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THE HEALTH SECTOR AT COPENHAGEN

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Health Issues As Reflected in the Programme of Action and Resolutions Adopted at the World Conference of the United Nations Decade for Women, July 1980, Copenhagen, Denmark

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Health was one of the three major, interrelated subthemes of the Conference on the U.N. Decade for Women held this past summer in Copenhagen. One entire section of the Programme of Action approved at the Conference is devoted to identifying objectives and priority areas for action at the national level. Much of the commentary on national development strategies, planning, and implementation is applicable to the health sector, e.g. the need for participation of women in decision-making, the need for improved data, the usefulness of grass-roots organizations. Numerous other parts of the Programme of Action have implications for the health of special groups--working women, rural women, migrant women, young women, etc. The part of the Programme of Action devoted to international and regional action deals, inter alia, with the role of WHO, the U.N. regional commissions, and the rest of the U.N. family of organizations. The relation of such international efforts as the International Drinking Water and Sanitation Decade to the interests of women is also covered. In addition, a number of resolutions passed at the Conference deal directly and indirectly with health-related matters and the role of development assistance.

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The health-related priorities outlined in Part 2 of the Programme of Action--relating to national policies--are addressed in the first instance to governments' domestic programs. The appropriate U.S. audience is thus the federal Department of Health and Human Services, Minnesota's Office of Health, or what have you. At the same time, these priorities dictate the recommended substance of the international development assistance programs called for in Part 3, relating to international and regional policy, and in Conference resolutions.

The health section of the Programme of Action alone includes eight "objectives" and twenty-three "priority areas for action," ranging from promotion of primary health care to protection of women and their families from harmful food additives and deceptive packaging; from programs for safe water, hygiene, sanitation, and shelter to programs against abuse of alcohol, tobacco, and drugs. A number call for greater access by women to education and training in health-related professions, and others for more research and data collection. Many other sections of the Programme of Action also have health implications. For example, the "right to protection of health,...including safeguarding of the function of reproduction" is recommended as a priority action relating to women's employment (para. 126). Non-governmental organizations are charged, inter alia, with helping to promote "public acceptance of family planning, including sex education" (para. 104).

Issues

The following is a much-simplified summary of the health-related material in the Programme of Action (Document A/Conf. 93/34) and the Resolutions approved at the Conference (Doc. A/Conf. 94/34/Add.1).

Integrated Programming: Improved health is a necessary aspect of overall development (para. 46, 141a) and vice versa (para. 44,45). See, for example, the linkages between food production and nutrition (para. 152,197, Res. 41), between women's education and the use of family planning (para. 211a), between women's income and their ability to care for their families (para. 129), and the general connection between basic human needs and the New International Economic Order (para. 45, Res. 47). All governments are urged to review, improve, and coordinate their programs relating to women's needs (Res. 14).

Primary Health Care is fundamental (para. 142, 229, Res. 14), especially in deprived rural and urban areas (para. 153, Res. 29). These programs should train and use women as doctors, as decision-makers, as community health workers, birth attendants, and to promote health within the family (para. 144, 149, 150, 199).

Related Programs are needed to improve hygiene, sanitation, safe water supplies, and shelter (para. 129, 154, 199, Res. 14, 25).

Particular health needs of women include maternal health care, nutrition, family planning, prevention and treatment of disease (including sexually transmitted diseases), health education (para. 145, 169), mental health (para. 141h), and relief from overwork (para. 155, 200). Preventing maternal and infant mortality is a particularly high priority (para. 158), as is improved food and nutrition (para. 152, 197). Breastfeeding should be promoted (para. 157) and the use of breastmilk substitutes and other foods of low nutritional value should be discouraged (para. 153).

Family planning is important both to safeguard women's health and to enable them, along with men, to exercise the right to decide on the number and spacing of their children (para. 146, Res. 1, 14). Public acceptance of family planning including sex education should be promoted (para. 103i, Res. 1).

Men's Responsibilities: Childrearing, family planning, household chores, and other aspects of family well-being should be the joint responsibility of both women and men (para. 64, 91, 101, 114, 136, 159, 202, 229, 236, 286). Family planning should be included in school curricula for both girls and boys (para. 146, 103i).

Occupational hazards, including toxic chemicals and radioactive waste, should be eliminated (para. 156) and safe working and home environments assured (para. 126, 155, Res. 37).

Abusive Practices: Domestic and sexual violence (para. 65, 163, Res. 5), mutilation practices (para. 162), and abuse of

alcohol, tobacco, and drugs (para. 164, Res. 20) all need to be prevented.

Special Categories: Adolescents (para. 161, 210, 211, Res. 27), elderly women, disabled women, and women living alone (para. 160, Res. 2,4) are special categories deserving of attention from the health system. So are women refugees (para. 244g, 248d, Res. 12, 13) and migrants (para. 205h, 258, Res. 3).

