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HEALTH NEEDS OF THE WORLD'S POOR WOMEN

Edited by
Patrick W. Blair

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**Based on the proceedings of the International Symposium
on Women and Their Health, sponsored by Equity Policy Center
and held June 8-11, 1980 in Port Deposit, Maryland**

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1302 18th Street, NW Suite 502
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Preface

This volume marks the end of a series of activities undertaken by the Equity Policy Center (EPOC) to provide substantive materials for the World Conference of the United Nations Decade for Women which was held in Copenhagen in July 1980. The themes for that conference were: education, employment, and health. EPOC chose health as its major emphasis, for in this area two quite different sets of ideas were emerging which needed to be brought together.

The first set of ideas were a result of the International Conference on Primary Health Care in Alma Ata, U.S.S.R. in 1978, the world community proclaimed that "all peoples" were entitled by the year 2000 to "a level of health that will permit them to lead a socially and economically productive life." Calling for a shift from hospital-based curative systems of health care delivery, the declaration saw primary health care as "the key" to attaining this goal for the world's poor. This shift in emphasis from institutions to people had special implications for women's health. Traditionally, maternal and child health care issues dominated in the thinking on women's health care; the new focus created an opportunity to examine a much broader range of issues, including occupational health, chronic disease management, health and nutrition, and reproductive health care.

The second set of ideas have their origin in the women's health movement which began arising spontaneously in many countries over a decade ago. An early target of this grassroots movement was the restrictive abortion laws which limited women's control over their own bodies. In the U.S., many women had reacted to male-dominated medicine by forming health collectives in which women were trained in self-care. Rape centers were being established to counter the callous handling of rape victims by police and hospital personnel. Shelters for battered women were multiplying. Internationally, encouraged by interest aroused during the 1976 International Tribunal on Crimes Against Women held in Brussels, networks were springing up among groups concerned with sexual violence, white slavery, and female circumcision. In India, for instance, women were organizing protests against sexual abuse and violence toward women by family members, husbands, and police. In Africa, there was a considered effort to collect information on the actual practice and health implications of various types of female circumcision. The use and abuse of female contraceptives became an issue for women in all countries from all socioeconomic levels. Unfortunately, however, this upwelling of concern by women for their physical and mental well-being went largely unnoticed by the international health establishment.

The underlying purpose of the International Symposium on Women and Their Health, on which this volume is based, was to bring together advocates of the women's health movement with professionals actively involved in primary health care. The question to be addressed was the extent to which current health systems respond to the special needs of women in their multifaceted roles as worker, citizen, and mother.

Each of the fifty-two women and men invited to the Symposium was asked to prepare a short paper discussing women's health issues from their particular viewpoint. The emphasis was on health delivery systems to the disadvantaged, particularly in the less developed countries, and how women's differing health needs could be better emphasized and addressed. Additionally, the emphasis was on identifying those areas

related to women's health about which little is now known and thinking about ways responsive programs could be initiated to respond to needs in those areas.

Yet the problem of reaching the poor, especially poor women, is worldwide. Therefore, included among the participants were women engaged in community health in the U.S. itself. Here was an opportunity for American minorities trying to reach the poor in their own communities to discuss common problems with Third World women and men in terms of reality rather than the often facile rhetoric of Third World unity. It was an equally valuable opportunity for the Third World participants to learn of the difficulties experienced by American minorities as they attempted to provide health care to the poor of their communities.

The symposium took place June 8-11, 1980 in a spacious old mansion set on the tranquil bank of the Susquehanna River. There was no formal presentation of papers. Rather, most of the discussion took place in five working groups, each with a specific theme: (1) Health Issues of Women as Workers, (2) Health Issues of Women as Mothers, (3) Health Issues of Women as Women, (4) Health System Responses to Women's Health Needs, and (5) Women as Members of the Health Care Team. In the final plenary, reports and recommendations from each working group were reviewed and clarified so that the workshop report included all the diverse ideas and attitudes represented at the Symposium. These reports, reprinted here in Appendix I, are meant to be a checklist, not a policy document. Decisions on implementing the many cogent recommendations must be up to other bodies.

To further the incorporation of ideas from the Symposium into national and international health programming, EPOC held over its foreign participants for two days in Washington so they could present workshop recommendations in person at a panel session of the Annual Meeting of the National Council for International Health. De-briefing meetings at USAID and PAHO were also scheduled for them.

A major follow-up activity took place at the July World Conference of the U.N. Decade for Women in Copenhagen. EPOC organized three panels at the World Conference's Nongovernmental Organization (NGO) Forum. At one of these, eight Symposium participants present at Copenhagen elaborated on the Symposium recommendations. The other two panels provided an opportunity for women from China, Somalia, and Nigeria, among other countries, to discuss problems of health and health care delivery in their own countries. Techniques for extending health education to poor women were thoroughly discussed: One successful method is the use in Costa Rica of tape cassettes played on the radio and in village meetings. The most contentious issues, not only at the panels but at the NGO Forum as well, related to female circumcision and contraceptives. While circumcision was generally viewed as an African problem better left to women from that continent to solve, safe contraception was recognized as an issue for women everywhere. Thus the panel recommended:

- That an international health standards committee be set up to develop international standards for contraceptives and medicines.

A second recommendation put forward by the panels reflected the international debate on refugees which consumed much time at the World Conference:

- That women pressure organizations in their own country servicing refugee camps to ensure that the special needs of women refugees are met, including help for mental stress as well as primary health care.

Many of the health problems in the less developed regions of the world are related to unclean water and inadequate sanitation. As this theme was repeated, it became clear that few women were actively involved in national or international efforts to provide clean water in their countries. Thus the final panel recommendation was:

- That women in every country work to ensure that there are women on the national planning committee for the International Drinking Water Supply and Sanitation Decade 1981-1990.

The Symposium, while emphasizing health problems, nonetheless concluded that women's roles in the delivery of health needed to be recognized and strengthened. It was gratifying for EPOC and several Symposium participants to be invited by the World Health Organization (WHO) to a multinational consultation which focused on women in the health profession, but saw them as key to the delivery of primary health care to women and men at the household level. The purpose of the consultation was to identify issue areas which might become the focus of future WHO programming. The issue areas given greatest priority include:

- Decisionmaking roles of women in health professions at all levels, but with emphasis on senior level positions, including roles in medical schools, professional societies, health ministries and planning agencies, as well as in institutions providing health;
- Present roles and contributions of women in village or community level informal systems and in home health care;
- The utilization of village or urban community women as paraprofessional health providers: What is adequate training, recompense? How does the use of women's organizations at the village or community level enhance the effectiveness of the selection, intervention, or training? How can the need for daycare centers provide a mechanism for providing health care and information to the mothers as well as children?
- Improved conditions and rewards for work as health providers to encourage retention and re-entry of trained women, especially nurses.

Case studies and policy papers in these areas are being commissioned for presentation at an international meeting of health planners and practitioners in August 1982. These papers will add significantly to the literature which illustrates the interconnection between health for women and health delivered by women.

In this manner, and through this volume, it is hoped that a greater recognition will be given to the special health needs of women in all their roles. EPOC conceived of the Symposium but had the generous help of the following women who participated in the planning process: Janice Burns, Pan-American Health Organization (formerly with Project HOPE); Rebecca Cook, Board of Directors, Pathfinder Fund and formerly with the Law Project, International Planned Parenthood Federation; Peggy Curlin, Centre for Population Activities; Vicki Hammer, World Health Organization; Sally Huber, Population Crisis Committee; Julia Graham Lear, Georgetown Medical School Community Hospital Program; Isabel Nieves, International Center for Research on Women; and VeNeta Masson, Community Medical Care, Inc. EPOC also had the

generous help of many concerned persons who suggested and supplied information about prospective participants and provided much information and advice relating to agenda topics.

EPOC consultants, staff, and interns worked long hours to ensure smooth arrangements both for the meeting and for the travel: Sarah Becker and Veronica Elliott, two accomplished health planners, assisted in the organizing; Naresh Johri masterminded the logistics; Lani Davison coordinated the program and oversaw proceedings preparation and publication; Cynthia Tutrone and T'jip Walker did a little of everything. Rita Doherty assisted in the initial stages of the project. Special thanks must go to Patricia Blair who wrote the cogent background paper on U.S. health programming for the developing countries (distributed at the Symposium and at the World Conference); compiled the Interim Report; and edited the Symposium papers.

One of the earliest and strongest supporters of this Symposium was Stephen C. Joseph, former Deputy Assistant Administrator for Human Resource Development, U.S. Agency for International Development. With his encouragement, three members of his staff, Patricia Baldi, Ann Tinker, and Theresa Lukas, contributed their expertise and advice through the several phases of this project. Irvin M. Cushner, former Deputy Assistant Secretary for Population Affairs at the Department of Health, Education and Welfare (HEW), was also very supportive and sponsored a seminar at HEW where EPOC introduced international issues relating to women and their health. Juel Janis maintained the link between EPOC and HEW. Throughout the preparation for this Symposium and other activities which EPOC undertook in connection with the World Conference, we had the enthusiastic support of Arvonne Fraser, former Director of the Office of Women in Development at USAID.

USAID provided basic planning costs for the Symposium and for publication of this volume. Additional support for publication came from HEW. Participant travel and conference costs were provided by the U.N. Fund for Population Activities, the U.S. Agency for International Development, the Pan-American Health Organization, the Asia Foundation, the Ford Foundation, and the World Bank. The HEW Center for Disease Control sent two of its staff members to participate in the Symposium. The Women in Development Office of USAID supported the background paper on U.S. health programming and paid for EPOC participation at Copenhagen. We wish to express our warmest thanks to them all for assisting in making the Symposium and its follow-up such a significant event.

Washington, D.C.
September 1981

Irene Tinker
Director
Equity Policy Center

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INTRODUCTION

The papers in this collection constitute an important resource for those concerned with the health of deprived women everywhere, especially those in the Third World. They were written by women, and some men, with first-hand expertise in health issues of specific concern to women. In contrast to many of those involved in research and planning regarding women's health needs, these authors do not see women only "from the waist down"--i.e., only in their roles as bearers and rearers of children. Rather, they attempt to focus on women as individuals at various stages of life and in various roles, including those of producers of economic goods and generators of family income.

The collection begins with a survey of women's health problems across the broad spectrum of developing countries. Several papers focus on generally neglected aspects of women's health, such as abortion, sexually transmitted diseases, and the consequences of domestic violence. One section provides a detailed analysis of malnutrition, perhaps the most basic and pervasive problem of poor women. Five contributors discuss parallel health issues from the point of view of deprived groups in the United States.

These authors and others offer many suggestions for reaching women in rural backwaters and urban slums. It is clear that many health-care programs today do not take account of the constraints on women's time and mobility or of the sociocultural inhibitions that minimize women's access to health services. A section on water and sanitation suggests that programs in that sector suffer from similar shortcomings. A number of these papers highlight the need for women-to-women delivery systems and the critical importance of programs that will give women the self-confidence, as well as the cash, to seek health care for themselves and their families.

In much of the Third World today, health policy and practice is undergoing review. The roles of doctors, nurses, and traditional healers are being re-evaluated for their effectiveness in reaching the poor majority. Changes are clearly needed in the typical hospital-based, urban-oriented systems and in the medical and nursing education that perpetuates them. The papers on health care providers in this collection offer useful insights into what needs to be done, as do those on national and international strategies. Reports on some promising health-care projects suggest the potential value to women of a new approach, for women are indeed the majority of the poor almost everywhere.

Many, perhaps most, of these authors have conducted research and analysis that was partly or wholly financed by international agencies. At the International Symposium on Women and Their Health they spent some time discussing how internationally financed research could be made more usable and acceptable in their home countries. In general, they noted that researchers in developing countries want and appreciate outside help but do not want to be overwhelmed by it. International pressure to spend large sums for research on "fad" subjects is particularly dangerous, because it tends to skew the pattern of inquiry and attract those who are tempted by the prospect of funding, the chance for travel, etc. On questions relating to women, especially, the "objects" of research need to be involved in the study design and informed of the results. Several participants mentioned potentially useful studies that had been transmitted only to the funding agency that sponsored them, thus cutting down considerably on their value. In some cases, the host governments were not even aware that the studies existed. These reports could be much more useful if funds were

included to translate them and circulate them at national and local levels. For related reasons, participants felt that it was important that international agencies use local consultants wherever possible, in preference to "outsiders" who might have less cultural awareness and sensitivity and who would, in any event, take their knowledge away with them.

The present collection attempts to conform to the spirit of those recommendations. It is comprised mainly of work by Third World authors with a continuing commitment to improving the health of deprived women. In most cases, the papers have been abridged or otherwise edited, but every effort has been made to retain and highlight their main points. They offer a wealth of thoughtful, constructive ideas and suggestions that will repay study by national and international policymakers.

I. TESTIMONY FROM THE THIRD WORLD

Voices from the Third World offer many insights into the health problems of poor women in Asia, Africa, and Latin America. They stress the effect on women of their double burden of work and family responsibilities. Zafrullah Chowdhury estimates that women are responsible for 70 percent of the work of food production, 50 percent of the animal husbandry, and 100 percent of the food processing and child-rearing (to say nothing of the childbearing) in Bangladesh. Ruth Shaw-Taylor cites similar statistics from Sub-Saharan Africa. A study of two communities in Ghana found that women averaged only 40.2 hours of leisure in a month, compared to 103.2 hours for men. Overwork, combined with pervasive malnutrition and frequent childbearing, opens the door to a multitude of afflictions. Cultural patterns decree that women eat less, work harder, and generally suffer in silence. As Belkis Wolde Giorgis and others point out, "development" often bypasses them; or, worse, deprives them of earlier sources of strength and independence.

The papers in this section stress women's needs for primary health care, family planning, and recognition of the many roles they play in helping their families to survive. Perhaps more interesting--because less often remarked on--is the stress these authors put on health-related factors sometimes thought to be of concern only to women from more industrialized societies. Sevgi Aral and Mary Guinan, for example, discuss the serious consequences in women and their offspring of sexually transmitted diseases. While it is admittedly more difficult to treat those diseases in women than in men, they argue that much more could be done in the way of research, education, and early detection and treatment for women than is being done at present. Sujata Kanhere points out that violence against women--rape, battering, burning, and criminal neglect--is all too common in the Third World but is usually passed over in silence by the doctors, nurses and social workers who should be dealing with its consequences. Nonceba Lubanga speaks of another kind of violence--the institutionalized discrimination in South Africa that permits such gross disparities in health and other sectors between whites and non-whites. Hamid Rushwan cites abortion as a major public health problem everywhere; he notes the benefits to be gained from liberalizing abortion legislation and offers other positive suggestions. Celia Ferreira Santos estimates that 300,000 to 340,000 Brazilian women die each year from the complications of induced abortion--a terrible, and largely unnecessary, toll. Almost all the papers underline the mental stress inherent in the many conflicting roles that women in developing societies play. Ruth Shaw-Taylor provides some interesting data from a study of psychoneurosis among Ghanaian women as well as insights into the value of traditional healers in treating them.

It is clear, as Banoo Coyaji puts it, that Third World women "are caught between the pincers of poverty and tradition." If there is one theme that runs throughout these papers it is that women in the Third World tend too readily to accept the status and roles that their societies have given them. This is particularly true, as Marie Assaad reports, with regard to the traditional practice of female circumcision. "While every effort must be made to strengthen the outreach of the health services," says Prabha Ramalingaswami, "it is equally important to strengthen the woman herself." The various government commissions on women have helped to identify needed changes, and those who plan and administer development programs would do well to heed them. But these writers seem to agree that self-awareness and self-respect on the part of women is fundamental to any real progress. Their prescriptions range from increased education and income-producing activities for women to more effective grass-roots organizing by women.

India: Women's Deteriorating Health

Bango J. Coyaji

It is often argued that the position of women in Indian society is higher than ever before. And that is true—for a miniscule number of upper-class, educated women in cities. But women and children, especially of the backward classes, continue to suffer, particularly in the rural areas. They bear the burden of childbearing, child rearing, and family care in addition to having to supplement the family's income through back-breaking work in the fields and factories. They have very little or no decisionmaking powers or self-esteem, even when they are wage earners.

The government's Advisory Committee on women's studies, in its report dated September 1977, found "indisputable evidence of a steady decline in the value of women in society," made even more disturbing by the fact that the process of deterioration has accelerated in the last three decades. This is evidenced by:

- greater mortality among women and female children (e.g., 61.1 per 1,000 for girls 0-4 years versus 55.5 for boys in 1971);
- persistent decline in the male/female sex ratio—from 979 in 1901 to 941 in 1961 and more steeply to 930 in 1971;
- glaring disparity between men and women (among poorer sections) in access to health care and medical care;
- increasing gap between men and women in literacy, education and training for employment. (Literacy rates for rural and urban women were 13 percent and 34 percent, respectively, as compared to 34 percent and 61 percent, respectively, for men.
- accelerated decline in women's employment since 1951; and
- declining representation of women in decisionmaking bodies at all levels.

There is a definite disparity between men and women among the poor in access to health care and medical services. A survey in Maharashtra State covering a population of 37,000 showed that a higher proportion of ailing boys under 15 got treatment than ailing girls. More adult women got either no treatment, free treatment, or traditional treatment and home remedies as compared to treatment received by men. While incidence of diseases caused by malnutrition is higher among women, the hospital rate of admission of boys and adult males for these diseases is larger. Female babies are invariably brought to hospitals or doctors at a much later stage than male babies. In spite of the heavy toll of lives of women during childbirth, maternity beds constitute less than 17 percent of total hospital beds. More than 90 percent of births in rural areas are handled by relatives and untrained birth attendants.

Excessive childbearing—too early, too often, too many, too late—takes its toll. Universal marriage, early age at marriage, high fertility, and the value attached to fertility (especially the bearing of sons) have the effect of pushing up the number of pregnancies and births per woman. Childbearing and rearing is considered her prime

function. High infant mortality reinforces the desire for more children as insurance against death, and the vicious circle goes on.

A survey by the National Committee on the Status of Women revealed that, in 48.53 percent of the families interviewed, males eat first and females eat whatever is left over. It is not surprising, then, that the nutrients intake gap in pregnant and nursing women is so high.

Nutrients Intake Gap for Pregnant Women*

<u>Nutrient</u>	<u>Daily Requirement</u>	<u>Actual Intake</u>	<u>Percentage Gap</u>
Calories	2500	1440	42 %
Proteins gms	55	37	33
Iron mgs	40	18	55
Calcium gms	1	0.2	80

* National Institutes of Health

Male/Female Inequality 2

1971

<u>Particulars</u>	<u>Females per 1000 males</u>
Literate	474
Illiterate	1342
Matriculate	277
Graduate	246
Workers	210

Women in India did not have to fight for the right to vote. The preamble to the Constitution of India has guaranteed to all its citizens--men and women--equality of status and opportunity, equality before the law, equality in employment. There is even a specific provision (Article 15/3) empowering the state to make special provision for women and children, if necessary, in violation of the fundamental obligation of non-discrimination.

In spite of this, believe me, women are second-class citizens. The girl is used to bowing to the father in childhood, to the husband in adulthood, and to the son in old age. Due to a tradition of male domination, women have become dependent and conditioned to bear all suffering silently. They are caught between the pincers of poverty and tradition. Development activities in a great many cases have had an adverse impact on them. In agriculture, food production, dairy, industry, and marketing, training has been given to the better educated men. Men and machines have therefore replaced women.

The first prerequisite to improve this situation is education of women and men. In addition to changing male attitudes, women themselves must get over the complacency and the tacit acceptance of their lot. Only then will they develop their personality, health, and freedom. Will they be happier? That is another question, since modernization and affluence bring their own diseases. At least in India, children still look after and respect their aged parents; there are no such things as old-age homes in my country.

A Double Oppression In Bangladesh

Zafrullah Chowdhury

Although oppression by economic conditions and cultural values is the common lot of women everywhere, Bangladeshi women face this double oppression in an extreme form. For the great majority of them, the notion of purdah means almost total seclusion within the walls and fences of their home courtyards. Women in Bangladesh do not engage in trade or in the sale of goods; they do not even do the household shopping. They travel rarely and then only in the company of a male chaperone. The few women who do venture into the street do so only for specific purposes and hurry to their destination, constantly dodging men who pass remarks. The result is that women are entirely unused to public life, and helpless if any problem arises. A sick woman will wait for her husband to return from work and accompany her to a doctor, not only out of modesty but because she simply does not know the way even if she has spent her whole life in the locality.

Changes in the law have had little effect. Although Muslim women are theoretically protected by some reforms—e.g., child marriage was outlawed; women were given guardianship of their children; some protection was introduced against a husband's polygamy or divorce—and the legal status of Hindu women has remained unchanged since Independence, anyone familiar with Bangladesh society knows that in practice Muslim women are considerably worse off than Hindus. This shows how minimal is the effect of the law on the reality of Bangladesh society.

Women in Bangladesh have two major functions, neither of which is recognized as having any value, either by the women themselves or anyone else. One is food production, the other childbearing and child rearing. To be a good wife or daughter, a woman must be visibly busy. This holds true for both poor and rich women. Evidently, money does not bring hired labor—either servants or milled rice—for women, at least not to the same extent as for men. Men gain at the expense of women.

Bangladeshi women are responsible for 70 percent of the work of food production, 50 percent of the animal husbandry, and 100 percent of the food processing and child rearing. The daily round of the village woman is literally very hard, strenuous labor. The sound of the dekhi (a wooden pestle pounding on a hollow stump) husking the paddy in a village may be romantic to the ear of the tourist, but in reality it is the sound of wasted human energy by a deprived class. Furthermore, daily life brings many occupational hazards. When cooking, the smoke of whatever the woman has been able to find for fire-making—leaves, wood, cow dung, kerosene—causes constant irritation and inflammation to the eyes. Dust from the handling of rice, jute, and sugar cane often leads to byssinosis (breathing difficulty and chest pain) and pneumoconiosis. By the time they reach 40, women usually complain of body aches, burning pains, headache, watering from the eyes, dimness of vision, etc. They also suffer from more digestive and sleep disorders, dyspeptic disorders, and bowel problems.

As elsewhere, the development process in practice displaces or bypasses women and leaves them worse off than they were before. When agriculture was done merely on a subsistence level, it did not even pay for itself, and thus women and children provided the major work force. Once something becomes a moneymaking concern, however, there is no place for women and they lose what little access to income they previously had. This has taken place, for example, with the husking of paddy; an estimated

one-third is now done by mill rather than with the dekhi. The same has happened with fish production. Previously, the fish were caught by hand or net; then the women cleaned, salted, and dried any that were not immediately sold in the market. Now fishing has become an export industry, depriving the local people of a source of food and introducing a cooperative factory (employing only men) doing that which used to be a source of income to women. The same pattern is evident in animal husbandry. A large cattle-breeding program in Bangladesh, started 25 years ago with West German financing, has never had a single woman employee, except for the staff doctor who was willing to fill this rather undesirable medical vacancy. Once dairy cooperatives were introduced, men took over the marketing of milk and eggs, depriving women, especially widows, of a traditional source of income.

There are only two significant government programs for women in Bangladesh: the Mother's Clubs of the Ministry of Social Welfare and the women's cooperatives of the Ministry of Local Government. And the latter are financed under the World Bank's population project, which shows clearly that it is the population "establishment's" fear of the fertility of Bangladeshi women, rather than a concern for them as people, which has prompted the establishment even of such small programs.

A major contributing factor to women's hardship in Bangladesh is indeed repeated pregnancy. Between the ages of 15 and 45, a rural woman will have an average of eight pregnancies, at least one of which will end in abortion or stillbirth. She will breastfeed each of her children for two to three years. Thus, as Table I shows, a woman can expect to spend more than half of her adult life either in pregnancy or lactation.

Table I

Time Spent in Pregnancy and Lactation

	<u>Months</u>
Childbearing age, in months, age 15-45 (30 x 12)	360, or 30 years
Pregnancies	
seven life births (63 months)	
one spontaneous abortion (5 months)	68
Breastfeeding	
five surviving children (120 months)	
two who die in infancy (12 months)	<u>132</u>
Total time in pregnancy or lactation	200, or about 17 years

The hazards of this repeated cycle of pregnancy and lactation cannot be overlooked. It is a known fact that pregnant and lactating women need more food nutrients, but nothing is forthcoming in the case of these women. They are always the last to eat in their homes and often, for the poor villagers, this means scraps or even days with nothing. Failing to get an adequate diet, they naturally suffer from malnutrition. There is a high incidence of iron deficiency anemia, vitamin A deficiency, and vitamin B-complex deficiency, and these deficiencies increase with parity. Combined with poor antenatal and obstetric care, this results in an extremely high

maternal mortality rate--570 per 100,000 births, as compared to 370 in India, 14.3 in Poland, and 7.7 in Sweden. Not all ill-health results in death, but these factors certainly have a serious effect on the quality of life of the women.

It is commonly accepted that pregnant workers are entitled to some holiday benefits, but Bangladeshi women are not so lucky as some women from Zaire in this respect. Early in this century, a system of "lying-in-village" was introduced in Zaire, whereby women live with a female relative during the last weeks of pregnancy. Here they have no agricultural duties and only the lightest of domestic chores. Even firewood is provided. Food is brought mainly by the family, and a small supplement of rice with palm oil is given out by the medical service. Birth records (June 1978-May 1979) show a strikingly lower stillbirth rate in women who used the lying-in-village (1.9 percent) than those who did not (4.2 percent) even though the standard of antenatal care for both groups was similar.

Society has now realized and accepted that the spacing of children is necessary. Nonetheless, child spacing can bring its own problems in a society as conservative as Bangladesh. I remember one young woman who, in using contraceptives to try to space her children a bit, experienced heavy bleeding, making it impossible for her to carry on her daily chores. Her husband told her that if she couldn't work, he would get another wife and that she had best return to her father's house. Divorce in the Indian subcontinent carries a tremendous social stigma. The woman therefore attempted suicide by insecticide and didn't thank me in the least for bringing her round to face her intolerable situation again.

One indication of how adverse conditions are for women is that there are actually fewer women than men in my country, in contrast to the usual pattern. The sex ratio of women to men is 925 per 1000 men in India and 962 in Bangladesh, and has been deteriorating steadily since 1901 due both to the general ill-health of women and to the pervasive preference for male children. A survey by Dr. K.J. Rao, of the Indian National Institute of Nutrition, notes that the neglect of female babies appears to be continuing: "Though protein calorie malnutrition was found to be higher in girls, more boys were brought to the hospital for treatment. Following the adoption of the small-family norm, the number of female children has declined markedly; whereas there is a 53 percent decrease in the number of female children, the number of male children has decreased by only 30 percent." Among adults, an increase in divorce and separation is being seen, usually for economic reasons, and this in turn leads to a highly increased suicide rate among women.

Maternal And Post Partum Health In India

Prabha Ramalingaswami

For women, maternity poses a special problem. In addition to the transition which she must undergo from being young and carefree to suddenly becoming a mother and responsible for bringing up her baby, she is faced with real health problems during this period. And each time she becomes pregnant, the hazard to her health becomes more intense. While medical science has made rapid progress in dealing with the special problems women face during pregnancy and childbirth, it is a strange paradox that these medical facilities are not available to many women. The bulk of economically dependent women, who are subjected to many disadvantages of life--lack of educational facilities, poverty, early marriage, large numbers of children, etc.--face far more intense health hazards. Without having a chance to get educated, a girl from the weaker section of society usually takes on the chores of the household, gets married young, and has a number of children. She is likely to go down in health with each pregnancy, as she does not have minimum health care during this period and may even face death.

In India, there is a free primary health center for every 100,000 population. Usually, each of the primary health centers has eight to ten subcenters, each with at least one auxiliary nurse midwife and a basic health worker. By the end of March, 1979, there were 5,400 primary health centers and 38,115 subcenters in position. Out of these, 4,568 primary centers had two or more doctors, 771 one doctor, and only 61 were without doctors.

Maternal and child health care (MCH) is one of the major activities of the primary health center. At each, there are eight to ten auxiliary nurse midwives, two lady health visitors, and one lady doctor to take care of these activities. In addition, there is a strong family welfare planning program. As part of the MCH program, anti-tetanus immunization and prophylactic activities against nutritional anemia and vitamin deficiency are undertaken. In addition, in some areas an Integrated Child Development Programme supplements the nutrition of the expectant mother and child.

While these activities are commendable and impressive, they reach only a small fraction of the people who need them. It is worth looking at the total dimension of the problem. According to the 1978 census estimates, 79 percent of the population resides in rural areas, and 48 percent of them live below the poverty line. With only 14.55 percent of the women working, and with a female literacy rate of 13.2 percent, one can visualize the extremely poor conditions in which the vast majority of women are living. Added to this is a system of early marriage, which actually worsens the health of these women because of a high frequency of pregnancies and equally high infant mortality rate. No wonder that anemia during pregnancy is common and accounts for one-sixth of the MCH deaths. That a high percentage of women do not get even the minimum MCH care during childbirth is reflected in the high percentage of deaths during childbirth (44 percent of total MCH deaths). Despite its extensive organization and being free, the health service system does not really reach these women.

The important question is how to provide at least the minimum care required for these women during pregnancy and childbirth and later for the infant. Family planning is important, all right, but the family planning program by itself cannot provide an answer to the health problems faced by women once they are pregnant, and family

planning can be effective only when health care is ensured for the living child. Adequately trained dais (traditional birth attendants) in very large numbers should make a difference if they were used as a sort of community health volunteer to strengthen the primary health center, but here a deliberate effort will have to be made to curb the tendency of the urban sector to grab the resources.

While every effort must be made to strengthen the outreach of the health services, it is equally important to strengthen the woman herself. In spite of living in very difficult conditions, these women exhibit remarkable moral strength. Every effort must be made to help the expectant mother belonging to this strata to supplement her own family income by indulging in some cottage industry or other activity which will fetch her a little extra money. With the economic stability this gives to the woman, and with the self-confidence that is generated in her, she will be in a better position to take care of her nutrition during pregnancy and later her baby's. Health education will be more effective. She herself will go for functional literacy and seek family planning services. She will be in a better position to reach health institutions when she requires medical care. In short, she will have the self-confidence to take care of her physical needs, which will strengthen her urge to give her best to the baby and to keep the family going and together.

A Communication Gap Regarding Female Circumcision*

Marie B. Assaad

Since getting involved in the study of female circumcision in Egypt, I have realized the great gap that exists between the many rural and urban women who support the practice and the small number of modernized women who ignore its existence, are shocked when they learn about it, and completely reject it. If we do not recognize and respect more traditionally minded people's experience and feelings and start our dialogue where they are, we will create a credibility gap which will inhibit any move for change.

Reports on shock, hemorrhage, trauma, and frigidity are often dismissed. In a culture where the deep-rooted values of pre-marital chastity and marriage are linked with excision of the external genitalia, any physical suffering is preferred to the social ostracism experienced by an uncircumcised girl. Moreover, the reinforcements offered to the otherwise neglected girl after the operation often make up for any pain or shock, as one woman, who was circumcised at age seven, reports:

I felt fine after two hours. My aunt fed me chickens and offered me special food for one whole week. To demonstrate our privileged new status, all the circumcised girls formed a chain, and, walking with our legs apart (sign of circumcision), toured the alley, singing and frolicking.

The following remarks made by a daya (traditional birth attendant) in a Nile Delta village I have studied may provide some insight into how strongly embedded the custom is and how far behind we are in providing convincing arguments against it:

Female circumcision is a deeply engraved custom that is passed on from grandmother to mother and daughter. It is done for beauty and cleanliness. The ugly external genitalia—i.e., the two leaves (labia minora)—must be cut off before they grow too big and dangle like a male organ... A year ago, when rumors spread around the village that female circumcision will be forbidden, and the government will enforce strict control, families went out at night by lamplight, seeking the help of operators in nearby towns. Many circumcised their daughters before they reached the right age...

According to this daya and many of the other women I interviewed, all the women they know, whether from their own immediate community or from other villages, towns, or Cairo itself, are circumcised. They cannot conceive of an uncircumcised woman. Again and again, like the women interviewed in a poor suburb of Cairo, the dayas emphasized how important it was for people in the village to conform to tradition and customary practice. One said:

*This paper is based on Marie Assaad's paper "Practical Proposals for the Eradication of Female Circumcision in Egypt," written in response to a request by Le Groupement Pour Les Droits des Minorites, Paris, April 1980.

We can't afford being different. We found our mothers circumcised; we learned that our grandmothers and great-grandmothers were circumcised, and we have to carry the tradition to our children and grandchildren... Once a man divorced his wife as soon as he discovered that, out of negligence, one of her two leaves was not cut off. This man told his wife, 'What have I married? A man or a woman?' News of the incident were propagated, and the woman did not know where to hide because of the scandal.

When asked whether she thought that circumcision affected libido, the daya retorted:

Of course not. All the women I know, including myself, enjoy our sex life just as much as our husbands do. We experience orgasm as our men, and derive the same satisfaction. If we were frigid we would have known it.

Clearly then, we need far more systematic information than we have if we are to develop arguments that will be convincing to the great mass of the people. In the first instance, epidemiological, psychological, and sociological research is absolutely necessary to substantiate the widely publicized objections to female circumcision. The few studies presently available in Egypt are neither representative nor do they answer in a systematic and convincing way many of the questions posed. We need to be certain of the actual physical and psychological damages caused, especially in relation to the milder form (sunna) practiced in Egypt. We need to ascertain that the milder form causes frigidity, that it is so traumatic that circumcised girls tend to have more psychological problems than those who are spared, that circumcised women suffer during sexual intercourse and childbirth. In addition, we need socio-anthropological studies to identify the meaning of the practice in relation to sociocultural patterns and values concerning women and girls. Our present limited knowledge does not equip us with arguments that are sufficiently convincing to the large number of perpetrators, including the mothers of young girls as well as the dayas who perform the operation.

Men's views on the custom are very important, too, but we have no studies describing these. We need to know which men support the practice, which do not, and why. And we need to ascertain whether men would truly refuse to marry uncircumcised girls, as is often claimed by women.

Until much more knowledge is available, the time is not ripe for open and far-reaching campaigns against female circumcision. Without systematic and not-easily-refutable information, such campaigns run the risk of having a counter effect on the masses. Those who perform these operations, who are closer to the masses, may either ridicule the views presented, create fresh arguments, or shroud the practice in greater secrecy. Any of these reactions could raise new problems that would impede effective action.

In particular, any undue stress on religious arguments against female circumcision runs a high risk of creating a religious issue where none existed before. All studies have indicated that both Christians and Muslims in Egypt practice female circumcision and that the practice is not linked specifically with Islamic beliefs. If we actively encourage some religious leaders to take a stand against the practice, others will inevitably take a stand in support of it, developing a religious opposition to any change.

This has been the experience with family planning. When much stress was laid on religious views and family planning, the rejectors used religion as a camouflage for other objections and the religious proponents were accused of adjusting their beliefs to suit political expediency.

This is not to say that there are no grounds for moving forward in the effort to combat female circumcision. In spite of the limited knowledge available, there is general agreement that the practice persists for two main reasons--to preserve premarital chastity and to safeguard female characteristics. Since both reasons are refutable on scientific grounds, sharing such scientific knowledge with policymakers, opinion leaders, health practitioners (formal and traditional), social workers, feminists, educators, and change agents in general would be a significant step. Because of their potential for leadership, these groups should form the first audience of instruction.

In our discussions and educational programs concerning this unnecessary operation, we should seek to achieve at least two goals: (1) to separate the question of circumcising young girls from the strong religious and social value attached to premarital chastity; and (2) to explain the nature and function of the clitoris. The educators need to argue the fact that premarital chastity is a moral issue and that modern Egyptian uncircumcised girls value premarital chastity just as much as circumcised girls do. The traditionalists must also be convinced that the unexcised clitoris and labia minora do not develop masculine characteristics and thus jeopardize a girl's chances for marriage. We should look at female genitalia in the same way we look at other parts of our body and excise them only in case of (rare) malfunction or abnormal growth.

Such information should be incorporated in the curricula of medical and nursing schools and in the training of service providers and family planning and social workers. We should begin now by developing information manuals based on existing case studies and research findings. One such manual should include a number of case studies where women and girls relate their own experiences and describe their own reactions to the operation; by a series of carefully pre-tested questions and answers, these women could provide what we know to be convincing answers. Such a manual should be quickly prepared and put in the hands of educators, trainers, and social workers to serve as an intermediate tool until more sophisticated material can be produced. If we begin carefully and with sensitivity, and if we continue to evaluate and adapt new research findings, we may reach our final goal--convincing the masses of the harmful and unnecessary damages caused by the practice of female circumcision.

Violence Against Women Is Also A Health Problem

Sujata G. Kanhere

Bimla Devi was married to Om Prakash in October 1951. Relations between them became strained within two years, and thereafter she was systematically ill-treated. On many occasions, she was denied food for days and given only grain-husk water. She managed to escape and her story ultimately reached the local magistrate. Om Prakash was convicted of attempted murder. In the court's judgment, it was stated that "the course of conduct adopted by the accused in regularly starving his wife in order to accelerate her end constitutes an attempt to commit murder."

This was a case which reached the courts. There are, however, innumerable such starving, ill-treated women who meet their slow deaths quietly. To understand why this takes place, one must look into the background of the general conditions of women in India. Their poor health and nutrition are the result of a deeply ingrained value system, which in turn is the product of a complex social web that accords women an inferior and expendable status--even in their own eyes.

In India, from early childhood, women are socialized to endure the most difficult of hardships for the sake of their family, husband, tradition, and "society." The Indian woman is made to negate her individuality and realize it only through blind devotion to others--males. Deep in her mind, the woman has sati as a model—a woman who cannot live without her husband. More than a century ago, when a man died, his wife had to burn herself to death on his funeral pyre; when she did not want to die, she was pushed into the fire, tied down, and drums were beaten to drown out her screams. This practice has been outlawed for many years, but it persists as an ideal; even now, the newspapers sometimes report a case of sati in a distant village. Can such a phenomenon, even as an image, allow the growth of a sense of identity or even a consciousness of one's own well-being?

The neglect of the female is seen in all aspects of life. But there is another side that is less well known, and that is how much violence women are subjected to by their husbands, their husbands' families, and the rest of Indian society. "Suicidal burning is relatively common among Indian women, mostly on account of domestic worries or because of the problem of dowry... Perhaps the most frequent method of doing this is to soak clothes in kerosene and then set them on fire. It is very difficult to extinguish such flames." That is how Parikh's Textbook of Medical Jurisprudence describes "suicides" due to burning. But it has been proven in the last few years that many of these cases are not suicides but murders--wife-burning to make possible another marriage, and another dowry, for the husband.

There are very few families in India in which a girl's life is not blighted by the terrifying curse of dowry. Though paying dowry has been illegal since 1961, the custom continues to flourish and has even percolated downward to the working class, where previously no such system existed. The girl's father has to borrow large sums of money which he has to repay all his life; she is the "stone at the neck" of the father.

Fifty cases of "dowry deaths," usually after an extensive history of torture, have been reported, and these are just the tip of the iceberg. Some figures are suggestive. One government hospital in Delhi alone registers about 4,000 burn cases a year, of which 75 percent are women. Hospital authorities suspect that nine out of ten of

these are dowry burnings. In every crowded residential area in Bombay, at least one such case is reported each month. And for every reported murder, hundreds go unreported, especially in the villages.

In most cases, beating, burning, and torture never become problems of health officially because the woman does not reach a doctor at all. The majority of women in India need to be taken to a doctor or to have permission to go to one. They are totally dependent, even for medical help, on the "breadwinner" of the family. Thus, battered women treat themselves. The bruise heals up on its own until it is ruptured by another attack. The doctor, if contacted, will treat the woman "medically," but he cannot stop the beating. The doctors as well as the women believe wife-beating to be natural, as natural as the rains. A popular Marathi proverb says, "If the rains make you shiver, and if the husband beats you up, where can you complain?"

Rape, too, is an accepted part of male-dominated society. Rapes have existed in India, as in every country, for millenia. In war, it is a gruesome, mass phenomenon involving many hundreds of women. After the Bangladesh war, for example, a team of young medics went to North Kamrup, in Assam, and treated more than 90 rape victims. Others reported similar findings. Mass rapes have also taken place in Marathwada, Pipra, Narainpur, everywhere where there is some communal or class violence. In the villages, landowners, forest guards, and police perpetuate their rule over women and the community.

These rapes have been passed off in silence for years. Indeed, one sees a total indifference to the point of callousness on the part of many doctors, lawyers, and social workers, who blame the women themselves for their plight. Suicide by raped women is not uncommon. One reason is that women, especially in Asian countries, are brought up to value their izzat (honor) before anything else in life--even their lives--and pavitrya (purity) is considered a divine virtue of women.

It is obvious that the exact number of women who are subjected to rape may never be recorded. Hardly any medical reports exist. For most of these women, medical treatment is a far-fetched "luxury." Even when they do see a doctor, the women are reluctant to tell the true reasons for their problems. Thus, the young medics who went to Assam after the Bangladesh war reported that the women didn't want to say they had been raped even when it was obvious. Their report comments: "We wished we could have brought along a woman medic, so that the women would have felt freer to come and speak; it would have been easier to convince them that they needed to be medically treated."

However, the situation is beginning to change in at least one area. In Dhulia, in northern Maharashtra State, local women have succeeded in putting an end to wife-beating in 50 to 100 villages. These women are mainly agricultural laborers and poor farmers. They had joined with men to form a Toilers Organization to struggle for human treatment from the landowners and to negotiate for decent wages. But the women soon realized that--although they were working shoulder-to-shoulder with the men against the landowners and the government--their husbands were still coming home drunk and beating them up. The women then came together. After some discussion, they marched on the local brewery, broke the pots and bottles of liquor, and threatened to tie up anyone who dared brew liquor again. When any man beat his wife, the other women marched to the house and compelled him to apologize to his wife, promising never to beat her again. Furthermore, when a woman agricultural laborer was raped in

Nadurbar by a landowner, she did not blame herself or keep quiet about it. She went out into her village and other villages and denounced him. Then the women dragged the landowner out of his house, smeared him with cow dung and black soot, made him sit on a donkey and took him around to all the villages. Nor was the raped woman scared to get herself treated medically.

The difference between the women's attitudes in the rural areas of Maharashtra and those in other parts of India is tremendous. What accounts for the difference? Surely one answer is that the women in Dhulia have learned the power of solidarity through the Toilers Organization. They were involved in changing a society which oppressed them in a number of ways. And that knowledge is beginning to carry over into changing the traditional, unequal relationships between men and women.

Africa: Health Requires Economic Advancement For Women

Belkis Wolde Giorgis

Maternal and child health is inextricably tied to the sociocultural, economic, and political conditions under which women and children live. Thus, the rapid replacement of subsistence farming geared to the needs of the rural population with cash-crop production for export is a major contributing factor to increased malnutrition in many parts of Africa. Kwashiorkor has appeared in districts where it was unknown before, coinciding with the shift from yams, bananas, and other subsistence crops to tea, coffee, etc. In addition, women and children in Africa are subject to a system of food taboos which legitimizes giving the adult male members of the family the best and most of what the community has to offer and denying women important food items such as meat and eggs.

Many children suffer from a more modern "taboo." Because of high-pressure promotional and advertising campaigns, the use of infant formulas is increasing in Africa, depriving children of the nutritional advantages of mother's milk and exposing them to illness and infection from inadequate resources and unsanitary preparation of formulas.

Another factor contributing to high morbidity and mortality is the scarcity of health resources. There are wide disparities in the access to health services for the rural and urban populations. The majority of those living in remote areas still derive their basic health needs from traditional midwives and healers. Even where primary health centers exist, the excessive work that women in Africa have to do has precluded them from full utilization of these services. In Africa, pregnancy and childbearing do not exonerate women from their responsibilities for the survival of the family.

Fertility levels in most parts of Africa remain high. In restrictive, male-dominated societies, children are one of the few resources that women control. High rates of mortality have compelled them to have as many children as possible to ensure the survival of a few. The less control women have over other kinds of resources, the more firmly they will be forced to rely on childbearing as a form of leverage on their environment.

It is no longer tenable to discuss malnutrition or other aspects of women's health without taking into account the roles of women in food production and allocation of resources. The mother is also the most important agent of health care, and education for women will help to determine how effective that care is. In Tanzania, for example, research has shown that children born of mothers with no education have half the chances of survival compared with children of mothers with five years or more of education. Thus, recognition of the roles women play and their contribution to family welfare would be a significant step toward lowering levels of mortality and morbidity.

