

PN-ABN-569

**WOMEN'S
HEALTH**
**THE ACTION AGENDA
FOR THE 90's**

18th NCIH International
Health Conference
June 23-26, 1991
Hyatt Regency Crystal City
Arlington, Virginia



CONFERENCE PROGRAM

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WORLD VISION

WOMEN'S HEALTH

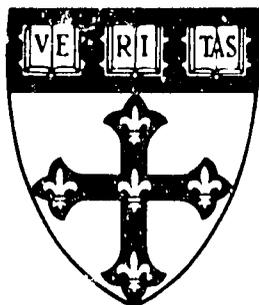
THE ACTION AGENDA FOR THE 90's

**18th NCIH International
Health Conference**

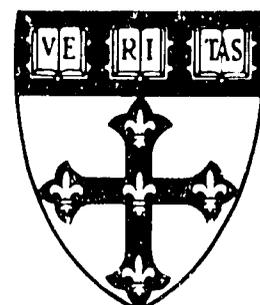
June 23-26, 1991
Hyatt Regency Crystal City
Arlington, Virginia



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Lecturer on Management, HSPH

COURSE CONTENT

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- Organizational Strategy
- Management Information Systems
- Micro Computer Operations With Hands-on Training
- Financial Management
- Human Resource Management
- Social Marketing
- Planning and Evaluation

WHO SHOULD ATTEND

The course is designed for managers and health professionals in government as well as non-government organizations, including hospitals, health centers and public health programs, at the national, provincial and district government levels.

FOR COURSE BROCHURE, APPLICATION AND FURTHER INFORMATION, PLEASE CONTACT:

Anne Mathew, Ph.D.
Office of Continuing Education
Harvard School of Public Health
677 Huntington Avenue
Boston, Massachusetts 02115 USA

Telephone: 617-432-1171

Facsimile: 617-432-1969

Telex: 501003 (Attention: Continuing Education)

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The Ford Foundation
The John D. and Catherine T. MacArthur Foundation
The Rockefeller Foundation
The United States Agency for International Development

The following organizations contributed to the Exhibitors Reception:

The Centre for Development and Population Activities
Program for Appropriate Technologies in Health
Population Services International

This conference would not be possible if it were not for the generous contributions of NCIH members.

NCIH DONORS

Organizations

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Linda Vogel
Karl Western
J. C. Wolgemuth
Joe Wray

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Welcome

Welcome to the 18th Annual NCIH International Health Conference, the first conference to focus on the totality of women's health needs. Nearly a year ago,

NCIH and the Conference Planning Committee distributed a call for papers on women's health. We were richly rewarded with more than 350 abstracts from all over the world. In addition to the more than 200 presenters scheduled to participate, we are pleased to have invited more than forty women's health specialists to speak in the Plenary and Forum Sessions. We are delighted to include so many people in the program. We only wish we could have included others who have contributed to this important subject.

In addition to sharing the latest technical information on women's health, that will be published in a technical monograph after the conference, the Planning Committee set a second goal, which is to generate an Action Agenda, or statement of proposed policies, recommendations, and initiatives that would positively affect women's health. We urge each one of you to actively participate in the development of the Action Agenda.

Ten major themes have emerged from the abstracts and invited program. They are: Infection, Nutrition, Morbidity, Mortality, Access to Care, Quality of Care, Listening to Women, Legislation, Policy and Advocacy, Socioeconomic Status, and Violence/Mental Health. We recruited ten reporting teams from both the 1991 Planning Committee and the Conference Program. Each team will cover the sessions of the Conference concerned with its assigned theme: including the Plenary Sessions, Forums, Concurrent, Roundtable, Poster, and Audio Visual Sessions.

During the conference, the reporting teams will meet each evening to discuss the day's events. Each team will develop a short paragraph outlining key points, innovative strategies, new insights, and recommendations based on the Conference presentations. These ten paragraphs will then be used to develop a draft of the Action Agenda Tuesday evening.



Anne Tinker



Peggy Curlin

The draft will be available for your review on Wednesday morning. During the Working Session, we ask you to choose one of the ten Breakout Sessions depending on your own area of interest. During the first part of each session, the reporting team will discuss highlights of the Conference that are related to the specific theme. You will meet in small groups within each Breakout Session and report back to the entire group to synthesize and incorporate modifications, additions, and comments. We will strive to insure that the Action Agenda is a consensus document; however, where there is significant dissent on a particular point, it will be noted. During this session participants will also identify relevant scientific and technical information to be included in the monograph.

After the session, the rapporteurs will modify the Action Agenda based on the Breakout Sessions. Following lunch and prior to the Closing Session speech by Gabriela Bocec, we will present the highlights of the revised draft and ask you to confirm it as an outcome of the Conference.

After the Conference, NCIH staff, in consultation with the reporting teams and members of the 1991 Planning Committee, will edit the Action Agenda. NCIH will disseminate copies of the final Action Agenda to Conference participants, policymakers, press, and other key decision-makers concerning women's health.

As a resource for you in developing the Action Agenda, Jill Gay and Tamara Underwood, from the NCIH Staff, developed a Background Paper for the 1991 Conference. This paper is included at the back of this program.

We clearly have a lot of work to do this week. We hope that everyone will fully participate in the development and discussion of the Action Agenda.

PEGGY CURLIN and ANNE TINKER
CONFERENCE PLANNING
COMMITTEE CHAIRS



WHO



UNICEF



UNDP

**INTERNATIONAL CONSULTATION ON CONTROL OF ACUTE RESPIRATORY INFECTIONS
WASHINGTON, D.C., DECEMBER 11-13, 1991**

The World Health Organization (WHO), United Nations Children's Fund (UNICEF), and the United Nations Development Programme (UNDP) cordially invite you to attend the **INTERNATIONAL CONSULTATION ON CONTROL OF ACUTE RESPIRATORY INFECTIONS (ICCARI)**.

As the first large international meeting devoted to the issue of the control of acute respiratory infections, ICCARI is expected to serve three important functions:

- Provide the international health community with up-to-date information on ARI control, including case management and national programme implementation;
- Promote global consensus on the actions needed to reduce ARI mortality; and
- Generate increased participation in efforts to combat ARI.

Registration is limited. For additional information, interested persons should contact the ICCARI organizers at:

The Task Force for Child Survival and Development
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effort to eradicate blindness, the world's blind population will reach 90 million by the year 2000.

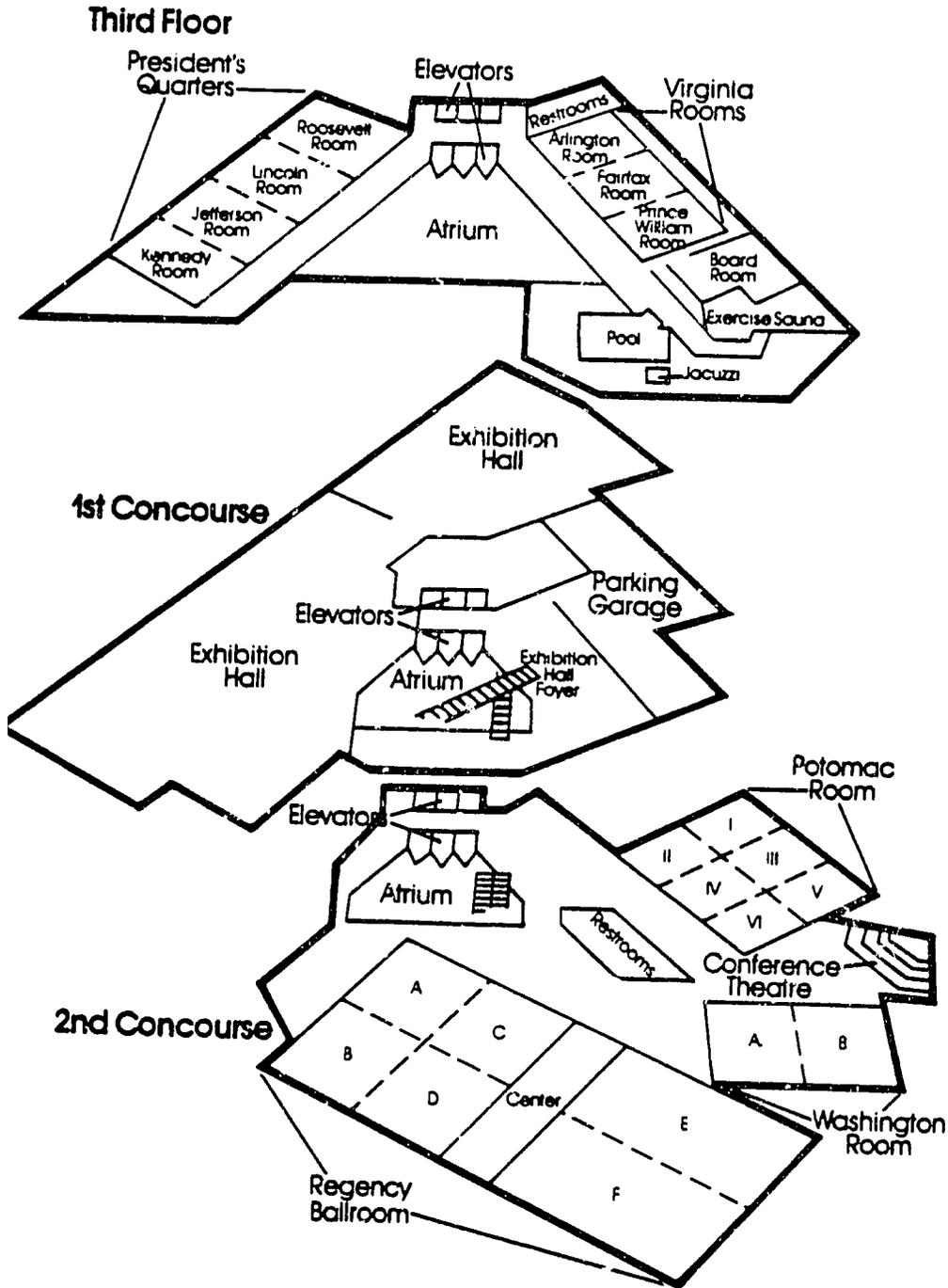
Your gift of \$30 will make such a difference to families in places like Asia, Africa, and South America as well as other less developed areas of the world.

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Helen Keller International, 15 West 16th Street, New York, NY 10011

If you are a federal or state employee, or a member of the military, you may make a donation to HKI through the Combined Federal Campaign by checking box 0316 on your form.

Meeting Rooms



GENERAL INFORMATION

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Registration & Information

Registration Hours

Sunday	June 23	Noon - 6:00 pm
Monday	June 24	7:30 am - 5:00 pm
Tuesday	June 25	7:30 am - 5:00 pm
Wednesday	June 26	8:00 am - Noon

Please wear your NCIH Conference Badge for admission to all sessions, the Exhibit Hall, and the Career Resource Center. Replacement badges cost \$10.00.

Registration includes:

- ◆ Welcome Reception
- ◆ Opening and Plenary Sessions
- ◆ Forums
- ◆ International Health Exhibit and Reception
- ◆ Public Policy Breakfast
- ◆ Membership Reception and Meeting
- ◆ Career Resource Center
- ◆ Caucuses and Auxiliary Meetings
- ◆ Closing Session and Luncheon
- ◆ Concurrent Sessions, Roundtable, Poster and Audio Visual Sessions
- ◆ Coffee Breaks
- ◆ Name Badge and Printed Program

International Health Exhibit

The International Health Exhibit features displays of the latest products, services, and programs in the international health field.

Monday	June 24	9:30 am - 6:00 pm
Tuesday	June 25	9:30 am - 5:30 pm
Wednesday	June 26	8:30 am - Noon

Visit the NCIH Booth #100 for information on membership, publications, and current initiatives in public policy and AIDS.

Career Resource Center

The Career Resource Center offers conference participants an opportunity to explore new career possibilities and to schedule interviews with employers currently recruiting staff in the international health field. The Center is located in the Exhibit Hall and is open only to conference registrants. The resume and job announcement binders will be available for sale after the conference.

Monday	June 24	9:30 am - 6:00 pm
Tuesday	June 25	9:30 am - 5:30 pm
Wednesday	June 26	8:30 am - Noon

Business Center

Mail Boxes Etc. will provide typing, photocopying, FAX, portable telephone, and mailing services at the business center located on the Ballroom Level.

Audiocassettes

Audiocassettes of selected sessions will be available for sale by Audio Recording, Inc, located on the Ballroom Level.

Child Care

Babysitters are available through the Hyatt Regency. Contact the Concierge for more information.

Messages

To contact other conference attendees, a message board is located near Registration. Message pads are available at the Information Booth.

Personal Property

The Hyatt Bell Desk has limited space for checked items. Contact the Concierge on the Lobby Level for assistance. NCIH will not hold items for you at the Registration counters.

For lost items, use the house phones to call Hotel Security.

Program Highlights

Welcome Reception

Ballroom Level

Sunday, June 23, 4:00 pm

Do not miss this informal reception for registered participants to kickoff the conference, meet fellow colleagues, and create new partnerships. Cash bar.

Opening Session

Regency Ballroom

Sunday, June 23, 6:00 pm

Keynote Speaker: **Carzen Barroso**, Senior Population Advisor, MacArthur Foundation

Please join Ms. Barroso and the Conference Planning Committee in the Opening Session of the 18th Annual NCIH International Health Conference.

Exhibitors Reception

Exhibit Hall

Monday, June 24, 4:00 pm

All participants are encouraged to join with representatives of international health organizations and other exhibitors in the Exhibit Hall for cocktails and conversation. Cash bar.

Martin J. Forman Memorial Lecture

Regency Ballroom

Monday, June 24, 7:00 pm

Sliding Toward Nutrition Malpractice—A Time to Reconsider and Redeploy

Speaker: **Alan Berg**, Nutrition Advisor, The World Bank
As Nutrition Advisor for the past eighteen years, Alan Berg has been the focal point for nutrition programs at the World Bank. Previously, he was a Senior Fellow at The Brookings Institution and a Visiting Professor of Nutrition at M.I.T. As Chief of Food and Nutrition for A.I.D. in India from 1966-70, he was responsible for coordinating relief during the Bihar famine. He has written several books on nutrition as an international health issue and his writings have appeared in *Foreign Affairs*, *The New York Times Magazine*, and the *Times*. The Martin J. Forman Memorial Lecture is an annual event sponsored by Helen Keller International.

Membership

Regency C/D

Meeting and Reception

Tuesday, June 25, 5:30 pm

Soviet Medical Students: Concerns, Opinions, and Demographics

Speaker: **Mary Theodore**, Albert Einstein College of Medicine

Current and prospective NCIH members are encouraged to attend this session for a report by NCIH staff and Governing Board Officers on current and future programs and initiatives.

Awards Banquet

Regency Ballroom

Tuesday, June 25, 7:00 pm

Keynote Speaker: **Antonia Novello**, U.S. Surgeon General.

NCIH takes this opportunity to recognize and honor outstanding achievements by members of the international health community. Do not miss this gala event honoring the recipients of the Women's Health Award, the Award for Service in International Health by an individual and an organization, and the Award for Leadership in International Health.

A limited number of tickets are available for sale at Registration for \$35.

Public Policy Breakfast

Regency Ballroom

Wednesday, June 26, 7:30 am

Join U.S. Representative **Patricia Schroeder** and **Ingela Thalen**, Minister of Health and Social Affairs of Sweden, for a discussion of women's health policy initiatives in the U.S. and Sweden.

Closing Session/Luncheon

Regency E/F

Wednesday, June 26, 1:00 pm

Keynote Speaker: **Gabriela Bococ**, Vice President, SECS, Romania

The final session will feature the highlights of the Action Agenda and a taste of what is in store for 1992.

Workshops

Women in the Middle: An Experiential Simulation Workshop *Washington B*

Sunday, June 23, Noon

Facilitator: **Sylvia Vriesendorp**, MSH

This simulation is for men and women who are interested in exploring the concept of middle-ness and how it affects women. Participants will leave the workshop with a better understanding of the forces that act upon the middle manager with an increased sensitivity to a women's perspective on being in the middle, with some ideas for empowering their own mid-level staff, and for those who train, with a new and easily replicable simulation.

No charge.

Methodology Workshops

1. Community Assessment of Maternal and Neonatal Health and Nutrition: A Dialogue *Arlington*

Monday, June 24, 11:30 am

Facilitator: **Willa Pressman**, MotherCare/CEDPA.

Panel: Alfred V. Bartlett, Johns Hopkins University; Magda Ghanma, CARE; and Angela Kamara, Columbia Univ. SPH.

Who should attend: NGO/PVOs, including women's organizations and others who have carried out such assessments. Bring several copies of your assessment instruments to discuss their pros and cons.

2. Using Anthropometry to Measure Women's Nutritional Status *Arlington*

Monday, June 24, 4:30 pm

Facilitators: **Mary Ann Anderson**, USAID and **Allan Kelly**, WHO, Geneva

3. Measuring Maternal Mortality: Old Constraints and New Opportunities *Prince William*

Tuesday, June 25, 11:30 am.

Facilitators: **Vincent Fauveau**, **Oona Campbell**, and **Veronique Filippi** of the London School of Hygiene and Tropical Medicine.

No charge.

Public Policy Workshop *Fairfax*

Monday, June 24, 11:30 am

Ruth Fischer, USAID Health Affairs Advisor, will discuss the Agency's recently established University Center. The Center was established to expand USAID liaison with university faculties and departments who can assist with its development objectives, as well as to increase collaboration between U.S. and developing country universities.

No charge.

Costing Safe Motherhood Programs *Potomac 2*

Wednesday, June 26, 3:00 pm

This workshop will draw together people who are interested in developing a database for use in costing research to improve the information base on costs, effectiveness and impact of maternal health programs. Participants will identify available information as well as likely site contact persons, and possible funding for future field work. An ongoing data working group will be formed to develop data protocols for field work, and to advance plans for the building of a database.

No charge

AIDS, NGOs, and Private Sector Initiatives *Tidewater*

Wednesday, June 26, 4:00 pm -

Thursday, June 27, 5:00 pm

Scarce NGO resources are being stretched by the exponential spread of HIV infection worldwide, requiring more innovative uses of available resources. The purpose of this workshop is to encourage NGOs/PVOs to develop approaches and explore broad-based sources of financial support, and promote partnerships among the NGOs/PVOs and the private sector in implementing AIDS program initiatives.

Registration: \$45

Workshops

Urban Health: What Do We Know? What Should We Know?

Regency C

Thursday, June 27, 9:00 am

This workshop on urban health, sponsored by the USAID Science and Technology Bureau's Office of Health, will provide participants with an opportunity to advance current thinking and contribute to the knowledge base presently available regarding urban health. Participants will hear a panel discussion and take part in small group discussions on issues such as quality assurance, the need for improved urban health information (and how to accomplish this), and alternatives to currently available health care delivery systems. Space is limited to 150 people. Sign up at the USAID booth in the Exhibit Hall.

No charge.

Strengthening Collaboration Between Research and Services

Potomac 2

Thursday, June 27, 9:00 am

Facilitator: Myrna Seidman, TvT Associates

Who Should Attend: Professionals concerned with the management and delivery of health and family planning services, as well as researchers conducting and applying research on service improvement.

Registration includes lunch.

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Auxiliary Meetings

NCIH Membership Orientation

Kennedy

Sunday, June 23, 2:30 pm

Join veteran NCIH members for an informal session to learn about NCIH, the advantages of being a member and the initiatives that exist to strengthen U.S. international health programs. New and prospective members, as well as visitors from abroad are invited to attend this meeting.

Student Caucus

Jefferson

Sunday, June 23, 2:30 pm

Facilitator: **Samir Banoub**, Univ. of Southern Florida Health Opportunities at USAID; Holly Fluty, USAID

Join other students for an instructive session on careers in international health. What are some of the resources available to help launch an effective job search in a highly competitive field? How do you write an appealing c.v.? Where are the jobs and how do you find them?

Nurses Caucus

Potomac 2

Monday, June 24, 11:30 am

This will be an informal, networking session, to give nurses a chance to meet each other and share information about resources, programs, and concerns related to international health. Bring your lunch.

Society of Public Health Educators (SOPHE)

Kennedy

Monday, June 24, 11:30 am

Brown Bag Lunch. The Society of Public Health Educators is a professional organization for health educators working in a variety of settings. Bring your lunch for this informal session to meet people with similar interests.

Univ. of Hawaii SPH

Prince William

Monday, June 24, 11:30 am

Emerging Problems and Threats to Women's Health and Status in the Developing World

Facilitator: **Walter Patrick**, Univ. of Hawaii, SPH
Panel:

Po-Ya Chang, Director, General Health, Taiwan,
"Women's Health in Newly Industrializing Countries: Taiwan"

Sister Peg Donovan, Director, Rural Health Center,
"AID's Tracks and Women at Risk in Tanzania"

Penny Hatcher, Univ. of Hawaii SPH, "War and Women's Health in the Shifting Sands of the Gulf Crisis"

Management Sciences for Health

Potomac 4

Monday, June 24, 11:30 am

Urbanization: The Challenge of Delivering Health Services to Urban Poor Women

Facilitator: **Diana R. Silimperie**, MSH

This session will explore issues and experiences surrounding effective delivery of health services to poor urban women.

PVO/AIDS Network

Roosevelt

Monday, June 24, 4:30 pm

Alternative Strategies to Providing Care for HIV Infected People

Panel:

Liz Mataka, Family Health Trust in Lusaka

Catherine Lwenya, Nairobi Hospice Terminal Care Center

Miria Matembe, ACFOD Uganda

Kaiya Montaocean, Center for Traditional Medicines

This session will discuss the issues pertaining to treatment and care and explore the role of NGOs in addressing the problem of providing care for HIV infected people and people with AIDS.

Auxiliary Meetings

APHA International Health Section

Lincoln

Monday, June 24, 4:30 pm

The focus of this mid-year meeting of the International Health (IH) Section of the American Public Health Association (APHA) will be to discuss strategies for advocacy by APHA on critical international health issues for the 1990s—including child survival, AIDS, and women's health. Participants will discuss recommendations proposed in the position paper now being developed by the IH Section for APHA's role in advocating policies and mobilizing resources for international health. Copies of the draft position paper will be available for review and comment. All APHA members are welcome to attend. The meeting will also afford an opportunity to find out about APHA international health activities.

Consortium for International Health Programs

Potomac 2

Tuesday, June 25, 11:30 am

Organizational Meeting

Overview: Anvarali Velji, Univ. of California Medical School at Sacramento

Organizational Progress to Date: Lynn Bickley, Univ. of Rochester School of Medicine

Moderator: Ross Pust, Univ. of Arizona School of Medicine

NCIH Partnership for Health Program

Potomac 6

Tuesday, June 25, 11:30 am

Facilitator: **Guruaj Mutalik**, NCIH

As part of its larger objective to enhance United States participation in international health cooperation, NCIH organized several international conferences during 1990-91 in Texas, Alabama, North Carolina and Massachusetts, to focus on issues related to health and development of women and children in the overall framework of Primary Health Care. The dialogue in which policy makers, health care professionals, PVOs, and academia participated, led to a critical review of the issues and suggested solutions for change.

The Population Council

Fairfax

Tuesday, June 25, 11:30 am

Facilitator: **Herve Ludovic de Lys**, Management Technical Advisor to PSND, Kinshasa.

With the participation of the Chief of the Health and Population Office of USAID/Kinshasa, Ray Martin, this meeting will explore the "USAID-funded health/family planning activities in Zaire: Current Situation and Prospects for Collaboration."

WIPHN

Kennedy

Tuesday, June 25, 11:30 am

The Women's International Public Health Network will host a guest speaker, **Nmondi Ngubo**, who will speak on the migrant women's plight in Africa. WIPHN members will also discuss needs, priorities and WIPHN's Save a Mom Campaign. The meeting will close with a ceremonial solidarity ritual.

ARHP is the

Association of Reproductive Health Professionals.

ARHP's principal objectives are to educate health care professionals and the public on matters pertaining to reproductive health.



ARHP TODAY is a dynamic organization that is taking the lead on contemporary reproductive health issues. Its interdisciplinary membership includes physicians and other health care providers, scientists, educators and consumers. ARHP keeps its members and others informed and involved, and accomplishes its objectives by:

DEVELOPING AND SPONSORING

scientific meetings, educational programs and other forums for the exchange of information among reproductive health care providers.

FOSTERING

the attainment of professional skills and the expansion of consumer knowledge pertaining to reproductive health.

PUBLISHING AND DISSEMINATING

information on reproductive health issues.

ADVANCING

public policies supportive of reproductive health.

Individuals with interest or expertise in reproductive health are invited to become members.

YES! I'm interested in receiving a packet with additional information.

NAME

ADDRESS

CITY STATE ZIP

PHONE

Send to:
ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSIONALS
2401 PENNSYLVANIA AVE., N.W., SUITE 350 • WASHINGTON, D.C. 20037-1718 • (202) 466-3825 • FAX (202) 466-3826

NCH691

Days at a Glance

Sunday, June 23

- | | |
|-------------------|--|
| 9:00 am - 4:00 pm | ◆ Conference of Christians for International Health |
| Noon - 3:00 pm | ◆ Women in the Middle: An Experiential Simulation Workshop |
| Noon - 6:00 pm | ◆ Conference Registration |
| 3:00 pm - 6:00 pm | ◆ Exhibitor Registration Open |
| 4:00 pm - 6:00 pm | ◆ Welcome Reception |
| 6:00 pm - 8:00 pm | ◆ Opening Session |



Monday, June 24

Theme I

Status and Determinants of Women's Health

- | | |
|---------------------|--|
| 7:30 am - 5:00 pm | ◆ Conference Registration |
| 8:30 am - 9:30 am | ◆ Plenary Session |
| 9:30 am - 6:00 pm | ◆ International Health Exhibit
Career Resource Center |
| 9:30 am - 10:00 am | ◆ Coffee Break |
| 10:00 am - 11:30 am | ◆ Concurrent Sessions |
| 11:30 am - 1:00 pm | ◆ Auxiliary Meetings (Cash Lunch) |
| 1:00 pm - 2:30 pm | ◆ Forums |
| 2:30 pm - 3:00 pm | ◆ Coffee Break |
| 3:00 pm - 4:00 pm | ◆ Roundtable, Poster, & Video/Film Sessions |
| 4:00 pm - 6:00 pm | ◆ Exhibitors Reception |
| 4:30 pm - 6:00 pm | ◆ Auxiliary Meetings |
| 7:00 pm - 9:00 pm | ◆ Martin J. Forman Memorial Lecture |

Days at a Glance

Tuesday, June 25

Theme II

Addressing Women's Health Needs

7:30 am - 5:00 pm	◆ Conference Registration
8:30 am - 9:30 am	◆ Plenary Session
9:30 am - 5:30 pm	◆ International Health Exhibit Career Resource Center
9:30 am - 10:00 am	◆ Coffee Break
10:00 am - 11:30 am	◆ Concurrent Sessions
11:30 am - 1:00 pm	◆ Auxiliary Meetings (Cash Lunch)
1:00 pm - 2:00 pm	◆ Roundtable, Poster, & Video/Film Sessions
2:00 pm - 3:30 pm	◆ Forums
3:30 pm - 4:00 pm	◆ Coffee Break
4:00 pm - 5:30 pm	◆ Concurrent Sessions
5:30 pm - 7:00 pm	◆ Membership Meeting & Reception
7:00 pm - 9:00 pm	◆ Awards Banquet



Wednesday, June 26

Theme III

Improving Women's Health—The Action Agenda

7:30 am - 9:00 pm	◆ Public Policy Breakfast
8:00 am - Noon	◆ Conference Registration
8:30 am - Noon	◆ International Health Exhibit Career Resource Center
9:00 am - 10:30 am	◆ Forums
10:30 am - 11:00 am	◆ Coffee Break
11:00 am - 1:00 pm	◆ The Development of the Action Agenda
1:00 pm - 2:30 pm	◆ Closing Session / Luncheon

Sunday - Monday (7:30 am - 10:00 am)

Sunday, June 23

9:00 am-4:00 pm

- ◆ Conference of Christians for International Health: *Tidewater*

The Bent-Over Woman

Noon-3:00 pm

- ◆ Simulation Workshop: *Washington B*

Women in the Middle

Noon-6:00 pm

Registration *Exhibit Hall Level*

2:30 pm-4:00 pm

- ◆ NCIH Membership Orientation *Kennedy*
- ◆ Student Caucus *Jefferson*

4:00 pm-6:00 pm

Welcome Reception *Ballroom Level*

6:00 pm-8:00 pm

Opening Session *Regency Ballroom*

Women's Health: The Action Agenda for the 90s

Welcome:

Janet Gottschalk, NCIH Governing Board Co-Chair

Remarks:

Peggy Curlin and **Anne Tinker**, 1991 Planning Committee Co-Chairs



Keynote Speaker:

Carmen Barroso, Senior Population Advisor,
MacArthur Foundation

Monday, June 24

Theme I

Status and Determinants of Women's Health

7:30 am-5:00 pm

Registration *Exhibit Level*

8:30 am-9:30 am

Plenary Session *Regency Ballroom*

A Woman's Road to Death

M. F. Fathalla, Director, Special Programme of Research, Development and Research Training in Human Reproduction, WHO

The Life Cycle of Women's Health



Barbara Boyle Torrey, Chief, Center for International Research, Bureau of Census

9:30 am-6:00 pm

Exhibit *Exhibit Hall*

Career Resource Center

9:30 am-10:00 am

Coffee Break *Exhibit Hall*

Monday (10:00 am - 11:30 am)

10:00 am - 11:30 am

Theme I Concurrent Sessions

1. Abortion

Washington A

Session Chair:

Lynn Erickson Fielder, Planned Parenthood Assoc. of Santa Clara County

Panel:

- *The Impact of Induced Abortion on Women's Health in Kenya*—Jean Baker, MSH
- *Consequences of Illegal Abortion in Chile*—Miren Busto, Corporacion de Salud y Politicas Sociales
- *The Impact of Illegal Abortion on the Ecuadorian Health System*—Graciela I. Salvador, Center for Population and Family Health
- *Abortion Attitudes of Puerto Rican Women*—K. Lisa Whittle, Centers for Disease Control

2. Access to Care

Potomac 2

Session Chair:

Jim Knowles, The Futures Group

Panel:

- *Experiencia de Participacion de la Mujer en la Organizacion e la Salud en una Region del Sureste de Mexico*—Maria Elena Alvarez, Centro de Investigaciones en Salud de Comitan
- *Male Doctor, Female Patient: Access to Health Care in Egypt*—Laurie Krieger, PATH
- *The Impact of Health Financing Policy Reform on Women's Access to Primary and Preventive Health Services*—Charlotte Leighton, JSI
- *Understanding the Childbirth Choices of Jamaican Women*—Maxine Wedderburn, Hope Enterprises

10:00 am - 11:30 am

Theme I Concurrent Sessions cont.

3. Female Morbidity

Potomac 4

Session Chair:

Marjorie Koblinsky, Mother Care Project, JSI

Panel :

- *Socioeconomic Factors of Reproductive Morbidity of Hausa Women*—Florence A. Bashmir, Ahmadu Bello Univ., Nigeria
- *Mortality and Morbidity, Factors and Determinants*—Mawaheb El-Mouelhy, Cairo Family Planning Association
- *Women's Health in Rural Bangladesh*—Kate Stewart, International Centre for Diarrhoeal Disease Research
- *The Use of Sample Registration System for the Prospective Data Collection of Maternal Morbidity*—Budi Utomo, Univ. of Indonesia

4. Listening to Women Talk About Their Health

Potomac 6

Session Chair:

Margaret Bentley, Johns Hopkins Univ. School of Hygiene and Public Health

Panel :

- *Women and Health: Migrant Women Speak in Bangladesh*—Shamima Islam, Center for Women and Development
- *Application of Ethnographic Research to Understand Perceptions of Women and Health Practitioners Regarding Specific Health Disorders in India*—Shubhada Kanani, University of Baroda
- *Listening to Zambian Adolescents Talk About AIDS*—Elizabeth Mataka, Family Health Trust
- *Health-Seeking Behavior of Tribal Women of Panchmahals, Gujarat for Their Gynecological Illnesses*—Pallavi Patel, Centre for Health Education, Training and Nutrition Awareness, India

Monday (10:00 am - 11:30 am)

10:00 am - 11:30 am

Theme I Concurrent Sessions cont.

5. Nutrition

Roosevelt

Session Chair:

Frances R. Davidson, USAID Office of Nutrition

Panel:

- *Undernutrition During Pregnancy and Lactation in India*—Mary Ann Anderson, AID
- *Anaemia in Pregnancy*—Saadiya Aziz Karim, Aga Khan Univ. Dept of Obstetrics & Gynecology
- *Nutritional Antecedents to the Major Cases of Maternal Mortality*—Kathleen M. Merchant, Colgate Univ., Dept of Geography
- *The Effect of Perity on Body Mass and Composition of Women During Lactation*—Juan Rivera, Inst. of Nutrition of Central America and Panama

6. Reproductive Tract Infections

Washington B

Session Chair:

Maggie Bangser, Int'l Women's Health Coalition

Panel:

- *How Women and Men Perceive RTIs, the Impact on Women's Lives and How Women Seek to Manage RTIs*—Fani Bang, SEARCH
- *Research Methods to Elicit Information from Women to Develop Programs and Policies on RTIs*—Hind Abou Khatib, The Population Council
- *Education and Counselling Interventions for Women and Youth at the Community Level*—Elizabeth Ngugi, University of Nairobi
- *Research Methods Needed to Develop Programs to Screen, Diagnose and Treat RTIs*—Inne Susanti, WKBT Caturwarga

10:00 am - 11:30 am

Theme I Concurrent Sessions cont.

7. Socio-Economic Status

Lincoln

Session Chair:

Giorgio Solimano, PAHO

Panel:

- *What Distinguishes Active Versus Passive Behavior Women from the Same Social Background?*—Salima Aziz Noorani, The Aga Khan Univ.
- *Women's Health in Southeast Asia*—Blair L. Brooke, The Population Council
- *Present Health Status of Women, Policy Initiatives, Health Movements and Issues for Action*—Meherun Nessa Islam, Women for Women
- *The Socio-Economic Factors Effecting the Health of Women in Zaria Environ*—Hajara Usman, Ahmadu Bello Univ., Zaria

8. Work and Women's Health

Jefferson

Session Chair:

Chloe O'Gara, USAID Office of Women in Development

Panel:

- *Women's Deaths and Morbidity During and After Harvest Season in Rural Pakistan*—Zeenat Khan, Aga Khan Univ. Hospital
- *The Impact of Manufacturing Industries on the Status and Health of Women*—Walter K. Patrick, Univ. of Hawaii SPH
- *Women's Workload and its Impact on Their Health and Nutrition*—Sisir Kumar Senapati, CINI-Child in Need Institute
- *Women and Guineaworm*—May Yacoob, WASH Project

Monday (11:30 am - 4:00 pm)

11:30 am - 1:00 pm

Cash Lunch

Exhibit Hall

Auxiliary Meetings

- ◆ Management Sciences for Health *Potomac 4*
- ◆ Methodology Workshop #1 *Arlington*
- ◆ Nurses Caucus *Potomac 2*
- ◆ Public Policy Workshop *Fairfax*
- ◆ SOPHE *Kennedy*
- ◆ Univ. of Hawaii SPH *Prince William*

1:00 pm - 2:30 pm

Theme I Forums

1. Beyond Reproductive Health—Nutrition, Violence, and Mental Health *Regency C/D*



Janet Gottschalk



Lori Heise



Freda Paltiel

Moderator:

- Janet Gottschalk**, Professor, School of Nursing, Univ. of Texas
C. Gopalan, President, Nutrition Foundation of India
Lori Heise, Senior Researcher, Worldwatch Institute
Freda Paltiel, Senior Adviser on the Status of Women, Canadian Ministry of Health and Welfare

2. Our Bodies, Our Perceptions *Regency E*



Norma Swenson



Emily Martin

Moderator:

- Norma Swenson**, Co-Director, Boston Women's Health Book Collective
Nadia Farah, American Univ. in Cairo
Sioban D. Harlow, Professor, Univ. of North Carolina
Emily Martin, Professor, Johns Hopkins Univ.

1:00 pm - 2:30 pm

Theme I Forums cont.

3. Women's Health is More than a Medical Issue *Regency F*



Cathie Lyons



Ysaye Barnwell



Caroline Moser

Moderator:

- Cathie Lyons**, Associate General Secretary, Health and Welfare Ministries Department, General Board of Global Ministries, The United Methodist Church
Ysaye Barnwell, Project Director, Gallaudet Univ.
Caroline Moser, Urban Specialist, The World Bank
Waafas Ofoosu-Amaah, Project Director, WorldWIDE Network

2:30 pm - 3:00 pm

Coffee Break

Exhibit Hall

3:00 pm - 4:00 pm

Theme I Roundtables

1. Reproductive Health Issues *Potomac 2*

- A. *Sexuality Management as an Important Health Component: Still a Filipino Women's Dream—La Rainne Abad-Sarmiento, Isis Int'l*
- B. *Woman as Victim and Vector: The Sexual Politics of Partner Notification in the Containment of HIV Infection—Susan Brockmann, SUNY Brooklyn*
- C. *A Cross-Regional Assessment of Determinants of Women's Risk Behavior for HIV/AIDS—Kathryn Carovano, AIDS COM/JHU*
- D. *Fighting AIDS in the Developing World: Preliminary Research Results from the Women and AIDS Program—Geeta Rao Gupta, ICRW*

3:00 pm - 4:00 pm

Theme I Roundtables cont.

1. Reproductive Health Issues *Potomac 2*

- E. *Reducing Maternal Mortality—Gaps Between Knowledge and Practice in an Urban Area in Nigeria*—Peju Olukoya, Inst. of Child Health and Primary Care
- F. *A Participatory Approach to Conducting a Community-Based Needs Assessment of Women with HIV Disease in New York City*—Annemarie Russell, Gay Men's Health Crisis

2. Socio-Economic and Cultural Issues *Potomac 4*

- A. *The Role of Gender, Socio-Economic, Cultural and Religious Pressure on the Health of Women*—Marie D. Alexandre, Drew University International Health Institute
- B. *The Impact of Belief Structure on the Health Behavior of Cambodian Refugee Women in America*—Barbara Frye, Loma Linda Univ. SPH
- C. *Sex Discrimination and Excess Female Mortality Among Children in Latin America and the Caribbean*—Elsa Gomez Gomez, PAHO
- D. *Women's Role in the Family Choice of Health Care: A Study Conducted in Tamil Nadu*—Anna K. Harding, Oregon State Univ.
- E. *Addressing the Potentially Conflicting Health Needs of Mother and Child*—Jody Heymann, Harvard Univ., Center for Population Studies
- F. *Somatization of Stress Among Urban Thai Women: A Cultural Interpretation*—Marjorie A. Muecke, Univ. of Washington, School of Nursing
- G. *Sociocultural and Medical Antecedents of Pregnancy Outcomes in a Rural Tribal Community in Western India*—S. Sridhar, Society for Education, Welfare, Action-Rural
- H. *Women's Perceptions of Their Health Needs: A Qualitative Study in Rwanda*—Sixte Zigurumugabe, CARE Rwanda

3:00 pm - 4:00 pm

Theme I Roundtables cont.

3. Measuring Women's Health Status *Potomac 6*

- A. *Women's Health Status in Vietnam*—James Allman, National Committee on Population and Family Planning
- B. *Women, Aging, and Health Promotion: An International Perspective*—Geri Marr Burdman, International Health and Aging Specialist
- C. *Measuring the Health Status of Women: The Conceptual Challenge*—Oona M.R. Campbell, London School of Hygiene and Tropical Medicine
- D. *Pilot Study Testing Triangulation Methodology to Elicit Opinions on Marital and Reproductive Issues in Nepalese Families*—Sarah Degnan Kambou, Boston Univ.
- E. *Health Concerns of Aging Women*—Lisa McGowan, ICRW
- F. *Correlates of Maternal Nutritional Status in the Republic of Guinea*—Nancy Mock, Tulane Univ. SPH&TM
- G. *The Health Status of Women in the Occupied Territories—Impact of the Intifada*—Mae Thamer, Policy Research Inc.

Theme I Posters *Ballroom Level*

- P1. *The Mothercare Project*—Colleen Conroy, Mothercare, JSI
- P2. *Maternal Mortality in Honduras*—Vincent David, Management Sciences for Health
- P3. *Methodologies for Measuring Maternal Health in Developing Countries*—Veronique G. A. Filippi, London School of Hygiene and Tropical Medicine
- P4. *The Sisterhood Method for Estimating Maternal Mortality*—Wendy J. Graham, London School of Hygiene and Tropical Medicine

Monday (3:00 pm - 9:00 pm)

3:00 pm - 4:00 pm

Theme I Posters cont.

Ballroom Level

- P5. *The Use of Mother's Health Card in Reducing Low Birth Weight Prevalence in Indonesia*—Mahdin A. Husaini, Nutrition Research and Development Centre
- P6. *Adolescent Girls: Nutritional Risks and Opportunities for Intervention*—Kathleen M. Kurz, ICRW
- P7. *Women at Work—The Top Ten*—Mpongo Landu, SANRU Basic Rural Health
- P8. *The Household Production of Village Women's Health in Nepal*—Sandra L. Laston, Case Western Reserve Univ.
- P9. *Teenage Pregnancy in Haiti*—Gerald Lerebours, Institut Haitien de L'enfance
- P10. *Balancing Rights and Needs in Sao Paulo*—Valeria Simoes Lira da Fonseca, Centro de Estudos e Pesquisas de Direito Sanitario
- P11. *Battering During Pregnancy*—Judith McFarlane, Texas Woman's Univ.
- P12. *Gender Differences in Prevalence and Treatment of Hypertension and Coronary Heart Disease*—E. Jeffrey Metter, Nat'l Inst. on Aging
- P13. *Women, Health and Urbanization in Khayelitsha, Cape Town, South Africa*—William M. Pick, Univ. of Cape Town
- P14. *Causes of Maternal Death in a Subdistrict of West Java Province*—James Thouw, Univ. of Padjadjaran

Theme I Video/Films

- *Population and People of Faith*—*Regency CID*
Jeanne B. Stillman, IDT
- *Villager to Villager: Promoting Health and Family Planning in Rural Nigeria*—*Regency E*
O. A. Ladipo, Univ. of Ibadan

3:00 pm - 4:00 pm

Theme I Video/Film cont.