Research Needs: Better and more up-to-date health-related data (para. 55, 92, 151) and more research into appropriate indicators of women's health and status (para. 147, 257, 279) are badly needed in many areas. Women doctors and researchers should be more heavily involved (para. 150).

Role of the International Community: Donor governments and international agencies, including non-governmental organizations, are asked to be supportive of these recommendations and to allocate resources to them (para. 212ff, Res. 1, 36, et al.).

These comments and recommendations are necessarily addressed to governments and organizations with many different purposes, resources, and levels of perception regarding women. Thus, no one institution is likely to find all of the health-related material applicable to it; conversely, more priority areas are likely to be applicable to any one institution than it is likely to be able to fund and administer. Thus, there is always room for choosing the most compatible among objectives and priority areas; by the same token, there is always room for adjusting existing programs and moving into new areas as perceptions change.

At Copenhagen, the U.S. delegation was particularly interested in ensuring that the Programme of Action included support for elderly and disabled women, and against domestic violence--all issues of special concern to women activists in the U.S. It also appears to have been active in supporting the notion of joint male/female responsibility for childrearing and family well-being. For the most part, the delegation did not take much initiative on health-related topics of special interest to the Third World, preferring--rightly--to let Third World representatives take the lead in matters of direct concern to them. Delegation members did, however, take an active part in developing sections regarding women refugees, especially their need for family planning information, and in drafting a resolution recommending an integrated approach to the health and welfare of women. They were able to support most Third World initiatives in the health sector.

Perhaps the most effective contribution of--and benefit to--the U.S. delegation was in promoting the notion and practice of networking among women and women's organizations. In this, the delegation was able to build on a substantial prior effort by AID, among others, to seek out Third World women's opinions on health issues. Many of the official and unofficial U.S. representatives at Copenhagen had already been in touch with their counterparts around the world. AID's health, population, nutrition, and women in development divisions have worked with women's groups on a variety of projects. The attendance of some Third

World women professionals in health and family planning was sponsored by private U.S. and international organizations, some of which had received support from AID. AID had also funded a pre-Conference symposium on women and their health which drew 50 participants from 26 countries; eight of these also went to Copenhagen and participated in three pre-Conference workshops on health matters. This process of informal exchange continued at the Conference itself and most especially at the simultaneous non-governmental forum, where numerous workshops, panels, and discussions on health-related subjects were held, more than twenty of them on family planning alone. Networking serves both to encourage women to work together in a context of equality and mutual respect and also to clarify the issues of greatest concern to women.

It is gratifying to note how much of AID's health programming related to women parallels the concerns expressed at Copenhagen. Both AID and the Copenhagen conference agree on the priority to be accorded to helping the poorest women. Both give strong support to the concepts of primary health care elaborated at the WHO Alma Ata Conference of 1978, including the need to use women as community health workers. Both seek to promote nutritional self-sufficiency in general and breastfeeding in particular. Both come down solidly in favor of family planning programs and measures to provide safe water and sanitation.

Some differences in emphasis can be discerned within these general areas of agreement. Thus, the Copenhagen delegates appear

to have placed greater stress on moving women into policymaking positions and on monitoring and data collection with specific reference to the effect of health programs on women. The need for targetting family-oriented programs to men as well as women figures more prominently in the Copenhagen documents. In practice, the programs for "maternal health care" advocated at the Conference might look somewhat different from the "maternal and child health" programs sponsored by AID. The needs of adolescents were given higher priority by Conference delegates than AID seems to feel is warranted. But in general, AID's health programs appear to be consonant with the wishes of the international community of women, at least as expressed in the Copenhagen documents.

In truth, health-related language at the Programme of Action's level of generality could hardly be called controversial. The recommendations and resolutions represent a broad consensus within both the health community and the women's movement. Even the family planning resolution, which might have been expected to generate controversy, was accepted without a vote; it was introduced by some 24 Third World countries.

However, some of the controversies concealed within the general language of the official documents surfaced at the Non-Governmental Forum. There some women raised questions (which others refuted) regarding the safety of the long-lasting contraceptive Depoprovera being used by some family planning groups (though not by AID itself). Also, African women spoke out against perceived "interference" regarding the practice of female circumcision, which

was seen as a problem for African women themselves to handle in their own cultural context. Concern was expressed that Third World governments were being pressured to endorse birth control, even to force women into sterilization. At the Forum, the demand for users--i.e., women--to participate in policymaking with regard to women's health programs was made more explicit. And at the Forum, it became clear that issues such as sexually transmitted diseases, illegal abortion, occupational safety, adolescent pregnancy, and domestic violence are issues for Third World and Western women. (These issues also tended to be the ones that were added at Copenhagen to the original draft Programs of Action, evidently on the basis of proposals from governments under pressure from women activists. (See Appendix A)

Focus for AID

The lessons for AID regarding programs that affect women's health flow perhaps more importantly from the Forum than from the formal Programme of Action adopted at Copenhagen. As noted, this is partly because the issues were posed more sharply at the Forum. Mainly, however, it was because one must look to the Forum for any detailed discussion of health issues; the official Conference was too preoccupied with political questions to give much time to analyzing or debating the sectoral subthemes of the Conference.