South Africa: Health And The Effects Of The Political System

Nonceba Lubanga

The disease pattern of blacks in South Africa and Namibia superficially resembles that of many developing nations. But this is where the similarity ends. South Africa is an affluent country which is not overpopulated like other parts of the world. The white population enjoys a standard of living comparable with, and in some cases superior to, that of any Western nation. The plight of the black population can only be attributed to the discriminatory system of apartheid.

The provision of health care and training of health professionals in South Africa mirrors apartheid in every respect. It affects the quantity of services provided, the structure of delivery and access to medical professions. The most recent estimates (1975) show a physician/population ratio of 1:400 for whites and 1:40,000 for blacks. The nurse/population ratio is 1:256 for whites and 1:1,581 for blacks. In terms of hospital services, in 1975 the bed/population ratio for whites was 1:96, while for blacks it was 1:186. Better staffed and "well equipped" hospitals are found primarily in urban areas, where most of the whites live, and in the mining areas, where healthy contract laborers are required for the production of minerals.

The resulting pattern of death and disease among blacks is very depressing. According to government statistics for 1970, the infant mortality rate for whites was 20.9 per 1,000, while that of the blacks was estimated at 100-110. In 1969, the rate recorded in the Transkei "homeland" was 216 per 1,000 live births. The government does not collect detailed statistics on the causes of death for blacks, but even the disparities among the other three main groups in South Africa are revealing. For example, deaths from infectious and parasitic diseases are 1.2 percent for white men and 1.0 percent for white women, but they are 4.5 and 4.4 percent respectively for Asian men and women, and 9.2 and 8.0 percent for Coloured men and women. Similarly, Coloured and Asian children die of diseases of early infancy at almost three times the rate of white children. These death rates reflect a lower standard of health and nutrition among non-white groups, with blacks suffering most of all. As many as 80 percent of the black children under two admitted to Johannesburg city hospital in 1975 suffered from malnutrition, as did 58 percent of those under ten.

Attempts to discuss the effect of racism on the health of African women is hampered by the fact that the little information that is available is rarely broken down by sex. Even the South African Official Yearbook concedes this to be the case: "The South African government also admits that, although the registration of African births and deaths is compulsory, the records are not reliable especially in the outlying rural areas."

Although women suffer from the same diseases that affect any poverty-stricken people, their poor health status is further exacerbated by childbearing, anemia, overwork, and poor nutrition. This is especially clear in the barren resettlement camps like Dunbaza, Lime Hill, Kuruman, and Stinkwater, where families without work permits are forced to go. For example, nutrition experts have confirmed that the rations provided for indigent women at Dunbaza are inadequate both in quantity and quality. The monthly ration consists of: maize meal, twenty lbs.; mealies, eight lbs.; beans, five lbs.; margarine, one lb.; skim milk, two lbs.; and salt, one-half lb. This diet, weak in calcium and vitamins, leads to deficiency diseases such as scurvy, anemia,

and pellagra. (It should be noted that South Africa exports large quantities of citrus fruits which might alleviate some of these diseases if they could be eaten by the undernourished blacks.) The women become victims of communicable diseases, the incidence and virulence of which are exacerbated by malnutrition. Tuberculosis, typhoid fever, dysentery, gastroenteritis, and bilharzia are rampant. Black women also suffer more from preventable gynecological and obstetrical complications such as prolapsed uterus, post-partum hemorrhage, puerperal sepsis, pelvic infections, pre-eclamptic toxemia. While maternal death is rare in developed countries and among white South Africans, it is clear even in the absence of specific data, that maternal mortality is quite common among blacks.

Much of the mental illness experienced by blacks, women in particular, is caused by the migrant labor system which disrupts normal family life. Men are forced to stay away for months on end, at best returning home for a few weeks a year, but often not seeing their families for years at a time. Many men find second families in their place of work and the rural woman is left with children, no money, and no husband. In a typical homeland area in the Transvaal, for example, a survey showed that 52 percent of the fathers visited their homes only once a year, 11 percent only once a month; in 12 percent of the families, the mother was single. In Kwazulu the situation is similar. More than 75 percent of breadwinners work further than 80 miles from home. When the men are no longer productive, they are sent back home to become an added burden to the wife.

When the situation becomes unbearable in the rural areas, some women decide to move to the cities to seek jobs. The situation is no different there. Having lived in a kind of extended family relationship in the rural areas, they find themselves alone in the cities. Maternity leave is rare, with the exception of certain institutions such as schools, hospitals, etc. In too many cases, the stress of living alone, under apartheid, leads to alcoholism and prostitution, an increase in venereal disease, illegitimacy, and illegal abortions.

The health system of South Africa, with its gross disparities, is part and parcel of the overall doctrine and practice of apartheid, and no radical change in health care delivery can be achieved unless apartheid itself is abolished. Thus, it is clear that the only way to solve the women's health problems is by abolishing the present political system.

Signs Of Mental Stress In Ghana

Ruth Shaw-Taylor

Although the emergence of modern development in Ghana has brought about an increase in the productive contribution of the individual Ghanaian woman, it has also increased the social stresses to which she is subject. In her home environment, the Ghanaian woman has retained most of the responsibilities and stresses of previous historical periods; the modern work environment has added a new dimension to the daily strains that confront her.

The results of a two-year study of psychoneurotic females shed some interesting light on the stresses experienced by Ghanaian women, although it is important to realize that the entirety of the population does not develop mental problems sufficiently severe to require psychiatric attention. The population studied was chiefly that of Accra, with a control sampling unit in a rural area known as Bortanor. Since most of the patients go to the traditional healers, an attempt was made to include patients from traditional healing units as well as psychiatric institutions.

Within a combined population of nearly one million, a total of 11,298 individuals were identified as having psychoneurosis for the first time in their lives. The overall results are summarized as follows:

- Incidence rates of psychoneurosis increased with age; the mean age for all cases was 30-35;
- Females exhibited a significantly higher incidence rate than males;
- Rates adjusted for age and sex were significantly different among economic groups;
- The urban area exhibited a constantly higher incidence rate than the rural area;
- Higher rates were found among divorced women, followed by single women, the separated, widowed, and married women in that order; and
- Adjusted incidence rates were highest among the employed; among them, the highest rates were found among professionals and semi-professionals, followed by those engaged in services, manual, clerical and sales, managerial, agricultural, and farming, in that order; variations in education had no significant effect on incidence rates.

Table I is based on questionnaire and interview responses from 5,132 psychoneurotic females. Almost nine out of ten cited one or more problems of environmental stress, and the range of problems cited paint a vivid picture of the dilemma faced by the modern Ghanaian woman.

Table I

Frequency of Social Problems Among Psychoneurotic Females

<u>Home Environment</u>	<u>Number</u>	<u>Percent</u>
not enough housekeeping money	820	15.98
husband is a drunkard/chain smoker	720	14.03
frigidity (not interested in sex)	620	12.08
wife beater	380	7.40
not satisfied sexually by husband/boyfriend	375	7.31
husband is a flirt	300	5.85
in-laws interfering with marriage	235	4.58
 <u>Work Environment</u>		
male counterparts make sexual approaches at work	475	9.26
status not recognized by male counterparts	320	6.24
other social problems (sterility, no cooperation from men, etc.)	312	6.08
no social problem cited	575	11.20

The most striking feature of this survey is the high proportion of respondents, especially among married women, who indicate that housekeeping money was not sufficient. This seems to be in line with the present economic problems and high cost of living in Ghana. Since a majority of our surveyed population belongs to a low economic status, this confirmed the intense degree of stress among this group of women who perform the multiple duties of a household.

To understand the root cause of these problems, one must look at the social roles of women and the traditional family in Ghana. Women are responsible for the care of small children, the gathering or production of the major share of the food consumed, and housekeeping work in general, including the fetching of water and food preparation. Catering to these daily family demands is time-consuming and extremely tedious. It is rare, especially in rural areas, to see adult men taking any part except when the wife has suddenly been taken ill. One estimate—for sub-Saharan African women in general—is that women take responsibility for the following percentages of the activities of a typical traditional household:

<u>Activity</u>	<u>Percentage Female Responsibility</u>
food production	70
food storage	50
food processing	100
animal husbandry	50
marketing	60
brewing	90
water supply	90
fuel supply	80

Not surprisingly, women spend far more time in productive activity than men, and have far less leisure. Hardiman reports, on the basis of a study of two Ghanaian communities, that the average woman has 40.2 hours of leisure in a month, while the average male has 103.2 hours.

The Ghanaian woman has always earned a living, and nowadays it is imperative for the survival of the family that she does. She is found in all occupations and professions, contributing in cash or in kind to her family of origin as well as to the conjugal family. In the Hardiman study, none of the women in the villages studied regarded "housewife" as her main occupation; even the very old women described themselves as farmers or traders long after their active working days were past.

The burden of housework should be emphasized, as it is one of the root causes of depressive neurosis. The difference between rural and urban homemakers is that the rural women accept housekeeping as a duty, while the educated woman feels exploited. One survey of Ghanaian women in full-time employment (teachers, nurses, clerical officers) reports that "more than half complained of insufficient time for rest and pleasure. Women think that chore performance should be joint (i.e., with their husbands where possible) in organization but at the same time feel a sense of heavy personal responsibility . . . leading to feelings of strain and inadequacy . . ."

Childrearing causes a lot of anxiety here. Children are usually of pre-school age. It is hazardous to have them on their own, yet parents can neither afford not to be gainfully employed nor to pay dependable help to take care of the children. Sometimes, the homemaker might send her child back to be looked after by her mother or some other near relation.

The interplay of traditional practices and the forces of social change has introduced several problems into marriage. The greatest concerns the need to reconcile the aspiration to modern life epitomized by the nuclear family with the responsibilities still owed to the extended family. The main indices of extended-family pressures are the interference of in-laws in marital matters and demands for financial support, not only from parents or siblings but also from nephews, aunts, and uncles. On the other hand, perhaps the most glaring example of the intrusion of traditional culture into modern life is in the area of extramarital sex. One reason for the prevalence of this practice is that, with polygamy still an important institution, male extramarital sex carries no serious stigma while it remains taboo for women.

When these pressures become great enough to cause psychoneurosis, what services are available to women?

Traditionally, the individual finds help in faith in the hidden forces and personal ancestral spirits of the traditional social setting. Problems in marriage and other problems are settled early on by an elder of the lineage, the chief of the community, and/or the traditional practitioner. In addition, day-to-day group activities such as fetching water and washing by the riverside offer women a perfect setting for group therapy and milieu therapy. Planting grains or pounding fufu, though laborious, acts as a form of catharsis whereby repressed feelings and tensions are released.

When ill feelings develop, and if this is accompanied by certain kinds of prolonged illness, the traditional healer, herbalist, cult healer, and fetish priest is approached. These healers have evolved a medical tradition suitable to the cosmological ideas of society and acceptable to the way of life of the people. Studies have revealed that they have a stock of remedies with which to treat ills; some have scientific validity, but by and large it is difficult to disentangle the scientific from the non-scientific. Most treatments include magico-religious ingredients such as exorcising a possessing spirit, making reparations for the violation of a taboo, recalling the victim's wandering soul, or countering the spell cast by witchcraft.

In many cultures, rituals are cathartic; impulses that cannot be readily satisfied may find expression thereby. Acting-out may give symptomatic relief. Rituals may also be repressive, enabling the conflict-ridden person to say, "It is not I, but he, who is guilty of such and such wishes." In the course of deciding which action to take, the traditional healer may encounter the patient's unconscious conflicts, help him to verbalize them and, in the manner of any good psychotherapist, bring them to the surface where the ego can begin to deal with them.

Traditional practices offer preventive services in the form of charms and good-luck symbols which preserve marriage and employment, protect children and property, and ward off evil. Rites of passage—at birth, marriage, bereavement, and so on—may also be called preventive psychotherapy. A major function of such rituals is to minimize the duration and depth of internal psychic conflict accompanying major changes in social role. The agonizing conflict commonly observed in Western societies at time of crisis seems to be, in part, a consequence of the unavailability of effective rites of passage.

Traditional medicine, although its forms are many and often hard to generalize, is built on accumulated understanding of people and reaches the grassroots level in coverage and methodology. Medical services, effective as they are, are grossly inadequate to meet the growing needs of the population; they reward curative rather than preventive medicine, and are urban rather than rural-oriented. In the field of psychiatry, these problems are compounded by the fact that the scientific treatments offered do not result in lifelong cures. Thus, it is especially important that traditional healers be incorporated into the field of psychiatry, for they have a lot to offer.

Health Issues Of Abortion

Hamid Rushwan

Abortion is one of the oldest medical procedures known. It is a sign of contraceptive failure of one form or another, be it in family health education or in knowledge, availability, or effectiveness of contraceptive methods. Today, an estimated 30 to 50 million abortions are performed each year throughout the world, half of them illegally. Such abortions carry significant health risks for women. In the Sudan, where abortion is permitted only for medical reasons, the hospitalization of patients with incomplete abortions absorbs considerable time and space in the crowded hospitals. It is now generally accepted that some action should be initiated to study the magnitude of the problem, improve its management, and reduce its incidence.

About two-thirds of the world population now lives in countries with liberal abortion laws. These changes have mostly been effected during the past decade. Liberalization of abortion laws is advocated for various reasons:

- Illegal abortions, performed in the back streets, present major health hazards to women in the form of maternal morbidity and mortality;
- The well-to-do in any society will always manage to obtain abortions, whatever the laws, either locally or abroad; liberal laws are needed to enable all strata of the community to have this opportunity;
- Abortion can have a major impact on population growth, especially in the initial phases of population control, which in turn can lead to more rapid economic development and higher standards of living;
- The right of individual women to control their own bodies has also been suggested as a point in favor of liberalizing the abortion laws.

These issues must be considered very closely with an effort to reduce the suffering of women from the ancient human problem of abortion. There is much evidence that a liberal law leads to the transfer of a great many previously illegal operations to hospital clinics and a subsequent decline in the maternal mortality rate due to sepsis following illegal abortion. In the State of New York, for example, the maternal mortality rate fell from 5.2 to 2.3 per 100,000 after the repeal of the abortion law. In Britain, there has been a decline in deaths due to abortion since the law was liberalized in 1967.

It should be mandatory, particularly in countries where health services are in short supply, to find out what illegal abortion costs the community. One authoritative estimate, based on research in Latin America, puts the cost of treating an abortion patient at 4.5 times that of a normal birth. In Accra, Ghana, a comparative study between hospital admissions for septic abortion and hospital-induced abortions established that the average periods of hospitalization were 2.17 and 1.54 days respectively.

To take another example, in Santiago, a city with one-quarter the population of London, an estimated 50,000 illegal abortions are performed each year--nearly half the number of legal abortions in all of England and Wales. Four out of every ten admissions to Santiago's emergency services are for abortion complications, if the figures revealed by Chilean medical studies in the early 1960s still hold. In the early 1970s, during the Allende government in Chile, abortion was approved for a brief period in one selected area of Santiago served by the Barros Luso Hospital. Some 3,250 hospital abortions were performed. This transfer from back street to hospital caused a measurable decline in admissions for abortion complications. The estimated cost-saving of the \$30,000 pilot scheme was \$200,000.

A Caribbean study of the cost of illegal abortion revealed that 1,234 women spent 4,409 days in the General Hospital, Port of Spain, during a 12-month period and nearly half required antibiotics and blood transfusions. Random samples like this only suggest the cost, not to mention the suffering, caused by abortions performed without proper medical care.

In Sudan, a study of 3,200 patients at the three main hospitals in Khartoum in 1974-1976, using the standard computerized abortion records forms of the International Fertility Research Program, revealed that:

- Incomplete abortion is a major strain on scarce and already overburdened hospital services in terms of bed occupancy, treatment costs, and staff time. It was the main cause of admission to gynecological wards in hospitals.
- The influence of socioeconomic factors (e.g., residence, education, and employment) on the bio-reproductive process was clear; there were important findings for health planning and provision of community services;
- The clinical aspects of the problem of incomplete abortion, especially sepsis, were much less than those reported from similar areas with restrictive laws. However, the drain on blood banks and the use of antibiotics, etc., was a great load on the clinical side.

The study found that abortion is a medium for motivation toward family planning. Following abortion, contraceptive acceptance climbed markedly for all groups of women. The percentage of women contracepting before abortion was 9.9 percent of those studied. At follow-up, the figure rose to 46.8 percent. Thus, contraceptive counseling in hospital may be a more influential motivating factor than education or socio-demographic factors, and might lead to a decrease in the incidence of abortions in the community.

To improve the management of patients with incomplete abortion and reduce human wastage, with consequent reduction in the cost to the community, the following recommendations were put forward as a result of this study:

- Establish an out-patient service at each of the major hospitals for incomplete abortion patients. (The situation at present is in-patient management.)

- Discontinue the use of general anesthesia and use sedatives, either alone or in combination with local anesthetics.
- Introduce vacuum aspiration method as a proven safe, efficient, and economical procedure for treatment of incomplete abortions.
- Establish routine follow-up clinics for patients with incomplete abortion for treatment of complications, contraceptive counseling, and family planning services.

At a minimum, countries with restrictive laws just study closely the problem of incomplete and septic abortions in an effort to improve their management and consider ways to reduce their incidence. The role of women's groups as a medium of education and change in respect of the whole issue of abortion and its consequences cannot be overemphasized, and they should be given this important role to play.

Brazil: The Health Implications Of Urban Pauperism

Celia Ferreira Santos

Generical woman is an abstraction; she does not have a concrete existence. In actual fact, each woman lives her feminine condition within many other aspects of life experience, of which one of the most important is class. Thus, the working woman in the poor classes is doubly powerless. Her social condition maximizes health problems derived from the place of her family group in the social structure.

Women in upper classes indicate personal achievement and financial independence from the husband as sufficient reasons for working outside the home. But poor women must work to help the family fight against pauperism. They are concentrated in low-paying jobs. Out of 6.2 million working women recorded in the last Brazilian census, more than half held one of three low-paying jobs: housemaids, (27%); farming work, (18%); first-grade teachers, (8%). At the same time, women accept that their natural duty is also to take care of the home, produce food to eat, and keep the house and clothes clean. At present, the workday of women who undertake both domestic tasks and work outside the home is estimated at 15 to 18 hours. The main health problems for working women who live with such low standards result from work overburden, undernutrition, bad or nonexistent sanitation, and exposure to bad weather and workplace pollution, leading to respiratory ailments.

One cannot consider women's health without focusing on another point: that in the patriarchal society, a woman's subordination and her condition as an object has always brought her a lot of problems. Her right to sex (viewed only as sin and guilt) has been denied. Conversely, motherhood is a duty. As for family planning, the government's main preoccupation is with high-risk pregnancy. The Center for Development of Brazilian Women said this about the real problem with high-risk pregnancy and the government's position:

To women who are risky cases, the use of pills adds further risks. Those who present heart problems, diabetes, or hypertension and take chances when becoming pregnant, are even more endangered by the pills.

According to the Program of Familial Planning, information about contraceptive procedures would be disclosed by means of a wide campaign of sanitary education. One may ask what range such a campaign would reach, since 30 percent of Brazilian women remain illiterate and most of them are concentrated among low-income people.

It is clear that poor women run enormous risks in becoming pregnant. In 1975 the Center for Development of Brazilian Women documented some of these risks for poor women in Sao Paulo:

Our reality shows that even the simplest laboratory tests, such as blood counts for anemia or examinations for parasitic worms or syphilis are not performed. More than half the Brazilian feminine population (54.4%) have had only 0-5 prenatal consultations, most of them after the sixth month, when problems are more serious

and sometimes cannot be solved any more... Eighteen percent make no consultation at all, and 25 percent have no right to medical care for childbirth under the government's social welfare laws. Even when their labor pains have already started, this 25 percent must go from one maternity hospital to another before they are finally admitted...

It is our opinion that, before conception, a woman must know the risks of conceiving and the risks of contraceptives. Thus it is important that she be informed about her health condition. Every woman must have warranties for the process of reproduction and this must begin during infancy and childhood (good nutrition and vaccination), must proceed during youth and maturity, during, after and between pregnancies.

Why do our pregnant women die? During pregnancy, 70 percent of deaths are caused by elampsia. During childbirth, 41.7 percent of maternal deaths are caused by hemorrhage. During puerperium, 40.6 percent of deaths are caused by infections. These data would be different if control of the risks of pregnancy were not a minority privilege. The process of reproduction requires that the woman who becomes pregnant has the assurance of medical care, and periodical consultation. And we know that this does not happen.

Abortion is one of the most important problems in Brazil concerning women's health. Brazilian law defines induced abortion as a crime punishable by up to ten years imprisonment (except in cases of proved rape or indisputable therapeutic indication), but this law is widely violated and there is general agreement on the need to reduce the number of abortions. Although current information is lacking, a general estimate is possible. In 1968 Moraes estimated that 25 percent of fertile women in Brazil become pregnant each year. United Nations data suggest that about half of pregnant women in developing countries will abort, either spontaneously or otherwise. Combining these two estimates suggests that the annual number of abortions in Brazil must amount to about 3.4 million, which experts consider the plausible figure. It has been estimated that about 20 percent of all women who abort contract infections and that half of these infected cases die. In the case of Brazilian women, this would mean that 300,000 to 340,000 fatalities are predictable this year because of infected abortion.

Besides provoked abortion, undernutrition and generally poor health status are responsible for the high rate of miscarriages. During a ten-day period in July 1979, 41 cases of abortion were admitted to the Hospital Amparo Maternal in Sao Paulo, which gives specialized medical care to an average of 11,000 poor pregnant women each year. Generally poor health status is one of the main causes of spontaneous abortions in that hospital. Out of that total, 1,500 women do not even have a place to go after discharge. Most of them are fired after the seventh month of pregnancy; studies which were carried out in such a population show that not more than 10 percent of employers permit the women to go on with their jobs after delivery. In order to overcome this difficulty, a Mothers Community (Comunidade de Maes) has been created. It is something like a day nursery where some mothers take care of the infants and children so that others may go to the factories. The problem of assisting the child so that the mother is free to work is one of the most serious faced by women in the low-income class, since it produces many consequences, with social connotations and bodily and physical implications for the health of both mother and child.

In sum, the working woman in the poor classes is submitted to a double domination relationship—as a woman and as a member of an oppressed class. The feminine condition maximizes health problems derived from pauperism and adds others which arise from being a woman belonging to the working-class in a social-class structure.

Sexually Transmitted Diseases, A Neglected Problem For Women

Sevgi Aral and Mary E. Guinan

In both developed and underdeveloped countries, diseases of the reproductive system, caused chiefly by sexually transmitted diseases (STD), constitute a very serious health problem for women. Perhaps the most important among such disorders is pelvic inflammatory disease (PID) and its complications. Besides the pain and suffering associated with these infections, a large proportion of women are left with scarred reproductive organs resulting in recurring infection, impaired fertility, and even complete sterility. The risk of ectopic pregnancy, a major cause of maternal death in both developing and industrialized countries, increases sevenfold in any woman who has suffered from PID. In addition, inadvertent transmission of an unrecognized infection from mother to offspring can result in death or deformity in the infant, thus adding more suffering and guilt to the heavy burden of a woman afflicted with a sexually transmitted disease.

Due to insufficient information and/or social taboos surrounding everything related to sexual behavior, sexually transmitted diseases and their complications have not received adequate attention in most societies up to now. Yet the condition required for their transmission--that is, sexual contact with more than one partner either serially or simultaneously--is universal. Even where a double standard exists and women have only a single sex partner all their lives, a woman can contract STDs from her more active partner.

The most common of the sexually transmitted diseases are gonorrhea and chlamydia infections. In the U.S., where reporting of gonorrhea to health officials is mandatory, one million cases are reported annually and evidence suggests that the actual incidence is twice as high. Less is known about chlamydia infections, but they appear to be even more common than gonorrhea in the U.S. and Western Europe. Far less is known about the incidence of STD in the Third World, but the many indicators we have suggest that this problem not only exists in developing countries but is increasing at an alarming rate. Studies from Africa, Latin America, and Asia report that gonorrhea is the most common of these diseases, though this may be because it is the best researched. It is believed that genital herpes, another sexually transmitted disease, is increasing in developing countries just as it is in Europe and North America. Once acquired, herpes is incurable, and the sores it causes periodically erupt to cause considerable morbidity.

The very nature of sexually transmitted diseases discriminates against women. Symptoms are slower to develop and harder to recognize in women than they are in men. Treatment is more difficult or, in some cases, impossible. Although chlamydia infections can be treated effectively in men, for example, this is seldom true for women. Women also suffer disproportionately from herpes, since the infection brings a considerable increase in risk for cervical cancer.

It is painful to note that sexually transmitted diseases are also the main preventable cause of involuntary infertility, a common complaint of women who come to family planning clinics in the Third World. In many parts of Central and West Africa, a high proportion of women are subfertile, and several studies suggest that subfertility rates are related to the prevalence of gonorrhea in those areas. Where a woman's importance is closely associated with her ability to bear children, fertility loss results

in drastically reduced status, even abandonment by her spouse and rejection by the only society she has known.

Sexually transmitted diseases cause yet another burden for women--the infection of their children during delivery. Inadvertent transmission of gonococcal infection, for example, may result in blindness of the infant if left untreated. Transmission of maternal chlamydia can result in newborn pneumonia or eye and ear infections. Genital herpes and syphilis, another STD, can also be transmitted to offspring and result in fetal wastage, stillbirth, neonatal death, or severe retardation.

Furthermore, women are less likely than men to be treated for STD, especially in developing countries. They are less likely to have access to, or time for, the health care and education which might permit early diagnosis and cure. The nature of the diseases creates additional reluctance, on the part of both women and health care specialists, to do something about the problem. First, a woman may fear she will be suspected of infidelity, even if she has in fact been infected by none other than her husband. Second, diagnosis requires the woman to remove her clothing, for a pelvic examination, an excruciating experience for many Third World women. In some Muslim countries, where virtually all doctors are men, women cannot even be addressed verbally by the physician, much less be touched by him. In Central and South America there are also strong cultural mores preventing women from undressing for a male physician.

When sexually transmitted diseases are not diagnosed and treated early and the disease is allowed to progress, the resulting generalized illness requires much more intensive care. Gonorrhea and chlamydia infections begin in the cervix of women and are often completely asymptomatic. If diagnosed early, before pelvic inflammatory disease occurs, appropriate and relatively cheap antibiotic treatment can effect a complete cure. But if left unrecognized and untreated, the infection spreads up into the uterus and fallopian tubes. At this point, abdominal pain and fever may be so acute that the woman seeks emergency service at a local hospital. Indeed, STDs and their complications are a rather significant economic burden on the health care system in many countries. Every year almost one million U.S. women are treated for pelvic inflammatory disease, for example, and over 200,000 are hospitalized. The incidence of ectopic pregnancy in the U.S. tripled from 1967 to 1977, paralleling the increase in gonorrhea over this time period.

What can be done? First of all, the need for training women health workers is of maximum importance in view of the sociocultural inhibitions on women receiving treatment from male physicians. Women must also be educated in understanding STD so that they will seek prevention and/or early health care. Most sexually transmitted disease can be prevented by the use of a condom during intercourse; the contraceptive methods used by women are not nearly so effective. Adequate diagnosis and treatment of sexually transmitted diseases must become part of the health care system, and this will require research devoted to finding more appropriate technology for diagnosis and treatment of these diseases in women. Although there is a fast, simple, accurate, and cheap diagnostic test for gonorrhea in men, the only accurate test for women is a cervical culture taken during a pelvic examination; this test is relatively slow, more complicated, expensive, and ill-suited for use in areas distant from laboratories. Until better tests can be developed, it may be useful to think in terms of treating women automatically if they are known to have had contact with an infected man; at least six out of ten such women will have become infected.

To summarize, women, especially in Third World countries, suffer a disproportionate burden, often unknowingly, from the consequences of sexually transmitted diseases. These diseases also place an unnecessary economic burden on the health care system. Most of them are preventable. Yet their prevalence will clearly continue to increase all over the world if something is not done about them.

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II. WOMEN AND NUTRITION

Any discussion of poor women's health problems must start with the fact of malnutrition, for this compounds all other problems. Women are particularly vulnerable to malnutrition. As babies, they are often weaned earlier and given less food than boy babies, with the result that, in some Asian and African countries, girls have less chance of surviving the first five years of life than do boys. Without adequate supplies of protein, calcium, and vitamin D, girls' pelvic bones will be small and may be deformed, causing difficulties later during childbirth. As adults, poor women must combine heavy work loads with reproductive functions, and both add to their nutritional needs. Pregnancy and lactation place special demands on their bodies, and ill-health robs them of the ability to use nutrients efficiently. As Peter Lamptey points out, most Third World women do not even get the 2200 calories a day recommended for the WHO/FAO standard "reference woman," and their true needs are almost certainly higher than that. With repeated childbearing and overwork, the "maternal depletion syndrome" becomes commonplace. The woman becomes prematurely old and worn out. Anemia, which affects about half the non-pregnant women and nearly two-thirds of the pregnant women living in developing countries, increases the risk of illness and death in both mother and her infants.

As José Villar notes, the overworked, malnourished mother is likely to produce an underweight, sickly child and the cycle will begin again. It may even be intensified by the decline in breastfeeding that is especially notable among the urban poor. Isabel Nieves suggests that this may have its roots in women's increasing need to earn money outside the home to support their families; as she says, any policy to reverse the decline in breastfeeding must take account of women's economic needs.

What can be done? "The only way to successfully break this escalating spiral of poor health for mothers and offspring," says Dr. Villar, "is to conceptualize health as an integral process which evolves throughout the life cycle, and to plan for health maintenance accordingly." Food fortification and food supplementation, while useful and even essential for malnourished women, are necessarily palliative, according to Elena Hurtado. Ultimately, the most effective way of improving nutritional status is through general economic and social development.

How Much Energy Do Poor Women Need?

Peter R. Lamptey

The energy and nutrient requirements of women depend on a number of variables which are interrelated in a complex manner. Some of these are: physical activity, body size and composition; age and sex; physiological state (pregnant, lactating, etc.); climate; other environmental factors such as disease. The average healthy woman in rural Ghana, a not untypical developing country, requires energy and nutrients for the following activities, whether voluntary or involuntary:

- As Women
 - Basal metabolic rate, sleep, etc.
 - Personal care
 - Recreation and rest
 - Other voluntary activities
- Mother and Wife
 - Pregnancy
 - energy requirements increase by 350 Kcal/day during last half of pregnancy
 - Lactation
 - requires an extra 550 Kcal/day during the first six months of breastfeeding
 - Care of children
 - Food preparation and processing
 - Household chores (e.g., laundry)
 - Nocturnal needs of infant and husband
- Economic Provider
 - Transport of water, food, and fuel
 - Work on the farm, animal husbandry, craft manufacture
 - Other forms of physical activity leading to generation of income directly or indirectly (e.g., factory work, taking food to market)

The nutritional status of this obviously overworked woman is limited by other factors: First, her dietary intake is limited by cultural inhibitions which allow the husband to receive the most nutritious part of the diet, leaving the rest for the mother to share with the children. These cultural taboos further inhibit her dietary intake during pregnancy and lactation, periods in which she needs extra energy and nutrients. Second, it will be extremely difficult to find a poor, underprivileged woman who is free from disease. Common maternal health problems are abortion, hemorrhage, puerperal sepsis, and eclampsia, to say nothing of the ordinary diseases that plague both men and

women--malaria, typhoid, intestinal infestations, etc. Women are also subject to chronic diseases such as hypertension, sickle cell disease, diabetes, etc. And because of their role as economic providers (farmers), they are subject to accidents like snake bites and injuries which, in the absence of accessible and appropriate medical care, are debilitating or even fatal. Infections and poor dietary intake interact to further worsen the health of women in developing countries.

In describing the energy requirements of adults, the FAO Committee on Calorie Requirements adopted the concept of a reference man or woman as a standard. Let us compare the FAO reference woman to the woman we have just described:

<u>Reference Woman:</u>	<u>Woman Of Developing Country (Ghana)</u>
She is 20-40 years old, weighing 55 kg.	She may be as young as 15 years (a teenage mother has special nutritional needs as a growing adolescent as well as a pregnant or lactating mother); the average Ghanaian mother weighs 53 kg.
She is free from disease, physically fit for active work.	Certainly not free from disease, she is usually malnourished and may have multiple infections and infestations. She may also be pregnant or lactating.
Activity: eight hours general household work, light industrial work, or other moderately active work.	She may start her day at 5 or 6 a.m. and continue until 8 or 9 p.m. Activities include grinding meal; sweeping the compound; laundry; preparing food; feeding young children; long trips on foot for water, fuel and food; heavy manual labor in very harsh weather.
Sleep: eight hours in a comfortable bed.	About eight hours, but sleep is usually on a thin mat on a hard floor in a crowded room with repeated insect bites throughout the night, which cannot be very restful.
Recreation: two hours in walking or more active recreation.	Recreation is usually seasonal and sometimes very demanding physically.

Nutrient Requirements

The moderately active, healthy woman <u>requires</u> an average of 2200 Kcal/day.	The very active, overworked, malnourished woman with multiple infections <u>gets</u> less than 2000 Kcal/day, pregnant or non-pregnant.
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If the diet of the tropical mother is deficient in calories, then deficiencies of other nutrients are usually more marked. Some of the common nutritional deficiencies found in adult women are:

- Anemia: This is usually due to a deficient dietary intake of both iron and folic acid. Other contributing causes are excessive blood loss, overutilization, deficiency in absorption, etc. The average hemoglobin of the non-pregnant woman in Ghana is 65 percent of the recommended level, and only 54 percent in the pregnant woman.
- Goitre: A deficiency in iodine is common in many parts of the Third World including Africa. It usually manifests itself either as an enlargement of the thyroid gland in women (more apparent during the reproductive period) or as cretinism in the baby.
- Protein and calorie deficiency: Mild and moderate forms of these deficiencies are common in women, especially during the childbearing period. Other vitamin and mineral deficiencies are common in other parts of the world.

Table I gives the WHO/FAO's recommended dietary allowances of the major nutrients for the disease-free, well-nourished person by age. The nutrient requirements for a diseased, overworked, and malnourished woman with repeated pregnancies will certainly be different:

- Infections will increase nutrient requirement.
- A person deficient of a particular nutrient will need a lot more than the recommended intake to rectify the deficiency, build up her stores, and remain normal.
- Stunting as a result of generations of undernutrition will probably decrease the energy requirements, since this is dependent on body size and composition.
- The strenuous physical activity that women undertake both at home and at work will increase these requirements.

In order to improve the nutritional status and health of women in developing countries we need to intensify our efforts in the following areas:

- Improvement in nutrition information and education, not only for mothers but for the whole population (including the men, who now take the better part of what is available);
- Increase in food production and distribution, recognizing the important role woman have to play as economic providers;
- Food fortification and supplementation where necessary;
- Nutrition rehabilitation where appropriate;
- Birth spacing;
- Introduction of appropriate technology to reduce the time and energy for food processing and preparation;

- Control and prevention of infections and other diseases; and
- Improvements in the formal education of women.

There is also an urgent need to study the activities and nutrient requirements of women in their various roles and stages of life—as adolescents, pregnant women, lactating women, non-pregnant mature women, and the elderly--and under the difficult and adverse environmental conditions in which they live. As this paper has tried to show, we will not necessarily solve the problems of Third World women even if we do, with great effort, reach the levels of dietary intake of the FAO's hypothetical "reference women."

FAO/WHO Recommended Dietary Allowances

Table 1. Recommendations for the daily intake of energy, protein, iron and calcium

Age and sex	Weight (kg)	Expression of requirement	Energy		Protein (g) ^a				Iron (mg) ^b			Calcium ^c (mg)
			(kcal)	(MJ)	A	B	C	D	A	B	C	
Infants												
6-8 months	8.2	per day	900	3.77	14	17	19	23	5	7	10	500-600
		per kg per day	110	0.46	1.62	2.02	2.30	2.71				
9-11 months	9.4	per day	990	4.14	14	17	19	23	5	7	10	500-600
		per kg per day	105	0.44	1.44	1.80	2.04	2.40				
Children, both sexes												
1-3 years	13.4	per day	1,360	5.69	16	20	23	27	5	7	10	400-500
		per kg per day	101	0.42	1.19	1.48	1.68	1.99				
4-6 years	20.2	per day	1,830	7.66	20	26	29	34	5	7	10	400-500
		per kg per day	91	0.38	1.02	1.26	1.43	1.67				
7-9 years	28.1	per day	2,190	9.16	25	31	35	41	5	7	10	400-500
		per kg per day	78	0.33	0.88	1.10	1.25	1.47				
Adolescents, male												
10-12 years	36.9	per day	2,600	10.88	30	37	43	50	5	7	10	600-700
		per kg per day	71	0.30	0.80	1.01	1.15	1.36				
13-15 years	51.3	per day	2,900	12.13	37	46	53	62	9	12	18	600-700
		per kg per day	57	0.24	0.72	0.90	1.02	1.20				
16-17 years	62.9	per day	3,070	12.84	38	47	54	63	5	6	9	500-600
		per kg per day	49	0.21	0.62	0.75	0.85	1.00				
Adolescents, female												
10-12 years	38.0	per day	2,350	9.83	29	36	41	48	5	7	10	600-700
		per kg per day	62	0.26	0.77	0.95	1.08	1.27				
13-15 years	49.9	per day	2,490	10.42	31	39	45	52	12	18	24	600-700
		per kg per day	50	0.21	0.63	0.79	0.89	1.05				
16-17 years	54.4	per day	2,310	9.67	30	37	43	50	14	13	28	500-600
		per kg per day	43	0.18	0.58	0.69	0.78	0.92				
Adults^d												
Reference man	65.0	per day	3,000	12.55	37	46	53	62	5	6	9	400-500
		per kg per day	46	0.19	0.57	0.71	0.81	0.95				
Reference woman	55.0	per day	2,200	9.20	29	36	41	48	14	19	28	400-500
		per kg per day	40	0.17	0.52	0.65	0.74	0.87				
During last half of pregnancy		per day	add 350	1.46	add 9	add 11	add 13	add 15	see text			1,000-1,200
During first 6 months of lactation		per day	add 550	2.30	add 11	add 21	add 24	add 28	see text			

^a "Safe levels of intake" of protein are described in terms of four different sources:
 A Milk or egg protein (relative net protein utilization (NPU) = 100)
 B Mixed diet rich in animal source foods (relative NPU = 80)
 C Mixed cereal-legume diet with small amounts of animal source foods (relative NPU = 70)
 D Staple cereal diets with few other sources of protein (relative NPU = 60)

^b Iron requirements are described in terms of three types of diets classified by the proportion of the energy derived from animal sources or soybean:

- A 25% or more
- B 10-25%
- C less than 10%

These sources range from typical North American diets to the cereals diets of Asia.

^c "Safe practical allowances" of calcium.

^d For description of reference man and reference woman see page 458.

Table 1B. Recommendations for the daily intake of several vitamins.

Age and sex	Weight (kg)	Vitamin A ^a (ug)	Vitamin D ^b (ug)	Thiamine (mg)	Riboflavin (mg)	Niacin (niacin equi- valents ^c)	Folic Acid ^d (ug)	Vitamin B ₁₂ (ug)	Ascorbic Acid (mg)
Infants									
6-8 months	8.2	300	10	0.4	0.5	5.9	60	0.3	20
9-11 months	9.4	300	10	0.4	0.6	6.5	60	0.3	20
Children, both sexes									
1-3 years	13.4	250	10	0.5	0.8	9.0	100	0.9	20
4-6 years	20.2	300	10	0.7	1.1	12.1	100	1.5	20
7-9 years	28.1	400	2.5	0.9	1.3	14.5	100	1.5	20
Adolescents, male									
10-12 years	36.9	575	2.5	1.0	1.6	17.2	100	2.0	20
13-15 years	51.3	725	2.5	1.2	1.7	19.1	200	2.0	30
16-17 years	62.9	750	2.5	1.2	1.8	20.3	200	2.0	30
Adolescents, female									
10-12 years	38.0	575	2.5	0.9	1.4	15.5	100	2.0	20
13-15 years	49.9	725	2.5	1.0	1.5	16.4	200	2.0	30
16-17 years	54.4	750	2.5	0.9	1.4	15.2	200	2.0	30
Adults									
Reference man	65.0	750	2.5	1.2	1.8	19.8	200	2.0	30
Reference woman	55.0	750	2.5	0.9	1.3	14.5	200	2.0	30
During last half of pregnancy		750	10	add 0.15	add 0.20	add 2.3	400	3.0	50
During first 6 months of lactation		1,200	10	add 0.20	add 0.35	add 3.6	300	2.5	50

^a Expressed as retinol; see page 473 for equivalent amounts of carotenoids.

^b Expressed as cholecalciferol; 2.5 ug = 100 I.U.

^c Niacin equivalent = 1 mg niacin or 60 mg tryptophan.

^d Expressed as free folic acid. Requirements expressed as "total folate" have been estimated to be twice as high as those shown (see page 478).

Women's Poor Health In Developing Countries: A Vicious Circle

Jose Villar and Jose M. Belizan

A woman's health, and nutrition in particular, must be seen as a processual event occurring throughout her whole life. Health programs will have appreciable impact only if they are oriented in this direction, rather than being focused only on the delivery rooms.

The nutritional and health status of women in less developed countries show a consistent pattern throughout their life cycles of malnutrition, infection, and their interrelationship. This situation is a vicious circle: poor, malnourished mothers produce malnourished children unable (though not for genetic reasons) to reach growth standards who, in turn, become poor and malnourished mothers themselves. In general, public health services in developing countries put little, if any, emphasis on preventive measures to break this spiral, notwithstanding recent attempts to reorient health services to "primary care."

Scant data are available on the nutritional status of women independent of their reproductive function. However, using pre-pregnancy information, it can be proved that they suffer from adverse health and nutritional conditions even before they conceive their own offspring. Recent reports from rural Guatemala, for example, have shown that the mean height for women in their first trimester of gestation was 143 + 5 cm or 88 percent of the equivalent U.S. average, a fact which points to chronic nutritional deficiency. In the same population, the pregnancy weight was 46 + 1.76 kg, or 78 percent of the mean weight for well-nourished women. Dietary intake during the first trimester was far below the Daily Dietary Recommendations for non-pregnant women. (This cannot be explained by nausea and vomiting, since these complications are almost unknown among Guatemalan Indians.) Chronic infection is also often associated with sub-optimal nutritional status; one study of women in rural Central America found that 48 percent had vaginal cellular changes indicative of inflammation, and the incidence of urinary tract bacterial infection was 22 per 100 pregnancies at conception. In short, the women in these various studies already had nutritional and health deficiencies at the onset of gestation.

This condition has repercussions on both the mother and her offspring. When the mother's height diminishes, the incidence of low-birth-weight infants rises, and if the mother is short and poor, the incidence of low birth weight rises sharply, reaching 15 to 40 percent of all live births in developing countries. Low birth weight is by far the greatest single hazard for infants, increasing their vulnerability to developmental problems and death. Of all infant deaths, two-thirds occur among those weighing less than 2500 g at birth.

An Institute of Nutrition of Central America and Panama (INCAP) study has shown that maternal supplementation can significantly reduce the incidence of low-birth-weight infants. However, the mother may still have undergone a process which could be considered a form of slow starvation. This is because the total weight of fetus, placenta, amniotic fluid, uterus, breast, interstitial fluid, and blood volume is about 20-1/2 pounds, or 9.3 kg. But the average Guatemalan mother gains only 5-7 kg during the course of pregnancy. Thus, one-quarter to one-third of the supporting structures for both the mother and the fetus during gestation must have been created at the expense of other maternal tissue.

Beyond the body's needs for childbirth, a woman has additional nutritional requirements if she is to sustain lactation successfully. First, she must accumulate fat reserves--an average of four kg during a full-term gestation. This will provide her with 36,000 additional Kcal, vitamin A, essential fatty acids, thiamine, niacin, and riboflavin, which are all energy-intake related. After the child is born, the lactating woman should have 600-800 Kcal per day more than the normal dietary intake. An additional intake of 20 g protein, as well as a general increment in almost all nutrients, is also recommended. These factors will allow the lactating woman to feed a baby for six months without any depletion of her own stores.