- *Outcomes of Care in Birth Centers, The National Birth Center Study*—*Regency F*
Marion McCartney, NACC

4:00 pm-6:00 pm

Exhibitors Reception

Exhibit Hall

4:30 pm-6:00 pm

Auxiliary Meetings

- ◆ APHA International Health Section *Lincoln*
- ◆ Methodology Workshop #2 *Arlington*
- ◆ PVO/AIDS Network *Roosevelt*

7:00 pm - 9:00 pm

Martin J. Forman

Regency Ballroom

Memorial Lecture

Sliding Toward Nutrition Malpractice—A Time to Reconsider and Redeploy

Speaker: **Alan Berg**, Nutrition Advisor,
The World Bank

Tuesday, June 25

Theme II

Addressing Women's Health Needs

7:30 am - 5:00 pm

Registration *Exhibit Level*

8:30 am - 9:30 pm

Theme II *Regency Ballroom*
Plenary Session

Women's Health Programs—Current and Future Directions

Mary Racelis, Regional Director, UNICEF

9:30 am - 5:00 pm

Exhibit *Exhibit Hall*
Career Resource Center

9:30 am - 10:00 am

Coffee Break *Exhibit Hall*

10:00 am - 11:30 am

Theme IIA Concurrent Sessions

1. Women and HIV/AIDS *Potomac 2*

Session Chair:

Michel Cayemittes, Institut Haitien de L'enfance

Panel:

- *Lessons Learned from AIDS Prevention Programs Directed Toward Women in the Spanish Speaking Caribbean and the United States*—Jennifer Alexander-Terry, Virginia Tech
- *The Impact of an AIDS Television Drama on an Urban Female Audience: The Kinshasa Experience*—Julie Convisser, PSI
- *Determinants of HIV/STD Risk Among Female Sex Workers in Kingston, Jamaica*—Marion Bullock DuCasse, National HIV/STD Control Programme, Ministry of Health
- *AIDS in Africa: The Cost of Drugs and Nursing Care*—Richard O. Laing, MSH

2. Innovative Models *Potomac 4*

Session Chair:

Naomi Baumslag, WIPHN

Panel:

- *The Role of the Church in Meeting the Health Needs of Women*—Charles R. Ausherman, Institute for Development Training
- *Food Aid and Women's Health: A New Approach in the Dominican Republic*—Hilary Cottam, Care International
- *Women's Tobacco Control Networks*—Deborah L. McLellan, APHA
- *Qualitative Needs Assessment of Women Village Bankers in Tijuana and Self-Education Guide on Domestic Violence*—Jill D. Salamon, Columbia Univ.

10:00 am - 11:30 am

Theme IIA Concurrent Sessions cont.

3. Obstetrical Risk and Referral *Potomac 6*

Session Chair:

James McCarthy, Columbia Univ., Center for Population and Family Health

Panel:

- *More Risk than Resources: Evaluating Alternatives for Obstetric Risk Management in a Developing Population*—Alfred V. Bartlett, Johns Hopkins School of Hygiene/INCAP
- *Assessing Antecedent Determinants for Detecting Women at Risk of Surgical Intervention for Obstructed Labor*—Philip G. Lampe, Family Health International
- *Refining the Risk Approach to Obstetric Care: An Epidemiologic Study in Zimbabwe*—Vivien Davis Tsu, Univ. of Washington
- *First Referral Services for Obstetric Complications*—Vivian Wong, The World Bank

4. Quality of Care *Roosevelt*

Session Chair:

Judith F. Helzner, International Planned Parenthood Federation, WHR

Panel:

- *Local Financing and Community Mobilization for Improving Quality of Maternal Care at Village Level in Niger*—Lynne Miller Franco, Univ. Research Corporation/ CHS
- *Evaluation of Maternal Services: The Client's Perspective*—Churamonie Jagdeo, International Centre for Diarrhoeal Disease Research
- *The Mystery Client: A Method of Evaluating Quality of Care of the Family Planning Services in the Haitian Private Sector*—Gisele Maynard-Tucker, International Planned Parenthood Federation
- *Promoting Reproductive Health in Jamaica: An Exercise in Grassroots Participatory Evaluation of Quality of Care*—Lou Witherite, Unitarian Universalist Service Committee

10:00 am - 11:30 am

Theme IIA Concurrent Sessions cont.

5. Talking With Women About Their Health *Lincoln*

Session Chair:

Cathleen A. Church, Johns Hopkins Univ.

Panel:

- *Public vs. Private Sector*—Robin Foust, Health Management Corporation
- *Researching Women's Health Problems Using Epidemiological and Participatory Methods to Plan the Inquisivi Mother Care Project*—Elsa Sanchez, Save the Children
- *Adolescent Girls: Health Education and Services in Low Income Areas in Mexico*—Itala Valenzuela, CEDPA
- *Dial-a-Friend: Increasing Access to Counseling and Health Services for Young Women in Metro Manila*—Edson E. Whitney, Johns Hopkins Univ. Center for Communication Programs

6. Traditional Birth Attendants and Community Health Workers *Jefferson*

Session Chair:

Clydette Powell, Management Sciences for Health

Panel:

- *The Importance of Educating Men in Women's Health Issues: Surprising Findings from a Pilot Project to Train Birth Attendants in Rural Papua New Guinea*—Joan Brabec, Project Concern International, New Guinea
- *Hospice and Women: Relieving the Physical, Emotional, Social and Spiritual Pain of Terminal Illness in Kenya*—Catherine Lwenya, Nairobi Terminal Care Centre
- *Towards an Evaluation of Midwife Programs in Rural Mexico*—Pilar A. Parra, Rutgers Univ.
- *Reaching Highest Risk Pregnant Women: Experience and Lessons from New York City*—Zeil Rosenberg, NY State Dept of Health

Tuesday (10:00 am - 2:00 pm)

10:00 am - 11:30 am

Theme IIA Concurrent Sessions

7. Women Helping Women *Washington A*

Session Chair:

Karen Otsea, Family Care International

Panel:

- *The Relationship Between Government Agencies and NGOs in Implementing Women's Health Projects at the Community Level*—Kate Kamba, Tanzanian Parliament
- *Lessons in NGO Cooperation: A National, Multisectoral Approach to Improving Women's Health*—Josephine Kasolo, Uganda National Council of Women
- *Incorporating Women's Perspectives into Health Projects*—Chinyelu Okafor, Univ. of Nigeria

8. Women's Rights *Washington B*

Session Chair:

Denise Rause, DC Women's Council on AIDS

Panel:

- *Violence Against Women in Mexico: Legislative Reform and Service Innovations for Battered Women and Rape Survivors*—Elizabeth Shrader Cox
- *Health Rights in Chile and the Convention on the Elimination of All Forms of Discrimination Against Women*—Claudia Iriarte, Corporacion de Salud y Politicas Sociales
- *Public Health Advocacy on Behalf of Women in Sao Paulo*—Livia Maria Pedalini, Centro de Estudos e Pesquisas de Direto Sanitario

11:30 am - 1:00 pm

Cash Lunch *Exhibit Hall*

Auxiliary Meetings:

- ◆ International Consortium *Potomac 2*
- ◆ Methodology Workshop #3 *Prince William*
- ◆ Partnership for Health *Potomac 6*
- ◆ The Population Council *Fairfax*
- ◆ WIPHN *Kennedy*

1:00 pm - 2:00 pm

Theme II Roundtables

1. Reproductive Health *Regency A* Programs

- AIDS Prevention in Four Communities of Kenya*—Milton Amayun, World Vision
- Infection Control: The Forgotten Factor in Providing Safe Family Planning and Maternal Health Services*—Marcia Angle, INTRAH
- Reducing Infant Mortality Risks Through Multiple Interventions in Pregnant Teens*—Patricia Canessa, Arts of Living Institute
- Pregnancy Care through Pregnancy Spacing: A Marketing Communications Theme to Save Lives in Jordan*—Gerald Hursh-Cesar, Intercultural Communication, Inc.
- Malaria and Pregnancy*—E. F. Patrice Jelliffe, Univ. of California SPH
- Mortality Impact of a Community-Based Maternity Care Programme in Rural Bangladesh*—Shamim Akhter Khan, ICDDR
- Breastfeeding as a Women's Health Issue*—Miriam Labbok, Georgetown Univ.
- Distribution of Risk Factors for Poor Pregnancy Outcome by Place of Delivery in Ahmedabad, India*—Dileep V. Mavalankar, NICHD/NIH

2. Addressing Women's *Regency B* Health Needs

- Women in Development or Mothers in Child*
- Survival*—Saha Amarasingham, Development Associates, Inc.
Successful Models of Participatory Planning.
 - Implementation and Management of Women's Health Programs*—Maureen Rowley Barnett, Nat'l Assoc. of Women's Health Professionals

1:00 pm - 2:00 pm

Theme II Roundtables cont.

2. Addressing Women's Health Needs cont. *Regency B*

- C. *The Male Role in Women's Health: A Framework for Analysis and Action*—Nick Danforth
- D. *Basic Health Education for Safe Water Supply*—Margaret Kaseje, Community Initiative Support Services, Kisumu, Kenya
- E. *Meeting Church Health Workers' Training Needs in Women's Health*—Bola Lana, Pathfinder Fund
- F. *The Influence of Reproductive Status on Rural Kenyan Women's Time Use*—Charlotte G. Neumann, UCLA SPH
- G. *Planning Drug Treatment for Pregnant/Parenting Women Through Interviewing Treatment Experts and Drug-Using Women Themselves*—Denise Paone, Beth Israel Medical Center
- H. *Empowerment: The Link Between Women's Health and Development*—Jane Stein, Health Services Research Center/UNC-CH

3. Planning, Management, Research and Education *Tidewater*

- A. *Financing Accessible Health Care: Issues in Family Decision Making and Resource Allocation*—M. J. Burns, Economist
- B. *Practical Considerations for Women's Health and AIDS Curriculum Development Projects: Examples From Nigeria and Kenya*—Katherine Mason, Columbia Univ.
- C. *Self-Care: An International Research Initiative in Women's Health*—Beverly J. McElmurry, Univ. of Illinois at Chicago
- D. *Women's Health Training: What Do We Mean?*—Rosalia Rodriguez-Garcia, Georgetown Univ.
- E. *Improving Access to Health Care by Integrating Gender Analysis with Institutional Development*—Patricia Krackov Salgado, CEDPA

1:00 pm - 2:00 pm

Theme II Roundtables cont.

3. Planning, Management, Research and Education cont. *Tidewater*

- F. *Prevailing Patterns and Policy Issues in the Use of Public Prenatal Care Services in Jamaica*—Carolyn Sargent, Southern Methodist Univ.
- G. *Role Reversal: Why Women in a Developing Country Use Less Hospital Care Than Men*—James Setzer, Abt Associates Inc.
- H. *A Research Agenda for Women and AIDS: Expanding Prevention Options*—Krystn R. Wagner, USAID
- I. *Getting Together or Further Apart?—Women's Studies and Health Sciences in Asia*—Soon-young Yoon, Institute for Research on Women

Theme II Posters *Ballroom Level*

- P15. *Development of a Safe Birth Kit in Bangladesh Using Qualitative Research*—Barbara J. Crook, PATH
- P16. *Increasing Access and Patient Satisfaction: Utilizing Mid-Level Practitioners in the Delivery of Women's Health Services*—Ellen Dorsch, Planned Parenthood of Northern New England
- P17. *Analysis of Missed Opportunities as a Tool to Improve Program Services*—Rebecca Fields, REACH, JSI
- P18. *Tetanus: An Opportunity to Link EPI with MCH*—Holly Ann Fluty, USAID
- P19. *Determinants of Non-Compliance With Iron Supplementation: A Review of the Literature*—Rae Galloway, The World Bank
- P20. *Motivating Development Agencies to Cooperate with the Community*—Cynthia Poonam Gil, Adult Basic Education Society
- P21. *Work and Women's Mental Health in Developing Countries: Guidelines for an Epidemiological Approach*—Sioban Harlow, UNC SPH

Tuesday (1:00 pm - 3:30 pm)

1:00 pm - 2:00 pm

Theme II Posters cont.

- P22. *A Tetanus Toxoid Immunization Coverage Survey in the Gorkha District of Nepal*—Beth M. Henning, Johns Hopkins SH&PH
- P23. *Cost-Effectiveness of a Nutrition Intervention Program for Pregnant Women*—Francisco Mardones-Santander, Institute of Nutrition and Food Technology
- P24. *Quality of Care in Six Operations Research Projects in Latin America and the Caribbean*—Antonietta Martin, The Population Council
- P25. *The Effects of Protein-Energy Supplementation in Early Infancy on the Anthropometry and Body Composition of Guatemalan Women at Adolescence*—Marie T. Ruel, Instituto de Nutricion de Centroamerica y Panama (INCAP)
- P26. *The Elderly Women: Adding Life to Years*—Gopal Sankaran, West Chester Univ.
- P27. *Nursing Interaction-Exploring Underprivileged Ethnic Women's Preventive Health Habits*—Bilkis Vissandjee, School of Nursing
- P28. *The Evaluation of a Nurses' Training Program on Child Spacing in Egypt*—Amgad Wahba, Univ. of Pittsburgh-School of Nursing

Theme II Video/Films

- *WIBANGE: TBA's, Their Training and Supervision*—Grace Nelson, Karawa Health Zone *Regency E*
- *NGO Fieldstaff Conduct Focus Group Pretests of a Regional Training Video*—Valerie Uccelani, AED *Regency F*
- *Encouraging African Women: A Feature Film that Presents a Positive Role Model*—Steven C. Smith, DSR *Regency C/D*

2:00 pm - 3:30 pm

Theme I Forums

1. *Changing Priorities in Women's Health—No Longer Last With Least* *Regency E*



Catherine Pierce Ann Van Dusen

Moderator: **Angele Petros-Barvazian**, Director, Division of Family Health, WHO
Ann O. Hamilton, Director, Population and Human Resources Department, The World Bank
Catherine S. Pierce, Chief, Special Unit for Women, Population and Development, UNDP
Ann Van Dusen, Acting Director, USAID Office of Health

2. *Initiatives in Women's Health—Safe Motherhood, Midwifery Programs and Year of the Girl Child* *Regency F*



Barbara Herz Chandni Joshi Barbara Kwast

Moderator:
Barbara Herz, Chief, Women in Development Division, Population and Human Resources Department, The World Bank
Chandni Joshi, Regional Resource Officer, UNIFEM
Barbara E. Kwast, Scientist, WHO
Maureen Law, Senior Fellow, International Development Research Centre, Canada

2:00 pm - 3:30 pm

Theme II Forums cont.

**3. What We Want—
Voices From the South**

Regency CID



Isabel Letelier



Phoebe Asiyo



Miria Matembe

Moderator:

Isabel Letelier, Member, International Commission,
Mujeres Ahora, Chile
Phoebe Asiyo, Goodwill Ambassador, UNIFEM
Joselina da Silva, CEAP—Women's Project, Brazil
Miria Matembe, ACFOD, Uganda
Sundari Ravidran, Rural Women's Social Education
Center, India

3:30 pm - 4:00 pm

Coffee Break

Exhibit Hall

4:00 pm - 5:30 pm

Theme IIB Concurrent Sessions

**1. Appropriate Technology
for Life Threatening Situations**

Potomac 2

Session Chair:

William V. Dolan, Esperanca

Panel:

- *Women Don't Have to Die: An Underutilized Technology Can Make a Difference*—Janie Benson, International Projects Assistance Services
- *Symphysiotomy: An Appropriate Alternative for Cesarean Section in Cases of Obstructed Labour*—Elly Engelkes, Interhealth
- *Conjunctival Pallor Categorization and Anemia in Pregnancy*—Derrick B. Jelliffe, Univ. of California SPH
- *Do-able Strategies for the Control of Cervical Cancer in India*—Usha K. Luthra, Maulana Azad Medical College Campus
- *Immunizing Against Liver Cancer: Training IEC for the Introduction of Hepatitis B Vaccine*—Scott Wittet, PATH

**2. Barefoot Doctors
and Midwives**

Potomac 4

Session Chair:

Michele M. Andina, Consultant

Panel:

- *Midwifery Education Among Displaced Cambodians in Thailand*—Denise Callaghan, Baystate Medical Center
- *Life Saving Skills Workshops for Ghanaian Midwives*—Margaret Marshall, ACNM
- *A Model Maternity Unit Through Continuing Education: A Sister Cities Approach to Safe Motherhood*—Charlene Pope, Univ. of Rochester School of Medicine and School of Nursing
- *Inservice Training for Women's and Children's Health Services in Three Hundred Poor Counties in China*—Xiao-Chun Qin, Ministry of Public Health, PRC

4:00 pm - 5:30 pm

Theme IIB Concurrent Sessions cont.

3. Controlling Infection *Potomac 6*

Session Chair:

Peter Berman, Harvard SPH

Panel:

- *Birth-Linked Tetanus and Sepsis Must Stop*—Francois Gasse, WHO
- *Syphilis-Associated Perinatal Mortality—A Quantifiable Problem with an Effective Intervention—Where is the Program?*—Jeanne M. McDermott, Centers for Disease Control
- *Infection Prevention Guidelines: Effectiveness of Instruments and Equipment Processing Procedures*—E. Noel McIntosh, JHPIEGO Corp.
- *Maternal Mortality Due to Tetanus*—Robert Steinglass, REACH, JSI

4. Enhancing Family Planning Programs *Washington A*

Session Chair:

Andrew A. Fisher, The Population Council

Panel:

- *Women's Reproductive Health in Urban Squatter Settlements*—Rennie D'Souza, Aga Khan Univ.
- *Falling Through the Cracks: Post-Abortion Family Planning*—Ann Leonard, International Projects Assistance Services
- *How AIDS Prevention Training is Contributing to Improved Quality of Care in Family Planning Programs*—Laura Smit, International Planned Parenthood Federation, WIR
- *Contraception During the Postpartum Period: Perspectives From Clients and Providers in Three Regions*—Cynthia Steele Verme, AVSC

4:00 pm - 5:30 pm

Theme IIB Concurrent Sessions cont.

5. Female Circumcision *Washington B*

Session Chair:

Gordon G. Wallace, Population Crisis Committee

Panel:

- *A Grassroots Project by Nurses in Nigeria to Eradicate Female Circumcision*—Christine Adebajo, National Association of Nigeria Nurses and Midwives
- *A World Review of Traditional Practices Affecting the Health of Women and Actions for Change*—Fran Hosken, Women's International Network News
- *Medical and Cultural Aspects of Female Circumcision in Somalia and Recent Effort for Eradication*—Asha A. Mohamud, Center for Population Options
- *Discouraging Female Circumcision Among Selected Kenyan Communities*—Joyce Naisho, AMREF

6. Preventing Maternal Deaths—What Works? *Jefferson*

Session Chair:

Deborah Maine, Columbia Univ.

Panel:

- *Regionalization of Perinatal Health Care in a Rural Area in Indonesia*—Anna Alisjahbana, Padjadjaran Univ. School of Medicine
- *Mortality Impact of a Community-Based Maternity Care Programme in Rural Bangladesh*—Vincent Fauveau, London School of Hygiene and Tropical Medicine and ICDDR
- *Maternity Care in Grenada, West Indies*—Virginia Hight Laukaran, The Population Council
- *The Quetza Henango Maternal Neonatal Health Project*—Barbara Schieber, INCAP

Tuesday - Wednesday (7:30 am)

4:00 pm - 5:30 pm

Theme IIB Concurrent Sessions cont.

7. Women Working for Change *Lincoln*

Session Chair:

Mary Beth Moore, PATH

Panel:

- *The Gono Gobeshona Approach in Improving Women's Health: The Case-Study of Banchte Shekha*—Angela Gomes, Banchte Shekha
- *The Effectiveness of Women-to-Women Health Care Delivery in a Traditional Society*—Suraiya Jabeen, Concerned Women for Family Planning
- *Our Projects, Ourselves: A Case Study in Haiti*—M. Catherine Maternowska, Columbia Univ.
- *Women Helping Women in War-Torn Mozambique*—Gail Snetro, Save the Children

8. Women's Empowerment— Critical for Health *Roosevelt*

Session Chair:

Sidney Ruth Schuler, John Snow, Inc.

Panel:

- *The Impact of Women's Empowerment Through Saving's Groups on Women's Contraceptive Behavior*—Aminul Islam, Save the Children
- *Using Our Own Resources as an Alternative Way of Improving Women's Health*—Bisi Ogunleye, Country Women Association of Nigeria
- *Women's Health: An Empowering Process to Identify Needs and Access Service in Rural Nepal*—Sheila Robinson, Univ. of Calgary
- *The Evolution of the Village Women's Development Program in the Kingdom of Tonga*—Seini Vakasiuola, Foundation for the Peoples of the South Pacific/Tonga

5:30 pm - 7:00 pm

Membership Meeting & Reception

Regency C/D

7:00 pm - 9:00 pm

Awards Banquet

Regency Ballroom

Women's Health in the United States



Antonia Novello, U.S. Surgeon General, Public Health Service, Department of Health and Human Services

Wednesday, June 26

7:30 am - Noon

Registration

7:30 am - 9:00 am

Public Policy Breakfast

Regency E/F



Russell E. Morgan, Patricia Schroeder, Ingela Thalen

Moderator:

Russell E. Morgan, President, National Council for International Health

Featured Speakers:

Patricia Schroeder, U.S. House of Representatives
Ingela Thalen, Minister of Health, Sweden

Wednesday (8:30 am - 11:00 am)

8:30 am - Noon

Exhibit

Career Resource Center

Exhibit Hall

9:00 am - 10:30 am

Theme III Forums

1. Instruments of Change— Media, Politics, and Research

Regency A/B



Abigail Trafford



Judith LaRosa



Carol Miller

Moderator:

Jodi Jacobson, Worldwatch Institute
Carol Miller, Legislative Assistant to Rep. Olympia Snowe
Abigail Trafford, Editor, Health Section, The
Washington Post
Judith LaRosa, Deputy Director, Office of Research on
Women's Health, NIH

2. Women Organizing— The Future of Activism

Regency C/D



Janet Benshoof



Ela Bhatt



Olivia Cousins

Moderator:

Janet Benshoof, Director, ACLU Reproductive
Freedom Project
Ela Bhatt, General Secretary, SEWA
Amparo Claro, ISIS International
Olivia Cousins, Chairman, National Women's Health
Network

9:00 am - 10:30 am

Theme III Forums cont.

3. Women's Rights as Human Rights

Potomacs



*Rebecca
Cook*



*Arvonne
Fraser*



*Adetoun
Ilumoka*



*Jacqueline
Pitanguy*

Moderator:

Rebecca J. Cook, Faculty of Law, Univ. of Toronto
Arvonne S. Fraser, Project Director, Univ. of Minnesota
Adetoun O. Ilumoka, Legal Practitioner, Women in
Nigeria
Jacqueline Pitanguy, President, Citizenship, Studies,
Information, Action, Brazil

10:30 am-11:00 am

Coffee Break

Exhibit Hall

Wednesday (11:00 am - 2:30 am)

11:00 am - 1:00 pm

The Action Agenda Working Sessions

- ◆ **Infection** *Regency A/B*
Rapporteurs:
Jeanne McDermott, Elisabeth Ngugi, Maggie Bangser
- ◆ **Nutrition** *Regency C/D*
Rapporteurs:
Kathleen Merchant, C. Gopalan, Kathleen Kurz
- ◆ **Morbidity** *Prince William*
Rapporteurs:
Oona Campbell, May Yacoob, Mawaheb El-Mouelhy
- ◆ **Mortality** *Potomac 1/2*
Rapporteurs:
Deborah Maine, Francine Coeytaux, Anna Alisjahbana
- ◆ **Access to Care** *Tidewater*
Rapporteurs:
Judith Timyan, Bisi Ogunleye, Sue Brechin
- ◆ **Quality of Care** *Roosevelt*
Rapporteurs:
Elsa Gomez, Barbara Mensch, Judith Helzner
- ◆ **Listening & Talking With Women** *Lincoln*
Rapporteurs:
Marcia Griffiths, Joselina da Silva, Joan Russ, Sue Brems
- ◆ **Policies and Strategies** *Jefferson*
Rapporteurs:
Jill Sheffield, Adetoun Ilumoka, Norma Swenson
- ◆ **Soci-Economic Status** *Kennedy*
Rapporteurs:
Adrienne Germain, Rani Bang, Jodi Jacobson
- ◆ **Violence Against Women** *Washington B*
Rapporteurs:
Freda Paltiel, Amparo Claro, Lori Heisi

1:00 pm - 2:30 pm

Closing Session Luncheon

Regency Ballroom

Remarks:

Linda Vogel, NCIH Governing Board, Co-Chair

Reproductive Health in Romania, Past Constraints and Opportunities for the Future



Keynote Speaker:

Gabriela Bocce, Vice President, Society on Education for Contraception and Sexuality, Romania

1992 International Health Conference

Judith Kurland, Boston City Health Commission

Health and Child Survival Fellows Program



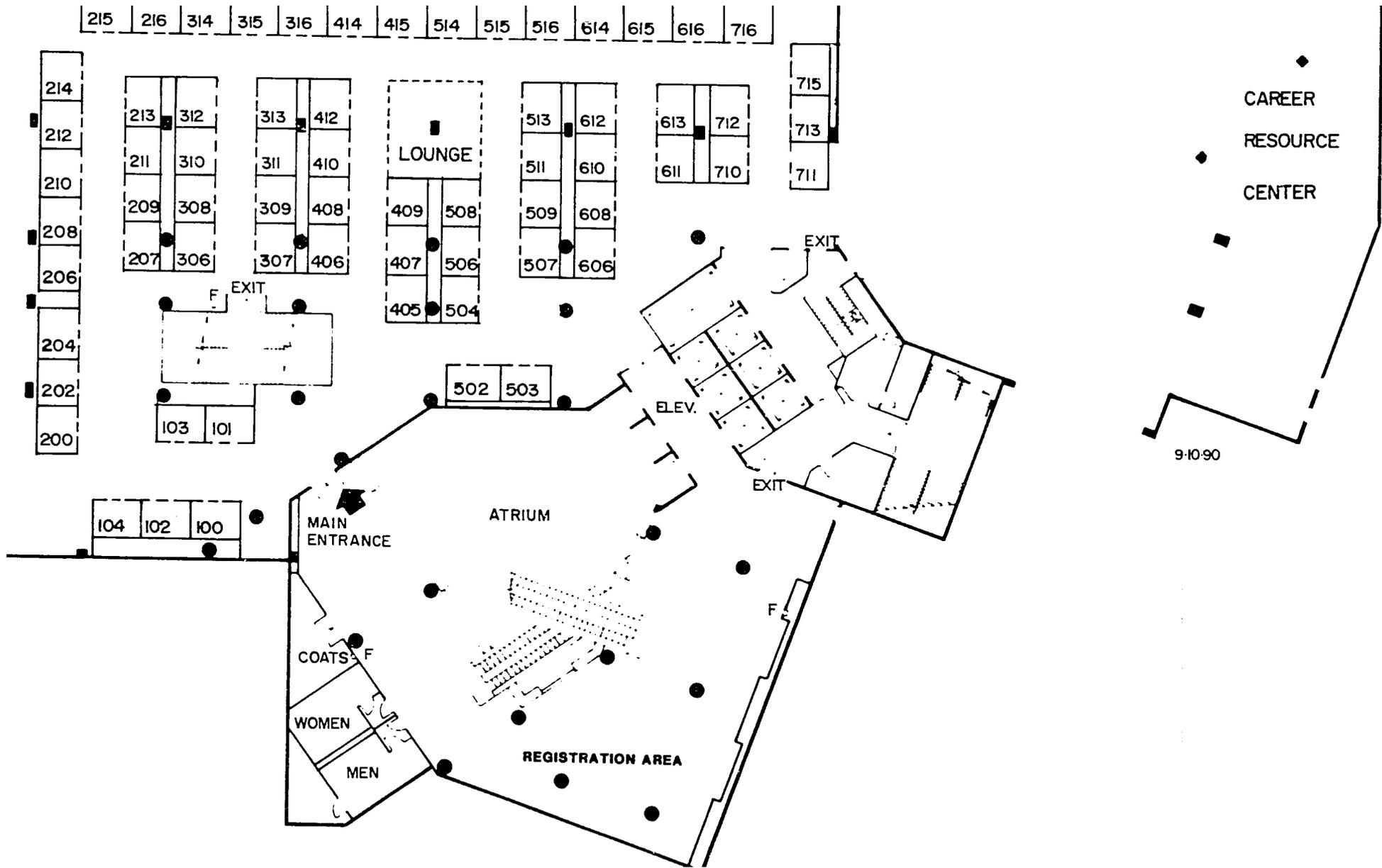
Two year fellowships
in international health and
child survival for junior to
mid-level health professionals

Master's degree required.

For more information, visit Booth #206
or write HCSFP, Johns Hopkins University
School of Hygiene and Public Health
Institute for International Programs
103 East Mount Royal Avenue, Suite 2B
Baltimore, MD 21202

Equal Opportunity Institution

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INTERNATIONAL HEALTH EXHIBIT

15

Exhibits

ADRA International Booth # 406
Silver Spring, MD

ADRA works with community groups to help people help themselves. Most of the agency's projects benefit mothers and their children. ADRA is currently working in over 65 countries.

Academy for Educational Development Booth # 211
Washington, DC

AED is a private nonprofit organization dedicated to addressing human development needs worldwide through education, communication, and information. AIDSCOM, HEALTHCOM, and Nutrition will be represented at the booth.

Afghan Community Services Booth # 715
Falls Church, VA

ACS provides refugee resettlement services to the 15,000 Afghans living in the Washington, DC metropolitan area. It also markets Afghan Crafts made in the refugee camps in Pakistan and the proceeds go towards their crafts development.

American College of Nurse-Midwives Booth # 216
Washington, DC

The Special Projects Section of ACNM collaborates with developing country institutions on the following types of projects: needs assessments, TBA programs, inservice/continuing education, pre-service curricula development, association building, and research.

American Red Cross Booth # 213
Washington, DC

Office of HIV Education has programs and materials focusing on the following: Training, Education, Workplace Youth, and African American and Hispanic Audiences.

The American Society for Tropical Medicine & Hygiene Booth # 315
Membership and information booth.

Association of Reproductive Health Professionals Booth # 513
Washington, DC

ARHP is an organization of physicians, scientists, educators and health professionals who share an interest and an expertise in the disciplines related to reproductive health.

Association of Schools of Public Health Booth # 503
Washington, DC

The ASPH represents the 24 accredited graduate Schools of Public Health in the U.S. and Puerto Rico.

Boston University School of Public Health Booth # 414
Boston, MA

The Center for International Health (formerly the Office of Special Projects) is located in the School of Public Health at Boston University. The Center conducts research, consulting, and training activities in the area of international health.

Boston Women's Health Book Collective Booth # 509
Somerville, MA

Bridge International Foundation Booth # 408
Washington, DC

Cholera, de-worming, malaria, dehydration, and other health projects Bridge International Foundation supplies: ORT packages, medication, health education, & water purification equipment at low cost to PVOs.

Case Western Reserve University Center for International Health Booth # 516
Cleveland, OH

Case Western Reserve University's Center for International Health serves as a multidisciplinary link to the wide-ranging international health resources of the University, its affiliated institutions, and the northern Ohio community.

The Centre for Development and Population Activities Booth # 104
Washington, DC

CEDPA works to enhance the health status of Third World communities through women managers and their institutions. Support programs focus on family planning, health education, and income generation.

Exhibits

Center for Communication Programs Booth # 101 & 103

Baltimore, MD

Search the POPLINE database on compact disc. Test your knowledge of population issues with the Population Reports quiz. See the latest samples of Population Communication Services sponsored productions. Recent issues of Population Reports are available.

Center for Population Options Booth # 316

Washington, DC

CPO's national/international programs promote "life planning" and sexuality education; foster access to health care through school-based and other community based clinics; and encourage education to prevent the spread of HIV/AIDS and STDs among adolescents.

Columbia University Booth # 502

New York, NY

The Center for Population and Family Health, the School of Public Health at Columbia University, conducts research, technical assistance, and training in developing countries. The School also supports programs in epidemiology, biostatistics, environmental health, tropical medicine, socio-medical sciences, gerontology, and health policy and management.

Conference of Christians for International Health Booth # 314

Brunswick, GA

CCIH provides a forum where Christian agencies and individuals concerned about international health work together on areas of mutual interest.

Development Associates, Inc. Booth # 308

Arlington, VA

Development Associates, Inc., an international consulting firm, works in areas of management, policy, education, organizational development, training, program planning and evaluation. Health programs include health and family planning training, drug abuse prevention, health care finance, and service delivery.

Development Through Self Reliance, Inc. Booth # 412 & 410

Columbia, MD

DSR produces and distributes social-message films working with Media for Development Trust in Zimbabwe. Also, we sell portable computers and specialize in exporting computers to Third World countries.

Family Health International Booth # 511

Durham, NC

FHI is a nonprofit biomedical research and technical assistance organization dedicated to improving all aspects of reproductive health, from reducing maternal and child mortality to slowing the spread of STDs, including AIDS.

FEMAP Booth # 212
(Mexican Federation of Private Health and Community Development Associations)

El Paso, TX

FEMAP is a private, non-profit health and community development association, based in CD. Juarez, Mexico, with 44 affiliated organizations throughout Mexico and 8,425 volunteer, community outreach workers.

Institute for Development Training Booth # 215

Chapel Hill, NC

IDT is a private, non-profit organization dedicated to improving women's health care in developing countries by providing training of health care professionals.

Institute for International Studies in Natural Family Planning Booth # 308

Washington, DC

The Institute for Reproductive Health (formerly IISNFP), Georgetown University, supports research, training, and technical assistance to promote natural fertility regulation (NFP and exclusive breast-feeding) worldwide.

Institute for Resource Development Booth # 210

Columbia, MD

The Demographic and Health Surveys (DHS) program is a nine-year project to assist developing countries in conducting national surveys on population and maternal and child health.

Exhibits

International Center for Research on Women

Washington, DC

ICRW seeks to improve the effectiveness of development policies and programs by undertaking research and information dissemination that raises the awareness of women's contribution to development.

Booth # 200

International Child Health Foundation

Columbia, MD

ICHF is dedicated to serving children's lives and improving their health with low-cost methods, through education, research, and demonstration here and abroad.

Booth # 405

International Medical Corps

Los Angeles, CA

IMC provides health care through training to countries in crises whose health care systems have been destroyed. IMC is a non-profit, non-sectarian, non-political organization committed to the mission of helping developing countries become medically self-sufficient.

Booth # 307

International Population Fellows Program

Ann Arbor, MI

The International Population Fellows Program offers population graduates two year fellowships in population and family planning activities with developing countries or international agencies.

Booth # 608

International Projects Assistance Services

Carrboro, NC

IPAS is a non-profit organization working worldwide to improve the health status of women and increase access to safe reproductive health services.

Booth # 606

INTRAH/ University of North Carolina Chapel Hill

Chapel Hill, NC

INTRAH, an international program of the UNC-CH School of Medicine, provides institutional development assistance in health/family planning from offices in North Carolina, Kenya and Togo.

Booth # 507

JCR Imports

Mt. Vernon, VA

Business accessories for women.

Booth # 710

Johns Hopkins University Health & Child Survival Fellows Program

Baltimore, MD

The Health and Child Survival Fellows Program (HCSFP) prepares health professionals for international careers through two-year, practice-oriented assignments.

Booth # 206

Johns Hopkins University Institute for International Programs

Baltimore, MD

The Johns Hopkins University Institute for International Programs (JHU/IIP) links research, teaching, and service activities at the School of Public Health with health programs in developing countries.

Booth # 208

John Snow, Inc.

Boston, MA

JSI provides technical assistance designed to enhance the effectiveness of public health programs and promote positive change to improve the quality of life in developing countries.

Booth # 610,612

Loma Linda University School of Public Health

Loma Linda, CA

Loma Linda University is a health science university with a distinctively Christian orientation. The School of Public Health has an international focus in its program, faculty, and student body.

Booth # 506

Management Sciences for Health

Newton, MA

A non-profit institution, MSH provides technical assistance to decision makers in developing to help close the gap between what is known about public health problems and what is done to solve them.

Booth # 202

Exhibits

Medical Service Corporation International Booth # 310

Arlington, VA

MSCI is a leader in providing technical assistance in the areas of public health and tropical medicine and will featuring their Vector-borne disease control projects.

Mobility Resources Booth # 312

Santa Fe, NM

Mobility Resources designs and sells innovative mountain bicycles and trailers to allow development workers to more easily and cost effectively make their daily rounds.

National Abortion Federation & Catholics for a Free Choice Booth # 613

Washington, DC

NAF is a national association of abortion and reproductive health care providers. Catholics for a Free Choice is a national educational organization that supports the right to legal reproductive health care, especially in the areas of family planning and abortion.

National Women's Political Caucus Booth # 712

Fresno, CA

National Women's Political Caucus is a bi-partisan feminist, political organization with state and local chapters in the U.S. Organized for the purpose of recruiting, training, and electing women to public office; as well as, raising money for women candidates and seeking appointments to decision making boards and commissions.

National Council for International Health Booth # 100

Washington, DC

NCIH is a private, non-profit membership association dedicated to improving health worldwide by focusing scarce resources on international health issues, increasing U.S. awareness and response to international needs, and by providing vigorous leadership to achieve this goal.

Pan American Health Organization Booth # 309

Washington, DC

PAHO Emergency Preparedness and Disaster Relief Coordination Program offers technical assistance to strengthen health disaster preparedness in the Americas through various workshops and training materials.

Pan American Health Organization Booth # 311

Washington, DC

The Pan American Health Organization is a non-governmental, non-profit international organization, the oldest in its kind in the Western Hemisphere.

PAHO/World Health Organization Booth # 313

Washington, DC

A comprehensive view of the most important topics of International Public Health as presented in the publications of the Pan American Health Organization and the World Health Organization. Free Catalogs.

PATH Booth # 102

Seattle, WA

PATH is a nonprofit, nongovernmental, international organization whose mission is to improve health, especially the health of women and children in developing countries.

Pathfinder International Booth # 504

Watertown, MA

Formerly The Pathfinder Fund, is a nonprofit organization that funds family planning programs in developing countries. Pathfinder provides technical assistance, management assistance, commodities, and financial assistance through its nine field offices.

Peace Corps Booth # 514

Washington, DC

The Office of Training and Program Support provides technical and material support for Peace Corps staff and volunteers in the field.

Exhibits

Population Reference Bureau Booth # 611
Washington, DC

The Population Reference Bureau is a private, nonprofit scientific and educational organization that gathers, interprets, and disseminates information about population.

PRITECH Booth # 204
Arlington, VA

Sponsored by the U.S. Agency for International Development, PRITECH is a consortium of internationally known organizations led by MSH. PRITECH assists developing countries to implement national ORT and diarrheal disease control programs.

The Futures Group Booth # 515
Washington, DC

The Futures Group is a marketing, market research, and management consulting firm specializing in social marketing/communications, policy analysis/development, modeling/forecasting, and women in development.

The Population Council Booth # 214
New York, NY

The Population Council, an international nonprofit organization, undertakes social and health science programs and research relevant to developing countries and conducts biomedical research to develop and improve contraceptive technology.

Tulane University Booth # 209
School of Public Health
New Orleans, LA

The International Health Academic Program at Tulane University's School of Public Health and Tropical Medicine provides long-term and short-term training at the Masters and Doctoral level.

University Research Corp./ Booth # 207
Center for Human Services
Bethesda, MD

URC/CHS provides technical assistance to improve service delivery in health and family planning programs. The focus is on project implementation, training, and quality assurance.

U. S. Agency for Booth # 614 & 615
International Development
Arlington, VA

USAID joins with partners to improve world health.

VITRON Booth # 616
Vienna, VA

Hemocue Hemoglobin and glucose systems are ideally suited for any decentralized test location. As detailed in numerous reports, the Hemocue method is simply faster, safer, and much more accurate than older methods *and—no one touches blood.*

WASH Project Booth # 409
Arlington, VA

Established in 1980 by the U.S. Agency for International Development to provide technical assistance in the water supply and sanitation sector for host governments, USAID missions, and other agencies and organizations engaged in development activities.

Wellstart Booth # 508
San Diego, CA

Wellstart is dedicated to international MCH through the promotion and protection of breast-feeding. Over 300 multidisciplinary health professionals from 25 developing countries are currently participating.

Women's International Booth # 407
Public Health Network
Bethesda, MD

WIPHN is a grass-roots, non-profit organization dedicated to improving women's health, nutrition, status, and networking with women making motherhood safe.

World Vision Booth # 415
Monrovia, CA

World Vision is a Christian humanitarian organization providing disaster relief, development, and support for the poorest of the poor in over 80 countries world-wide.

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CONFERENCE INDEX

Speakers

Phoebe Asiyo, Goodwill Ambassador to the United Nations Fund for Women, has been an active spokesperson for Kenyan women's health and well-being for several decades. As a member of the Kenyan Parliament, she introduced a motion to amend the children's act to ensure that both parents take equal responsibility for children born out of marriage. As a member of the U.N. Subcommission on the Prevention of Discrimination and Protection of Minorities, she was committed to the eradication of female circumcision.

Ysaye M. Barnwell, currently on the staff at the National Academy of Gallaudet University, directs the project "AIDS: Impacting the Black Deaf Community". Ms. Barnwell has been on the faculty of Howard University and holds degrees in Speech Pathology, Public Health and Cranio-Facial Studies. In addition to her research and development of training materials in the area of medical, legal and social issues of child physical and sexual abuse, Ms. Barnwell is an actress, choral director, and performer in the acappella quintet, *Sweet Honey in the Rock*.

Carmen Barroso, Senior Advisor to the World Population Program at the MacArthur Foundation, comes from Brazil, where she served as Chairperson of the Committee of Reproductive Rights of the Ministry of Health, was a member of the National Council on Women's Rights, and taught at the university level. She has been a consultant to the Ford Foundation, as well as several United Nations organizations, was a Visiting Scholar at Cornell's International Population Program and a Hubert Humphry Professor at Macalester College.

Gabriela Bocec, as Vice President and one of the founding members of the Society on Education for Contraception and Sexuality, (SECS), is a Romanian pediatric nurse specializing in pedagogy, nutrition and community nursing. She is the Deputy Director of the Post-Basic School of Nursing in Bucharest and leader of a national task force organized by the National Nursing Association to revitalize nursing in Romania. She has testified before the U.S. Senate on reproductive rights and has been recognized by the Women's Legal Defense Fund.

Olivia Cousins is Chair of the Board of Directors for the National Women's Health Network and associate professor at the Borough of Manhattan Community College. She is health coordinator for the Department of Physical Education, Health Education, Recreation and Dance, where she recruits and trains adjunct instructors, plus organizes events and programs.

Joselina da Silva, an Afro-Brazilian women's activist in the Black Consciousness and feminist movements in Brazil, has had more than 15 years of experience as a teacher and organizer. She has been active in several of the political and cultural organizations established to serve the black community, particularly those which address the needs of women. She is a founding member of Black Women's Association of Baixada Fluminense and currently works in the women's section of the centro de Articulacao de Populacoes Marginalizadas, a networking center for grassroots organizations working for low-income communities.

Janet Gottschalk, Professor of Nursing and Biomedical Sciences, University of Texas Medical Branch, has been teaching nursing since 1963. Currently Co-Chair of the NCIH Governing Board, Dr. Gottschalk has travelled widely, served on several boards of international private voluntary organizations, and written and lectured extensively on international nursing, primary health care and community health, and human rights, specifically in El Salvador, Nicaragua, and the Philippines.

Ann Hamilton, an economist trained at the London School of Economics, has worked at the World Bank since 1970, where she has served as the Chief of the Indonesia and India Divisions and is currently the Director of Population and Human Resources Department. Prior to joining the Bank, Ms. Hamilton worked at the International Division of the Bureau of the Budget and on the President's Task Force on the War Against Poverty.

Speakers

Lori Heise, Senior Researcher with the Worldwatch Institute, a non-profit research group in Washington, D.C. that studies global problems, has written and lectured extensively in the area of violence against women as a worldwide human right, health, and development issue. She directed a maternal and child health project in the rural highlands of Guatemala and prior to joining Worldwatch, was a policy analyst at the EPA and an environmental health consultant.

Chandni Joshi is a Nepali women's development and empowerment specialist who, as UNIFEM Regional Representative, assists in the day-to-day develop of UNIFEM-assisted activities in a region which includes Pakistan, Bangladesh, India, Nepal, Bhutan, Sri Lanka, Maldives, Afghanistan and Iran. She has served with several government and non-governmental agencies, has written extensively on women's development in South Asia, and has been awarded for her achievements by His Majesty the King of Nepal.