A number of useful programming recommendations emerge from the Forum discussions. One AID observer who attended most of the Forum sessions about family planning returned with the

following recommendations, among others (see Memorandum of 8/26/80 from P. Baldi to S. Joseph):

--Continued AID support for training women administrators and managers is essential.

--AID data collection activities regarding women's participation should be revised and upgraded.

--AID should attempt to involve users (women) in planning some health-related projects in order to develop a "user perspective model."

--AID should make better use of women's grass-roots and voluntary organizations, especially on the issue of female circumcision.

--AID should provide seed money for more projects that enable women to earn incomes and should study carefully the relation between women's income and fertility.

--AID should take care to explain the factual basis for controversial aspects of its programs, to minimize misunderstandings by both Third World and U.S. women, e.g. U.S. fact sheet on Depopovera had good effect at Copenhagen.

The recommendations cited above relate primarily to family planning. Other more general ones can be drawn from the Copenhagen discussions:

--Programs for adolescents, including (but not restricted to) sex education, deserve higher priority.

--Programs employing women community health workers should ensure that they are paid equally with men workers and should

include the same kind of support measures--arrangements for child care, etc.--as those for women workers in other sectors.

--Primary health care programs should include support for the development of appropriate technology to enable women to carry out family care responsibilities (e.g., cooking nutritious meals) more efficiently and effectively.

--In areas where sexually transmitted diseases are widespread primary health care programs should train community health workers to recognize and treat these diseases in men, and research should be supported regarding ways to recognize and treat these diseases in women at early stages.

--Primary health care programs should train workers to recognize (and refer or, if possible, treat) the ill-effects in men, women, and children of toxic chemicals used in agricultural production.

--Health programs should be culturally and psychologically sensitive to women's needs, e.g., for personal dignity, and this will require re-orientation of traditional medical training.

--Family care and family planning programs should be targeted to men as well as women.

APPENDIX A

Extract from U.N. Doc. A/Conf. 94/34

Copenhagen Conference, Programme of Action
Part Two: III.B.2, Section on Health*

2. Health

Objectives

141. To improve the physical and mental (amendment sponsored by Canada) health of all members of society through:

(a) An improvement in the health status of girls and women, as a necessary aspect of over-all socio-economic development

(b) Formulation of demographic policies

(c) An improvement in health care for women (during child-bearing and) throughout their life cycles

(d) The increased participation of women and men, not only as beneficiaries of (in) the promotion of health but also (and) in the formulation and implementation of policy decisions regarding health at community and national levels; (amendment sponsored by Mexico); (women should be fully included in all processes of health policy and care)

(e) Studies of the causes of diseases, the establishment of clinical and epidemiological research programs and the organization of services to deal with national problems; (based on an amendment from Argentina)

(f) The development of policies and programmes aimed at the elimination of all forms of violence against women and children and the protection of women of all ages from the physical and mental abuse resulting from domestic violence, sexual assault, sexual exploitation and any other form of abuse ; (development of policies and establishment of effective help for women who suffer physical abuse, including rape); (based on amendments from France and others)

(g) Training human resources for health programmes of the required quantity and quality; (amendment from Mexico)

(h) The inclusion of the mental health aspect as well as alcoholic and drug programmes as part of over-all health programmes for women.

*Underlined material was added at Copenhagen to the draft Program of Action; bracketted material was omitted. Sponsors of these amendments, where known, are indicated in parentheses .