But most poorly nourished mothers in developing countries do not deposit fat during pregnancy as reserves and their daily nutritional intake during lactation is almost always below the WHO/FAO recommendations. Their average weight gain during gestation is only 5-7 kg instead of the 10-12 kg believed necessary for adequate fat accumulation. Indeed, mothers who breastfeed for periods of nine months can lose 2-4 kg in comparison to their pregestational weight. In a very ill-fed mother, loss can sometimes be as much as 7 kg after a year of lactation.

Lactation under the adverse physical and environmental conditions in Third World countries not only represents a drain on the mother. It also affects the infant, because, as Jelliffe and Jelliffe have shown, the "milk of malnourished women is often suboptimal in quantity and quality, with lower values of fat (calories), water-soluble vitamins, vitamin A, and somewhat lower calcium and protein." While values for milk protein in the Jelliffe study did not show large differences between well- and ill-nourished women, they are insufficient to support the needs of intrauterine growth-retarded infants, who represent 20-30 percent of all live births in rural areas. It has been shown that the protein requirements for this special, but very vulnerable, group can reach values of 2.5 g/100 Kcal, as compared to the 1.41 g/Kcal found in the milk of malnourished mothers. When the period of rapid growth starts to decline at about the third month, the mother's protein quality is almost at the 1.47 g/100 Kcal that the infant needs as can be seen in Table 1, but these mothers would need to produce more than a liter of milk a day to reach the total amount of protein required. Similar comments can be made regarding calories. Table 2 makes clear that, after the second month of life, growth-retarded infants cannot get required calories from mother's milk.

Figure 1, based on data from a longitudinal study of poor, rural Guatemalan children who were fully breast-fed for at least a year, demonstrates graphically that the physical and environmental factors characteristic of developing societies act jointly to produce a female population which, at six months of life, is already at a disadvantage. The weight gap between these Guatemalan infants and those in affluent societies, including low-birth-weight babies in developed countries, widens through the first year of life. By age five, the difference is considerable; ten years later, the cycle will be resumed when these girls become mothers.

Thus, a thorough assessment of the evidence points to the conclusion that little improvement can be expected in women's health and nutritional status if interventions are conducted only during the period of pregnancy. Interventions during the last trimester, as is often suggested, appear to be particularly futile in light of this evidence. The only way to successfully break this escalating spiral of poor health for mothers and offspring is to conceptualize health as an integral process which evolves throughout the life cycle, and to plan for health maintenance accordingly.

It must be made clear that the discussion of human milk should not be misconstrued to mean that women should not lactate. Breast milk is best for healthy infants of well-nourished women. Where these conditions do not exist, public health measures must be instituted to meet them. It would also be incorrect to claim that the only solution to this problem is to prevent these women from getting pregnant. The means to improve basic maternal health and nutrition are both evident and available. It is society's responsibility to act on this knowledge; then couples, in the context of their societies, will decide when to have children and how many to have. They should also be empowered to act on that choice.

Table 1. Protein in Human Milk - Intrauterine Growth Retarded (IUGR) Infant Requirements
(poorly nourished populations)¹

Month of Life	Avg. wt. (g)****	Estimated Protein Requirements for IUGR Infants*		Protein in Human Milk from Malnourished Mothers Assuming 600 cc of Milk a Day**		% of Adequacy	
		Total/day (g)	g/100 Kcal	Total/day (g)	g/100 Kcal***	Total/day (g)	g/100 Kcal
Birth	2150	6.90	2.52	4.80	1.40	69	56
1 month	3040	7.71	1.95	4.80	1.40	62	71
2 months	3930	8.50	1.66	4.80	1.40	56	86
3 months	4850	9.33	1.47	4.80	1.40	51	95

* Calculated based on weight given above.

** Volume uniformity during the first three months of life was assumed.

*** .8 g/100 ml protein (15) and 57 Kcal/100 ml (average reported) (16) were assumed.

**** Cruise, M.D. Pediatrics. 51 (1973):620.

¹ Adapted from: Villar, J. and Belizan, J.M. American Journal of Clinical Nutrition. 33:536-541, 1980.

Table 2. Calories in Human Milk* - IUGR Infant Requirements

Months of Life	Estimated Calorie Requirements for IUGR Infants: Kcal/day**	Calories in Human Milk from Malnourished Mothers Assuming 600 cc of Milk a Day***	% of Adequacy
Birth	273	392****	143
1 month	395.2	392	99
2 months	510.9	392	76
3 months	630.5	392	62

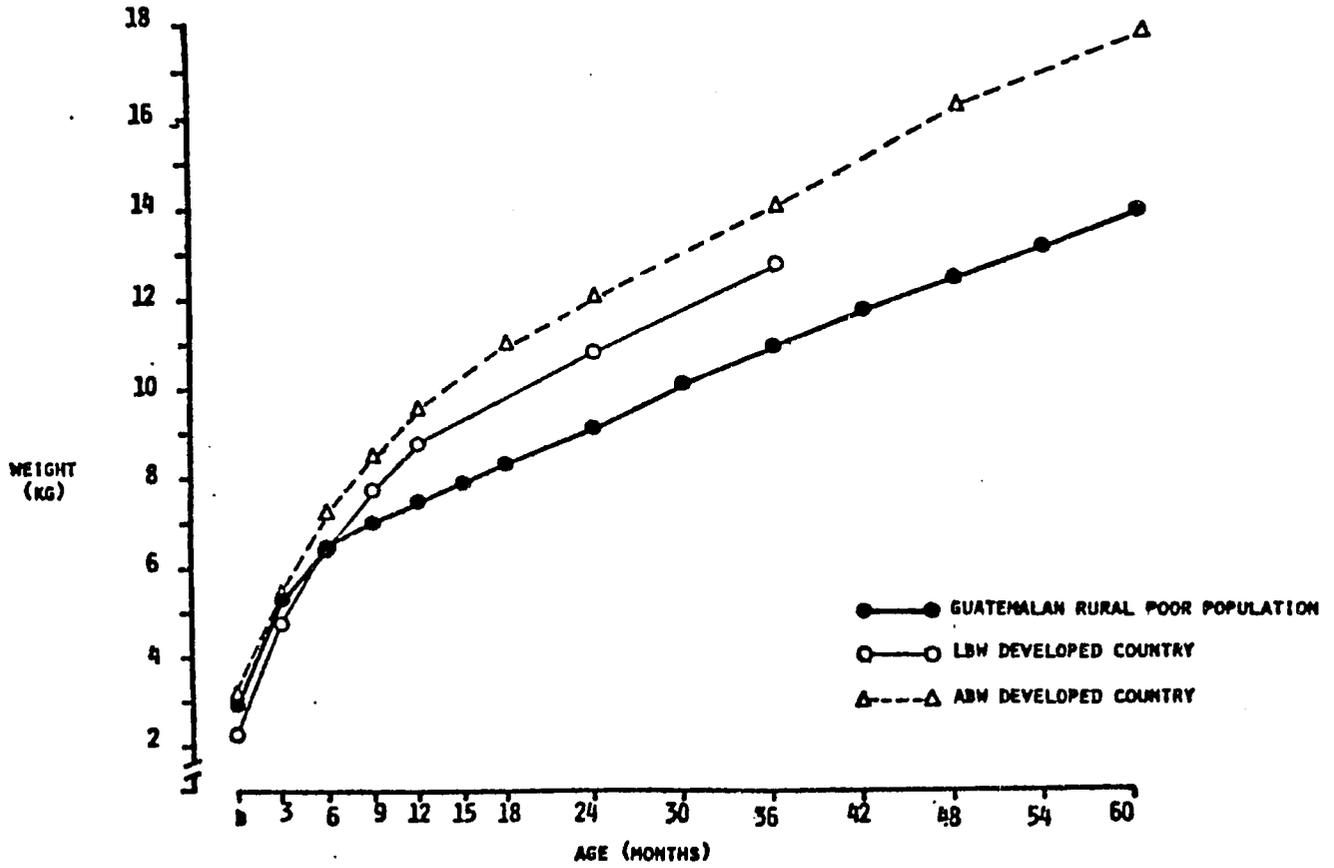
* Volume uniformity during the first three months of life was assumed.

** Calculated using same infant weight as in table 1.

*** The average between the mean and the lower value for well-nourished women as a reference for Kcal/100 ml (57 Kcal/100 ml) (16) was used.

**** 15% increment for the estimated 345 Kcal/day for a more conservative figure.

Figure 1: 50th Percentile Of Weight Gain In Female Children From Selected Populations*



* Source: Belizan, J. et al. The Patulul Study. (Unpublished data)

Changing Infant Feeding Practices: A Woman-Centered View

Isabel Nieves

Much concern has been expressed recently over the decline in breastfeeding among the urban poor in developing countries. Attention has focused on the undeniable fact that breastmilk is best for the infant, and on the role of formula-producing companies, whose unethical advertising practices in promoting bottle feeding have exploited and capitalized on the predicament of poor women in the Third World. There is, however, another set of issues to be addressed, and that is the implications of breastfeeding for the mother.

Breastfeeding is essential to infant nutrition. At the same time, it cannot afford to be detrimental to women. Any policy to reverse the decline in breastfeeding among the urban poor must, therefore, take account of women's needs if it is to be a true, holistic rendition of a complex human situation. Two general issues appear to be the most important:

1. The nutritional status of the lactating woman must be just as central a concern as the nutritional status of the infant. For a woman to breastfeed successfully without it being detrimental to her own health, it is essential that she gain about 10-12 kg during pregnancy and that she increase her caloric and nutrient intake by 20-25 percent during the time she is breastfeeding. Otherwise, she may be at risk of depleting her own resources, especially if her pregnancies are not well spaced.

The medical and nutritional literature tends to consider maternal nutrition only in the context of its impact on lactation and infant well-being. The question of what effects lactation has on women whose nutritional and health status are not optimal is not a popular one to ask. Yet, the average woman in developing countries does not gain even the minimum recommended weight during pregnancy, and the evidence is that her diet deteriorates after childbirth.

In order to safeguard women's health, adequate maternal weight gain during pregnancy must be insured through supplementary feeding programs for women as an integral component of all activities to promote breastfeeding. Indeed, the efforts to maintain a woman's adequate nutritional status ought to begin prior to the onset of pregnancy. Furthermore, women should not be forgotten once delivery is over and lactation has been initiated. A woman's health status should continue to be monitored and measures taken to ensure that her diet is adequate, both in terms of increased caloric intake and of the required increments of other nutrients during the period of lactation.

2. One cannot dismiss the possibility of a relationship between women's changing productive roles (understood as much more than work outside the home or salaried employment), and concurrent changes in infant feeding practices. Declines in breastfeeding are most severe in modern urban and peri-urban situations, and women's productive roles are undergoing the most rapid changes in precisely those environments, where their economic needs are increasing, their roles as primary and secondary earners are becoming critical, and the bases of their traditional productive roles are rapidly disappearing. Physical mobility and time flexibility have become matters of survival strategy for many urban women. Furthermore, traditional support networks, essential for a woman to successfully establish breastfeeding, are not being recreated in modern urban situations.

Past discussions of the factors responsible for early adoption of mixed feeding practices (breast and bottle) among poor women in developing countries have implicitly assumed that the causes are the same as those in industrial nations. Based on studies conducted in Western industrial situations, many of the physicians, nutritionists, and public health workers who conduct breastfeeding studies (without benefit of social science training) assume that attitudinal and value factors are the primary determinants of a poor urban woman's decisions regarding the feeding of her infant. They argue that, since breastfeeding is now increasing in Scandinavia, France, and the U.S., where women's options for work outside the home are expanding, then the pursuit of economic activity by women cannot be a major factor in explaining the decline of breastfeeding in less developed countries. The accepted wisdom appears to be that poor Third World women's desire to become "modern" and to emulate high-class urban women has prompted them to reject breastfeeding. One researcher called bottlefeeding "a disease of civilization."

This belief--that attitude rather than economic necessity is the major determinant of behavior--has important consequences for programming that seeks to promote breastfeeding. If attitude is the key, then, the argument goes, women constitute the core of the "breastfeeding problem" and women must be reeducated. In this model, women become the passive targets of manipulation. But their needs for physical mobility and time flexibility in a hostile urban environment are not addressed. Repeated studies have shown that Third World women are working outside the home in greater numbers than census statistics indicate. They are productive in the marginal and traditional sectors of the economy. They also have to put in long hours of monotonous and physically demanding work in the home, and this work is not as compatible with childcare as Western analysts tend to think. Thus, the constraints of women's productive responsibilities must be considered in any attempt to change their infant feeding practices.

Nutrition For Women, An Investment In Human Quality

Elena Hurtado

Whatever the scientific differences of opinion on the nutritional requirements of men and women, there is no debate over the fact that the nutritional requirements of pregnant and lactating women are greatly increased over the needs of a non-pregnant, non-lactating woman. This paper will focus on the effects of unfulfilled maternal nutritional requirements on both mothers and children. It is based on the results of a longitudinal food-intervention study involving various levels of food supplementation, which was conducted by the Institute of Nutrition of Central America and Panama (INCAP) in four rural Guatemalan communities.

The INCAP study, as well as others, documented the effects of maternal undernutrition on fetal growth, infant growth, mental development, lactation, and the birth interval. The evidence points to the importance of food supplementation of maternal diet but it also underlines the importance of pre-pregnant nutritional status. To deal with this latter problem a longer-term approach is required. It calls for programs that will expand food production and increase food availability, health and nutrition, education, family planning, etc.

1. Maternal Nutrition and Fetal Growth

During pregnancy, modifications in the maternal hormone system help to maintain the availability of nutrients to the fetus relatively independent of alterations in maternal diet. However, when maternal dietary deficiencies reach critical low levels, there is a decrease in the effectiveness of the mechanisms that maintain fetal nutrition. When this happens, other factors become crucial to fetal weight gain: pre-pregnant nutritional status of the mother, her nutrient intake during pregnancy, and the efficiency of conversion of maternal tissue into nutrients available for fetal growth.

Considering the unfavorable nutritional status of a large percentage of women in developing countries, it is not surprising that developing countries account for 94 percent of all low-birth-weight babies throughout the world. The INCAP researchers found an association between maternal height and head circumference--both measures of past nutritional status--and the birth weight of their children. A similar relationship has been found between prepregnancy weight and the birth weight of children among mothers of the same height.

Caloric supplementation during pregnancy clearly helps. It caused an increase in weight gain during pregnancy in the INCAP study population, and maternal weight gain is strongly associated with birth weight in both industrialized and developing countries. Furthermore, the association between caloric supplementation and birth weight was observed in consecutive pregnancies of the same mother. Preliminary results of this investigation also showed a significant correlation between caloric supplementation and duration of gestation.

2. Maternal Nutrition and Infant Development

Low birth weight babies have higher rates of infant mortality than babies with better birth weights. In the INCAP study, the proportion of infant deaths was greater in the low supplemented mothers than in the high supplemented mothers (that is,

supplementation during pregnancy and lactation). A difference in the proportion of children with physical growth retardation up to six months of age in relation to the level of caloric supplementation of their mothers during pregnancy and lactation was also reported, which may be related to the fact that supplementation of lactating mothers was associated with an increase in breast milk as well as in duration of lactation.

It has been reported that low birth weight is associated with deficits in mental performance. The INCAP study showed birth weight to be associated with performance on the Brazelton Assessment Scale and a motor subscale of a Composite Infant Scale at six months of age. Furthermore, significant correlations were found between gestational supplementation and test performance at age six months in consecutive siblings within the same family.

3. Maternal Nutrition and Birth Interval

The cumulative effects of sequential reproductive cycles can lead to general "maternal depletion," as shown by progressive weight loss and a prematurely aged appearance. The more poorly nourished a woman is, the longer the inter-pregnancy interval needs to be for her body to replenish its nutrients and to adjust to its pre-pregnant state.

In this connection, the length of postpartum amenorrhea can be significant. It has been suggested that the nutritional status of the mother affects the length of postpartum amenorrhea and thus the speed with which fecundity returns. The INCAP longitudinal study did indeed find that the more poorly nourished women were before and during pregnancy, the longer was the duration of postpartum amenorrhea. It is thus tempting to predict a population increase from improving maternal nutritional status. But this is not necessarily so. The contraceptive effect of lactation is well known. Better nutrition is associated with longer periods of lactation and reduced infant mortality. The increase in the length of lactation thus might increase the length of postpartum amenorrhea, while reduced infant mortality should prolong lactation in cases where a death would have occurred.

Thus, investments in nutritional programs are investments in human quality, which is a key to development. The alternatives range from direct to indirect approaches. The effects of direct approaches such as food fortification are on the level of specific nutrients. In Guatemala, for example, a rise in the level of vitamin A in the breastmilk of rural women was observed with the introduction of vitamin A-fortified sugar in the diet; fortification of sugar with iron is presently being investigated.

Food supplementation is a somewhat less direct approach, but its importance is clear. In a review of the relationship of maternal nutrition and lactation, the Jelliffes conclude that—as with so much else concerning the health and nutrition of young children—the emphasis should be in large measure on the mother. Nonetheless, the women and children in greatest need of supplementation services in developing countries may be the ones who take least advantage of them because of income, time, and other constraints; attendance may also be limited by language and cultural barriers between service providers and consumers. At best, supplementation programs are palliative.

Development programs are ultimately the most effective way of improving nutritional status. This means the integration of different programs, including nutrition, which have human development as their general objective. Within this

approach, mothers at high risk of delivering low-birth-weight babies can be identified and offered special nutrition programs. Characteristics of such programs would be their emphasis on the utilization of local resources, appropriate technology, and community participation.

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III. TESTIMONY FROM THE UNITED STATES

In many ways, the health concerns of women in the United States are quite different from those of the Third World. Their health status is likely to be far higher, for one thing, especially if they are white and middle class. They may seek greater attention for such problems as unnecessary surgery or complications of menopause or alcoholism in women. Minorities have some special needs; Blacks, for example, suffer excessively from hypertension and Native Americans from obesity.

But in many other ways, particularly for minority women, American women's health concerns are remarkably similar to those of their Third World sisters. They, too, need better access to primary health care, especially in rural areas. Access to safe, legal abortions--which are being made increasingly difficult for the poor to obtain--is also a problem for American women, as is teenage pregnancy (although children in the U.S. may be conceived more often out of wedlock). As in the Third World, mental stress among women, relatively high to begin with, is greatly intensified in the presence of poverty and racial discrimination. Julia Graham Lear notes that fully one-third of ordinary Black women in the U.S. have been found to suffer from a level of distress comparable to that of most mental health patients. American women also complain of inappropriate care from a male-dominated health care system. These problems are even more acute in the case of Hispanic and Native American women, where cultural and linguistic barriers compound those created by gender differences. The consequences of inadequate care are graphically described by Sandra Salazar and Sister Pauline Apodaca, for Hispanics, and by Kyle Cross and Joyce Kramer, for Native Americans.

In the U.S., women have recently begun to organize in order to deal with some of these problems themselves or to put pressure on those in authority. Julia Graham Lear mentions women's clinics and other non-traditional service centers. Sister Pauline notes some of the health benefits that migrant workers in California have won through their trade union. As she points out, not all of these benefits relate to the health clinics; the outlawing of "el cortito," the short-handled hoe, probably does more than prenatal care to improve the health of a pregnant farm worker.

Women's Health Needs in the United States

Julia Graham Lear

The notion that there is value to be gained in focusing on women's health, as distinct from men's, has only recently gained some acceptance in the United States. Only in the late 1960s, as an outgrowth of the women's movement, did health activists and researchers begin to point out that sex could make a difference in determining a person's access to health care, the quality of care received and the financial burden of that care.

On the face of it, women in the United States appear to have a great deal to be pleased with in their medical care. Women's life expectancy averages seven years longer than men's. They account for sixty percent of all adult physician visits, and their health has benefitted from a sharp reduction in fertility rates—from 30.1 per 1,000 women in 1910 to 23.7 per 1,000 in 1970 and 15.3 in 1978. Despite these encouraging statistics, other numbers suggest that not all American women receive the health care they need or are happy with the health care they get. Thus, in 1977, although abortions are legal in the United States, they were not performed in 80 percent of public hospitals and 63 percent of private hospitals across the country. And while women may have difficulty obtaining access to abortion services, they may have too much access to other surgical procedures. In that same year, women experienced 120.2 operations per 1,000 women compared to a rate of 77.8 operations per 1,000 men. The three most frequently performed in-hospital surgical procedures in the United States were biopsies (1,173,000), D & Cs (995,000) and hysterectomies (705,000). These numbers do not include the 1.2 million abortions which are performed annually.

The care provided by traditional medicine in the United States has so alienated some women that they have begun exploring alternative modes of health care delivery. Women's clinics, whose services range from comprehensive primary care to limited contraceptive care, have been established in many communities. While these clinics represent only a fraction of total medical care provided to women, their establishment suggests the significant dissatisfaction with mainstream medicine.

Parallel to the emergence of women-managed health services has been the development of a feminist critique of American medicine. Feminist health professionals and writers have examined the structures of the medical care system, from training of providers to delivery of services, and concluded that the health care system does not serve women well. The publication of Our Bodies, Ourselves (1973), written by the Boston Women's Health Book Collective, represented a unique blending of the women's self-help health movement and the feminist critique of traditional medicine.

The cumulative result of the past ten years of writing on women's health and American medicine has been the identification of a variety of problems in women's interface with the health care system. These include difficulties in obtaining care for certain medical problems, questions of quality of care relating to surgical rates and drug-prescribing behavior of physicians, exposure to carcinogens in the workplace, and special problems in obtaining care for poor women.

Access to Medical Care: Problems in Alcoholism, Drug Abuse and Abortion

Availability of services is a fundamental prerequisite for good health. In three areas, there has been a particular failure to recognize women's health care needs. These areas are alcoholism, drug abuse, and abortion services.

Alcoholism is the eighth largest killer in the U.S. It is estimated that between 20 and 50 percent of the alcoholics in the country are women, but few services have been made available to them. For example, in 1976, only 14 of 574 treatment programs funded by the federal government were designed to treat women. Of the 600 halfway houses identified at that time, only 30 were for women. Of 384 federally funded research projects on alcoholism, only 16 included women as research subjects and only five of these were specifically concerned with women alcoholics. The assumption apparently was that what is true of male alcoholics is true of female alcoholics physiologically, emotionally, economically, and culturally--assumptions that recent data have thrown into question.

Similarly, there has been little empirical research on the female drug addict, despite evidence that there may be differences in male and female responses to treatment. A 1974 study found that the dropout rate of female addicts from treatment programs was twice that of males. A 1973 study found that women addicts seek treatment in significantly fewer numbers than males.

The issues of women's health care and women's rights intersect most clearly on the issue of access to abortion services. Until 1971, most abortions in the U.S. were illegal. In that year, the U.S. Supreme Court held that states may not prohibit abortions or make the procedural regulations applying to abortion so onerous that the right to abortion is effectively denied. Nonetheless, anti-abortion forces have had considerable success in limiting the reach of that decision. By 1977, abortions were not performed in 80 percent of the public hospitals and 63 percent of private ones; this has had a particularly burdensome effect on rural women.

Quality of Care Issues

Birth Control Drugs and Devices. Criticism of inadequate testing of drugs and devices to control female fertility or treat postmenopausal conditions appears to head the list of complaints women have about the quality of medical care in the United States. Concern that patients participating in drug studies have not been given adequate information, deceptive advertising, and inadequate attention to the risks for women posed by certain drugs have been major issues.

Controversy over the drug DES is an example of this issue. DES, diethylstilbestrol, a cancer-causing drug, was used in the United States for thirty years as a drug to avert miscarriages. Several million pregnant women took the drug and a reported 2.1 to 3.5 million DES daughters were born to these women. A documented 120 have developed a rare form of vaginal cancer. Ninety percent of the DES daughters are estimated to have abnormal structures in the vagina or cervix that may be pre-cancerous. Of growing concern are the increasing numbers of DES daughters reporting pregnancy problems. Although DES has been removed from the market as a growth-promoting additive in cattle feed, it remains approved for use as an emergency, morning-after, postintercourse contraceptive.

Unnecessary Surgery. Hysterectomies in the United States increased by fifty percent between 1966 and 1975. In 1975, 725,000 hysterectomies were performed,

making it the second most frequently performed surgical procedure. Hysterectomies are not only numerous, but expensive. The average length of hospital stay required for recovery from a hysterectomy is 11.5 days. In 1977, \$1.7 billion in hospital care alone was spent on hysterectomy patients. An additional \$467 million was spent on physician fees.

Only ten percent of hysterectomies are mandatory or cancer-related; ninety percent are elective. In light of the high surgical rate, the elective nature of the surgery, and the lack of knowledge about why some physicians choose to operate for some symptoms while others treat the symptoms differently, women's health activists both inside and out of government are pressing for government and private studies of the issue as well as public awareness campaigns and use of second opinions prior to surgery.

Caesarian-section deliveries have also risen sharply in recent years. The caesarian-section rate has more than doubled between 1968 and 1977, rising from 5.0 to 12.8 percent. According to a recent report, there has been little assessment of the risks and benefits of caesarian sections to mothers and children. A major concern is that as caesarian sections become more routine, physician practice and resident training to perform caesarian sections routinely become more entrenched. In response to pressure from women's health advocates, the National Institutes of Health sponsored a conference on caesarian section in September 1980 to assess the meaning of the current trend and to recommend responses.

Occupational Health. As growing numbers of women, 40 million of them, have joined the workforce, occupational health hazards have become an increasing concern. Data have confirmed the relationships between birth defects, cancer, miscarriages, and exposure to toxic substances. However, new studies indicate that work which is dangerous for women, such as exposure to lead, mercury compounds, vinyl chloride and anesthetic gases, may be equally unhealthful for men. Rather than undertake to provide a safe environment for all workers, industries have, on the whole, preferred to exclude women from unsafe environments. Recently, two United States government agencies have attempted to balance the interests of reproductive health and employment equity with guidelines that require that if a firm worries about the reproductive health of women, it should worry about the reproductive health of men. If an employer has information that exposure to a substance would harm female reproduction, then it may exclude women workers from jobs involving exposure to the substance. However, within six months, the firm must by itself or in cooperation with others, conduct research on the effects of the substance on male reproduction.

Teenage Pregnancy is a major public health problem in the U.S. An estimated 11 million American teenagers are sexually active and, of those, about one million adolescent girls—one in ten aged 15 to 19—become pregnant each year. Of these, 600,000—two-thirds of them 17 or younger—give birth and 90 percent keep their babies, even though as many as 80 percent of the pregnancies are estimated to be unwanted. Increased sexual activity among teenagers, failure to use contraceptives, and a recently enacted prohibition of federal support for poor women's abortions have contributed to this growing epidemic of teenage pregnancies. Feminists suggest that sex-role stereotyping and the failure to provide alternative futures, especially for poor minority women, also contribute to this problem.

Special Problems of Low-Income and Minority Women

The health problems common to all women are exacerbated by poverty and racial discrimination. Perhaps because of the greater amount of poverty among all minority racial groups, except Asians, non-white Americans experience higher infant mortality rates, lower life expectancy, and generally poorer health. Life expectancy for minority women is seven years less than for white women.

Although all low-income women share common health problems stemming from malnutrition, poor sanitation, and stress, there are issues of special concern to each minority group in the United States.

The number one health problem for black Americans is undoubtedly uncontrolled hypertension. One in four American blacks experiences uncontrolled high blood pressure compared with one in six whites. As pointed out by the National Black Health Providers Task Force, the consequences of this rate are enormous--blacks have three to four times the rate of fatal strokes found in the general population, and more than that in the 35-44 age group. The Task Force found sufficient opportunities for research and provider training to recommend a 20-year effort targeted on hypertension in the black community.

A recent health survey found substantial differences in psychological well-being between blacks and whites, which was especially pronounced among women. Seventy percent of white males reported a positive sense of well-being compared to 54 percent of black males. Fifty-four percent of white females reported a sense of well-being compared to only 37% of black females. Indeed, a third of the black female respondents indicated a level of distress comparable to that reported by three-fourths of an independent sample of mental health patients.

The Spanish heritage population, which is the second largest racial/ethnic minority in the U.S., is more distinguished by what is not known about its health status than what is. There are no nationwide data on Hispanic infant mortality, e.g., or on maternal mortality, life expectancy, and birth rates. A national conference to identify priorities in health services research for Hispanics was convened in September 1979. Among the issues identified were the need for education and health-promoting programs focused on Hispanics, the importance of research on health-services utilization by Hispanic sub-groups, and the need for research to be sensitive to the diversity within the Hispanic population.

The Asian and Pacific Islander population, which lives primarily in the western U.S. and in urban areas, is a unique minority in that it is relatively rich, well-educated, and healthy. Whether existing favorable longevity rates for Asian-Americans will continue through the 1980s, however, is open to question. Southeast Asians have been entering the country at a rate of 14,000 per month since late 1979. Many of these new arrivals do not share the high socioeconomic profile of the Japanese and Chinese Americans.

American Indians and Alaskan natives are the smallest racial minority singled out for special attention. Despite impressive gains in reducing infant and maternal mortality, sharp contrasts continue between Indian health status and that of the U.S. population as a whole. Considerable resources have been expended in the development of improved services for Native Americans over the past 20 years. Why these services are not achieving improved health outcomes is a question that should command the attention of health-services researchers.

The Root of the Problem

The neglect of women's health needs has stirred far-ranging controversy as to the underlying causes. Some have argued that the inattention to women's health must flow from some organized effort to deny women control of their bodies; others argue that the abuse, especially in unsafe drugs, is the result of capitalist enterprises attempting to increase profits. Still others suggest that the most serious problems are the result of inequities due to income bias rather than sex bias. This writer, however, argues that women's health problems may be neglected because the people who make public policy, who conduct medical research, who educate physicians, and who deliver medical care, are for the most part, men who share the biases of American society concerning women.

While some changes are occurring--the past few years have seen a sharp increase in the number of women admitted to medical school, for example--many things remain the same. None of the 127 medical schools is headed by a woman. Few women physicians hold tenured, professorial positions. Power in private medicine also evades women; only one percent of the American Medical Association's 1980 House of Delegates were women, for example. Until more women who are sensitive to women's health concerns participate in health policy and program decisionmaking, the gains of the past few years will rest on shaky foundations.

Recommendations Regarding Latina Women

Sandra A. Salazar

The Raza population--those cultural/ethnic groups which share a common ancestral mixture of indigenous Indian and colonizing Spanish--is the second largest minority group in the United States. By the year 2000, Raza--or Latinos, as they are sometimes called--are likely to be the largest of the minority groups. Historically, they have been confronted by patterns of social and economic inequity characterized by:

- Culture in conflict: These cultural patterns (i.e., language, extended family, social customs), which have aided in the survival of Raza through difficult economic periods and racist social environments, have been, and continue to be, in constant contradiction to the established trends promoted by the dominant institutions in the U.S.
- Economic marginality: Low incomes, substandard housing, poor working conditions, and lack of education have all taken their toll on the health status of the Raza. The incidence of many diseases is significantly higher in the Raza population; mortality and morbidity rates are higher; and Raza suffer from more environmental and occupational health hazards than the general population. In spite of these pressing health needs, many Raza communities have few accessible and acceptable health services, and numerous communities have none at all.

Raza women suffer even more proportionally from these inequities. The first attempt on a statewide basis to draw a picture of the health care needs of Raza women occurred in October 1979, in the state of California. The following data and recommendations are extracted from the document prepared at that time by the California Raza Health Alliance.

Unfortunately, comprehensive health statistics on the Raza population in general in the United States are sporadic and disjointed at all levels. The data picture for Raza women is even worse. This lack of statistical information has negative implications for needed planning, funding, and services. There is, however, a small body of information that can facilitate culturally relevant delivery of health services and can serve as a basis for the planning of new programs. For example:

Population

- Median age of Raza females is 20.2 years, vs. 29.7 years in the total U.S. population;
- 49.5% of all Raza females are 19 years or younger, vs. 34% of all U.S. females;
- 3.5% of Raza females are older than 65, vs. 11.5% of all females;

- 20% of Raza families have a female head of household, vs. 14% of all families;
- 39.1% of Raza females with children have three or more children, vs. 21.1% of all such females.

Socioeconomic

- Median earnings of Raza women are 74% of the median for all women;
- 48% of Raza female-headed families have incomes below the poverty level;
- 30% of Raza women have four years or more of secondary school, vs. 62% of all women;
- 2.2% of Raza women have a college education, vs. 10.6% of all women;
- 53.6% of Raza women are employed in low-benefit occupations (e.g., operatives, service workers), vs. 33.2% of all women.

Raza women, as is true of the Raza population as a whole, are a youthful population; the median age for Raza in 1974 was less than 21 years. This would seem to indicate a need for obstetric and gynecological services, since a high proportion of the female population is of childbearing age. The lower percentages of husband-and-wife families, larger families, and lower income levels among Raza would tend to indicate likely barriers to health-care services. The particular burdens of Raza women become apparent when one realizes that Raza women are more likely to be divorced than Raza men, and that they support nearly 50% of all Raza families in poverty.

Raza women represent a significant percentage of the more than 26 million Americans who have no health insurance; 23% of the non-insured persons in California have incomes below the poverty level. Furthermore, current private and semi-private insurance programs often provide inadequate or no coverage for maternity services, exclude coverage for pre-existing conditions like diabetes and birth defects, do not cover preventive examinations like Pap smears, will pay for vasectomy but not abortion, and deny family planning and pregnancy-related coverage to single women.

Raza women poor enough to be eligible for the Medicaid program (Medi-Cal) experience great difficulty in utilizing these benefits. A recent study on the availability of obstetrical care, for example, revealed that 20 counties in California have no resident obstetricians or none who provide care to Medi-Cal recipients. These counties are primarily rural. Another recent study documented the shrinking proportion of California obstetrician/gynecologists who accept Medi-Cal clients; the proportion declined from 65% to 46% between 1974 and 1977.

In order to address the service gaps of current delivery systems as well as to relate more fully to the totality of women's health-related needs, specialized women's health care programs have sprung up with dedicated support of many feminists. But many of these programs fail to deliver relevant services in relation to the psycho-social and language needs of Raza women. In particular, the social service, mental health and allied health programs fail to adequately address issues related to ethnic identity.

Thus, women may get satisfactory services in relation to their gender, but they may be lacking in culturally relevant health programs.

The outstanding issues relative to the delivery of health services to Raza women revolve around a lack of accurate data on which to ground policy decisions and program planning, a lack of participation by Raza women as providers and policymakers, a lack of available health services which incorporate the special psycho-social and economic needs of Raza women, and a dominant health care system which views women as a cause of illness rather than as an agent for improved health.

Among the topical issues in need of research and action are:

1. Special service needs of particular sub-groups of Raza women, particularly those of undocumented women, women with developmental and physical disabilities, and rural and migrant women.
2. Health services related to female reproduction and sexuality, particularly the availability of obstetric and gynecological care and abortion services; contraceptive research priorities; workplace hazards impacting on pregnancy outcomes; pregnancies without artificially created hazards to the woman and fetus; and Spanish-language educational materials regarding sexuality.
3. Mental health service related to prevention and treatment which incorporate the emotional and psychological needs of Raza women, especially those that relate to battered women, victims of rape and other forms of sexual assault.
4. Health services available to post-menopausal women and gay women also deserve special priority. Since most available health services are related to reproduction and sexuality, these two groups of Raza women are often ignored.
5. Health services available to substance abusers require attention. Alcohol and poly-drug use among Raza women require approaches appropriately tailored to culture and language.

Migrant Workers: A Report From The Clinic

Sister Pauline Apodaca

It was a very hot, humid afternoon in August 1967 when I, a clinical instructor at the Good Samaritan Hospital School of Nursing in Dayton, Ohio, was catapulted into the world of the migrant farm worker. A young man had just been brought to the hospital emergency room from adjoining Darke County, after having fallen over in the field, apparently from a stroke, while picking tomatoes. He had no identification on him. No one could understand what he was saying, but someone surmised from his brown skin that he might be speaking Spanish and I was called to translate.

It is difficult for me to convey the enormity of the fear and apprehension experienced by this 22-year-old man, who was unable to comprehend what was happening to his body and who realized that, instead of accumulating money to send home to his family in Mexico, every hour in the hospital was plunging him deeper in debt. (Fortunately, in this case the Church Women United of Dayton, through a local newspaper, mobilized a fund for him and his family and brought his wife to his side within 72 hours.)

For me, these events were a turning point. I had read about the farm workers in California and the Delano Grape Strike, but I was in no way prepared for the unbelievably inhuman conditions in almost all of the farm labor camps in Darke County, which houses 2,000, mainly Spanish-speaking, migrants.

As I became aware of my temporary neighbors, I was encouraged by a persistent Dayton Church woman to help out in the evening clinic run by the Darke County Migrant Ministry. I did so for four years, and we did increasingly good work. Our services reached progressively more people. Ohio also passed some excellent--though unenforceable--legislation protecting the state's 35,000 migrant workers from unscrupulous crew leaders and growers. Still, nothing really changed.

Slowly, I learned that even our best programs left farm workers dependent on our accidental presence and passing good will. More slowly, I recognized our own complicity and our special responsibility. I realized that I could probably be more effective working with the United Farm Workers (UFW), the struggling union led by Cesar Chavez in California.

In both Ohio and California, women migrant workers have trouble getting adequate health care, especially during pregnancy. By the time the ravages of wind, sun, heat, and cold, frequent childbearing, and a deficient diet that can lead to iron-deficiency anemia have taken their toll, the women appear much older than their age. Their longevity is 15 to 20 years shorter than the national average. Along with the many environmental, occupational, and other physical health hazards, they are subjected to many emotional stresses--the loss of familiar surroundings and relatives for about half the year, the lack of assurance of plentiful work, concern for their children's health and care, concern for the wage earner's health, fear of pregnancy, concern that they will not make it home in the fall with enough savings to tide them over the lean time.

Many women do not seek medical supervision until late in a pregnancy, which results in higher risks for both mother and baby. This reticence to seek medical supervision seems to stem partly from the transiency of the life. It is hard to change

doctors every two or three months, especially if the medical personnel do not speak Spanish or there is no certainty that a translator will be available. Going to a doctor is a stressful situation at best, but much more so where intimate verbal and physical examinations are required. These women look on pregnancy as a very private affair and are extremely modest.

Accessibility of the health facility is also an important factor. In Ohio, the labor camps are far removed from the Clinic. Even if the family owns a car, the woman usually does not drive, so she is dependent on her husband or, more often, the crew leader. The crew leader usually charges \$10 a person to take his bus to the Clinic, and then only if there are enough people to make it monetarily or otherwise worthwhile. Sometimes it is sexual favors that are extracted as payment.

There is also a question of time. A woman with one, two, or more children who has labored 10 to 12 hours in the field is hard-pressed to make time for going to the Clinic. She must prepare the evening meal and perform all other needed household tasks under very primitive conditions. The man in the household does not help, nor is he expected to. Thus, if the woman is not experiencing great discomfort, she is not going to exert herself to get to the Clinic, especially if she has had one or more uneventful pregnancies. (When infants are born with deformities or other complications, they are usually accepted as an act of God, in punishment for sin or as a test of faith, and not associated with lack of good prenatal care.) Furthermore, the woman may not want to have her fears confirmed. Who knows? Maybe her menstrual period is late because she got her feet wet or because she took a cold shower while perspiring or ate incompatible foods or any one of a dozen wishful reasons. Once her husband knows she is pregnant, he will pay less and less attention to her, long before she is ready for this.

Even after a pregnancy is confirmed, the women's work and home responsibilities remain the same. Most work as long as they can, despite the backstraining stoop labor and the heavy 33-pound tomato hampers or 24-pound strawberry lugs they need to carry around. Field work exposes them to many toxic chemicals used in agriculture which can cause contact dermatitis, eye irritations, severe headaches, nausea, vomiting, and diarrhea, to say nothing of possible genetic alterations and miscarriages.

There is a growing acceptance of family planning among these women. Almost all favor spacing their children, but between their Catholic religion's prohibition and their husband's need to be in control, some feel they cannot consider the use of artificial contraceptives. Little has been done to make instruction in the Natural Method available and feasible. Some have accepted the IUD, which in many areas is encouraged because it is relatively simple, safe, and effective. Among those who opt for oral contraceptives are some of the women from Mexico, where the pill is available without a doctor's prescription; unfortunately, the over-the-counter pills are often the high-estrogen types now banned in the U.S. (because they tend to promote blood clots and the risk of strokes and heart attacks), but sold with impunity elsewhere by multinational pharmaceutical companies.

In California, the Union has brought significant health benefits to women workers. It was not until the UFW demanded and won provisions for sanitary facilities as part of every union contract that portable toilets and handwashing facilities became accepted requisites, along with potable water and individual cups. Where there is no union present, these amenities may be provided, but usually are not. The Union discovered they even had to negotiate the specific distances of the portable toilets, which were being left at the starting edge of the field instead of being moved at intervals to be

reasonably accessible. This convenience may not seem important to some, but to the women who must squat in public view to relieve themselves, it is very important, and has helped to obviate cystitis and kidney problems, which result from prolonged urinary retention, and bowel problems that stem from ignoring the body's natural messages. The welcome privacy that toilets provide during the menstrual period cannot be minimized.

A significant reform that has enabled pregnant workers to remain on the job much longer is the outlawing of "el cortito," the short-handled hoe. Since 1975, all weeding and thinning of lettuce has been done with a regular hoe in California. This means not having to work all day bent in two from the waist, which can result in severe back strain, reflux esophagitis, headaches, dizziness, and varicose veins.

Having seen, from my work at the UFW Clinic in Salinas, the benefits that unionization can bring, I yearn for the day when farm workers throughout the country will have enough strength to break the shackles of servitude to the crewleader and negotiate with their employers for decent, safe working conditions, fair wages, and the benefits that most other workers have had for years.

Health Problems Of Native Americans

Kyle J. Cross

Native American women's health problems are similar to those of the Third World women, in that they share problems of poverty, racism, neo-colonialism, sexism, oppression, lack of independent resources, and lack of trained and skilled providers from their own people. It must be remembered, however, that each tribe is different culturally, linguistically, genetically, environmentally, socially; therefore, problems will vary from tribe to tribe, particularly in the manner in which each tribe handles its problems.

In general, Native American women exhibit a pattern of diseases different from, and beginning earlier than, those of the dominant culture:

- Cardiovascular and related diseases are becoming more prevalent;
- Diabetes and associated problems have an earlier onset, occurring often during adolescence (a high correlation appears between early onset of diabetes and blindness);
- Obesity is an increasing problem; it further complicates the already high incidence of heart disease and diabetes;
- Otitis media occurs frequently among infants, children, and young adults and leads to a high rate of deafness among adults; learning, social, and psychological disabilities can result if the problem continues undiagnosed; some children have been labelled mentally retarded when what really ailed them was ear infection;
- Cancer is of concern, particularly where exposure to uranium mining and other carcinogens seems to be on the increase, as among the Lagunas and the Navajos; also of concern is the possible carcinogenic effect of pesticide spraying on reservation land.

Native American women also suffer from numerous problems that are unique to them as women:

- Problems during pregnancy result from lack of adequate prenatal care, poor nutrition habits, alcohol and drug abuse, and the potentially damaging effects on the infant known as fetal alcohol syndrome;
- Indian women are seeking abortions, particularly younger ones, and there is a lack of counseling available that is culturally and spiritually relevant to Indian women;
- The emotional trauma experienced by Native American women when they give their child up for adoption is often neglected, as the focus is directed toward the needs of the child;

- Indian mothers must cope with a lack of day-care centers which could give them greater freedom to function independent of their children;
- Physical abuse occurs; the boundaries of the reservations and closeness of family ties makes it difficult for an Indian woman to find shelter;
- Rape, incest, and community violence are problems Indian women encounter more frequently now; there is a lack of support systems to provide appropriate counseling and therapy in a manner which is culturally meaningful for the woman, although tribal groups are passing more ordinances claiming their abhorrence of such behavior;
- Widespread inadequacies in the procedures used to obtain informed consent from Indian women for sterilization procedures prompted a reform of regulations for federally-funded sterilizations.

Many problems affecting the total well-being of Indian women are related to the disintegration of the family. Historically, Indian women were gatherers and preparers, mothers, companions, teachers, spiritualists, leaders. The intrusion of the dominant white culture on the tribe's natural environment and lifestyle through forced relocation and assimilation efforts affected the traditional existence of the tribes. In addition, the male-female relationship among Indian people is being affected by economic necessities which force more and more wives and mothers into the job market.