Barbara E. Kwast, a Dutch nurse-midwife, is currently serving as a scientist in the WHO Division of Family Health, where she develops global family health programs, concentrating on the contribution of nursing and midwifery to program goals in integrated maternal child health/family planning activities in the context of primary health care. She has had extensive experience in Malawi in hospital management, training, and management of training programs for midwives and traditional birth attendants.

Isabel Morel Letelier is a well-known speaker on human rights in Latin American. She is currently a Senior Fellow at the Institute for Policy Studies, where she directs both the Human Rights and Third World Women's Projects and participates in the World Economy Working Group. She was a board member of Survival International, U.S.A. and the 1987 recipient of the Gamaliel Chair in Peace and Justice. In 1975, Ms. Letelier founded the Chile Committee for Human Rights and in 1984, the Working Group for Democracy in Chile. Since the lifting of her exile she has returned to Chile.

Cathie Lyons, as Associate General Secretary of the Health and Welfare Ministries Department, General Board of Global Ministries, the United Methodist Church, is the chief executive officer for the church's international health work and its work in the areas of health advocacy, advocacy with persons with handicapping conditions, older adult advocacy and child and family advocacy. She initiated the department's work in the areas of child advocacy networking, women's health strategies, AIDS ministries, and Health For All. She has written and lectured widely on health and justice issues.

Emily Martin is the Mary Garrett Professor of Arts and Sciences in the Department of Anthropology at Johns Hopkins University. She has also taught at the University of California, Irvine, and at Yale University. Her book, *The Women in the Body: a Cultural Analysis of Reproduction*, won the Eileen Basker Memorial Prize from the Society for Medical Anthropology.

Miria R. K. Matembe, an attorney-at-law, is a member of the National Resistance Council and serves as the Commissioner of the Uganda Constitution Commission. She has been active as a law lecturer and as a member of the Women Lawyers Association of Uganda.

Caroline Moser, an Urban Specialist with the World Bank, is on leave from the London School of Economics, where she is the Convener of the Graduate Program on Social Policy and Planning in Developing Countries. Her current research is focused on the impact of structural adjustment on the urban poor. Prior to joining the Bank, she has undertaken research and consultancy work in Colombia, Nicaragua, Peru, India, Indonesia, Botswana, Egypt and Jordan for several United Nations organizations and has published widely on the informal sector, community participation, and gender planning.

Speakers

Antonia C. Novello, a pediatrician and clinical professor of pediatrics, is the first woman and the first Hispanic to hold the position of Surgeon General of the United States. Dr. Novello advises the U.S. public on health matters such as smoking, AIDS, diet and nutrition, environmental hazards, and the importance of immunization and disease prevention. She oversees the activities of the 5,700 members of the Public Health Service Commissioned Corps.

Waafas Ofori-Amaah is Project Director for the Global Assembly of Women and the Environment at WorldWIDE Network, a non-governmental international network of women concerned about development in environmental management. A Ghanaian national, she has conducted research on environmental management for WHO and the United Nations Environment Programme. Ms. Ofori-Amaah, who has worked at the International Institute for Environment and Development, has analyzed the legal and institutional aspects of environmental and natural resource management in developing countries.

Freda L. Paltiel, Senior Adviser, Status of Women, Health and Welfare in Canada, is a policy adviser with extensive experience in the fields of health, social policy, and public administration. The author of several publications on women and mental health and on violence against women, Ms. Paltiel serves as an adviser to WHO and represents Canada at many intergovernmental and Expert Meetings. A graduate of Queen's and McGill Universities in Canada and the Hebrew University School of Public Health and Community Medicine, in Jerusalem, she has chaired and currently remains a member of the Executive Subcommittee on Women, Health and Development of PAHO.

Catherine S. Pierce, a demographer, is Chief of the Special Unit for Women, Population and Development at the United Nations Population Fund (UNFPA). Ms. Pierce, who has been with UNFPA since 1980, was previously Chief of the Inter-regional and Non-governmental Organizations Branch. A graduate of Marymount College, she holds advanced degrees from Purdue University and Georgetown University.

Patricia Schroeder, Democratic congresswoman representing the First District of Colorado, has taken a leadership role on critical issues of foreign and military policy, arms control and disarmament, women's economic equity and educational opportunity, and civil and constitutional rights. As the most senior woman in Congress, she is Dean of the Colorado Congressional Delegation and currently chairs the Subcommittee on Military Installations and Facilities, and sits on the Subcommittee on Research and Development in the House Armed Services Committee. Ms. Schroeder is the Co-Chairman of the Congressional Caucus for Women's Issues.

Norma Swenson, President and Co-Director of the Boston Women's Health Book Collective, has been active in issues related to childbirth, women's health, and international women's health movements since 1962. She co-authored *Our Bodies, Ourselves, The New Our Bodies, Ourselves*, and *Ourselves Growing Older*. Ms. Swenson has worked with many women's groups internationally and has served as a women's health consultant to several national governments, private foundations, and other organizations; including, WHO. Recently, she co-founded the Women's Institute for Childbearing Policy, a consulting and advocacy organization. She currently teaches at the Harvard University School of Public Health.

Abigail Trafford is the editor of the Health Section of *The Washington Post*. Ms. Trafford has worked for *US News and World Report* as the assistant managing editor of science, medicine, and health. Previously, she worked for *Time Magazine* as full-time stringer at the Johnson Space Center in Houston, Texas, covering the space program. Ms. Trafford is a graduate of Bryn Mawr College and recipient of a 1980 journalism fellowship at the Harvard School of Public Health. She is the author of *Crazy Time—Surviving Divorce*.

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RT = Roundtable CS = Concurrent Sessions	I = Theme I II = Theme II	A = Morning Session B = Afternoon Session
La Rainne Abad-Sarmiento	I RT	June 24, 3:00-4:00 pm
Christine Adebajo	IIB CS: Female Circumcision	June 25, 4:00-5:30 pm
Jennifer Alexander-Terry	IIA CS: HIV/AIDS	June 25, 10:00-11:30 am
Marie D. Alexandre	I RT	June 24, 3:00-4:00 pm
Anna Alisjahbana	IIB CS: Preventing Maternal Deaths—What Works?	June 25, 4:00-5:30 pm
James Allman	I RT	June 24, 3:00-4:00 pm
Maria Elena Alvarez	I CS: Access to Care	June 24, 10:00-11:30 am
Saha Amarasingham	II RT	June 25, 1:00-2:00 pm
Milton Amayun	II RT	June 25, 1:00-2:00 pm
Mary Ann Anderson	I CS: Nutrition	June 24, 10:00-11:30 am
Michele M. Andina	IIB CS: Barefoot Doctors and Midwives	June 25, 4:00-5:30 pm
Marcia Angle	II RT	June 25, 1:00-2:00 pm
Charles R. Ausherman	IIA CS: Innovative Models	June 25, 10:00-11:30 am
Jean Baker	I CS: Abortion	June 24, 10:00-11:30 am
Rani Bang	I CS: RTIs	June 24, 10:00-11:30 am
Maggie Bangser	I CS: RTIs	June 24, 10:00-11:30 am
Maureen Rowley Barnett	II RT	June 25, 1:00-2:00 pm
Alfred V. Bartlett	IIA CS: Obstetrical Risk and Referral	June 25, 10:00-11:30 am
Florence A. Bashmir	I CS: Female Morbidity	June 24, 10:00-11:30 am
Naomi Baumslag	IIA CS: Innovative Models	June 25, 10:00-11:30 am
Janie Benson	IIB CS: Appropriate Tech. for Life Threatening Situations	June 25, 4:00-5:30 pm
Margaret Bentley	I CS: Listening to Women	June 24, 10:00-11:30 am
Peter Berman	IIB CS: Controlling Infection	June 25, 4:00-5:30 pm
Joan Brabec	IIA CS: TBAs and Community Health Workers	June 25, 10:00-11:30 am
Susan Brockmann	I RT	June 24, 3:00-4:00 pm
Blair L. Brooke	I CS: Socio-Economic Status	June 24, 10:00-11:30 am
Geri Marr Burdman	I RT	June 24, 3:00-4:00 pm
M. J. Burns	II RT	June 25, 1:00-2:00 pm
Miren Busto	I CS: Abortion	June 24, 10:00-11:30 am
Denise Callaghan	IIB CS: Barefoot Doctors and Midwives	June 25, 4:00-5:30 pm
Oona M.R. Campbell	I RT	June 24, 3:00-4:00 pm
Patricia Canessa	II RT	June 25, 1:00-2:00 pm
Kathryn Carovano	I RT	June 24, 3:00-4:00 pm
Michel Cayemittes	IIA CS: HIV/AIDS	June 25, 10:00-11:30 am
Cathleen A. Church	IIA CS: Talking With Women	June 25, 10:00-11:30 am
Colleen Conroy	I Poster	June 24, 3:00-4:00 pm
Julie Convisser	IIA CS: HIV/AIDS	June 25, 10:00-11:30 am
Hilary Cottam	IIA CS: Innovative Models	June 25, 10:00-11:30 am
Elizabeth Shrader Cox	IIA CS: Women's Rights	June 25, 10:00-11:30 am
Barbara J. Crook	II Poster	June 25, 1:00-2:00 pm
Rennie D'Souza	IIB CS: Enhancing Family Planning Programs	June 25, 4:00-5:30 pm
Nick Danforth	II RT	June 25, 1:00-2:00 pm

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Vincent David	I Poster	June 24, 3:00-4:00 pm
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William V. Dolan	IIB CS: Appropriate Tech. for Life Threatening Situations	June 25, 4:00-5:30 pm
Ellen Dorsch	II Poster	June 25, 1:00-2:00 pm
Marion Bullock DuCasse	IIA CS: HIV/AIDS	June 25, 10:00-11:30 am
Mawaheb El-Mouelhy	I CS: Female Morbidity	June 24, 10:00-11:30 am
Elly Engelkes	IIB CS: Appropriate Tech. for Life Threatening Situations	June 25, 4:00-5:30 pm
Vincent Fauveau	IIB CS: Preventing Maternal Deaths—What Works?	June 25, 4:00-5:30 pm
Lynn Erickson Fielder	I CS: Abortion	June 24, 10:00-11:30 am
Rebecca Fields	II Poster	June 25, 1:00-2:00 pm
Veronique G. A. Filippi	I Poster	June 24, 3:00-4:00 pm
Andrew A. Fisher	IIB CS: Enhancing Family Planning Programs	June 25, 4:00-5:30 pm
Holly Ann Fluty	II Poster	June 25, 1:00-2:00 pm
Robin Foust	IIA CS: Talking With Women	June 25, 10:00-11:30 am
Lynne Miller Franco	IIA CS: Quality of Care	June 25, 10:00-11:30 am
Barbara Frye	I RT	June 24, 3:00-4:00 pm
Rae Galloway	II Poster	June 25, 1:00-2:00 pm
Francois Gasse	IIB CS: Controlling Infection	June 25, 4:00-5:30 pm
Cynthia Poonam Gil	II Poster	June 25, 1:00-2:00 pm
Angela Gomes	IIB CS: Women Working for Change	June 25, 4:00-5:30 pm
Elsa Gomez Gomez	I RT	June 24, 3:00-4:00 pm
Wendy J. Graham	I Poster	June 24, 3:00-4:00 pm
Geeta Rao Gupta	I RT	June 24, 3:00-4:00 pm
Anna K. Harding	I RT	June 24, 3:00-4:00 pm
Sioban Harlow	II Poster	June 25, 1:00-2:00 pm
Judith F. Helzner	IIA CS: Quality of Care	June 25, 10:00-11:30 am
Beth M. Henning	II Poster	June 25, 1:00-2:00 pm
Jody Heymann	I RT	June 24, 3:00-4:00 pm
Fran Hosken	IIB CS: Female Circumcision	June 25, 4:00-5:30 pm
Gerald Hursh-Cesar	II RT	June 25, 1:00-2:00 pm
Mahdin A. Husaini	I Poster	June 24, 3:00-4:00 pm
Claudia Iriarte	IIA CS: Women's Rights	June 25, 10:00-11:30 am
Aminul Islam	IIB CS: Women's Empowerment—Critical for Health	June 25, 4:00-5:30 pm
Meherun Nessa Islam	I CS: Socio-Economic Status	June 24, 10:00-11:30 am
Shamima Islam	I CS: Listening to Women	June 24, 10:00-11:30 am
Suraiya Jabeen	IIB CS: Women Working for Change	June 25, 4:00-5:30 pm
Churamonie Jagdeo	IIA CS: Quality of Care	June 25, 10:00-11:30 am
Derrick B. Jelliffe	IIB CS: Appropriate Tech. for Life Threatening Situations	June 25, 4:00-5:30 pm
E. F. Patrice Jelliffe	II RT	June 25, 1:00-2:00 pm
Kate Kamba	IIA CS: Women Helping Women	June 25, 10:00-11:30 am
Sarah Degnan Kambou	I RT	June 24, 3:00-4:00 pm
Shubhada Kanani	I CS: Listening to Women	June 24, 10:00-11:30 am
Saadiya Aziz Karim	I CS: Nutrition	June 24, 10:00-11:30 am
Margaret Kaseje	II RT	June 25, 1:00-2:00 pm
Josephine Kasolo	IIA CS: Women Helping Women	June 25, 10:00-11:30 am
Shamin Akhter Khan	II RT	June 25, 1:00-2:00 pm

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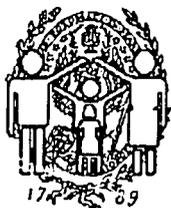
Zeenat Khan	I CS: Work and Women's Health	June 24, 10:00-11:30 am
Hind Abou Khattab	I CS: RTIs	June 24, 10:00-11:30 am
Jim Knowles	I CS: Access to Care	June 24, 10:00-11:30 am
Marjorie Koblinsky	I CS: Female Morbidity	June 24, 10:00-11:30 am
Laurie Krieger	I CS: Access to Care	June 24, 10:00-11:30 am
Kathleen M. Kurz	I Poster	June 24, 3:00-4:00 pm
Miriani Labbok	II RT	June 25, 1:00-2:00 pm
O. A. Ladipo	I Video/Film	June 24, 3:00-4:00pm
Richard O. Laing	IIA CS: HIV/AIDS	June 25, 10:00-11:30 am
Philip G. Lampe	IIA CS: Obstetrical Risk and Referral	June 25, 10:00-11:30 am
Bola Lana	II RT	June 25, 1:00-2:00 pm
Mpongo Landu	I Poster	June 24, 3:00-4:00 pm
Sandra L. Laston	I Poster	June 24, 3:00-4:00 pm
Virginia Hight Laukaran	II B CS: Preventing Maternal Deaths—What Works?	June 25, 4:00-5:30 pm
Charlotte Leighton	I CS: Access to Care	June 24, 10:00-11:30 am
Ann Leonard	II B CS: Enhancing Family Planning Programs	June 25, 4:00-5:30 pm
Gerald Lerebours	I Poster	June 24, 3:00-4:00 pm
Valeria Simoes Lira da Fonseca	I Poster	June 24, 3:00-4:00 pm
Usha K. Luthra	II B CS: Appropriate Tech. for Life Threatening Situations	June 25, 4:00-5:30 pm
Catherine Lwenya	IIA CS: TBAs and Community Health Workers	June 25, 10:00-11:30 am
Deborah Maine	II B CS: Preventing Maternal Deaths—What Works?	June 25, 4:00-5:30 pm
Francisco Mardones-Santander	II Poster	June 25, 1:00-2:00 pm
Margaret Marshall	II B CS: Barefoot Doctors and Midwives	June 25, 4:00-5:30 pm
Antonieta Martin	II Poster	June 25, 1:00-2:00 pm
Katherine Mason	II RT	June 25, 1:00-2:00 pm
Elizabeth Mataka	I CS: Listening to Women	June 24, 10:00-11:30 am
M. Catherine Maternowska	II B CS: Women Working for Change	June 25, 4:00-5:30 pm
Dileep V. Mavalankar	II RT	June 25, 1:00-2:00 pm
Gisele Maynard-Tucker	IIA CS: Quality of Care	June 25, 10:00-11:30 am
James McCarthy	IIA CS: Obstetrical Risk and Referral	June 25, 10:00-11:30 am
Marion McCartney	I Video/Film	June 24, 3:00-4:00 pm
Jeanne M. McDermott	II B CS: Controlling Infection	June 25, 4:00-5:30 pm
Beverly J. McElmurry	II RT	June 25, 1:00-2:00 pm
Judith McFarlane	I Poster	June 24, 3:00-4:00 pm
Lisa McGowan	I RT	June 24, 3:00-4:00 pm
E. Noel McIntosh	II B CS: Controlling Infection	June 25, 4:00-5:30 pm
Deborah L. McLellan	IIA CS: Innovative Models	June 25, 10:00-11:30 am
Kathleen M. Merchant	I CS: Nutrition	June 24, 10:00-11:30 am
E. Jeffrey Metter	I Poster	June 24, 3:00-4:00 pm
Nancy Mock	I RT	June 24, 3:00-4:00 pm
Asha A. Mohamud	II B CS: Female Circumcision	June 25, 4:00-5:30 pm
Mary Beth Moore	II B CS: Women Working for Change	June 25, 4:00-5:30 pm
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Chloe O'Gara	I CS: Work and Women's Health	June 24, 10:00-11:30 am
Bisi Ogunleye	IIB CS: Women's Empowerment—Critical for Health	June 25, 4:00-5:30 pm
Chinyelu Okafor	IIA CS: Women Helping Women	June 25, 10:00-11:30 am
Peju Olukoya	I RT	June 24, 3:00-4:00 pm
Karen Otsea	IIA CS: Women Helping Women	June 25, 10:00-11:30 am
Denise Paone	II RT	June 25, 1:00-2:00 pm
Pilar A. Parra	IIA CS: TBAs and Community Health Workers	June 25, 10:00-11:30 am
Pallavi Patel	I CS: Listening to Women	June 24, 10:00-11:30 am
Walter K. Patrick	I CS: Work and Women's Health	June 24, 10:00-11:30 am
Livia Maria Pedalini	IIA CS: Women's Rights	June 25, 10:00-11:30 am
William M. Pick	I Poster	June 24, 3:00-4:00 pm
Charlene Pope	IIB CS: Barefoot Doctors and Midwives	June 25, 4:00-5:30 pm
Clydette Powell	IIA CS: TBAs and Community Health Workers	June 25, 10:00-11:30 am
Xiao Chun Qin	IIB CS: Barefoot Doctors and Midwives	June 25, 4:00-5:30 pm
Juan Rivera	I CS: Nutrition	June 24, 10:00-11:30 am
Sheila Robinson	IIB CS: Women's Empowerment—Critical for Health	June 25, 4:00-5:30 pm
Rosalía Rodríguez-García	II RT	June 25, 1:00-2:00 pm
Zeil Rosenberg	IIA CS: TBAs and Community Health Workers	June 25, 10:00-11:30 am
Marie T. Ruel	II Poster	June 25, 1:00-2:00 pm
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Jill D. Salamon	IIA CS: Innovative Models	June 25, 10:00-11:30 am
Patricia Krackov Salgado	II RT	June 25, 1:00-2:00 pm
Graciela I. Salvador	I CS: Abortion	June 24, 10:00-11:30 am
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Carolyn Sargent	II RT	June 25, 1:00-2:00 pm
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Sidney Ruth Schuler	IIB CS: Women's Empowerment—Critical for Health	June 25, 4:00-5:30 pm
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Laura Smit	IIB CS: Enhancing Family Planning Programs	June 25, 4:00-5:30 pm
Steven C. Smith	II Video/Film	June 25, 1:00-2:00 pm
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Mae Thamer	I RT	June 24, 3:00-4:00 pm
James Thouw	I Poster	June 24, 3:00-4:00 pm
Vivien Davis Tsu	IIA CS: Obstetric Risk and Referral	June 25, 10:00-11:30 am
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Hajara Usman	I CS: Socio-Economic Status	June 24, 10:00-11:30 am
Budi Utomo	I CS: Female Morbidity	June 24, 10:00-11:30 am
Seini Vakasiuola	IIB CS: Women's Empowerment—Critical for Health	June 25, 4:00-5:30 pm
Itala Valenzuela	IIA CS: Talking With Women	June 25, 10:00-11:30 am
Cynthia Steele Verme	IIB CS: Enhancing Family Planning Programs	June 25, 4:00-5:30 pm
Bilkis Vissandjee	II Poster	June 25, 1:00-2:00 pm
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Amgad Wahba	II Poster	June 25, 1:00-2:00 pm
Gordon G. Wallace	IIB CS: Female Circumcision	June 25, 4:00-5:30 pm
Maxine Wedderburn	I CS: Access to Care	June 24, 10:00-11:30 am
Edson E. Whitney	IIA CS: Talking With Women	June 25, 10:00-11:30 am
K. Lisa Whittle	I CS: Abortion	June 24, 10:00-11:30 am
Lou Witherite	IIA CS: Quality of Care	June 25, 10:00-11:30 am
Scott Wittet	IIB CS: Appropriate Tech. for Life Threatening Situations	June 25, 4:00- 5:30 pm
Vivian Wong	IIA CS: Obstetrical Risk and Referral	June 25, 10:00-11:30 am
May Yacoob	I CS: Work and Women's Health	June 24, 10:00-11:30 am
Soon-young Yoon	II RT	June 25, 1:00-2:00 pm
Sixte Zigurumugabe	I RT	June 24, 3:00-4:00 pm



THE INSTITUTE FOR REPRODUCTIVE HEALTH

(formerly Institute for International Studies in Natural Family Planning)

GEORGETOWN UNIVERSITY

was established at the Georgetown University School of Medicine in 1985, funded primarily by the United States Agency for International Development, to study and promote natural fertility regulation in collaboration with developing and developed country institutions.

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- Training
- Technical Assistance
- Information, Education, Communication

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- Acceptability

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- Professional Education
- Program Support

For further information contact: The Institute for Reproductive Health, Georgetown University, Department of Obstetrics and Gynecology, 3800 Reservoir Road, NW, 3PHC, Room 3004, Washington, DC 20007 USA. (202) 687-1392

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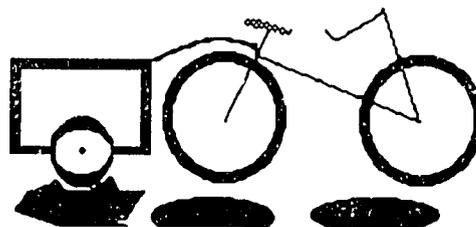
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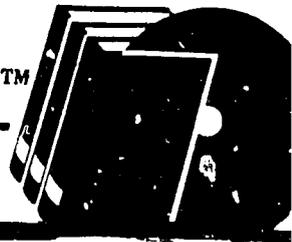


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Women in Danger: A Call for Action

by Jill Gay
and
Tamara Underwood

Executive Summary

Traditionally, women's health has received attention only as it affected the health of infants. At the end of the United Nations Decade for Women, however, the Safe Motherhood Campaign was launched focusing attention on the health of mothers. While an important breakthrough, there remain significant gaps in our understanding of women's health because of this singular focus on women's reproductive role.

Poverty and discrimination against women are crucial to an understanding of women's health and well-being in both the United States and the Third World. In particular, the combined effects of two decades of economic crisis and Structural Adjustment Programs, designed to re-invigorate developing country economies, have increased women's burdens and worsened their lot. Already suffering from unremunerated double days, discriminatory wages and limited access to land, women have watched their meager incomes fall. Women, who represent the majority of poor adults, have fewer resources and greater responsibilities as government social services are cut. Women are less able to feed and care for themselves and their families.

Poverty and discrimination affect the health of women and girls throughout their life cycle. Discrimination in feeding and health care means that girl infants and children suffer higher rates of malnutrition than boys and die of easily preventable childhood diseases. Adult and older women are also frequently undernourished and experience critical micro-nutrient deficiencies. Many women endure illness and die needlessly because they lack access to basic health care. Limited access to prenatal care, family planning and fertility control services result in hundreds of thousands of pregnancy related deaths in the United States and developing countries. Poor or little information and lack of control over their bodies also results in infertility or death from sexually transmitted diseases including AIDS.

In addition, violence against women of all ages is a serious health problem. A lifetime of violence and discrimination has deleterious effects on women's mental health.

Women of reproductive and post-menopausal age also suffer from breast and cervical cancer. Unfortunately little is known about prevalence rates in developing countries and few women have access to care and treatment. Women's paid and un-paid labor engender specific occupational health risks ranging from pesticide exposure and water borne disease to sexual abuse.

This paper underlines the challenging task in front of policy makers and health practitioners, as they work to understand and effectively address women's health needs.

Preface

The National Council for International Health (NCIH) is a U.S.-based non-governmental organization whose mission is to improve health worldwide. While NCIH exists to serve the developing world, NCIH also helps to apply what is learned abroad to serve the underprivileged in the United States. Since its inception in 1971, NCIH has developed into a major U.S. voice in the international health field with a membership of 160 organizations and 2,000 individuals. NCIH's annual conference is of particular importance as a venue for health practitioners and policymakers to exchange ideas and information.

The purpose of this paper is to focus more attention on the health needs of women by putting "the Woman in Maternal and Child Health (MCH)." While the 1991 Conference may consider some of the points raised in this paper, the deliberations of conference participants will in no way be limited to what is presented in this paper.

Women and Health: A Definition

"Women and Health" refers to a separate field of inquiry and needed action. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."^{1a} This definition applies to the health of both men and women. Women, like men, need "adequate housing, food, income, clean water, sanitation, education and 'appropriate' health care."² But women, especially poor women, are less likely to have these needs met.

A vital part of the definition of women and health is discrimination. "As we look into the question, we realize that a woman's health is more than a medical issue. A woman's status and her health are intricately intertwined. Any serious attempt to improve the health of women - if it is to succeed - must deal with those ways in which a woman's health is affected negatively ... simply because she was born female." Central to the definition of "Women and Health" are the underlying concerns related to discrimination, poverty, and class.

Women also have physical differences from men that result in specific health risks. Pregnancy, childbirth, breast cancer, and cervical cancer are a few examples. Yet these physical differences have too often been used to delimit and circumscribe women. Until recently, women have frequently been recognized and valued principally as mothers.⁴ While women's capacity for childbearing is a critical issue, defining women primarily by this single dimension is discriminatory.⁵ The ideology that women's natural destiny is to fulfill the biological role of procreation has been pervasive.⁶

A Few Facts: Women Are Dying

Too many women are sick or die unnecessarily from preventable causes. The majority are from the poorest populations of Africa, Asia, Latin America and the Middle East. A few facts and figures will begin to illustrate the severity of the problem. More than 500,000 women a year die from complications resulting from pregnancy and childbirth. Most of these deaths are preventable.⁷ Over 99% of the maternal deaths take place in developing countries.⁸ Half of all women worldwide between the ages of 15 to 44 years suffer from anemia, a serious debilitating condition.⁹ A survey of 45 underdeveloped countries found that girls die at a higher rate than boys between ages 1-4 in all but two countries.¹⁰

This Background Paper concentrates on the health of Third World women. But the problem of the poor and underserved, the majority of whom are women, is present in industrialized countries, as well as our own society. "Many of the problems and conditions of poor people in the United States mirror the health problems and conditions which exist for many of the poor people in developing countries."¹¹ Currently in the United States, there is an "appalling lack of attention given to women's health care needs. Women's (health) needs have been shamefully neglected. The basic issue is equity."¹² Therefore, this Background Paper also considers U.S. women's health. Yet it is clear that women in

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the developing countries face far more adversity, poverty, discrimination, and lack of resources than women in the United States.

Underlying Causes: Poverty and Discrimination

According to the World Bank, more than one billion people in the developing world live in poverty, struggling to survive on less than \$370 a year.¹³ The structure of the world economy has negatively affected the world's poor and their health.¹⁴ As Development Alternatives with Women for a New Era (DAWN), a network of Third World women, has observed, "Existing economic and political structures tend to be highly inequitable", reserving "resources, power, and control for small groups of people."¹⁵

"Development processes have often exacerbated these inequalities and have been harmful or indifferent to the interests and needs of the poor."¹⁶ From these inequalities, significant sectors of the population have been deprived of basic needs: adequate nutrition, health, housing, water, energy, sanitation, and education.¹⁷ For example, in the world as a whole, over one billion people have no safe water supply.¹⁸

"Poverty is often the greatest health hazard."¹⁹ In the United States also, according to the Institute of Medicine, "it has long been established that the poor have a significantly higher burden of illness than the non-poor."²⁰ Poverty is also correlated with hunger and malnutrition. "Poverty as the root cause of hunger is a global reality."²¹

Women constitute the majority of the world's poor adults, in the Third World and in the United States.²² Two-thirds of all American adults classified as poor are women.²³ Women predominate among the world's most disadvantaged: 15 million refugees and about 1,000 million homeless.²⁴ In the United States, the vast majority of homeless families are headed by women with two or three children.²⁵

Dr. Carmen Barroso explains why women are poor: "The economic subordination of women is achieved principally through the sexual division of labor. This translates into segregation between male and female activities. From this follows the devaluing of women's work, which is defined as "non-work" i.e. domestic work and in general reproductive work. Women's work is seen as merely complementary to men's work and as less important. This devaluing of women's work is reflected in economic terms. Women's labor is either not paid or is paid too little. Women's work is also undervalued as a social and cultural phenomenon, from the perception of women themselves (who will affirm that 'I do not work' after an exhausting day of 14 hours of household activities) to the mechanisms of gathering data, scientific investigations, and formulation of public policies."²⁶ Women in the United States are also disadvantaged in the labor market due to occupational segregation and sexual harassment. In the United States, women work mostly in the secondary labor market characterized by low wages, high turnover, and poor benefits. Women are more likely than men to be obliged to leave the labor market to raise children or care for an ill spouse or parent.²⁷ At the same time, women with small children now work in increasing numbers because they are single heads of households, or because a spouse's income is insufficient for a family's needs.

The United States Public Health Service Task Force on Women's Health identified the increasing number of women living in poverty as one of the most important factors currently affecting the health status of women.²⁸

The economic policies of the 1980s have had a profound effect on women. The numbers of poor, especially poor women, both in developing countries and in the United States, have grown while resources to provide health care have decreased. Women, comprising the majority of the world's poor, have suffered disproportionately. According to the Institute of Medicine, the number of people in poverty in the United States rose from a low, of 23 million in 1973 to a high of 34 million in 1984.²⁹ Moreover, developing countries face Structural adjustment programs. Structural adjustment is the formal International Monetary Fund (IMF) term to describe the programs the IMF designs for Third World debtors.³⁰ Structural Adjustment Programs (SAPS) result in:

- * increasingly high levels of unemployment
- * sustained reduction in real wages

- * increasingly high prices of essential consumer goods
- * deliberate cuts in the quantity and quality of basic public social services, particularly in education and health
- * the inability of the public sector to keep pace with the growth of population.³¹

Austerity measures of structural adjustment programs place additional burdens on women.³² According to the Pan American Health Organization (PAHO), in Latin America, "Economic adjustment policies were imposed at great social cost: in 1980, 30% of the population was poor, whereas in 1989, an estimated 40% of the Region's population - 170 million people - lived in poverty. Half of the poor had incomes too meager to buy enough food."³³ Under increasing economic pressure in the past four years, 37 of the poorest countries have cut health spending by 50%.³⁴ Peggy Antrobus, the General Coordinator of DAWN, summarized the impact of Structural Adjustment Programs on women's health: "These policies lead to impoverishment and therefore have had the severest impact on the poor, those least able to sustain the loss of services." Cuts in social services jeopardize women by reducing their access to services and "increasing the demand on their time, as they have to fill the gaps created by the cuts. Women's health is affected by the demands of their multiple roles as producers and those who continue to have primary responsibility for the care of their families."³⁵ Finally, austerity measures threaten to reverse the tangible advances made by women for better jobs, education and health. "While the focus on meeting practical needs in the areas of employment, education, health, and nutrition was important, we failed to recognize that even these practical gains are easily reversed if women lack the power to protect them when resources are scarce, which is exactly what has happened in the context of structural adjustment policies."³⁶

A rapid rise in military spending has also negatively affected resources for women's needs, particularly health concerns. Wars have resulted in devastation of civilian populations and an increase in refugees.³⁷

Because of discrimination, women are more likely to be poor. Because poverty is correlated with higher rates of mortality and morbidity, women are at greater risk for sickness.

Hard Work, No Pay

Women's domestic and reproductive work comprise activities vital to the survival of the woman herself and her family yet these activities are taken for granted in a man's world. "Whether we consider their legal, social, or economic status, that of women is universally lower than men's."³⁸ In developing countries, women spend from 10 to 16 hours a day doing housework, caring for children or other vulnerable family members, preparing food, and raising from 60 to 80 percent of the food for the family.³⁹ For this, women receive little recognition or recompense.

Collecting water, vital for the survival and health of the family, is another important unpaid activity of women in many parts of the world which increases their workload.⁴⁰ Many of women's water-related tasks increase their risk for water-related illness. The importance of water quality for health is clear: many human diseases are transmitted by water, such as cholera, typhoid, infectious hepatitis, or are otherwise water-related, such as bilharzia, guinea worm, malaria, sleeping sickness, yellow fever.⁴¹ The unpaid labor of women in collecting water and firewood also has consequences for their health by increasing energy expenditure. Women may take up to four or five hours a day to get water, carrying back an average load of 55 pounds. A study in East Africa showed that carrying water can consume 12 percent of the caloric intake of women, and in drier and steeper areas, up to 27 percent.⁴² "If men had to fetch drinking water," said one male member of India's Planning Commission, "then 230,000 villages would not have remained without water after 30 years..."⁴³

In some parts of the world, another important unpaid activity of women is collecting firewood. "Fuel shortages have reached crisis proportions in many regions so that women do not have enough wood to boil water or cook proper meals."⁴⁴ Fuel shortages result in negative consequences for nutrition.

Another unpaid activity of many women around the world is the responsibility for much of the cooking. This entails its own special health risks.

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Emissions from fuel used for cooking are dangerous sources of air pollution in the home.⁴⁵ Debilitating burns are also a significant health hazard.

Austerity measures have increased women's long workdays of unpaid labor. According to a UNICEF official, austerity measures have decreased public expenditures and cuts in social services have increased women's 'double load'.⁴⁶ One study found that women are the ones who work more because family incomes are lower. Women must decide what to give the children for supper when there is no money in the house. Women look after a sick person when the hospitals are in crises. Women stand in long lines for medical attention, or looking for other alternatives when the hospital is not an option.⁴⁷

This Land Is His Land

While women produce most of the world's food, they often do not reap the benefits of their labor. Women do 60-80 percent of the agricultural labor in Africa and in Asia, and 40 percent in Latin America.⁴⁸ Yet food distribution, as discussed later in this paper, favors males.

Without access and rights to land women's ability to grow food necessary to their nutritional well-being is seriously hindered. Yet women have title to only one percent of the world's land.⁴⁹ An example of legal discrimination is the Agrarian Reform Law in Honduras which applies only to those women who are single or widowed with responsibilities for children. For a Honduran man, the only qualification is to be Honduran and over sixteen years of age.⁵⁰

In recent years, land ownership has become increasingly concentrated, with large tracts of land going to either the wealthy or agribusiness, which has become increasingly multinational.⁵¹ In Pakistan, India and Bangladesh, one-quarter of the population is landless. The majority of this growing group of landless is women. And worldwide, women represent many of those dispossessed of land by the increasing concentration of ownership.⁵² In some countries, women have been instrumental in working for land reform.⁵³ Women have also been critical in devising innovative solutions to food crises situations, such as in Mozambique, where women have formed "Green Zones," cooperative gardens.⁵⁴ Austerity measures have had an adverse impact on women by favoring export "cash" crop production at the expense of subsistence crops. Typically, export crops have been grown under the control of men. Women have been required to work in the fields planting, weeding and harvesting, but the income accruing from the sale of such crops has gone to their husbands. Women have frequently lost access to better land as it was diverted from subsistence crop production under their control to export crop production. Export crops have always been allocated better seeds, fertilizers, credit and extension services - and this has meant discrimination against women.⁵⁵

Underestimating the amount of agricultural work done by women is very common. Statistics often measure wage labour, not unpaid work.⁵⁶ Housework done by members of a family in their own homes is excluded from the category of active labor by the International Labor Organization, the United Nations System of National Accounts (UNSNA), international organizations, multilateral organizations, and national governments. Therefore, much of women's unpaid labor is not considered active labor by policymakers in international organizations and government officials.⁵⁷ Because much of women's work is not considered active wage employed labor, resources have not been allocated to women, failing to alleviate their work burden or increase their productivity.

Women in the Paid Labor Force: Last with the Least

Because poverty is one of the greatest health hazards, it is necessary to understand why women predominate among the poor. One reason is women's disadvantageous position in the formal labor market.

Besides all their unpaid labor, women constitute almost a third of the measured labor force in developing countries.⁵⁸ Women's share in the industrial labor force of developing countries rose from 21% in 1960 to 26.5% in 1980. This increase is partly a result, however, of the fact that women provide cheap labor to large multinational corporations (MNCs).⁵⁹ These corporations can easily transfer their operations to whichever country provides the cheapest labor, most advantageous tax write-offs, or labor forces where unions are

illegal.⁶⁰

Because women's labor is cheaper than men's, women predominate in export-oriented labor intensive manufacturing in Export Processing Zones (EPZs) dominated by MNCs. But these jobs have numerous disadvantages. "Workers in EPZs tend to enjoy fewer rights than workers in private formal sector factories outside the zones; and their jobs are more vulnerable to the vagaries of the world market and protectionism in developed countries."⁶¹ Women have been at the forefront of protests to demand better working conditions in EPZs.⁶²

And even outside these zones, within the formal labor force, women predominate in low paying jobs with fewer benefits and less security. Women tend to be clustered in low-skill jobs with little potential for training and advancement.⁶³

One-third to one-half of all agricultural laborers in the Third World are women.⁶⁴ And in these insecure, labor intensive occupations, women's numbers are increasing. Women who work as wage laborers constitute a growing segment of the agricultural labor force. Export fruit companies in Chile and Costa Rica rely almost exclusively on women for harvesting, processing and packing fruits.⁶⁵ In Mexico, one third of the 4.5 million day laborers are women, and their living conditions are deplorable. Women, who migrate seasonally, live in cheap sheds, without access to even basic provisions in terms of health care and nutrition. These female migrant laborers are also easy targets for sexual abuse.⁶⁶

As in other occupations, women agricultural laborers are paid less than men. In countries as disparate as Cameroon, Indonesia and Peru, researchers have noted that women wage laborers in agriculture are hired for lower-paid agricultural tasks or are paid less than men for similar work.⁶⁷ The prevalence of temporary wage labor in agriculture has increased in recent years. The commercialization of agriculture and the current economic crises in the Third World has caused increased landlessness, forcing both men and women into temporary wage labor.⁶⁸

Third World women who have jobs in the formal sector consider themselves fortunate. In some countries, up to 85% of women are employed in the informal sector, including occupations such as street vending, marketing produce and handicrafts, and domestic services.⁶⁹ Women predominate in the informal urban sector.⁷⁰ Such informal sector work is frequently the only occupation that allows the presence of her children at her workplace.⁷¹

Employment in the informal sector may be correlated with lack of access to health care. Those employed in the informal sector are not covered by government provided health care services in many countries of the world. And in countries where access is predicated on the ability to pay, women earning negligible sums in the informal labor market have difficulty obtaining needed health care. In some countries domestic work employs the largest number of women. Domestic workers are also among the most ill treated of workers with the fewest legal rights.⁷² Domestic workers can be particularly subject to physical abuse and sexual harassment.⁷³ "Household work is not chosen, nor is it a vocation. People become domestics simply because they need to survive and receive an income."⁷⁴ Yet despite tremendous difficulties, domestic workers have organized unions to demand better conditions.⁷⁵

While women work at low paying, insecure jobs, they may often be the sole source of income for the family. "In addition to their home production and health provider roles, women are the sole breadwinners in one-fourth to one-third of the families in the world."⁷⁶ An Agency for International Development study found that female-headed households are the poorest group in every country.⁷⁷ It is not surprising that women-headed households are poorer than male- or jointly-headed households because of the limited types of work available to women and their poor access to land.⁷⁸

Due to the economic policies followed during the 1980s, more women have to work.⁷⁹ Ecuadorian women have been severely affected by the fact that fewer men than before are generating a reliable income and the value of their wage packet is lower than it was ten years ago. First and foremost, more women have to work at lower rates of pay.⁸⁰ At the same time, the cost of living has increased for low-income households.⁸¹ The combined effect of cuts in

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wages, inflationary food prices and increased expenses on education and health has meant that the majority of households are poorer in real terms.⁸² As Carmen Barroso found in her study of poor women in Brazil, "The recessive adjustment policies can thus be said to have clearly resulted in an excess of work for poor women; more women are working longer hours to earn less; more women are working in unacceptable and unstable conditions...all in a fruitless attempt to maintain the low standards of living that they had six or seven years ago."⁸³

Literacy and Health

Female literacy and education are a key to improved health for women and lower maternal mortality rates.⁸⁴ Yet girls and women are consistently discriminated against in access to education. According to UNICEF, "around the world, close to one billion people over the age of 15 are illiterate, two-thirds of whom are women."⁸⁵ "The gender gap in schooling is very wide."⁸⁶ Two-thirds of women over age 25 have never attended school whereas half of men over 25 have attended school.⁸⁷ Where there are limitations on the number of eligible children that can be enrolled, girls are more likely to be left out than boys.⁸⁸

Literacy and education represent opportunities for advancement. Both are crucial to enabling poor people to reduce their poverty.⁸⁹ For women, in particular, education is key to a higher income level and finding employment outside the home.⁹⁰

Progress in education is being undermined by austerity measures and the economic recession of the 1980s. "During the 1960s and 70s, rapid progress was made in increasing primary school enrollment rates. But this trend has now been reversed in many countries by economic recession and austerity."⁹¹ Debt servicing and structural adjustment programs introduced to restore economic growth have seriously affected expenditures on health and education. In the 37 poorest nations of the world, spending per head on education has declined by approximately 25 percent in the past decade.⁹²

The Case for a Life Cycle Approach

Women's health has traditionally been subsumed under the academic field of "Maternal and Child Health" (MCH) and/or Population Sciences within the field of Public Health. Within MCH, until recently, attention was devoted mainly to the mother's health only in so far as it affected the infant's or child's health. At the end of the UN Decade for Women (1976-1985), public health experts began asking the question, "Where is the M in MCH?"⁹³ The Safe Motherhood Campaign launched in February 1987 by the World Health Organization (WHO), the World Bank, and UNFPA has been a breakthrough in focusing attention on the mother's health.⁹⁴ The Safe Motherhood initiative represented the first time that systematic reviews of existing data on the problem of maternal health and mortality were presented. A plan of action was recommended for implementation by countries and the international and bilateral aid agencies.⁹⁵

Population science experts in the past have also focused on women's health, but again, mainly in terms of how their fertility affected population growth.⁹⁶ This focus on a woman's health principally in relationship to her ability to bear or abstain from having children has led to major gaps in the understanding of her health during other periods of her life. Women who are infertile or choose not to have children have also been neglected. "Women are entitled to health services in their own right, and not simply in relation to reproduction."⁹⁷ Indeed, numerous women's groups in the Third World and in the United States have been working to put "women at the center, respecting their needs, their health, and their rights."⁹⁸

Discrimination, as mentioned earlier, affects the health of women throughout their life cycle, from infancy until death. In many societies, starting in infancy, girls receive less food and preventive health care than boys.⁹⁹ In addition, "Girls between the ages of 5 and 16 are generally not considered appropriate clients for any of the major health programmes such as family planning, child survival, or safe motherhood."¹⁰⁰ Even in adolescence, health needs of girls beyond reproduction have received scant attention. During

women's reproductive years, ages 15-44, little is known about the impact of women's roles on the incidence of infectious diseases, and on their occupational and mental health. Health needs related to women's roles in carrying water, washing, and gathering firewood are not fully understood. Also, little is known about how illness affects women's lives. The health needs of post-menopausal women have only recently begun to receive attention.¹⁰¹ Yet, the health of the girl-baby will affect the health of the girl-child which will in turn affect the health of the adolescent girl, and so on, throughout the life cycle.¹⁰²

Hunger and Nutrition

Women's increased landlessness and lower incomes with which to purchase food have been delineated in the previous sections, "This Land is His Land" and "Women in the Paid Labor Force: Last with the Least." Given these realities, it is not surprising that women throughout their life cycle are at particular risk for malnutrition simply because they were born female.