142. Promote primary health care with the participation of the communities as the overriding health priority and as a fundamental vehicle for achieving the health goals and objectives of the World Plan of Action. (amendment from Mexico)
143. Give high priority to meeting the health and needs of women within primary health care, with particular attention to the special needs of women in rural and depressed urban areas (of developing countries) and monitor health programmes in order to secure that women's health needs are properly met. (deletion proposed by the United States)
144. Formulate official policies to involve women in planning and carrying out health programmes at all levels particularly to increase the participation of women at decisionmaking levels.
145. Ensure accessibility for all women to maternal health care (including care during pregnancy and childbirth and post-natal care), nutrition (including measures to control nutritional anemias), family planning, prevention and treatment of infectious diseases--including sexually transmitted and non-communicable diseases--and parasitic diseases, through the establishment of a comprehensive family health, nutrition, and health education network, in order to give (a greater number of) women better access to health care. (additions sponsored by Belgium, Argentina)
146. Develop, implement and strengthen (Mexico) child welfare and family planning programmes and family planning information for inclusion also in school curricula for girls and boys (Belgium) on safe and acceptable fertility regulation methods so that both men and women can take the responsibility for family planning to promote the health, safety and welfare of mothers and infants and to enable women to exercise the right to decide freely and responsibly the number and spacing of their children. Family planning should be facilitated as one means of reducing maternal and infant mortality where high risk factors prevail, such as high parity, too frequent pregnancies, pregnancies at the extremes of reproductive age, (Australia), and the frequency and danger of secretly performed abortions. (France)
147. To promote the physical and mental well-being of women, make provision for additional research over the next few years to facilitate analysis and assessment of the status of women. (Belgium)
148. Develop programmes to improve the training and utilization of community health workers, especially women, traditional medical practitioners and birth attendants and elderly village women; support women in their contribution to primary health care both within the family and the community particularly with reference to self-care and self-reliance in health.
149. Draw the attention of doctors and other health professionals (with regard) to the health needs of women in general, not only in relation to pregnancy and childbirth; emphasize preventive medicine and the need to share responsibility and decisionmaking with professionals in other disciplines and with women themselves. (Argentina suggested specifying anthropological research as an input into policymaking.)

150. Establish official incentive policies to give women greater access to training in the medical (and health) professions and in (health and) health-related research in accordance with local and national needs. (deletion from Mexico)
151. Develop simple economic, social, and cultural indicators (at village level) in order to obtain better data on trends in morbidity and mortality among women and their access to and utilization of health services. (deletion from Argentina) Establish a national basic health information system to provide up-to-date and reliable indicators of prevailing conditions, future trends and resource productivity. (Mexico)
152. Give high priority to the formulation and implementation of food and nutrition policies based on the needs of women, particularly pregnant and lactating women, and those of women and children (USSR, et al.) of lower socio-economic status in both rural and depressed urban areas; establish educational programmes through professional schools and community agencies to improve the quality, availability, preparation, preservation, rational use and distribution of food, especially locally grown foods.
153. Protect the health and safety of women and their families from contamination, spoilage, and adulteration of foods, harmful additives and preservatives, mislabelling, deceptive packaging and irresponsible promotion of foods of low nutritional value and of breast milk substitutes. High priority should be given to the enactment and enforcement of comprehensive legislation, where appropriate, and the creation of appropriate standards of safety, health, product information and quality, including standards of safety, health, product information and quality, including standards for the preparation, preservation, packaging and labelling of foods and other products sold in the markets. Women and men should be instructed as to the right and hygienic use of such products. Information as to the right to such protection should be widely disseminated through schools, the media, and village and community organizations.
154. Develop explicit programmes at national and local levels to improve hygiene, sanitation and access to safe water supplies and shelter as fundamental bases for good health.
155. Develop policies to ensure a safe working environment both in the home and in the work place and provide appropriate technology to relieve the workload of women. Carry out specific studies on labour hygiene and safety, particularly in branches of activity in which the health of women might be affected.
156. Introduce legislation aimed at eliminating occupational health hazards likely to affect reproductive functions, reducing environmental pollution, and controlling disposal of toxic chemicals and radioactive waste. (Australia)

157. Promote extensive health education programmes, including special efforts to encourage positive traditional practices, especially breastfeeding, and to combat negative practices detrimental to women's health.
158. Formulate specific programmes for the prevention of maternal and infant mortality, giving priority to depressed rural and urban areas and to most vulnerable population groups. (Cuba)
159. Encourage formation and implementation of social support measures such as maternity and parental laws, child care, breastfeeding breaks, etc., to enable women and men to carry out parental roles in the most optimal and healthy manner.
160. Direct special attention to the needs of elderly women, women living alone, and disabled women.
161. Establish programmes giving full medical attention to adolescent women, since adolescence is a critical time in women's biological and psychological development and also involves a change in their relationship to the social environment in which they live. (Argentina)
162. Prevent mutilation practices which damage women's bodies and health. (Belgium)
163. Promote research into the extent and causes of domestic violence with a view to eliminating it; take measures to eliminate glorification of violence against and sexual exploitation of women in the mass media, literature and advertising; provide effective help for women and children who are victims of violence, e.g., by establishment of centres for treatment, shelter, and counselling victims of violence and sexual assault. (based on amendments proposed by Canada et al.)
164. Formulate a plan of action for the protection of women against abuse of alcohol, tobacco, and drugs and also excessive use of certain medicaments, principally by informing them of the hazards these substances present for them and their children. (Belgium; similar concerns expressed by Mexico and Iceland)