The effects of colonization, oppression, and racism combined with rural isolation, forced relocation, lack of health resources, and lack of adequate mental health services result in a perpetuation of mental health problems for both women and men. Self-destructive behaviors include excessively high rates for suicide, accidents, alcohol and drug abuse, alcohol-related incidents, and, more recently, obesity. The problems associated with alcoholism are devastating to Native American women. There is a general lack of counseling services and facilities which meet the specific needs of Indian women and mothers. For example, an Indian woman may reject rehabilitative services because her children will be placed in an outside environment during the period of her (or their) treatment. During excessive drinking bouts, there is an increase in violence, often leading to accidents and deaths.

The widespread occurrence of obesity indicates a lack of nutritional awareness and understanding of the necessity of physical activity and recreation by Indian women. Natural food sources such as wild game, fruits and vegetables were often removed and destroyed during the process of colonization.

Health care services for Indians have been recognized as a special treaty obligation provided by the federal government since the Snyder Act of 1921. However, the actuality of Indian health care has never achieved a level of service delivery comparable to that provided for the mainstream of society. The Indian Health Service (IHS) is plagued with staffing and facilities problems as well as an inadequate budget and inefficient management. Its authoritarian attitude is strongly influenced by the Western medical model. There are very few Indian women professional health-care providers, although many are employed in lower-paying jobs. Women are neither recruited nor encouraged to advance at the professional level, which creates an atmosphere dominated by male perceptions of women's problems. The direct involvement of Indian people remains minimal, although the director of the IHS has as one of his functions "developing individual and tribal capacities to participate in the operation...."

The use of traditional medicine by Indian women is a factor to be considered by health care providers. Although they are not as well known as their male counterparts, most reservations have women who practice their native healing processes. IHS has done little to seek out and hire traditional practitioners, however; it remained for the National Institute of Mental Health to fund the first--and only--traditional medicine training program in 1966 at Rough Rock, Navajo Nation.

The solution to these problems will vary from tribe to tribe. There needs to be a real effort by the Indian people, including Indian women, to identify the problems, increase their own manpower, and remedy the situation through the tribe's self-determination efforts. The Indian Health Service needs to develop special programs, including preventive techniques, that focus on the unique problems of Indian women. Services must be extended to meet the needs of the urban and off-reservation Indians. Perhaps most important, the numerous health problems of Indian women should be viewed from a holistic point of view. In traditional medicine, life is viewed as a balance between the individual and the world around him and any disharmony or disruption becomes a disease. This approach can be applied today. For example, a holistic approach to treating diabetes would not involve medical attention alone, but would also include a program of exercise, proper nutrition, family involvement for support, and motivation of the women toward total self-care.

Urban Indians, A Neglected Group

Joyce Marie Kramer

The great majority of the 800,000 Native American Indians, Eskimos, and Aleuts in the United States do not live on federally recognized reservations. In 1970, 44 percent of Indian Americans lived in urban areas and another 28 percent in non-reservated rural areas. Because they are not attached to a reservation, these Indian Americans do not have access to the benefits of the Indian Health Services (IHS) or to many of the other resources to which Indian nations are entitled by treaty. Urban Indians commonly return to their rural community, at considerable expense, for health care at IHS hospitals. By so doing, they can also consult traditional healers and receive the emotional and social support that their extended kin and home community can provide. Nonetheless, more and better urban health services are clearly needed.

It is, of course, in the federal government's interest to minimize the number of people to whom it is obliged. Consequently, it is common for people who define themselves as Indian to be denied services because they cannot provide sufficient proof of their heredity. The results are very divisive. In some instances, a mother may be eligible for treatment at an IHS facility while her children are not. In other cases, Indian communities are set at odds and their self-esteem threatened. In North Carolina, for example, the reservated band of Eastern Cherokee, numbering about 5,000, refuses to acknowledge the Lumbee, who are a non-reservated rural Indian people numbering approximately 40,000.

While motivated to move to a city by high aspirations, many Indians are frustrated in their desires to improve their standards of living. Twenty-one percent, or three times as many urban Indian American families as Euro-American families, were below the federally defined poverty level in 1970. Nine percent of urban Indian households lacked a complete and private bathroom. Without the natural support of the rural-based extended family, women find satisfactory child care a formidable problem. Makeshift arrangements often involve leaving the offspring for relatively long periods with relatives or friends, which may be misunderstood as parental "disinterest" or "neglect" by non-Indian authorities and used as grounds for removing children from their parents' custody. In 1974, it was estimated that 25-35% of all Indian children had been taken by authorities and placed in foster homes, adoptive homes, or institutions.

Not surprisingly, symptoms of the stressful positions in which they find themselves are exhibited in the physical and emotional health of urban Indian populations. The statistics speak for themselves: the death rates among Indian Americans who live in cities from diabetes, homicides, and suicides are more than twice the comparable rates for the rest of the U.S. population. Deaths from accidents among city-dwelling Indians occur at a rate more than four times that for the general population; their death rate from cirrhosis of the liver is 3-1/4 times greater, and from tuberculosis, nine times greater. As with the high suicide and homicide rates, an extraordinarily high arrest rate (due primarily to a far greater rate of alcohol-related offenses) is symptomatic of the alienation that Indians experience in the urban environment.

Table

Conflict With the Law
(per 100,000 population)

<u>Ethnicity</u>	<u>Urban Arrest Rate</u>	<u>Rural Arrest Rate</u>
Indian-American	27,535	3,593
Afro-American	7,715	976
Euro-American	2,423	890

Because they commonly assume the role of family caretaker, urban Indian women not only have to deal with their own frustrations, but they take on a disproportionate share of the responsibility for helping others to cope. Yet the resources at their disposal are grossly inadequate. Not only do they lack extended-family and community support, but the health service system is commonly ill-equipped to meet the special needs of Indian clients. I am reminded of the Indian woman incarcerated (after attempting suicide) in the psychiatric ward of the hospital where I was living some years ago. When I met her, she seemed greatly relieved to have another Indian woman with whom to talk, and she told me her story. Along with her infant daughter, she had moved to the area with the child's Euro-American father, whom she had met on the reservation thousands of miles from where they were presently located. Apparently, he was ashamed to let his colleagues know about his Indian family and kept her in a trailer far from town without car or public transport. On occasion, she would get "drunk" and complain about how he was treating her, which reinforced his decision not to marry her. She lost the will to live.

The doctors treating this woman were all Euro-American males. Convinced that they would agree with her "husband's" negative assessments of her, the woman was unable to confide in them. Furthermore, as privileged members of Euro-American society, they had little ability to empathize with her predicament. With the assistance of a local organization of urban Indians, we were able to help this young woman gain the confidence and self-esteem she needed to cope effectively within the urban environment. In fact, she ultimately became a "pillar" in our organization and a joy to us all.

Recently, the Indian Health Improvement Act was enacted, calling for improved health services for urban Indians. While a step in the right direction, more fundamental changes in policy will be required to prevent, rather than simply treat, the problems of urbanization experienced by Indian American people. But first the federal government must get out of the business of defining ethnicity. Such a move would enable those who have been officially denied their identities as Indians to rally community, state, and national support for improving the health and welfare of their people. The point is not to inhibit change, but rather to promote self-directed change of the type desired by the local community.

It is my experience that when Indian communities have incentives to organize in their own behalf, women emerge as strong leaders. This occurs in spite of the government's tendency to select and train men for positions of leadership. This I believe occurs because Indian women learn from adversity how to be tough, while at the same time they learn, in their roles as caretakers, to be kind. Such qualities should be fostered, not denied.

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IV. REACHING WOMEN

Throughout this collection, the point has been made that—despite the good intentions of many governments and institutions—women are not getting the basic health care they need and that levels of health among both women and children are suffering as a result. The papers in this section suggest some of the reasons why this is so and offer suggestions for reversing present trends. In general, the writers agree with Douglas Lackey, who says that there is much to be done "if the end result of the primary health care movement is not to be merely a multiplication and complication of the existing problems of health care delivery."

Thus, Mr. Lackey points out that rural health schemes are typically very expensive to build and maintain, and that they seldom allow for enough material or staff support for community workers. He and Joyce Naisho call attention to underinformed, harried, and often unpleasant client/health worker relationships. He offers statistics on the limited diagnostic skills of health workers at existing clinics, to say nothing of limitations in their ability to treat common ailments. Where the health worker is also male, where health centers are too far away or open at inconvenient times, or where women must depend on their menfolk for transport or money to obtain health services, further impediments are put in the way of women seeking health care.

Perhaps more fundamental, as Nirmala Murthy notes, women often do not seek health care until it is too late: "Women, because of their responsibilities at home, and out of ignorance, tend to neglect their illnesses until they become too sick to move around," she says. By the time they are sick enough to know that they should attend the clinic, it is much more difficult for them to do so." Yet field workers, including nurse-midwives, are usually not trained or authorized to provide curative care, believing that patients are responsible for getting themselves to the clinic or hospital.

The lessons drawn are the obverse of the problems:

(1) Women, more than men, need health services literally on their doorsteps. These services must include a heavy dose of health education. But Nirmala Murthy insists that they must also include at least interim curative care, and Kaval Gulhati underlines the need to include family planning services and supplies. They and others are skeptical that new Community Health Worker (CHW) schemes will accomplish this purpose, since CHWs are not being trained for these roles and since, in practice, many CHWs are men who, in traditional societies, will not have access to women at home.

(2) Women need to lessen their dependence on male family members for money and mobility if they are to obtain more and earlier health care for themselves and their children. Indeed, Susan Ueber-Raymond reluctantly concludes that health services for women have little chance of being implemented except on a cost-recovery basis, which in turn will require that women be better able to pay for health services. Education and income-generating opportunities for women are vital. Kaval Gulhati sees a potentially important source of income and status in woman-to-woman distribution of family planning and other health-related supplies. Patricia Blair suggests that nutrition-related activities—production of weaning foods from local crops, etc.—could similarly promote health while bringing women independent income. Several papers note the efficacy of women's organizations in promoting these and other development activities, though Linus Ndungu cautions against women's organizations that do not spring from the needs and traditions of the rural people.

(3) Training for health workers in the field and at primary health centers needs to promote new ways of operating and include more extensive skills in diagnosis and treatment. Furthermore, training needs to be accompanied by adequate technological support for field workers. Health workers will need to be much more active in seeking women out, listening to their health problems, and offering practical help as well as simple health education. It goes without saying that all these tasks will be easier if more of the health workers are women and if women, consumers as well as providers, have greater say in the design and implementation of health programs.

Practice Versus Theory In Primary Health Care (East Africa)

Douglas Lackey

Modern health delivery systems have not been able to adequately address the major health problems of rural East Africa from either the curative or preventive/promotive standpoint. The addition of community-based health workers to act as a link between rural villagers and the modern health system will go a long way to improve the situation, and at a relatively low cost. However, the provision of the necessary technical support is easier said than done.

First of all, both capital costs (\$400,000 to build a 14-bed health center in Kenya; \$150,000 to build a simple two-unit dispensary in Southern Sudan) and recurrent costs (\$30,000 per year to run a health center in Tanzania) in the modern health sector, even in rural areas, are very high, making it extremely expensive to achieve expanded coverage.

Second, community-based workers require technical support in the form of supervision, continuing education, sometimes drugs, etc. Absent this technical support and/or adequately staffed and supplied referral facilities, it is questionable whether the modern health system should be expanded.

There are other problems: The basic and continuing educational training for health providers, including nurses, is too curative oriented, with little practical teaching experience or exposure to field work. Once in the field, rural health workers rarely have enough resources--staff, drugs, laboratory services, etc.--to carry out a viable curative program. These constraints, coupled with lack of supervision and little professional contact with other health personnel lead to low morale in the health services.

On the preventive/promotive side, resource limitations again are a major problem. Vaccines are either in short supply or, due to breakdowns in the cold chain, they lose their potency. Environmentalists/sanitarians do not receive enough practical training or instruction in behavioral change methods; nor are they usually provided with tools, transport, or a resource budget for buying cement, pipes, etc. Mobile health services invariably encounter transport difficulties; even if they are operational, extended field trips are avoided since staff are unwilling to be away from home and families for long periods of time.

The majority of people affected by the drawbacks of the health system are women who, with their children, make up about 80 percent of the people attending rural health facilities. Women are preponderant because (1) their heavy work loads and numerous pregnancies make them more liable to anemia and obstetrical and gynecological problems; (2) it is considered a woman's duty to take the child to the clinic; in some tribal groups, it is demeaning for men to attend clinics with women and children; in any case, about one in three households in Kenya is headed by a woman, as a result mainly of male migration to the cities in search of employment; and (3) women usually receive information about the services available from health workers, who are mainly women, from women's groups, which are quite active in Kenya, or during home visits by health workers. These information sources do not reach men as readily.

Treatment interventions available to women generally include antenatal, maternity, and postnatal services, child health, family planning, and general treatment

of health problems and diseases. Outreach services like mobile maternal and child health clinics are rarely scheduled to suit the customers, however. Instead, women normally have to come to where the services are provided, which requires time, money and general inconvenience for the already overburdened mothers. The referral system exists more in theory than in practice due to lack of, or cost of, public transport and a reluctance of traditional people to leave their home areas.

Some insight into how the modern health delivery system works in the context of rural Kenya can be had from a study of antenatal services in Makindu Division of Machakos District made by the African Medical and Research Foundation (AMREF). Makindu is a more-or-less poverty-stricken area. Its 100,000 people mostly practice small-scale mixed farming and animal husbandry. Their health problems are consistent with those of other poor rural areas in Kenya—malaria, malnutrition, measles, diarrhea, upper respiratory tract infections, tuberculosis, leprosy, etc. Antenatal services are provided at five health facilities—a government 30-bed hospital, two government dispensaries, a mission dispensary, and a private company hospital. Between 1973 and mid-1977, 50.5% of the women (10,108) attended antenatal clinics at least once. During this period, 1,539 normal deliveries, 71 stillbirths, and 16 maternal deaths occurred in the health facilities. The remaining 84% of women who had attended antenatal clinics delivered at home.

As part of the study, 173 women at reproductive age were asked about the delivery of antenatal services at the government health facilities. It was found that all the women were aware that services were available at all five facilities. Of the respondents, 71 (41%) delivered at home only, 54 (31%) had delivery at home and hospital, and 48 (28%) at hospital only. Reasons for delivering at home included the long distance or lack of transport to the hospital or lack of bus fare (68%) and the availability of a traditional midwife (29%). Sixty-eight respondents mentioned problems in the antenatal clinics: waiting time too long (53%), unfriendly reception from nurses (29%), and lack of waiting space (18%). Many women would rather use their limited funds to buy food for their families and be attended by a traditional healer who might be willing to wait for payment.

Indeed, one can question whether it is worth the time and money for women to seek services of the so-called modern health delivery system. Operational research studies conducted by AMREF indicated that rural health facilities in Kenya allot an average of one or two minutes per patient, too short to allow the health worker to take a proper medical history and examination. Coupled with lack of adequate training in clinical skills, this makes the health worker unsure of the diagnosis and treatment. For instance, in one district, 49 (73.1%) out of 67 feverish children under five years were diagnosed as malarial; but blood slides indicated that only 26 (38.3%) actually had malaria. No effort had been made to rule out other causes of fever by taking a proper history and examining ears, throat, or other organs for inflammation or disease. In two other districts, only 10 out of 47 (21.3%) health workers could prescribe adequately for gonorrhoea, a very common condition in their practices. For cases of tuberculosis, only 34 (47.9%) out of 71 clinical officers in the three test districts knew the proper combination of drug dosage and duration; by creating a drug resistance, consistent underdosage may have done more harm than good over the years.

Another important issue is related to the client-health worker relationship. One AMREF researcher reports:

Overall, mothers do not get a friendly reception, particularly at their referral hospital. Mothers are left alone with instructions to

call for the midwife when they are just about to deliver. They are sometimes ordered to sluice the hospital linen soiled during pregnancy. This treatment is enough to make mothers develop a negative attitude toward delivering in this particular hospital.

The educational difference between the providers and the customers of health services is a contributing factor to the poor relationship that often exists between them. Educated women are able to interpret health messages, are easier to educate regarding health, and have fewer harmful cultural values regarding health behavior. They are in a better position to demand effective health services and to assess the performance of health service providers. Yet no woman out of 800 households in the Makindu Division surveyed by AMREF had more than seven or eight years of education.

If the end result of the primary health care movement is not to be merely a multiplication and complication of the existing problems of health care delivery, factors such as those discussed above must be rectified.

Tradition And Other Constraints On Health Care For Women In The Sudan

Joyce Naisho

In order to increase coverage of the widely scattered rural population of southern Sudan, the Ministry of Health has decided to create a new rural health facility—the primary health care unit—to provide service for an average of 4,000 people each. Medical assistants, working from dispensaries, and village midwives do what they can at present, but it is estimated that they do not cover more than 20 percent of the rural population. It is hoped that the new program will reach at least 85 percent of the population. The new units are to be run by a cadre of community health workers, each to be selected by his or her village and trained for nine months in one of four new schools.

A lot remains to be done, however, especially in improving care for women. The sort of work that the village woman in southern Sudan does leaves her permanently tired and frequently ill. As early as at age six or seven, she begins to learn to care for the family, minding babies, tilling the land, and generally helping in the daily chores. Marriage comes very early, often at 13-15 years of age. In southern Sudan, where a groom can pay up to 100 head of cattle for a young bride, the girl has to justify her expense by bearing many children and by endless hard work. She wakes up as early as 5:30 in the morning to prepare porridge or tea for the family. Then she has to fetch enough water for drinking and cooking and often for brewing beer for the elders. (It is not rare to see the men drinking under a tree for hours on end.) In addition, she has to grind maize or millet for the main meal. Before this can be cooked, she has to fetch firewood. As if that is not enough, she must do agricultural work; in the Sudan, a conservative estimate is that the rural mother produces 50 percent of the family's food.

No wonder such women have health problems. Among the 50 to 60 women who attended the weekly antenatal clinic at the health center where I worked, anemia was a major problem, mainly due to poor nutrition and frequent attacks of malaria. Production of breast milk was low and had calamitous results on the nutrition of the family. Contributing factors included constant pregnancies and delivery, although infertility, caused mainly by untreated pelvic infections, fibroids, and fistulas, was also a problem.

And yet, the introduction of child spacing is not accepted, for several reasons: It is claimed that southern Sudan is large enough to accommodate more people; the use of contraceptives is held to encourage women to be unfaithful to their husbands; and Sudanese women must have as many children as possible to ensure family continuity and to cater for natural wastage from high infant mortality.

Will the new primary health care units be able to improve care for these women? The first problem is that there are no female community health workers. Although villagers were not prohibited from choosing either sex, in practice all community health workers so far selected have been male. This is partly because few women have the necessary education, partly because men do not permit their women to be away from home for the nine-month training program, and partly, perhaps, because of cultural prejudices against women.

Male community health workers are taught basic maternal and child care and family planning during their training, but they have little chance to get practical

experience. They are still faced with the customary inhibition on women being treated by men, to whom women are not supposed to give information or expose themselves. How can a woman explain her gynecological problems to a male health worker when in ordinary life certain anatomical parts are not freely mentioned to the other sex? Since there is total lack of privacy for history-taking at the health units, female patients are especially reluctant to disclose all their problems.

A second problem is that there is a very inadequate patient/health worker relationship. The large numbers of patients force a production-line system of processing, with no time for patient and health care provider to adjust to each other. Overwork, inadequate facilities, and limited knowledge on the part of health workers encourage rapid processing. In any event, few health workers stay in one job long enough for patients to build confidence in them over time.

Furthermore, if these units are to be successful, they will have to find a way to amalgamate traditional practice with modern medicine. Many patients see the "modern" doctor before, during, or after consultation with the traditional medicine man. They recognize that certain conditions, like a broken leg, can best be treated in a hospital, and they have acquired a taste for injections. But the traditional practitioner still has many advantages. He does not laugh at his patients when they ascribe their ills to vengeful gods or witchcraft, nor does he isolate them in hospitals in times of trouble.

What is to be done? Based on my experience in the Sudan, and previously in Kenya, I would suggest:

- That more girls be given a chance of education. In the long run, this will break the vicious circle of inadequate education, lack of job opportunity, and resulting lack of influence in the community.
- That every opportunity be taken to encourage the formation of women's groups and activities. Extension workers should provide some stimulus for this.
- That maternal and child health be given priority in the training of all health workers—medical assistants, nurses, community health workers, etc.
- That traditional birth attendants, traditional herbalists, and medicine men should whenever possible be given simple training in hygiene and be encouraged to cooperate with the health services and refer patients in need.
- That all health care providers devote part of their time to health education, with emphasis on prevention and promotion of health.
- That health education be included in the curriculum of primary and secondary schools.
- That further studies be undertaken to determine the health problems and services required for females—the young, women of childbearing age (whether mothers or nulliparous) and the elderly, in all parts of the country.

Indian Women's Need For Curative Care

Nirmala Murthy

One of the startling findings of the Committee on the Status of Women in India was the consistently higher death rates among women compared to men at all ages until 50. This finding was an indication that health services are not reaching women in India, especially the rural women.

Even a casual visitor at a primary health center would notice a preponderance of male patients. In one of the studies on health care utilization carried out by the Indian Institute of Management, Ahmedabad, patient attendance data showed that women (10-50 years of age) formed the largest single group having less access to curative services. In the clinics studied, we found the sex ratio of patients coming to be seen by the doctor at a primary health center to be about five to one in favor of men. (This ratio, of course, excludes women attending the maternal and child health clinic, but these women are seen almost exclusively by the auxiliary nurse midwife and rarely by the doctors; the maternal and child health centers are not geared to provide general curative care.) If women were to start demanding their share of medical attention, utilization of the health centers would increase considerably.

Why do women not seek treatment?

Most studies emphasize geographical accessibility of the health center as the determining factor for increased utilization, since over 80 percent of patients come from within four or five kilometers of the center. Typical solutions then suggested are: find central locations for primary health care centers and/or add more subcenters, mobile units, and health field workers in order to reach a larger percentage of the population. In practice, however, these solutions do not necessarily produce the desired effect. For example, the Community Health Worker Scheme is designed to take health services to each village with the specific intent of reaching more women and children. At the design stage, it was envisaged that more women would be selected as community health workers in order to extend health services to women patients at home. In reality, however, more than 90 percent of health workers were men and the number of female patients they see is far less than the number of male patients.

The present referral system assumes that there will be effective screening of patients at the field level; that health workers will see the patient for some time before they become a medical emergency; and that there is enough time for a patient to be transported to the health center or hospital. Especially in the case of female patients, these assumptions are often not valid.

Furthermore, there are many misconceptions regarding women patients, even among doctors at primary health care centers. "Most women will not want to see a male doctor," they think. "Women do not like to come to the clinic, but they send their men to the centers to get medicine for them." But these explanations do not fully explain why so few female patients are registered at the centers. Furthermore, we found, surprisingly, that centers with female doctors did not have any different ratio of male and female patients than those where there were only male doctors. Even at health subcenters that were staffed exclusively by female auxiliary nurse midwives, more male patients came for curative treatment than female patients.

Another explanation one often hears from male doctors at primary health centers is, "Women are more resistant to disease, and hence less prone to falling sick than men." This is not valid, of course. But what does seem to be valid and is one of the fundamental problems to be considered while designing health systems for women is: Women, because of their responsibilities at home, and out of ignorance, tend to neglect their illnesses until they become too sick to move around and attend to their normal chores. Often, too, they are dependent on others in the family to get them needed medical attention, which typically has the effect of delaying the health visit. Thus, women do not attend the health clinic when they ought to, and by the time they are sick enough to know that they should attend the clinic, it is much more difficult for them to do so. Under these circumstances, the health care that women need is one available literally at their doorsteps and drastic in curative measure.

This pattern of behavior in women runs directly counter to the general understanding among health personnel, both doctors and nurses, that patients should seek out the doctor or nurse, not vice versa. In many places, auxiliary nurse midwives are told not to provide any curative care in their field visits, which are primarily meant for antenatal care, family planning, and other preventive activities. For medicines, women are asked to come to the clinic.

This distinction between providing curative and preventive care is dysfunctional from women's point of view, and the health center staff should be aware of this fact. Among the reasons often cited for why women do not go to the subcenters are: subcenters do not have effective medicines; subcenters are not open at convenient times for women (i.e., in the early afternoon, when women are more likely to be free but when the subcenter is likely to be closed to enable the nurse-midwife to go on field visits); and auxiliary nurse midwives are not seen as competent to treat illnesses. In any event, subcenters are ill-equipped to provide curative care for those who have become seriously ill, and primary health centers are too far away. As a result, women have to go to local healers, injectionists, or private doctors who can give injections.

If this is a typical scenario of what happens in the villages, then the question is, how can health services be made more responsive to women's needs? The present system seems to lack two elements which we think are essential for providing effective health services to women. Given that most of them do not seek help on time, the health system should have:

- (1) a mechanism to encourage women to seek early help; and
- (2) a capability of handling medical emergencies in the field.

Simply expanding the present system will not be effective in meeting women's health needs unless these two elements are incorporated.

What can be done to encourage women to seek early help? First, the attitude that curative care is the patient's responsibility has to be modified in the case of women. Health workers will have to realize that it is not enough to treat the patients who come to them. Having female doctors and health workers will certainly help in encouraging women to come to the clinic, but that alone is not enough. Both male and female health workers will have to be active in identifying women who are ill, persuading them and their families to get help, and even helping the patient get to the doctor if such help is needed.

Another possibility for educating women on the need to seek earlier help when they are sick is to plug the health services into women's group activities, such as mother's clubs or income-generating programs. These are ideal situations where women can get group support and encouragement.

Responsibility for handling medical emergencies in the field will fall heavily on auxiliary nurse midwives. Unfortunately, they are not now sufficiently prepared to handle medical emergencies in the field, nor do they have the necessary equipment. They are responsible for many health activities and cannot maintain technical skills in the areas of midwifery and curative treatment to the point where they can handle medical emergencies on their own. The only way to reinforce these skills is through constant training and re-training, as well as through strict quality control in recruitment of nurse midwives in the first place.

The solutions suggested in this paper would not require huge financial commitments or changes in the "sociocultural milieu," but only more understanding and appreciation about women's special problems and a commitment to deal with them.

Right And Wrong Styles For Women's Organizations

Linus K. Ndungu

Kenya is a poor country and has health problems that are typical of developing countries. It cannot support, and does not need, American-style feminist organizations. This is a decisive factor which a poor country has to consider.

We recognize that women play a key role in the family, and that no health program would succeed without them. Sixty percent of the population consists of women and children under 15 years old. There is a high fertility rate (3.6); infant mortality is also high (102 per 1,000 live births). There are maternal and child care problems which can be greatly reduced as women's health improves.

Since 1973, the Ministry of Health has started some categorical projects which aim at tackling the major health problems, many of which have women and children as their main targets. These include: family health, including family planning; communicable diseases; diseases and conditions resulting from, or provoked by, inadequate environmental sanitation; and health problems relating to malnutrition and undernutrition. With help from the World Bank and the U.S. Agency for International Development, we have also built demonstration health clinics which provide comprehensive care to mothers and children.

It is true that women can accomplish a lot more by working in groups. Women also have special health problems which can be tackled through group organization. For example, we have problems relating to harmful traditions such as female circumcision, which is practiced in parts of eastern Kenya. But any organized effort to improve the health or status of women must contribute to the welfare of all. Otherwise it fails. If women's organizations in Kenya concentrate on advocating liberation of women from exploitation by men, their chances of survival will be limited.

The government does encourage and support women's organizations. We have such organizations as Maendeleo ya Wanawake (women development), Mabati groups, and many others. It is interesting to note that the most successful organizations are those that are led by women who are practical and who have not had much school education. Perhaps school-educated women tend to become separated from the less-educated majority. As soon as leadership goes to very educated women, performance declines.

The main point is that any organization, whether of women or men, should seek to improve the status of everyone. The Mabati women, for example, succeeded to build better houses for all women members, and they were supported by the men and by the government. By improving the houses, they improved the health conditions of their families. This is the kind of women's organization that a poor country like Kenya needs.

Women-To-Women Delivery Systems For Family Planning*

Kaval Gulhati

The Government of India espouses an egalitarian philosophy and condemns discrimination. But by failing to address the specific health needs of women, it in fact contributes to their position of disadvantage.

Indian women's main health problems have been identified as high maternal and infant mortality, maternal morbidity, lower life expectancy at birth, mental disorders, a high suicide rate, and malnutrition. Data on differential mortality by age and sex provide disquieting statistical evidence of higher female mortality, reflecting the absence of health and maternity care for young women and female children. This situation is to a great extent the result of family structure—the relative status, within the household, of women and girls as opposed to that of men and boys. Discrimination within the family results in deep-seated attitudes of negligence and in disregard for females' health care needs even during illness.

The Indian government has thus far avoided consideration of discrimination within households. If it is serious about promoting equality and providing adequate health care, however, it must establish policies and programs that will reach women in their homes, taking into account their total health needs.

Foremost among women's health needs is that of effective and accessible family planning services, for demographic as well as humanitarian reasons. No matter what a woman's age, lack of contraceptive protection is a very real threat to her health. In developing countries, malnutrition and lack of sanitation combine with the strenuous burden of women's work to greatly multiply the hazards of pregnancy and childbirth. A 1980 analysis of reproductive safety by the International Fertility Research Program estimates that maternal mortality is up to 10 times higher in developing countries than in developed ones.

India's traditional clinic-based health delivery system, which "integrates" women's needs into the maternal and child health program, is largely ineffectual because constraints such as distance, cultural restrictions, and cost make it inaccessible to poor women. And the recently created Community Health Workers Scheme consists mainly of local men who receive only short-term training and are expected to continue their farming. It is unlikely that they will have any access to women in the household for motivation or supply of family planning services.

Furthermore, it is essential that the system meet the needs of women of all ages—teenage wives, young mothers in their twenties, and older women—with appropriate contraceptive services and supplies. In India, the IUD is employed as a terminal contraceptive technique rather than as a method for spacing. Of the 23 percent of couples of childbearing age who are protected by contraception, 82 percent are sterilization and IUD acceptors with a mean age of 32. The remaining 18 percent—presumably, younger couples—employ the conventional methods of foams and condoms.

*This paper is based on Kaval Gulhati's article, "Women's Reproductive Health: A New Perspective for India," published in the Draper Fund Report, Improving the Status of Women, No. 9, October 1980.

An additional 90 million married women, approximately half of them aged 15 to 24 years, are not protected at all.

The severe decline of vasectomy services since the mid-1970s has caused increased hardship for older women who have completed their childbearing. It remains to be seen if the present government can and will resuscitate the vasectomy program, which fell victim to the backlash created by an earlier campaign of compulsory male sterilization. Meanwhile, millions of women who do not have access to the clinic system and who are unlikely to be helped by the male community health workers--but whose husbands might be willing to have a vasectomy--are left unprotected.

Even more important, the contraceptive needs of younger women must be addressed. It is the teenage brides and young mothers who experience the highest maternal mortality rates. The death rate for girls aged 15-19 is almost 50 percent higher than that of their male cohorts and, at ages 20-24, almost 80 percent higher. The young women can hardly be expected to accept sterilization or the IUD; but contraceptive pills are virtually unknown and unavailable to poor women, especially in rural areas. The continued reluctance of the medical establishment to provide a non-prescription pill-distribution system is puzzling in the face of mounting evidence that oral contraceptives are favored by women in many developing countries, including Indonesia and Mexico. Relaxation of the present restrictive policy would do much to improve the health and reproductive status of young women. The alternative is to condemn them to the continued risk of premature death or morbidity via early and frequent pregnancies and abortions.

The need and desire for family planning services are demonstrated by the fact that many Indian women use traditional but ineffective methods of preventing pregnancy and resort to abortion when these methods fail. In 1966, the Indian Ministry of Health and Family Planning estimated that about one in four pregnancies was terminated by abortion, often through unsanitary, dangerous methods.

If the current national health care structure cannot meet the demand for family planning, what alternatives are there? Since the 1930s, the Indian women's movement has emphasized the importance of birth control and abortion as the right of every woman and, along with financial independence, as crucial to the emancipation of Indian women. Several private programs operating throughout the country illustrate these concerns, but they are small and cannot reach many women.

One approach that has not been tried on any large scale is the household, or community-based women-to-women delivery system for the provision of information supplies and follow-up. Such a system, which could reach every female in the community, would be implemented and managed by women to meet the basic health care and family planning needs of girls and women. It would have several advantages:

- Programs run by women are likely to respond to women's total health and family planning needs in a way that programs run by men seldom can. In addition, the neighborhood approach, with frequent door-to-door follow-up visits--possible only when the visitors are women--is likely to provide a more "caring" and acceptable service than a large bureaucratic system.
- Women from the community, trained as managers to run the delivery system at the village level, will be provided employment, and thus financial independence and enhanced

status. They will serve as role models for younger women in the community and provide examples of alternative role choices for women.

- Once the delivery system is established--with a manager, supervisors and field workers, and a simple logistical supply and administrative system--it can be used to "piggy-back" other developmental services and commodities that women want.

At the national and state levels, government departments for women could be created with a mandate to integrate women, through training opportunities and operational responsibilities, into developmental programs at managerial levels. The supply and logistical network required for distributing key commodities such as simple medications and contraceptive pills could be decentralized and run by women in their own communities. The orientation of these delivery systems would provide a fundamental departure from the current practice of viewing women as targets, or passive recipients, of development programs. Women would function instead as active participants and contributors to the health and development process in their communities.

In a complex society like India, there is no single approach or method that can be universally acceptable. If we can keep a spirit of optimism, however, and pursue new ideas with imagination and commitment, we can succeed in meeting the health and family planning needs of all women. In so doing, we will improve the quality of life of all people.

The Women And Health Connection

Patricia W. Blair

The basic contention of this paper is that women's health needs will not be met if health programming continues to focus narrowly on the health sector alone. Such problems as malnutrition, fatigue, and excessive fertility, to say nothing of various forms of violence against women, are intimately bound up with women's generally low status and lack of opportunity for education and employment. It would not be possible to reduce abortion as a public health problem until laws and attitudes regarding contraception as well as abortion begin to catch up with medical technology. Research on women's health issues is likely to remain of low priority if scientific establishments continue to be overwhelmingly male. Nutritional and other health benefits sometimes depend on development of new technology, which in turn requires higher priority for women's concerns. Programs to improve the status of women, along with literacy, income distribution, and the like deserve priority in their own right; they can also be expected to improve the outlook for women's health, promote successful family planning, and so on.

In addition to intensified efforts to raise the status of women, three areas--all of which lie at the interface between health concerns and women-in-development interests--seem particularly appropriate for development activity.

1. Expand the Number of Women in Decisionmaking Positions

As in other fields, it is questionable whether health development programs will ever reflect women's needs and concerns adequately in the absence of women at all levels of the health system. Women need to be motivated and able to express their own health concerns, and their concerns require greater political visibility and priority at policy-making levels, particularly where public health systems continue to be dominated by male physicians.

It is crucial that women "consumers" of health services be included in consultations at the community level if acceptance of new health interventions is expected. Too often, women's participation begins, if at all, after a development service has been planned and set up, and takes the form of paying small fees, listening at meetings, upkeep of facilities, or even simple acceptance of "benefits." Any community consultation--which itself may be pro-forma--takes place with men.

The new thrust toward primary care is likely to provide greater opportunities for training women as midwives, village workers, and other physician extenders on the lower rungs of health care, where women dominate in most countries. The role of traditional birth attendants, used by up to 90 percent of rural women in developing countries, is also increasingly well-recognized. A good number of programs for upgrading their skills (and, in some cases, using them to promote family planning) are underway, though too little attention is yet paid to their wider roles in providing abortions, female circumcision, marriage counseling, and help for menstrual disorders, infertility, and the like.

Women activists tend to emphasize the importance of opening up new fields of work for women. But nursing and other health occupations will remain an important source of independent income, and the number of women in these occupations needs to

be expanded, especially in countries like Sudan where health providers today are largely male. Their training needs to extend beyond maternal and child health matters and include the ability to diagnose and treat.

It should be remembered, however, that these women, no less than factory workers, are subject to the problems that attend working a double day. Community health workers and other physician extenders are likely to retain a full range of household and child-care duties. They may not be able to perform their functions adequately without special arrangements, especially if they are--as is quite likely--heads of their own households. Maternity leaves, child care, and flexible working hours are some of the measures frequently advocated. In the case of single women, housing may be a special problem.

Women are most seriously underrepresented at higher levels. If enough women are to be included at decisionmaking levels to make a real difference in health programming, more of them will need to be trained as physicians, administrators, and researchers. Most importantly, the supply of women with management skills needs to be increased. The women-in-management course of the Centre for Population Activities, a private Washington-based effort to train middle-level Third World women with management potential, is one example of what can be done. This course is an imaginative blend of confidence building, assertiveness training, and nuts-and-bolts training in such things as project preparation, record-keeping, and fund-raising. The 350 or so women who have completed the women-in-management course--about half of them from the health and family planning sectors, half from integrated women's programs--now form a mutual-support network of people in both government and private positions who are beginning to train their compatriots. This kind of activity needs to be greatly expanded.

2. Make Better Use of Women's Organizations

Health-sector programming also needs to make better use of women's organizations, both grass-roots and voluntary, and to employ more women who are in a position to open up natural channels with women leaders. Women's groups represent a considerable resource for improving women's health. Indeed, the impetus for starting some of the oldest and best organized of them was health-related--homemaking for Mother's Clubs in Korea, vaccinations and family planning for Concerned Women in Bangladesh, clean water for self-help groups in Kenya, etc. Many of these groups quickly branch out into nonhealth related fields as the connection between family health and women's income becomes apparent and the habit of cooperation grows. In Indonesia, for example, village planning groups that arose spontaneously to help women get contraceptives from distant supply depots have now expanded into weaving, tile-making, and other direct economic undertakings. The People's Health Center in Bangladesh is supporting vocational education programs and agricultural credit along with basic sanitation, hygiene, nutrition, and family planning.

By the same token, groups devoted to women's welfare more generally often find themselves involved in health-related issues. Women's groups that seek to encourage late marriage, modernize abortion laws, start rape crisis centers, call attention to hazardous working conditions, and generally raise the status of women can all have important health effects. There is room for a more conscious promotion of this women-and-health nexus, based on a better understanding of the formal and informal networks for women's communication.

3. Recognize Women's Need for Time and Money

One major constraint on the effectiveness of health-related programs is that poor women often lack time and money to follow new health practices, however desirable. Health programmers would, therefore, do well to look for projects that can do double duty--that would, say, generate income for women while improving family nutrition, or save women time while making more water available for family hygiene. By the same token, "women's projects" might more readily become viable if they were rooted in women's continuing concern for their families.

Nutrition-related projects seem particularly suited to this double-pronged approach, especially where they could build on women's existing skills. For example, women's groups in Cameroon operate hand grinding mills that save women time and generate some income; they could become the basis for small-scale preparation of weaning foods. Similarly, vegetable gardening projects could include solar dryers or other appropriate technology so that women could store and market any surplus. If water sources were closer to their villages, thus saving time on water hauling, women could use improved water supplies for both hygiene and income-generating projects like poultry-raising.

Two important caveats in connection with this range of projects are that women need to have control over allocating any time saved from traditional tasks and that they be taught to maintain and repair any machinery involved. In the past, some labor-saving projects intended to give women more time for family care have failed to fulfill their purpose because husbands simply used their wives' newly available time for jobs that had previously been the men's responsibility. Men have retained a near monopoly on the knowledge of how to maintain and repair water pumps, grinding machines, oil presses, and the like, thus perpetuating women's dependence and in some cases even taking over responsibility for what had been women's sources of independent income.

The common thread in all three of these suggested approaches is that they would benefit greatly from interchange between programs concerned with health, family planning, and nutrition, and those concerned with raising the status and visibility of women in development. Until greater interchange takes place, certain kinds of programs are in danger of falling between the slats, and these are most likely to involve programs affecting the underserved aspects of women's health.

Paying For Women's Health Services: A Financial Dilemma

M. Susan Ueber Raymond

One of the operational realities of responding to the health needs of women in developing countries is the inevitable question--who will pay? There is no such thing as a free aspirin. The following discussion, while not exhaustive, is meant to raise some unpleasant realities--realities with which policymakers and women interested in health programs must ultimately deal.

Financing for health services can be generated from a number of sources. In developing countries, government-sponsored agencies, either ministerial or welfare-based, provide most of the financing for general public services; in 1976, these expenditures generally amounted to between \$1 and \$3 per capita. Public welfare/insurance programs covering specific industry or income groups also provide health-related funds in a few developing countries. On the private side, scattered income surveys suggest that private expenditures for services and drugs amount to between seven and ten percent of family budgets, of which over one-third is spent on pharmaceuticals. In addition, private resources are spent in the traditional health market for services of local birth attendants, traditional healers, etc.

Unfortunately, when public-sector health constraints and extremely low family incomes coincide, as they do in most developing countries, the result is a public health service which is, on the one hand, the major health alternative for the poor and, on the other, badly managed, sporadically supplied, and totally unresponsive to the needs of the population. Examples of such situations are only too well known. The dilemma faced by policymakers seeking to respond to the needs of women is how to pay for women's services without overburdening public resources, straining already low family incomes, and/or simply robbing the coffers of some already poorly financed health program to fund another.

Three general types of options exist: The first is to seek external agency support. While this may be appropriate for short-term investments, it does little to cover medium- and longer-term recurring costs. Even if external financing for operating costs were available, it might be undesirable for countries aiming at political and economic self-reliance to accept such funds.

A second option is to generate new governmental resources for women's programs by (1) reallocating resources within the health budget away from more traditional programs or (2) increasing the overall health budget, assuming that some percentage of such an increase would be made available to women's programs.

The reallocation tack is unlikely to succeed for two reasons: First, the recurring costs of existing programs are the result of sunk investments; barring the elimination of existing institutions, they tend to be financial givens. Second, reallocations usually generate political and/or bureaucratic opposition from entrenched interests or professional constituencies. Ministries of Health, normally weak to begin with, are unlikely to be willing to run such a gamut of opposition on behalf of women, who have little political power or constituency of their own.

Increases in the overall health budget might come about in three ways: greater allocations to health from a static national budget; an increased national budget in

which the health budget increases proportionally, or increased public resources via some type of cost-recovery policy. The first two methods are highly unlikely to succeed. Health is generally perceived by budget-makers as having low intersectoral financial priority (compared to the income-generating industrial or financial sectors, for example) and, in any event, any increased allocations would be likely to be absorbed quickly by inflation rates faced by existing programs.

In the face of historical trends and current economic realities, therefore, the cost-recovery approach may be the most likely solution. But this approach also raises problems. Very few developing countries have any cost-recovery policies applicable to the public health sector, the theory being that basic health (and, by association, basic health care) is a right to be guaranteed by public services to every citizen regardless of income level. Where they do exist, cost-recovery policies are normally limited to specific types of institutions (e.g., hospitals) or programs (e.g., food-for-work activities).

If we assume, however, that the resource constraints of the 1980s could force a change in present "free services" policies, what cost-recovery options might be available to finance women's programs?

First, non-health services or products could be taxed and the income allocated to women's programs. This option places the least financial burden on the health sector and its users per se, but it requires both support from the taxed sector (not usually dominated by women) and financial management capability (normally in short supply). Some experiments in using a general tax for health purposes are underway, notably in Brazil and Ivory Coast, but they are not necessarily applicable to women's programs. (In Brazil, a tax is placed on agricultural products, the return from which is used to support rural health services for farmers, agricultural workers, and their families. The system is viable basically because (a) those taxed are also served by the health programs and (b) Brazil has the public capacity to manage the program. In Ivory Coast, a proposal has been made to levy a tax on water from newly developed water systems, the return from which would be earmarked for public health education programs regarding water use; it is too early to tell whether the scheme is viable.)

Second, a fee could be placed on the use of, for example, hospitals or elective surgery or some other health-related service and the profits allocated to finance women's programs. Yet without an income proviso such an approach risks imposing additional financial burdens on low-income families. However, income criteria are notoriously difficult to administer even in the most bureaucratic of developed countries.

Finally, fees could be imposed on the users of women's services themselves. This is clearly a double-edged policy. Cost recovery is simplified because the target group is easily identifiable. Yet, because women seldom hold the purse-strings in a local economy, they may not be able independently to pay the fees that are imposed. Thus, this option could effectively remove services from the women most in need.