It is conservatively estimated that more than a half-a-billion of the world's people are chronically hungry. Hunger is not confined to the Third World. There are 18 to 20 million people in the United States who are so poor that they do not get the nutrients they need.¹⁰³ Other estimates have been as high as more than one billion chronically hungry people worldwide with hunger affecting 35 million people in the United States.¹⁰⁴ Women predominate among the malnourished and hungry.¹⁰⁵

Beginning in infancy, nutrition is critical to good health. Yet even in infancy, girls in many parts of the world often receive fewer nutrients than boys.¹⁰⁶ In many societies, boys are breastfed longer than girls, and are given more nutritious and greater quantities of food once weaning ensues.¹⁰⁷ As a Latin American folk saying puts it: "Cuando la comida es poca, a la nina no le toca" (When there is little food, girls get none).¹⁰⁸

Where nutritional discrimination against girls exists, it can happen in both poor and better-off households. Thus, increasing the amount of food available is not necessarily sufficient to eliminate malnutrition among girls.

A malnourished girl's growth is stunted. This can be a matter of life and death later as she attempts to give birth under hazardous conditions.¹⁰⁹ In Zaria, northern Nigeria, it is estimated that 25 percent of childbearing women are stunted.¹¹⁰ Malnutrition of a female infant begins with the malnutrition of her mother.¹¹¹

Malnutrition is just one indicator that reflects discrimination against girls. A survey of 45 underdeveloped countries found that in 43 of them more girls aged one through four died than did boys the same age. In many countries, the causes of higher death rates - nutritional deficiencies, acute respiratory infections, measles, and diarrheal diseases - are largely preventable.¹¹² This suggests that, in addition to receiving less food, girls also receive less health care, and other social benefits which enhance their survival chances.¹¹³ For example, in rural Bangladesh, more boys than girls were taken in for care at a diarrhea treatment center even when ambulance transport and treatment were free.¹¹⁴ As Barbara Herz of the World Bank points out, girls "face sharply higher rates of mortality, morbidity, and malnutrition."¹¹⁵ In many countries in the Third World, the lack of health care and sustenance received by girls is so great that it outweighs basic biologic tendencies for girls to die at the same or lower rate than boys.¹¹⁶

And it is not just early in life that girls receive less food. Among adults, women are more frequently undernourished.¹¹⁷ In many societies, women eat after the men have had their fill, with the result that they tend to get less of the more nutritious foods. A survey of 898 villages throughout the world found it to be a general rule that the needs of the men were given priority at meals.¹¹⁸

Another nutritional affliction that entails specific health risks for women is anemia. Approximately half of all women aged 15-44 and two-thirds of pregnant women in the Third World suffer from anemia.¹¹⁹ Anemias occur up to 20 times more frequently in pregnant women.¹²⁰ Severe anemia results in faintness, loss of mental concentration, and reduced capacity for physically demanding work.¹²¹ Anemia brings a high risk of obstetrical complications. Post-menopausal women are also at particular risk for anemia.¹²²

Lack of sufficient calcium has specific risks for women. Shortage of

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calcium in childhood leads to small pelvic structure and difficult childbirth.¹²³ Post-menopausal women are also more susceptible than men to calcium loss leading to frequent fractures. A Jamaican study carried out in Kingston found that 34% of women 65 and over had insufficient levels of calcium.¹²⁴

Austerity measures have exacerbated women's nutritional problems. Lower incomes together with increased food prices, more export crops and less subsistence farming have had deleterious effects on women. Studies have revealed "a widespread deterioration in the nutritional status of ... pregnant and lactating mothers in both rural and urban areas in countries with IMF stabilization and World Bank Structural Adjustment Programs."¹²⁵

Women's Reproductive Health

Reproductive health has been defined as "the ability to enjoy sexual relations without fear of infections, unwanted pregnancy, or coercion; to regulate fertility without risk of unpleasant or dangerous side effects; to go safely through pregnancy and childbirth; and to bear and raise healthy children."¹²⁶ To this definition, one might more explicitly add informed choices for fertility regulation, education about one's body, and knowledge of and treatment for STDs which can result in infertility. Reproductive health also includes preventive health care and good quality maternity services to enable women to bear the children they desire. Services which offer choices and full information empower women to manage their overall health and sexuality.¹²⁷ The reproductive health issues which will be considered in this Background Paper are: family planning, abortion, infertility, maternal mortality and morbidity, reproductive tract infections including sexually transmitted diseases (STDs) such as AIDS, violence against women, sexuality, cervical cancer and breast cancer.

Family Planning

"Like pure water and like nutritious food, family planning is essential for good health."¹²⁸ A woman's capacity to decide if and when to have children is key to her overall well-being. Preventive health care to enable a woman to safely bear children if she so desires, is also important.

Only 27 percent of couples in the Third World (except China) use effective birth control methods.¹²⁹ A majority of couples wish to space the timing or limit the number of their children.¹³⁰

A large number of couples who do not want more children do not use contraception: "Less than half the married women who said they wanted no more children were using contraception."¹³¹ In addition, "in many countries unmarried women are denied their right to family planning, usually on moral grounds. But the evidence shows that this rarely prevents sexual activity among unmarried people; it simply leaves large numbers of women vulnerable to unwanted pregnancy."¹³² Over one-third of the 140 million women in the developing world who have become pregnant in the last 12 months did not want to have another baby.¹³³

Barriers to a woman's ability to control her own fertility include a number of factors. Many couples still have no access to effective contraception. Cultural factors and religious beliefs may interfere with a woman's desire for family planning. Many women now excluded as a matter of policy from contraceptive services want access. In many countries, these include the young, the unmarried, and those who do not yet have a child. Many women need easier access to services. Those who are employed or have great demands on their time often face major obstacles in obtaining services. These include inconvenient hours, travel over long distances just to reach a clinic or contraceptive dispenser, hours of waiting in the clinic, or repeated visits for service because of shortage of supplies or personnel.¹³⁴

"Even when contraceptive services are available, women face substantial additional obstacles to access and to effective use. These include the inconvenience and health risks of contraceptives themselves, women's fears about side-effects, the ignorance of many women about sexuality, and their powerlessness in sexual relations."¹³⁵

Other elements, such as a choice of methods, information given to women, and the need to treat women with respect are also important to a woman's ability to obtain family planning methods.¹³⁶ A wide range of

excellent contraceptive choices have yet to be invented and prospects for their development do not look promising.¹³⁷ More contraceptive choices for men are necessary. Women's contraceptive needs change during her life cycle, and women need different contraceptive options. Sterilization abuse has been a problem, both in the United States, among minority populations, and in the Third World. Sterilization abuse occurs when sterilization is the only family planning alternative offered, when financial incentives are used to promote sterilization as a choice, and/or women are not fully informed as to the irreversible nature of sterilization.¹³⁸ In the United States, women's groups such as the Committee for Abortion Rights and Against Sterilization Abuse (CARASA), and in the Third World, groups such as the Women's Commission of the Centro de Articulacao de Populacoes (Center for Networking of Marginalized Communities) have been at the forefront of struggles against sterilization abuse.¹³⁹ In other settings, sterilization has not been available as a choice to women.

Abortion

The number of women's lives ended prematurely mainly because of the lack of low-cost, preventive health care in the form of family planning services is truly staggering. As many as 200,000 or more Third World women die needlessly every year due to botched abortions.¹⁴⁰ Providing access to safe abortion services would prevent from one-fifth to half of all maternal deaths.¹⁴¹ It is primarily poorer women who seek abortions from untrained persons resulting in greater risk for post-abortion complications.¹⁴² Women have always and will continue to resort to abortion because contraceptives fail, users fail, contraceptive services are not always available and accessible, or abortion is simply preferable to contraception for some women at some times.¹⁴³

One-third of the population of the developing world - more than one billion people - live in countries where abortion is prohibited, or permitted only to save a woman's life, or in cases of rape or incest.¹⁴⁴ Even where abortion is legal, services may not be safe, affordable or available.¹⁴⁵ Contributing to this lack of access to abortion is current United States policy initiated in 1984, when the U.S. announced that it "does not consider abortion an acceptable element of family planning programs and will no longer contribute to those of which it is a part."¹⁴⁶ The effect has been to deny Third World women access to family planning services that "include abortion as an option or fail safe assurance in the case of contraceptive failure" - options which United States women are constitutionally guaranteed.¹⁴⁷ This policy is being challenged by women active in the reproductive rights movement, both in the United States and in the Third World.¹⁴⁸

Infertility

Infertility is a significant public health problem in certain regions of the world.¹⁴⁹ Surveys have found that an average of 12 percent of women who had passed their childbearing years in 18 Sub-Saharan countries were childless.¹⁵⁰

Untreated and undiagnosed STDs contribute to high infertility rates.¹⁵¹ Few services are available for women with STDs, particularly socially acceptable ones. Another factor contributing to high infertility rates is infections resulting from either unsafe abortions or unsanitary conditions during and after childbirth.¹⁵² Childless women face stigma in many cultures: sometimes the penalty is desertion or divorce.¹⁵³ As we have seen with other illnesses, infertility seems to prevail among the poor.¹⁵⁴

Pregnancy - Related Death and Illness

Each year, half a million women die from causes related to pregnancy and childbirth. Yet maternal mortality data has been gathered only recently and "no one knows exactly how many women die each year as a result of becoming pregnant. Most of those who die are poor, they live in remote areas and their deaths are accorded little importance."¹⁵⁵

Causes of maternal deaths are related to: septic abortions, hypertension, toxemia, hemorrhage, obstructed labor, and infection.¹⁵⁶ Certain diseases become more serious or fatal in combination with pregnancy: malaria, hepatitis, heart disease, anemia, and diabetes. For example, malaria during preg-

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nancy greatly increases the risk of cerebral malaria and death.¹⁵⁷

Maternal mortality also has a devastating effect on families. "In one study, 95 percent of the children of such mothers had also died within a year of their mothers' death."¹⁵⁸

Illness during pregnancy, even when not fatal, can be particularly debilitating. An estimated 8 million women experience nonfatal pregnancy-related complications every year.¹⁵⁹ "The so-called 'minor complaints' of pregnancy - nausea and vomiting, backache, fatigue and sleeplessness - are rarely addressed even though these conditions may significantly impair women's well-being and their ability to work. Conversely, women may not view some complications of pregnancy as illness. Swelling of the hands and face may be an ominous sign to health workers, but few women regard such an occurrence as illness."¹⁶⁰ Guinea worm disease is so painful and debilitating that it leaves a woman unable to care for either herself or her family.¹⁶¹ But illness in most pregnant women does not entitle the woman to either rest or medical care. Many women know that during their pregnancy, they should work less and increase nutritional intake. But women usually find doing so impossible. One Indian village woman said: "Certainly pregnant women should have special foods like milk, fruit, and ghee. Such foods make the baby healthy. But I could not eat such things during my last pregnancy, for we were short of money at the time."¹⁶² While women would like to rest more during pregnancy and following birth, they are rarely given this option. Another village woman noted: "How could I take leave? My husband and daughter would have been hungry if I had not cooked for them. Why, the very day the baby was born I brought a head-load of fodder and cut it with the chopping machine for the buffalo."¹⁶³

A Deadly Alphabet Soup: RTIs, STDs and AIDS

Some, but not all, reproductive tract infections (RTIs) are sexually transmitted. Acute RTIs cause physical discomfort, personal embarrassment and marital discord. Subacutely or chronically, RTIs compromise women's ability to achieve and sustain pregnancy as well as to produce healthy children. Particularly in the developing world, RTIs frequently have a great impact on a woman's status within her family and her community, as well as on her physical comfort.¹⁶⁴

Both men and women have similar prevalence rates (frequency of occurrence) for the majority of sexually transmitted diseases (STDs). STDs can lead to sterility in both men and women. But women usually are blamed for childlessness.¹⁶⁵ Diagnosis of STDs is harder for women than for men. Symptoms are less obvious for women. Women usually suffer greater disapproval for having contracted STDs and thus avoid clinics.¹⁶⁶ Access to care is another problem. Unfortunately, screening and treatment for infection have rarely been incorporated into services offered at family planning, antenatal, or maternal-child health (MCH) clinics. Many physicians lack adequate training to recognize and treat STDs in women. If care for RTIs is available at all, it is only through STD clinics, settings that are usually socially unacceptable for women.¹⁶⁷ Family planning care needs to be coordinated with RTI screening because contraceptive methods alter women's risks of RTI.¹⁶⁸

AIDS is the STD killing the most people. As many as three million women worldwide are currently infected with Human Immunodeficiency Virus (HIV), the virus that causes AIDS.¹⁶⁹ HIV is transmitted through sexual intercourse, contamination by infected blood (e.g., blood transfusions, accidental injury with contaminated needles, sharing of contaminated needles by drug users) and perinatally.¹⁷⁰ Since it is estimated that half of those carrying the virus will develop AIDS within ten years of their initial infection, millions will die unless a cure is found. Yet possibilities for a cure seem remote. Prevention campaigns through education about means of transmission have not been thorough, either in the U.S. or in many developing countries. Ignorance about HIV is a basic obstacle to protection against HIV infection. Sexuality education has received low priority due to religious sensitivities. Yet many lives are at stake.¹⁷¹ Women in Thailand have been at the forefront of protests on the need for AIDS prevention programs.¹⁷² AIDS has become the leading cause of death for women aged 20-40 in major cities in sub-Saharan Africa.¹⁷³ In Kampala, Uganda, surveys of pregnant women have shown HIV

seroprevalence rates of 24 percent.¹⁷⁴ A majority of women with AIDS are poor.¹⁷⁵

Women who work as commercial sex workers are at very high risk for contracting HIV infection.¹⁷⁶ Prostitutes are too rarely described in the scientific literature as women who need services because they are HIV positive, rather they are described as 'reservoirs of infection'.¹⁷⁷ Given the increasingly severe economic conditions more and more women and young girls have been driven into prostitution as a means of survival which in turn increases the numbers exposed to HIV infection, such as in the case of Ghana.¹⁷⁸

But all low-income women, not just prostitutes, are at risk because they are financially vulnerable. As Miria Matembe, a member of Ugandan parliament put it: "The women tell us they see their husbands with the wives of men who have died of AIDS. And they ask, 'What can we do? If we say no, they'll say: pack up and go. But if we do, where do we go to?' They are dependent on the men and they have nowhere to go."¹⁷⁹

The increasing numbers of women who are drug users and partners of drug users are also at high risk. And women who receive blood transfusions, whether during caesarian births or other operations have also been exposed to HIV infection where blood has not been carefully screened.

Because HIV can be transmitted perinatally, women with HIV face agonizing choices over pregnancy and childbearing. But as noted earlier, when society defines the primary function of a woman as bearing children, not bearing children makes that woman an abnormal part of society. A study in Kinshasa, Zaire found that many HIV-positive women were unwilling to sustain birth-control use, saying they desired a child.¹⁸⁰

Violence Against Women

Violence against women is a major public health problem. Violent crimes against women include rape, assault, robbery, incest, sexual and physical abuse, and battering.¹⁸¹ "The real extent of violence against women has been largely hidden, widely denied, professionally condoned..."¹⁸² No systematic worldwide studies of violence against women have been done. A few examples of documented prevalence of violence against women demonstrate that violence is widespread. In Peru, 70 percent of all crimes reported to the police are of women beaten by their partners. A study in the biggest slum of Bangkok, Thailand, found that 50 percent of married women are beaten regularly. In one study in the barrios of Quito, Ecuador, over 80 percent of women interviewed had been beaten by their partners.¹⁸³

In the United States, according to the Senate Judiciary Committee, the rape rate is increasing four times as fast as the overall crime rate. One in five adult women has been raped. Between 3 million and 4 million women are beaten each year, 1 million so severely that they seek medical help. More than half of all homeless women are fleeing domestic violence.¹⁸⁴ Minority women in the U.S. are more likely to be victims of crime, as are women who are poor. Yet a recent survey by the Centers for Disease Control found that 53% of the medical schools in the United States had no instruction on family violence.¹⁸⁵

In some countries, there is no legal redress against domestic violence.¹⁸⁶ Even though violence against women occurs at all class levels, domestic violence has increased as the financial situation of the poorer households has become even more precarious.¹⁸⁷ Incest and child sexual abuse can lead to teenage pregnancy, as well as severe psychological damage.

The use of violence against women as a method of torture among political prisoners has also been documented.¹⁸⁸ Women frequently experience sexual abuse in situations where their other human rights are being violated.¹⁸⁹ Many women have shown unrelenting courage in the face of such degrading circumstances.

Another form of culturally sanctioned violence is genital mutilation. An estimated 84 million girls and women in the world today have undergone some form of female genital mutilation. The most serious forms of genital mutilation involve excision, in which the clitoris and all or part of the labia minora are removed; and infibulation, in which the clitoris, labia minora, and all or most of the medial part of the labia majora are removed.¹⁹⁰ "Long ago my sister died

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after circumcision. She couldn't pass urine and was not taken to a doctor". "I have been circumcised...My daughter, who is 17 now, has not been circumcised. I told her she didn't have to be grateful for anything in her life, except that she is uncircumcised."¹⁹¹ Dr. Nawal El Sadaawi recalls: "During my period of service as a rural physician, I was called upon many times to treat complications arising from this primitive operation, which often jeopardized the life of young girls."¹⁹² Female genital mutilation can lead to severe pain, infections, psychological disorders, urinary complications, difficulty or impossibility of sexual relations, difficult labor, infertility, and death of the woman either as a result of the operation or during childbirth.¹⁹³ Women who have undergone genital mutilation are physically impeded in their ability to enjoy sexual relations. A number of African women's groups, such as the Inter-African Committee, the Association of African Women for Research and Development (AAWARD/AFARD), and the National Association of Nigeria Nurses and Midwives have been working to educate those affected about the health implications of genital mutilation. Phoebe Asiyu, a Kenyan who serves as Goodwill Ambassador to UNIFEM, stresses the urgency of the problem: Why has it taken "20 years since we first discussed the issue and made a recommendation for the U.N. to do something. And what did they decide to do? - appoint an expert. It is heartbreaking that it should take so long to deal with a practice that has disabled women in Africa...How long are we going to wait while our women are stitched up?"¹⁹⁴

Sexuality

"I have five children and I have had seven pregnancies and it is only now that I learned how I got pregnant," said one Ivory Coast woman.¹⁹⁵ Women have consistently expressed interest in more self-knowledge about sexuality.¹⁹⁶ Sexuality is a vital part of women's health.¹⁹⁷ Lack of information and education about their bodies, sex, and sexuality leaves women vulnerable to both physical and emotional abuse by men.¹⁹⁸ In some instances, if a woman insists on condom use or other modifications in sexual practices, she may risk physical abuse, ostracism or loss of financial security.¹⁹⁹ In societies where a belief in male supremacy coexists with restrictive social structures that limit women's economic, social and legal independence, men often maintain strong control over female sexuality. Due to double standards of sexual behavior, sexual coercion, and gender discrimination in schooling, employment, and property and legal rights, girls and women are frequently powerless to avoid intercourse.²⁰⁰ Research with women worldwide reveals that most sexual activity is ultimately determined by men. Many women define sex to a large extent by what gives men pleasure.²⁰¹ As one low-income woman in the Bronx put it: "Men decide what is going to happen sexually." Research has not been widely conducted on the relationship between cultural values, sexual norms, and actual sexual behavior.²⁰² Little information to educate women about their sexuality had been written until The Boston Women's Health Book Collective produced its landmark book, *Our Bodies, Our Selves*.²⁰³ The National Black Women's Health Project has been instrumental in sexuality education for women of color in the United States.²⁰⁴ Women's knowledge of their bodies is often influenced by a very negative medical view of the normal bodily processes.²⁰⁵

Cancer

Cervical cancer is the leading cause of cancer death in the Third World. Despite the fact that cervical cancer can be easily detected and cured if identified early, many of the half a million new cases of cervical cancer that occur per year go undetected and untreated. In many areas of the world at least 3 percent to 5 percent of adult female deaths are due to this cancer. Even a single Papanicolaou smear for screening in a woman's lifetime will reduce the death risk from cervical cancer by about 50 percent, if followed by appropriate treatment.²⁰⁶

Among women in the United States, breast cancer is the leading cause of cancer death.²⁰⁷ Reductions in death from breast cancer may depend on interventions resulting in early detections and treatment.²⁰⁸ Women may themselves reduce their risk of death from breast cancer if they know how to examine themselves and can report lumps to trained health professionals for

further evaluation. Yet most women are not trained to conduct such simple, self-help preventive measures with no financial costs.

Occupational Health

Some of the occupational health risks with regard to women's unpaid labor have already been discussed.

Within the formal labor market, large-scale occupational health studies have generally excluded women. Instead of a lifecycle approach, including midlife and older women workers, studies of women's exposure to occupational hazards have, appropriately or inappropriately, focused on reproductive outcome.²⁰⁹

Within the formal labor market, women have specific health risks. Pesticide poisonings may affect women disproportionately since their agricultural work tends to bring them into closer contact with the crop. And in the electronics factories of South-east Asia women as young as 25 have severely impaired eyesight from assembling tiny silicon circuits.²¹⁰

The prevalence of sexual harassment as a public health problem in the workplace is also largely undocumented - anecdotal, but universally acknowledged.

Mental Health

Every woman's mental health is affected by the way her society regards and treats women.²¹¹ Women's emotional health is affected by discrimination.²¹² For older women in developing countries, depression is the most common psychological disorder.²¹³

Access to Services

Access to care is a critical issue. The inequitable distribution of health resources is one of the greatest problems in many developing countries as well as in some developed countries, such as the United States.²¹⁴ In fact, the number of people worldwide without access to health services is unknown.²¹⁵

Services to assist women during childbirth are seriously inadequate. "In Africa, Asia and parts of Latin America, half or more of pregnant women face birth without help...Millions have chronic illnesses or are sterile as a result."²¹⁶ Approximately half of all deliveries in the developing world (excluding China) are supervised by Trained Birth Attendants (TBAs).²¹⁷ TBAs are often the only affordable, accessible, and culturally sensitive options for women in developing countries. TBAs often are not provided effective training, nor are their referrals to needed tertiary care always accepted.²¹⁸ Yet in many developing countries, women who do have a choice may still choose the TBA over a crowded and humiliating hospital birthing experience.²¹⁹

Access to good primary care with back-up hospital care for high-risk pregnant women may save their lives. But in many parts of the world, most women do not have access to hospital care. For example, in East Africa, only 10% of women needing this life-saving operation had a Caesarian section. However, a study of Latin American maternity hospitals found that Caesareans may be performed for reasons other than the welfare of the mother or the child: additional fees which can be charged, doctor's convenience, the ability to perform an illegal sterilization at the same time as the C-section, etc.²²⁰ C-section operations increase the risk of maternal mortality twelve times.²²¹ Access to hospital based care, therefore, is not necessarily a guarantee of good care. "Modern obstetrics...often serves the economic and social interests of elites rather than those of the great majority of women in need of basic care."²²²

In developing countries, despite the need and cost-effectiveness of preventive health care measures, an estimated 70 to 85% of total health spending goes toward curative care.²²³

While funds for curative care are absolutely necessary, preventive care is extremely cost-effective. Available, accessible prenatal care which treats women with respect and dignity is an essential element of preventive health care. Developing countries show a dramatically lower rate of mortality among women who have had regular prenatal care coupled with referral centers, compared with women who are first seen in labor.²²⁴ Prenatal care is also vital to ensure good maternal health in the United States. According to the Institute of Medicine, "Poverty is one of the most important correlates of insufficient

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prenatal care.²²⁵ Again, this holds true for the developing countries.²²⁶ No more than one third of pregnant women in developing countries receive any formal prenatal care.²²⁷ This same statistic holds true for poor women in the United States.²²⁸ Adolescents are particularly unlikely to receive adequate, if any, prenatal care.²²⁹ Simple health care measures provided during prenatal care could prevent major threats of disease. For example, five doses of tetanus toxoid with proper intervals between doses and before the first pregnancy, can protect a woman for life. Yet only about 17 percent of women worldwide were adequately immunized by July 1988.²³⁰

Women's health needs for services outside of reproductive health are rarely addressed. In developing countries, for example, while women are just as likely to have malaria as men, they are less likely to seek or receive treatment. Women are held back by the necessities of child care, household duties, and the lack of ready cash to pay for transport, even if transport is available.²³¹ When women become ill, there are usually few other household members willing or able to care for them.²³² They also may not be the ones who can make the decision to access care or may not perceive that they have a problem. Moreover, health services have not incorporated a lifecycle approach to the totality of women's health needs. The needs of post-menopausal women are particularly neglected. "If women are undervalued, then older women must be the most undervalued of all."²³³ Older American women, for example, are at severe disadvantage. Medicare, designed to assist older persons in need of health care, covers only 44% of health care bills and covers virtually no nursing home care.²³⁴ Because the chances of women being placed in nursing homes is much higher due to longevity and as widows, there is less likelihood of a caretaker for them, American women are disproportionately hurt by Medicare's shortfalls. Many older women are forced to deplete their personal resources until they qualify for Medicaid in order to cover nursing home costs.²³⁵ But change is afoot. In the United States, legislation has been introduced to require that the National Institutes of Health (NIH) include women and minorities in research study populations and create a Center for Women's Health Research and Development at NIH.²³⁶

Distribution of health resources in developing countries has been exacerbated by Structural Adjustment Programs (SAPs) which have decreased the availability of services while at the same time increasing user fees.²³⁷ SAPs decrease funds available for government provided health care services. For example in Latin America, according to PAHO, "Scarce funds made it difficult to cover the rising cost of critical imports like vaccines, equipment, and pharmaceuticals."²³⁸ Yet more people than ever need government-provided health care. Part of this need for expansion in services is due to natural population growth. But in addition, in Latin America, "more than 150 million people who were unemployed or had lower disposable incomes were not covered by social security, nor could they afford private care."²³⁹ Also as poverty increases, health worsens. This same pattern has been noted in the United States, where in the past decade the numbers of poor have grown but fewer funds have been allocated for their health care. The Medicaid program was designed to provide health care for the poor. Yet, Medicaid covers less than one-half of the poor. According to the Institute of Medicine, the proportion of poor covered by Medicaid has decreased: it is estimated that in 1976, 65% of the poor were covered by Medicaid; by 1984, this had declined to only 38%.²⁴⁰ As noted earlier, women constitute the majority of the poor.

Austerity measures have decreased access to services and may also lead to increased rates of maternal mortality. A review of maternal mortality in sub-Saharan Africa found that the debt crisis and structural adjustment programs have resulted in cuts in programs and scarcity of equipment and drugs.²⁴¹ In Nigeria, in 1983, all aspects of maternity care at the hospital were free... By 1988 patients were asked to pay for most of the materials needed for their treatment. As a result most patients stayed at home and came to the hospital only as a last resort if a serious complication developed. Even then a long time was spent by relatives looking for money or materials, and the mean interval between admission and surgery increased strikingly. These delays in seeking help and in instituting treatment may have contributed to recent high maternal morbidity and mortality rates in Zaria (Northern Nigeria) and can be attributed

to SAP.²⁴²

Toward the Future

Women everywhere are organizing and struggling for change. Women in the Third World have spearheaded movements against domestic violence, against deforestation, for land to grow crops to feed their families, and are organizing for better work conditions in the Export Processing Zones and as domestic workers.²⁴³ Women's Global Network for Reproductive Rights, Isis International, and the many women's groups throughout the world which comprise these networks have led the way in organizing more humane health care.²⁴⁴ "The analysis and suggestions for change which are offered by low-income women to improve their lives need to guide the policies and programs that are developed."²⁴⁵ Discrimination has been recognized as a major problem for women. The challenge remains to reduce and remove severe and widespread this discrimination. The Conference dialogue and "The Action Agenda", should be a useful tool to guide policymakers, health workers, and citizens who wish to improve women's health and their empowerment.²⁴⁶ Provided comments on the draft manuscript of the Background Paper: Jose Barzelatto, Ford Foundation; Elayne Clift, consultant; Francesca Dixon, NCIH; Joan Dunlop, International Women's Health Coalition; Adrienne Germain, International Women's Health Coalition; Janet Gottschalk, Co-Chair, NCIH Board; Don Hopkins, Global 2000, The Carter Center; Marge Koblinsky, MotherCare; Frank Lostumbo, NCIH; Faith Mitchell, Hewlett Foundation; Russell Morgan, NCIH; Allan Rosenfield, Columbia University School of Public Health; Jill Sheffield, Family Care International; Margaret Snyder Norma Svenson, Boston Women's Health Collective; Judith Timyan, consultant; Ellen Wasserman, consultant; and a special thanks to Robert Guitteau for assistance in research.

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INTERNATIONAL POPULATION FELLOWS PROGRAM

The International Population Fellows Program, sponsored by the University of Michigan's Center for Population Planning and funded by the United States Agency for International Development, offers fellowships for recent graduates and population professionals. Fellows may be assigned to work in Third World countries with population and family planning organizations or in international agencies involved in population and family planning. The objective of the program is to provide developing countries with technical expertise from U.S. professionals who have completed advanced degrees. Simultaneously, it offers professionals relevant overseas experience which prepares them for careers in international population assistance.

Individuals who have earned a graduate degree at the masters or doctoral level in population or a related field and are U.S. citizens or permanent residents are eligible to apply. Both recent graduates and mid-career professionals are recruited. Fellows may be placed in ministries of health, non-governmental organizations, family planning agencies, A.I.D. cooperating agencies, universities, and other institutions involved in international population planning. Fellows assist in such areas as operations research, demographic research, policy analysis, training, family planning evaluation, management, and population information, education, and communication. The typical placement is for two years.

Informational interviews will be conducted during exhibit hours on Monday, June 24 and Tuesday, June 25, 1991. Please schedule an appointment at booth #608 in the exhibit hall.

WOMEN'S HEALTH

THE ACTION AGENDA FOR THE 90's

18th NCIH International
Health Conference
June 23-26, 1991
Hyatt Regency Crystal City
Arlington, Virginia



ABSTRACTS

Theme I Concurrent Session: Abortion

Session Chair: Lynn Erickson Fielder

"THE IMPACT OF INDUCED ABORTION ON WOMEN'S HEALTH IN KENYA"

Jean B. Aar, Resident Advisor, Family Planning Management Development (FPMD) Project,
Management Sciences for Health (MSH), and
Dr. George Ras, Child Survival Fellow, AMREF, Kenya

In Africa, unwanted pregnancies put women at risk of morbidity and mortality associated with childbearing; some women seek induced abortion as a response to this situation. It is difficult to document precisely the extent of abortion-related morbidity and mortality in Kenya, or the underlying factors contributing to unsafe abortion. Recent hospital data from Nairobi indicate that perhaps 20 percent of all maternal deaths may be due to complications from induced abortion. Other provincial and district hospital data reflect similar patterns.

As a step in understanding and combating the growing problem that unsafe abortion represents in Kenya, qualitative research was carried out to document the case histories of 30 women who underwent induced abortion. An urban group of low-income women were interviewed in-depth to identify sources of information about induced abortion and the decision-making process, and to describe the abortion experience among this group.

The study's findings revealed that being unmarried or unemployed, as well as a number of other economic factors, were important contributors to the decision to abort. Other reasons given for seeking abortion included ineffective use of contraceptives and method failures. The study also identified and described two main types of induced abortion: the "professional" abortion, conducted in private facilities by medical personnel; and the "community" abortion, performed by a variety of untrained practitioners. The latter type was found to be much more common among this urban group of women.

Consequences of Illegal Abortion in Chile: Documentation and Prevention

Miren Busto, Programa de Salud y Políticas Sociales, Chile

In Chile, in the final days of a 16-year military regime, all abortions for any reason, including to save the life of the mother, were outlawed. Women undergoing abortions and the persons performing them can be imprisoned for eight years. Family planning services, once widely available, are now very limited in government facilities. PROSAPS, a Chilean nongovernmental organization for applied research, policy analysis and public education related to health, reproductive rights and status of women, is investigating the consequences of abortions obtained illegally with their attendant risks of physical and psychological damage. This is the first study of its kind in Chile.

A multi-disciplinary team is studying the situation of women who are hospitalized for complications after abortions with respect to psychosocial conditions, health, and life quality. Through interviews with the hospital patients, the factors associated with unwanted pregnancies and with the decision to abort are documented. An immediate application of results from the study's first phase is training hospital personnel to create a supportive rather than a judgmental psychological ambience, and to encourage family planning for prevention of unwanted pregnancies in the future. In the second phase of the study, as a test of preventive measures, counseling, family planning and other services will be initiated in a selected community.

A major PROSAPS' objective in this study, as in all its research, is change of policies that are inimical to the health of women, such as a policy which does not permit even therapeutic abortions. Public discussion of the findings, communication with policy makers, and mobilization of women's and human rights' organizations is as basic to the PROSAPS' research design as is the selection of the sample and analytic methods. For the Action Agenda, the project provides documentation of the process of advocacy and of the steady accumulation of evidence necessary to influence policy.

THE IMPACT OF ILLEGAL ABORTION ON THE ECUADORIAN HEALTH SYSTEM: A RETROSPECTIVE ANALYSIS

Graciela I. Salvador, M.D., M.P.H., Center for Population and Family Health - Columbia University School of Public Health, NY, NY
Diana Molina, M.D., Instituto Juan Cesar Garcia, Quito, Ecuador

In Ecuador, as in other countries of Latin America and the Caribbean, abortion is restricted by law and is only permitted under certain conditions, such as for the mother's health, rape or incest.

Illegal termination of unwanted pregnancies has been directly associated with maternal mortality as well as with a variety of costs - human, economic, social and psychological - all of which have been extensively documented.

The purpose of the study is to quantify the morbidity and mortality resulting as a complication of illegal termination of pregnancy. The social impact on the human as well as physical resources of the health care system of Ecuador will be analyzed.

To obtain information on the number of septic abortions resulting in hospitalization, a retrospective hospital chart review and analysis will be conducted by teams of Ecuadorian students from health-related fields. This project will begin November 1, 1990.

Morbidity, mortality and medical expenses will be determined through a review of hospital records for a period of not less than five years. Only health care facilities with at least five years of available records will be included in the collection of data. Hospitals representative of the three geocultural regions of the country (highlands, Pacific coast, and Amazon forest regions) and the three levels of health care delivery will be part of the study.

Descriptive epidemiology will be used to determine the magnitude of the problem of maternal morbidity and mortality related to septic abortion.

After completion of the present study, data will be available to assist in the development of a more in-depth analysis of this issue. In addition, it is hoped that after dissemination of the results, further discussion of women's reproductive health, especially abortion, can be initiated which will have policy implications.

Abortion Attitudes of Puerto Rican Women K. Lisa Whittle, MPH Joan M. Herold, Ph.D.

This study describes the abortion attitudes of women in Puerto Rico using 1982 data from a survey representative of all women ages 15 to 49 on the island. Bivariate and multivariate analysis indicate that education and religiosity are the most important predictors of abortion attitudes. Increased education increases abortion approval and increased religiosity decreases abortion approval. Interactions between education, religion, and religiosity indicate that Catholics with education levels greater than high school are less approving of abortion than Catholics with less schooling, regardless of degree of religiosity. For members of non-Catholic religions, increased education affects only the more committed, making them less approving of abortion. Indicators of geographic mobility and residence show that women who reside in SMSA's and who grew up outside of Puerto Rico or who ever migrated outside of Puerto Rico are more likely to approve of abortion than other Puerto Rican women, especially if they are well educated. Women who are employed or who are divorced are also more likely to approve of abortion. In general, family size, contraceptive use and age are not significant in explaining the variation in abortion attitudes. Women who reported having undergone an induced abortion are much more likely to approve of abortion than those who have not.

Our results indicate that as women become more "modern", e.g., entering the labor force to support their families, controlling their reproductivity, becoming exposed to non-traditional ideas and values, their approval of abortion increases.

Theme I Concurrent Session: Access to Care

Session Chair: Jim Knowles

EXPERIENCIA DE PARTICIPACION DE LA MUJER EN LA ORGANIZACION DE LA SALUD EN UNA REGION DEL SURESTE DE MEXICO.

DR. MARIA ELENA ALVAREZ CUEVAS Y DR. JOSE JUAN SOLORZANO MOQUEL.

La participación de la mujer en la búsqueda de un nivel más alto de salud para ella y su familia conlleva a analizar una serie de factores que estimulan su inserción al trabajo organizado en salud y la búsqueda de nuevas estrategias alternativas. El presente estudio describe un trabajo de organización de cuatro grupos de mujeres pobres y marginadas (aproximadamente 150 mujeres) de áreas sub-urbanas de Comitán, Chiapas, cabecera de la región fronteriza sur de México. Incluye la descripción de las características propias y en conjunto de las mujeres que participan en ese trabajo. Se analizan los aspectos sociales, económicos, políticos y religiosos que obstaculizan y retrasan la organización del trabajo. Además de estos aspectos también se describen los éxitos en los programas desarrollados como formación de recursos humanos en la atención primaria de la salud, apoyo a familias en riesgo incluyendo nutrición suplementaria a niños de bajo peso, control prenatal y algunos procesos productivos, así como la metodología para llevarlos a cabo. Finalmente se presentan los resultados obtenidos. Con la presentación de este trabajo se pretende dar a conocer los esfuerzos realizados por las mujeres de esta región que consideramos de interés a nivel internacional.

Male Doctor, Female Patient: Access to Health Care in Egypt. Laurie Krieger and Mohamed El Feraly.

In many parts of the world, access to health care depends not only upon availability of health care facilities and trained personnel, but on the gender of health care providers. Often women do not wish to or are not allowed to receive treatment from male providers. Government health units in Egypt assure virtually all citizens access to a physician. In most cases, particularly in rural Upper Egypt, the physician is male. Data derived from clinical experience in rural Upper and Lower Egypt, and qualitative research throughout Egypt suggest reasons and solutions for women's often limited access to health care, despite the availability of physicians.

Male and female attitudes toward women consulting male physicians vary by region, class, and religio-political outlook. For example, attitudes prohibiting women from visiting male physicians are very strong in Upper Egypt, where few health units have female doctors. Consequently, many Upper Egyptian village women do not receive medical care, even in emergencies.

Egyptian females' ability to consult a male physician depends on several factors: the attitude of their male guardian (usually husband, father, or brothers); their own attitude, based upon traditional notions of female modesty; their perception of the skills and commitment of male vs. female physicians (the reason some wealthier urban women do not visit female physicians).

Female physicians may limit women's access to health care by refusing to practice in rural areas. All Egyptian doctors practice for two years post-medical school in government health units. Few female graduates agree to practice in rural Upper Egypt, usually far from the protection of their families.

Providing more female physicians for those who want them would help remedy the problem. Better access to education for rural Egyptian girls might insure that more become physicians willing to practice in their home areas. Male guardians' negative attitudes and women's modesty are very pervasive and often result in women's suffering. Until female physicians are geographically equitably distributed, information, education, and communication techniques could be used to change the attitude of male guardians and help male physicians become sensitive to women's concerns.

Title: The impact of health financing policy reform on women's access to primary and preventive health services
Author: Charlotte Leighton, Ph.D.

Understanding the Childbirth Choices of Jamaican Women

Maxine Wedderburn
Kingston Jamaica

The purpose of the paper is to identify some of the principal ways in which recent health financing policy reform efforts affect women's access to primary and preventive health care, especially in Africa. The paper presents findings on some of the factors that affect women's willingness and ability to pay for health services for themselves and their children. The main data base for the paper comes from a multiple regression analysis of data from a large sample survey conducted in rural Senegal. This data is complemented by observations from other African countries. Survey findings help identify more effective and equitable strategies for promoting women's contribution to financing primary and preventive health services and the paper points out the implications of the survey findings for design of health financing policy reform.

This presentation will discuss the objectives, methodologies and findings of a qualitative research investigation in Jamaica. The study was requested by the Ministry of Health to provide information on the behavioral and attitudinal factors which influence childbirth choices (location and type of provider) of Jamaican women. Research results have been used by the MOH to plan alternative childbirth facilities in several parts of the island.

Jamaican women now overwhelmingly choose hospital delivery, especially in and around periurban Kingston. This has resulted in severe overcrowding and reduced quality of intrapartum care. Conversely, in rural areas, women of high parity, among whom much of the maternal mortality in Jamaica occurs, frequently choose to deliver at home, without assistance from a trained attendant.

Through focussed group discussions utilizing projective techniques, and in-depth interviews, the study explored underlying beliefs, perceptions and attitudes contributing to current childbirth preferences. It also determined the level and conditions of acceptability of the MOH's proposed alternative childbirth facilities.

Results include widespread lack of knowledge among women of the risks/problems associated with pregnancy and childbirth, and poor patient/provider interaction.

Theme I Concurrent Session: Female Morbidity

Session Chair: Marjorie Koblinsky

BY F. A. BASHIIR COUNSELLING CENTRE
AHMADU BELLO UNIVERSITY, ZARIA.

SOCIOECONOMIC FACTORS OF REPRODUCTIVE MORBIDITY OF HAUSA WOMEN: A CASE OF VESICO VAGINAL FISTULA (VVF)

Vesico Vaginal Fistula is a pathetic disease condition of young mothers given out in early marriage by their parents before their reproductive organs are fully matured for birth demands. This is common practice among the rural Hausa Women. Most of the victims of V V F are divorced by their husbands and rejected by members of their families. They drift into towns and cities in search of treatment and livelihood.

Identification of V V F in Zaria and environs was carried out followed by focus group discussions (FGD) conducted by five members of women in Nigeria (WIN), a non-governmental organization. The discussions were taped and later transcribed. Forty five (45) V V F were involved. They were found in compounds referred to as "Gidan Pisari" (The house of urine). These compounds are without light or running water.

Personal data of the women revealed that all fall within the age range of 16 - 45 years and have had VVF varying from 3 - 12 years. All lost the babies with which they had VVF. All are illiterate and perceived their situation as the will of Allah (God).

Though the availability of Medical services was the attraction for Zaria, 75% never registered with hospital since they came and none of them had surgery done. They get their livelihood by doing menial jobs by day and prostitution at night. They were very interested to learn income generating activities.

Some recommendations were made for their rehabilitation.

WOMEN'S HEALTH STATUS IN EGYPT LEVELS OF REPRODUCTIVE MORTALITY AND MORBIDITY FACTORS AND DETERMINANTS

MAMAHAB EL-MOUELHY

The status of women's health in Egypt and the factors that can affect it.

Levels of maternal mortality and reproductive morbidity

among Egyptian women.

Reproductive health risk factors and women's perception to them.

The status of women and its relation to their well being.

Assessing morbidity and mortality levels among women in

developing countries.

