. Although countries have reported measures to improve health services in all areas, there are still disparities, manifested by the differences in rates, where these were available, between high and low socio-economic groups, between rural and urban women, and between minority groups and the rest of the population. The disparities between countries are most obvious. Although health services are not necessarily to be equated with good health, there is a link between the availability of health services and the social health status of women.

146. Socio-economic changes arising from unequal and rapid development, complicated by massive rural-urban migration and rapid population growth, and in some countries by military conflict, reduce the effectiveness of the measures taken by many countries to improve health services and to improve health and nutrition.

147. The lack of financial resources is a major obstacle, compounded by inflation. A maldistribution of services favouring the affluent urban areas, inadequate infrastructure and poor communication and transport create problems of equity. The limited access to rural areas hampers the delivery of services. Problems of communication are compounded by illiteracy, a lack of awareness and information, the tenacity of traditional beliefs and practices, which are manifested in a reluctance to accept innovations, and in the lack of community participation in some health programmes. The excessive physical activity characteristic of the work patterns of rural women not only precludes their participation in health programmes but also adversely affects their health.

148. Additional problems are inadequate training and supervision of health administrative personnel, a lack of defined policies, and a lack of co-ordination between different agencies, compounded by the shortage of trained staff. The participation of women in health-sector occupations indicates some increase at the levels of decision-making and planning, and a larger increase in the lower ranks of the profession. The persistence of social, religious and cultural attitudes that may no longer have validity, the lack of political commitment and an inadequate perception of the long-term health benefits of family planning, rather than its demographic aspects, restrict access to family planning for many groups of women.

149. As a result of these findings, the following broad priority areas for action by Governments, international organizations and women themselves are indicated:

Public health measures to ensure protection and improvement of the environment, to provide safe, available water supply and to conserve natural resources;

Recognition of the social and health needs of women that are defined by, but extend beyond, their reproductive role;

Measures aimed at the reduction of maternal and infant mortality and the elimination of inequality among women in health status and access to health services;

The extension of measures to provide primary health care in the broad terms of the Declaration of Alma-Ata, with the integration of modern and traditional medical systems and the removal of barriers to women's equal participation in the delivery of health services.

150. The broad areas for action indicated above will be outlined in greater detail in the Programme of Action for the second half of the United Nations Decade for Women.

151. Efforts to improve health services for women and children will benefit the health of the whole community. It is important that women themselves should become involved in the process of health care delivery, not only as consumers but also as active participants and planners. Efforts should therefore be made at the onset of any health planning process to integrate significant numbers of women with a strong commitment to issues concerning women, at the decision-making level as well as at other levels of the health-service delivery system. Attention should also be paid to social, cultural and economic considerations, in order to plan and carry out effective health-care delivery systems in developing countries, in order to avoid some of the problems that have been encountered in developed countries.

152. It is important that during the second half of the Decade action to improve women's health should become a reality, as a positive contribution to social and economic development, equality and peace.