Thus, both cost-recovery and non-cost-recovery options for financing women's programs in poor societies contain inherent contradictions. If the politically least onerous cost-recovery options are attempted, the women in most need may be unable to afford the services. On the other hand, if the politically most controversial or managerially most difficult options are attempted, the burden would be removed from women recipients but the programs are unlikely to be financed.

The horns of this dilemma must be faced or else even the best-designed programs for women's health will not be implemented. Solutions must, of course, be worked out on an individual national basis. In general, however, I believe, that given the position of women in impoverished societies and the realities of their individual needs—any solution must go beyond the health sector. If, as we have seen, cost-recovery options provide the most potential for implementation, then they must be accompanied by attempts to increase the role and financial capabilities of women. Income-generating activities, introduction of technology to reduce the physical strains placed on women, particularly in poverty settings, and creation of institutions for easing child-care responsibilities—all these and more must form the framework within which financial options are considered. Only in this way will women develop the political clout to insist that appropriate health programs be mounted and have the financial capability to pay for them on a continuing basis.

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V. WATER AND SANITATION

In developing countries, women are usually the ones who fetch and carry water for household use. They are also the main users and dispensers of water and the transmitters of wisdom and custom regarding personal hygiene. Thus, they are inevitably the chief targets of programs to provide clean water and improved sanitation.

In order to make use of such programs, as the papers in this section indicate, women need three things—time, technology, and education. Letitia Obeng and Margot Badran emphasize the inordinate amounts of time women spend fetching water for household use; four to six hours a day is not uncommon—on top of all the other household and agricultural tasks that women must do. If safe water supplies and clean latrines can be brought closer, women are likely to welcome them. Indeed, Letitia Obeng favors bringing running water directly into rural households.

All three writers emphasize how easily contamination and disease can spread, even if latrines are provided and water is safe to begin with. Technological needs of a relatively simple sort must be filled if women are to avoid perpetuating the cycle of contamination and recontamination. Margot Badran emphasizes the role of contaminated water vessels, dippers left on the ground, unwashed hands and food, and the like. Mary Elmendorf suggests that water and sanitation authorities provide women with "soap and a hand basin, and adequate carrying and storage containers, along with conveniently located, unsmelly, safe latrines." She underlines the importance of designing facilities that are compatible with local custom and preferences.

Educational efforts would fall on partially prepared ground. Religion and custom frequently prescribe regular personal hygiene. Mary Elmendorf points out that women quickly make the connection between safe water and healthier children. Margot Badran describes traditional de-silting and disinfectant techniques for "purifying" water. Nonetheless, much more is required. And, as Mary Elmendorf notes, "understanding the needs for better sanitary habits is not a simple process, . . . particularly in the area of human defecation—a taboo subject in many cultures, with overtones of magic, witchcraft, or just Victorian prudishness." Fears of disease, of snakes, of falling into latrines are other factors to be overcome. In this, as in technology, project designers will have to listen closely to women and elicit their participation from the start if their efforts to bring clean water and sanitation to rural areas are to succeed.

Women, Water and Waste: Beyond Access*

Mary L. Elmendorf

The worldwide tragedy of infant death caused by diarrhea and dehydration is closely related to a lack of adequate sanitation and safe water, yet neither peasants nor scientists seem to be able to prove that interventions in water supply and sanitation bring about better health. In seeking an explanation for this paradox, one must look beyond technology to the roles and attitudes of the people who are expected to use new water and sanitation facilities, particularly the women, who are the primary users of water and the socializers of their children in matters of personal hygiene. The low impact of past water and sanitation programs is primarily attributable to non-use and misuse of new facilities, not to the engineering aspects. Until women are involved and understand the importance of good sanitation, we can expect limited acceptance.

Evidence shows that, as mothers begin to understand the dangers of even infant feces--not necessarily "the germ theory" but the cause/effect relationship between water and diarrhea--they will change their behavior. For example, when the piped water system in the Maya village of Chan Kom, Mexico, broke down after two years of operation, the women went to the mayor to complain that their children were becoming sick; they clearly saw the relationship between the lack of clean water and the increased incidence of diarrheal illness.

Understanding the needs for better sanitary habits is not a simple process, however, particularly in the area of human defecation--a taboo subject in many cultures, with overtones of magic, witchcraft, or just Victorian prudishness. Taboo subjects are perceived as extremely private and personal, and information about them does not flow easily or rapidly through a community. When new water and sanitation programs are introduced by and to men, who are usually the decisionmakers, women are not likely to be part of the information network. There is a dearth of information on the roles of women in this field. More research is needed to obtain relevant sociocultural data on their problems and constraints, and more attention needs to be given to ensuring their participation in decisionmaking.

The importance of community participation has come to be recognized, even if it is too seldom practiced. Less well recognized is the need for scatological data in order to understand attitudes and customs toward human excreta. Sociocultural variations among villages and sexes in the same country, as well as those of different continents and climates, are to be expected. However, amazing similarities with respect to fears and constraints appear in cross-cultural studies.

Cultural inhibitions can and do provoke the misuse and underuse of safe water supply and waste disposal systems. For example, the common perception that children's

*This paper is based on Mary Elmendorf's paper "Women, Water, and Waste: Beyond Access," presented at the Seminar on Impact of Interventions in Water Supply and Sanitation in Developing Countries sponsored by USAID March 25-28, 1980 in Washington, D.C. "Women, Water, and Waste: Beyond Access" was also used at the Equity Policy Center Mid-Decade Workshop, "Women, Water, and Waste" at the Mid-Decade Forum in Copenhagen in July 1980.

feces is "harmless" can be a continuing link in chains of reinfection when baby diapers are washed along with the dishes in water from a newly installed standpipe. A study of 525 latrines in India revealed that many more women used the latrines than men, while the children's feces were thrown on garbage heaps. In the Yucatan, mothers hold their babies over the dirt floor of the hut or just outside to urinate or defecate. In Honduras, women do not use the same latrine as men for fear of becoming pregnant; this limits the use of even household latrines to female members of the family. In Tanzania, people believe that the excreta of fathers and daughters should not be mixed. In many places, children defecate just outside the latrines because they are afraid of falling through the large opening; our case studies showed that this fear was widespread in Latin America, even in urban barrios in Managua with newly installed flush toilets.

There may also be practical reasons for nonuse of new sanitary facilities. Defecation habits may point to informal uses of excreta for productive purposes in the fields. In Latin America, for example, defecation in cornfields or on coffee plants is considered to have a fertilizing function. Similarly, fruit trees are purposely planted over old, filled latrine pits. In some areas, human excreta is deposited near the house, to be consumed by pigs.

Another set of problems has to do with the appropriateness of technology. The design of the facility for excreta disposal may not be in accordance with the local mores, of which latrines not adapted to a squatting position are the best known examples. The opposite may occur. In Guatemala, for example, seats are preferred, as a place to rest and to prevent falling in. Greater care should be taken in designing separate facilities in the field for men, in deference to their needs during the day as well as to sociocultural attitudes. Portable latrines with fertilizer reuse capacity might be particularly appropriate.

Village mothers will not know how to break the fecal/oral route of infection—without which we cannot expect much improvement in health—until they have some important bits of additional equipment to go with improved facilities for water and sanitation and excreta disposal. Women need soap and a hand basin, and adequate carrying and storage containers, along with conveniently located, unsmelly, safe latrines. Do latrines have to continue to be so far from the homes when there is no well to pollute? Do privies have to emit such unpleasant odors that they cannot be nearer to or attached to the home? How can water for hand-washing be made easily available to the latrine? Can there be more dialogue with the women with respect to where they wash clothes, dishes, hands, their children, and themselves? If water is made available for laundry and bathing, can it be reused in an aqua-privy? Do we think of bathroom planning only for urban areas?

The fecal/oral reinfection route is well known, but there has been very little designing of facilities to help break this vicious circle. If there is only one pail and no money to buy another, of course it will be used for everything. If there is no top for the pail, a covering with leaves is a poor substitute. Inexpensive, even subsidized, kitchen, laundry, and bathroom equipment and soap will make it possible for villagers to take advantage of improved interventions in water and sanitation. In several countries, brightly colored, lightweight plastic water jugs and tubs have had ready acceptance. In Guatemala, as an incentive in promoting personal hygiene, a simple package containing a wash basin, soap dish, pails, and shelf to attach to the latrines was given as a reward to each household following inspection of their new privy. I would add a mirror and soap to such a kit. And a dipper. To use a dipper or cup is much easier than trying to lift a heavy pail or jug.

And with these, training instructions for the women on how to use and manage the new equipment are needed. Audiovisual messages and health education should relate specifically to the effective use of the new equipment—both community and household—so that it can be used efficiently with pride and pleasure. These messages must be directed primarily to women, for they are the key to the realization of our goals of water and health for all.

During the 1977 United Nations Water Conference in Mar del Plata, thirty nongovernmental organizations issued a statement on "the special situation of women in regard to water;" it recommended that developing countries:

- Include strategies to develop human resources at the community level to meet local needs;
- Ensure equal access for women to training with regard to the maintenance, management and technology of water sources and supplies;
- Ensure the participation of women in local councils and planning boards responsible for making decisions on community water supply; and
- Recognize the increasingly effective role that women, nongovernmental organizations, and other women's organizations can play in the education of public opinion for needed change.

One Vote For Water On Tap

Letitia E. Obeng

Water-related disease organisms have no particular preference for the sex of their victims. They will use whoever makes himself or herself available to perpetuate their species. And yet, water is so important for life that contact with unsafe but readily available surface water often cannot be avoided. Water is unique: there is no substitute for it. Plants wilt and perish when denied water for long periods. Human beings die in a matter of days when deprived of drinking water.

Unfortunately, largely as a result of neglect and concern for economic and political gain during the colonial era, when a firm basis could have been laid for the installation of safe and effective domestic water supply in the developing world, such water was provided only to some sections of the urban community. For rural people, piped household drinking and domestic water was, and still is, considered an unnecessary luxury.

Even now, though such domestic facilities as electricity and telephones are made available in some rural areas, the responsibility of ensuring the availability of domestic and drinking water remains with women. Women and children still have to fetch water daily, sometimes from very long distances. They have been known to travel up to several kilometers in the dry season just to dig and scoop water from dry river beds. An extensive survey of water use in East Africa has shown that water carriers in rural areas spend a mean time of 45 minutes per day collecting water, and up to four hours in some communities.

A common but quite irritating male excuse for doing nothing to ease women's "water fetching" activity is that "rural women like to gather at favorite streams and water holes to wash clothes and enjoy each others' company." How ignorant such people are of the culture of others and the average rural woman's idea of social intercourse! Certainly, if she had water on tap for washing clothes at home, she would not risk going to a river to be bitten by mosquitos, blackflies, and tsetse flies or to be infected with bilharzia.

At present it is estimated that three-quarters of the people in the developing world have to rely on surface water for everyday use. Unfortunately, the uneven distribution of global fresh water resources makes it overabundant in some places and scarce in others. Furthermore, widespread contamination and pollution render some water sources unsafe and unusable, even when water is present in sufficient quantities.

The sad point is that, over decades, so much has been spent in improving water supply for rural people that, had effective strategies been adopted, this enormous number of people without safe water would have been reduced considerably. Between 1971 and 1975, a total of \$1,543.1 million from national sources, and an additional \$151 million from external sources, was invested in rural water supply in 61 countries. This amount is impressive by any standard. But the situation changes only very slowly.

In tropical developing countries, water-related diseases create serious public health conditions. Two hundred million people are infected with schistosomiasis, for example, and 600 million more are threatened. The larva of the schistosome worm, deposited in the feces or urine of an infected person, develops in aquatic snails in quiet village ponds

and slow reaches of rivers and streams such as are frequented by women and children in the course of their daily chores. Similarly, the embryos of the female guinea worm are discharged when an infected source--a leg or foot--is put in cold water; the embryos then enter a water crustacean, the cyclops, which is so small that it can easily be swallowed in drinking water by unsuspecting victims, more often than not women and children. At least five types of dysenteric diseases are transferred to the mouth from fecal sources through contaminated water, fruits and foods, unclean hands, fingers, utensils, and even soiled clothes. Scabies and skin fungus are examples of disease-causing organisms which thrive when left to grow for long periods on unwashed skin, while satisfactory personal hygiene reduces the chances of eye infections and infection with lice, ticks, and fleas. If, through health education, communities understood the need to avoid contact with infected water sources, the need for good personal hygiene, and the wisdom of boiling drinking water, the spread of these diseases could be slowed.

Beyond education, however, serious consideration should be given to provision of piped domestic water for each household. Urban people who have piped water at home seldom acquire infections. In temperate regions, water-related parasitic diseases tend now to be scarce, although malaria used to be present and cholera and typhoid used to kill the rich and poor alike. The change for the better has resulted from the institution of safe water supply and sanitary measures. Piped household water in rural areas should not be seen as a luxury, but as a necessity, and planned for on a long-term basis. In the long run, the installation of effective and lasting water supplies turns out to be less expensive than repeated replacement and repairs of water supplies based on ineffective short-term "appropriate" technologies.

Contamination In Practice*

Margot Badran

Adequate water is fundamental to improved health. Until this basic need can be satisfied, there is little merit in undertaking other hygiene and sanitation programs. At the same time, however, even where supplies have been improved, a variety of problems arise at public water points or in domestic use.

Inevitably, these problems involve women, since women are the main haulers of water for domestic consumption, the main users of water for cooking, washing, and cleaning, and the main dispensers of water to family and guests. The women from the Nuba and Arab villages I studied in South Kordofan Province, Sudan, commonly expressed awareness that polluted water is a disease vector, but their perception seems to be linked to turbidity or visible pollution, which they try to treat with traditional de-silting devices and plant "disinfectants." Their understanding does not usually extend to avoidance of non-protected water sources or to careful storage and use of water.

The water from newly installed handpumps set on concrete platforms should be safe if the well has been constructed properly. But women waiting at the pump in the (invariably long) queues put their water containers--clay jars or old tin petrol cans--directly on the ground, where they pick up dirt. By the time the women get to the pump they do not, because of the number of people waiting, take time to clean the containers or their hands. Thus, the water is probably contaminated during collection. In addition, the short concrete troughs that are meant to accommodate runoff from spilled water are often blocked at the outlet in order to collect water for animals to drink, providing further opportunities for contamination.

Likewise, the water in village reservoirs is likely to be contaminated, especially at times of low water, by the activities of those fetching water or by their animals. Indeed, animals--especially goats but also cows and occasionally donkeys--are ubiquitous at public water points. They gain entry to reservoirs through open gates or holes in the thorn or barbed-wire fencing. It must be understood that the rural population in this part of Sudan has traditionally relied on keeping animals as an important key to survival; people will go without water themselves to feed their animals. Thus, the customary water-use sequence at public points is (1) water the animals, (2) fill the carrying vessel, and (3) quickly wet face, hands, and arms before leaving.

Furthermore, it should not automatically be assumed that new water supplies will entirely supplant traditional sources. In subsistence-level communities like those in South Kordofan, people are wholly preoccupied by the struggle to produce for survival. Transporting water alone can take four to six hours a day, while queuing at water sites may add another hour or so to the task. Consequently, users will be attracted to new water sources mainly by savings of time and energy. The message that safe water

*This paper is based on Margot Badran's paper, "UNDP Project GLO/78/006 Low-Cost Water Supply and Sanitation, A Report on Mission to Sudan" February 1-March 7, 1980.

promotes good health is unlikely to provide sufficient motivation by itself. Careful siting of new water inputs is critical, since this factor will to a large extent determine use levels.

Even with good siting, one cannot assume that new improved sources of pot-able water—handpumps and reservoirs with treatment plants—will be used throughout the year. During the rainy season, when the whole community is engaged in farming the crops that provide the year's food, these facilities will be underused or not used at all. At this time of year, when time and energy are most needed, most people will use rain water. Moreover, at some sites there is a small charge for treated water, which may further induce people to use rainwater when it is available.

In the home, water is stored in zirs (terracotta jars) kept in the inner courtyard, usually directly on the earthen floor; most are left uncovered. (Arab communities appear to be somewhat more fastidious than Nuba ones about elevating and covering the jars; I saw some jars supported on petrol tins or slung on a tree.) There is commonly one cup that is used as a dipper. Some people keep the dipper on a nearby hook or tied up near the water jar, but many simply leave it on the floor. The dipper has a short handle, so that the hands of the person drawing water may contaminate the contents of the zir.

Virtually all food is prepared near the ground by the woman, who squats or sits on a low stool as she cooks. Contamination occurs when unclean water is used to wash and cook food, when the stirring implements are placed on the floor and then back in the pot, when the gourds and other food containers are left unwashed, when food is left uncovered, and when insects enter the food while it is being stored or during preparation.

Since food is eaten with the hands, personal hygiene becomes especially important. Various non-water anointing agents or smoke baths are used as personal cleansing processes, but they require too much time to be daily cleansing options for the hard-working women. Muslims observe the prescribed ritual ablution of the face and body before prayer; women appear to pray less often than men. However, health benefits from this would appear to be minimal in the absence of adequate water supplies. Regular and frequent washing with water is simply not feasible for most village and nomad people during the dry season; body washing once or twice a week would be a high average. The washing of clothes and covers has low priority when water is scarce, and soap is too expensive for some.

In principle, adults and older children are supposed to remove themselves a good distance from the domestic areas to urinate or defecate, but in practice they do not seem to venture more than ten or twenty meters from their houses, in part for fear of the scorpions and poisonous snakes that lurk in the bush, especially at night and during the rainy season. Younger children relieve themselves virtually anywhere. Latrines do not form part of the traditional house structure.

As a result, most areas near human habitation are contaminated with excreta to a greater or lesser degree; particularly in the absence of adequate personal hygiene, they provide a reservoir of a wide variety of infections. During the rainy season, human excreta washes into the seasonal streams, the water from which fills the reservoirs and replenishes the catchment pools; some pollutants may also reach shallow underground aquifers.

Rural people's first priority must be for water, of any quality. Nonetheless, they have an active interest in having clean water. The lack of water for adequate personal hygiene, and the use of poor quality water for domestic consumption, clearly pose serious health hazards. Since the primary target of water supply, sanitation and health education in rural areas must be the women, it is important to involve women in the design and delivery of these programs; only in this way will some of the considerations outlined above be adequately taken into account.

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VI. HEALTH CARE PROVIDERS

Most of the women who wrote the papers in this section are themselves health care providers--doctors, nurses, and health development professionals. They show substantial agreement on the changes in their professions that will be needed if the primary health care movement, so important to women and children, is to fulfill its promise. Their basic message is perhaps best expressed by Prabha Ramalingaswami, when she says, "Modern medicine cannot succeed in rendering service to the needy unless awareness comes to those who practice it." With varying emphases, they appear to be advocating what VeNeta Masson calls "healing in the feminine mode"--that is, the "creation of an environment conducive to healing and the mobility of the patient's own capacity to help himself."

Luz-Helena Sanchez believes that her fellow women doctors, especially, need to "fight against an ideology that considers women only as reproducers or candidates for birth control." Dr. Ramalingaswami points out, on the basis of her survey of young medical students in India, that even maternal and child health problems and family planning do not occupy an important place in the thinking of young doctors, male or female; instead, they think largely of sophisticated hospital-based medicine.

Lillian Gibbons suggests that much the same has been true of nurses, and she wonders both whether nursing is changing fast enough "to put nurses in leadership roles in community health" and whether nurses "see the need to incorporate community workers into the health teams and to view their contribution with respect."

One hopeful sign is that the role of nursing is undergoing redefinition in a number of places and a number of ways. Mary Jane Seivwright describes the nurse-practitioner program in Jamaica, which will enable senior nurses to meet a wider spectrum of their patients' needs, curative as well as preventive. Yvonne Ortega de Castillo reports on other efforts to expand nursing roles and free them from clerical chores. Theoretically, if nurses have more training and recognition, they will be able to work more effectively with less-skilled, community-based health workers to make primary health care in rural areas a reality. Suliana Siwatibau and Joyce Jett-Ali argue that rural health care could be further strengthened if more attention were paid to training traditional healers and birth attendants, who already treat the majority of women in developing countries.

The Challenge For Health Care Providers

Lillian K. Gibbons

"Health for all by the year 2000" is the noble goal to which governments throughout the world committed themselves at the Alma Ata Conference in 1978. This refers to an attainable level of health that will permit people throughout the world to lead a socially and economically productive life.

If primary health care is deemed an appropriate strategy to this end, its effective implementation is contingent on a series of determining factors. One of these is the commitment level on the part of health care providers, especially nurses.

Unfortunately, the focus of nursing education programs has been minimally directed to community health, as is implied by primary health care. The greatest proportion of nurses throughout the world continues to work in hospitals in and around large metropolitan areas. There are many reasons for this, one of which is that educational programs for nurses remain hospital-oriented. But primary health care aims to address the main health issues in the community, and over 60 percent of the world's population lives in rural areas.

The role of nursing is changing in many parts of the world, but is it changing fast enough to put nurses in leadership roles in community health? Do nurses not see an effective power base in being allied with the community and the people to whom nursing's mission is directed? Is there sufficient vision and confidence among nurses today to view the real needs of people, especially women who are the most vulnerable, and to assume appropriate leadership in redirecting today's illness-oriented medical care system to a system of health promotion and disease prevention? Do the continuing education programs designed by nurses for nurses reflect an understanding of the real health care needs of populations? Are nurses preparing themselves to help people attain a more just and equitable level of total development? Do nurses see the need to incorporate community workers into the health teams and to view their contributions with respect? Is nursing prepared to work with other sectors which have significant roles in development?

In recent times, there has been a proliferation in the number and types of nursing ancillary personnel. Their titles vary—auxiliary, aide, promoter, helper, communicator, health volunteer. Does this plethora of health care providers imply a renewed commitment to solve priority primary care problems, especially as they affect large numbers of rural and peri-urban poor women? Numbers in and of themselves do not necessarily impact on complex problems. The impact will best be felt where there is a sincere commitment to health development.

The primary health care movement is growing rapidly, and will continue to do so with or without nursing input. Communities are recognizing their right to have care and are taking responsibility in promoting the training of their own village workers. These community workers are sensitive to the needs of their people and are often advocates for their community within the institutional health care system. The goal of "health for all" leaves room for everyone's participation. Cooperation among all types of health care workers is essential if the level of health is to improve significantly.

Nursing's preparation for the future, if it is to be allied with the focus of development, must embrace a framework which acknowledges the importance of economic, social, cultural, and political factors as well as biological and physiological. This preparation will redirect the practice of nursing and change its role. Priority will be given to sustaining and promoting health, including promotion of self-care among all people. Nursing will collaborate with other health team members to assure adequate, accessible, acceptable health care. The rigid barriers of what a nurse can do, versus what a physician or auxiliary can do, will be tempered by what the community believes and manifests as their right and need for care. The shaping of a healthy future is much too complex to be left to any one profession or discipline. Its appeal goes to all people. We nurses must strengthen our ability to sustain the process of development in which all men, women and children have the right to maximize their human potential.

How Doctors Look At Health Care Issues

Prabha Ramalingaswami

Doctors occupy a key position in any health service system. It is important to understand their attitudes toward social issues, since the types of services they give to people are likely to reflect those attitudes.

I will present here some of the preliminary findings of a study of the attitudes of medical students which are relevant for women's health. Our sample survey consisted of 533 final-year medical students from ten medical colleges in India, representing different types (state and central government, private, mission-run, etc.) and geographic areas. The students were administered a questionnaire containing a number of sections to be filled up. These questions were open-ended. Students were asked to write whatever they knew. They were assured that there were no right or wrong answers. Every effort was made to assure the students that we were interested in their views.

The students responded very well. They took the questionnaire seriously and answered as carefully as they possibly could. Some results stand out and are interesting. For example, students were asked what they thought were the implications for health of the fact that 80 percent of India's population lives in villages. One in five students (19.32%) talked of the difficulties for doctors of staying in rural areas, and a like number talked in general about needing more medical facilities and more primary health centers. Nobody talked about maternal and child care problems or referred to maternal and infant mortality.

A second question probed the students' views regarding medical auxiliaries, as follows: "It is often said 'Doctor as a team leader.' In your opinion (i) what is that team? and (ii) what are its duties and importance?" Significantly, relatively few responses, including those from women medical students, mentioned maternal and child care and family planning, the overall figures being 5.44 percent of the male students and 7.50 percent of the female. It is interesting to note that family planning was mentioned by slightly more students, with the difference being particularly marked among female medical students. (8.7% of female students mentioned family planning as compared with only 4.37% for maternal and child health.)

Students were asked what they knew about community health workers/volunteers. Very few mentioned giving simple health care (5.07%) or tackling village health problems (4.60%), much less maternal and child care. It is noteworthy, however, that two to three times as many female medical students as males appeared to know that community health volunteers perform these functions.

Finally, students were asked "What is meant by primary health care and what is its relevance to India?" From the answers (see Table I), one can only conclude that students have not thought much about maternal and child care problems even in relation to that question. This is true even though these same young doctors look with favor on gynecology and obstetrics as a medical specialty. When students were asked to rank the specialties they preferred, gynecology was among the first six mentioned. But the students seem to see gynecology as a specialty that is practiced totally in an urban, hospital setting.

Table I

Components of Primary Health Care, As Seen By Medical Students

<u>Response</u>	<u>Males (350)</u>	<u>Females (183)</u>	<u>Total (533)</u>
Maternal and Child Care	12.29%	16.39%	13.70%
Family Planning	1.71	6.01	3.19
Health Education	32.71	12.57	19.89

Although analysis of this study is still in progress, one thing is painfully clear. Maternal and child health problems do not occupy an important place in young doctors' thinking, whether they are male or female. One does not know whether one would get a different response pattern from young doctors in another country. However, if one can hazard a guess, the responses would not be very different, since the medical curricula and professional culture in most countries, including India, do not give an important place to maternal and child health problems.

The young doctors whom I have studied have almost finished their undergraduate studies. They certainly have completed the study of preventive and social medicine. But they can only think of better quality medicine, more sophisticated and more professionalized medicine for those who reach the hospital. In this, the young doctors reflect the professional culture that prevails today in medical science and health services.

My plea is that, if we want to improve the health care for rural women and women belonging to the weaker section of society, it is essential to make the doctors conscious of the complex nature of these problems. Modern medicine cannot succeed in rendering service to the needy unless awareness comes to those who practice it.

An Example of Holistic Care (Washington, D.C.)

VeNeta Masson

Like the majority of health-care facilities in the United States, Community Medical Care (CMC) was not planned for the express purpose of meeting the particular health needs or expectations of women. Indeed, it did not occur to me as one of the founders—and a woman besides—that there might be significant differences between the sexes in the realm of health care. True, I was aware of the women's movement in the U.S. and the part it has played in helping women to assume control over decisionmaking regarding their bodies and themselves. I was also conscious of my own experiences both as a health worker and recipient of health care, not all of which have been positive insofar as encounters between the sexes are concerned. Nevertheless, I was convinced that the structure of CMC would be equally well suited to the needs of all men, women, and children who would come to us for health care. Thus, I am pleased to have this opportunity to look back over our experience during some 21 months of operation with a specific focus on whether and how we are meeting the needs of our women patients.

CMC opened in September 1978, with the aim of providing quality health care in economically impoverished and medically underserved areas of Washington, D.C. The only family medical practice in its geographical area, CMC maintains office hours 20 hours each week and affords patients 24-hour-a-day access to the staff via a telephone answering service. Health services offered include general medicine, minor surgery, office gynecology, dermatology, pediatrics (including comprehensive well-child screening), prenatal care, nutrition counseling, audiometry, electrocardiography, laboratory tests (many of which are done on site) and, in addition, supportive counseling, guidance in self-care, and health teaching.

Integrated with the office practice is a home-care program designed to meet the health needs of the homebound "vulnerable elderly" in the immediate area. Components of the program include what we call whole health maintenance (diagnosis, treatment, counseling, etc.), visits from trained neighborhood volunteers, and hospice care for terminally ill patients.

At present the paid staff of CMC includes a family physician, registered nurse, health aide, receptionist/business manager, and administrative intern, along with two volunteers. A network of consultants, cooperating agencies, and specialist physicians complements the expertise of the in-house staff.

CMC's aim is to become self-sustaining financially. It operates on a fee-for-service basis with a graduated payment scale based on income and family size; many patients are covered by government programs for the poor and elderly. Until fees and government reimbursements can pay the full costs, additional funding is being sought in the form of foundation grants and private donations.

Distinguishing features of CMC's approach to health care include its:

Holistic framework: As we say in our brochure, "We treat each person who comes as a whole person--whole in body, mind, and spirit." The CMC team meets together with individual patients to identify health problems and strengths and to formulate a mutually agreed plan of action. The focus throughout is on prevention of disease and achievement of an optimal level of health.

Integrated/comprehensive approach: CMC staff work as a team, each member contributing his or her unique skills and personal abilities. CMC programs also span the range of adult and child health care, preventive and curative services, and home and office settings.

Neighborhood focus: The primary focus of CMC is on the neighborhood in which it is located and the people who live there, most of whom are poor and many of whom are elderly or in poor health. At present, about half our patients come from the immediate neighborhood.

Cost effectiveness: When care is fragmented and health is poor, health-care costs rise rapidly. CMC's approach and range of services result in improved health status, a marked decrease in the duplication of diagnostic tests and health services, fewer hospitalizations, and an increase in patients' satisfaction with the care they receive.

Community liaison: CMC works closely with many community agencies. We have contractual agreements with the D.C. Visiting Nurse Association and the Washington Hospice Society. We belong to an informal association of six community-based health centers who work closely with one another to complement and support each other's programs. We also work closely with other missions of the Church of the Saviour in the areas of housing, employment, education, child welfare, and literacy action.

A representative sample of 114 women and 98 men out of the approximately 1,000 active patients presently served by CMC reveals some interesting differences in the reasons that men and women come to the clinic for the first time. The greatest difference is in the routine physical examination category, which has a preponderance of men and very few women. The second largest is in the genito-urinary category (which encompasses prenatal and postpartum care, family planning, venereal disease and other vaginal infections, and urinary problems such as cystitis), where there are many more women than men. Other areas of differential demand are gastrointestinal conditions (including ulcers and "nervous stomach"), vague complaints (weakness, fatigue, depression, anxiety, dizzy spells, etc.), and infectious processes (upper respiratory infections, ear infections and flu), all of which have a significantly higher proportion of women.

The two major categories seem to be distinguished by the fact that they are role-related. In this particular population, where there is much poverty and unemployment, the vast number of physical examinations requested by men were qualifying exams for employment, disability, shelter, rehabilitation programs, or some other reason. Women in the CMC neighborhood, on the other hand, are often single, unemployed parents, and the types of public and private assistance available to them do not generally require them to have a health examination.

The role of women as sexual partners and mothers accounts for the high number of visits for gynecological concerns: birth control, vaginal infections (venereal and non-venereal), pregnancy tests, and prenatal care. While the men in the CMC sample have their share of visits for the diagnosis and treatment of venereal disease and other genito-urinary problems, the range of these sex-linked conditions is not nearly so broad.

If the number of visits for routine or required examinations is subtracted from the totals, women patients outnumber men 110 to 67, leading one to believe that women in the CMC population are either sicker than men or more likely to use our services. It is

interesting to note that the other three categories in which women significantly outnumber men are often linked to stress, although—given the small numbers in the sample and the case that could be made for the relationship of stress to virtually any health problem—it would be inappropriate to speculate further about the ways in which women manifest stress and seek to deal with it. It is entirely possible that, because most of the women in the CMC population are mothers of young children or members of households with children, they are more often exposed to the common infections and communicable diseases of childhood. It is also possible that women are simply more likely to seek health care for conditions as vague as anxiety or as minor as the common cold.

Much more could be done to analyze and interpret these and other data in our files. What I find remarkable in this preliminary look at the differences in the reasons for which men and women use health services is that they do seem to exist!

I have heard more than one of our male patients say something like this when asked why he had come to see the doctor: "Well, my leg got to bothering me so bad that I thought I'd bring it down here and get it fixed." The problem is discrete and impersonal: I have a problem with this part of my body and I want to get it fixed. The consultation with the health worker becomes a straightforward matter of problem-solving which, in most cases, does not attempt to relate this to any larger whole or explore possible implications for the patient's general well-being.

A woman, however, is more likely to experience a health problem in the context of her whole life and her milieu. She might say something like this: "I've been so upset lately, I don't know whether that's what's causing this pain or whether the pain is what's making me upset. Nothing's going right and I'm shouting at the kids. It's got to the point where I have to do something." Her concept of what is wrong, while less focused, is more comprehensive, and she often needs help in examining and clarifying the situation with an experienced and sensitive listener. These two examples are stereotypes, but they contain a kernel of truth.

My observations and experiences have also brought me to the conclusion that there are masculine and feminine healing modes. The first is epitomized by the modern physician (of either sex) and the second by the nurse (female or male). Western medicine is problem-oriented. Medical problems are identified, analyzed, and treated, often as discrete entities which might be disembodied and examined quite apart from their owner, the patient. Nursing, in contrast, can be conceived as healing in a feminine mode where healthy relationships, the creation of an environment conducive to healing, and the mobilization of the patient's own capacity to help himself are therapeutic media.

I suggest that the new focus on holistic health care in the United States represents a re-evaluation of healing in the feminine mode and of the importance of diffuse awareness as well as focused problem-solving in restoring and preserving health. Just as men and women have masculine and feminine elements within their psyches, so both physicians and nurses can and do function in both masculine and feminine modes. Certainly, I know this to be true in our own setting, where the physician is a perceptive listener and counselor and the nurse has been known to diagnose and treat medical problems. Still, the two prototype health workers, doctor and nurse, seem to function best as a team where the expertise and perspective of each can complement and enhance those of the other. This also gives the patient the option of consulting a male

or female health worker--or both together if he so desires. Thus, a structure like CMC, with its holistic framework and team approach, seems to me well suited to meet the needs and expectations of women as well as men, to the degree that staff members are cognizant of the potential differences between the sexes and are comfortable in employing both masculine and feminine healing modes.

Thoughts Of A Woman Doctor

Luz-Helena Sanchez

I used to think, as the majority of us health professionals do, that we have to keep some distance from our patient population so as to better and more objectively serve their needs. I have come to realize how this approach can create a powerful elite of experts, WE, the health professionals, as opposed to THEY, the patients, the sick, the powerless, as if we could lock ourselves up in an ivory tower and disregard the fact that all of us live and share to some extent the conflicts of our society, that our values sometimes conflict with patients' values and might even become damaging to a particular patient or group of patients.

The traditional approach confines social knowledge to a minority. It assumes that science and its application, technology, exist in kind of a neutral land where assumptions about the world are made without any political implications. This is a dangerous and escapist assumption, one that might serve purposes to which we do not subscribe. It has been particularly damaging to women as users of health services.

When we look at health programs in Latin America today, one wonders if there is any concern at all for women. Women's needs and interests are seldom taken into consideration in health policy planning; as a matter of fact, projects sometimes work against the best interests and health of women. These thoughts do not belong with me. They are the result of lengthy discussions with other women, of academic information, and above all they are the result of my professional and personal experience and of my relation with women who suffer basically because they happen to be women in a social milieu not particularly suitable to people's happiness. Some women are able to enjoy fully the material benefits of the social organization in which they live. But the vast majority of the women in my country do not.

I am going to address--briefly and necessarily superficially--two programs that have been of fundamental importance to women in the last years--nutrition programs and birth control programs. It will be clear that women's perspective has been lacking through the whole planning and implementation process.

The Nutrition Programs

From the time a female is born she bears the potential either to exercise or not her reproductive capability. It is only in the former event that women become objects of interest to nutrition programs, and then only because the women's nutritional status makes an impact on the nutritional status of their offspring. The wording of documents on maternal and child health makes this painfully obvious.

Pregnancy, breastfeeding, child rearing, add an extra burden to women. When one reviews the literature on nutrition, one is surprised how little attention is paid to the effects of these events on women's nutritional status. Instead, most literature concerns the effect of maternal nutrition on child growth and development, quantity and quality of breastmilk, the anovulatory period, and the impact of breastfeeding on the child. Women as women are not an interesting topic to health researchers and policymakers.

Beyond any doubt, undernutrition is one of the most severe problems that women have to face in most regions of the world, Latin America included. This is true from a

triple perspective—1) because women are held responsible fully for the nutrition and other needs of the family unit, 2) because many women in Latin America are basic food growers and providers, and 3) because they themselves are victims of undernutrition, aggravated by the extra burden of pregnancy and child-rearing.

In Latin America, food supplementation programs have existed since the sixties. Up to now, they have failed to improve the overall nutritional status of the population. On the contrary, the situation has worsened. Significantly, the Colombian government has been withholding the results of the most recent nutritional survey on grounds of national security, and I understand this is true in other countries in Latin America.

There is evidence that points to the following facts: Supplementation in the last trimester of pregnancy seems to produce gains in infant birth weight only when the woman had previously had a minimally adequate protein/calorie intake. This implies that there is a threshold below which a short intervention program does not improve the situation, either because the level of depletion is so severe that longer periods for intervention should be considered or because there are structural damages that make food utilization by the body more difficult.

There is also evidence of a positive relationship between previous nutritional status and length and amount of lactation. And yet the media component of the typical nutrition program seems to blame women when their babies are inadequately fed, making them the scapegoats of an otherwise unjust social situation.

Nutrition programs have had to move the point of intervention ever further back. The first programs were targeted to school children; then they moved to preschoolers; now intervention in the last trimester of pregnancy and the first six months of breastfeeding is being recommended. A better approach might be to see the nutritional status of women as a continuum of deterioration which might be producing irreparable damage that cannot be solved by last-minute interventions. Until we are able to do this, supplementation programs are bound to fail.

In truth, undernutrition results from food scarcity, and food scarcity, in most Latin American countries, is the result of heavy concentration of land in very few hands, of progressive dispossession of the peasant population, the emphasis on profitable export crops, and the displacement of the labor force by capital-intensive technology, which in many instances has affected women more dramatically than men. Only in Cuba has the undernutrition problem been successfully dealt with. This is because a strong commitment to long-term restructuring, without the setting up of a costly bureaucracy, has been reached within society.

The Birth Control Programs

Birth control programs in Latin America are a good example of how women are the objects of policies set up in the name of a political and economic power that is absolutely alien to most women in our countries. Thus, Dr. R.T. Ravenholt, the director of population programs for the U.S. Agency for International Development, was quoted in the St. Louis Post-Dispatch (April 22, 1977) as saying that population control is needed to maintain "the normal operation of U.S. commercial interests around the world," since "continuation of the population explosion would result in such terrible socioeconomic conditions abroad that revolutions would result." Similarly, the World Bank Annual Report for 1979 says: "Slower population growth would not only help to contain the future dimensions of the employment problem; without it, for many

countries, the immense demands for social and economic infrastructure are likely to pose a crippling burden on public budgets and planning capacities."

Where are women's interests considered in these remarks? In this context, the body of women seems to become an anachronism that can be restored only through a carefully designed program of control. Women's wants, needs, interests are the object of manipulation and do not come into the picture except for rhetorical purposes.

In making these criticisms of birth control programs, I do not mean to oppose their existence. On the contrary, I believe it is a woman's right to have a free choice based on the best available information. But the search for and promotion of techniques that lead to the fastest possible decline in fertility rates has resulted in a disregard for any side effects of drugs taken for long periods of time by malnourished women; they have also resulted in a situation where informed consent is an empty slogan for the majority of women. Unless women organize and make specific demands on the health system, the situation is not going to change.

Women in the health professions have a very important role to play in influencing and bringing about changes in the health system. We should fight against an ideology that considers women only as reproducers or candidates for birth control. We should learn and push others to learn, to approach women from a comprehensive perspective, as historical and social beings with physical as well as emotional needs.

From Nurse To Nurse-Practitioner

Mary Jane Seivwright

Developments in the role of nurses and nursing have been retarded by, and closely parallel to, the traditional myths associated with the role of women in society throughout the ages and across nations. Thus, we have often been reminded that a woman's place is in the home. Women are said to be less intellectual than men, and not capable of making important decisions. There are some who hold that a woman, by her very nature, is unfit to hold certain jobs—usually the high-status positions. It is also said to be unfeminine for a woman to show aggressiveness. (Yet most people agree that behind every successful man there is a woman!) It seems hardly necessary to say that most of these myths have long ago been exploded by the performance of women all over the world.

The traditional definition of nursing is similar in many ways to myths about the nature and role of women: The nurse is one who cares or nurtures. Thus, the mother "nurses" her baby; and the "nurse" takes care of the children at home. As long as this concept prevailed, no need was seen for any particular education or training for nurses. The major requirement was a kind heart and a capacity for long-suffering. This could be termed the age of the "HEART" in nursing, when religious orders predominated the scene.

With the advent of institutional care for the sick in the late 18th century, it became clear that nursing required something more than a kind heart. The nurse needed some skills, however rudimentary. She had to be able to make and apply poultices and fomentations, give fever baths, assist with the "cupping" of joints, and, most importantly, restrain the lunatics. Even if she could not read or write, the nurse had to be strong and have a good pair of hands. This might therefore be described as the age of the "HANDS" in nursing.

Since around the mid-19th century, however, nursing has undergone tremendous and rapid changes. Florence Nightingale, who is internationally recognized as the founder of modern nursing, demonstrated that nurses, in order to be effective, must have formal education and training. Scientific knowledge must be the cornerstone on which safe and effective nursing practice is built. It might be said that this concept has led to the age of the "HEAD" in nursing.

Today, we recognize that the ideal professional nurse is one who has achieved a proper balance between heart, hands, and head. She must be one who really loves people; one who has been arrested by a strong desire to serve. She must be skilled and competent in performing the many highly technical tasks required of her as she tries to cope with the advanced technology of medicine and health care; and she is required to possess the most up-to-date knowledge in the physical, biological, social, and behavioral sciences which influence her practice. Above all, she must possess the intellectual capacity and curiosity that will ensure continued learning and self-improvement, both as a member of the health care team and as an involved citizen.

If we accept the broadened definition of health, which includes emotional, social and physical factors, then it becomes imperative that nurses be prepared to redefine their functions and accept the responsibilities implied in caring for the patient as a total person and member of his social unit, the family. Further, the patient and his

family must be viewed in the larger context of the community and society and must be involved in planning for and meeting their own health care needs.

Not to be overlooked, either, is the very important function of the nurse in coordination of patient care, from diagnostic procedures to rehabilitation services. As the most constant member of the health team (that is, with round-the-clock responsibility and/or physical presence), the nurse is the one who must see that the spiritual and emotional needs of patients and their families are met and that their humanity and dignity are cushioned against the impact of advanced technology and increased specialization.

Thus, for some time now, leaders of the nursing profession have been advocating a formal expansion of the cure functions of the nurse. Our argument has been that nurses are already performing certain highly technical activities out of necessity; therefore, the medical and nursing professions should get together and identify those traditional medical functions which the nurse has been performing or can be delegated to perform. The nurse could then be adequately prepared to assume these functions. She should receive fair compensation for the additional responsibility, and her expanded practice protected by legislation.

The Government of Jamaica has accepted this position, and is relying heavily on the nurse in the expanded role of "Nurse Practitioner" for the implementation of its proposed comprehensive primary health care program. In view of the nature of our health problems, the overwhelming health care needs, the proven capabilities of professional nurses, the need for a broader nursing career structure with promotional opportunities for senior staff nurses, the unavailability of medical personnel to serve the majority of our citizens, and the forecast of an even greater deficit of medical personnel in the future, family nurse-practitioner programs are imperative. The general aim is to develop programs that will prepare senior professional nurses for greater clinical responsibilities in the health service. Administratively, the nurse-practitioner relates to the nursing officer in charge in fulfilling her responsibilities as a nurse and to the medical officer in charge in her expanded role, which includes functions of a medical nature.

In Jamaica, we are now training our third class of nurse-practitioners (having started in 1977), totalling 67 persons, fourteen of whom are nurse pediatricians. Specifically, the intent of the family nurse-practitioner course is to give experienced nurse-midwives advanced medical/nursing education and training, so that they will be able to meet a wider spectrum of the health needs of adolescents and adults (sick or well), focusing on primary care in a variety of health agencies and settings. Small opinion studies done by students of the Advanced Nursing Education Unit have shown that nurse-practitioners are well-received by other health personnel as well as (and particularly) by the health-consumer public. The program is now in the process of being expanded to include preparation of mental health/psychiatric nurse-practitioners, as well as re-activation and upgrading of a course to prepare nurse-anesthesiologists.