"WOMEN'S HEALTH IN RURAL BANGLADESH

By
Dr. Kate Stewart
Dr. Maxine Whittaker

In order to provide a quality MCH-FP service delivery programme and to allow women, culturally restricted in their movement patterns, access to health care services for their problems, one needs to provide an appropriate constellation of services. As a diagnostic exercise, the Matlab MCH-FP Project of the ICDDR,B undertook a study to identify common health problems experienced by rural women in this country. Choosing a single day to ask of every woman visited by the female community health worker, two questions were asked - how do you feel in your health today and have you taken any medicines today.

The research findings show that, amongst WRA (15-55 year were interviewed, n = 738), most problems were experienced by 25 - 35 year old age group. Contraceptive users were more likely to have experienced a problem than non-users. The commonest problems experienced by all women were: dizziness, headache, weakness, burning sensation of body/skull/hands/feet, leg cramps, backache and introital itching. Approximately 6% of the women surveyed complained of suffering, on the day of interview, from a reproductive tract problem, with slightly less % of women suffering so if non-user.

The authors discuss the importance of understanding the general condition of women's health upon an MCH-FP programme. They recommend the development of appropriate programmatic responses to these problems. In addition, they raise issues requiring further exploration - such as the impact of common health problems and responses to that (such as use of medicines) upon family planning use effectiveness and acceptability.

The Use of Sample Registration System for the Prospective Data Collection of Maternal Morbidity

By Budi Utomo and Perdu Riono

The objective of this paper is to demonstrate the use of Sample Registration System (SRS), which is now on-going in the Indramayu Regency, West Java, Indonesia, for the early detection of pregnancy, and for monitoring maternal morbidity and mortality, complications of delivery, and neonatal mortality. This SRS uses a modified data management technology which has been successfully implemented in the Bangladesh Sample Registration System under the MCH/FP Extension Project. The system of data management has been designed to be an integrated system of field data collection activities and computer operations. The database generated from the study exists in two places: the Household Record Book (HRB) which is a hand-held register that interviewers maintain and update, and the Household Master File (HMF) which is a computerized system of recording, checking and reporting summary of HRB data. The study field operation starts in October 1989 with the baseline survey of 10,000 households or approximately 45,000 population to collect socioeconomic and sociodemographic data in both household and member levels. The baseline data are then being updated prospectively through regular household cycle visits of every three-month. Updating includes recording of information on changes of household and individual status, and demographic events occurring in the last three-month or 90-day. Starting in January 1991, all new pregnancies will be continuously identified through the SRS, in which a question on date of last menstruation period is asked on every woman aged 12-49 years. If the date of last menstruation period is more than 5 weeks, a urine pregnancy test is conducted. This test has been considered a powerful enough to detect early pregnancy. When a pregnant woman is identified, a sticker with her name and characteristics will be generated, with the aim of reducing data linked errors. These stickers will be placed on the prospective pregnancy module which is designed to collect monthly data on maternal morbidity and mortality, complications of delivery and postpartum including neonatal mortality. A special cycle visits of every one-month will done to all pregnant women starting from the date of the identification of pregnancy until two months postpartum.

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Theme I Concurrent Session: Listening to Women

Session Chair: Margaret Bentley

ABSTRACT by Shamima Islam

In rural Bangladesh, women significantly carry health-related experiences and remain major health-care providers, but written documentation concerning these experiences and methodologies to extract these indepth information of poor women is quite scarce and rarely talked about.

Based on taped material (part of a bigger case study), using the transcribed language of the women, the simple narration by women identify some of their direct experiences and perceptions in the given context.

The intrinsic part of the testimony contributes to health documentation on rural women and demonstrates the richness of indigenous narration. It fills the gap both on content and on methodologies and can serve as an instrument for varied orientation on health issues in developing countries.

APPLICATION OF ETHNOGRAPHIC RESEARCH TO UNDERSTAND WOMEN'S PERCEPTIONS OF HEALTH AND DISEASE IN U.R.S OF BARODA, INDIA
BY - DR. SHUBHADA KANANI
LECTURER, DEPARTMENT OF FOODS & NUTRITION, M.S. UNIVERSITY OF BARODA
AND
CONSULTANT, BARODA CITIZENS COUNCIL, BARODA, INDIA

ABSTRACT

The anthropological approach is increasingly gaining importance in public health interventions. The present study conducted by a non-government organisation Baroda Citizens Council, aimed at understanding the emic perspective of over 300 slummothers regarding female physiology, adolescent growth and development, pregnancy and lactation, general gynaecological morbidity and health seeking behaviour. Ethnographic methods used: focus group discussions, free listing and pile sorting, key informant interviews of women and indigenous practitioners. RESULTS: 1. Most women recognized five organs in the female body - Liver, intestines, heart, lungs and uterus. Menstruation was considered desirable and was 'expulsion of heat and unwanted substances from the body'. Breast development, onset of menarche and weight gain marked the changes from girlhood to womanhood. Early marriage and motherhood (10-14 years) 'spoil the body of a girl'. Effect of present nutritional status of the girl child and adolescent on her future health was largely unknown. 2. Pregnancy was a 'hot condition' hence 'hot' foods were to be avoided. In lactation, consumption of strength giving foods and restriction of certain foods was practised. Self experience or experience of neighbours/relatives chiefly determined the preferences of women for home or hospital deliveries. Home deliveries were preferred mainly for convenience; hospital deliveries were preferred as 'doctors in hospitals can handle any complication of childbirth'. 3. Several health problems were not viewed as such by women but considered an inevitable part of reproductive life. Frequently mentioned general morbidities included backache, headache, bodyache, 'thin or less blood' (anemia?) and weakness; gynaecological morbidities included leucorrhoea, menstrual disorders, infertility, complaints attributed to tubectomy/hysterectomy. 4. Etiological factors of diseases were linked to the socio-economic environment, over which, women said, they had no control. 5. Treatment was sought only when symptoms debilitated women and was discontinued usually once symptoms disappeared. Both allopathic and indigenous practitioners were sought; frequent changes of practitioners being common if rapid relief did not result. The triad of qualitative ethnographic research, quantitative data collection and services mutually complemented each other. Further similar studies are required in developing countries.

HEALTH SEEKING BEHAVIOUR OF TRIBAL WOMEN OF PANCHMAHALS - GUJARAT FOR THEIR GYNAECOLOGICAL ILLNESSES
BY: Pallavi Naik and Indu Capoor

ABSTRACT

There is increasing recognition that women's health is a neglected area that requires both research and programmatic attention. Clinical studies of gynecological problems of women in selected settings within India have shown a high prevalence of infections.

There is a "common wisdom" among health providers and public health professionals that women do not seek appropriate medical care for gynecological infections. Anecdotal data report that important factors for this lack of care include women's shyness and lack of knowledge about the severity of these infections. There is a great need to understand the women's health seeking behaviour for gynaecological illnesses to improve the planning and implementation of the health programmes.

An indepth study in a tribal area of Gujarat was conducted to explore women's perceptions of a specific illness, safed pani (white discharge) and their health seeking behavior in response to its occurrence. Unstructured interviews were conducted with women suffering from white discharge. Key informant interviews were conducted with traditional birth attendants and local healers. The study investigated the terminology and classification system for the illness and investigated the relationship between women's perception of causation of the illness and their health seeking behavior.

Abstract Not Available for Publication

Theme I Concurrent Session: Nutrition

Session Chair: Frances R. Davidson

Undernutrition during Pregnancy and Lactation in India:
Heavy Work and Eating Down as Determinants

Mary Ann Anderson

Nutritional status of 1,073 pregnant and 713 lactating women in rural India was assessed by cross-sectional survey. A local weight for height standard was devised. In early pregnancy, 56% of women in Gujarat and 63% in Maharashtra weighed less than 40 kg. Estimated pregnancy weight gain was 6 kg. At term, the average mother was less than 100% of standard weight for height for nonpregnant women. Severe anemia (hemoglobin <8 g/dl) in 3rd trimester affected 30% of women in Gujarat and 47% in Maharashtra. Edema and hypertension were rare. An arm circumference of ≤ 22.5 cm had 77% sensitivity and 71% specificity for predicting weight below 40 kg. Deliberate food restriction in pregnancy was negatively associated with weight of Gujarat multigravidae (-1.0 kg). In Maharashtra, maternal employment was negatively associated with weight in 3rd trimester (-1.7 kg) and in lactation (-1.0 kg). Effective interventions to improve maternal nutrition are urgently needed.

Nutritional Antecedents to the Major Causes of Maternal Mortality

Kathleen M. Merchant, Ph.D.

The four main clinical causes of death in child birth are hemorrhage, eclampsia, infection and obstructed labor, accounting for 20-35%, 15-25%, 5-15% and 5-10% of maternal deaths, respectively. These events are interrelated and frequently occur in combinations. For example, obstructed labor can lead to the tearing of tissue causing blood loss and ultimately an infection could set in and any of these could be recorded as the cause of death. Maternal mortality generally results following an obstetric/gynecologic emergency that the health care community and in particular, physicians, traditional birth attendants, midwives and health workers are responsible for minimizing and preventing. For this reason, most of the research and discussion addressing its occurrence and prevention has centered around issues of health care delivery and treatment during the acute phases of the emergency. Although the immediate aspects of obstetric emergencies are crucial and urgent topics for any program which hopes to make motherhood safer, a long-term view is also necessary and still lacking. Some very important antecedents and aggravating factors to the major causes of maternal mortality have not received adequate attention. The most obvious of which is the contribution of nutritional status to either increasing or decreasing the prevalence of risk factors for maternal debilitation or death.

Adequate nutrition is something that is required from conception onwards. If food intake is inadequate in quality or quantity, later repercussions on health and well-being are to be expected. Therefore it should not be surprising that nutritional problems aggravate and increase the risk for the major causes of maternal death. Significant blood loss through hemorrhaging is much more serious in anemic women. Given the estimated prevalence of 47% iron deficiency anemia among women of developing countries, clearly the severity of hemorrhaging (the top cause of maternal mortality) could be reduced through reduction of anemia. It is reported that approximately 50% of maternal deaths in Indonesia and Egypt and over 30% of deaths in India are due to postpartum hemorrhage. The interrelationship between malnutrition and infection is well established. For example, it has been demonstrated that even mild deficiencies of iron have led to reduced immunocompetence. In addition, vitamin A deficiency reduces immunocompetence. Pregnant women are at increased risk for vitamin A deficiency. The potential hazards of micronutrient deficiencies to the immunocompetence of women should not be overlooked. Small maternal stature is a well-known risk factor for obstructed labor. Stunting is a common result of the chronic undernutrition experienced by many living in circumstances of poverty. Although most clinicians recognize the increased risk of labor for women of smaller stature, the magnitude of the risk relative to maternal and fetal size has not been determined among poorer populations. In addition, contracted pelvises result from deficiencies of micronutrients such as vitamin D. The misshapen pelvis can make vaginal delivery more difficult or even impossible. A nutritional link to the etiology of eclampsia is less clear but dietary factors such as sodium have been implicated and this is an active area of current research.

Given the high prevalence of stunting, anemia and other specific micronutrient deficiencies within women of the lower socioeconomic levels of developing countries and the limited access to adequate obstetric care, the implications of these nutritional factors on strategies to reduce maternal morbidity and mortality are extensive. Research partially funded by the WHO Safe Motherhood Research Programme and by the UN ACC/SCN.

ANAEMIA IN PREGNANCY A CONTINUING PROBLEM IN A DEVELOPING COUNTRY

Dr. Saadiya Aziz Karim (Asst. Professor, Obs/Gynae Department)
Dr. Farid Midhet (Senior Instructor, C.H.S. Department)
Dr. Yasmin Akhtar (Inst. Tor., C.H.S. Department)

AGA KHAN UNIVERSITY, KARACHI, PAKISTAN

Anaemia in pregnancy is a common problem in the developing world. Previous hospital based studies in Pakistan have shown an incidence of 19% in the Punjab province (Rizvi, 1980), and 63.8% in a big hospital in Karachi (Hashmi, 1973). Another study by the first author (Aziz Karim, S., 1988) involving three major hospitals of Karachi revealed that 8% of the antenatal clinic population of middle to high socio-economic class and 29% of lower class were anaemic. These figures, however, do not reflect the true picture of the communities. Prior research has linked the occurrence of anaemia with diet, food taboos and hook-worm infestation (Jackson, 1987), whereas our second study (AZIZ KARIM et al, 1989) suggested a relationship between anaemia and low socio-economic class, diet, and high parity. The predominant type of anaemia in Pakistan is iron-deficiency anaemia.

The Community Health Sciences and Ob/Gyn departments of the Aga Khan University have designed a community based study of the pregnancy outcomes in the urban squatter settlements of Karachi, where the University has operational primary health care (PHC) programmes. All pregnant women are administered a risk factors assessment questionnaire, and are followed up until delivery. Perinatal information is collected to identify complications during child birth and birth weight of the child. The incidence and types of anaemia, its relationship to the socioeconomic and other factors, and its effects on the maternal and fetal outcome is also recorded. Anemia is detected clinically and by automated hematology analysis at the University Hospital's laboratory. Serum ferritin and folic acid levels are also determined for anemic women. Stool and urine examinations are carried out routinely on all participating women. This paper will present the findings from the first part of the study, comprising of about 150 women in one squatter settlement in Karachi. The data on risk factors assessment and follow-up of these women is currently being computerized, and a report of the in-depth analysis will be available by May 1990.

THE EFFECT OF PARITY ON BODY MASS AND COMPOSITION OF WOMEN DURING LACTATION.

Rivera J, González-Cossío T, Martorell R, Merchant, K.

Background and hypothesis. The pernicious cycle of short birth intervals and subsequent adverse pregnancy outcomes, each pregnancy producing yet further depleted women and unhealthy infants is called "maternal depletion syndrome". The hypothesis that the depletion of maternal body stores would be aggravated by higher parity, as a result of the high energy demands of pregnancy and lactation, was tested.

Data and sample. As part of a longitudinal study between 1969 and 1977 anthropometric measurements and dietary intake data were obtained periodically during pregnancy and lactation in a group of women living in four rural villages in Guatemala. Dietary supplements were made available to these women and were consumed ad libitum on a voluntary basis. Supplement intakes were recorded daily. Anthropometric measurements included weight, height, seven skinfolds, five circumferences and three lengths. Arm and thigh diameters and muscle areas, as well as the sum of six skinfolds were obtained. The sample used for analysis included women with two consecutive pregnancies who breastfed for at least 18 months.

Analytical methods. Measurements of body mass and body composition were compared within women, between subsequent reproductive cycles at different points in time during lactation. The mean differences resulting from subtracting the anthropometry of the previous cycle from the anthropometry of the consecutive cycle were obtained. Differences were statistically tested by means of paired t-tests. Multivariate analysis was used to test the differences controlling for potentially confounding variables.

Results and Discussion. Body mass and composition measurements were generally larger for consecutive as compared to previous reproductive cycles. For example, at 15 months of lactation, the mean weight of women was 1.32 Kg larger ($p < 0.05$) for the subsequent as compared to the previous cycle. Overall, the differences remained significant after controlling for maternal age, parity, weight, and length of lactation of the previous cycle; for the interval between consecutive births; and for differences between consecutive cycles in dietary and supplement intakes and in the birth weights of the offspring. It is concluded that there is no evidence of maternal depletion of body stores resulting from repeated pregnancies in this population and that, contrary to our expectations, body stores improved with higher parity.

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Theme I Concurrent Session: Reproductive Tract Infections Among Third World Women:
Challenges for Practitioners and Policy Makers
Session Chair: Maggie Bangser

The Context of Reproductive Tract Infections
Dr. Rani Bang

Reproductive health care needs to be broadened beyond maternity care and family planning to include care for gynecological and sexual problems, safe abortion services, and sex and reproductive health education. To further understand the full range of women's reproductive health needs, a population-based study of gynecological and sexual diseases, of which the presenter was a co-investigator, was done in two rural villages in India.

The researchers attempted to develop a community-based approach to comprehensive reproductive health care by undertaking participatory research, fostering mass education with the people's involvement, and by making care available through village-based female workers and improved referral services.

Results of the study showed a very high prevalence of gynecological diseases. The consequences of the infections included: difficulty in occupational and domestic work because of chronic backache caused by pelvic inflammatory disease and cervical erosion; fetal wastage; neonatal infections; anemia; disharmony due to sterility; anxiety and stress.

The presentation will discuss the role of reproductive tract infections (RTIs) in women's lives, based in part, on the findings of this research study. Specific topics will include how women perceive RTIs, and the impact of RTIs on women's lives including physical and psychological well-being.

Research Methods Needed to Elicit Information from Women
Dr. Hind Khattab

This presentation will be based on ground-breaking research in a rural area of Egypt that seeks to measure reproductive morbidity and its determinants with special reference to Middle Eastern society. The objectives of the study are to:

- determine the prevalence of reproductive morbidity in the community through medical evaluation;
- test an interview-questionnaire, and compare those findings to the results of the medical evaluation;
- assess the level and nature of obstetric morbidity in the community, based on interviews with a subsample of women; and
- investigate the intermediate and background determinants of reproductive morbidity and of women's awareness of their reproductive health status.

The presentation will discuss effective and respectful research methods used to elicit information from women, and suggest how these data can be used to develop programs and policies for the management of reproductive tract infections.

Education and Counseling Interventions at the Community Level
Dr. Elizabeth Nguqi

This presentation will be based on community-based research conducted in an urban area and a rural area of Kenya which seeks to reduce the incidence of sexually transmitted diseases (STDs) and AIDS. The program seeks to educate people about the diseases, their consequences and means to control the spread of STDs and AIDS. Specific strategies used in the program include:

- participation of people through community-based organizations such as political, educational, health and religious groups;
- assessment of people's attitudes on STDs and AIDS through dialogue in the community;
- motivation and education of health care providers;
- organization of prostitutes into self-care groups for education and condom distribution; and
- education through conventional means, such as media.

The presentation will discuss education and counseling interventions for women and youth at the community level, including simple information and action programs with prostitutes and non-prostitutes.

Research Methods Needed to Develop Programs to Screen, Diagnose and Treat Reproductive Tract Infections
Dr. Inne Susanti

Reproductive Tract Infections (RTIs) constitute a serious, but largely hidden, public health problem. The extent and severity of such infections in Indonesia is virtually unknown. No population based survey has been undertaken in the area, and the few clinical studies done to date have been limited by the technology of diagnosis and sample size applied. There has also been a preoccupation with the identification of relatively rare STDs in the population such as syphilis and gonorrhoea, to the exclusion of more common bacterial and fungal infections.

A study of RTIs in Bali, of which the presenter is a co-investigator, was designed to address this problem by investigating the prevalence of a wide range of RTIs, validating diagnoses through the application of state-of-the-art techniques, and reinterpreting the clinical priorities and approaches related to RTIs. A major purpose of the study was to generate a more adequate understanding of RTIs in clinic practice in Bali, encourage further studies in other areas of Indonesia, highlight important challenges to the National Family Planning and National Health programs, and increase awareness of the seriousness of RTIs on the part of international agencies and donors.

The presentation will focus on the Bali research project, specifically, resources needed for clinical and laboratory work, and the ways in which the research findings can be used for the development of programs and policies.

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Theme I Concurrent Session: Socio-Economic Status

Session Chair: Giorgio Solimano

Abstract Title: Present Health Status of Women, Policy Initiative, Health Movement and Issues for Action.

Presented By: Meherun Nessa Islam
Dhaka, Bangladesh

Health status of women in Bangladesh ranks poorest in the world. It is a country where life expectancy of women is lower than men, and infant, child and maternal mortality is one of the highest in the world. Here, the discriminatory attitude towards women prevails from cradle to grave. This is manifested in various forms, such as differential feeding, nurturing and caring of a female child; high level of illiteracy and low school enrolment of girls; forced or arranged teenage marriage; social pressure to start child-bearing right after marriage; prolong and uncontrolled child-births; neglect or lack of nutritional care of feeding-mothers; desertion or threat of desertion of ailing women in old age; grinding poverty and biased inheritance laws, to name only a few.

When growing up as a female child means learning to view her body with suspicion, shame and guilt-feeling; when a menstruating girl is considered unclean and left to herself to cope with the situation; when the entire health-care system is not only inadequate but also insensitive to the needs of the majority of women, the issue of women's health is not a simple case of improving medical facilities or greater resource allocation to health clinics. There is no doubt that some of these maladies could be ameliorated by a timely and appropriate medical care. But the improvement of women's health status requires a massive investment in our social, cultural and legislative milieu; and an active involvement of women themselves in projecting women's actual role and status in the society; and in defining the national commitment and priorities in respect of women's need.

A health movement has already begun in Bangladesh gathering strength through organizing international, regional and national conferences and workshops. The women pressure groups are trying to build a solid information base backed by their collective experiences and research findings to influence national and international policy-making bodies which operate in Bangladesh. The women groups are issuing news-letters, conducting press conferences, staging mass demonstrations and submitting position papers to various governmental and other agencies. They are also asserting themselves in planning and policy-making for equitable share of national resources for education, health and employment. Health is not an isolated issue; it is a multi-dimensional aspect of women-in-development. And change in their status, including health, would not come unless women themselves are an active and leading agent in the process of ushering the changes.

WHAT DISTINGUISHES ACTIVE VERSUS PASSIVE BEHAVIOUR OF WOMEN FROM THE SAME SOCIAL BACKGROUND:

SALIMA A. NOORANI

In Pakistan society male dominance comes in the way of women's health and development to a very major extent and provides a near impenetrable patriarchal system supported by archaic socio-economic and political structure of a third world country. The male is the bread earner and decision making power lies with him. The woman has no control over her destiny. It is said that a young girl is inherited by her father at birth, by her husband on marriage and by her son at widowhood. The birth of a girl child signals to most, a financial liability, investment in whose health and education is futile as 'tomorrow' she will leave for her husband's home. The male-oriented structure of our society inhibits equal attention, affection, food and family spendings from reaching the girl child. She is passed from father's dominance to husband dominance at a very tender age. Participation of women in the educational process, vocational institutions and the making of the labour force is entirely restricted at this involves the sharing of power. Working women are under-paid and under appreciated. Most of them work under informal contract on condition that they will behave. There are no laws to protect their rights. Sexual harassment, wife beating and discriminatory laws are very much rampant. Sexist attitudes are prevalent in schools, colleges, universities, qualified jobs, art and literature, etc. All these factors come in the way of women's well being. I and my team took Orangi as the project site. Orangi was chosen as it represents a large squatter settlement with many problems, frequent in many parts of the world. Taking Orangi as the site of research and implementation of the project, the team explored political, social and economic trends existing there, which have moulded Orangi women to take an active rather than a passive role in their community.

Currently, I and my team are implementing the project by conducting a research which is operational and prospective in nature and will help to identify both active and passive characteristics of community women as well as to develop ways for women to join on a common active-role platform. I and my team expect its findings to help women in Orangi initiate a process of empowerment and self-reliance leading to their well-being and good health.

WOMEN'S HEALTH IN SOUTHEAST ASIA: STATUS AND NEEDS

by

Blair L. Brooke, Anna Alisjahbana, Kritaya Archavanitkul, Siti Oemijati Djajanegara, Sri Harijati Hatmadji, Marilou Palabrica-Costello, Yawarat Porapakham, John Stoeckel, Florence Tadiar, and Davone Vongsack.

Statement of purpose: The paper will describe the rationale for the Population Council's program on women's health in Southeast Asia and will provide profiles of women's health and factors affecting women's health in Indonesia, Laos, Philippines and Thailand. Crucial women's health issues in the region will be highlighted, and recommendations for research and action discussed.

Design and methodology: The paper will consist of a literature review of women's health studies in Southeast Asia, summarizing what is and what is not known about women's health status and the factors affecting women's health in Indonesia, Laos, Philippines and Thailand. Special attention will be given to the implications of research findings for issues requiring attention from researchers, program planners and managers, policy makers, and women's groups.

Analysis of major findings: While there is substantial literature concerning child survival, family planning and family health in Southeast Asia, there are only a very small number of studies focussed on the comprehensive health needs of women in the region. In some cases, national and regional data on mortality and morbidity are published in aggregate and fail to describe sex differentials. Information about maternal mortality is sketchy and estimates vary widely. Information about broader aspects of women's health, such as cancer, preventable diseases, accidents, rape and violence against women, occupational and mental health, as well as the definition of and accessibility of needed care, is scarce. This preliminary investigation suggests that there is a dearth of information needed to guide program planners and policy makers, and that improvements are needed in health status reporting systems as well as the provision of services appropriate to women's health needs in the region.

Implications for "The Action Agenda": Beyond "Safe Motherhood" to "Safe Womanhood." Summarizing current knowledge about women's health and identifying gaps in that knowledge are essential first steps to identifying avenues for policy and programmatic change to address women's health needs. Although much attention has been paid recently to putting the "M" back into MCH, attention on women's health seems to remain targeted at issues related to childbearing and child rearing. Because there is more to women's health than maternal health, there is a need to investigate and address health issues affecting women at every stage in their lives, both at work and at home.

The Socio-economic Factors Affecting the Health of Women in Zaria Environ

Hajara Hassan
C.S.F. No.
A.R.N. Zaria.

This paper looks at the status of women in Zaria Environ and its effect on their health. The health of people in third world countries like Nigeria is affected by a variety of factors. These include the lack of availability of water supply, sanitation, immunization against disease, health education and family planning. In the case of women there are other factors which are crucial to the status of their health.

This study takes an in-depth look at some of the socio-economic and cultural determinants of women's status, in a predominately Muslim Hausa society where the majority of the women are illiterate of low income and where over 80% of them are married before they are 18 years of age.

It critically examines their life styles, work loads, the nature of whatever activities they are engaged in and their exposure to health hazards. It also looks at women's level of education and personal income as well as their access to health facilities. Their position within the family unit and their roles in influencing decision making especially as it pertains to their health and that of their families.

Theme I Concurrent Session: Work and Women's Health
Session Chair: Chloe O'Gara

**THE IMPACT OF MANUFACTURING INDUSTRIES
ON THE STATUS AND HEALTH OF WOMEN**

The impact of manufacturing industries on women workers is examined with reference to changes in their status and health. The effect of increased work opportunities for women through foreign multinationals located in Asian countries especially in the Free Trade Zones (FTZ) is compared with that in local manufacturing industries.

Multinational corporations are seen to have lower standards of health protection in manufacturing and marketing in the developing countries than in home-country operations. Women who represent the majority of the work labor force in such multinational industries are often the victims of inadequate health protection policies. Various health problems including those that affect reproductive health, such as the teratogenic effects of toxic chemical exposure, spontaneous abortion, miscarriage and cancer are being increasingly recognized.

A model to analyze the expanding role of multinationals in Asian countries, consequent work opportunities, benefits and health hazards for women working in these industries, is proposed. Even though women are seriously affected by these occupational health hazards, multinational corporate enterprises continue to rationalize setting such high levels of "acceptable" risk.

Walter K. Patrick, MD, PhD

**WOMENS DEATHS AND MORBIDITY DURING AND AFTER THE HARVEST
SEASON IN RURAL PAKISTAN**

AUTHORS:
MS. ZEENAT KHAN, BACHELOR NURSING STUDENT, A.K.U.H.
DR. FARID MHDHET, SENIOR INSTRUCTOR, C.H.S. DEPT. A.K.U.H

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Rural women in developing countries participate in the economic activities of their families, even though they are pregnant or lactating at that time. This is in addition to the usual household chores. The increased physical activity raises their risk of morbidity and mortality. Pakistan is predominantly a rural agriculture society, where 70% of the population lives in the rural areas. Most rural women in Pakistan perform tasks related to agriculture. Their physical activity during the harvest season is, therefore, increased. In Pakistani rural societies, infant deaths are significantly increased during and just after the harvest season, as compared to urban societies, (Federal Bureau of Statistics [FBS], Pakistan: Demographic Sample Survey Reports, 1985-1987). It may be postulated that because women are busy during harvest season and can not look after their children at home. Maternal deaths also increase during and just after harvest season, (FBS Reports, 1985-1987), although this increase is not statistically significant.

The authors have designed study to examine the hypothesis that mother's mortality and morbidity is increased during and after harvest season in the rural agricultural societies of Pakistan. A three pronged approach is being adopted: (1) Data from existing sources (FBS Reports) is being examined in detail for complications, and their time of occurrence, as compared to urban areas; (2) A small scale survey is designed to assess the timing of maternal morbidity and mortality in one rural area of the Sind province of Pakistan; (3) A large scale maternal and infant mortality survey is being conducted in the Balochistan province of Pakistan during November 1990 to January 1991. This is a study of 20,000 households in four rural district of the province. Data on maternal deaths from this study will be analyzed in order to determine the precise cause of deaths. Findings from these sources will be used to examine the relationships of mother's death and morbidity with physical activity during the harvest.

**Women and Guineaworm:
The Use of Anthropological
Methodologies in Epidemiology.**

by May Yacoub, PhD., H.S.A.

Abstract Not Available for Publication

This study reports on the impact of maternal morbidity due to guinea worm, drancunculiasis, on the care and health of children under 24 months and the ability of mothers to care for their families during these extended periods of disability. This study of 42 women in two rural Nigerian communities found that the disease of guinea worm is responsible for half of child immunization default and deterred women from using maternal services. It kept women from their jobs and trade activities, costing an average of approximately \$ 50 in lost income, a sizeable chunk considering the annual per capita income in the area of approximately \$100. Other problems experienced included loss of appetite and reduced food intake, unattended child illnesses, and disabling secondary infections resulting from unhygienic self treatment. The ill women and their dependants put great strain on the support network of family and relatives, a network already weakened in many cases when several other members were also afflicted with guinea worm.

The paper discusses the issue of collecting data that is not epidemiological in nature. It outlines the usefulness and relevance of this type of data. Finally, this paper also outlines some of the reasons for the paucity of such studies and suggest ways for addressing the need for such qualitative studies.

Theme I Roundtables

SEXUALITY MANAGEMENT AS AN IMPORTANT HEALTH COMPONENT: STILL A FILIPINO WOMEN'S DREAM * LA RAINEE ABAD-SARMIENTO *

One important aspect of women's health is the ability to manage their own sexuality. This involves the ability to decide and control their fertility, and the achievement of good reproductive health and fulfilling sexual relations.

The majority of the Filipino women have not yet attained this healthy ability to manage their own sexuality. Poverty, unjust social structures, unresponsive government and the 'machismo' culture embodying patriarchal relations in society have prevented them from achieving this.

Widespread poverty has caused malnutrition and other physical debilities that have made women more vulnerable to pregnancy-related illnesses. Lack of privacy and the prevailing belief that women exist to fulfill their men's sexual urges contribute to unsatisfying sexual relations. Lack of education leads to incomplete knowledge about their own bodies. Coupled with traditional beliefs and practices about menstruation, contraception and pregnancy, the processes the body undergoes within the life cycle have been mystified.

Government services for comprehensive health care are inaccessible to the and are insensitive to their specific needs as women. Information and services to safe, effective and affordable contraceptive choices and infertility treatment are lacking or inadequate. Cases of unspaced and frequent unwanted pregnancies and childbirths have thus, increased, causing early ageing and general weakening of women's bodies. This has also contributed to the increase of unsafe induced abortions to about 150,000-750,000 yearly. Moreover, rarely are women made to participate in the formulation of national policies that affects them most, such as on the country's international debt repayments and the population/family planning programs.

At present, only a number of women's programs consider women's own feelings and perceptions about themselves regarding the interrelated factors that bring about these conditions, specially among women from the base or the so-called grassroots women. Should other concerned agencies aim to change the prevailing picture towards women's emancipation and good health, they must ensure the women's participation in all the processes involved.

THE ROLE OF GENDER, SOCIO-ECONOMIC, CULTURAL, AND RELIGIOUS PRESSURE ON THE HEALTH OF WOMEN (Marie D. Misener, Provincial Coordinator, Project-BEAL)

Our society is made up of men, women, and children, but it is known that women and children have the highest rate of morbidity and mortality. About a decade ago a lot of measures and structures were put in place to reduce infant mortality and morbidity rate. But so far not so much has been done for women. Health for all by the year 2000 could be a myth if measures and structures to increase women health are not taken and the factors that directly affect women health are not identified.

In Cameroon it is known that women's mortality rate is 4.7% and the morbidity rate is about 2% due to infections, hemorrhages, and pregnancy complications. The above causes originate from cultural, socio-economic, religious, and gender factors. Therefore, in order to increase women's perception of health risks and decrease those risk factors which affect them directly we must do an analysis of the following:

The major factors which affect women's health and which are related to culture, custom, and environment are: premature marriage, premature pregnancy, and repeat or too close pregnancy. Based on custom or habits in the northern part of Cameroon a man is not allowed to touch another man's wife (even for a medical examination) without authorization of the husband. Women in that part of the country prefer to die if the husband does not authorize medical care.

The second factor which affects women's health or perception of health risks and benefits is gender. In Cameroon like in many African countries a woman is uncared and disrespected and is not allowed to go to school, to visit friends, and to be seen by a doctor, (especially a male health provider) without her husband being there. In Cameroon the medical team is made up of about 7% males and in rural areas the health provider is generally a male. The principal role of a woman is procreation.

The third factor affecting women's health and sets a limitation to health services and information to women is religion. In a Muslim society, women is not allowed to go out during the day, to seek information. According to the Quran women has no right to her life once married, and women should be given in marriage because the Quran said that a woman should know only her husband.

The fourth factor which puts women's health at stake is the socio-economic background. The richer the family the sooner the women will go in marriage. Therefore, the women become more exposed to health risks.

Based on the above factors the question of increasing women's perception of health risks and benefits and putting in place a program of treatment and prevention is possible if some policies are worked out at all levels to protect the right of women.

WOMEN'S HEALTH IN VIETNAM: CURRENT STATUS AND FUTURE PROSPECTS

JAMES ALLMAN, PH.D.

This paper reviews women's health status in Vietnam drawing on available national epidemiological, health and family planning data. Findings from the 1988 Demographic and Health Survey provide information on fertility, family planning, breastfeeding, women's desired family size and marriage patterns.

Special studies from health institutions indicate that in spite of declines in infant mortality and improvements of health of children, the risk of maternal mortality is still high. Factors related to maternal mortality are discussed and recommendations for improving the situation.

Findings from a 1988 field survey of rural women in two northern provinces are presented. Conducted in collaboration with the Vietnamese Women's Union, this survey provides detailed information on what women themselves see as their health problems and needs.

The policy implications of both the national data and the field survey are discussed in the conclusion along with a consideration of the potential impact of recent socioeconomic changes on women's health in Vietnam.

WOMAN AS VICTIM AND VECTOR: THE SEXUAL POLITICS OF PARTNER NOTIFICATION IN THE CONTAINMENT OF HIV INFECTION

S. Brockmann, MPH, Columbia University School of Public Health, New York, NY

STATEMENT OF PURPOSE: This exposition explores the uses of partner notification for arbitrating the sexual dialogue between men and women in the context of HIV transmission and containment.

DESCRIPTION OF DESIGN AND METHODS: As of January 1, 1990 over 11% of the more than 35,000 cases of AIDS in the US were women. Much has been written of the increasing proportion of the total cases that females are coming to comprise, and together with this has been an increasing interest in the traditional public health tool of partner notification to warn these women. To varying degrees, different states have pursued contact tracing programs as mandated by federal funding of state AIDS activities. The text and subtext of the stated purpose of these programs will be investigated, with emphasis on the deconstruction of gender roles and sexual responsibility.

MAJOR FINDINGS: The policy of voluntary patient or provider-assisted contact tracing is replete with assumptions of the politics of sexual interaction between men and women. Without any research in the area of sexual accommodation and power to sustain workable models, woman is figured in a persistently traditional role as victim of errant husband (since heterosexual transmission is privileged in partner notification schemes) or as vector to yet unborn children. A male-oriented research tendency in science today has impeded research into women's desire to be the beneficiary of partner notification programs, thus paternalistically assuming what is best for her.

IMPLICATIONS: Partner notification programs foster a composite of woman as unable to protect herself from the sexual transgressions of her male partners, and as a dangerous source of death to the unborn. The infusion of danger into sexuality due to infection panic must be replaced by an empowered woman who can negotiate her sexual encounters without institutional intrusion. "Glass ceilings" that hamper economic progress, a welfare system that eschews job training and placement, and a pervasive lack of opportunity for women allow a disregard for the woman to initiate sexual behaviors as well. Partner notification programs do little to generate a change in this underlying condition, and are thus doomed to fail.

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Theme I Roundtables

WOMEN'S HEALTH IN SOUTHEAST ASIA: STATUS AND NEEDS by

Blair L. Brooke, Anna Alisjahbana, Kritaya Archavanitkul, Siti Oemijati Djajanegara, Sri Harijati Hatmadji, Marlou Palabrica-Costello, Yawarat Porapakham, John Stoeckel, Florence Tadiar, and Davone Vongsack.

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Analysis of major findings: While there is substantial literature concerning child survival, family planning and family health in Southeast Asia, there are only a very small number of studies focused on the comprehensive health needs of women in the region. In some cases, national and regional data on mortality and morbidity are published in aggregate and fail to describe sex differentials. Information about maternal mortality is sketchy and estimates vary widely. Information about broader aspects of women's health, such as cancer, preventable diseases, accidents, rape and violence against women, occupational and mental health, as well as the definition of and accessibility of needed care, is scarce. This preliminary investigation suggests that there is a dearth of information needed to guide program planners and policy makers, and that improvements are needed in health status reporting systems as well as the provision of services appropriate to women's health needs in the region.

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WOMEN, AGING & HEALTH PROMOTION: AN INTERNATIONAL PERSPECTIVE

Gerl Marr Burdman, Ph.D.

The aging of populations is a worldwide phenomenon with important implications for developing as well as more developed nations all of which are undergoing rapid demographic transitions. With demographic changes have come dramatic shifts in the health status and needs of women throughout the world.

Health of older women is largely a product of experience, lifestyle, culture, and genetic factors. In many parts of the world, frequent pregnancies and childbirths as well as physical and emotional burdens placed on women throughout the life span directly affect their health status in later years.

Demographic and health status indicators will be examined and presented along with case studies highlighting health concerns of aging women from Latin America, Africa, Asia and the Caribbean as well as North America, Europe and Oceania. Major challenges in each region and potential solutions will be discussed focusing on improving and maintaining the quality of life for women throughout the life span.

A practical and positive focus on aging as a normal process within a framework of health promotion for women will be presented. In any culture, measurement of a woman's health involves looking at how well she copes with life events and/or challenges and the extent to which life routines are maintained. Cross-cultural implications of health promotion among women that will be discussed within the context of the action agenda include:

- economic implications and access to resources
- coping strategies
- cumulative effects of lifelong health habits
- inter-relationship of mind-body-spirit
- positive approaches to enhancing life satisfaction in later years

MEASURING THE HEALTH STATUS OF WOMEN: THE CONCEPTUAL CHALLENGE

WENDY J. GRAHAM AND OONA M.R. CAMPBELL

The objective of this presentation is to highlight the contribution of measurement-related factors to the neglect of women in resource allocation for health programmes and in public health research. As the recent interest in maternal health has now progressed beyond the need for information primarily for the purpose of advocacy, measurement-related factors have emerged as powerful constraints on programme action. Three outstanding needs for information can be identified: firstly, to establish the levels and trends of specific health outcomes in women; secondly, to identify the characteristics and determinants of health outcomes; and thirdly, to monitor and evaluate the effectiveness of programmes designed to influence health outcomes. The methods for meeting these needs are being addressed within a four-year international programme of research on measurement-related issues in women's health, co-ordinated by the London School of Hygiene and Tropical Medicine. The presentation will focus on the conceptual challenges which have been highlighted by this research and which must be overcome in order to provide adequate information for an Action Agenda.

Inadequate information is a reality which has to be faced throughout the world, but particularly in developing countries. The quality, quantity and scope of health-related data are the elements of this inadequacy and may be discussed in terms of four factors: the indicators, the data sources, the measurement techniques, and the conceptual framework. In this presentation, the neglect of women's health and the lack of information are shown to be self-reinforcing and constitute a measurement trap sprung by these four factors. Dismantling this trap reveals a weak conceptual framework to lie at the very centre.

Women's health has tended to be conceptualized as a discrete, negative state, characterized by physical rather than social or mental manifestations, and by a narrow time-perspective focused on pregnancy, delivery and the puerperium. The implications of this conventional view are apparent not only in the minimal attention paid to the 'M' in MCH but also in the preoccupation with one extreme of the health continuum - maternal death. The need to broaden the concept of women's health and to develop equally broad operational definitions represent important steps forward which must be taken as part of the Action Agenda. The emphasis placed on operational research by the current major initiatives in women's health must be complemented by an equivalent emphasis on methodological studies. The call for improved information by international and national agencies is still not as loud as nor in unison with the call for action.

A CROSS-REGIONAL ASSESSMENT OF DETERMINANTS OF WOMEN'S RISK BEHAVIOR FOR HIV/AIDS

CAROVANO, Kathryn

AIDSCOM/THE JOHNS HOPKINS UNIVERSITY

Statement of Purpose: Around the world, women are at increasing risk for AIDS, primarily as a result of their sexual behavior. In order to be effective, prevention programs must be based on an understanding of the behaviors that place women at risk, and the cultural, social and economic factors that influence those behaviors.

Description of the Design and Methodology: Three countries were selected: one each from Africa, Asia and Latin America, the three regions in which AIDSCOM operates. In each site, a target population of women was identified on the basis of an initial assessment of potential risk and possible access. Local PVOs involved in women's health promotion were enlisted to assist in the development and implementation of the research strategy.

Both qualitative and quantitative research was conducted at each site. The data collected focused on assessing women's knowledge of AIDS, STDs, and family planning practices; their attitudes toward sex, sexuality, and AIDS prevention; and their perceptions of personal risk and risk reduction strategies. Women's perceptions of their ability to control sexual decision-making was also examined.

Analysis of Major Findings: The data from each site were analyzed to identify the gender specific, cognitive, social and economic factors that influenced the practice of high-risk behavior as well as the adoption of risk reducing behaviors. Comparisons across regions will be made. Implications of the results for designing interventions to change behavior will be discussed.

Implications for The Action Agenda: In order to protect themselves from HIV infection, women need to acquire increased control over sexual decision-making. This implies a need to invest in the development of both improved, women-controlled prevention technology, and efforts to influence the cultural, social and economic factors related to women's sexual behavior.

Theme I Roundtables

THE IMPACT OF BELIEF STRUCTURE ON THE HEALTH BEHAVIOR OF CAMBODIAN REFUGEE WOMEN IN AMERICA

Barbara Frye, DrPH, RN
Assistant Professor
International Health/Health Education
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This ethnographic study of Cambodian refugee women explored the congruence between traditional beliefs about issues of women's health and subsequent behaviors during illness and childbearing episodes. Thirty-four Cambodian refugee women were interviewed in their homes in the Cambodian language using focused interviewing technique. An information base on traditional beliefs about women's health issues was obtained including data on perceptions of disease causation and illness classification, health risks, efficacious treatment modalities including the effects of blending scientific and traditional methods, behaviors to avoid when ill, preventive behaviors, preferred care providers, and practices during the childbearing cycle. Illness and childbearing behaviors were then tracked over an eight month period among the 34 informants. Behaviors during the 61 subsequently occurring illness and pregnancy-related episodes were tracked on the above described parameters of traditional belief structure. These behaviors were then compared to the previously stated traditional beliefs.

There was close congruence between stated traditional beliefs and subsequent observed behaviors. Illnesses and childbearing were perceived as creating states of disequilibrium. Most illnesses were perceived as resulting from stress (described as "thinking too much") and external environmental forces creating an internal state of "bad wind". Subsequent culturally dictated behaviors, which might appear bizarre or ineffectual by Western standards, sought to restore equilibrium. These behaviors were occasionally blended with scientific care.