Unfortunately, but perhaps not surprisingly, there has been opposition to the concept of the nurse-practitioner from some in the medical profession. They fear, it is said, that the nurse will soon begin to "hang out her shingles" and compete with doctors! This, you will agree, is a great pity. However, we feel confident that this particular hurdle will soon be overcome and new dimensions in the development of the health care systems and the nursing profession achieved. Actually, what started out as a Jamaican project has now spread to the Eastern Caribbean, where a Family Nurse

Practitioner Programme was launched in February 1980. The project is headquartered in St. Vincent and will admit students from all the less developed countries of that region (including Belize), as well as from Barbados.

Thus, nursing has moved from a fledgling art of the 18th century to a sophisticated art and science in the 20th. At the same time, not only are we endeavoring to preserve the "heart" in nursing, but we are determined to put a "soul" in as well. In this way, we believe that the profession will be able to attract and retain young women and men with the required level of ability and commitment. Only in this way will we be able to provide our people with the quantity and quality of nursing service that they need and richly deserve.

Trends In Nursing

Yvonne Ortega de Castillo

The manpower goals of the Ten Year Health Plan formulated by the Ministry of Health of the Americas in 1972 are slowly being met, although there is great variation in the different countries. Only a few countries have adequate levels of nursing personnel. (see Table 1) In 1970, the comparable average rate in Latin America was 2.3 nurses and 8.8 auxiliaries.

Table 1

Proportion of Nurses and Auxiliaries in Central America, 1975

<u>Country</u>	<u>Ratio of Nurses per 10,000 population</u>	<u>Ratio Auxiliaries 10,000 population</u>
Costa Rica	3.8	11.4
El Salvador	2.0	4.5
Guatemala	1.2	6.1
Honduras	1.0	5.4
Nicaragua	2.7	9.5
Panama	6.3	13.3

Lack of adequate manpower is not the only limitation in the health service delivery system. Supplies, budgets, data information and systematic supervision are insufficient. In many places, roles have not been clarified, which has led to conflict. Other limitations are the inaccessibility of numerous rural communities and lack of incentives for the personnel. Field training in rural areas is scarce, due to limited financial support.

One important problem has been the legal obstacles to an expanded role for nursing. Traditionally, public health nurses have worked in maternal and child health and family planning, nutrition, general morbidity, and control of communicable diseases. Health education has always been a basic function and is an area in which the nurses have considerable skill. But they have had limited clinical (curative) skills. And they have often had to spend 40 to 60 percent of their time in non-nursing tasks such as secretarial work, messenger service, and housekeeping tasks, matters that could be handled by less well-trained and less costly persons.

Recently, studies and seminars in which nurses participated have helped to encourage an expanded role for nursing. For example, in the Tegucigalpa workshop (1977), with participation from Central America and Panama, an expanded role was defined in the areas of prenatal care, birth attendance and care of the newborn, post-partum care, family planning, child growth and development, and participation in community health organization. Skills learned in formal short courses on women's and child health enable nurses to give more care and attention to women and children. These include general physical assessment of the prenatal woman, taking samples for pap smears and gonorrhea cultures, insertion of intrauterine devices, and the detection of abnormalities. Skills related to child and newborn assessment, with emphasis up to age six, include general physical assessment, detection of abnormalities and diseases frequent in these ages, evaluation of the developmental status of the child, and management of the total care of the well child.

Efforts are being made also to upgrade nursing personnel in administrative skills and community development through continuing education and in-service training as well as through fellowships for nurses to study abroad. Generally, the training programs of the community health workers, including those for traditional midwives, are being given by nurses in collaboration with other members of the health team. Some of these assessment skills are being taught in basic nursing education programs. The changes in the direction of nursing education are thus congruent with the changing health care system.

Services are being extended to the rural areas through implementation of a client referral system—from the community up to major hospitals, with steps in between of the health post (manned by a nursing auxiliary), the health center (with physician, nurse), and regional health centers and hospitals. This system, and the training that underlies it, enables nursing personnel to be more assertive in their decisions. They do not need constant physician authorization for care that is within their competence. In some health services, where only nursing personnel give direct care, they have responsibility for all the health care services, in addition to the administrative functions. In others, however, physicians continue to serve as directors of health centers, even though their hours of service are limited; in these cases, nurses assume administrative responsibility with little authority.

In summary, community health nurses are being taught new skills and are taking new responsibilities. There is slow growth in the numbers of nurse manpower, and limitations are gradually being overcome. But nursing will have to exert pressure on the health system to overcome remaining limitations. If these limitations are not overcome soon, the nursing role will remain in the traditional subordinate, passive mode in many areas.

A Role For Traditional Healers

Suliana Siwatibau

Fiji's situation is representative of that of other small island nations in the Pacific, and is probably not very different from most developing countries. Over 60 percent of the population is rural, served by widely scattered health clinics. Women spend 73 percent of each working day on domestic and food-gaining activities. Little time is left for leisure or for their own care. Thus, easily accessible village traditional healers become more convenient for most women's health needs. Further, western-trained medical personnel at clinics and hospitals are often brusque or condescending, while traditional healers welcome patients in a comforting familiar atmosphere.

A recent survey by the University of the South Pacific identified some 143 herbal healers, of which 60 percent were females. Of the 467 remedies regularly used by these healers, 30 percent were either specifically or mostly for women. This shows a high inherent demand on the traditional health system by women.

The use of traditional healers seems a necessity, but government attitudes and legislation have ensured that it will become a second-rate health system. Our traditional health system is neither officially recognized nor encouraged. Western-trained doctors scorn it. Much knowledge has been lost. Those who practice do so with trepidation in the face of possible ridicule or even court trial. This remnant of a once well-developed health system is what most rural women and their young children depend on.

Traditional healers are also widely used in urban centres. Here patients sometimes visit both traditional and 'western' doctors. One of the busiest urban traditional healers interviewed was specialized in female ailments only—complications of birth, problems of menstruation, female infertility, etc.

From our survey findings the following points can be drawn:

- (i) Traditional medicine continues to fulfill many people's needs despite official ostracism.
- (ii) Women, particularly rural women, often rely on the more approachable and convenient traditional healers.
- (iii) Traditional healers need to be recognized, and their skills upgraded through appropriate training. This is especially important for women and young children who rely on them.
- (iv) Women themselves need to be better informed about their own health needs—particularly about good nutrition and first aid—both traditional and 'western.'
- (v) Research into the nature of traditional medicine needs to be encouraged.
- (vi) Possible incorporation of traditional medicine into the national health system should be investigated.

Traditional Birth Attendants And The Need For Training

Joyce Jett-Ali

African traditional birth attendants constitute a primary source of health care for mothers and newborns in rural areas in Africa. (It is estimated that over 80 percent of all deliveries in rural Africa are handled by traditional attendants.) Although typically illiterate and without formal training, the true traditional birth attendant is an obstetrician, an herbalist, a gynecologist, and a pediatrician. Her role includes employing technical and mystical skills to insure good health for the mother and newborn. The profession is one of the few remunerative ones that exist for women in traditional African society.

Rural women prefer to deliver at home because of distance and lack of transport to maternity centers, because of economic factors, and because of sociocultural attachment to village traditions. The traditional midwife is perceived as a professional by the women in her community. She occupies a responsible, respected position in her field. If a young woman rejects the traditional midwife, who may also be a relative, in favor of a professional midwife, the resulting conflict may be too high a price to pay for perceived advantages. Furthermore, the traditional birth attendant can act as an important link between the process of childbirth and the control of invisible "forces" which threaten the process, while a professional midwife may ignore these beliefs and practices. For example, the way the placenta is buried is thought to determine the destiny of the child or the fertility of the mother; it must not fall into the hands of malintentioned people.

Proponents of traditional birth attendants generally acknowledge that they need training in some aspects of modern health care. Left untrained, their good will may unwittingly produce negative results. Furthermore, training helps to increase the social visibility of women who previously had been content to live in social marginality. It provides access to non-formal education and the possibility of increased income. It can help to create a sense of professionalism and organization, which in turn may lead to establishment of associations and codes of ethics.

Many health professionals and decisionmakers, however, oppose training for traditional birth attendants, or support it only as a stop-gap measure while the training of midwives and nurses is accelerated. This negative attitude is the result of a cultural and educational gap between the modern and traditional health systems. Health professionals are frequently urban and educated in Europe, with little interest in rural traditional practitioners and little understanding of the sociological aspects of public health. If they are male—and male nurses are most often assigned to rural hardship posts—they are automatically excluded from the rites of childbirth, and if they are assigned to work with tribes other than their own, they face a communication barrier within the community. The professional midwives do not understand the traditional beliefs and practices, and some of them fear that traditional birth attendants will reduce their importance and number of clients.

Legalization of traditional birth attendants is highly improbable in most African countries. Governments fear that trained birth attendants would demand payment and status equal to professional government midwives. They consider the traditional practitioners too old to assimilate knowledge and too attached to tradition to change their ways. For her part, the traditional birth attendant often fears government and

health authorities. Realizing that she practices outside the law, she is understandably reluctant to collaborate with nearby health staff. She knows that she will inevitably take the blame when difficult cases are evacuated to the nearest health facility.

Rural women are caught between these two health systems, the modern and the traditional. It will be a long time before enough nurses and midwives are trained to serve in rural Africa, and even longer before they will choose rural environments over urban ones. Meanwhile, traditional attendants continue to deliver babies for rural women who continue to prefer delivering at home.

In this context, it is inconceivable that traditional birth attendants are not trained. The challenge lies mainly with the health professionals. They should encourage a change in attitude and atmosphere so that a dialogue between the two health systems can be established, especially at the local level between the health post staff and surrounding village midwives. One approach could be to train both the older traditional practitioner and her younger apprentice, so that long-term goals and criteria of both health systems can be met more fully. This approach would soften an abrupt break with traditions and at the same time encourage the gradual process of social change. The current trend in training programs includes the following objectives: non-interference with normal labor, basic hygienic nursing care, and elementary nutrition education. Such training, if carefully conceived, can produce long-term benefits both for the health of rural women and for the status of an important group of income-earning rural women.

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VII. EXPERIMENTS IN PRIMARY HEALTH CARE

The papers in this section describe community health projects in depressed rural areas in five countries, including the U.S. Each is attempting to use community-based, community-serving workers with varying qualifications and degrees of training to bring about improvements in the health of the local people. It is interesting to note that the most successful of these projects originated from private-sector initiative, although all now have links of one sort or another with local and national government services. Only Project PUSH, in central Philippines, appears to lack the motivating force of grass-roots religious or institutional support.

The major themes of these reports from widely scattered places are remarkably similar. Among them are:

1. Community participation and understanding is essential, especially in the selection of the community health worker. As Trinidad de la Paz notes, with regard to the community workers in southern Mindanao, "where the trainee was not really chosen democratically, but rather by the village captain and/or officials, the Katiwala was not accepted by the residents and consequently was ineffective." Leela Jayasekara goes even further. In the experience of the Sarvodaya movement in Sri Lanka, she says, the key participation required is that of the mothers: "Experience has proved that any other source of recruitment has a feeble follow-up in the village." (The Black Churches Program in North Carolina, according to Ethel Jackson, sought a 2-1 ratio between men and women workers on the ground that "men might talk more readily to other men about certain types of problems.")
2. Efforts to improve community health will quickly involve other aspects of community development. Community health workers are, in Banoo Coyaji's words, essentially "agents for social change." In her project in Maharashtra, health workers have even "persuaded villagers to allow backward classes to use the common well and enter temples." "Many Katiwala," Trinidad de la Paz reports, "have evolved into resource mobilizers and linkage builders for their communities, initiating community development projects."
3. Much can be accomplished by mobilizing resources internal to the village, and Fatou M'Baye worries that Maisons Familiales in rural Senegal have not yet learned to take enough responsibility on their own. Sarvodaya's experience is particularly instructive in this respect. The environmental clean-up and repair project in North Carolina is also noteworthy. Nonetheless, sooner or later community health workers must have links to higher levels of health care and to other government services. If local officials or government workers feel that they are being bypassed or supplanted, they can easily undermine the success of the project. In Project PUSH, as Estela Villarete reports, these linkages are highly formalized, but they exist in the other projects, too. Indeed, one of the community health worker's greatest potential contributions may be his or her ability to mobilize resources from outside the village--curative care in a clinic or hospital (as in Maharashtra and elsewhere), contributions of surplus food from distant regions (as in Senegal), or help in upgrading the local water supply (as in North Carolina).

4. Self-motivation and skills in community mobilization are more important for community health workers than extensive training in the specifics of health care. Most of the projects have put progressively greater emphasis on communication skills in their training programs. Furthermore, community workers benefit greatly from reorientation sessions in which they can compare their experiences with others, add to their substantive qualifications, and generally rekindle their enthusiasm. Sarvodaya does not even offer specific training in community health until a village volunteer has had considerable experience running the local community kitchen, taken two general training courses, and shown "special aptitude" for health work.

The Katiwala in Mindanao, Philippines*

Trinidad de la Paz

The Russians have their "feldshers," the Thais their "wechakorns," the Mexicans their "promotores de salud." In the southeastern tip of the Philippines, in Mindanao, we have the Katiwala.

As of this writing, there are only 61 rural health physicians in this region of the Philippines, giving a doctor/population ratio of 1-51,194. The efforts of the Health Ministry notwithstanding, there is very little change in the leading causes of morbidity and mortality. The ten leading causes of illness and death are still communicable diseases. Of special concern to health workers is the degree and prevalence of malnutrition among pre-schoolers, because this renders them highly vulnerable to infections.

There is a pressing need to depart from traditional solutions. Educating more young people to become doctors and nurses is not the answer. Young professionals will not be enticed to practice in rural areas, where 75% of the population live, until better roads are built and better transportation facilities provided, until the peace and order situation is ameliorated, until opportunities for professional advancement and for educating their children are upgraded. Lack of material returns discourages professionals from setting up practice among the rural and urban poor. The government, already hampered by financial and manpower constraints, cannot meet the need and the right of all citizens to adequate health services.

There is a growing realization that a new type of health worker is called for. Such a health worker should come from the community to be served and should be supported by them. The worker would be trusted by the people, be attuned to their needs while at the same time have the leadership to organize the people and together seek solutions to the community's health problems.

The Katiwala Program had its beginnings in 1968, when a group of Catholic couples, a unit of the Christian Family Movement (CFM) together with a Redemptorist priest as chaplain, decided to do something about the health conditions in some of the squatter areas in Davao City, where poor living conditions gave rise to a high incidence of communicable diseases and various degrees of malnutrition among both adults and children. Seventy-five percent of children under five years were malnourished; tuberculosis was rampant. Almost every resident of the slum areas was host to some form of parasite. Poverty and marginal living barred these people from private sources of health care. So great were their numbers that even the Public Health System found the problem beyond its capabilities. At that time, one public health nurse served 40,000 people. Many of the sick went to the herbolario, hilots, and other traditional healers.

Phase I The Free Clinic: At first, CFM responded to the need with a free medical clinic, set up on the ground floor of the Redemptorist monastery. The priests and their

* This paper is based on "The DMSF Katiwala Experience: An Approach Towards the Building of a Primary Health Care Support Structure at the Community Level," by the DMSF-IPHC Project Staff, Trinidad C. De La Paz and Asuncion J. Chin.

parishioners helped in cash and in kind. Mothers and their sick children formed long queues around the clinic Monday and Thursday of every week for two years. Many were served and served well, but all those connected with the free clinic realized that the "dole-out" was not the solution to the area's health problems. The people were getting difficult to control, the lines too long. There was too much confusion.

Phase II The Medical Cooperative: At this point, the clinic was taken over by the Development of Peoples Foundation, under the management of a group of civic-spirited citizens. It was decided to restructure the clinic into a medical cooperative with a membership fee of P1.00 and monthly dues of P0.50. Medicines were provided to the sick at cost and a limited amount of financial aid was available in case of hospitalization.

These moves rekindled the enthusiasm of the people. In the first years of the clinic, the clients had been recipients of services and supplies. Now they were members, with certain obligations and responsibilities. They regained a sense of pride and dignity. The members from each squatter area elected "leaders" who represented them at meetings with clinic staff and acted as liaison between staff and members. In time, the clinic was serving 14 different squatter areas in the vicinity, but without an increase in volunteers it was not humanly possible to expand the services.

Phase III Trained Workers to Extend Clinic Outreach: After much consideration and discussion on how to meet the need for health services right in the communities, the idea of training primary health workers emerged. From 1972 to 1977, five groups of Katiwala were trained by the Development of Peoples Foundation.

The approach of the Katiwala Training Program comes from Paulo Freire's book, The Pedagogy of the Oppressed: "While no one liberates himself alone, neither is he liberated by others.... The correct method lies in dialogue." Thus, the Katiwala both learns and teaches in the training program. She both teaches and learns in her community. If a Katiwala moves around her village doing only tasks and forgets the process through which she accomplishes her goal, she loses touch with her community.

Training content is flexible enough to adjust to felt training needs of the participants. The students and teachers learn from each other, share insights and experiences. A spirit of freedom, enthusiasm, humor and camaraderie, and uninhibited questioning is encouraged throughout the sessions. No one fears ridicule.

Over time, and with greater experience, the content of the courses changed. More and more emphasis on preventive work, group dynamics, motivation, and demonstration techniques were integrated into what had been mainly training in curative medicine. Quizzes, field activities, and twice-a-week clinical apprenticeship were scheduled so that learning is better internalized. In addition, each trainee was paired with a graduate Katiwala who could help her practice her newly acquired skills.

Phase IV The Community-Based, Community-Serving Health Worker: Six years after the first groups of Katiwala were trained at the Development of Peoples Foundation, the Davao Medical School was established, under university and private sponsorship, to train medical students closer to their points of origin and to emphasize community (as against hospital) practice. The Katiwalas were trained on the same campus, in order to foster the teamwork and camaraderie that ideally should exist in a health team. Their training was also adjusted so that the future health workers would be less dependent on the core facilities in Davao City. The basic intent was to develop a program that could be expanded and replicated in other rural communities.

The Katiwala has thus evolved from being a clinic-aide with linkages to communities into a community-based and community-serving village health worker implementing her Katiwala Action Plan. This shift necessitated an emphasis on community building and resource mobilization, and over the years has resulted in the following program revisions:

- More intensive community preparation to receive and support the Katiwala, the first step being the active participation of the community in the selection of the Katiwala trainee;
- Integration into the training program of communication skills, community building techniques, and traditional medicine and folk practices found to have a scientific basis;
- Conduct of re-echo training in the communities by the Katiwala to speed up dissemination of health and nutrition information, and also to reduce overdependence on Katiwala time and services;
- Emphasis on the utilization of local community resources and leadership in the implementation of the Katiwala Action Plan. This includes setting up of a new medical and social-services referral system where there is no clinic to act as a central focus;
- Shift from purely health activities to health-related community development projects.

There are now 269 community-based, community-serving Katiwalas in the rural areas around Davao City. In the absence of public health services, the Katiwala delivers the following: maternal and child care; control of communicable diseases through motivation of the community to participate in sanitation and immunization programs; and first aid in emergency situations. In addition, the Katiwala is an organizer of family health classes, a coordinator of various social service programs in the community, and a community development worker, identifying and pooling resources toward community projects. The Katiwala is linked with the Institute of Primary Health Care at the hospital through a Katiwala Coordinator—a young, highly motivated college graduate who helps with community preparation, training, and evaluation, as well as with continuous program development. Continuing education and other helpful information sessions are held in the Katiwala communities.

For the first nine years, the Katiwala were recruited, trained, and fielded with minimal formal linkages with government agencies, although informal contacts existed with Regional Training Center and Ministry of Health personnel and vaccines, nutrition, and contraceptive supplies came from government agencies. Now, because of the expansion of the Katiwala program to the rural areas, and the resulting need for a system of referral to other government services, these linkages have been expanded and formalized.

A three-day field review of the Katiwala program was done in May 1979 by its national and international sponsors. Some of the findings were:

- Where the community was really involved in the choice of the Katiwala, there was very good cooperation, resulting in an effective Katiwala. Where the trainee was not really chosen democratically, but rather by the village captain and/or officials, the Katiwala was not accepted by the residents and consequently was ineffective;
- Where social preparation was done conscientiously, the residents understood the role and functions of the Katiwala and called on her, at first for health problems and later for leadership and liaison with other local officials. But where the Katiwala Coordinator, under time pressure, did not spend enough time in social preparation, the Katiwala was not "known" and could not be effective;
- Where linkages with government agencies were strong and the local personnel did not feel they had been bypassed, the Katiwala was accepted as a bona fide member of the team and was called on in the implementation of various local projects. In one area, however, the barrio captain was not properly approached and involved from the start; he subsequently blocked the work of the Katiwala and refused to have anything to do with the project.

Lessons drawn from the three-day review were as follows:

1. That proper linkages with the various government agencies at all levels are of primary importance.
2. That social preparation cannot be shortened without sacrificing the essence of the Katiwala program. Success depends on the understanding and acceptance of community members. Experience has shown that four months of intensive social preparation is the least time needed in order to explain the program.
3. That the Katiwala cannot be expected to remain only a health worker. As she matures and becomes more experienced, other opportunities will present themselves. Many Katiwala have evolved into resource mobilizers and linkage builders for their communities, initiating community development projects.
4. Primary health care workers from the community need not have a high educational attainment, but they must have a high degree of motivation to serve their fellows.

Given these elements, it has been demonstrated that government and private agencies can cooperate successfully and that a self-sustaining primary health care support structure can be established in rural communities.

Sarvodaya Children's Services, Sri Lanka

Leela Jayasekara

Sarvodaya Shramadana, in its literal sense, means the process of bringing about the AWAKENING OF ALL. Over the past 22 years, the Sarvodaya Movement--which was founded by A.T. Ariyaratne, a teacher from Colombo--had developed from a volunteer social service organization into a Movement that gets immensely involved in all aspects of community development, especially health.

At the inception, the volunteers worked with backward communities in the poorest villages to help people find ways to help themselves. They helped build roads, construct drinking-water wells, and dig toilets--any essential need which would benefit the entire community. Nowadays, the Movement is much larger and no longer depends on educated volunteers from the city. Villages that want to have Sarvodaya Children's Services take most of the responsibility themselves.

As a first step, once it has been invited by the village leaders to do so, Sarvodaya organizes a big work camp called a Shramadana. Work in such a camp is done by manual labor alone. A strict code of discipline is observed, and several hours a day are spent in labor and education through dialogue, lightened by song and dance. Participants practice the four principles of Buddhist philosophy:

- METTA, or respect for life, loving kindness, and the well-being of all;
- KARUNA, or compassionate action;
- MUDITHA, or the experiencing of dispassionate joy that one gets when one is involved in compassionate action; and
- UPEKHA, or equanimity, the development of a balanced personality.

These four principles, when practiced during shramadana activities, make people aware of their true meaning. Individuals learn to relieve each other's suffering and learn to live in groups as members of one family, practicing the age-old customs of DANA (sharing), PRIYAVACHANA (pleasant speech), ARTHACHARYA (constructive activity), and SAMANATHMATHA (equality). During a shramadana camp, the participants have an opportunity to discover that they can solve common problems themselves, if the spirit of awakening their own potentiality is exploited. The camp activities will be only the beginning of the process of satisfying the "Ten Basic Needs" of the community--environment, water, clothing, food, basic health care, housing, communication, energy, and education, both spiritual and cultural.

The methods used in the Sarvodaya approach are original, in that they harness every member of the community, irrespective of age and experience. During the work camp, various groups band themselves together into small organizations relevant to their ages and occupations. These organizations are the mark of a Sarvodaya village. There will be a Mothers' Group, two Children's Groups (pre-school and school-age), a Youth Group (ages 15-25), and Farmers' and other occupational groups. Taking off from the village development work started at the camp, and after mutual discussions with

their village elders, they continue as specific groups with their own special areas of work.

The Mothers' Group is considered the most important, since it is responsible for the welfare of the children, the most vulnerable population in the community. Each Mothers' Group has its own framework and codes of discipline, but they are all founded on the Sarvodaya philosophy. Mothers of all ages, including expectant and lactating mothers, are eligible to participate in the activities, which concentrate on health, nutrition, and pre-school education of a very elementary level. As Sarvodaya groups, they cooperate with other women's groups to make available better knowledge in the fields of rural crafts and small income-generating projects. They also see that food is made available every day to all the children who participate.

Every village has a center set apart as the Sarvodaya Children's Center. This is the place where the care of mothers-in-waiting is organized and where the older children start their own activities. Most important, the younger children, aged two to five, assemble here every morning to be fed and cared for. Each child contributes to the "family pot" and all share what is available—a bunch of flowers, a stick of firewood, a handful of green leaves for the morning cup of gruel, or whatever. The token "matchboxful of rice" that the children do not fail to bring is now a byword in Sarvodaya villages. At a very early age, the children learn the value of community living and sharing.

This service is manned by a volunteer from the village who has been trained for two weeks in nutrition, hygiene, and simple play activities at one of the 12 Sarvodaya Development Education Centers. Sarvodaya insists that the mothers of the community, who are the beneficiaries of the Children's Services in direct and indirect ways, select the volunteer to be trained. Experience has proved that any other source of recruitment has a feeble follow-up in the village. The trainee should normally be 18-25 years old, of good educational level, and in good health. She has to be free of family encumbrances. This rule has to be observed strictly, since the trained woman will have to serve without pay until the community can find sources of remuneration for her. The volunteer has to be acceptable to the village. She has to have a pleasing personality in order to be able to have good rapport with personnel from the public sector. Above all, she must have affection for children and be acceptable to them.

Once selected, the trainee has to make a survey of her village before she begins her course. This survey is done in order to make her aware of the possibilities and, more important, problems that she may face in implementing her program. The survey also helps the trainers to get a view of the area in which the trainee will work. (In some cases, Sarvodaya may be able to help get the public sector to correct such problems as water facilities or land.) The village elders, in the meantime, have to find suitable accommodation for the Children's Center and otherwise get the village ready to carry out the service as soon as the training is over; Sarvodaya does not assist in getting the environment ready. The entire community has to cooperate fully to make the Service a satisfactory one.

The first stage in the life of a trained community worker is to take over the activities of the Community Kitchen. The aims of the Community Kitchen are:

- To have an environment suitable for children;
- To cultivate a small home garden to assist the nutrition program;

- To have a small amount of food in storage to tide over lean times;
- To take good care of water and its storage, and to train the children to drink only boiled, cooled water;
- To have a toilet for the children and train them in good toilet habits;
- To have a compost pit for kitchen garbage, which will later serve as fertilizer for the home garden;
- To train children to share and altogether be good comrades at play.

After at least six months' experience, the volunteer may return to a Sarvodaya center for an additional training program of three months. In this course, the training is more specialized, involving greater numbers of professionals, and includes extensive exchange of ideas and experiences among the trainees themselves.

A further three-month training program in mother and child care, general health care, and administration is open to experienced volunteers who show special aptitudes. Medical personnel from the public sector take a leading role in this community health care training program, and the trainees have many opportunities to participate in health clinics and get to know the medical personnel in their district.

Once the trained health care worker goes back to her village, she has to take over the community health services in at least ten nearby villages in addition to her own, to bring good health care service, and to see that the state health authorities visit these villages regularly. She works out of the village community kitchen, aiming at motivating the mothers to get their pre-school children immunized and encouraging expectant mothers to attend the MCH clinics. She also helps mothers to learn good nutrition and gives advice in supplementary feeding of their breast-fed babies. (Sri Lankan mothers still have to learn that breastmilk is not all that is necessary for the baby until it is one year.) Another very important task is to see to the sanitation of the village, and start a campaign to clean wells and organize Shramadana camps to build toilets if there are not enough to meet the needs of the village. In these activities, the youth of the village come to her assistance very readily.

Sarvodaya's experience has shown that development activities should give a prominent place to women. Traditionally, the Sri Lankan woman had a very special place in the home, as wife and mother. Gradually, this dignified position deteriorated, due to the migration of male family members to urban areas in search of work. Now, with the progress of the re-awakening program of the Sarvodaya Movement, the dignity of rural labor is once again considered important, and the position of the woman is coming back into its own. Women are important because their natural interest will be toward the future, the future of their children. Through their participation, better facilities are extended to the children, who are the hope of the world.

The Vadu Budruk Project, Maharashtra, India

Banoo J. Coyaji

The first 20 years of my professional life were spent in setting up a modern department of obstetrics and gynecology and helping to set up a sophisticated teaching hospital with specialties and super-specialties. Like my colleagues at the King Edward Memorial Hospital (K.E.M.), a nongovernmental institution in Pune, I was blissfully ignorant of the health situation and health needs of the country. It began to dawn on me that there was something wrong when, in spite of excellent services at the hospital, there was still very high perinatal, infant, and maternal mortality, a high degree of anemia, a high incidence of preventable diseases, and a reluctance to accept family planning methods in patients coming from villages within 20 or 30 miles of Pune.

Out of these insights grew the Vadu Budruk Rural Health Project, an attempt by the K.E.M. Hospital to deliver comprehensive health care to a rural population in partnership with local and state governments. The project had its beginnings in the Rural Health Center at Vadu Budruk, set up in 1972 with financial support from OXFAM. Vadu Budruk was such a backward area that there were no facilities of any sort. The people wanted a health center, but there was a conflict between the community's idea of its priorities and ours. The villagers were interested only in curative medicine; they were lukewarm to what we thought was important--maternal and child care, immunization, sanitation, environmental medicine, and family planning. We had to compromise by providing curative medicine as an entry point for acceptance of a package of comprehensive health care.

It was soon apparent that curative care did not automatically lead villagers to change their habits with regard to preventing ill health. Furthermore, due to lack of roads and transport, nearly 70 percent of our patients came from an area within three miles of the center.

Therefore, in January 1977, with plenty of enthusiasm and very little expertise, we embarked on a scheme to put community health workers (CHWs) in 19 villages (total population 30,000) to mount a well-directed health education program for the village leaders and the community at large. Let it be clear that these community health workers are not doctors, barefoot or otherwise. They are not quacks let loose on unsuspecting rural masses, as detractors of this scheme allege. They are not physicians at all, nor are they extensions of physicians trained to replace or support them. They are, rather, trained for a task for which doctors are not adequately trained and which, with few exceptions, doctors do poorly or not at all.

The communities were involved right from the beginning. The scheme was explained at a public meeting. The villagers were asked to recommend women and men from their villages who they thought were suitable for part-time voluntary work. The most important criteria for selection were acceptability to the community, previous welfare work, and involvement in village affairs. A committee of representatives of the village community, the local district government, and the hospital selected 45 persons, 23 men and 22 women from among those recommended. Each of these received a three-week training course at Vadu Budruk, consisting of a few lectures, films, many demonstrations in the field, and group discussions. Great stress was laid on collecting vital statistics, health education, sanitation, maternal and child health, immunization, preventive and promotive care.

At the end, after evaluation and grading, 19 women and 20 men were finally selected to be community health workers. Their ages range from 20 to 50. Thirteen of the 39 belong to socially backward classes. Three of the women are completely illiterate and only two of the men have completed school. Fourteen of the 19 women are housewives, and only five of the young men are unmarried. Most of them are economically backward, with only ten having landholdings of ten acres or more.

Once trained, the community health workers were sent back to their own villages with specific tasks to do. No medicine or kits were provided for the first six months, although there was continuous in-service training and monitoring by the project staff. There have been several re-orientation courses of one week each where project work was reviewed, problems discussed, and solutions evolved. As skills were mastered, new techniques were introduced. Technical backing comes from multi-purpose workers and health assistants at the primary health units and from doctors at primary health care centers. These in due course will be converted into rural hospitals with a referral system right up to the teaching hospitals in Pune.

An important feature of the scheme is that a meeting is held in a different village each month, attended by the community health workers, the villagers, and project staff. This is a forum where the community discusses its problems with, or appreciation of, the volunteers and makes suggestions. It is this experience of articulating its needs and priorities which will eventually enable the community to take over the full responsibility for its health. There are many problems and pitfalls, not only medical but social, economic and political.

The community health workers are expected to function as important change agents in their village. They register all pregnant women, visit them in their houses, do Hb estimation, and distribute hematinics and calcium. They give advice on nutrition and health education and persuade pregnant women to have tetanus toxoid vaccine. An important task is to detect high-risk mothers and make sure that they are examined by the auxiliary nurse midwife, public health nurse, and, if necessary, the doctor.

Community health workers are encouraged to be present at deliveries to ensure cleanliness and take birth weights. They distribute compact delivery packs to each pregnant woman and teach the birth attendants, 82.5% of whom are relatives or neighbors, how to use them. They detect and transport abnormal cases to the health center. Eight have been trained as birth attendants, and others wish to be so trained. Postnatal visits are made regularly in the patients' homes, where the community health workers give advice on postpartum, neonatal care, cleanliness, and nutrition. The CHWs detect children at risk or with handicaps and refer them. Their skill at convincing villagers has helped us to achieve a high rate of immunization.

CHWs register all marriages, births, and deaths. They maintain an eligible couple register, and motivate couples for family planning. They are depot holders for pills and condoms, and bring cases to the health center for IUD insertion and sterilization, following them up for problems during home visits.

Health education is a very important part of their work. It is given during home visits, talks at village meetings, and orientation camps, using simple aids and wall posters. Nutrition and nutrition education is another important activity. CHWs are involved in the Casa Feeding Program for children, encouraging kitchen gardens and the planting of fruit trees. They have helped us to spot children with night blindness in 14

of the 19 villages and to treat them with massive doses of vitamin A. They also encourage cleanliness of the home and its environs, disinfect wells and ensure that they do not become infected. They organize disinfection of river water with chloriwat, disposal of wastewater in soakage pits, and building of sanitary latrines.

CHWs take slides in cases of fever, start presumptive treatment with chloroquine, and give curative treatment to positive cases of malaria. They give simple sulphaguanadine and start oral hydration in patients' homes for gastroenteritis. Treatment of minor ailments like cold, fever, minor skin problems and first aid is given. They follow up long-term therapy of tuberculosis and leprosy at home. They are taught their limitations and are responsible for quick referral of cases beyond their competence.

The community health workers are also agents for social change. They have persuaded villagers to allow backward-class people to use the common well and enter temples. They have formed cooperative societies, women's clubs, farmers' clubs, and youth clubs.

We were amazed at what the villagers can be taught to do for themselves. Much of 1977 was spent in learning, collecting vital statistics, and making mid-course corrections. Yet, by 1979, the following had been achieved:

- Awareness of their health needs by the community;
- 100% registration of antenatal cases and their coverage with nutrition supplements;
- Sterilization of 55% of eligible couples;
- A birth rate of 26 per 1,000;
- A high immunization status; 87.5% of pregnant women have received three doses of tetanus toxoid vaccine;
- 50% reduction in incidence of malaria and gastroenteritis;
- 100% disinfection of public wells, building of soakage pits, sanitary latrines and gobar gas plants; and
- Flourishing of kitchen gardens and fruit trees.

We have also learned some lessons:

1. The target population is scattered over a large area; poor roads (which are water-logged in the rainy season) and poor transport facilities make communication difficult.
2. There is a shortage of professional personnel at all levels, especially of those capable of training the trainers of community health workers. Doctors are not available to man the health centers. Their turnover is very high, since doctors are interested mainly in private practice. They have no concept of community health and are not capable of training or supervising paraprofessional and village health workers. They judge their effectiveness by the number of people who crowd their out-patient departments:

This is not the fault of the doctors but of their training. Medical education as it exists today has no relevance to the needs of health care of rural India. As in other developing countries, key senior medical personnel and planners have received much of their training in the West. They have tried to establish similar systems of medical care in India, with their super-specialization and skyrocketing costs. Medicine as it is practised in New York and London cannot be expected to meet the needs of our remote villages and tribal areas, where the doctor/population ratio is anything between one in 30,000 to one in 100,000.

Similar comments can be made with regard to nurses and auxiliary nurse midwives, who are being trained in city hospitals with emphasis on curative services. The first necessity is to retrain the available doctors and nurse midwives and change the curriculum of medical education to lay great stress on community health. The nurse midwives need to be trained in rural hospitals, in the milieu where they will have to function. The 30-bed rural hospital and the Auxiliary Nurse Midwives Training School now being established at Vadu Budruk are steps in the right direction.

3. We have found that a three-month training course, however intensive, is not satisfactory for community health workers. They cannot absorb such concentrated training, and yet they cannot leave their homes, families and jobs for a longer period. Repeated re-orientation courses of one week are more useful, and provide feedback for future training. Continuous in-service training, supervision, and support pay the greatest dividends.
4. The practitioners of indigenous medicine are an important resource which must be brought into the mainstream of community health care. Even today the majority of the people go to the traditional healers for their health needs. Cannot they, with some training in community health, be absorbed into our health service? There is much resistance. Ayurveda has a great deal to offer. If practitioners of modern and traditional medicine come together with an open mind, maybe from the grass-roots it will be possible to integrate a health delivery system that is truly national.
5. Rural health is a bottomless pit unless there is socioeconomic development. Participation, mobilization, and total involvement of the masses is a prerequisite not only in providing rural health, but in all rural development.

Maisons Familiales Rurales, Senegal

Fatou M'Baye

The African woman must be educated to juggle her position in the traditional society, to adapt herself to a new situation, and to accomplish some new aspirations. In order to reach these objectives, several factors, which are characteristic of women's situations in developing countries, must be taken into account.

On the negative side, one finds: economic stagnation; underemployment in subsistence agriculture and absence of other employment opportunities; cultural traditions hindering development efforts; traditional tasks which are particularly difficult—carrying water, wood, and other heavy loads, agricultural work using traditional tools, pounding and crushing of grains and almonds, meal preparation with traditional utensils and ovens, etc.; mediocre living conditions because of a scarcity of goods, services, and, above all, financial means; isolation, with few means of communication; inadequate health services; unfavorable environment, exposing women to communicable diseases and malnutrition; lack of political representation and participation in national decisionmaking processes; attitudes of men, who tend to look down on women's roles in the majority of African countries; attitudes of women, affected by a contradictory situation of conservatism and change.

If African societies have negative aspects in terms of women's development, they also have some positive ones as far as women are concerned: The existence of villages gives a natural social organization. Training of artisans, medicine men, etc., is part of the cultural life, linked to traditional rites and popular festivals and passed from mother to daughter. There is a traditional pattern of equality or complementarity between men and women; in certain African traditions women are even superior (e.g., there were queens in ancient Dahomey and matriarchal societies in parts of Senegal). Religious beliefs are open to change (e.g., the animist societies of lower Casamance and Thiès regions in Senegal).

In Senegal, after independence, women felt a need to organize themselves at the local level. In this way the community organizations called Maisons Familiales Rurales were created after 1964. By 1978, 28 Maisons Familiales had been organized in the regions of Casamance, Thiès, Diourbel, and Fleuve. Membership had grown to 2,951 men and 3,089 women. A general assembly of delegates, elected democratically by the branches, meets at the end of each year to assess their mission and make suggestions for the future.

The Maisons Familiales are not like other traditional organizing structures. They are a creation of families grouped in an association of parents each of which decides its own orientation. Their effectiveness depends in great part on the dynamism of the members who make up the organization. Local Maisons Familiales are supported by local dues and by central and regional structures; the latter, with financial assistance from the government, provide training to community "monitrices" in organizational techniques, agriculture and animal husbandry, marketing, health, homemaking skills, childrearing, etc. By July 1978, five groups of about 25 community workers each had been trained and three more were at various stages of their three-year training course. The course pays particular attention to the mobilization of young people in rural settings.

The results of the branch associations can be considered generally positive in spite of some gaps here and there. The branches have not yet learned, however, to take enough responsibility on their own. This may be due to insufficient training at the branch level; the members' fear of managing in the present environment of insufficient guarantees, especially of money; and the unwillingness of trained staff to turn over responsibility to people who cannot read and write. (To these last we say, remember the Wolof proverb, "No one can be a teacher of anything when he has never been a student.") Nonetheless, there have been some heartening instances of mutual aid among the branches. For example, the branch at Diaoule, with help from the National Committee, organized an operation of solidarity in favor of the members in Guede, which was suffering from drought; they sent five tons of millet for 25 francs per kilo, 15 francs under the market price. The spirit with which this operation was carried out merits attention.

Project PUSH, Panay Island, Philippines

Estela Rose Villarete

The Panay Unified Services for Health Project, otherwise known as Project PUSH, which was jointly designed and financed by the Government of the Philippines and the U.S. Agency for International Development, is a complex, multi-level, multi-agency effort to extend the services of several government agencies to 600 depressed barangays (villages) on Panay Island in the central Philippines, while at the same time avoiding duplication and overlapping of government programs. Responsibility for implementing the project lies with the Regional Development Agency; each agency and each level has identified roles and functions within the structure.

Statistics reveal that more than half of hospital admissions in Panay are due to preventable diseases related to deficiencies in nutrition, sanitation, or personal hygiene. Although the island produces food (rice, fish, fruit, and feed grains) in excess of its consumption needs, 85 percent of its young children are malnourished. The area also suffers from very high tuberculosis and pneumonia rates. Poor water supplies and sanitation facilities have made gastroenteritis and parasitism the third and fourth most common causes of illness. Health and nutrition problems are complicated by a high birth rate, which further increases the burden of feeding the family on meager family incomes. It has been estimated that only 15-20 percent of the total population, and far fewer in the rural areas, have access to adequate medical care.

Project PUSH began in early 1979. Under the Regional Development Council, the project administration has begun to drill new deep wells in some areas and shallow driven wells in others, to improve open dug wells, and to construct water-sealed toilets in the target villages. It will help to organize village-owned and -managed drugstores stocked with commonly used over-the-counter medicines at reasonable prices. Four provincial health laboratories will be upgraded to improve early detection of tuberculosis.

But the key to the project is the Barangay Health Worker (BHW), a resident of the village nominated by the village assembly to respond to simple medical problems and undertake preventive and promotive health activities in the village. BHWs must be between 18 and 45 years old, with at least six years of formal education, and willing to commit themselves to working full time in the village for at least a year. It is important that the BHWs be widely respected and possess leadership ability, since they serve as the community's link with higher levels of medical care and other government development programs.

The BHWs are paid employees of the provincial government working under the supervision of Rural Health Midwives and Rural Sanitation Inspectors. After six weeks of basic training from cooperating agencies, the BHWs function as extenders of the services provided by the area Rural Health Units at the barangay level. They work in seven general areas—environmental sanitation, family planning, nutrition, communicable disease control, curative medicine, vital statistics, and community organization—to identify community needs, organize community activity, mount educational campaigns, refer patients, etc. They provide nutrition services and commodities to malnourished children and act as re-supply points for contraceptives. The BHWs do not, however, duplicate or replace the services of existing community workers or other government agencies. Where services already exist in the barangay,

the BHW's role is facilitative and assistive. Where services do not exist, the BHW must act as initiator, organizer, and interim implementor until the activities can be transferred to the appropriate government agency or institution.

For its part, in addition to nominating the BHW, the barangay community assembly is expected to pass a formal resolution accepting the project and to commit itself to provide the labor and local materials for any infrastructure project built in the village, as well as to maintain the wells and other environmental sanitation projects once they are built. The decisionmaking process in the barangay is aimed at the attainment of a self-reliant community. The villages themselves choose which health-related projects to work on, with the BHW acting only as a facilitator and resource allocator.

Although the project began two years ago, eight months were needed for organizational activities, conducting orientation and planning conferences, training of trainers, and conducting management workshops at different levels involving different agencies. By mid-1980, the project had been able to recruit, train, equip, and deploy 100 Barangay Health Workers. Actual field work of the first batch of 26 BHWs started on September 1, 1979; the second batch of 24 BHWs commenced work on December 16, 1979, and the third batch of 50 in June 1980.

Table 1 shows the accomplishments of the first two groups of BHWs in the part of the program devoted to building environmental sanitation infrastructure. In addition, the BHWs were able to mobilize their communities in other health-related projects such as construction of 719 units of blind drainage for liquid-waste disposal and 600 compost pits for solid-waste disposal. Weekly feeding programs for children were organized. Mothers' classes were conducted, and barangay communal gardens were maintained, the excess from which can be sold to fund other community health projects.

Ultimately, with the help of the BHWs and the cooperating government agencies, the project hopes to reduce the incidence of tuberculosis, tetanus, and gastrointestinal infection by 25 percent; immunize at least 70 percent of the target population with BCG and DPT; reduce infant mortality by 25 percent; reduce the crude birth rate from 31.5 to 24 per thousand; increase contraceptive use from the present 23 percent to 38 percent; greatly reduce the incidence of second- and third-degree malnutrition among children six years and younger and rehabilitate at least 10,000 existing cases; provide an adequate safe water supply to 80 percent of project households; and provide integrated health services in the 600 target barangays.

Table 1. Comparative Chart On Project Accomplishments In Relation To Targets By Province*

Province	Targets for 8 Operational Months September 1, 1979 to May 31, 1980				Project Accomplishments as of May 31, 1980				
	Drilled Deep Wells	Shallow Driven Wells	Open Dug Wells Improvement	Household Toilet Facilities	Drilled Deep Wells	Shallow Driven Wells	Existing Open Dug Wells Improvement	Spring** Development	Household Toilet Facilities
Iloilo	18	18	36	360	18	18	18	-	360
Capiz	10	10	20	200	10	10	5	1	200
Aklan	8	8	16	160	-	55	-	-	425
Antique	10	10	20	200	-	-	-	6	300
Guimaras	4	4	8	80	2	7	3	2	157
TOTALS	50	50	100	1,000	30	90	26	9	1,442

* Source: Villarete, Estela Rose, "The Role of the Barangay Health Worker." Philippines: Project PUSH, June 1980 (Mimeo).

** Reallocated from deep drilled wells especially in areas where drilled wells are not feasible due to very low water level.

Two Projects in Rural North Carolina, U.S.A.*

Ethel J. Jackson

The School of Public Health of the University of North Carolina at Chapel Hill has been involved in two interesting self-help demonstration projects that have relevance for developing countries as well as for rural communities in the United States. Both projects focus on poor black neighborhoods in rural Chatham County.

The first we call the "Black Churches Project," which is now in its second year. This project was started after a number of black ministers approached Dr. John Hatch, of the School of Public Health, for help. They were concerned about health problems in their communities—especially hypertension, diabetes, and problems with pregnancy due to poor nutrition or lack of prenatal care—that were not being addressed adequately by existing public services. Ultimately, the project involved a cluster of black churches within seven miles of one another, chosen not only for reasons of administrative convenience, but also because we hoped that the churches would work together on other community development projects in the future.

Historically, the church was one of the few places in the American South where Blacks were allowed to meet in groups and develop talent and leadership. Today, the church still plays a central supportive role in Black communities. It plays a significant part in caring for the ill and giving support to families in times of crisis. Important community events are announced at church, and after services the members informally exchange information, give accounts of friends and family, and often arrange for the exchange of labor and other resources. We felt that by working with the church, an institution that would remain in the community long after we did, we could strengthen and expand social-support roles that the churches were already playing. Through the church, we hoped to involve community members in collective action, which is at times the only way for people living with conditions of poverty and racism to exert an influence over their environment.

With the approval of the ministers, we asked each church congregation to choose three well-respected people, one man and two women (we suspected that men might talk more readily to other men about certain types of problems), who would attend 12 to 14 evening training sessions run by the project staff with the help of resource people from local human-services programs. By selecting the participants themselves, the churches began to accept ownership of the project. Other ways in which we encouraged ownership by the community were by having participants select topics and identify and invite speakers, and by holding the meetings in each of the eight participating churches on a rotating basis.

* This paper is based on "A Report on the Rural Community Environmental Education and Action Project" by John W. Hatch, Ethel J. Jackson, and Marquis A. Eure, a paper presented at the 107th Annual Meeting of the American Public Health Association in New York City, November 7, 1979. It is also based on the article, "Involving the Southern Rural Church and Students of the Health Professions in Health Education," by John W. Hatch and Kay Lovelace and published in Public Health Reports, Vol. 95, No. 1, February 1980.

Ultimately, 12 women and six men attended the training sessions. At their urging, alcoholism, teenage pregnancy, child abuse, and housing problems were added to the list suggested by the ministers. As important as specific content was the substantial skill-building component included in the training. Role plays, games, case studies, modeling, and involving participants in decisionmaking for the project all formed part of the training, as did practical advice on counseling, use of community health and human services resources, operation of audiovisual equipment, and development of ways to involve the entire church in health promotion.

One session on teenage pregnancy illustrates the value of the techniques used. We knew as we planned the session that among the participants were people with many different beliefs and values concerning adolescent pregnancy. After a spirited discussion based on a pictorial representation of the problem, it was clear that the participants considered teenage pregnancy an interactional problem in their community, not just a problem of lack of information. Suggestions for community action included sponsoring a group for community teens and/or a group for parents to deal with the problem. Had we confined ourselves only to providing information at our session, we would have neglected important community needs. Similarly, a session on hypertension revealed many local beliefs with which we were not familiar; had we not been able to deal with these, our advice on good health practices might have been ignored.

Evaluation of this project has been difficult because we have not wanted to interfere with existing styles of community interaction. The idea, after all, was to give added knowledge and skills to health opinion leaders and natural helpers in the community who were already providing informal services. Nevertheless, we see this project as a model which could be used by community health centers to extend their education services beyond the clinic walls by drawing on community institutions that are already providing vital support functions.

The second project of interest and general relevance concerns a self-help approach to environmental risk reduction. The rural poor in our area are at risk from a number of preventable health problems associated with hazardous conditions in their homes. For example, four times more rural poor people die or are injured in fires than people occupying better housing in better protected communities. Some of these hazards--such as structurally unsafe housing or reliance on unsafe heating equipment--are primarily associated with poverty. Others may be attributed to lack of knowledge as to the risk involved in using an unprotected water supply, relying on waste disposal systems that promote the growth of insect populations, feeding infants food that has been contaminated by rodents, etc.

Short of national commitment to provide decent housing for all (which seems politically unlikely at this time), much can be accomplished on a self-help basis by educating and mobilizing the rural poor. Thus, an adequately maintained outhouse may be safer, from a health perspective, than an indoor toilet connected to an inadequately designed or improperly placed septic tank, even if the local housing code specifies indoor plumbing as "standard." Again, a wood-burning stove of appropriate design, properly installed and maintained, is preferable to a "more advanced" unit that contains engineering defects or is difficult to maintain because replacement parts are not available or affordable.

For these reasons, the overall goal of our 1978-79 Community Environmental Education and Action Project was to develop community problem-solving capacities and self-reliance for dealing with environmental problems. We estimated that local

residents, with minimal outlays of money and technical support, could themselves reduce 75-80 percent of the hazards in their community.

Project staff included a director, a project coordinator (who was a health education specialist), a handyman with skills in carpentry, masonry, and bricklaying, and two graduate students in the Department of Health Education. They conducted educational seminars to develop community awareness of the health toll that hazards take as well as workshops to teach people how to eliminate basic defects. Local residents were encouraged to organize themselves to remove certain hazards and to develop linkages with local service agencies (such as the Community Action Agency, Council on Aging, etc.) so as to obtain help in removing others.

In order to encourage local residents to assume an active role, the project staff began by focusing on the hazards that initial survey revealed were viewed as priorities by the community--rotten porch floorboards, rotten steps, leaky roofs, missing or broken railings, broken windows, etc. A series of informal committees were established to do most of the work. Thus, a Telephone Outreach Committee informed people of meetings and other events of community interest; a Materials Committee searched for cheap or donated home-repair materials; a Social/Fundraising Committee coordinated fundraising activities, community socials, etc.; Men's and Ladies' Groups helped make the actual repairs in participating homes; and a Youth Committee helped on neighborhood cleanup as well as painting and repairs at the local community center. In addition, the local Community Action Agency was drawn into a community effort to get its water supply upgraded. In the end, of the 59 specific hazards identified as first priority by the community, 52 were actually reduced. (See Table 1.) One of those was the porch of an elderly lady who kept small children for working mothers during the day; her back porch was in very poor condition and some children had already fallen through the rotting floorboards.

We believe that this project demonstrated that self-help is an effective and low-cost approach for reducing environmental hazards. It also demonstrated that local residents can organize, plan, and implement activities for reducing health and safety risks in their homes and community and, in the process, develop confidence in their abilities to deal effectively with other such problems.

Table 1. Reduction of Risk Factors Identified by the Community¹

1 Category of Risks	2 Health/Safety Risk Factors	3 Number of Requests For Repairs	4 Number of Repairs Made
A. Risk Factors Related to Thermally Inefficient Homes	1. Leaky roof	7	4
	2. Door won't open or close*	4	4
	3. No plastic or storm windows	4	4
	4. Leaky Plumbing	2	2
	5. Windows that wouldn't shut*	1	1
	6. Broken window-panes*	2	2
	7. Uninsulated pipes	1	1
B. Risk Factors Related to Structurally Unsafe Housing	1. Rotten porch floorboards	15	14
	2. Rotten porch steps	14	13
	3. Handrail missing, worn, broken or unstable	6	4
	4. Unstable porch column	1	1
C. Risk Factors Related to Insect, Vector and Rodent Control	1. Screens torn	2	2
TOTAL		<u>59</u>	<u>52</u>

* Items starred once are also related to insect, vector and rodent control.

1. Source: Hatch, John W.; Jackson, Ethel J.; Eure, Marquis A. "A Report on the Rural Community Environmental Education and Action Project." Paper prepared for the 107th Annual Meeting of the American Public Health Association, New York, N.Y., 1979.

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VIII. SOME NATIONAL AND INTERNATIONAL STRATEGIES

Despite the leavening effect of the many innovative projects mounted by nongovernmental organizations, government institutions carry most of the responsibility for delivering health care to the mass of rural people. Their policies are therefore of the utmost importance. As the papers in this section and elsewhere indicate, two large international conferences--the International Women's Year Conference of 1975 and the Alma-Ata Conference of 1978--have had considerable influence on the direction of official policies for integrating women into development planning and, in the health sector, for promoting the concept of primary health care for all, with specific emphasis on women and children. Isabel Rojas-Aleta offers some details regarding recent policy shifts in Southeast Asia. Theresa Lukas reports on U.S. efforts to integrate women's concerns into AID programming generally and the health sector in particular. Susan Cole-King maintains that the Alma-Ata recommendations provide a good starting point for open-minded, practical evaluation of primary health care programs.

Other papers in this section reflect some of the newer concerns regarding women's health that were discussed at the most recent international conference of importance to women--the World Conference of the United Nations Decade for Women held in Copenhagen in 1980. Thus, Jeyarajah Jeyaratnam, from Sri Lanka, and Wei-nan Cheng, from China, pick up on one aspect of women's health that was much discussed at Copenhagen, that of occupational health and governmental efforts to mitigate the effects of toxic substances on women and their offspring. Billie Miller explains why the population policy of Barbados must deal with teenage pregnancy, abortion, and women's rights as well as with more intensive family planning programs. One's general impression is that governments are moving, usually slowly but sometimes boldly, to bring their policies into line with internationally supported recommendations.

Women's and Health Programs in Southeast Asia*

Isabel Rojas Aleta

In Southeast Asia, national development plans issued after International Women's Year in 1975 reflect the desire for coordinated planning for the integration of women in development. Examples are Malaysia's Third National Development Plan and Thailand's Fourth National Economic and Social Development Plan for 1977-81. The latter includes among its new integrated development strategies the strengthening of the status of women and youth and the involvement of its national planning agency in the formulation of medium- and long-term plans to raise the status of women.

In Malaysia, the National Advisory Council on the integration of women in development was established by the government in 1976. It advises government and nongovernmental organizations on program directions, serves as central machinery for the submission of women's problems, and provides a liaison with appropriate authorities. The Council has formulated a plan of action which covers education and training, equal participation, health and family planning. The plan urged the examination of legislation on marriage, divorce, citizenship, immigration, legitimacy, inheritance, taxation, pensions, and how these affect women's rights to equal treatment.

The growth of Malaysian multipurpose women's cooperatives, which now number 51, is especially noteworthy. One of the oldest and biggest of these is the Ayer Hitam Women's Multipurpose Cooperative. Established in 1964, it now covers a population of 52,000, of whom 22,370 are women. The cooperative has involved itself in such activities as land redemption, land development, and home management. For several years now, it has been functioning without any direct government assistance and administration, having made a profit of more than \$250,000 as early as 1975.

The Indonesian National Plan of Action was created by an interministerial committee as part of an overall national development plan designed to become a master plan for government and private organizations. The Plan is multisectoral and includes sub-plans of action for politics and law, economics (including migration, employment and cooperatives, and social welfare), and areas relating to family, health, rural development, and culture. It includes specific activities to heighten women's participation:

- Assistance to women's organizations at the national and regional levels through the Associate Minister of Women's Affairs to improve the managerial and leadership skills of women;
- Training of village women leaders of the family welfare movement in planning, organizational, and managerial skills;

*This paper is based on Isabel Rojas Aleta's paper, "A Review and Comparative Analysis of Roles and Status of and Programs for Rural Women of ASEAN Countries," presented at the ASEAN Consultation Workshop on the Role of Women in Population and Development sponsored by the Food and Agriculture Organization and the Population Center Foundation, Manila, Philippines October 29-November 2, 1979.

- Family-life education for non- or sub-literate girls and women, including literacy and civic and practical skills for better family life.

Kowani (Congress of Indonesian Women) is the umbrella organization for about 42 kinds of women's organizations throughout the country. Its objective is to strengthen women's rights, solidarity, and cooperation among Indonesian women. It has promoted home industries and handicrafts, community development training for women, preschool education and child welfare, guidance of women and girls in the area of marriage, family welfare, legislation, labor, and family planning.

In the Philippines, the National Commission on the Role of Filipino Women was created in 1975 by presidential decree to serve as a coordinating body with interdisciplinary and multisectoral representation from both government and private sectors. It was mandated by the government to advance the status of women and facilitate their effective participation in national development. A *Balikatan* (shoulder-to-shoulder) movement was launched by the Commission in January 1977 as its prime strategy for fully integrating women in programs for social, economic and agricultural development. This is being achieved through coordination of government and organized private-sector affairs rather than by establishing a new entity or superstructure. By the end of 1978, the movement had spread to almost all provinces.

The *Katipunan ng Bagong Lipunan* (KBP), or Association of the New Filipina, is a national organization of rural women aimed at promoting equality with men in law, in employment, and in the home. KBP membership was 8,000 in 1972, two years after it was organized; by 1978, the association had 16,000 members in 17 provinces, with its various chapters engaged in money-making projects. The association encourages self-help projects at the community level and supports government programs that will raise the consciousness of the people.

All national development plans of the Association of Southeast Asian Countries (ASEAN) are concerned with maternal and child health and family planning; this latter is particularly important, since almost half of the maternal deaths are associated with high birth rates, high parity, and advanced maternal age. A number of national plans reflect a new concern for women as whole beings, rather than merely as reproducers. There is also recognition that their social role has an important consequence in the health and nutritional status of the family and community.

Much improvement in health care has come about with the establishment of rural clinics to provide maternal and child health care. However, the increase in the health standards of women and female children is not yet satisfactory. Thus, some ASEAN countries have adopted the new approach being promoted by the World Health Organization (WHO)—to provide primary health care for all, especially the rural population. In the Philippines, Thailand, and Indonesia, pilot primary health care programs are currently being developed and tested.

In Malaysia, the majority of women have access to family planning and fertility information services. Among the countries which have experienced a reduction of 25% or more in crude birth rates are Malaysia, Singapore, and Thailand. Lesser declines are reported by Indonesia and the Philippines. An Indonesian fertility survey shows that from 23 to 30 percent of married women are currently using contraceptives. In

Thailand, 51.2 percent of married women at reproductive age who were surveyed in 1978 had used contraceptives at least once, though only 36.7 percent were using them at the time of the survey. Although birth rates are declining, the use of contraceptives has remained largely a woman's concern. In Singapore, for example, 49 percent of women aged 15 to 44 years, were practicing reversible contraceptive methods, and another 21 percent had been sterilized but only one percent were protected because their spouse had a vasectomy.

In Indonesia, the number of public health centers, which are responsible for maternal and child health care, increased by 62.7 percent (from 1,058 to 2,843 units) between 1969 and 1975. At the subcenters, a trained village midwife is available for every 18,000 women to provide maternity care and family planning services.

Nutrition education, which targets mostly women, is conducted through several programs by different agencies in all of the ASEAN countries. Taman Gizi, the nutrition rehabilitation center in West Java, Indonesia, for example, serves as a focal point for nutrition education for mothers in pilot villages and for feeding programs for the rehabilitation of their malnourished children. In addition to nutrition education, the program in the Philippines includes such activities as food supplementation and food production campaigns conducted in coordination with government and private agencies.

A review by Teresia Silva of 21 projects aimed at strengthening the role and participation of rural women in development in seven Asian countries (including Indonesia, Malaysia, Philippines, and Thailand) resulted in the following observations, among others:

1. At least ten of the 21 projects are described as integrated rural development projects in which women are assisted to develop themselves and to participate, in partnership with men, in several interrelated and multisectoral programs. Program components include health and nutrition, functional literacy, income-generating activities, agri-skills training, cooperatives, development of women's organizations, and appropriate technology. In 15 projects, the field worker is an outside person employed and trained by a government ministry or nongovernmental organization.
2. There is a lack of articulation in most of the projects of objectives and program elements that aim to raise rural women's level of consciousness and motivate them to develop positive attitudes regarding their roles and status.
3. In a number of projects, participation of women is limited to implementation, where they are seen primarily as beneficiaries rather than as partners in development.
4. Capacity-building is often overlooked. Where the projects do identify self-reliant development as a goal, there is a strong emphasis on intensive and continuing training in leadership and managerial skills for indigenous women workers, leaders, organizations, and members. Significant attention is also given to self-evaluation and criticism as well as to motivation through peer recognition.
5. There are clearly identifiable strategies utilized in the different phases of development activity regarding women; in chronological order they are: data gathering; raising of awareness; group formation; and training of women and groups to act as pressure groups, express their opinions, and make decisions.

Based on these general insights, the following recommendations are made:

1. To achieve equitable development, the needs and activities of women should enable them to become self-directing individuals or groups. This requires not only functional literacy, but also positive attitudes toward self-reliance and skills in problem-solving, organizational leadership, and management of projects.
2. Rural women need assistance to ease the burden of their traditional roles so that more time and energy are released for their involvement in new economic and social activities. Assistance in the performance of two of their most difficult tasks, gathering firewood and carrying water over long distances, is especially important.
3. The dearth of research on the situation of rural women, the limited services and activities implemented for and by women, as well as the lack of evaluation and documentation of ongoing programs, emphasize the need to support basic and action-oriented participatory research studies. The research should not be merely academic, but should aim to involve rural women themselves in the research process, and the objective should be the development of replicable prototypes which can serve as links in a chain leading to greater and more systematic change.
4. If women are to become effective partners of men, developmental efforts should be integrated with those of men in all sectors. The involvement of men can facilitate the sharing of roles and the participation of women in other affairs outside their traditional activities.
5. There is a need to seek out capable and committed change agents. Emphasis should be given to the training of middle-level and field workers to acquire the necessary human and technical skills in the management of such programs. Where possible, field workers should be local and identified with the community.
6. Another important and urgent task is to expose decisionmakers, most of whom are men, to the problems of poor rural women and to the importance of their roles in rural life. In this way, the decisionmakers can gain insight into what women do and what needs to be done.

Governments have taken the lead in the development of women, primarily through the formulation of policies, goals, objectives and plans of action and budget allocation in national development plans. But much more could be done, especially in the area of legal status of women, providing accessible rural services, enhancing the participation of women in the full range of public services, educational and employment opportunities, research and information exchange. Furthermore, nongovernmental and international agencies, in line with national plans for the development of women, can continue to serve as catalysts for the development and validation of innovative schemes that can serve as vehicles of change for the development of rural women.

Approaches to Occupational Health

Jeyarajah Jeyaratnam

For demographic, humanitarian, and economic reasons, the provision of health care to the working population must be considered relevant and important. Unfortunately, our colonial heritage had a stifling effect on the development of occupational health programs in Sri Lanka, since, following British tradition, responsibility for occupational health was given to the Department of Labour, whose main interest was to enact and enforce legislation rather than to provide health services.

Within this general climate of neglect, the health of women workers has been neglected even more, despite an increase of nearly 30 percent in the labor force participation rate of females between 1971 and 1981. An analysis of women in employment indicates that 22 percent of the workforce in Sri Lanka comprises women. Approximately 60 percent of the females employed work in agriculture, the majority of them on tea and rubber estates, where they outnumber male workers. Their work usually consists of plucking tea leaves, tapping rubber latex, weeding, and picking coconuts. Women are also heavily represented among nurses, teachers, medical doctors, stenographers, typists, maids, weavers, tailors, potters and clay workers.

The most important question that needs to be asked with regard to women in employment is whether there exist jobs which are a hazard to women's health exclusively. In this context, the one subject that immediately comes to mind is the relation between pregnancy and work. From the scientific standpoint, there are extremely few work situations where a female should be excluded on health grounds. Those most commonly discussed are situations where parents are exposed to chemical substances like methyl mercury, vinyl chloride, lead, benzene, and anesthetic gases which are potentially hazardous to the offspring. There is evidence that some occupational chemicals may have adverse effects on the male reproductive system. But in the case of teratogens, or transplacental carcinogens, it is only the mother's exposure which could affect the fetus. To this extent, the problem is sex-specific. Since the subject is very much in the grey area of knowledge, it is virtually impossible to lay down accurate guidelines for the control of the working environment. Nonetheless, the potential for transgenerational carcinogenesis clearly exists.

What are employers using fetotoxic chemicals to do? One alternative often suggested by female workers employed in such a situation is the use of a waiver of liability. This solution is unacceptable in principle and in addition makes the employer potentially liable to later suit from the child who may suffer the consequences of his mother's exposure. The alternative of removing female workers from a potentially hazardous environment once they discover they are pregnant is unsatisfactory, since by then the damage may already have been done. Thus there is no satisfactory approach other than to invoke all possible avenues of worker protection before considering the adoption of exclusionary employment practices.

Besides chemicals, physical factors related to certain occupations have been identified as having a deleterious effect on the childbearing capacity of the female worker. For instance, in Iran, carpet weavers must sit in cramped positions for long hours, resulting in skeletal deformities in the fetus; in some cases, these women have to be delivered by Caesarian section. In India, heavy physical labor in the tea estates, jute

milling, and at coal mines are thought to be important factors in contributing to fetal wastage among workers who become pregnant. In these cases, the problem is relatively simple; employers can easily remedy the situation and prevent any hazard to health.

How Occupational Health Problems Are Handled In China

Wei-nan Cheng

The Chinese Constitution, adopted following the founding of New China in 1949, stipulates that "women enjoy equal rights with men in all spheres of political, economic, cultural, social and family life." Men and women receive equal pay for equal work. Women in China take an active part in productive labor. In the cities, there are 30 million women workers and office employees. The total number of women who work in party or government organizations has reached 4,300,000, while one-third of all primary and middle-school teachers, 26 percent of the lecturers and professors in higher institutions, and one-third of the technical personnel are women. Among the country's eight million doctors and paramedical personnel, 58.6 percent are women. In agriculture, women constitute about half the labor force.

Since China's liberation, four cardinal principles have been conscientiously implemented in health work: (1) serve the workers, peasants, and soldiers; (2) put prevention first; (3) give full scope to both Western and Chinese traditional medicine; and (4) facilitate medical work by mass movements. All medical care is free in the city. In the countryside, over 90 percent of the production brigades have cooperative clinics that provide clinical care throughout the year for a low fee. If occupational disease occurs, labor legislation permits the transfer to a safer area or retirement with full pension, based on the individual's entire wage.

The occupational health of women in China is intimately related to the position that women occupy in China's social system. In the past, occupational health problems were viewed from the point of view of men's physiology. In recent years, much greater attention has been paid to the specific needs of women.

As in other countries, many new chemical and physical agents are found in developing industries, and some of these have uncertain health effects. Therefore, regular medical examinations are instituted and industrial hygiene measures incorporated. Threshold-limiting values also are instituted to minimize possible occupational disease. We are greatly concerned with several health matters where women are particularly at risk. One of these is the problem of toxic substances that pass to infants from mothers in breast milk. We are also monitoring many agents for possible teratogenic effects, and are investigating the whole question of toxic substance-induced anemia and thrombocytopenia, which might result in increased menstrual blood loss. We are looking into the effects of heavy physical work which may cause uterine prolapse. Because of these and other concerns, most women workers are in the textile industry and other occupations like food processing, machine and electronic assembling, machine operation, welding, and farming, where toxic exposures are minimized.

Attempts are made to use traditional medicine to facilitate treatment of occupational disease, such as in the management of mercury poisoning, especially if the patient is sensitive to dimercaprol. Stephania tetrander is used to treat silicosis, and acupuncture is commonly employed to treat lower back pain and joint pains associated with manual handling of materials and an excess of physical work.

In the cities, labor insurance regulations guarantee special care for women during pregnancy, childbirth, and nursing. In the countryside, women do not work in wet paddy

fields during menstruation and pregnant women do only light work. Nursing mothers work near their homes. Each city has one or more maternity hospitals, which are all part of women's health network. These hospitals include district and county hospitals, and health centers in the communes, the factories, and the neighborhoods. These hospitals and clinics are also the mechanism through which physicians carry out health surveys, particularly of cancer incidence where early detection and treatment are the goal. In these areas, all women are examined yearly.

Furthermore, under the guidance of the hospital-based network, factories develop a special care system for women during pregnancy, childbirth, and nursing. Most of the factories provide rooms for expectant mothers who rest an hour longer each day after their seventh month. During maternity leave, a mother is visited by medical workers from the factory clinic and members of the hospital group. In a like manner, periodic examinations and treatment of women is carried out in the countryside by the cooperative medical care system, the barefoot doctor service, and increased use of mobile medical teams of city hospital doctors.

However, it must be recognized that China is still a developing country, with a relatively backward economy; science and technology and traditional habits are not yet completely changed. Therefore, there are still many difficulties, and much progress is yet to be made. The cultural level of women in China varies from place to place and the number of women scientists and technical personnel is relatively small. Many women still cannot avoid heavy physical labor and tedious household chores. Welfare facilities, such as nurseries, still fall short of demand, and the policy of equal work and equal pay has not always been fully carried out in the countryside.

The Roots of Population Policy in Barbados

Billie A. Miller

To understand the health and population policy of Barbados, it helps to know its physical constraints. Barbados is a small coral island in the Eastern Caribbean not far from the mainland of South America. Within the confines of 166 square miles there are 254,500 people (mid-1977), or 1,533 per square mile, one of the highest population densities in the world. Furthermore, public health is improving and opportunities for emigration are diminishing, adding still further pressure on the limited room for expansion within Barbados.

For these reasons, the government has given steady support to efforts to lower the rate of population growth and thereby attain a better socio-economic status. It provides about three-fourths of the local funding for the Barbados Family Planning Association and has introduced a family planning component in clinics throughout the island. This year, the Association celebrated its 25th anniversary. It has pursued a vigorous campaign to bring information and education services to all sections of the community through the media and through education programs for youth, industrial workers, and large male groups.

Thanks to firm governmental support from the earliest days, the Family Planning Association has been able to make a remarkable impact on the island's population profile. Between 1954 and 1979, the birth rate was more than halved, falling from 33.7 per thousand in 1954 to 16.2 in 1978. Now, however, as a result of the reduction in emigration, we are seeing an increase, which is likely to be spread over at least the next decade, in the number of persons entering the fertile age groups. If the trend toward lower birth rates were to be reversed, the additional services required would place a severe strain on our already delicate economy.

Thus, it is necessary to maintain expansion of the family planning program. The present Minister of Health, mindful of the possibilities of a further bulge in the population, has determined to work toward integrating the Family Planning Association's services into the network of government polyclinics. The UNFPA has agreed to fund this activity in the first three polyclinics over the next three years. A new educational outreach program will be added to serve the surrounding communities. Eventually, a complete community service will be available throughout the island.

Another urgent need is for new abortion legislation. Obstetricians in the main acute general hospital have complained repeatedly of the number of admissions for early miscarriage, which was the third highest cause of hospitalization in 1975, 1977, and 1978, and the second in 1976. A large proportion of these hospitalizations results directly from illegal interference with the pregnancy. Physicians emphasize the danger to the health of the woman, to her future prospects for fertility, and the possibility of severe, even fatal, illness.

A draft bill has now been prepared to provide for abortion up to 20 weeks gestation. It is based on the recommendations of a National Commission on Abortion which was set up in 1974 after a few vocal women mounted a campaign for liberalizing the law. The bill's provisions were widely discussed. Medical practitioners and social workers (but not nurses) were generally supportive. Most of the churches agreed to limited grounds for abortion, though many felt that potential psychological or social

harm to the mother was not, as proposed, adequate ground for terminating a pregnancy. At the suggestion of the National Commission on the Status of Women, which was set up in 1977, safeguards such as counseling were included in the structure of proposed services.

The new abortion bill, which has been held up due to delays in drafting, is now expected to be on the statute books before the end of 1980. Services are to be provided free in the main hospital. Despite some lingering opposition, the Family Planning Association also plans to provide an abortion service free or at minimal cost.

There is an obvious need for improvement in family-life information and education, especially for school children, since nearly 40 percent of all pregnancies in Barbados occur in girls under the age of 20. Family-life education in the schools is considered at least a partial answer to the high rate of teenage pregnancy. The Barbados Family Planning Association has mounted successful campaigns among young people and women in industry. Curricula have been developed to introduce a comprehensive family-life education program in all schools. But the Ministry of Education has failed to make the subject a reality and public opinion has generally remained lukewarm, if not hostile. A number of schools pay lip-service to the concept but limit the sessions to a few "safe" subjects. Only a smattering of teachers have been trained even at a minimal level and the decision to include family-life education remains that of the head-teacher. Now the government is trying a new approach. Family planning nurse-educators, after training in Jamaica, are taking the program into the schools; they have been able to discuss topics which the teachers feel inadequate or unwilling to present themselves.

It has also become clear that considerably more attention must be paid to the working mother. Seventy percent of children are born illegitimate, and the common-law union or the visiting union is as common as formal marriage. In these circumstances, the support of the family is precarious and most young mothers have to work. Instead of being seen as a source of comparatively cheap and docile labor, it should be recognized that working mothers have a significant role in the molding of future generations.

Conditions in the factories are far from satisfactory. The industrial development sector of government has yet to insist on a creche for working mothers and there are no facilities for breastfeeding. (If there were, they would probably not be used--such is the strength of high-powered salesmanship which has persuaded women over the years to settle for inferior milks given by bottle rather than nature's own food.) It may well be necessary to legislate for an extended period of maternity leave after the birth in order to ensure that the child is adequately cared for at this vital period of life.

Equally important, the concept of self-worth must be introduced early. During International Women's Year (1975) there was a good deal of exploration of the legal and health implications of women's rights. Investigations revealed that a good deal of sexual exploitation was still possible, due mainly to social factors. Discussions in the Ministry of Health focussed on the great need to penetrate the consciousness of young women at the grass-roots level.

Again, education appears to be the key in both the formal and nonformal sectors. Clinic nurses have been instructed to talk to patients about, for example, the right of the woman to make her own decision to use contraception or the right to want a father for one's child. But it is hard to find nurses or other resource people able to discuss such matters with confidence even in small groups; the tendency is to revert to the

traditional formal talk on child care or family planning. In the future, it will be necessary to mount in-service training seminars or to send people further afield for insights into the whole field of women's rights and women's behavior and its consequences, particularly for the health of both mother and child.

Integrating Women in Development: Programming in AID

Theresa A. Lukas

The political and economic commitment required to move the integration of women in development from an aspiration to a reality must emanate from developing countries themselves, from women's groups in particular. Nonetheless, those of us in the U.S. Agency for International Development (AID) and other donor organizations promoting primary health care are beginning to recognize the many opportunities that exist to work with countries to advance women's interests and needs for health care. The payoffs for this sort of collaboration promise to advance not only the development and fulfillment of women, but also that of the entire population.

While the "ball," so to speak, is in the "court" of the host countries, and especially of women's groups, we in AID are trying to prepare ourselves to help in meeting the development challenge. Our first need is for information. Before AID or other donors can establish a sound development strategy which includes women's interests, and particularly those relating to health, they need to improve their understanding of women's lives in different societies. Important information which is needed to guide overall development strategies relates to the decisions which women of different income groups routinely make at different times in their daily lives, during the different stages of their lives with respect to the allocation of their controllable resources (including women's own time).

Since the consumption decisions that women make, especially with regard to health care, have a direct impact on the health and well-being of the entire family, the international donor community needs to give greater attention to improving its knowledge about women's lives. It is heartening, therefore, that the Program of Action for the second half of the U.N. Decade for Women recommends developing "simple economic, social and cultural indicators in order to obtain better data on trends in morbidity and mortality among women and their access to and utilization of health services." While being a step in the right direction, recognition of the need for more and better data on women by the international community of countries and donors is but one step toward filling the present informational and motivational void. Individual donors must reassess their own investment priorities to determine if women are in fact being integrated into development strategies as well as they can be, and if not, what is the best way to proceed to ensure that they will be in the future.

For its part, AID has formally recognized the need to promote sensitivity to women's interests in national development. The Women in Development Office promotes—through information dissemination, technical assistance, and applied research—the integration of activities benefitting women into the Agency's development assistance portfolio. In addition, the staff of this office, in cooperation with designated representatives in AID missions and Washington technical and country offices, monitors project development throughout the agency in order to take advantage of opportunities to integrate women into the activities undertaken with host-country governments. The Congress of the United States has included specific provisions in the Foreign Assistance Act to assure that a minimum amount of the annual foreign assistance budget is allocated to supporting such activities.

Preliminary efforts are under way in AID to demonstrate the usefulness and feasibility of disaggregating, by sex, data collected through development projects. A

complementary effort, advocated widely but yet to be initiated, is the inclusion of appropriate baseline measures of the female target groups in the design of new projects. Regularly collected and monitored baseline measures by sex would be a major step toward developing the comprehensive data base needed.

AID staff are required to undertake a "social soundness analysis" in the course of developing a project. This analysis seeks to estimate the social acceptability and appropriateness of the proposed activities to individuals and institutions in the host country and, thus, the extent to which anticipated benefits can be expected to materialize. The social-soundness analysis has been recognized by agency staff concerned with women's interests as a valuable means through which intersectoral investigations into women's issues can be initiated and information assembled.

Not only are more and better data needed, but also improvements in evaluation methodology. Work has begun, both formally and informally within AID, to improve evaluation of development assistance programs. Within this general effort, attention will be given to assessment of how these programs have affected women and how they could be redesigned to improve their impact on women.

The Women in Development Office conducts an annual review of AID's progress in integrating women into its programs. There is a recognized need by involved staff to more fully exploit these opportunities within AID's health, population, and nutrition programs. In particular, it has been suggested that the Women in Development Office ought to collaborate with the technical offices responsible for developing health, population, and nutrition programs in designing and funding a series of studies of women's interests and roles in the development process. Such a program would require a serious effort to correctly conceptualize women's relationships, rights, and responsibilities within various social groups, especially the family and local community, and their access to resources.

Evaluation That Is Useful to Decisionmakers*

Susan Cole-King

Real progress in health programming can only be made if we are constantly willing to examine accepted practices, to ask fundamental questions about even the most sacred cows. This is what evaluation is really about. It is not a technique but an attitude—a willingness to be open-minded and critical about what is happening.

Over the past year or so, the international community as a whole, in the forum of the World Health Assembly, has set itself a staggeringly courageous (cynics have called it utopian or naive) target, of achieving health for all peoples by the year 2000. One can dismiss this as just another example of "globaloney," or take it as a serious and exciting challenge to mankind. We all know that health for all is technically possible. The real questions are whether it is socially and politically possible, as this depends on profound changes in attitudes and behavior at all levels of society, within the health sector and outside it, in rich countries and poor ones.

Evaluation can play an important role in contributing to such attitude changes. Measurement of progress toward a goal, after all, can create incentives and affect motivation. It can be a political lever. If, in Country X, it is apparent that the infant mortality rate in one part of the country or one socioeconomic group is twice as high as in others, or that, at the international level, Country A has an average infant mortality rate two-thirds higher than Country B with a similar per capita income, then policymakers may be stung to take action.

Secondly, to measure progress is itself an indicator of real commitment to the goal. If we are not willing to measure what we are achieving, we cannot be very serious about our commitment. Thirdly, levels of health are increasingly recognized as being sensitive indicators of overall development of a country or of particular groups within it. And finally, measurement of progress is a valuable management tool for planning and adaptation, for developing more appropriate and effective strategies and for clarifying and sharpening objectives.

Unfortunately, over the past few years, the health sector has suffered from separation of different management functions into isolated, compartmentalized systems. Independent disciplines, each with its own specialists, have proliferated in the areas of health planning, health management, evaluation, and communications, and these specialties are often institutionalized in separate units in ministries of health. The U.S., especially its academic institutions, is in my view the main culprit contributing to this overspecialization and complexity. It has been disastrous, I believe, in that it has led to over-theoretical and over-elaborate concepts divorced from reality and practice. Primary health care in particular has suffered. There is an urgent need today to integrate managerial functions, to simplify and demystify them, making health planning, health management, and evaluation a single process of health development which everyone can use and understand.

*This paper is based on Susan Cole-King's keynote address at the June 1980 National Council for International Health Annual Meeting in Washington, D.C. It appeared in International Health: Measuring Progress, published by the National Council for International Health in 1980.

International and funding agencies need to learn how and where to spend their money more effectively. Planners and program managers need to know whether objectives are being reached and whether, in the light of experience, they are the right objectives in the first place. Health workers need to get feedback. Are they reaching the mothers at risk for antenatal care? How many of the children have been vaccinated and, most importantly, who has not been vaccinated? Is malnutrition decreasing, if not why not, and what are the underlying causes and what can they do to change the situation? The people themselves will want to ask a range of similar questions from which to learn. Are we getting what we think we need from this health program? What do we really need? Has anything improved for us? How much is sickness contributing to our poverty? What can we do ourselves to change our situation?

Today, decisionmaking for health development, if it occurs at all—and there seems to be a kind of blind momentum governing some of the health bureaucracies I have had experience with—is rarely based on rational criteria. Information may not be collected at all; the wrong or irrelevant information may be collected; it may be in too-indigestible a form to be used; it may be too late; and, even when appropriate information is available, it may not be used. Part of the problem is that the questions that decisionmakers need answers to are often ill-defined, or may get asked only after an information system has been set up. Further research and evaluation is often called for as an alternative to action or to postpone having to make a difficult decision.

There is an erroneous assumption that evaluation must be objective. There is no such thing as objective evaluation. Decisions about the information to be collected, choice of samples, selection of criteria, relative weighting, methods of statistical treatment, and presentation of results all involve value judgements which need to be made explicit. It is arrogant and exploitative for researchers, funding agencies, or health planners alone to determine what should be investigated and how. The beneficiaries themselves have a legitimate claim to ask questions. Investigators and their subjects inhabit different realities, and we have to find ways of achieving consensus.

There is also a tendency in the health field to reject information that is not in the form of hard statistical data. But some of the important aspects of a program may not be measurable. The social/anthropological disciplines have much to teach us health professionals. In the words of a social scientist: "Truth in the field of human affairs is better approximated by statements that are rich with a sense of human encounter."

It is important, furthermore, to distinguish between objectives and targets. The latter are milestones, which are assumed to lead toward objectives but may in fact direct attention away from what is really happening. For example, many countries have set targets for achieving specific levels of health manpower. One African country I have visited recently has virtually achieved the doctor/population target of 1/12,000 that it set itself ten years ago. But the doctors are so poorly distributed that there are many administrative districts of 150,000 population or more where there are no doctors at all.

The primary health care concept, as outlined at Alma Ata, can be used as a statement of objectives from which the criteria for assessing the value of a program can be derived. The most important questions to ask will then follow naturally. For example, in relation to community involvement, one main question might be, "What is the nature and extent of community participation? Subquestions would include, "Is the

community involved in planning, management, and control of the health programs at peripheral and at more central levels? Are local resources used? What kinds of resources (labor, cash, buildings, mass activities)? Is there a community health worker or workers? What proportion of the community participates in health activities and from which socioeconomic groups do they come? Have any community projects been initiated?" It is possible to do this kind of exercise for other areas of primary health care such as coverage and accessibility of primary care components, intersectoral coordination, integration and support by the health system, cost-effectiveness and resource allocation, and quality of services. This approach seems to be much more practical than the systems approach so much in vogue lately. While it is conceptually useful to classify indicators in terms of inputs, process, outputs, and outcomes or impact, the systems approach is not so useful for reaching the best decisions.

Feasibility and cost will determine what information can be collected and, perhaps more importantly, what can be analyzed and interpreted. Too often evaluation results are only available long after the time for decisionmaking has passed, because the data collected took years to process. I would like to make a plea for the less rigorous and less technically sound studies, for simpler, more manageable evaluations which can be done by those actually involved in the programs. Evaluation is best conceived as a process that should be built into the ongoing management rather than carried out by outside experts.

This does not mean that there is not also a role for external evaluation. Fresh, and possibly more objective, insights brought in by external evaluators can be useful, provided there is a viable mechanism for feedback into the decisionmaking process. Voluntary agencies have a special responsibility here. They have been pioneers in developing new and alternative low-cost health programs. Because of their flexibility, they have been able to experiment and develop innovative approaches which could not be done by governments or international agencies. But results need to be properly evaluated and reasons for success or failure understood, before these approaches can be replicated on a wide scale. So let us exchange ideas. Let us above all stimulate each other and discuss how we can stimulate others, whether village health workers or government planners, to adopt more open and critical attitudes. Perhaps then we will be able to meet the larger challenge of health for all by the end of this century.

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Appendix I

Interim Report, International Symposium on
Women and Their Health

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Summary of Workshop Discussions

Participants at the International Symposium on Women and Their Health met in informal working groups to explore five major, and overlapping, themes:

- Exposure of women to health hazards (Working Group 1);
- Women as seekers of health care for their families (Working Group 2);
- Women as seekers of health care for themselves (Working Group 3);
- Health system responses to women's health needs (Working Group 4); and
- Women as members of the health care team (Working Group 5).

Three days of lively debate and discussion revealed many differences in approach--not unexpectedly, considering the wide range of backgrounds, concerns, and experiences represented among participants. But they also revealed substantial consensus on a number of points. The following were among the most important areas of priority concern:

1. Socioeconomic environments are primary determinants of women's health.

Poverty and discrimination are basic causes of poor health among the majority of women in the Third World and among special groups everywhere. These two factors are particularly detrimental to women, who suffer not only from the general tendency of national and international systems to work against the interests of the poor in rural areas and urban slums, but also from additional hardships resulting from their dependence on male-dominated power structures in their families, communities, and countries.

Thus, Group 2 asserts that the health problems of Third World mothers will not be substantially reduced without basic structural transformation of society leading to more equitable distribution of resources and power. Group 3 calls attention to societal conditions which invite psychological stress in women and even physical abuse against them. Group 3 also notes the special health problems associated with women from such deprived populations as migrant workers, national minorities, refugees, and, in South Africa, non-whites; Group 1 added exploited factory workers to this list.

As Group 4 points out, income-producing activities for women may be particularly important in overcoming their economic and societal constraints. Thus, if women had enough money to buy more and better food for themselves and their families, much malnutrition among women could be eliminated. If they could pay for health services, fewer community health programs would fail for lack of recurrent-cost funding.

2. Health care must treat women as total human beings.

Women play multiple roles as workers, mothers, citizens, etc., which cannot be satisfactorily separated out. As a result, programs that concentrate on only one aspect of women's health--maternal and child care, for example, or family planning--cannot meet all of women's health needs. Working Group 2 thus calls attention to the vicious circle in which undernourished, underweight baby girls grow up to become malnourished,

overburdened mothers who in turn give birth to underweight, vulnerable babies. Working Group 1 underlines the stresses resulting from women's need to combine work activities with child care.

The primary health care movement--which calls for "health for all by the year 2000"--was seen as an important means of meeting the health needs of both women and men as total human beings, and of re-integrating fragmented health delivery services. Thus, Working Group 5 stresses the need for integrating health and family planning activities within the general health care system as well as for linkages among all sectors affecting health. Group 1 stresses the need to develop nutritional standards for poor Third World women that take account of their generally poor health status as well as their generally heavy work-related energy expenditure.

The importance of child spacing to women's health was recognized by all. Special concern was expressed by a number of working groups, however, regarding family planning programs that operate in isolation from general health care services; many felt that such programs fail to protect women from potential health hazards that may be associated with contraceptive use.