The Cambodian refugee population is a population for which there is minimal data on the traditional health culture. The value of this study is that it links the Cambodian woman's traditional health belief system to field-based observation of behavior, demonstrating close adherence between belief and behavior. The findings of this study have specific implications for the planning and delivery of health care services and the development of culturally relevant health education messages targeted to Cambodian women. In the broader arena, this study suggests that traditional beliefs among ethnic minority women frame subsequent behavior. It illustrates the need for ethnographic data conceptually linking health beliefs and behaviors of ethnic minority women as the basis for designing educational and service strategies.

Fighting AIDS in the Developing World: Preliminary Research Results from the Women and AIDS Program.

Geeta Rao Gupta, International Center for Research on Women

The rising incidence of HIV infection and AIDS cases among women in many developing countries signals an immediate need for education and prevention. The risk of HIV infection is a reality not just for subpopulations such as commercial sex workers, but for all women -- urban and rural, married and unmarried, and of different ages and socioeconomic backgrounds. Despite this rising incidence little is presently known about the determinants of women's risk of HIV infection and about women's behavioral options for AIDS prevention -- information that is critical to the design of appropriate and effective HIV/AIDS prevention strategies for women.

The objective of ICRW's Women and AIDS program, a cooperative agreement with the Office of Health, A.I.D., is to identify ways in which women in developing countries can reduce their risk of HIV infection. To meet this goal, ICRW has funded fifteen research projects in the developing world that describe and analyze factors that account for women's risk of HIV infection and recommend feasible preventive strategies with immediate applicability for action. Preliminary findings from some of these projects will be presented and the innovative methodological approaches used to study this sensitive topic will be described.

SEX DISCRIMINATION AND EXCESS FEMALE MORTALITY AMONG CHILDREN IN LATIN AMERICA AND THE CARIBBEAN

Elsa Gómez Gómez

The purpose of this paper is to identify patterns and causes of excess female mortality among children throughout Latin American and Caribbean countries. Following the work of Ingrid Valdron on this subject, this paper attempts to test two major hypotheses concerning the causes of higher female mortality in childhood: by analyzing the contrasting characteristics of the situations in which boys and girls show higher mortality.

The first type of hypothesis suggests that sex differences for specific causes of death tend to be constant: given an association of certain causes of death with each sex, variation in sex differences for total childhood mortality will depend on the relative contribution of specific death causes to total mortality. The second type of hypothesis states that sex differences for specific causes of death vary according to environmental conditions such as the extent of sex discrimination. One crucial form of sex discrimination, inequity in food allocation within the family, is examined here.

Two main sources of information served as basis to evaluate the importance of sex discrimination as a cause of sex differences in mortality: first, the time series mortality data, by cause and age, as compiled by the Panamerican Health Organization over the last 10 years for each and all countries in the region; and second, the Demographic and Health Surveys conducted by the Institute for Resource Development Vestinghouse/Macro Systems, and the World Fertility Survey, over the last 15 years in some countries of the region, which provide mortality rates (and in some cases, anthropometric measures of nutrition) for infants and young children. The evidence suggests that in some situations, particularly those marked by scarcity of resources, girls are given lower priority than boys in terms of feeding. This practice manifests itself in lower nutritional status for girls, which in turn contributes to girls' greater susceptibility to infectious diseases and higher mortality.

In terms of action agenda, information that helps identify the existence of the problem in a given country constitutes the essential first step towards the correction of the anomalous situation. Following the identification of the problem at an aggregate level, further studies at the local level will be needed to specify prevalences and causal mechanisms in order to develop appropriate programmes of prevention and intervention aimed at female infants and children.

WOMEN'S ROLE IN THE FAMILY CHOICE OF HEALTH CARE: A STUDY CONDUCTED IN TAMIL NADU, INDIA VILLAGES

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Although the role of women as health care providers is well documented internationally, researchers have failed to ask women about their responsibilities in making health care decisions, and the barriers they have experienced in health care access. In the U.S. as well as in rural India, health care exists within a cultural milieu, and the provision of health education which affects health care choice and behavior is subject to cultural variations. Current evidence indicates that families in rural India as well as in other developing nations do not have access to traditional and biomedical health services, and are severely affected by diseases that might easily be prevented or eradicated.

The purpose of this research was to determine if the choice of family health care during illness differed according to demographic, socioeconomic, or cultural variables, and to report health care needs expressed by women in these families. Quantitative and qualitative data were obtained during interviews with 200 village women in Tamil Nadu, India, who served as proxies for their families. The pre-tested, structured survey solicited (1) demographic, socioeconomic, and cultural information about family members, (2) family use of health services during illness, and (3) opinions about the health care system.

The results showed that the choice of family health care differed significantly ($p > .05$) according to the educational level of the family health care decision maker, and selected socioeconomic and cultural factors. Even though women were often not the designated head of household, they made health care decisions jointly with their husbands, and freely expressed opinions about health needs for their families and the community. Younger, more educated women were outspoken and adamant about the need to simultaneously increase education opportunities and reduce poverty while seeking avenues to improve health services. Recommendations to provide these women with educational and leadership opportunities to enhance the health status of their families and communities are included.

The value of soliciting information about health care preferences and related educational needs is evident as educators and researchers are evaluating progress toward the global goal of "Health for all by the year 2000". Providing health care and education for the increasing number of minority and foreign populations in the U.S. requires an assessment of potential cultural barriers that affect health choice and health status. It is essential for health professionals to have cross-cultural knowledge about health care decisions that are made in the context of larger social systems.

Theme I Roundtables

Addressing the Potentially Conflicting Health Needs of Mother and Child

Sally Jody Heymann, M.D., M.P.P.
Center for Population Studies
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Women's and children's health needs are frequently treated as always being the same without examination. In important ways, this has led to women's health needs being ignored in a variety of settings. In one case, a woman with terminal cancer was forced to have a court ordered caesarian section to deliver a premature infant despite the surgery posing immediate risk to the mother's life because the court believed her cancer might be fatal prior to the end of the pregnancy. The caesarian section resulted in the death of both mother and child. The court order was subsequently overturned, too late for this family. It is critical that health professionals examine the issues raised by and policy responses to this and similar cases where women and children's health needs may either appear or actually be in conflict.

While fortunately, woman and their children often share common health needs, this is not always the case. This study examines the case of the pregnant or post-partum woman who is chronically or terminally ill. The study focuses on the mother with AIDS. The methodology is bipartite. First, standard decision analytic tools are examined to reveal how options, outcome measures and objective functions can be made more sensitive to the balance of needs of woman and children. Second, the literature from ethics and moral philosophy is reviewed for its treatment of conflicting human needs and rights.

Findings specific to the HIV infected mother include: 1) implications for education, counseling, birth control and prenatal programs 2) approaches to breast feeding programs 3) insights into resource allocation. The fundamental significance for an action agenda for women's health is discussed. The ramifications include: 1) the need for health programs to recognize when they are addressing the need of women, children, or both 2) when these needs are in harmony and when in conflict 3) methods for addressing potential conflicts.

Triangulation: Gatekeeping Patterns in Nepalese Families and Their Implications for Reproductive Health

Sarah B. Degnan, MPH, Catherine J. Schlager, MS and
Yogendra Pradhananga, DrPH

STATEMENT OF PURPOSE: In January 1990, researchers from Boston University and Tribhuvan University collaborated on a KAP study of Nepalese women who had delivered within the past year. The goal was to define more precisely determinants leading to ante-natal, natal and post-natal care among Nepalese women and to begin to isolate the role of socioeconomic development, as opposed to cultural milieu, on behavior. The project was planned as a three-arm study, with each arm to be conducted in a distinct socioeconomic "zone". Due to political unrest, we were only able to complete the first arm of the study in semi-urban Pokhara. A pilot study was conducted in tandem with the main KAP study to test a triangulative research methodology eliciting opinions about marital and reproductive issues among respondents, their husbands and mothers-in-law. The goal was to identify major coalition patterns around important reproductive issues among these three key figures; to understand how "alliances" within the family affect a woman's reproductive health and her access to services; and, to identify potential intervention points.

DESCRIPTION OF DESIGN AND METHODOLOGY: For the main KAP study, we purposefully constructed a sample by selecting wards dominated by one of the four castes under study and identifying all target ethnic group households in the ward. Mothers were interviewed in Nepali by teams of Nepalese and American interviewers. A near universal sample of target ethnic groups was achieved in six representative wards of the town; 308 mothers participated in the study. For the pilot study, interview teams enrolled mothers-in-law and husbands when both were present in the household of a respondent enrolled in the main study and when both were willing to participate in the study. Individual questionnaires were developed by adapting key questions from the mother's survey. Questions dealing with extremely private marital matters were excluded from the mother-in-law's questionnaire to avoid creating embarrassment or antagonism within the family. Thirty-two households (10.3% of the main study population) were enrolled in the pilot study. Because enrollment in the pilot study was determined by self-selection, the findings must be considered as illustrative and instructive rather than generalizable.

ANALYSIS OF MAJOR FINDINGS: Preliminary analysis suggests that there are several issues concerning marital relationships and reproduction that can create potentially inhibitory coalitions for a particular family member (i.e., the wife). Many of the issues under study relate to the role and status of affinal women in their husbands' households. These coalitions appear to be fluid; surprisingly, women and their mothers-in-law are sometimes allied against the husbands. Of particular interest are the allocation of food during pregnancy, husbands' and wives' social lives outside the extended family unit, husbands' support of wives during family conflicts, perceived pressure to procreate, desirability of the last pregnancy, decisions about contraceptive use, perceptions about treatment of pregnant women, and the desirable age at marriage for Nepalese women.

IMPLICATIONS FOR THE ACTION AGENDA: Affinal women face enormous challenges during assimilation into their husbands' family. Reproduction plays an extremely important role in facilitating a woman's acceptance. Public health professionals must better understand family dynamics in order to design responsive health programs that speak to a woman's social reality. Coalitions (or "gatekeeping") exist and often prohibit a woman from seeking care for herself. In the short-term, health care providers must be able to recognize and negotiate with coalition partners when necessary. In the long-term, we must educate women so they can negotiate for themselves.

Health Concerns of Aging Women

Margaret Lycette, International Center for Research on Women

Although the population in developing countries is aging rapidly, the resulting health implications have not been adequately addressed. Two implications are a shift in the nature of diseases from communicable and parasitic to chronic, and a corresponding increase in the need for informal and formal long-term care. Attention given now to the health problems of the aging may help alleviate the escalating health costs found in the developed countries. A large proportion of the aging population are women, especially in urban areas. The economic contribution of women past their reproductive age (45 to 70 years) argues for attention to be paid to their specific health issues.

The International Center for Research on Women, with funding from the Office of Health of USAID, will report results from an extensive review of the major health concerns of aging women and of the service projects that currently address these concerns.

Correlates of Maternal Nutritional Status in the Republic of Guinea

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Although the nutritional status of children under five years has been extensively studied and accepted as a proxy indicator for community nutritional status, there have been relatively few studies that examine the factors related to maternal nutritional status. Indeed, strong empirical evidence has not been provided to support the use of under five nutritional status as a proxy for other population groups. The purpose of this study is to investigate the relationship between maternal and child nutritional status as well as to examine factors related to maternal nutrition.

The data summarized in this study resulted from a recent cross sectional sample survey of mothers having children under five in the middle province of Guinea. A sub-sample of 534 women were included in the analysis presented here. The questionnaire assessed socio-demographic and economic characteristics of households as well as agricultural practices, household food availability and consumption patterns. Anthropometric data were collected for both mothers and their children under five years. Correlation and regression analysis were used to investigate the relationship between maternal and child nutritional status and factors related to maternal nutritional status respectively. The Body Mass Index (BMI) was one of the major indicators of nutritional status used in this analysis.

A major finding of this study is that maternal and child nutritional status are highly correlated ($r=0.19, p<0.01$). Factors that significantly predicted maternal nutritional status as indicated by BMI include family socio-economic status (SES), ethnic group, maternal age, participation in agricultural activities, and distance from water source. Breastfeeding status was not significantly related to BMI. As expected, correlates of maternal height include largely socio-economic variables: husband's principal occupation, exposure to education, family SES and maternal age.

These findings suggest that while maternal and child nutritional status are highly related, maternal demographic factors and household activities may have a significant impact on maternal status. Nutritional programs, therefore, should focus on the specific nutritional needs of women.

Theme I Roundtables

SOMATIZATION OF STRESS AMONG URBAN THAI WOMEN: A CULTURAL INTERPRETATION

by Marjorie A. Muecke, RN, PhD

Among so-called "somatizers," women and Asians are generally thought to predominate. This paper reports on a study of symptoms of stress among 237 middle aged urban Thai women and 210 of their 24-year old children (daughters and sons). Most frequent somatizers were young adult women, and least frequent were middle age women, yet all reported significantly more frequent symptoms of stress than has been reported for normals in the USA. The paper explains the findings in terms of both the meaning of symptoms to the respondents, and of the cultural interpretation of being female in contemporary Thai society.

Reducing Maternal Mortality - gaps between knowledge and practice in an urban area in Nigeria

Olukoya, A.A. and Bamisaiye, A.

The Maternal Mortality ratio in Nigeria is unacceptably high at 1500 per 100,000 live births. In this study, an attempt is made to examine maternal health knowledge in relation to maternal health practices of women in Lagos to ascertain whether lack of knowledge is likely to be a factor explaining less than optimum maternal health behaviour and thus poor maternal health outcomes. Focus groups sessions and a community survey were carried out amongst women living in a predominantly low class urban area of Lagos. The UNICEF/WHO/UNESCO Facts For Life material was used to assess the level of maternal health knowledge. A gap between maternal knowledge and maternal practice was identified, together with various cultural, socio-economic and attitudinal constraints which functioned to breach knowledge and health action on the part of the women in this study. The findings also suggest a need to review maternal health services in Nigeria with respect to quality of care at all stages of services provision: ante-natal, delivery and post-natal.



Theme I Roundtables

A PARTICIPATORY APPROACH TO CONDUCTING A COMMUNITY BASED NEEDS ASSESSMENT OF WOMEN WITH HIV DISEASE IN NEW YORK CITY

Annemarie Russell, M.S.W., M.P.H., Coordinator, Program Evaluation, Client Services Department, Gay Men's Health Crisis, Inc., New York, New York

Abstract Not Available for Publication

The Gay Men's Health Crisis, the world's first and largest AIDS service, education, and advocacy organization initiated an assessment of the counseling, educational, and advocacy needs of women with HIV Disease in New York City. A participatory approach was developed to involve both health providers in the women and HIV Disease community, as well as affected women through the use of Advisory Committees to facilitate a comprehensive and relevant documentation of needs. This involved reaching out to the community of providers and engaging women with HIV Disease. The process of partnership building with community based providers, and with women with HIV Disease will be described, as will the overall methodology followed, challenges encountered, highlights of resulting information, intense feelings engendered as a female provider, and lessons learned from this research activity. This is an example of an attempt to document the service needs of women with HIV Disease for creative use in the program planning process for this population.

Sociocultural and Medical Antecedents of Pregnancy Outcomes in a Rural Tribal community of western India. Pankaj Shah

Maternal morbidity and mortality have remained high in most parts of the developing world despite improvements in health care delivery. In India the maternal mortality rate (MMR) has been stagnant at between 400 to 600 deaths per 100,000 live births per year for over two decades. Figures for morbidity from hospital data are known to be poorly representative. The present study is being conducted in the project area of a voluntary health organization, which comprises an economically underdeveloped rural tribal population of around 45,000 in 40 villages in Gujarat, western India. The project has been delivering comprehensive primary health care services to the community for over 8 years and in addition, conducting field operational research.

This on-going study aims to probe the antecedents of various observed pregnancy outcomes in order to understand the reasons for the observed health related behaviour and decisions taken in the family which have an apparently overbearing influence on pregnancy outcome. Pregnancy outcome, as judged by the condition of the mother and the child upto 6 weeks after birth has been taken as a sensitive indicator of the general level of women's health. In-service records of the course and outcomes of pregnancies in the project villages were analysed to obtain the medical profile of the group in question. In a typical year, 1988-'90, there were 1041 childbirths in these villages, of which 962 (92.4%) took place at home, the remaining at hospitals. Nontribals, primigravidae, and women from nearer villages availed of hospital services significantly more often. There were in all, 7 maternal deaths, the major cause being post-partum haemorrhage, and 68 perinatal deaths, mostly related to low birth-weight. However, for such outcomes, factors beyond the purely medical seemed to be primarily responsible.

A stratified sample of families of women having different pregnancy outcomes in the more recent pregnancies is then investigated using ethnographic research techniques and an attempt is made to assess possible factors contributing to decisions made in the family which led to the pregnancy outcome. The relative roles of level of education, economic handicap, the family's perceptions of the woman's health condition, faith in modern health services and traditional healers, and various sociocultural factors are explored, and an attempt is made to evolve an understanding of the inter-relationships of these factors as they operate in the project area. The possible implications of these findings in terms of further research as well as possible changes in approach to delivery of health services are outlined.

AIDS KNOWLEDGE, ATTITUDES AND PRACTICES AFFECTING WOMEN IN ZIMBABWE

by
Ellen Tagwireyi, SRN
Milton Amayun, MD, MPH

This paper describes the results of a KAP survey done in three communities representing three different social strata in Marondera, a rural district of Zimbabwe with an urban capital.

In 1989, World Vision Zimbabwe started the implementation of a HAPA (HIV/AIDS Prevention in Africa) project in Africa, in collaboration with the National AIDS Control Committee of the MOH and the District Medical Team. As part of its activities, two baseline surveys were implemented to document the knowledge, attitudes and practices of the target population living in commercial farming areas, urban area and communal areas. The first KAP survey involved 2,043 respondents from 21 farms. The second survey involved 560 respondents from communal areas and 440 respondents from Marondera town, the urban area.

There are significant segments of the project population that hold beliefs that negatively impact women and their health. For example, the following were documented in the survey:

1. 64% of the population believes that prostitutes are the most important obstacles to AIDS prevention.
2. 81% of the male respondents said they look for other partners when they are separated from their spouses.
3. Both women and men have negative attitudes towards the use of condoms.
4. Women, in general, think they cannot influence the sexual behaviour of their partners.

The results of the project's KAP survey confirm that traditional cultural practices in Zimbabwean society place women at higher risk than men due to the dominant role of men in determining sexual behaviour and the large number of men abandoning their families in many African countries, forcing women into prostitution.

Training is a very important component of the project. Women leaders in the community, village community workers and traditional midwives are being trained to disseminate information to other women. A logical long-term goal should be to address socio-cultural factors in the political arena.

Theme I Roundtables

ABSTRACT TITLE: The Health Status of Women in the Occupied Territories -- Impact of the Intifada

AUTHOR: Mae Thamer, Ph.D.

STATEMENT OF PURPOSE: This study examines the current health status of Palestinian women in the West Bank and Gaza Strip, with particular emphasis on the effect that living under conditions of trauma and conflict has on the physical and mental health of women.

DESCRIPTION OF THE DESIGN AND METHODOLOGY: Based on review of available published and unpublished data and information, this study presents a comprehensive review of the current health status of Palestinian women in the Occupied Territories. The data includes United Nations and WHO reports, information from the Government of Israel, and reports and information from non-governmental sources and on-site technical assessments.

ANALYSIS OF MAJOR FINDINGS: The study's major findings are divided into two areas: the physical and mental health of Palestinian women. The health status of Palestinian women has deteriorated over the past three decades as evidenced by an increase in injuries and fatalities among women as well as in pregnancy complications and stress-related disorders. Women have incurred one-fourth of all Intifada-related injuries; there has been an increase in home baby deliveries, with a concomitant increase in maternal and infant mortality. Pregnant women have experienced a significant increase in miscarriages due to the use of tear gas in enclosed areas as well as stress and other factors. The psychological stress resulting from the Intifada has produced a marked increase in high blood pressure, diabetes, headaches and psycho-somatic illnesses among women.

IMPLICATIONS FOR THE ACTION AGENDA: This study emphasizes the broader context in which the health of women in many areas of the world must be considered. Specifically, many women in developing countries live under conditions of conflict and trauma which are often not taken into account when developing national health policies and programs and donor support for developing countries. It is hoped that this presentation will lead to discussion of policies and programs that effectively address women's (and family's) health under these conditions.

**WOMEN'S PERCEPTIONS OF THEIR HEALTH NEEDS:
QUALITATIVE STUDY IN RWANDA TO DEVELOP A MATERNAL HEALTH STRATEGY**

Sixto Zigurungabe, CARE RWANDA
Carla Rull Bussen, PLANNING ASSISTANCE

Often program planners develop community health programs without having in-depth insights into existent community perception of problems and potential solutions. There is a growing recognition that initial information must be collected from the community and, similarly, that quantitative data is not sufficient to understand community attitudes towards health problems or the most appropriate ways to address those problems in a given area. Prior to developing a strategy to improve maternal health, CARE RWANDA and PLANNING ASSISTANCE, in collaboration with the Ministry of Health and the National Office of Population (ONAPO) in Rwanda, conducted in-depth qualitative interviews with women, men and traditional health practitioners to assess existing knowledge, attitudes, and practices concerning pregnancy, family planning, childbirth, nutrition, and health center services for women.

Population pressures on available resources in Rwanda, Africa's most densely populated country, have led to increasingly deteriorating living conditions for the Rwandan people. Rwandan women bear much of the burden of these conditions as they carry more than 60% of the family/work load and have, on average, 8.6 children. Data suggest that women suffer from a high incidence of complications related to reproduction, poor nutritional status and an elevated susceptibility to communicable diseases. At the same time, women's utilization of health services is low.

How do women perceive these problems? At what point do they confer with local health practitioners? When do they turn to the health system for assistance? Do men perceive women's health as a priority issue? These and other questions were explored through a series of group and individual interviews carried out by a team of interviewers including social workers and health workers who were trained for five days prior to the data collection. CARE RWANDA health staff and a local sociologist supervised the team's work and facilitated the simultaneous analysis of the data as it was collected in the field. The community data collection revealed that communities do identify certain problems related to women's health and do have strategies for dealing with them.

The study provided invaluable information for the development of maternal health initiatives that build on existing community competencies and helping networks. The resulting program is now in the initial stages of implementation in a northeastern prefecture of Rwanda. Health workers and local authorities are continuing to work with the communities being served to ensure on-going adaptation and refinement of program initiatives to local realities. The Rwanda experience underscores the critical need for community input—from women and from men—in order to develop effective and sustainable strategies to improve women's health.

Theme I Posters

MOTHERCARE PROJECT Colleen Conroy

In most developing countries, pregnancy and childbirth are seen as familiar, natural and safe events. Yet statistics show that this is often not the case: each year, nearly half a million women in developing countries die of complications of pregnancy and childbirth. Moreover, of the 10 million infant deaths that occur in these countries each year, nearly half take place during the first month of life. The MotherCare Project was created to assist countries, communities and individuals to identify and implement solutions to the widespread problems affecting maternal and neonatal health and nutrition.

The MotherCare Project aims to improve pregnancy outcomes through a household- and community-based approach using three basic strategies:

1. Influence the range of behaviors affecting the health and nutritional status of mothers and newborns;
2. Strengthen women's abilities to seek and utilize available resources; and
3. Strengthen and coordinate relevant service systems that respond to the health and nutritional needs of mothers and newborns.

MotherCare is currently conducting long-term demonstration projects in Indonesia, Bolivia and Guatemala. Technical approval from the Ugandan Ministry of Health has also been received to conduct Nurse-Midwifery Training. In demonstration projects, strategies are being developed and tested for improving maternal and neonatal health and nutrition.

In addition to its long-term projects and short-term technical assistance and training activities, MotherCare has developed the following materials:

- Maternal Anthropometry for Prediction of Pregnancy Outcomes Summary Statement
- Live Saving Skills Manual for Training for Literate Midwives
- Breastfeeding Situation Analysis Methodology
- A Framework for Investigating Behavioral Determinants of Maternal Health Care Choices.
- A Framework for Intervening to Reduce Maternal and Neonatal Morbidity
- Anemia Prevalence Bibliography
- Neonatal Tetanus Bibliography

"MATERNAL MORTALITY IN HONDURAS: A NATION-WIDE SURVEY OF RATES, CAUSES, AND RISK FACTORS"

Vicent David, MCH Advisor, Management Sciences for Health/Honduras, J.C. Ochoa Vasquez, Chief, Women's Health Care Department, Ministry of Public Health, Honduras, and M. De Jesus Castellanos, Teaching Coordinator, Gynecology/Obstetrics, National Autonomous University, Honduras

In Honduras, a national survey was recently undertaken to evaluate mortality rates and causes for women of child-bearing age as well as maternal mortality rates, causes, and risk factors. During their year of social service, 46 physicians, representing each of the Honduran health areas, investigated the deaths that year of all women between the ages of 12 and 50. The deaths were detected through hospital reports and through a network of community-based informants established by each investigator. Data were collected on socio-economic characteristics, obstetrical and medical history, evolution of the death-related pregnancy, and probable cause of death. In addition, two controls were selected for each hospital maternal death to study odd ratios for selected risks factors.

One thousand seven hundred and fifty-seven deaths were investigated, giving a mortality rate of 1.43/1,000 per year. With a rate of 221/100,000 live births, maternal mortality, as defined by WHO, represented 22 percent of the deaths and was the leading cause of death, followed by infectious diseases (18%), trauma (15%), and tumors (12%, of which 42% were cervical cancers). Among the 381 maternal deaths registered, 67% occurred outside of a hospital. The leading causes of death, especially at the community level, were hemorrhages (33%), infections (21%), and non-related deaths (19%).

The typical profile for maternal death was that of a woman of age 35 or more, with a number of previous normal deliveries who, after an uneventful, uncontrolled pregnancy, gave birth at home and developed a postpartum hemorrhage due to placental retention or uterine hypotony. Abortion was recognized as a contributing cause of death in eight percent of the cases. The case-control study confirmed that rural residence, earthen floor, age over 35, multiparity, short birth interval, previous history of abortion and failure to obtain prenatal control were the major risk factors, at least for hospital deaths.

From the results of previous surveys and estimates from United Nations life tables, we estimate under-reporting to be between 15% and 37%, but closer to the former. The survey was designed to decrease underreporting in specific instances such as maternal mortality and particular causes (abortion) by not specifying cause of death as an entry criterion for the informants.

This methodology, which provides both a good estimate for maternal mortality rate and a detailed structure of the maternal mortality, could be used successfully in small to medium size countries or provinces. In Honduras, the regional findings, written up by the investigators as a thesis, were rapidly distributed to the regional and area health teams. National and regional findings will be used to reshape women's health care strategies.

METHODOLOGIES FOR MEASURING MATERNAL HEALTH IN DEVELOPING COUNTRIES: AN INTERNATIONAL RESEARCH PROGRAMME

SAYED A.H. ABDULLAH, AYSEN BULUT, OONA CAMPBELL, MUSITTAQUE CHOWDHURY, ENEFIK ESSIEH, VERONIQUE FLIPPI, ELIZABETH GOODBURN, WENDY GRAHAM, SUSANA SCHKOLNIK, HARMEN SIMONS AND YOUSSEF WAHEDI

It is now widely acknowledged that the absence of adequate information has been a cause and an effect of the neglect of women's health. Gathering information must clearly be balanced with the ability to act upon the findings. In developing countries, pragmatism is crucial and action must continue in the face of weak information. Delaying the initiation of women's health programmes until perfect data are available would condemn the lives of thousands of individuals - women and their children - to premature death or to serious physical, social or mental debilitation. Improving the quality and quantity of data must, however, be supported by comparable efforts to increase the awareness of the policy and programme implications of using particular health measures and methodologies. This poster presentation describes an international research initiative which specifically and uniquely addresses key measurement-related issues in women's health.

In January 1989, the initiative was launched by the Maternal and Child Epidemiology Unit at the London School of Hygiene and Tropical Medicine. The primary objectives of the research programme are to evaluate existing methods for measuring maternal health in developing countries and to devise, pilot and promote the use of new approaches. The programme has now embarked on the fieldwork phase in collaboration with six institutions and organisations in developing countries. The poster introduces the six studies and indicates how they will contribute both to improving maternal health in these specific local and national settings and to measurement-related problems of international significance.

THE SISTERHOOD METHOD FOR ESTIMATING MATERNAL MORTALITY: THE STRENGTHS AND THE WEAKNESSES

WENDY J. GRAHAM

Many developing countries lack community-based estimates of the level of maternal mortality. The constraint this imposes on the effective planning, management and evaluation of programmes aimed at reducing maternal mortality is self-evident. It is less evident how the majority of developing countries can be expected to meet the call for reliable estimates by 1995. This presentation focuses on an innovative technique, the sisterhood method, which offers a means of gauging the level of maternal mortality that is straightforward, inexpensive and quick by comparison with the existing alternatives in most developing countries. The objective is to assess the strengths and the weaknesses of the method which have emerged since the original field trial in late 1987.

The sisterhood method is an indirect technique which uses the proportion of adult sisters dying during pregnancy, childbirth or the puerperium, reported by adults in a census or survey, to derive a variety of indicators of maternal mortality. The method was developed by William Brass and Wendy Graham of the London School of Hygiene and Tropical Medicine in direct response to the demand for reliable estimates generated largely by the Safe Motherhood Initiative. With the results from the first field application in The Gambia arising at a time when many developing countries lacked a baseline estimate of maternal mortality from which to launch programme action, the sisterhood method rapidly received international attention. A continuous process of evaluation and refinement has been in operation over the last three years as further field applications have taken place. The method has now been utilized in a wide variety of settings and experience accumulated both on the practical issues related to data collection as well as on the factors which influence the suitability of the method in different developing country contexts. The time is ripe for assessing what the method can and cannot contribute in terms of improved information on maternal mortality for programme action.

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Theme I Posters

THE USE OF MOTHER'S HEALTH CARD IN REDUCING LOW BIRTH WEIGHT: PREVALENCE IN INDONESIA

M.A. Husaini, Y.K. Husaini, R. Odang and N. Gunawan

The Mother's Health Card has been used in the MCH programme in Indonesia for promoting better maternal and foetal health by increasing the level of awareness of the pregnant women, the village cadres and health workers through the graphic presentation of weight and height. By using the graphic, the women who were at risk of delivering low birth weight can be significantly identified ($Se = 66.7\%$; $Sp = 75.4\%$). The village cadres (who had been trained in the correct use of the tools) with a limited formal education were able to complete the card easily. The study revealed that the card was simple, action oriented and relevant for primary health care. Low birth weight in this study was low (6.4%) compared to the national rate of 14.0%. The card was also served as a tool for mediating iron pill supplementation and tetanus toxoid vaccination. The women had more frequently visit for antenatal care; on average 4 to 5 times visit during pregnancy or above the government targeted (4 times). In view of the health transition the prospects for reducing high prevalence of low birth weight and infant mortality rate particularly neonatal mortality at national level are encouraging.

APPLICATION OF ETHNOGRAPHIC RESEARCH TO UNDERSTAND WOMEN'S PERCEPTIONS OF HEALTH AND DISEASE: A STUDY OF BARODA, INDIA
BY DR. SHUBHADA KANANI
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CONSULTANT, BARODA CITIZENS COUNCIL, BARODA, INDIA

ABSTRACT

The anthropological approach is increasingly gaining importance in public health interventions. The present study, conducted by a non-government organisation Baroda Citizens Council, aimed at understanding the ethnic perspective of over 200 women regarding female physiology, adolescent growth and development, pregnancy and lactation, general gynaecological morbidity and health seeking behaviour. Ethnographic methods used: focus group discussions, free listing and pile sorting, key informant interviews of women and indigenous practitioners. **RESULTS** Most women recognized five organs in the female body - liver, intestines, heart, lungs and uterus. Menstruation was considered desirable and was 'expulsion of heat and unwanted substances from the body'. Breast development, onset of menarche and weight gain marked the changes from girlhood to womanhood. Early marriage and motherhood (10-14 years) 'spoilt the body of a girl'. Effect of present nutritional status of the girl child and adolescent on her future health was largely unknown. 2. Pregnancy was a 'hot condition' hence 'hot' foods were to be avoided. In lactation, consumption of strength giving foods and restriction of certain foods was practised. Self experience or experience of neighbours/relatives chiefly determined the preferences of women for home or hospital deliveries. Home deliveries were preferred mainly for convenience; hospital deliveries were preferred as 'doctors in hospitals can handle any complication of childbirth'. 3. Several health problems were not viewed as such by women but considered an inevitable part of reproductive life. Frequently mentioned general morbidities included backache, headache, bodyache, 'thin or less blood' (anaemia) and weakness; gynaecological morbidities included leucorrhoea, menstrual disorders, infertility, complaints attributed to tubectomy/hysterectomy. 4. Etiological factors of diseases were linked to the socio-economic environment, over which, women said, they had no control. 5. Treatment was sought only when symptoms debilitated women and was discontinued usually once symptoms disappeared. Both allopathic and indigenous practitioners were sought; frequent changes of practitioners being common if rapid relief did not result. The triad of qualitative ethnographic research, quantitative data collection and services mutually complemented each other. Further similar studies are required in developing countries.

Adolescent Girls: Nutritional Risks and Opportunities for Intervention

Kathleen M. Kurz, International Center for Research on Women

Adolescence may be an important, though unappreciated, time to improve the nutritional status of girls. If they can be reached before their first pregnancy, improvement may allow girls to enter their reproductive years with better nutritional status, resulting in healthier outcomes for them and their children. If the adolescent girls have become pregnant, improvement is needed because their nutritional needs are already greater than those of non-pregnant adolescent girls and those of older pregnant women. For girls, adolescence brings with it such nutritional risks as iron deficiency due to blood loss from menstruation, increased energy needs due to accelerated growth, and numerous risks if pregnancy occurs. Adolescence may provide opportunities to postpone pregnancy, as well as to improve the nutritional status of girls.

In the first phase of a new program funded by the Office of Nutrition, A.I.D., at the International Center for Research on Women, issues related to adolescent nutrition are identified. Also, opportunities for intervention are proposed for the subsequent phase of investigation to be carried out at sites in Africa, Asia, the Caribbean, and Latin America.

WOMEN AT WORK - THE TOP TEN

Mpongo Landu and Franklin C. Baer

SANRU Basic Rural Health Project
c/o Dr. Franklin C. Baer
APO New York, NY 09662

Women are the moving force for development in many developing countries. The women of Zaire are key actors in the provision of primary health care at the home and community level. This poster display illustrates the "top ten" jobs that women perform in promoting primary health care at the community level:

- o mother the farmer
- o mother the ORS chemist
- o mother the nutritionist
- o mother the milk provider
- o mother the family planner
- o mother the growth monitor
- o mother the health educator
- o mother the health activist
- o mother the traditional birth attendant
- o mother the water/sanitation supervisor



Personal Note: The artist Mpongo Landu is well known in Zaire for his drawings relating to primary health care. His close association with the SANRU Basic Rural Health project for more than five years has resulted in an impressive collection of drawings spanning all aspects of primary health care many of which are included in the book "A" for is Alma Ata by the same authors.

CV

Theme I Posters

THE HOUSEHOLD PRODUCTION OF WOMEN'S HEALTH IN NEPAL

LASTON, Sandra L. (Case Western), BLACK, Robert E. (Johns Hopkins), SCHUMANN, Hebra A. (Case Western).

This paper examines the household production of women's health in three panchayat villages in Nepal. Reported acute and chronic morbidity of women (mothers, grandmothers, and older female siblings) in 1167 households is examined in relation to educational patterns in the household, household economic status, household density, stated food availability, and the availability of water and sanitation facilities. Diarrheal disease morbidity in a subset of adult women in 352 households is examined in terms of behavioral risk factors for diarrheal disease transmission including food preparation, handwashing, and hygiene practices.

The data presented in this paper were collected as part of a prospective study on the nutritional and diarrheal status of preschool village children undertaken in 1989-1990. The data collected include demographic profiles of 1167 households and diarrheal disease surveillance and household observations in 352 households. The households included in the sample are all high caste (Brahmin and Chetri) to control for the effect caste may have on the determinants of health status in this setting. At the time of the demographic interview, reported acute and chronic morbidity (including diarrheal disease, respiratory, and other chronic conditions) of all household members was ascertained. Six months diarrheal disease surveillance in the subset of 352 households assessed diarrheal disease morbidity in study children, their caretakers, and other household members. Two ninety minute observations were undertaken each month in the subset of 352 households to ascertain the workload of women including caretaking patterns, food preparation activities, and hygiene practices. The considerable workload of women leaves little time for health promotion activities within the household. The implications of these time constraints on the household production of health and other research findings will be discussed.

TEENAGE PREGNANCY IN HAITI

Lerebours Gerald, Deboré Barnes, Aurore Augustin
Institut Haïtien de l'Enfance
Port-au-Prince, Haïti

Pregnancy during adolescence is traditionally thought to have severe social, medical, physiological and psychological effects for the involved teen and her family. Although teen pregnancy is a concern among medical personnel in Haiti, in this highly fertile, low-contracepting society rapid social change has led to a deterioration of social mores regarding sexual activity with young girls, and child-bearing appears to be one of the few perceived methods for women of acquiring social status. We use data from a national cohort study of maternal mortality to examine pregnancy and birth outcomes among women 13 to 19 years of age. With approximately 50% of the target cohort of 12,000 pregnant women recruited, 11% are under the age of 20, and 2% are 16 and under. In this sample, teens have had up to 1 previous birth by age 14, and up to 3 by age 17. They come from the same socio-economic levels as their adult counterparts, are less likely to smoke, and have more education and better self-perceived health. Analyses on the final sample will include outcomes of pregnancy, and use and perceptions of prenatal care facilities. Detailed social and medical histories will be obtained in cases of mortality of these young mothers and their newborns. Goals of this sub-study are to improve our knowledge of medical and social problems specific to teenagers, in the context of proposing special programs targeted to them.

Balancing Rights and Needs in Sao Paulo: Integrating Health Services for Women, Children and Workers Authors

Valeria Simons Lara de Fonseca, Claudia Maria Bogus
Centro de Estudos e Pesquisas em Direito Sanitário
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Rosemary Barber-Madden, Ed D. Maternal and Child Health Program, Center for Population and Family Health, Columbia University School of Public Health

Addressing the health needs of the population in the face of huge budget deficits and changing political structures has become a major challenge in Brazil. A new constitution passed in 1988, guarantees the right to health for all and strengthens the role of local governments in coordinating health services, thus enabling cities like São Paulo to develop local health priorities. The new government of the Worker Party in São Paulo established worker health as a major priority in 1988. It was originally proposed that Worker Health Centers would replace traditional MCH services in communities with low utilization rates and a large number of factories. A pilot study was undertaken in Vila Romaria by the Center for Research and Study in Public Health Law, University of São Paulo, São Paulo Municipal Health Department, and the Maternal and Child Health Program, Columbia University School of Public Health to analyze community needs as they relate to this new policy mandate. The study involved the analysis of epidemiologic and demographic data, a community health needs survey, the use of group interviews and in-depth interviews with health post personnel to obtain their perceptions about target populations and utilization and an analysis of the new worker health program guidelines and staffing patterns.

Based on these analyses, it was concluded that despite the large number of factories (and workers) in the community, there is a sizeable population of women and children in Vila Romaria using the MCH services, the majority of community residents are not aware of the existence of the health post, there exists a larger target population of women and children who might use the service if they knew of its availability and there is a sizeable elderly population (primarily women) in need of cardiology and geriatric services. These results were clearly not anticipated by the Municipal Health Department. This paper not only describes the study methodology and results but also the proposal for an integrated Health Reference Center which recognizes the needs of women and children as well as workers in Vila Romaria, the actions taken to advocate the establishment of this program and the Health Department's response.

BATTERING DURING PREGNANCY Judith McFarlane, R.N., C., Dr.P.H.

Two to three million American women are battered each year by their male partners. One woman is beaten every 18 seconds. Forty percent of women homicide victims are killed by their male partner. Injury accounts for more years of life lost before age 65 than both heart disease and cancer combined. Battering is the foremost cause of injury to women.

Battering also occurs during pregnancy with women reporting blows to the pregnant abdomen, injuries to the breast and genitals, and sexual assault. A recent study at Texas Woman's University documented one in twelve healthy pregnant women to have been physically battered during the present pregnancy. Among the women battered, 87% had been physically abused prior to pregnancy and 29% reported the abuse increased following pregnancy. When pregnancy outcome was analyzed in another study of 589 postpartum women, battered women were four times more likely to deliver a low birthweight infant.

In 1990, the U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control funded a three-year, multi-site, prospective, stratified cohort study of 1,200 pregnant women. The purpose of the study is to establish the frequency and severity of battering during pregnancy and effects of the abuse on maternal and infant health. This poster presentation will review the methodology and preliminary data results.

Theme I Posters

Gender Differences in Prevalence and Treatment of Hypertension and Coronary Heart Disease
E. Jeffrey Metter, Jerome Fleg, K. Kopac, D. Binckley, C. Bacal, A. Rosenberg, D. Kramer
NIA, Gerontology Research Center, Baltimore, MD 21224

This study compares the prevalence and treatment of hypertension (HTN) and coronary heart disease (CHD) in volunteer women and men participants in the Baltimore Longitudinal Study of Aging (BLSA). The BLSA offers a unique opportunity to compare and contrast health in a highly educated and motivated, community dwelling group of individuals. Data from 577 women and 301 men entering the study since 1978 were used for this analysis. Participants return for evaluation every two years, at which time they undergo more than 2 days of testing, including a complete health evaluation and record of medication usage. Diagnosis lists are subsequently prepared by the examining physician. The prevalence of HTN and CHD was estimated from the diagnosis lists, and medication usage was examined to determine treatment. The prevalence of HTN in the women was lower than men until the menopause and subsequently equalled or surpassed the men with the highest prevalence being 41% in 75-79 y.o. women and 35% in >85 y.o. men. Treatment patterns were similar once HTN was diagnosed with 63% of the women and 62% of the men being treated at the visit at which HTN appeared on their diagnosis list. On the other hand, the prevalence of diagnosed CHD remained lower in women with a maximum of 35% in women over age 85 and 55% in men over age 85. More women with CHD had a clinical diagnosis of angina (65%) than men (44%, $\chi^2=5.02$, $p<.05$), while men had a higher, but not significantly higher, percentage of myocardial infarctions by history. Treatment trends for CHD appeared to show that women received medication later following the diagnosis than the men, but once treated, the number and types of medications were the same. A total of 15 men as compared to 3 women had surgical procedures to correct the damage to their coronary arteries. The preliminary findings from this study argue that not only the development of hypertension and coronary heart disease are different by gender, but the clinical presentation of the disease as it develops and subsequent treatment may differ.

WOMEN, HEALTH AND URBANIZATION IN KHAYELITSHA, CAPE TOWN, SOUTH AFRICA.

AUTHORS: WILLIAM M. PICK, DI COOPER, JACK KLOPPER, MARGARET HOFFMAN, JONNY MYERS

This study examines some aspects of the health of women in the peri-urban area of Khayelitsha, Cape Town, South Africa. Decades of rigidly enforced influx control as part of the state's policy of apartheid, have led to 'abnormal' migration patterns affecting largely the African women, who were not allowed to join their spouses in the urban areas. Since the repeal of some of the legislation in 1986 (and immediately before), the tempo of rural-to-urban migration has increased dramatically.

An attempt is made to quantify some of the effects of this migration on the health of women by means of in-depth interviews and a household interview survey.

Interesting differences in fertility, child mortality, gynaecological illness, knowledge of AIDS and cervical smears are found between women with stronger rural links and those women with weaker rural links.

Differences in health service utilisation are found. This information has important implications for health service provision as well as for specific health interventions.

CAUSE OF MATERNAL DEATHS IN A SUBDISTRICT OF WEST JAVA PROVINCE: ARE THEY PREVENTABLE?

James Thouv, A. Alisjahbana,
Wawang S. Sukrya, A. Venas Ngantung

ABSTRACT

Eighty percent (80%) of Indonesia's population live in rural areas (villages) and 85% of deliveries occur at home. Maternal and child mortality rates are high. To date no exact maternal mortality figures are available nor are the causes of death known nationwide. An intervention study based on the Risk Approach Strategy was done in Tanjungsari (a subdistrict) over a 2 year period (1988, 1989). Interventions consisted of special training of TBA's in identifying cases at risk and appropriate referral of these cases, while doctors at the Health Centers were actively involved with supervision of all TBA's. Twenty (20) maternal deaths were recorded for a maternal death ratio of 480/100,000 in this subdistrict. The main causes of deaths of infants and mothers were malpresentation, low birth weight, birth trauma/asphyxia, postpartum hemorrhage, prolonged labor, postpartum sepsis and toxemia. Further analysis revealed that almost all mothers' deaths were associated with labor and delivery, (1 death was caused by septic abortion). Risk factors such as age and multiparity were identified with 6 deaths occurring in women 35 years of age and 2 women Para 5 or over. Referral, a vital component of health care was beset with problems. Out of 20 fatal cases over the 2 year period, 18 were referred by the TBA's and 6 women refused the referral. Eleven (11) died at home, 2 died en-route and the other 7 died in the District Hospital. The maternal mortality is high due to:
1. Lack of knowledge and motivation of the population.
2. Failure and problems of the referral system.
3. Short-comings and lack of facilities at the Health Care providers level.

An Analysis of preventability is also presented.

Theme I Videos/Films

VILLAGER TO VILLAGER:

PROMOTING HEALTH AND FAMILY PLANNING IN RURAL NIGERIA

O. A. Ladipo, Eugene Weiss, Grace Edun Deiano, Gay Jean Triplett

Villager to Villager is an exciting 30-minute video documentary illustrating the community-based provision of health and family planning services in rural Nigeria. Villagers are chosen by their communities to become volunteer village health workers to provide basic curative and preventive health and family planning services. They are carefully trained and supervised by local government health workers. Through illustrations of training classes, role plays, and interviews with two experienced village health workers, as well as real situations in clinic and village settings, this video highlights the strong communal links the health agents have with the members of their villages and the dedication with which they provide services to their neighbors. Despite the fact that many of the agents are illiterate, they return from their training course with knowledge of complex health concepts and the ability to communicate them to other villagers through community health meetings, home visits and songs.

Villager to Villager is the second video program to be produced describing community-based work by the collaborating institutions. The first, *Health and Family Planning in the Marketplace*, focuses on market traders as health and family planning agents. The programs described in the two videos started as pilot projects in two local governments in Oyo State, Nigeria, and have now been taken over by the Local Governments as the State Ministry of Health seeks to replicate them throughout Oyo state. They are also being adopted through much of Nigeria and elsewhere in Africa.

OUTCOMES OF CARE IN BIRTH CENTERS

The National Birth Center Study

Judith P. Rooks, C.N.M., M.S., M.P.H., Norman L. Weatherly, Ph.D.,
Eunice K. M. Ernst, C.N.M., M.P.H., Susan Stapleton, C.N.M., M.S.N.,
David Rosen, M.P.H., M.P.A., and Allan Rosenfield, M.D.

In this prospective study, the outcomes of 11,814 women admitted in labor to 44 free standing birth centers in the United States were reported in the December 29, 1989 *New England Journal of Medicine*. The women and infants were followed through their delivery or transfer to a hospital and for at least 4 weeks thereafter.

Eighty percent of the labors and births were attended by certified nurse-midwives, 16.0 percent by physicians, primarily obstetricians and 4 percent by midwives (who were not certified nurse-midwives) or registered nurses.

The cesarean section rate was 4.4 percent (compared to a national rate of 25%). The overall intrapartum and neonatal mortality rate was 1.3 per 1000 births (similar to rates reported in large studies of low risk hospital births). There were no maternal deaths. Patient satisfaction was very high 98.8 percent.

Birth centers offer a cost savings of almost one half that of hospital births. They have been successfully used with both rural and urban populations. Women participate in the care they receive and are involved in all decision making. Few health services provide such innovative, safe, low cost care with such a high degree of satisfaction.

"Population and People of Faith: It's About Time" An educational video

Charles R. Ausherman, MPH, Ph.D., Executive Director and
Jeanne Betsock Stillman, B.A., MSPH, Director, New York Office,
Institute for Development Training

As stated in a recent United Nations Population Fund publication, "As mothers, producers or suppliers of food, fuel, fodder and water, health care providers, traders and manufacturers, political and community leaders, women are at the center of the development process." Often they are the moral and spiritual guide of the family as well. The "Population and People of Faith" project focuses on how such programs as women's health, literacy, education and other development programs, brought about with strong church leadership, can help improve lives of the family and community, and help the global community to confront the challenges of population growth and distribution, resource use and environmental deterioration.

The Institute for Development Training, in collaboration with representatives of several denominations, has produced a pilot video for use by church audiences and other interested groups. Entitled "Population and People of Faith: It's About Time", the video conveys the urgent need for Christians and other people of faith to inform themselves about population growth and environmental facts and their human consequences, to work with their denominations and other policymakers, and otherwise to contribute their personal and group efforts and assistance to relevant programs in the U.S. and abroad.

The video treats the consequences to women and their families of too many children born too close, to women too young or too old, or otherwise unable to care for them. It explores how women and men in the U.S. and abroad can work together to achieve the aim of better stewardship of the earth. Examples of successful efforts to meet these challenges are shown. A call to action encourages viewers to consider their own role and responsibility in policies, programs and other actions to address this important issue. Church leaders and population and development experts from the U.S. and from developing countries are featured and guide the audience in discussion of questions and possible action solutions.

A companion study guide is being prepared which will summarize issues presented in the video, present basic additional information, guide viewers to additional resources, provide exercises and stimulating possibilities for action, and help viewers to develop from a faith perspective actions based on their study and discussion.

Theme IIa Concurrent Session: HIV/AIDS Session Chair: Michel Cayemittes

Lessons Learned From AIDS Prevention Programs Directed Toward Women in the Caribbean and the United States

by Jennifer Alexander-Jerry

The purpose of the following study is to document and analyze the processes for mobilizing women, a new high risk population, in AIDS prevention programs. This study examines programs that have addressed two populations, female commercial sex workers and women of the general population. Three, or possibly four, exemplar AIDS prevention programs in the Dominican Republic and in the United States will be the subject of case studies. The case studies will document (a) the processes employed to build linkages with the designated community of women and; (b) the PVO's development of an approach to the problem of AIDS prevention within the cultural and environmental context of that specified community. The studies are intended to present lessons learned from the field, both efforts that have proven successful as well as those which have failed.

Case studies of each program will be employed. This methodology allows for use of multiple sources of information: historical data, written documentation from field notes, interviews with health care workers, program participants, and non-participants, and women involved in grass roots movements. Multiple data sources provides an opportunity to cross-validate information and results in a more in depth examination of an issue. Presently, major findings cannot as yet be flushed out as research is underway.

Implications of the results for "The Action Agenda" abound: the study offers lessons learned from the field of AIDS prevention; information on how common barriers to involving women have been surmounted with respect to a highly sensitive and stigmatizing disease; documentation of approaches to AIDS prevention that have been developed within the context of the social and cultural environments which guide women's behavior.

The Impact of An AIDS Television Drama on an Urban, Female Audience : The Kinshasa Experience

By: Julie Convisser, Kyungu Homat, Kambamba Sola Ami, Population Services International, AIDS Education Program (PSI PEM/STIDA), Zaire
Elisabeth Liebow, Population Services International

PURPOSE: 1. To determine the degree of women's comprehension and retention of the key messages contained in a PSI-produced televised sketch about AIDS, "Bujisa Nzoto," in Kinshasa, Zaire. 2. To measure the impact of the sketch on the attitudes and behavior of the target audience with regard to AIDS prevention.

DESIGN & METHODOLOGY: In collaboration with Zaire's National AIDS Committee, Population Services International is implementing a mass media AIDS information, education and communication campaign. An AIDS drama, performed by a local drama group and developed and broadcast with technical support by the project, has been televised periodically after being shown for the first time on World AIDS Day, in December 1989. An impact survey was conducted among a representative sample of the target audience in Kinshasa (n=250, 50% female respondents) the day after one of the show's rerroadcasts.

FINDINGS: In Zaire, where every major urban center has television coverage through satellite relay, and nearly 70% of the population has access to it, television is proving to be a surprisingly effective communication channel, particularly for women (and their newborns) who are disproportionately affected by HIV infection and AIDS. Briefly, 50% of females interviewed nearly 70% saw at least part of the drama, and 97% of those who reported seeing the drama were able to recount the general plot. Nearly all who reported seeing the drama correctly identified AIDS as the principle theme; 68% of those who saw the drama liked it because it "gave advice" about AIDS, and 28% liked it because it was "educational." Over 90% of those who saw the drama identified the key message as AIDS prevention, which was articulated in a variety of ways including sexual promiscuity leads to AIDS and fidelity within a marriage is the best way to avoid AIDS. Importantly, 93% of respondents reported that the drama had an impact on their behavior, with nearly 50% saying it encouraged them to remain faithful to their spouse; 21% saying it encouraged them to abstain from sex.

IMPLICATIONS: Mass media, especially television, should be used to the fullest degree possible as an innovative vehicle for educating women about AIDS (transmission and prevention), and for motivating the adoption of "safer" sexual behaviors. It is unclear to what degree AIDS prevention mass media programs truly influence behavior, but post-tests suggest they may effectively reach women with the intended messages.

DETERMINANTS OF HIV/STD RISK AMONG FEMALE SEX WORKERS IN KINGSTON, JAMAICA

White, Elizabeth*, Weller P*, Figueroa P*, Brathwaite A*,
Ducasse M*, Cohen JB **.

* National AIDS Programme, Jamaica; ** AIDSCOM/Academy
for Educational Development, Washington DC.

Objective: To develop and assess effective educational interventions to reduce the risk for HIV/STDs among a population of female sex workers through a comprehensive study of HIV/STD seroprevalence, clinical treatment needs, and KAP related to sexual practices, condom use, knowledge of AIDS/STD, and demographic variables.

Methods: Participants were first recruited for interviews in the streets, bars, and clubs by trained peer counsellors and contact investigators. Benefits to participants included medical examination and treatment for STDs as indicated. Secondary recruitment activities focused on clinic-based services, partly due to inhibitory police activities in the areas. In 9 month period, 111 women were recruited for the study.

Results: Recruitment of the sample was difficult due to police activities and to reluctance of participants to travel to clinic or to leave their work. Interestingly, the opportunity to be tested for HIV proved to be a greater benefit to participants than the offer of medical exam and care. Nine of 111 were confirmed serologically positive for HIV; 9 had gonococcal infection; 37 had serological evidence of syphilis. 92 of the 111 have 5 or less customers per week and 55 have a "special man." 96 have used condoms with customers but only 63 use them with their "special man." AIDS/HIV awareness and prevention knowledge was high; almost all (98) reported more frequent use of condoms due to fear of AIDS. Condom use skills review indicated 75% with skill deficits. Data analysis of risk variables will be presented. The use of peer counsellors proved invaluable in all phases of the study.

Conclusions: The study determined several important factors for future AIDS/STD prevention among this population: (a) female sex workers can be accessed and recruited for a study, including interventions; (b) the population is knowledgeable of AIDS/STDs and prevention; (c) HIV testing is an important benefit to the population; (d) increased condom use is high, but correct condom use skills are low; (e) considerable risk of infection to/from the women's "special man" partners remains. Follow-up studies are planned.

"AIDS IN AFRICA: THE COST OF DRUGS AND NURSING CARE"

Richard O. Laing, MSc, MD, Drug Management Program, Management Sciences for Health,
and Kisali Pallaogyo, MSc, Muhimbili Hospital, Tanzania

In Africa, women bear the major burden for nursing in addition to the responsibility for many domestic tasks. In this respect, AIDS not only affects those personally affected by the disease, but also the many others who carry the burden of nursing sick adults and children. Planning to support women in this additional role should thus be an important part of any national AIDS control plan.

To date, most emphasis has been placed on the additional drug cost for the treatment of opportunistic disease. However, a study carried out in Tanzania demonstrates a methodology for quantifying both the nursing and drug costs of a national health system. The model, which is applicable to any country with a Type II transmission pattern and available sero-prevalence data, builds upon the work of Over, Scitovsky, and Bertozzi in order to demonstrate the practical impact of different policy options.

This quantification model clearly shows that the major cost of AIDS treatment is in nursing services rather than drugs. Such costs lead to an emphasis on home care, which puts an additional demand on women in the community. This study therefore makes recommendations as to how the health system can change to support women in home nursing activities.

Theme IIa Concurrent Session: Innovative Models

Session Chair: Naomi Baumslag WIPHN

"The Role of the Church in Meeting the Health Needs of Women"

Charles R. Ausherman, Ph.D., Executive Director, Institute for Development Training and Olivia Holmes, President, Holmes Research, Ltd., Specialist in Social Marketing

Statement of Purpose: In light of evidence that women's socio-economic status and well-being are inversely related to their fertility and to overall population growth rates, this paper: (1) illustrates the contribution of church-related health programs in this area; (2) shows evidence that the organized church is largely unaware or has become apathetic regarding the need to focus on and improve women's health services including family planning; (3) introduces a development education program for the grassroots American church audience to strengthen their commitment to funding and shaping policies and programs for improved women's health services, through church-related programs in developing countries and in the U.S.

Design and Methodology: Our methodology for studying women's health service delivery policies and programs involved literature search and interviews of key policymakers in selected, large Protestant denominations. This is supported by results of focus group research at the grassroots church level concerning knowledge and attitudes about women's health programs supported by churches overseas. Feedback from these studies is used to develop a video and guided study program for use principally in churches.

Analysis of Findings: The authors analyze findings in conjunction with a distinguished Steering Committee representing major denominations, population communications professionals, and marketing specialists. Research findings are fed directly into the script, images and choice of interviewees for the video and into the study guide.

Implications for the Action Agenda: This development education effort is expected to:

- * increase awareness on the part of a broad church-going public about the interrelationships of women's status, health, fertility and population issues;
- * increase individual and group action in development efforts, such as "adopt a health program" projects, sister church relationships, and the like;
- * increase pressure on policymakers in the U.S. to support appropriate programs for women's health including improved reproductive health;
- * increase individual and group funding of relevant women's health programs abroad.

FOOD AID AND WOMEN'S HEALTH: A New Approach in the Dominican Republic

Hilary Cottam

The priority for PL480 programme food aid is maternal child health (MCH). Women remain however largely ignored both in official guidelines and practical implementation.

The Dominican Republic is no exception to this rule despite disproportionately high maternal mortality rates. The focus is on child malnutrition yet the three most common causal factors*, low birth weight (14%), maternal illiteracy, and absence of exclusive breastfeeding are directly related to women's/maternal health. The challenge calls for innovative use of the food resource to ensure impact on maternal health status.

To address the urgent need to refocus a traditional and largely inoperative national MCH food distribution project CARE Dominicana implemented a broad, highly participatory analysis of both malnutrition and the current response. The result was the redesign of the project with the emphasis on maternal health.

Working from the rural clinics, through the framework of a minimum of three prenatal checks, the project aims to ensure maternal health through three major interventions. Education and training both of the mothers and clinic personnel through succinct and targeted messages. Implementation of a community based targeting strategy to ensure that both education and an appropriate food ration reach all mothers at risk. Finally, an Operational Research (OR) component to test ration sizes and food use at the household level with the objective of establishing effective, replicable interventions for this target group on whom little/no related information exists. The latter component is being implemented with CENISMI.

Implementation started in July 1990. Results of the OR study and first progress evaluation will be available in June 1991.

Dissemination of project results is expected to have implications in the wider debate surrounding the need to redirect MCH projects more towards maternal needs and most importantly, in the refocusing of food use policy.

* CENISMI: National Centre for Studies in Maternal and Child Health.

Women's Tobacco Control Networks: Agents for Change

Michele Bloch, M.D., Ph. D., and Deborah L. McLellan, M.H.S.

Statement of Purpose

Tobacco use by women and girls represents one of the greatest challenges to public health professionals and advocates for women's health. To tackle this issue, tobacco control coalitions must be broadened to include groups interested in women's issues, and women's groups must be educated to the necessity of undertaking tobacco control. Research must also be conducted on successful women-centered tobacco use prevention and cessation programs. The Women vs. Smoking Network (WSN) and the International Network of Women Against Tobacco (INWAT) were founded to reverse and prevent the death and disability suffered among women by tobacco use.

Description of Design and Methodology

WSN coordinates a broad-based coalition of individuals, women's leaders, women's groups, and health organizations within the U.S. The activities in which it engages are: tracking the tobacco industry's marketing practices toward women and implementing counterstrategies; educating women's organizations and women leaders in tobacco control; providing training and guidance in media and advocacy techniques; and maintaining a computer network linking and informing tobacco control advocates across the U.S. and world-wide. INWAT's major objectives are to counter the targeted marketing world-wide of women by the tobacco industry and to assist in the development of women-centered tobacco prevention and cessation programs. To this end, important activities include: coordinating and sharing international tobacco control strategies, especially about women; raising awareness of issues of gender and tobacco use within the tobacco control movement and the international health movement; and assisting in the development of tobacco cessation and advocacy training, designed for women.

Analysis

The existence of WSN and INWAT has brought both national and world attention to the targeted advertising of women and girls by the tobacco industry. WSN raised national awareness about the blatant targeting of less advantaged women by RJ Reynolds' Dakota cigarette. INWAT members raised world awareness about marketing campaigns in India (the Mx. cigarette) and in Hong Kong (Virginia Slims) targeted at women who traditionally have had low prevalence rates (<10%) of smoking.

Both networks circulate periodic updates and analyses provided by members worldwide.

WSN has educated women's organizations on women and smoking issues. INWAT is increasing women's participation in the tobacco control movement and is connecting researchers worldwide who are developing women-centered tobacco use prevention and cessation programs.

Implications for the Women's Health Agenda

Through the sharing of contacts, information, policies, and strategies, networks can empower women worldwide to change their health status. Specifically, WSN and INWAT will ultimately reduce tobacco use prevalence rates and tobacco-related mortality rates suffered world-wide by women.

Qualitative Needs Assessment of Women Village Bankers in Tijuana, Mexico and Development of Self-Educational Guide on Domestic Violence

Jill D. Salamon, MPH and Mary Luz Velazquez

In 1990, the Maternal-Child Health International Public Health Internship Program of Columbia University, sponsored by The Pew Charitable Trusts, was invited to send an intern to Tijuana, Mexico. The purpose was to assist in developing health education materials for the Foundation for International Community Assistance (FINCA) programs for women village bankers. Additional funds were provided by FINCA.

FINCA organizes village banks with women from Central and South America. FINCA's main goal is to promote sustainable economic self-sufficiency amongst impoverished people through revolving loan funds or micro-enterprises. FINCA directs its programs to women, because it is believed that if a woman's economic situation improves so will that of her family.

The village bankers of Tijuana, Mexico requested educational materials on health issues for use during their weekly bank meetings. An intern was sent to conduct a needs assessment of the village bankers' health needs, develop a format for the self-educational materials and train community members to create additional materials.

This paper discusses the qualitative research methods (discussion groups, participant observation, interviews, and group interviews) used to conduct the needs assessment of the village bankers and the results. The findings of this research assisted in identifying the health topics of importance to the village bankers of Tijuana. The topics identified included: domestic violence, alcoholism, drug prevention and detection in children, parasites, and women's infections including STDs and AIDS.

This paper also contains the first self-educational guide that FINCA will use; this first guide is on domestic violence. Village bankers throughout Mexico will use the guide to facilitate discussions on domestic violence so that bank members can identify and understand domestic violence. It is expected that this will lead to collective action and the creation of local resources to assist families suffering from domestic violence. Now that FINCA has created the format and method of presentation for their health materials, trained community members are continuing to produce more guides on the other issues identified in the needs assessment.

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Theme IIa Concurrent Session: Obstetrical Risk and Referral

Session Chair: James McCarthy

MORE RISK THAN RESOURCES - EVALUATING ALTERNATIVES FOR OBSTETRIC RISK MANAGEMENT IN A DEVELOPING POPULATION. Alfred V. Bartlett, Elizabeth Paz de Roccaletti, Marco Antonio Roccaletti. DEPT. OF INTERNATIONAL HEALTH, JOHNS HOPKINS UNIVERSITY, SCHOOL OF HYGIENE AND PUBLIC HEALTH/INSTITUTO DE NUTRICION DE CENTROAMERICA Y PANAMA (INCAP)

In developing countries such as Guatemala, inadequate management of obstetric risk results in high levels of maternal and perinatal mortality. Programmatic efforts to reduce this mortality are constrained by available resources - Guatemala has the capability to attend 20% of deliveries in its hospitals, with the remainder attended in communities, principally by traditional birth attendants. The widely recommended strategy for assignment of these resources is the "risk approach". This approach classifies pregnancies into risk categories based on maternal characteristics which are known predictors of risk. To evaluate the feasibility of this approach in a developing population, we employed the data from a prospective study of perinatal mortality in a typical rural indigenous Guatemalan community. Using intrapartum infant deaths as the "adverse outcome" to be prevented, we examined the usefulness of maternal characteristics in predicting such an adverse outcome. Characteristics evaluated included first pregnancy, age (17 years, age 240 years, 23 and 26) previous pregnancies, prior obstetric problems (miscarriage, stillbirth, premature birth, neonatal death, cesarean birth), birth interval (14 months), 50% survival of liveborn children, and stature (145 cm). Considering these characteristics individually, for every woman with a characteristic who suffered an adverse outcome, between 6 and 19 others had the same characteristic and uncomplicated births. The proportions of all women having each characteristic ranged from 4% (age < 17, age > 40) to 44% (3 previous pregnancies). Requiring more than one characteristic to classify a mother as "high risk" increased the proportion of "high risk" mothers experiencing adverse outcomes, but left substantially greater numbers of adverse outcomes outside the "high risk" category. Using various sets of characteristics yielded detection of 93% of mothers experiencing adverse outcomes, but did so at a cost of classifying 70% of all mothers as "high risk". In the same population, a small number of obstetric events (including malpresentations, prolonged labors, and prolonged rupture of amniotic membranes) were associated with 80% of adverse outcomes. These obstetric problems occurred in under 20% of all births. Based on these analyses, our programmatic intervention to reduce maternal and perinatal mortality is focused on improving recognition and management of "risk events" rather than on risk screening and classification. Such analysis and re-focus of resource allocation strategies may be necessary for obstetric risk management in other developing country settings.

Refining the Risk Approach to Obstetric Care

An epidemiologic study in Zimbabwe

Vivien Davis Tsu

Screening pregnant women for characteristics thought to be associated with poor obstetric outcome has long been considered an essential component of antenatal care services. While the idea of identifying women at high risk for obstetric complications has special appeal in the developing world, where medical resources are scarce and the majority of women deliver away from medical facilities, there have been very few studies evaluating the effectiveness of the risk approach. Results of a case-control study of two major obstetric complications, obstructed labor and postpartum hemorrhage, carried out in Harare, Zimbabwe, illustrate that our understanding of risk factors can be greatly improved by careful, multivariate analysis of existing data. Even with better delineation of risk factors, though, efficient prediction of labor complications before the onset of labor may be an unreachable ideal.

Assessing Antecedent Determinants for Detecting Women at Risk of Surgical Intervention for Obstructed Labor

CB Berzain, MPH, S Duale², MD, MPH, PG Laape¹, MA, R Dominik¹, MPH

¹Family Health International ²Zaire Basic Rural Health Project

This paper assesses two approaches for designing a basic screening tool for use at the primary level to detect women at risk of surgical intervention for obstructed labor. The analysis is part of a larger study of maternity care services in the Karava Health Zone of northern Zaire.

Baseline data were collected for 3,790 women who delivered in the health zone's referral hospital from 1984-86. Six antecedent risk factors detectable through screening by traditional birth attendants or community health workers were included in the analysis. Two methods were used to define "at risk" status based on various combinations of six factors: maternal age, height, cutaneous status, number of previous deliveries, outcome of the last delivery, and previous cesarean section.

In the first analysis we used a simple algorithm based on adjusted relative risks. All risk factors except maternal age <18 were associated with a significant increase in the crude relative risk (RR) of surgical intervention for obstructed labor. When adjusted for height, the RR for all other variables decreased, suggesting the association was dominated by height. At different height cut-off points, the sensitivity and positive predictive value of the screening criteria are higher for primiparas than for multiparas.

In the second analysis we used logit regression (LR) to develop a risk matrix. The results from the LR analysis allow for selection of different probabilities as the "at risk" cut-off point. Four risk levels were arbitrarily chosen, resulting in four distinct screening tools comprised of different combinations of risk factors.

The results of this analysis provide information about advantages and disadvantages of alternative screening tools. The criteria used require no clinical expertise and minimal training and can be conducted outside the clinic setting by primary health workers. When implemented effectively, the screening tools can identify most women at risk of major complications at delivery. Prenatal care, early referral and adequate medical attention can then help save these women's lives and improve their overall health.

"FIRST REFERRAL SERVICES FOR OBSTETRIC COMPLICATIONS"

Vivian Wong, Public Health Specialist, World Bank

One factor that contributes to high rates of maternal mortality in developing countries is that few hospitals are equipped to treat obstetric complications. The World Health Organization has specified "essential obstetric functions" that should be provided at the first referral level. In many countries, however, life-saving procedures such as cesarean section are only provided in the teaching hospitals. Various program designs that attempt to overcome this obstacle to Safe Motherhood are presented.

Theme IIa Concurrent Session: Quality of Care Session Chair: Judith F. Helzner

Local Financing and Community Mobilization for Improving Quality of Maternal Care at Village Level, Niger

Lynne Miller Franco, ScD; Theresa Hatzel, MPH; Wayne Stinson, PhD; Tisna Veldhuyzen Van Zanten, PhD
PRICOR Project, Center for Human Services

Niger currently has nearly 7,000 active traditional birth attendants (TBAs) who have received training in delivering simple maternal and child health care services. These female VHWs are found in 44% of all villages in Niger, representing an important resource for providing maternal services to women in the periphery. The 1988 PHICOR systems analysis of the VHW program included assessment in 27 villages of maternal care services provided by these female VHWs. Observations of prenatal and postnatal service delivery and interviews with VHWs and women uncovered many weaknesses in the quality of care delivered by these VHWs, such as curatory antenatal care, lack of sterile razor blades in female VHWs' kits, and unhygienic handling of newborns. Discussions with community leaders showed that the communities did not feel responsible for the functioning of the VHWs, offering little remuneration, moral support, and help in managing drug kits. Finally, supervision from the health systems was insufficient: the average number of supervision visits per village was 1.2/year.

Despite shortcomings in the quality of services provided by female VHWs, the systems analysis showed that 65% of the 169 women who had delivered in the past year had been assisted by a VHW during or after delivery. In light of the extensive network of VHWs, and the relatively high rate of utilization, further research was undertaken in Spring 1993 to uncover sustainable measures for strengthening the VHW system while respecting the constraints posed by severely limited financial resources. Three studies ensued: 1) a cost analysis of supervision and training for the VHW system, 2) an evaluation of current central (MOH) and district level (local tax revenue) financing for the VHW program, and 3) a study examining the possible types and areas for community support.

The community support study set out to assess the community members' perceptions of the services provided by the female VHWs, their reliance on the female VHW's services, and their willingness to participate in improving the functioning of maternal services in their villages. Focus group discussions with community members and female VHWs themselves conducted in eight villages throughout the country revealed that communities found the female VHWs' services to be essential for safeguarding the health of women and newborns. This study also indicated that a number of reasons could explain the apparent lack of community involvement: a lack of awareness that they are responsible for supporting a program imposed from above; a lack of skills and experience in recognizing and addressing problems; and a lack of knowledge of various strategies they could employ to offer support. When presented with various alternatives for organizing village participation, community members expressed near unanimous interest in these measures. Types of community support discussed included: financially supporting the female VHW to attend refresher training, assisting the female VHW in acquiring drug stocks and supplies, and establishing and enforcing a fee-for-service incentive system.

The evaluation of MOH and district financing levels revealed that about 20% of districts are currently supporting VHW activities through their local tax revenue. If other districts could be encouraged to adopt the same strategy, resources for improving the quality of maternal care at village level would be further increased. Projections from the VHW program cost analysis indicated that the expense of strengthening performance could be reduced to more affordable levels by employing some innovative, minimalist strategies for training and supervision. Several such strategies are currently being tested through operations research. With joint financing and support from communities, districts and the MOH, it is possible to improve the quality of maternal care at the village level, capitalizing on the extensive VHW network to improve maternal health conditions in rural Niger.

Evaluation of maternal services: the clients' perspective by Churamonie Jagdeo and Kate Stewart

In Bangladesh, the maternal mortality rate is 6 per 1000 live births. This is close to 100 times that seen in most developed countries. In 1987, the Maternity Care Project was initiated in Matlab through the Matlab Maternal and Child Health and Family Planning (MCH/FP) Project. The goal of this project, which is still ongoing, is to decrease maternal morbidity and mortality through the provision of maternal health care services at the household level by nurse midwives and specially trained female paramedics.

This presentation will describe an evaluation of the maternal services which was done from the clients' perspective. The goals of this study are to 1) improve the quality of care provided by the project health professionals and to improve the acceptability of the services. The objective of this study is to obtain information on the clients' perspective regarding both the quality of and their need for maternity services. Knowledge from this study will guide programme efforts to improve the training of the service providers and to develop better educational messages.

The study utilizes an in-depth interview technique used by skilled local interviewers. Field testing of the instrument was done. Translation of the transcripts and cross-validation of these were undertaken prior to analysis.

Findings of this study will be considered in the planning and implementation processes of a national maternal and neonatal health care project by the Government of Bangladesh. Variables identified in this study can be used to develop other maternity care services.

THE MYSTERY CLIENT: A METHOD OF EVALUATING QUALITY OF CARE OF THE FAMILY PLANNING SERVICES IN THE HAITIAN PRIVATE SECTOR

By Dr. Giselle Maynard - Tucker
Port-au-Prince Field Office, IPPF/WHR

IPPF/WHR is the implementing agency for the private sector family planning project, an example of partnership in the international health involving 9 private organizations. (The project was described at the 1990 NCIH Conference). Among the technical interventions provided in the area of evaluation is the initiation of a "mystery client" strategy. This method consists of direct observations of family planning services and clinic conditions by trained Haitian housewives playing the role of "mystery clients." Visits to the clinics are made on a random basis without prior notice. Evaluation of services by a "mystery client" permits the assessment of the fundamental elements of quality of care from the client's perspective. On a weekly, rotating basis, informants visit clinics asking for information concerning contraceptive methods. They are trained to make direct observations and to record their interaction with clinic personnel, and their observations are collected and analyzed by the field office staff.

A pilot test of the method was conducted in 12 private clinics in Haiti between April and June 1990. Problems were identified in the areas of: choice of method, interpersonal relationships, technical competence, accessibility and client satisfaction. Based on the successful pilot experience an ongoing monitoring project was developed. Initial findings demonstrate that the mystery client methodology of evaluation of quality of care of family planning services offers valuable information from the client perspective and is a useful tool in program design and monitoring. Implications for the "Action Agenda" include the creativity of this approach in generating women client's own views of a health service, and the ways in which administrators and policy makers can be linked to data from the grassroots level to trigger change.

PROMOTING REPRODUCTIVE HEALTH IN JAMAICA - AN EXERCISE IN GRASSROOTS PARTICIPATORY EVALUATION OF QUALITY OF CARE

Lou Witherite, Chair
Elizabeth Colt
Julius Boateng, MD (Ghana)
Blossom White (Jamaica)

The Unitarian Universalist Service Committee (UUSC) is undertaking a major effort to incorporate a reproductive health care assessment based on quality of care, with the Stakeholder Analysis, an effective evaluation methodology for integrated community development projects, in which "stakeholders" are all those with a "stake" in the project design, implementation, and outcome. To date, most of the work on reproductive health quality of care has focused on service delivery, whereas most grassroots organizations rely on access to services provided by others. The challenge is thus: how do grassroots organizations promote quality of care in a project when their project components include family life education but interaction with the service provider is beyond their control? Similarly how do grassroots organizations promote quality of care in participatory evaluation processes, such that the c. of c. elements are, to the extent possible, in the hands of project implementers?

A Stakeholder Analysis of Reproductive Health (SARH) Team was formed to work with the Olympic Gardens Skills Training Project (OGSTP), which provides skills training, basic business practices, personal development, and family life education (FLE) to women in a low-income neighborhood of Jamaica. OGSTP does not provide contraception; women seek government or private clinic services. The SARH Team met with a wide range of project-related and non-project related people through focus group discussion and individual interviews to identify stakeholder views on project purpose, indicators of success, indicators of the FLE component's effectiveness, program strengths and weaknesses, and recommendations for change. The Team also reviewed project data, investigated points of service referral, and sought information on similar projects in Jamaica.

Stakeholders unanimously identified acquisition of money-earning skills as the chief goal, and that the project had succeeded in achieving this. Criteria for success varied, but the common thread was women's independence and the ability to get money without resorting to casual sex. Regarding the FLE component, stakeholders believed information-giving to be the main objective. However, the SARH Team noted an overwhelming and unsatisfied demand for information on contraceptive side effects, new contraceptive technologies, and pregnancy complications. Health professionals reported widespread sexually transmitted diseases, but the evidence shows a high level of awareness about them. The situations in which STDs are spreading are frequently tied to monetarily driven sexual activity, regardless of knowledge. The SARH Team identified information giving as a formal mission of the project. However, staff devote considerably more time to individual counselling and ongoing referrals, but they were not cited as objectives by participants. They are therefore informal missions of the OGSTP.

The SARH Team and project implementers developed 2 sets of recommendations: 1) re: program management and content. In sum, they recommended that counselling and referral-giving be acknowledged as formal program purposes and that training, data collection, and client follow-up be set up within a modified, non-service based quality of care framework. The report suggests key questions and indicators of quality of care. 2) Participatory Evaluation - they recommended a Jamaican be attached to the project on a continual basis to facilitate stakeholder workshops and program assessments, so that stakeholder views continuously inform program revision.

GA

Theme IIa Concurrent Session: Talking With Women

Session Chair: Cathleen Church

Public vs. Private Sector: One Common Goal

Robin F. Foust

Improving the health of mothers and infants is a national/international challenge. The United States' infant mortality rate ranks 10th among developing nations. Significant reduction of the infant mortality rate and elimination of racial and ethnic differences in pregnancy outcome will not occur through simple continuation of current efforts. One of the barriers to lowering the United States rate is reaching and effectively communicating to women of childbearing age. The U.S. Department of Labor estimates by the year 2000, 64% of the workforce will be women. Initiatives have been implemented in the public health sector and the causes and barriers these strategies have to deal with are an important battle in the war on reducing the incidence of infant death and preterm birth.

Health Management Corporation will present evidence that supports that the worksite is an important point of access for attaining our Nation's Maternal and Child Health objectives for the year 2000, that has not been effectively used in the past due to the financial, educational, and social barriers.

Barriers to overcome for preterm risk management through the worksite include:

- Employees/spouses have insurance for maternity care
- Working women are seeking appropriate care
- Women are receiving all the information they need from their doctors.
- Our workforce is educated and know about preterm labor and prenatal care.
- It is not a problem among "the" workforce.

This presentation will use slides and discussion to:

- Review the United States' Objective for the Year 2000 in the area of Maternal and Child Health.
- Identify barriers to private sector initiatives vs. public sector programs.
- Discuss the problem of preterm birth in the U.S.A. including costs, trends and other related costs.
- Describe the design and methodology of successful employer sponsored programs.
- Report outcomes including individual cases as well as the impact on employer's healthcare claims costs.
- Present challenges to the audience on the need to support both private and public sector initiatives in pre-term birth prevention and reduction of infant mortality rates.

ADOLESCENT GIRLS: HEALTH EDUCATION AND SERVICES IN LOW INCOME AREAS IN MEXICO

Authors: Itala Valenzuela and Sylvia Flores

This paper discusses a project developed by the Jocotepec Women's Development Centre (JWDC), in collaboration with the Centre for Development and Population Activities (CEDPA), to provide adolescent girls with health and family planning information and services.

The project was designed by Sylvia Flores, a nurse and JWDC's Director, when she observed that lack of information and education was perpetuating high rates of unwanted pregnancy in semi-rural and rural Jocotepec. JWDC and CEDPA will present how the JWDC chose to combat this problem by adding a six-week health and sex education course for adolescents to complement its on-going skills training and clinical services for women. Strategies used to generate community support for this potentially controversial education program will also be discussed. By creating a support network of community leaders, including Jocotepec's mayor, parents and teachers, the education program attracted over 2,000 participants, both in- and out-of-school, within its first 19 months. Broad-based community support fostered the expansion of the education program to adjacent barrios and motivated adolescent family planning acceptors. The project has already been successfully replicated in a similar environment in Mexico, and non-governmental organizations in other Latin American countries have requested assistance to adapt the Jocotepec program in their own communities.

The Action Agenda must recognize that adolescent pregnancy programs, an often neglected component of women's health programs, will succeed when they are designed and supported at the community level.

RESEARCHING WOMEN'S HEALTH PROBLEMS USING EPIDEMIOLOGICAL AND PARTICIPATORY METHODS TO PLAN THE INDUSIVI WOMERCARE PROJECT

Elsa Sanchez and David Rogers, Save the Children/Bolivia, and Lisa Howard-Graban, John Snow Inc.

This presentation will describe the processes, experiences and results of a case-control study and a participatory maternal health needs assessment, and how these two studies were combined to develop an action plan for a 2.5 year maternal health program in Indusivi Province, Bolivia.

- I. **EXPANDED CASE-CONTROL STUDY** will provide "hard" data on the causes of maternal and neonatal mortality.
 1. **Case-control Study:** The unmatched case-control study design is based on the number of neonatal deaths per year in the study area, encompassing approximately 20 cases registered from November 1988 to November 1990. Two controls per case are randomly selected from Save the Children's ISCF-BI registers of infants born the same year in the same subarea.
 2. **Verbal Autopsies:** During case-study interviews with mothers of neonatal mortality cases (or other informant in the case of maternal death), data will be collected to discern the probable medical cause of death. The medically-trained interviewers will summarize the events and symptoms associated with the death.
 3. **Process Diagnosis:** The decisions, contextual factors, and processes leading up to the event that directly resulted in a death will be examined to identify at what point health-seeking behavior or the health system failed.

II. **PARTICIPATORY MATERNAL HEALTH NEEDS ASSESSMENT** will provide qualitative data from the target group's perspective.

1. **Design and Staff Training:** Together, the JSI and SCF/2 teams will develop the objectives and methodology of the "auto-diagnostico", and train the field staff.
2. **Planning the Study with Women's Groups:** Implemented in two stages, the first is to gain the trust and confidence of the women so they feel comfortable speaking about their problems; to discuss with the women the importance of analyzing their maternal and neonatal health needs, and; to build a common understanding of maternal and neonatal health problems and what they are called in Aymara. In the second stage, the women will design and field test appropriate materials for the participatory assessment, and determine the size and composition of the population to be studied.
 3. **Women's Group Members Implement the Study.** Using instruments and methods developed in phases I and 2, women's-group members interview other community women about their health, beliefs, traditions and customs related to pregnancy, birth, puerperio and care of the neonate.
 4. **Share and Analyze Collected Data:** The women will share the data they collect using a technique SCF/B developed called the "bandera de salud" which helps women to visualize the frequency of specific health problems. The staff leads discussions on the qualitative information they gained during the assessment and facilitates the women in reaching a consensus on which priority maternal and neonatal health problems are feasible and desirable to work on.

III. **PROGRAM PLANNING USING THE RESULTS FROM THE TWO STUDIES**

The program planning stage will combine the results of the case-control study and the participatory women's health needs assessment to develop an action plan for a 2.5 year, community-based, primary maternal and neonatal health program, benefiting women in 30 rural communities.

SCF/B will divulge and analyze the information from the two studies with the community groups and health sector technicians. The epidemiological information from the case-control study will be correlated to the quantitative and qualitative information from the participatory maternal health needs assessment. Technical staff will develop materials that create village women's groups to analyze fairly sophisticated information. The technicians' role is to identify the statistical correlates and medical relationships between the two studies. The community women's groups will prioritize those problems and attendant interventions in order of feasibility and importance.

DIAL-A-FRIEND: INCREASING ACCESS TO COUNSELING AND HEALTH SERVICES FOR YOUNG WOMEN IN METRO MANILA

Edson E. Whitney, Senior Program Officer; Patrick L. Coleman, Senior Communication Advisor to the Philippines; Jose G. Rimon, Project Director; Sung Hee Yun, Chief Asia/Near East; D. Lawrence Kincaid, Senior Evaluation Specialist. The Johns Hopkins University/Center for Communication Programs (JHU/CCP); Aurora Silavan-Go, Director of Programs, Population Center Foundation (PCF) and Wynn Abuejela, Project Officer (PCF)

This unique, highly successful project designed to promote responsible sexuality among youth brought together the talents of the entertainment industry, advertising agencies, a private foundation and private business to bring counseling and referral services to the doorstep of young women and men in Metro Manila, Philippines.

This paper will discuss the design, implementation and results of this project in which JHU/CCP worked with PCF in Manila to launch two music videos, stressing sexual responsibility, through the commercial market. Both songs reached the top of the charts. A subsequent media campaign linked the already popular songs to a telephone hotline with four counselors trained by the project to respond to the callers' concerns and refer them to the appropriate counseling and health centers near their homes. Survey results show that 10% of 15 to 24 year olds in Metro Manila used or completed hotline calls. The majority of callers were young women in this age group.

The hotlines continue to receive calls and are frequently referred to in popular media even after the formal campaign ended. Corporate donations and in-kind support have generated more than \$1.3 million to supplement the actual project budget. An innovative approach and the collaboration of the public and private sectors combined to produce a sustained program providing counseling and referral to young women.

Theme IIa Concurrent Session: Traditional Birth Attendants and Community Health Workers

Session Chair: Clydette Powell

The Importance of Educating Men on Women's Health Issues: Surprising Findings From a Pilot Project to Train Birth Attendants in Rural Papua New Guinea

J. Brabec, B. Rasmussen, RN

Statement of purpose:

The implications of educating men about issues involving women's health care needs are examined, based on Project Concern International's (PCI) pilot project to introduce the role of village birth attendant (VBA) in rural Papua New Guinea (PNG).

Design and Methodology:

PCI has successfully trained women to serve as birth attendants in 15 villages in rural Papua New Guinea, where obstetric services and perinatal care are virtually non-existent. Within the project site and generally throughout PNG, the role of traditional birth attendant is not well-established, owing to a cultural taboo against female blood, which is considered very dangerous to men. Women, including primiparas, either give birth alone, often in secluded areas of the bush, or with the assistance of another woman with neither training nor skills in birthing procedures.

The PCI project recruits and organizes villages, after securing initial approval from the male village elders. Each village selects two candidates for VBA training. The VBAs are trained to provide perinatal care, including nutrition counseling and promotion of tetanus toxoid vaccination. They must demonstrate competency in safe birthing techniques for uncomplicated deliveries and in the identification and referral of high-risk pregnancies and deliveries.