3. Women need health care throughout their lives.

Participants recognized the special hazards to which women are subject during their reproductive years, but they emphasized the relation of those hazards to both earlier and later periods in women's lives. Thus, Working Group 2 calls for special attention to better nutrition for adolescent girls. Working Group 3 calls attention to the need for medical, social, and psychological research concerning women's health problems after menopause. Participants also emphasized the needs for health care during the reproductive years, not only for maternal and child care programs and others associated with women's roles as mothers, but also for protection for themselves and their children against such hazards as exposure to toxic substances in fields and factories. Treatment for involuntary sterility, especially that resulting from sexually transmitted diseases, was also recommended by several working groups.

4. Women must be represented in the health delivery system at all levels.

As Working Group 5 noted, women have advantages as health-care team members, in that they are better able to reach the most vulnerable parts of the community--i.e., children and other women--and are often more acceptable to them as health providers. Nonetheless, concern was expressed that women would not be trained and compensated on a par with men as community health workers, and that, if adequate remuneration were offered, men would be given most of the new jobs opened up. Groups 4 and 5 also insisted that women need to be involved at higher policymaking levels in the health sector and that, to do so, they need greater access to advanced training, research fellowships, and the like. At the other end of the spectrum, they emphasized the importance of systematically including women in health-related decisionmaking at the community level. Group 3 calls special attention to the need for women to act as their own advocates in matters of health.

Many other points were made in the course of the Symposium. What follows is a summary of the findings and recommendations of the working groups.

Working Group 1

HEALTH ISSUES OF WOMEN AS WORKERS

An accurate and comprehensive picture of women's work-related health issues will only emerge from the full recognition of the totality of women's work. Much of women's work is still unrecognized and undervalued. It must be measured and recorded, in order to meet the health needs that arise from women's work activities in the home, in the fields, and in the modern industrial and service sectors, as well as in childbearing and childcare. Girls' work-related responsibilities start at an earlier age than boys' and often extend through old age until death.

A medical dimension of the issue is that observations and information on occupational health are based upon male physiological characteristics. The possible differential effects of work-related health hazards of women are therefore not fully understood. A case in point is the question of exposure to pesticides and other toxic substances. We do not know how female reproductive physiology reacts to such an exposure and the implications for reproductive success.

The following issues and recommendations should be considered in the context of the framework mentioned.

Recommendations

1. Funding must be made available for research to increase knowledge on work-related health and disease based on female physiological characteristics. The study of the differential impact of work-related hazards on the health of men and women should be encouraged and facilitated.
2. The energy women require to carry out both their childbearing and other productive tasks has just recently begun to be measured. It is suggested that international standards of women's caloric and other nutritional requirements be immediately revised and modified in accordance with the accumulating evidence that women, especially poor women, undertake more taxing physical activities than the healthy middle class women whose nutritional requirements form the basis for present standards.
3. Traditional dietary practices concerning women's eating patterns must be modified in the context of their real needs and increased food availability for all members of the household.
4. In the Third World, women's household work is heavily burdened by the need to fetch water daily. It is suggested that the provision of easily accessible, safe water supplies to reduce this burden should be intensified.
5. Women who work outside the house and also have motherhood and home responsibilities may experience stress-related health complications due to inadequate childcare. It is suggested that whenever possible childcare and related facilities should be made available.
6. The exploitation of female labor by national and transnational corporations (TNC) exposes women to a number of health hazards which are not yet well described and documented.

- a) Women and workers in national corporations and TNCs, as well as those in the informal labor force, should be allowed, encouraged and helped to unionize in order that, among other things, they can collectively bargain for adequate health protection measures and benefits in the workplace.
- b) International pressure must be brought to bear on TNCs to stop exploitative practices detrimental to the health of women workers.
- c) Women who work for TNCs should be fully and accurately informed of the occupational health hazards that may be present in the workplace at the time employment begins.

7. Legislation enacted to protect women's health in the workplace is, in many cases, outdated and obsolete, serving only to bar women from employment opportunities. Conversely, the recent expansion of working opportunities for women in the textile and electronics industries controlled by TNCs, has not been accompanied by a concurrent modification of protective legislation to cover women in these hazardous situations.

- a) Current International Labor Organization conventions on legislation to safeguard the health of women workers must be immediately revised to rectify these errors.
- b) National labor codes should be reassessed in light of this evidence as well.
- c) Care must be taken that health-related legislation for women workers is "protective" rather than "protectionist" in character.
- d) Protective legislation must be immediately enacted and enforced to prevent experimentation on women subjects.

8. Labor force participation patterns among women are marked by entry, exit, and re-entry cycles due to the multiplicity of women's roles, including childbearing. Every time they exit from the formal labor force, women may lose accumulated seniority which would have entitled them to health benefits and social security. It is suggested that Workers' Benefit Programs, specifically those related to the provision of health care, social security benefits, and health insurance should be restructured to take note of the labor force patterns of women. Social security systems should also be expanded to cover workers in the informal labor forces of modern economic sectors, where women are invariably concentrated.

9. Every effort should be made to encourage women, especially minority and refugee women, to have access to education, employment, and retention of jobs at all levels in the health care fields.

Recommendations adopted in plenary session, Wednesday, June 11, proposed by Ms. Nieves

Family Planning:

1. Concern must be voiced over the international pressure brought to bear on governments to endorse birth control, and over the national abuse of family planning.

2. Deliberate birth spacing is essential to the maintenance of women's health. Therefore, contraceptive availability for explicit family planning purposes should be promoted only in the context of health care and health service delivery for mothers and children. Further, family planning must occupy a proportional, not an overemphasized, place vis-a-vis other components of the larger maternal child health programs.

3. A user-oriented family planning approach that allows the couple, as the decisionmaking and reproductive unit, to function as such, should substitute for the now prevalent target approach that isolates women and treats them as the problem.

4. The same health standards must be applied when assessing the safety of contraceptives for women in Third World countries and in affluent societies. In the United States, for instance, the Food and Drug Administration has ruled that the long-lasting injectible Depo-Provera must be proved safe before it can be made available to the general population as a contraceptive. In Latin America, in contrast, the Pan-American Health Organization has recommended that Depo-Provera may be made generally available until it can be proved to be definitely unsafe. The United Nations Fund for Population Activities (UNFPA) and the United States Agency for International Development also perpetuate this double standard, the latter by providing funding for other agencies, including UNFPA, which makes Depo-Provera available to Third World women in Bangladesh and elsewhere.

Working Group 2

HEALTH ISSUES OF WOMEN AS MOTHERS

The Societal Context

Any attempt to diagnose the health problems of women as mothers must first address itself to the general conditions under which most women live. The particular sociocultural conditions of the society have a direct impact on the health of women as mothers. Women cannot be thought of as abstractions from these realities. Lack of such a perspective will continue to treat the consequences, rather than causes, of why women as mothers in the twentieth century have to live under deplorable conditions.

Women as mothers are not a homogeneous group. There are all kinds of mothers: African mothers, Asian mothers, Indian mothers, Black mothers, mothers who live in rural areas or in urban areas, in slums, on plantations, in tribal homelands, in nomadic groups, under apartheid, etc. These disparities have to be acknowledged if we are to identify the health needs of women as mothers.

Besides being mothers, women have to assume a multiplicity of roles to fulfill their responsibilities. Women are the chief providers of food; they are responsible for water and fuel portage; they care for and nurture their children and the other members of the family or household unit; they are the first-line health providers. In designing a strategy to respond to the health needs of women as mothers, therefore, one cannot generalize priorities. The particular needs of women in a class-divided society, and also the multiplicity of their roles, translate into different levels of demand.

The Situation of Mothers in Developing Countries

- The majority of poor women in developing countries live in either rural areas or in urban slums.
- The major health problems of these women are related to malnutrition and to environmental factors which are disease-related and mostly preventable.
- Appropriate health care responses are limited since services are mostly located in urban areas and are, moreover, curative and hospital-based.
- The complex interaction between the health of women and their nutritional status is further compounded by pregnancy and lactation.
- Health programs for women have been oriented to the childbearing period even though their health problems are obviously not confined to the period of reproduction.

Special Risk Categories

It may be useful to think of the health problems of women as mothers in these categories: adolescent mothers; non-pregnant women; pregnant and lactating women.

(a) Adolescents

- The major health problem of this group is early and unwanted pregnancy and the social stigma often associated with it. Adolescents are also more likely to seek illegal induced abortion with serious complications.
- Health care, including sex education, family planning information and services, as well as abortion services, is virtually non-existent for this group.
- Adolescent mothers, whether pregnant or lactating, have special needs both as mothers and as growing adolescents.

(b) Non-pregnant Mature Women

- This group of women has health needs which must be addressed--such as contraception, prevention of sexually transmitted diseases, and screening for cervical and breast cancer. Services for this group are poor and inadequate.

(c) Pregnant and Post-Partum Women

- Adequate prenatal care, including nutrition supplementation, has been shown to be the most effective measure of reducing the high maternal morbidity and mortality found in developing countries.
- The existing services for pregnant and lactating women are inadequate (poor services), inaccessible (too few), inappropriate (inconvenient opening hours) and often times non-existent.
- In some urban institutions in developing countries, there has been a tendency to adopt expensive and sophisticated medical equipment (e.g. fetal monitoring) while the majority of pregnant women have no basic care.
- Most of the health care during delivery is provided by untrained traditional birth attendants whom the health system has yet to recognize, train, and incorporate into the health system.
- Other maternal health problems include hemorrhage before, during, and after delivery, puerperal sepsis and toxemia.
- Women are also subject to a number of diseases, some of which are worsened by pregnancy and lactation. The most important is of course, malnutrition, but others such as malaria are more common among pregnant women because of a lowered immunity associated with pregnancy.

Other general issues that affect all mothers include:

Contraception

In some countries, there is indiscriminate use of contraceptives without adequate information, advice, and follow-up. In others, family planning services are inadequate in terms of information and availability of services.

Abortion

This is undoubtedly one of the major causes of maternal morbidity and mortality.

Nutrition as Special Issue

As discussed earlier, the health and nutrition problems of women as mothers cannot be considered independently from the other roles of women as economic and food providers. Moreover, women become mothers in particular socioeconomic and political environments that, for the majority of women in developing countries, are not conducive to adequate standards of health and nutrition. The issues of inadequate food production and availability, uneven distribution of land and other resources, and displacement of women from the work force by technological advances lie at the roots of the health and nutritional problems of women in developing countries.

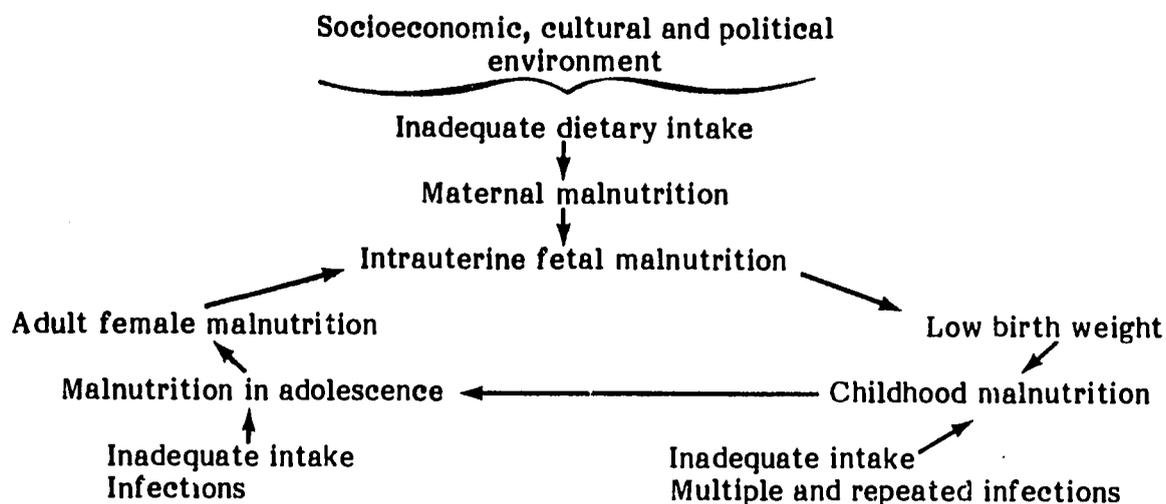
Nutrient requirements depend on a number of interrelated variables such as physical activity, body size and composition, age, physiological state (non-pregnant, pregnant, and lactating), and diseases.

A number of FAO/WHO expert committees have developed recommended dietary allowances for the essential nutrients for various groups, including women. The nutritional requirements recommended for women have been calculated taking as reference a Caucasian, healthy, and well-nourished woman who performs eight hours of general household work, light industrial work, or other moderately active work. In developing countries, however, the most "typical" woman will most often be an adolescent, who is not free from diseases and parasites, who is overworked, and who can expect to be either pregnant or breast-feeding throughout her reproductive period. Nutritional requirements will be different for this woman.

Whatever reference standard is used however, the dietary intake of women in developing countries has been shown to be inadequate. Her dietary intake may be further limited by food taboos, especially those which apply to pregnancy and the post-partum period, and by discriminatory food distribution practices within the family which allow adult males to receive the greater and most nutritious part of the diet, leaving the rest for the mother to share with small children.

The nutritional problems of women start in utero and continue through adulthood. It is a vicious circle in which poor, malnourished mothers produce growth-retarded newborns, who then become malnourished children who cannot reach growth standards, malnourished adolescents and, finally, poor and malnourished mothers themselves. Infection aggravates this picture. These relationships are summarized in Figure 1.

Figure 1.



Recommendations

In presenting the following requirements, the group reiterates its earlier observation that the health problems faced by poor Third World mothers stem largely from a societal situation that generates and perpetuates conditions of mass poverty. Unless, therefore, the society undergoes basic structural transformation leading to a more equitable distribution of resources and power, the health problems of Third World mothers will not be substantially reduced. The recommendations that follow must be seen in this light. While they advocate specific changes that may prove helpful to many mothers, they will not in the long run improve the health of mothers as a whole so long as the existing unjust situation prevails.

Two further prefatory remarks need to be made. Since it is difficult to isolate women's motherhood roles from their roles as workers and community providers and to characterize mothers as belonging to one homogeneous situation, health programs for mothers should take into consideration these other roles and situations as well. Further, health programs should not restrict their attention to the childbearing aspects of the motherhood role but rather view mothers in the total context of womanhood.

(a) Health Care

- Women need early prenatal and postnatal services that are available at times which accommodate the women's schedules. No woman should be deprived of adequate health care, especially pregnant and lactating mothers, because of inability to pay. Child-care facilities will aid the mother while she receives medical attention.
- Mothers who are representative of the clients need to be involved with the management issues of health clinics, especially the maternal and child health aspects.
- Mothers need assistance with the spacing of their children by ensuring the availability of safe and effective contraceptives. It is essential to inform, supervise and do follow up on the effects of contraceptive use by women, especially those who are malnourished. Further, women and men need services which provide treatment for infertility and sexually transmitted diseases.

(b) Nutrition

- Since the chronic undernutrition that affects the health of women becomes a major health hazard when the woman is pregnant and lactating, efforts should be made to increase the daily intake of food by pregnant and lactating mothers. These efforts should also be applied to adolescent girls so as to reduce the severity of this problem in later years. Subsidized food packets should be made available to this group.
- Income-generating schemes for mothers and adolescent girls should be formulated and implemented so that they can use these added earnings to enhance their health and nutritional status.
- At the national level, policymakers should seriously consider the impact--negative or positive--of any development of programs on household food production and consumption.

(c) Supportive Activities

- Appropriate technology to lighten the burden of physical work and time spent on extended, tedious tasks needs to be developed. This could include a suitable water-supply system, improved storage jars, more efficient stoves and food grinders, food preservation, etc.
- To relieve mothers' household work burdens, further efforts should also be directed toward the re-education of men for behavior change regarding the sharing of household work;
- Reducing the effects of environmental hazards on mothers can be accomplished through the elimination of contaminated water, poor sanitation, pesticides, etc.
- Health education, covering nutrition and sex education as well, should be intensified for women. The ill effects of smoking, alcoholism and drugs, especially on pregnant women, needs to be given attention, since these are relatively new problems for women in developing countries.

Conclusion

There are many approaches that can improve the health and nutritional status of mothers, and these need to be actively pursued. Nonetheless, strong efforts also need to be made to bring about basic changes in the organization of society so that the people as a whole, and the women among them, will have some hope of a decent life in the not-too-distant future.

Working Group 3

HEALTH ISSUES OF WOMEN AS WOMEN

The workshop which considered the health of "women as women" attempted to identify those health issues which are unique to women and which were unlikely to emerge from the discussions of the other groups. As our conversation evolved, we focused on three basic concerns which will be elaborated below: common medical problems, physical abuses of women, and unique problems of special population groups. As a final focus, the workshop identified opportunities for improving women's health through the role of women as their own health advocates. In this presentation, the group's recommendations are included in the discussion of each issue.

Common Medical Problems

Women, throughout their lives, in their respective societies, are faced with specific health problems which burden them solely or to a greater extent than men. Five health problems seem to be especially important in this context: sexually transmitted diseases, mental health problems, abortion, menopause, and sterilization.

Sexually transmitted diseases are a rapidly growing problem all over the world. The very nature of these diseases discriminates against women. They are harder to diagnose and harder to treat in women than in men. The health repercussions of sexually transmitted diseases in women are also much more serious, and include pelvic inflammatory disease—a very painful and serious condition—involuntary infertility, ectopic pregnancy, cancer of the cervix, even death. Although syphilis is a sexually transmitted disease which has serious consequences for men as well, all of the other infections, especially herpes, chlamydia, and gonorrhea, cause greater suffering in women. Furthermore, the social, economic and psychological repercussions of sexually transmitted diseases are much more serious for women, especially of the Third World. Involuntary infertility causes great pain to women for whom reproduction is a major life function and whose societal positions are mainly defined in terms of their reproductive performance. Although there are several causes of infertility, the most frequent preventable cause is sexually transmitted diseases. At this time there is clearly a need for (a) more research on low-cost, effective diagnostic and therapeutic regimens for sexually transmitted diseases, and (b) for sex and health education for women of all societies before they become sexually active, so that they can effectively prevent such infections or get treatment early enough to avoid life-threatening complications.

The multiplicity of roles that women so effectively play in developed and underdeveloped societies alike produce considerable psycho-social stress. In addition to these stress sources, the women of the Third World are additionally burdened by the superimposition of the traditional and modern definitions of behavioral expectations on each other. The resulting mental health problems—whether they appear as neuroses, psychoses, or psychosomatic disorders—are serious indeed. Every effort should be made to reinforce the communal support systems available to women, to minimize the impact of such stress. Where appropriate, traditional healing practices should be reincorporated into the main health care system, especially in relation to the mental health problem, to aid women in coping with their emergent psychological problems.

The risks to women's health and life that result from abortion cannot be exaggerated. Abortion is definitely not an acceptable method of birth control, family

planning, or contraception. Nevertheless, the issue of abortion is a women's rights issue. The need is for liberal abortion laws which tend to improve the conditions under which abortions are performed and thus bring down the morbidity and mortality associated with this health problem. There is need for further research evaluating the effects of variations in abortion laws on maternal morbidity and mortality. And there is need for improved counseling with regard to contraceptives; the unavailability of, and the occasional failure of, contraceptives cause an inflated need for abortions.

A related issue is that of sterilization. This procedure needs to be available to those who want it and must not be performed unknowingly on others who do not. Every effort should be made to assure that women who undergo sterilization procedures fully understand the implications beforehand and thus make a fully informed decision in this regard.

Last, but not least, menopause is a health stage which produces problems for women universally. The needs for medical, social, and psychological research on this issue are obvious and yet have been neglected thus far.

We also want to suggest that women should advocate responsible life styles for all. This is an area where humankind can help itself, can set an example to itself. How can we reconcile the fight against occupational hazards with the smoking, drinking, bottle-feeding and dangerous driving that we gratuitously inflict upon ourselves? The possibility of immediate and inexpensive prevention of these serious health hazards could provide encouragement and confidence to deal with the other non-self-inflicted hazards (proposed in plenary by Dr. Villar).

Physical Abuse of Women

Today we use the term "physical abuse" of women and not "domestic" violence or issues "personal" to women. This itself is a major development in the area of women, women's health, and women's struggles. There are many people, institutions, and organizations, that still talk about the physical abuse of women as if it were a personal problem or a domestic issue. But there is a substantial and increasing layer of women which regards violence or physical abuse against women by other women or by men as a public, social and political issue that could and should be talked about, discussed, and acted on.

There is very little information and research on the various forms of physical abuses against women. Much greater and detailed research is necessary in every aspect described. This research and information should be circulated internationally so that we may identify the issues concerning women internationally. Though the particular physical abuse is suffered by particular women in particular situations, we need to respond to every form of physical abuse against women, wherever and whenever it takes place, respecting the feelings and ideas of those women.

- (a) Female Circumcision: Female circumcision is a complete or partial removal of the female genitalia, generally between the ages of 6 and 10. It is practiced in some countries of Africa and the Middle East, and by some groups in Latin American countries, too. There is a controversy about the origin of the practice, as the Muslims as well as the Christians in some countries practice it. The practice is based on a complete ignorance of the role of the genitalia: There is a fear that the female genitalia would grow into male external sexual organs if not cut off in time; there is also a fear that the uncircumcized girl would be over-sexed and hence could not be married off.

The practice has grave implications for the health of girls, as it is often done with unsterilized, primitive tools. However, the problem has to be dealt with sensitively since it is deeply ingrained in centuries' old custom. It is true that women have helped to perpetuate the custom, but only out of a fear that no man would marry their daughters if they remained uncircumcized. However, not much study has gone into the attitudes of men to uncircumcized girls, nor into the way circumcision affects women's sexuality.

- (b) Unnecessary Surgery: This is very much a problem of the women in the United States. There has been a doubling of the rate of Caesarian-section and hysterectomy in the last few years. Even in some countries of Latin America, cases of C-section surgery have skyrocketed. In private hospitals, the rates have risen by 700-800% in the last decade. Public hospitals have also had very high rates. One reason for this is that the entire medical system is totally out of control of women and women are considered to be "easily expendable." The capitalist health care system does not cater to the interests and feelings of women.
- (c) Wife-burning and Wife-beating: Wife-burning is an Indian phenomenon the immediate cause of which is the dowry system. Though legally prohibited in India since 1961, the dowry system still continues and takes a toll of thousands of women. Some unscrupulous husbands or their families, having repeatedly acquired dowry money from the girl's father, set fire to the wife by pouring kerosene on her body and burning her to death, thus freeing the husband to marry again and get more dowry. One hospital alone registers 4,000 burn cases a year, of which 75% are women; nine out of ten of those are dowry burnings. Until very recently, these murders were passed off as suicides or accidents. Now women are organizing against dowry and wife-burning.
- (d) Rape: There has been a great deal of discussion about rape. But on the whole, there is a total lack of knowledge and information about the different types of rapes around the world. Marital rape is being discussed and exposed in Europe and America.

In Asia, some of the biggest rapists have been police and army personnel and authorities. In Chile, too, women have been raped by their prison guards; if they become pregnant, they are refused abortion, which creates additional and grave problems in terms of the physical and mental health of women. Raped women are also the victims of sexually transmitted diseases. Despite the urgency of the problem, there has been very little research on these aspects of the issue.

- (e) Medical Experimentation: Women in developing countries, as well as poor and migrant women in developed countries, have been used as guinea pigs in the experimentation of drugs and contraceptives such as Depo-Provera that may have adverse effects. This has very serious consequences on the already poor health of the women. Together with international pressure against such dangerous practices, poor women should be made conscious of potential health hazards and also of their rights regarding their own health. Research should also be done on the effect of exposure of women to pesticides, especially on their reproductive organs.

Special Populations

- (a) Women Migrant Farm Workers: These are workers who travel from region to region harvesting seasonal crops, mainly fruit and vegetables. In the United

States, these workers include minorities like Latinos, Blacks, American Indians, and poor whites. In Europe, they are Turkish, Greek, Italian, and other "guest workers." Because they have to be constantly moving, it is difficult for migrant farm workers, especially pregnant women who need continuous pre- and post-natal care, to have access to health care services on a regular basis. There is usually no transportation to the doctor's offices, and clinics are opened during the day when these farm workers are at work. Little research has been done of the effect of pesticides on women farm workers.

(b) Women Under Apartheid: South Africa is not an underdeveloped country and, therefore, there is no excuse for the high prevalence of malnutrition and preventable communicable diseases which are so rampant among the non-whites, especially women and children. Two of the most far-reaching aspects of apartheid are:

- The system of migrant labor, which disrupts families by making it against the law for migrant laborers to bring their families to the place of work, and
- The establishment of homelands where land is non-arable, with severe soil erosion, and where even subsistence farming is impossible. Here, women, children, the elderly, and incapacitated men who are no longer productive in the industrial sector are dumped.

While maternal death is rare in developed countries and among South African white women, it is quite common in Blacks. There is no available comparative data to specify the rate of maternal mortality between black and white women, but differential infant mortality rates—which are 20.9 per 1,000 live births for whites and 100-110 (estimated) per 1,000 live births for Africans—suggest that maternal death rates are high among African women.

International pressure is required for the abolition of the system of apartheid in South Africa and denied populations in other countries like the United States. Women's groups should boycott South African products, companies that have investments in South Africa, and, most importantly, give aid and support to the Liberation Movements.

(c) Prostitution: Prostitution is an activity which results from socio-economic problems of most countries; by definition, it is a health hazard.

(d) National Minorities: National minorities exist all over the world and they are created by certain socio-political systems. In terms of women's health there are two main consequences: (a) lack of cultural sensitivity by the health care team to the needs of national minority women, and (b) imposition of cultural values by the dominant health care providers on women as patients.

(e) Undocumented Workers, Displaced Women and Refugees: Undocumented workers are people who enter a country because of economic pressures in their own countries without legal papers. Displaced women and refugees—Palestinians, South Africans, Cambodians, refugees from Bangladesh and Central America—share common problems with undocumented workers because no government is responsible for them and they are therefore uniquely vulnerable. More work needs to be done to assess the magnitude of health problems of these groups, as well as national minorities.

Women As Their Own Advocates

Throughout the earlier discussions of other groups in general, and of this group in particular, it was observed that on several issues dialogue verged on what were clearly political issues but then failed or neglected to deal with them. This group is perhaps best suited to grasp the opportunity to make a political statement which will help women to evolve a strategy for political action and involvement—not merely with the politics of the health issues which are our immediate concern but with the whole environment within which women function.

Even though health tends to lead the way in women's issues—as Dr. Halfden Mahler, Secretary-General of the World Health Organization, notes: "women's health is the key to the health of future generations"—there is an urgent need for us to attack the root causes rather than the effects of these many problems by concentrating on persuading the sources of power and policymaking. We need to enlist the help of men in this endeavor, because the same issues which say something bad for women are more often than not at the same time saying something bad for men. Solutions cannot be found by women in isolation from men any more than they can be found by men in isolation from women. The entire problem is a human one.

Women operate in a vicious circle in which they themselves perpetuate through their children the very values which we decry today. The tendency to self-denigration is still distressingly evident even in matriarchal communities which continue to promote the male of the species as dominant and superior.

Women as women have the power to educate and inform themselves of their rights and privileges—to be their own advocates. They can break out of the vicious circle by taking initiatives in their own interests and the interests of those lives they influence. They possess considerable power and must wield it. This power may not be generally perceived in orthodox or conventional terms, but, however humble or however circumscribed, women must wield it in order to bring pressure to bear and recognition of our problems—whenever we can and wherever this power lies.

We want to say, too, that suggestions for change in health policies and in delivery systems must be mindful of the disastrous results of past attempts to superimpose modern Western values on traditional developing country societies. We need to recognize the worth of what is good in all systems and try to tailor-make a modern system if this is what we want.

We have talked a great deal about the multiplicity of tasks which fall to the lot of late-twentieth-century women. This is not new. The Jamaican poet, Andrew Salkey, makes a statement about Caribbean women which is universal. He says: "Our Caribbean women are our unsung revolutionaries, our vanguard people, the ones who take the strain, carry the visible and the invisible burdens, make the telling plans, dream the real large dreams, and, forever, act in the face of overwhelming odds." As women, we must find our area of power and use it and not be afraid of conflict, confrontation, or aggression because these can be constructive. The Talmud tells us that we are not expected to complete the task, but neither are we at liberty to abstain from it.

Working Group 4

HEALTH SYSTEM RESPONSES TO WOMEN'S HEALTH NEEDS

Basic to all of the working groups' discussions was a recognition that the health of women is different in different societies and countries. Thus, the response of health systems to these needs must differ accordingly. What nations and cultures have in common, with respect to the needs of women, is that women's needs have been systematically neglected by the existing health care systems. The following discussion incorporates what this and other groups have identified as women's health needs, attributes of the response required of the health system to meet those needs, and the constraints impeding the achievement of the desired response.

We know of no existing health system that satisfactorily meets the many health needs specific to women. These needs have been elaborated in the other working group reports. They include health problems associated with pregnancy and childbirth, problems associated with sexually transmitted diseases which lead to infertility in women, and problems of psychological and physical stress resulting from a multiplicity of roles in socioeconomic systems hostile to such conditions. While many health systems purport to serve women through their maternal and child health programs, in practice the focus has usually been on child health with relative neglect of the needs of women.

The group discussed at length how the concept "Health Care System" should be defined. We decided that a good health care system is one which meets the health needs of all of the people within its jurisdiction. This means that health systems need to expand out of conventional boundaries into health promotion and disease prevention based on women's felt needs. The particular services offered and the way in which the health care system is organized depend on the unique needs and characteristics of a specific population; since these needs are different across countries, it was not considered possible to make global recommendations at this level of detail. However, the group decided that it is possible to determine whether or not the system is performing well, especially with respect to women regardless of the specific country of population, by assessing certain attributes of its services and methods of organization.

Constraints to achieving desired responses from the health care system to women's needs are:

- (a) Political ideologies and value systems which tend to subjugate women's political, economic, and social interest, thereby depressing their right to direct participation in decisionmaking processes at all levels.
- (b) Political economies which fail to allocate a just share of national resources to provide for women's health needs.
- (c) Absence of coordination and cooperation among existing governmental organizations and structures which are responsible for implementing programs in accordance with women's health needs.
- (d) The "guild-like" influence that various groups of professional health workers, especially doctors, have on standards of medical practice training requirements, and curricula content which reduces both numbers of health care workers and the

relevance of their skills to health needs of Third World countries' populations, especially women.

- (e) Lack of adequate communication, transportation and information networks, medical personnel, drugs and supplies, and supervision which adversely affect and prevent needed health care services from being available to populations, especially women, living in rural or otherwise isolated areas.

Recommendations

1. National Policy Formulation

Policymakers should not treat women as unproductive dependents but rather, as productive workers who contribute valuable resources to their families and societies. The formulation of policy statements on health should recognize that every woman is a worker inside the labor force. Even work at home, as mother and homemaker, constitutes economic work. Such work indirectly contributes to men's earnings by providing energy replenishment for their labor. Thus, regardless of her major occupation, society must acknowledge a woman's role in the economic process and must give her opportunities to attend to her special needs.

All government and health policies have important implications for women's health needs. It is therefore imperative that women's interests be represented in the planning, implementation, and evaluation of health projects. Women representatives of every socioeconomic and ethnic group should be systematically included in health-relevant decisionmaking bodies both at the local and the national levels.

The implementation of this recommendation requires that special efforts be made to enable women from underserved segments of the population to participate. These efforts should include compensation for any resources expended (including expenses and loss of income incurred) as a result of their service on health planning and advisory boards at the community and other levels.

Further, we recommend that health-related agencies should seek out and consult with existing women's groups and traditional health healers (such as midwives and female herbalists) in the needs assessment, planning, and evaluation of projects.

Acknowledging that the inclusion of these proposed mechanisms for ensuring women's input are "costly" in terms of time and material resources, we believe that the implementation of these recommendations should take precedence over other potential uses of the same resources. Without women's input, projects risk being irrelevant, inappropriate, and even counterproductive. The success of health projects in meeting the health needs of women requires the input of both the trained health worker and the potential recipients of the programs themselves.

2. Primary Health Care

A desirable health system should expand its primary health care to address the problems of accessibility, acceptability, and relevance of health care services to better meet the health needs of women.

There is a need for alternative health delivery systems based on the primary health care concept which will give particular emphasis to services for women and ensure a wider coverage of maternal and child health care by:

- (a) Use of female community health workers;
- (b) Use of traditional healers (in particular, traditional birth attendants) trained in basic health services with emphasis on aseptic techniques during childbirth;
- (c) Maternal and child health activities being given priority in primary health care programs;
- (d) Services at times and places convenient to the needs of women;
- (e) Adequate support to the health system in terms of:
 - Reorientation of health workers at all levels to the health problems of women;
 - Training of health workers in communications skills, community mobilization, health behavior (including smoking and alcoholism), etc.;
 - Provision of drugs, vaccines, transport, support, and effective information and referral systems; and
 - Developing information systems to monitor the quality of maternal care and to evaluate health services related to women.

3. The Role of Health Systems in Dealing with Health Hazards

The issue of health hazard associated with women's activities in the fields, home, or factory is a joint responsibility of the Ministry of Health, the other concerned ministries, and employers wherever relevant.

The group considered occupational hazards specific to women, such as those associated with exposure of the reproductive organs to pesticides, other toxic chemicals, and contaminated water. In industry, women face special problems when they are required to handle machinery or equipment that are designed for male physiology. In the electronics industry, which is female-dominated, women face a special risk of damaging their eyesight. Typically, women are usually unaware of these risks.

Health ministries should be responsible for identifying risks and for informing women of both short-term and long-term effects of such risks. Information on specific actions necessary for the elimination or reduction of these risks should be forwarded to relevant departments and industries.

There is a need to create a monitoring agency to ensure that women's health issues emanating from programs and activities of other ministries and agencies are taken care of. This agency must be located outside of the health ministry but have as one of its functions the promotion of women's health interests (for example, promoting occupational health clinics, child care centers, regulatory reforms in industry with high health hazards for women, etc.). The type of agency to be created will differ from country to country.

4. Financial Viability

The longer term viability of health programs designed to address women's needs depends in part on a pool of financial resources. This is particularly important because

of domestic and international resource constraints. Women's health programs often represent low priority in national planning and are sometimes poorly articulated politically. Without financial resources they are likely to experience budget cuts or program elimination during a financial crisis.

To some extent, financing of health programs does not require major investment resources. Much of the programmatic needs are not for major projects but for expansion in the functions of the health system.

The more crucial financial issues revolve around recurrent-cost financing both by public organizations and by private incomes. A number of options exist for using public resources for women's health programs. These options include increasing the national budget for the health sector (with a commitment to allocate more to women's programs); designing of programs to recover costs through taxes, product-specific duties, fees from services, etc., or any combination thereof.

The viability of any of these options is highly specific to the situation of each country. Indeed, any option which proves viable must also be designed according to the resources found in that specific situation. While general financial design prescriptions cannot be forwarded, it is emphasized that some viable provision to cover recurrent costs must be an integral part of any health system or program in response to women's needs.

In situations in which cost-recovery programs are viable, methods must be designed to ensure that the resources are available to women in cases where services for women are needed.

Surveys indicate that between 7-10% of family income is spent on private and/or public medical services. However, the control of resources does not always rest with women. Moreover, when incomes are particularly low, health expenditures are likely to be much higher than 10% of family income; thus, they are not indicative of family income capability. For this reason, targeted cost-recovery policies may also require the implementation of broader income-generating activities for women. These include improvements in technology, access to child care facilities, and so on.

These facilities will be of some use not only in financing women's health programs, but also in making resources available for improving the social, political and economic status of women.

We recommend that health programs be developed to enable women to seek external financing for major investment costs, but viable systems of financial self-reliance need to be developed to ensure that recurrent costs are independently borne over the longer term.

Working Group 5

WOMEN AS MEMBERS OF THE HEALTH CARE TEAM

The group began by considering a definition of the health team and its composition and then proceeded to identify the categories of women workers who are usually found on health care teams.

The main issues addressed were as follows:

- The changing role of women on the health team;
- The health care system as curative-oriented and urban-based, without intersectoral linkages;
- Current formal education/training programs of team members, which do not prepare them for new changing roles;
- Lack of resources for training women for these changing roles and discrimination in the selection of women for higher training opportunities; and
- Inadequacies in remuneration for community health workers.

1. The Changing Role of Women on the Health Care Team

In most countries, the majority of health care team members are women. Primary health care activities are directed primarily at women and children.

Women have certain attributes which are considered assets in their team membership role. For example, they are thought to be better able to reach selected health care targets; more acceptable as health care providers by most communities; and can forge linkages with other development sectors more easily. Some aspects of this change are revolutionary in nature and require a completely new look at education/training programs as well as organizational structures.

Recommendations

Women health care team members should be afforded the necessary support systems which would enable them to function efficiently and effectively in their new roles. The support systems include:

- Adequate and relevant education/training programs;
- Legal authorization to practice, where necessary;
- Administrative authority commensurate with functional responsibilities;
- Representation/involvement in policymaking bodies/activities as appropriate;
- Adequate remuneration and recognition for services, taking into account the level of responsibility and technical skills required.

Indicators of Change

- More women occupying policy and decisionmaking positions within the health care system.
- More women in control of or actively participating in budgetary matters and allocation of available resources—financial, material, and human.
- Positive performance evaluation reports of women team members in their new roles; also, satisfactory outcomes/results from impact studies of community health care programs.

2. Orientation of the Health Care System

The present health care system is almost entirely curative-oriented and urban-based. Very few resources are allocated to preventive and promotional work. The system has no intersectoral linkages with other disciplines such as agriculture, irrigation, water supply, sanitation, and education.

This is an important women's issue. Health care services do not reach 80% of women who live in rural areas and urban slums. They do not meet the basic needs of women such as maternity and child health care, health education, or even rudimentary curative and emergency services.

Women in jobs in community health who attempt to meet these needs are frustrated due to lack of resources and support. Health planners and decisionmakers do not see the necessity of making any change in the system.

Since there is no intersectoral coordination, different categories of workers not only do work in unison, but they do not know what others are doing. This leads to inefficiency and waste of resources at all levels, to the detriment of women's health and interests.

Recommendations

It is necessary that there be a complete reversal in priorities and budget allocations in the health services. Every year, greater and greater budget provisions should be made for primary health care in general and maternal and child health in particular. There should be a moratorium on building of new medical colleges, research, and other institutes of excellence until such time as women's health needs are fulfilled.

There should be integration of health and family planning activities and intersectoral linkages.

Indicators of Change

- Clean water supply, sufficient nutritious diet, sanitation;
- Improved maternal and child health and other basic health services for women;
- Diminished infant and maternal mortality; increased expectations of life at birth and increased literacy in women, leading to a better quality of life.

3. Educating and Training Women Health Team Members

Women all over the world play a major role in the health care system. But the content of existing education/training programs is not appropriate to the level and scope of health care services required today; and it does not reflect the preventive and promotive activities necessary to meet the community needs. The existing education/training programs are hospital-oriented and do not equip the health worker to operate adequately within the community, particularly in rural areas.

Now very little attention is given to problems related to maternal and child health, nutrition, food production and many other concerns related to women and their health, such as rape, prostitution, sexually transmitted diseases.

There is a lack of resources for training women for these changing roles and a discrimination in the selection of women for higher training opportunities. This is obviously a women's issue. To be effective workers in the health team, training of women is required. Women also need additional training to overcome lack of education. Increased budget allocations are required for training programs to be developed.

Lack of opportunity for women health workers to acquire higher-level training limits the possibility of their obtaining promotions. Advanced training for leadership roles is essential for women health workers to become more assertive and to be effective members of decisionmaking bodies.

Recommendations

- A radical change in education/training curricula must be made to meet the community needs. This change must cover a wide scope in interdisciplinary approaches to education/training of team members in communication skills, interpersonal relationship.
- The curriculum must be controlled by women who have special skills and are experienced in community problems.
- Training should include preparation for leadership.
- Training should be rural-based.
- Adequate resources should be made available by governments and international agencies for the training of all levels of women health workers. Training of these women should have the highest priority in any country.
- Women should not be discriminated against when opportunities arise for fellowships and advanced training by national and international agencies.

Indicators of Change

- Successful primary health programs;
- An increase in population coverage;
- A decrease in infant mortality rate, maternal death rate, and morbidity;

- Increased village-based education/training programs.
- Number of women in decisionmaking positions will increase;
- Number of women being trained will be increased;
- Quality of their professional services will be improved;
- Increase of health coverage to the rural population, based on effective coordination with intersectoral linkages.

4. Recommendations for Community Health Workers and Others

Community health workers, mainly women, do not always receive remuneration for their services. This is obviously a women's issue, because the large majority of community health workers are and should be women. Even though she is a volunteer, she is giving up three to four hours of her hard-working day to work for the community. Therefore, some compensation should be given to her, and the community should be able to do it. If necessary, the community can be subsidized by government and local bodies.

Similar considerations would apply to all female workers in the health team in developing countries. They seek employment in order to increase the family income. And, in spite of doing a full-time job, they continue to carry on the role of housewife, mother, and wife, without any assistance to ease the burden. This is an important issue for women, since in several areas of employment the female worker gets a lower wage than the male worker even if she is doing the same work.

Recommendations

- Equal pay must be given for equal work; women should receive maternity leave plus all other benefits, including tax benefits, that men enjoy. The woman health worker should be paid on a scale commensurate to her qualification and experience.

Indicators of Change

- Improvement in the socioeconomic status of all members of the health team, including the health workers.
- Equal opportunities for advancement with men.

Appendix II

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(Ph.D., School of Advanced International Studies, School of Hygiene and Public Health, Johns Hopkins University) Responsible for design and management of CPR programs aimed at developing drugs and vaccines for tropical diseases. Formerly, Project Officer in Population, Health and Nutrition in the Africa and Middle East Division, World Bank. (Working Group 4)

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ARGENTINA

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INTERNATIONAL SYMPOSIUM ON WOMEN AND THEIR HEALTH

Visiting Participants

Wednesday, June 11

Celestine F. Arndt - Author, "Health Seeking Behavior in Wegeriya, Sri Lanka," 1977.

Patricia Baldi - Associate Director and Acting Deputy Director, Office of Population, U.S. Agency for International Development.

Gayle Gibbons - Director, Clearinghouse on Infant Feeding and Maternal Nutrition, International Health Programs, American Public Health Association.

Michael S. Gerber - Executive Director, International Medical and Research Foundation.

Pamela Johnson - Social Science Analyst, Social Analysis and Rural Development Division, Near East Bureau, U.S. Agency for International Development.

Stephen C. Joseph - Deputy Assistant Administrator for Human Resource Development, U.S. Agency for International Development.

M. VeNeta Masson - Nurse, Home-Care Director, Community Medical Care, Inc.

Ina Lee Selden - Editor, Salubritas, International Health Programs, American Public Health Association.

A NOTE ABOUT EPOC

The Equity Policy Center (EPOC) was founded in 1978 as a non-profit research, communications, and educational group to study and promote means toward more equitable distribution of income and resources in the U.S. and abroad. EPOC's goal is to ensure that the impact of national and international programs on the individual is equitable regardless of sex, age, health, ethnic background, nationality, or place of residence, while recognizing that the different needs of individuals may require different laws, regulations, delivery systems, or funding. Its chief focus at present is on programs affecting women.

During the 1970s, as more and more studies documented the adverse impact that development was having on poorer women around the world, there was a tendency among women's groups to call for special programs to train, study, or support women and women's organizations. The resulting programs have produced a body of knowledge and experience which can be used to improve the design of general development programs so that poor women, as well as poor men, in fact benefit.

Unfortunately, this emphasis on "women's programs" has also tended to separate women's concerns out from general development issues, a tendency that allows unsympathetic planners to argue that women's needs are being met when, in fact, such programs are generally underfunded, peripheral, and easily cut in times of financial constraint.

Thus, a new strategy seems in order, one that starts with selected issues which cannot be solved without the active participation of women—household energy, village water supply, primary health care, food processing, and the like. Such a strategy emphasizes that women's needs are an indivisible part of national development while at the same time recognizing that special delivery systems, different communications networks, or other design adaptations may have to be made if women are really to be reached.

EPOC believes that this strategy should underlie women's development activities in the 1980s. Because women planners and developers are more likely to have the skills necessary to design and carry out such programs, EPOC is also pressing for the productive use of more women in all development agencies and organizations.