Analysis of major findings:

In the initial recruitment of villages, we were gratified by the interest in the project shown by the men in the majority of villages we approached. In one case, a village that was not recruited for the project requested to be included, and the men constructed a birthing house to demonstrate their commitment. In two other villages, men requested and were given a course in reproductive physiology, family planning, STD, and the effects of nutrition and lifestyle on pregnant women and babies. Men are now offered this course as part of the project. In addition requests have come from male-dominated organizations in non-project villages. PCI has documented in the last year that in the villages where it has trained a VBA, 37% of births now receive trained assistance, in contrast to an estimated 5% of births receiving trained assistance in the rest of the district.

Implications for THE ACTION AGENDA:

The education of men in health problems faced by women, and their involvement in the solutions, have profound potential for effecting positive change in the general status of women in these villages.

Reaching Highest Risk Pregnant Women: Experiences and Lessons from New York City

Zell Rosenberg, M.D., M.P.H., Marta Baez, Robert Gatti

Pregnant low income and minority women in New York City have been documented to receive very late or no prenatal care (20% citywide and over 40% in selected communities). These women often have additional risk factors in their medical profiles (e.g. poly-substance abuse, homelessness, risk for AIDS). It is not surprising that infant mortality rates (e.g. 13.1/1000 live births citywide and 20.9/1000 in East Harlem) continue to remain much higher than N.Y. State (10.7/1000) and U.S. National (10.1/1000) averages.

In order to reach the hardest to reach poor pregnant women, two approaches have been vigorously implemented in the New York City Metropolitan Region: (a) increased financial access to services through the statewide Prenatal Care Assistance Program (PCAP) with expanded Medicaid eligibility and (b) development of model "community health worker" cadres, employed and supervised by grassroots community organizations, bringing health services to target women's homes.

For PCAP we report program utilization estimates following first year implementation of streamlined eligibility criteria to include women with incomes up to 185% of the poverty line notwithstanding legal residency status as well as results from a series of in-depth, on-site case reviews. These reviews highlight current barriers for bringing high quality services to ethnically diverse inner city populations as well as proposed solutions.

For community health workers, we detail how the special approaches used to select, train and supervise these workers in eight distinct high risk target geographic areas relate to the unique health needs found in the communities themselves.

Lessons learned in serving these highest risk, low income pregnant women- common to developing and developed urban settings- in urban areas are summarized. Issues involving community mobilization, social marketing, integrated service delivery by community based workers, overcoming language and cultural barriers, and ensuring program quality through monitoring are highlighted.

Title: Hospice and Women: Meeting the physical, emotional, social and spiritual pain of terminal illness in Kenya.

Author: Ms Catherine Lwenya, Administrator, Nairobi Hospice, KENYA

ABSTRACT

The stage of life where "health" may appear an inappropriate word is during a terminal illness. However helping to meet the needs of this time and bringing about a feeling of social, spiritual and even physical wellbeing to the patient and family is the work of Hospice Movement all over the world.

The Author describes the Kenyan initiative started in 1990, describing the experiences of the needs of patients and families and the role of women as patients, carers and professionals engaged in appropriate planning and teaching of the Hospice approach.

The aim of the care and teaching programmes is to enable all terminal patients whether suffering from cancer, aids or other illnesses, to have access to the Hospice approach from caring professionals and volunteers throughout Kenya.

The present needs and five year plan will be discussed.

Towards an Evaluation of Midwife Programs in Rural Mexico: Cooperation or Co-optation of the Traditional Birth Attendant

Pilar Alicia Parra Ph.D
Laura Cao-Romero MA

The health care system in Mexico was built upon a western model in which curative rather than preventive medicine is emphasized. However, the incorporation of indigenous midwives into maternal and child care and family planning programs by several public health agencies is an exception to the governmental health policies. The continued reliance on midwives by rural women makes the government programs most important because provides this sector of the population of modern contraception and ensures a referral system for those women with a difficult pregnancy that a midwife recognize she is unable to resolve. This paper presents the evaluation to midwife programs given by the Mexican Institute of Social Security (IMSS) and by the Secretariat of Health (SSA). Participant observation and in-depth interviews were utilized to assess the impact of the training programs on midwives. Preliminary findings show that the instruction and educational practices are based on the assumption that midwives have schooling experience, when half of the midwives do not have enough schooling to be able to apply abstract constructs to practice. Also, the content of the program is based on western medical obstetrics and dismiss the knowledge and indigenous technology that midwives already have. Thus, in order to implement programs that have the capability to offer rural women the benefits of both health systems, the programs require not only training on upgrading midwives' skills in modern antiseptic techniques, but the recognition of the contributions of traditional health practices, the research of elements and practices to foster its understanding, and the improvement of the educational practices to make sure that a complete learning experience is taking place.

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Theme IIa Concurrent Session: Women Helping Women

Session Chair: Karen Otsea

The Relationship Between Government Agencies and NGOs in Implementing Women's Health Projects at the Community Level: The Experience in Tanzania

Kate Kamba, Secretary General, Women's Organization of Tanzania

Statement of Purpose: Maternal mortality in Tanzania has not declined in the last 15 years. This reflects a number of factors: the poor quality and inaccessibility of health services, high fertility linked with very low contraceptive prevalence rates, and the poor social and economic status of women in Tanzania. Additional factors include an apparent increase in unsafe abortions and growing rates of adolescent pregnancy. The Women's Organization of Tanzania (WOT) plans to complement government efforts to reduce maternal mortality by 50% by the year 2000 and play a major role in addressing the underlying and direct causes of high maternal mortality. Its major contribution will be to help educate women and other community members about reproductive health issues, and to provide family planning services for rural and urban women.

Design of Activity: A number of information and service delivery activities will be undertaken to reach rural communities, especially women. These include:

- The establishment of family planning clinics in four municipalities that will serve all women, regardless of age or marital status, with family planning and reproductive health services.
- The provision of contraceptives through a community based distribution (CBD) program that will reach young people and men.
- The development of educational materials on a range of reproductive health topics, including nutrition, indicators of high risk pregnancy and delivery, family planning methods, STDs and AIDS, and other relevant topics. These materials will be developed in cooperation with government ministries, other NGOs, and religious organizations. Dissemination will be through UWOT branches in rural areas, as well as through appropriate government and NGO channels.

These activities will complement and support efforts by the Ministry of Health to improve and expand family planning services.

Analysis of Activities: Given the scarcity of resources in Tanzania, the government's target of a 50% reduction in maternal mortality can only be achieved if major efforts are carried out to prevent maternal health complications as well as provide treatment once complications develop. Community education and family planning are the most effective (and cost-effective) means of preventing reproductive health problems. Tanzania offers a unique opportunity to test the effectiveness of these strategies in Africa because of high literacy rates, a strong historical emphasis on self help and community based activities, and the existence of a number of government agencies and NGOs that have structures reaching down to the grass roots level. These efforts must, however, be fully supported by the government, and integrated into other programs aimed at improving women's health.

Implications for the Action Agenda: The success of this initiative will provide valuable lessons in a number of areas. First, it will be a test case of close collaboration between government agencies and a large, broadly based women's organization. Second, it will demonstrate whether community education on the prevention of maternal health complications can contribute significantly to the reduction of maternal mortality and morbidity. Third, it will indicate whether education and outreach efforts targeting men and other decision makers can help mobilize support for improved women's health and family planning, and fourth it will provide an example of how women's organizations can help make family planning services in Africa less clinic based and reach a broader audience.

Women's Use of Health Services: A Survey in Rural Uganda

Karen Otsea

STATEMENT OF PURPOSE: As part of a community based, non-governmental project to reduce maternal mortality and morbidity in Uganda, a survey was conducted to identify social, cultural, economic, and other obstacles that inhibit women from using available health and family planning services. The objective was to identify ways in which the utilization of health and family planning services could be expanded, as well as to identify beliefs and practices at the community level that negatively affect women's health and well being. The information is being used to help design a health education campaign targeting women, men and other community members. In addition, results will be shared with government agencies, religious groups, and other NGOs that provide maternal and child health care to encourage them to design their services more appropriately so as to respond to women's needs, concerns, and preferences.

DESIGN AND METHODOLOGY: 340 women and 100 men were surveyed in each of the eight project districts for a total of 3,200 responses. The survey gathered background information on each of the respondents, then asked a series of questions designed to elicit information on attitudes and behavior regarding pregnancy, childbirth, and the use of family planning. The survey included questions about what types of health services are available, where women obtain antenatal care, where they deliver, who attends deliveries, and whether family members assist them with household work during pregnancy. Men were questioned primarily about their attitudes toward family planning, desired family size, and how they felt about their wives' earning income.

ANALYSIS OF FINDINGS: Survey data are now being analyzed. Preliminary findings indicate that poor health is a common condition for women, reflecting the prevalence of malaria, respiratory illnesses, and sexually transmitted diseases. Awareness of family planning is fairly high, but accurate knowledge is rare and many people harbor misconceptions about the risks and complications of various methods. Antenatal care rarely involves more than one visit. A very high proportion of births take place outside of health facilities, often in the home with a relative or TBA in attendance. Education levels are low, particularly for females. Many women report having no money, although they are often embarrassed and reluctant to discuss this issue.

IMPLICATIONS FOR THE ACTION AGENDA: Efforts to improve women's health must be based on an accurate, complete understanding of the many social, economic, and cultural factors that influence women's desire and ability to use available services. These factors can be classified as family/home environment (women's access to cash income, willingness of husband to pay for health services), community environment (social pressures to be strong and not admit illness, knowledge and awareness of local symptoms, signs, and health care services), environment attitudes of health care workers, availability of supplies and drugs, etc. Much more needs to be done to provide women with the information and tools to prevent their own health problems, assess the severity of symptoms, and to take appropriate action on a timely basis. In addition, the attitudes of men are a key determinant of women's health in terms of planning and women's ability to take action. Interventions to increase men's support for their own reproductive health is essential.

Women Helping Women: Incorporating Women's Perspectives into Health Projects

Chinyelu Okofor, Ph.D. Senior Lecturer in Nursing, College of Medicine,
University of Nigeria, Enugu

Statement of Purpose: The high rates of maternal mortality and morbidity in Nigeria have prompted a series of activities in recent years. In 1990, special seminars were held in each of Nigeria's four Primary Health Care Zones to elicit the views of local women on maternal health problems in their communities, and to provide them the opportunity to propose ways of improving the situation. More than 500 people (mostly women) participated in the seminars. The comments, suggestions and commitment to action from some of the participants of the Zone A seminar form the basis of the activities discussed in the paper.

Summary of Activities: Following the Zone A Safe Motherhood seminar, several different groups of participants approached the author, the chief organizer of the seminar, and requested assistance in planning and implementing Safe Motherhood activities in their communities. In a series of meetings with the individual groups (health and non-health professionals), and a larger meeting with all four groups, plans for multi-faceted community based interventions were devised. The groups will act independently, but meet regularly to share ideas and discuss common obstacles. The plans complement the community based orientation of the government's PHC system, and could help achieve the Ministry's goal of providing health care for all Nigerians. Specific activities are likely to include:

- (a) Seminars and workshops for community and religious leaders, women's organizations, TBAs and other local health workers to raise awareness about the problems of maternal mortality and morbidity, and to mobilize them to action.
- (b) Specialized training seminars for midwives to encourage better relations with TBAs, and to establish TBA-midwife networks in project communities.
- (c) Training program for TBAs toward identification of high-risk pregnancy and referral, family planning counseling and referral, etc.
- (d) Establishment of community-based transport schemes in cooperation with village leaders to ensure that women in need can be taken to appropriate health facilities. Schemes may include a village savings fund designated only for use in case of obstetric emergencies.
- (e) Development and use of various health education materials and media, including dramatizations of the social and medical causes of maternal mortality and morbidity targeted specifically at adolescent boys and adolescent girls/young mothers.

Analysis of activities: The author analyzes the importance of including women in all phases of project development and implementation -- from defining the problem to devising interventions and evaluating it. The importance of involving non-medical personnel in a community problem that has both medical and non-medical origins -- and similarly differing and complementary solutions -- is also examined.

Implications for the Action Agenda: The activities discussed in this paper are expected to:

- improve women's reproductive health in selected areas in Zone A.
- increase community awareness about, and response to, the many factors contributing to pregnancy-related illness and death.
- develop management and planning capabilities among the women's groups involved.

Lessons in NGO Cooperation: A Small Scale Multi-Sectoral approach to Safe Motherhood

Mrs. Henrietta Owusu, Chairperson, Ghana NGO Safe Motherhood Committee and President,
Ghana Registered Midwives Association

Statement of Purpose: Since the Safe Motherhood Initiative was launched, discussions have stressed that while a majority of maternal deaths result from obstetric complications, the more indirect and fundamental factors contributing to maternal mortality and morbidity include women's lack of education, low social, economic and legal status, and poor nutritional status. In an effort to develop an appropriately multi-faceted response to maternal health problems and death, the Ghana Registered Midwives Association (GRMA), Planned Parenthood of Ghana (PPAG), and the Ghana Federation of Business and Professional Women (GFBPW) formed the Ghana NGO Committee for Safe Motherhood (SMC). This paper will summarize the experiences of the Ghana NGO Safe Motherhood Committee (SMC) from its creation in 1989, through various stages of activity, and ending with the recent development and adoption of a plan to establish a pilot 'Safe Motherhood Care Center' in an underserved rural area of Ghana. It will present the advantages and disadvantages of such collaboration as experienced by the national NGOs involved.

Summary of Activities: In 1989, the Ghana NGO Committee for Safe Motherhood (SMC) was formed to draw upon the varying strengths of the three organizations in planning and implementing a Safe Motherhood project in Ghana. The SMC believed that activities urgently required by underserved Ghanaian women are those which:

- (1) promote the timely identification of high risk pregnant women;
- (2) ensure transport of emergency cases to referral facilities;
- (3) broaden and strengthen the skills of nurse-midwives to include family planning and related care;
- (4) train non-health care professional to compensate for limited access to medical personnel and facilities; and
- (5) promote health awareness related to pregnancy and childbirth throughout the community, and mobilize communities in the identification and avoidance of high risk pregnancies;
- (6) increase the income of rural women.

While the Committee contemplated several approaches toward achieving these objectives (from an urban clinic that would generate excess revenues to subsidize activities in rural areas, to a set of pilot projects in several areas), they have recently settled upon one site and a project plan that introduces direct health services, community health education and income generating activities in a phased approach over the initial two-three years.

Analysis of Activities: The author analyzes the advantages and difficulties of this type of collaboration, discussing issues of 'process' (conflicting schedules, changing personnel) and 'content' (different priorities, complementary skill areas) as they relate to the activities of the SMC over the past two years.

Implications for the Action Agenda: This collaborative effort is expected to:

- improve the health status of women in the selected community
- increase awareness in the community of the factors which contribute to maternal illness and death
- improve the earning potential of rural women
- serve as a model for future collaborative efforts among the Committee NGOs

Theme IIa Concurrent Session: Women's Rights Session Chair: Denise Rouse

VIOLENCE AGAINST WOMEN IN MEXICO: LEGISLATIVE REFORM AND SERVICE INNOVATIONS FOR BATTERED WOMEN AND RAPE SURVIVORS

Elizabeth Shrader Cox, MPH

Women's health issues encompass more than maternal mortality, nutrition, contraception, and medical care. Women's health status is directly linked to social status: developing countries cannot improve one without improving the other. All health problems must be addressed, including those related to violence against women. This presentation, based on recent research and interviews with Mexican PVOs, governmental agencies, and activists, will outline the problem, its public health impact, and public and private sector initiatives.

From 80,000 to 160,000 rapes are committed annually; these underestimated figures do not include conjugal or date rape. Perhaps one third of Mexican women will experience physical violence from a husband or boyfriend some time in her life. The physical, social, and psychological costs of rape and battering—in terms of injury, loss of life, work absenteeism, generational effects of violence, stress, and low self esteem—make violence against women a major public health concern.

The impetus for service innovations comes from grass roots feminist organizations. The Mexican anti-rape movement began in the early 1980s, and the first rape crisis center was founded in 1982 in Mexico City. Since that time, some thirty organizations nationwide have provided services to rape survivors. The National Network Opposed to Violence Against Women lobbies for legislative change and better treatment of rape survivors. As in other countries, feminism and the anti-rape movement are the roots of the battered women's movement in Mexico. Rape crisis counselors, struck by the lack of services for battered women and recognizing the high prevalence of domestic violence, founded in 1987 what remains the only organization in Mexico that specifically addresses the issue of battering. Outside Mexico City there exist several women's groups working on violence against women issues. These groups generally have fewer resources at their disposal, but because they are located in smaller cities, tend to have a broader impact on local populations. Details of service innovations will be discussed.

In 1988, some 100 women's organizations held the first National Forum on Sex Crimes to inform the Mexican legislature on these issues. That same year, the Attorney General convened a Commission on Violence, which has worked with prominent feminist attorneys and anti-rape groups to draft legislation, passed in July 1990, for better treatment of rape survivors and stiffer penalties for rapists. Details of the legislation will be discussed.

Mexico's legislative reforms and service innovations may serve as models for other developing countries that wish to incorporate these strategies in their action agenda to address women and violence issues.

Health Rights in Chile and the Convention on the Elimination All Forms of Discrimination Against Women

Claudia Iriarte, Programa de Salud y Políticas Sociales, Chile

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was ratified in Chile in 1989. If this is to have any significance for women, changes in laws and policies must follow. PROSAPS, a nongovernmental organization for applied research, policy analysis and public education related to health, reproductive rights and status of women is analyzing the civil and criminal codes as the first step toward finding the areas where legislative reform is needed in order to put the principles of the CEDAW into Chilean law. The time for prompt action is propitious given the free election of a government after 16 years of military dictatorship.

The project involves the Ministry of Health, the Parliament, the Chilean Bar Association, the National Women's Organization, medical societies, the family planning association, and human rights groups, working in task forces on sections of the law appropriate to their organizations. Direct influence on policy makers comes from the composition of the task forces and the high levels of the members within their organizations.

Articles of the CEDAW provide the framework for the analysis of laws, synthesis of findings, and advocacy or policy change. For example, Article 16 which seeks to eliminate discrimination against women within marriage and the family raises the question as to safeguards for the rights of women to decide the number and spacing of their children, and access, without asking permission, to information and services for family planning. The PROSAPS project is documenting the deficiencies in Chilean law with respect to those rights.

The organization of this project, the documents produced, and the process of analysis and dissemination of findings demonstrate an effective way to conduct research on the legal and social context of women's health status. Of particular importance is the example this project gives of the use of CEDAW to mobilize support for the Women's Health Agenda.

Strengthening Women's Rights to Health Care in Togo

Mme Ava Nana
Member, Togo Supreme Court

Mr. Papa Gaya
INTRAH Regional Director
for Franco phone Africa

Despite their strong traditional role in the country's economy, women in Togo have only recently gained legal rights to make decisions about their reproductive health care. This presentation by the author of the Togo Code of Persons and Families traces the traditional status of Togolese women and outlines the changes made by the Code of Persons and Families, adopted in the mid-1980s. With emphasis on the women's protection section of the code, the presenters discuss women's rights to health and family planning services without spousal consent. It also describes the impact of the new Togo National Family Planning Service Policy. Finally, Togo's situation is compared with that of other African countries, and general recommendations for action are offered.

Public Health Advocacy on Behalf of Women in Sao Paulo: Learning to Participate in the Planning Process

Authors: Livia Maria Pedalini, Centro de Estudos e Pesquisas de Direito Sanitário F.S.P.-U.S.P.; D. de Souza, N. Agreass, Pastorate for Health and Marginalized Women; M. B. Valente, D. B. Kawabata, São Paulo Municipal Health Department, V D'Assisles, East Zone Health Movement; A.L.P. Schritzmeyer, Brazilian Bar Association

In 1988, a new constitution was adopted in Brazil in which guidelines for community participation in the development and implementation of the national health system were delineated. The health and welfare of women and children were given high priority. Implementation of these guidelines present a major challenge in a city such as São Paulo with a population of 15 million (of which an estimated 5.0 million are women of childbearing age). The City's Municipal Health Department offers a variety of health services. In order to determine the extent to which community organizations are actively participating in planning health services for women and children in São Paulo, a study was undertaken by the Center for Study and Research in Public Health Law, University of São Paulo, and representatives of the Health Movement of the East Zone, Pastorate for Marginalized Women, Brazilian Bar Association, and the Health Pastoral Agents Training Project, the São Paulo Municipal Health Department, and the Maternal and Child Health Program, Columbia University School of Public Health. The purpose of the study was to develop a profile of community organizations, examine their role in planning services for women, and to develop a basis upon which technical assistance programs in the areas of law and public health could be developed. A sample of 12 community organizations in 4 zones of the city were selected. In-depth interviews were conducted.

This paper will describe these organizations, their constituents, membership, history, funding, advocacy objectives and strategies used and results obtained. The information gathered indicates that the majority of community organizations (movimentos populares as they are known in Brazil) are organized and led by women, they are involved in activities which include specialized courses on women's health including the status of women's work, sexuality, discrimination, family planning and the politics of health, publishing newsletters and producing radio programs, and major efforts to improve access to health care. One such organization, for example, reports that several new hospitals and health posts were constructed as a result of their advocacy. However, these organizations also report barriers to progress such as sexual discrimination and socio-economic conditions.

Theme II Roundtables

WOMEN IN DEVELOPMENT OR MOTHERS IN CHILD SURVIVAL? SHIFTING INTERNATIONAL STRATEGIES AND EMERGING NATIONAL PRIORITIES IN HEALTH SECTOR DEVELOPMENT.

Saha AmaraSingham

Major changes in development strategies adopted by international donors in the 1980s has changed the focus of development assistance from multi-sectoral, integrated approaches to single, vertical interventions. In the health, population, nutrition sectors this has led to the disruption of the previous two decades' strategies where the emphasis was comprehensive plans in setting national priorities for health sector development. As the Third World nations enter the 1990s the ambitious goals set forth in Health for All by the Year 2000 have been abandoned in favour of the survival of children through single, supposedly more attainable interventions through the mother who was to be the vanguard of Primary Health Care, which would be strengthened through programs in Maternal and Child Health, Family Planning, and Family Health programs.

Instead, the new emphasis is that the mother will take on the role of the woman who will become the beneficiary of the more profitable programs of Women in Development that will change the societal configurations which, in the year 2020 or beyond will benefit all developing countries.

This paper will examine MCH, FP, FH and WID programs in the Philippines, Sri Lanka, Pakistan, Bangladesh, Egypt and Jordan to support the thesis that the conflicting role of mother and role of development woman will seriously disrupt and severely damage the gains that were made in improving the health status of children during the past two decades. The data of donor assisted programs from these countries will be used extensively to demonstrate that the shifting international donor strategies are not in synchronization with the emerging national priorities which were jointly agreed upon as the path for achieving the goals of Health for All by the Year 2000 at Alma Ata.

Infection Control: The Forgotten Factor in Providing Safe Family Planning and Maternal Health Services

Marcia Angle, M.D., M.P.H.

Improper or incomplete infection control procedures in family planning and primary care service facilities put women's health care providers, other clinic workers and patients themselves at significant risk for infection or cross-infection.

Basic infection control measures that can be easily and inexpensively practiced in FP and maternal health clinics include barriers (gloves, etc.), washing, decontamination, high level disinfection, sterilization, and containment and proper disposal of clinic wastes. The presentation will discuss the risks of cross-infection, define preventive measures and outline their practical applications under conditions of limited resources. Simple infection control precepts will be suggested for use in training programs for several categories of clinic personnel.

AIDS PREVENTION IN FOUR COMMUNITIES OF KENYA

by

Milton Amayun, MD, MPH
Alemu Mammo, DrPH
Florence Muthuuri, SRN

In 1989, World Vision Kenya started the implementation of an AIDS prevention program with funding from the HIV/AIDS Prevention in Africa (HAPA) program of USAID. The purpose of the project was to reduce the transmission of HIV/AIDS among selected high risk groups in four communities of Kenya (2 urban slums, 1 peri-urban and one rural). The primary approach was to integrate information, education and communication (IEC) activities into ongoing health and development activities. Methodologies included mass media campaigns, counselling, volunteer health worker training, and active involvement of persons with AIDS (PWAs). Targetted groups were in- and out-of-school youth, women of childbearing age, drivers, prisoners, commercial sex workers and intravenous drug users. Whenever possible, peer educators and PWAs were involved in the dissemination of key messages. A series of KAP surveys are planned to measure program impact, with a baseline survey completed at the start of the project.

The use of peer educators and PWAs was significant in reaching high risk groups like commercial sex workers and intravenous drug users, but the stigma of the disease in the general population prevents them from being effective in the community at large.

The first year of project implementation indicates the following lessons learned:

1. There is a fundamental need to target groups according to level of risk with different methodologies.
2. The use of messages in targetting high risk groups should not only take into consideration the group targeted but also the socio-cultural characteristics of the communities.
3. KAP surveys may be helpful in measuring long-term impact, but they are costly, time-consuming and can detract the project from pursuing planned interventions.
4. AIDS prevention programs cannot ignore the enormous material and emotional needs of PWAs.
5. The increasing numbers of orphans and their needs will become an important factor in measuring the impact of HIV/AIDS in Kenya.

Successful Models of Participatory Planning, Implementation and Management of Women's Health Programs

Author: Maureen Rowley Barnett

In the United States we are currently witnessing the feminization of healthcare. Women are the primary users of healthcare services, make 85 percent of the healthcare decisions, and will be cared for by an increasingly feminized provider population. This trend has led to a growing number of hospital sponsored women's programs that vary from on-site education only to full service ambulatory care centers including primary care, diagnostics and education.

Regardless of structure the successful system will challenge traditional stances toward patient autonomy, decision-making, and collaboration. These programs respond to key issues for women in healthcare: an attitude change, the de-medicalization of women's normal functions, shared decision-making and gender specific information. This presentation will focus on U.S. programs and implications for developing countries, demonstrating models of participatory planning and management with women as key providers.

Methodology

The OMNI Center for Women's Health & Medicine, a full service ambulatory clinic beyond reproductive care will be the focal point of discussion, with emphasis on planning, marketing and management. In addition, evidence of the common principles guiding other successful programs throughout the U.S. will be incorporated to support the stance that patient autonomy, shared decision-making and collaboration are essential.

Analysis of Major Findings

The achievement of program objectives for U.S. hospital-sponsored women's programs will be evaluated against utilization, patient satisfaction surveys and market research.

Implication for the Action Agenda

The lessons learned from the women's movement, the feminization of healthcare, and successful program development provide both a theoretical framework and practical application for meeting women's health needs in developing countries.

Theme II Roundtables

The Importance of Educating Men in Women's Health Issues: Surprising Findings From a Pilot Project to Train Birth Attendants in Rural Papua New Guinea

J. Brabec, B. Rasmussen, RN

Statement of purpose:

The implications of educating men about issues involving women's health care needs are examined, based on Project Concern International's (PCI) pilot project to introduce the role of village birth attendant (VBA) in rural Papua New Guinea (PNG).

Design and Methodology:

PCI has successfully trained women to serve as birth attendants in 15 villages in rural Papua New Guinea, where obstetric services and perinatal care are virtually non-existent. Within the project site and generally throughout PNG, the role of traditional birth attendant is not well-established, owing to a cultural taboo against female blood, which is considered very dangerous to men. Women, including pumparas, either give birth alone, often in secluded areas of the bush, or with the assistance of another woman with neither training nor skills in birthing procedures.

The PCI project recruits and organizes villages, after securing initial approval from the male village elders. Each village selects two candidates for VBA training. The VBAs are trained to provide perinatal care, including nutrition counseling and promotion of tetanus toxoid vaccination. They must demonstrate competency in safe birthing techniques for uncomplicated deliveries and in the identification and referral of high-risk pregnancies and deliveries.

Analysis of major findings:

In the initial recruitment of villages, we were gratified by the interest in the project shown by the men in the majority of villages we approached. In one case, a village that was not recruited for the project requested to be included, and the men constructed a birthing house to demonstrate their commitment. In two other villages, men requested and were given a course in reproductive physiology, family planning, STD, and the effects of nutrition and lifestyle on pregnant women and babies. Men are now offered this course as part of the project. In addition requests have come from male-dominated organizations in non-project villages. PCI has documented in the last year that in the villages where it has trained a VBA, 37% of births now receive trained assistance, in contrast to an estimated 5% of births receiving trained assistance in the rest of the district.

Implications for THE ACTION AGENDA:

The education of men in health problems faced by women, and their involvement in the solutions, have profound potential for effecting positive change in the general status of women in these villages.

Financing Accessible Health Care: Issues in Family Decision Making and Resource Allocation

M. J. Burns

In most industrialized nations, health care is financed at the national level. There is a presumption of universal, uniform coverage; access, availability and quality of care, however, may not be equal. In principal, women and infants have the same access to health care as men, but they may disproportionately suffer when services required only by women and infants are targeted for reduced funding. In the developing world, there are insufficient fiscal resources to provide national health insurance, and not enough health care providers to meet the needs of the population in general or of women and infants in particular. In both the industrialized and the developing countries household financial resources are insufficient to pay health care fees, severely limiting access to services, and skewing health care delivery.

Access to health care may be further inhibited by control of financial resources and decision making within the family. The extent to which men control financing of and access to care for their families in the industrialized or the developing world, and the extent to which monetization and other forms of economic and financial development shift resource control in traditional societies from women to men, merit further study. Among poor families financial and other resources are generally too limited to permit adequate access to health care, and men's control of family finances, decision making and time allocation -- a control which may be increased by monetization and salarization -- may further inhibit access to scarce health resources.

Access for women to health care can be improved by public financing of free health clinics for women and infants -- the costs of which are paid off many times in subsequent foregone costs -- and the establishment of a direct relationship between health care providers and women and their infants, a relationship that does not require participation of men as controllers of family decision making and family temporal and financial resource allocation.

Reducing Infant Mortality Risks through Multiple Interventions in Pregnant Teens

Patricia Canessa MA
Karen Robson MA

Infant mortality rates have been drastically reduced by the Arts of Living Institute (a comprehensive adolescent pregnancy program funded by a joint effort between the State of Illinois Department of Public Health, the City of Chicago Board of Education and United Way under a private child welfare agency) through the utilization of a multidisciplinary and inter disciplinary interventions. A total of 1,200 pregnant adolescent (90% below poverty level), ages 11 to 19 are involved every year in the program receiving continued academic education within an alternative school setting to compensate poor achievement levels and motivate school engagement. In the same site, a WIC Nutrition Program provides nutrition-diet information and food coupons on ongoing basis, and an strong educational component is built within the school day providing health, social skills and parenting training through a partnership with a private social agency, who also provides additional supportive services that include individual and family counseling, referral to perinatal centers, outreach and follow up, home visiting and primary health screening. The Infant Mortality rate was reduced from 22.0 per 1000 in non white low income population at the city of Chicago level to 6.0 per 1000 in the isolated high risk population. Other positive outcome relate to reducing the rate of repeated pregnancies from 35% in the city to 5% in the selected group increase of birth weights to an average of 7 lbs, and diminishing the prenatal and postnatal complications of adolescent pregnancy and delivery.

The program impacts young women in helping them to become more informed and able to make mature decisions and choices around the health, reproductive, vocational and social aspects of their lives, therefore improving the opportunities for their children. Other aspects such as maternal bonding, school enrollment and ability to reach out to supportive systems were substantially increased.

The Male Role in Women's Health A Framework for Analysis and Action

Nick Danforth and John Karefa-Smart, MD

From birth onward, the longevity and quality of females lives are commonly affected by a range of male attitudes and behaviors. Men may affect female health directly by discriminating against wives and daughters in family and community decision-making (such as in deciding who eats what, or where water and sanitation facilities will be located), by vetoing maternal health care, or by physical abuse. Less visibly, men often affect women's health unconsciously by preventing their wives from having the time, money, or education which would enable them to seek health, nutrition, sanitation, or family planning services.

This paper outlines the range of male behaviors which affect women's health and provides a framework for analyzing and understanding those behaviors. The purpose of this framework is not only to demonstrate both the negative and positive roles played by men in women's health but also to indicate ways in which male roles in different cultures can be better understood and, in some cases, improved. Examples of West African and other programs designed to improve male involvement in safe motherhood and maternal-child health will be discussed.

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BASIC HEALTH EDUCATION FOR SAFE WATER SUPPLY
Margaret Kaseje and Lazarus Koech
Community Initiative Support Services
Kisumu, Kenya

The objective of the Basic Health Education Project initiated in 1989 was to assist rural communities to improve and take care of their own water resources over a period of 36 months. In addition, the community was encouraged to practice basic health hygiene related to safe use of water, through a strategy of providing basic health education to groups and households. The Project was located in South Gem, Siaya District, Kenya and worked with existing groups with a total population of 40,000 comprising 6,500 households. Most of the community groups had women members as the majority.

A community based health care model was used with the assumptions that the community provides the major drive and impetus for sustainable change in improved health in a given community and that any health intervention must use an integrated approach.

Since women are the main users of water, the Project undertook to find out women's attitudes toward safe and adequate water and sanitation as a prerequisite for an effective health care strategy. The process and impact of women's involvement in the water and sanitation program was analyzed and evaluated. Women's role in planning and implementation of the water program before and after the information and education intervention was determined. Changes in household labour distribution and economic returns to households resulting from the water technology intervention was assessed. Perceptions and social values on women's role before and after the intervention was also determined. The Project documented acceptance and use as well as non-acceptance and mis-use of various improved water and sanitation systems by women as influenced by their needs and physical status. Emphasis was on sustainable activities using existing community resources and other relevant services. Health education messages were linked to existing beliefs and practices and were aimed at improving health practices related to water. The messages were developed together with the community over a period of one year.

Preliminary results indicated that while access to appropriate sources of clean water proved difficult, traditional attitudes toward 'clean' water and proper use of water was a major constraint. Perceived roles of men, women and children in everyday household use of water was also a constraint. Conclusions are that: A community based approach in addressing water related health problems is more likely to produce sustainable change, particularly where traditional attitudes and practices are addressed. Community resources are limited but can be efficiently used when augmented with resources of other service providers such as government and non-governmental organizations. Addressing gender roles in water related activities requires full participation of every segment of the community. Women are directly concerned with water and sanitation but their participation needs to be made more effective and productive.

MORTALITY IMPACT OF A COMMUNITY-BASED MATERNITY CARE PROGRAM
IN RURAL BANGLADESH

By V. Fauveau et al.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

A programme to reduce maternal mortality was implemented and evaluated as part of a primary health care project in a rural area of Bangladesh. The programme consisted in posting trained midwives at two decentralised health outposts, with the responsibility of attending as many home-deliveries as possible, detecting obstetrical complications at their onset, and managing these complications on the spot, or accompanying the patients to the project maternity centre for higher level care. The impact of the programme was evaluated by comparing obstetric maternal mortality ratios between the programme area and a neighbouring control area without midwives. Other characteristics, including coverage and utilisation of health services and family planning were similar in both areas. Ratios per 1000 live births maternal deaths due to obstetric complications were similar both areas during the three years preceding the start of the programme (4.4 vs 3.8 per 1000 live births, ns). In contrast the ratio became significantly lower in the programme area than in the control area during the three years following the start of the programme (1.4 vs 3.8 per 1000 live births, $p=0.02$). Ratio of deaths from causes other than obstetric were not different.

These results suggest that posting midwives in villages, a giving them the means to home treat common obstetrical problems at their onset or to refer them, have the potential to decrease direct obstetric mortality rates by as much as two-thirds. Inputs for such a programme to work and the constraints for its replication at a large scale, however, should not be underestimated.

Breastfeeding as a Women's Health Issue

Miriam Labbok, M.D., M.P.H., Director, Breastfeeding and Maternal and Child Health Division, Institute for International Studies in Natural Family Planning, Georgetown University, Washington, D.C.

The legitimacy of breastfeeding as a cornerstone of child survival strategies has long been established. Traditionally, breastfeeding promotion efforts have focused on increasing (or preserving) the incidence and duration of women's breastfeeding practices, especially exclusive breastfeeding, for the wellbeing of her infant. More recently, breastfeeding promotion efforts are beginning to highlight the child-spacing aspects of breastfeeding as beneficial to women's health as well as to overall population goals. Although it is recognized that there are maternal benefits to be derived from breastfeeding, these benefits are generally considered of lesser importance.

This presentation is essentially a position paper as the time is long overdue to establish breastfeeding as a major factor impacting women's health and overall well-being. Clearly there are physiological benefits to be derived from breastfeeding, among them, lessened blood loss in the post-partum period, reduced incidence of hemorrhage and rapid uterine recovery following the birth of a baby. Exclusive breastfeeding sustains lactational amenorrhea and a result, prolonged infertility which permit a woman's body to recuperate and be replenished prior to the onset of a monthly blood loss and/or a new pregnancy. Recent studies also indicate breastfeeding may reduce the incidence of ovarian and breast cancers, thus identifying breastfeeding as contributing toward women's well-being across the life-span.

Rarely, however, can the status of women who are mothers be evaluated apart from the status of their children. From the perspective that maternal and child health/well-being are interdependent and interactive processes, breastfeeding also contributes to a woman's overall health and well-being as her infant's health is assured, as she has income available not spent on infant formula and has more time available not caring for an infant ill from the effects of bottle-feeding. Likewise, the income generated by a mother's employment has been found to increase a woman's options, the amount of disposable income available to the family, and thus, the health and well-being of her children. An increased understanding of these interacting processes in a mother's life will enhance our understanding and resolve in including breastfeeding in the agenda to improve women's health and overall well-being across the lifespan.

"Meeting Church Health Workers' Training Needs in Women's Health"

Jeanne Betsock Stillman, B.A., M.S.P.H., Director, New York Office, Institute for Development Training, and Bola Lana, Program Officer for Clinical Services and Training, Pathfinder Fund, Family Health Services Project, Lagos, Nigeria

Statement of Purpose: This paper reports the results of projects to adapt and expand prototype curricula of the Institute for Development Training to meet the needs of church-related health workers in Nigeria, Kenya, and Indonesia, and highlights results from China. These curricula include the *Training Course in Women's Health*, and the *AIDS Curriculum* originally developed with IPPF. In each country (except China) the church-related health system is the second largest; e.g., in Nigeria it represents 40% of all health services. Despite its size and significance, this system is sometimes neglected by governmental and donor agencies. We address the methodology of the adaptation process, including its technical assistance component and the pattern of collaboration established with representatives of the church health network, other PVOs, ministries of health and donors.

Design and Methodology: We present and compare case study illustrations and analyze correspondence and trip reports, interviews, data from pre-tests and post-tests of training materials, budgets, and workshop evaluations.

Analysis of Findings: The paper: (1) provides a comparative analysis of adaptation issues encountered in the study countries (women's health status, target audience, language, level, availability of materials, cost, utilization, etc.); (2) highlights special needs and interests of the church-related health sector, e.g. establishing relationships with traditional medicine, holistic approach to health care, the spiritual role of the health worker, etc.; (3) identifies the "felt needs" and key training issues in women's health in specific countries, e.g., "female mutilation," "vesico-vaginal fistulae," "role of women as caretakers for persons suffering from AIDS," "special needs of minority groups"; and (4) addresses issues related to coordination and collaboration with government health services, other PVOs, and donors.

Implications for the Action Agenda: If we are to meet the health-care and educational needs of all women, the importance of addressing the training needs of health workers in the church-related health sector is clear. This paper provides insights into: (1) a model approach for meeting these training needs; (2) issues and approaches unique to the church health sector; and (3) the benefit of adapting training materials from an existing base so as to promote cost-efficiency. The paper also provides insights into useful approaches to working with church health networks, including collaboration with other PVOs and with donors and addresses needs for follow-up work.

It may be noted that the Primary Health Care movement began with church-sponsored programs in several countries around the world. We may find that the churches' new approach to holistic health care coupled with PHC will be the wave of the future in addressing women's health, roles and status and combatting the special health risks women face by "just being female".

Theme II Roundtables

Practical Considerations for Women's Health and AIDS Curriculum Development Projects: Examples From Nigeria and Kenya.

Katherine Mason MPH and Hadi El Tahir, MD MPH

The education and training of health providers is an essential component in the achievement of health for all. In many developing countries, however, health workers do not have the opportunity to receive adequate in-service (i.e. on the job) training.

The need to update and strengthen skills in service delivery has been identified by health care providers as well as policy-makers.

To increase the effectiveness of training, instructional materials must reflect community and national health priorities as well as the educational, professional, cultural, and language needs of the learning audience. Where resources are scarce, a strategy in curriculum development is to adapt existing prototype modules to fit the needs of the targeted learning audience. The focus of this presentation will be the establishment of international cooperative projects to adapt women's health and AIDS prototype training materials produced by the Institute for Development Training.

The planning for such projects requires numerous practical considerations. Through discussion of upcoming adaptation projects in Nigeria and Kenya, the panelists will underscore the logistics and necessary groundwork that may supply the basis for successful project implementation. The authors staffed these projects as interns of the MCH International Public Health Internship Program of Columbia University, which is funded by The Pew Charitable Trusts.

Distribution of Risk Factors for Poor Pregnancy Outcome by Place of Delivery in Ahmedabad, India. By: Dr. D.V. Mavalankar, Dr. C.R. Trivedi, Dr. R.H. Gray.

The risk approach is an accepted as important means of delivering targeted health care to mothers and children. Fundamental to it is the assessment of risk in the community. The purpose of our study was to assess the prevalence of known risk factors for poor pregnancy outcomes in the city of Ahmedabad, India. This information is required to assess population attributable risk so as to design preventive programs.

A sample survey was conducted among mothers who had delivered in the past year. A two stage cluster sample was used to identify 1,169 mothers of whom 92.7% were interviewed. Information was collected on sociodemographic, maternal biological, antenatal and behavioral factors related to poor perinatal outcome.

Fifty one percent of the mothers had delivered at government institutions, 32% delivered at private maternity homes while 18% delivered at home. Almost all home deliveries were carried out by untrained birth attendants. These three groups of women differed substantially on prevalence of important risk factors such as obstetric history, maternal anthropometry, use of antenatal care and diet. Overall, the mothers delivering at private maternity homes came from higher socioeconomic group, mothers delivering at home came from the lowest socioeconomic group while those delivering at government institutions were from lower to intermediate group. Use of the prevalence information to calculate population attributable risk is demonstrated.

The differences in prevalence of risk factors by place of delivery has important implications for organization of Maternal health services in the community. Any intervention program must take into account differing risk distributions among subgroups of mothers in a community. Barriers to use of available services are discussed.

Self-care: An International Research Initiative in Women's Health
McElmurry, B.J., Huddleston, D.S., Poslusny, S., Al-Gasseer, N., Tlou, S., Hamede, H., Chaiphitbalsarisd, P., Um, I.

WOMEN'S PERCEPTIONS OF REPRODUCTIVE TRACT INFECTION - A RURAL BANGLADESH STUDY

By
Ms. Rezina Hita
Ms. Churamonie Jagdeo
Dr. Maxine Whittaker
Dr. Kate Stewart

In order to improve the acceptability of MCH-FP service delivery within the Bangladesh programme, and to better address an identified problem of reproductive tract infections, the authors undertook a qualitative research study in Matlab, Bangladesh.

A small sample of women, including contraceptive users and non-users, were interviewed in depth by trained local social scientists. Concepts of discharge, when and why does a reproductive tract infection become a problem for these women, management strategies adopted and their perceptions of cause and effect were elicited. In addition, women's perceptions and experiences of "the male factor" are elicited. Treatment expectations - both type and outcome - are also defined.

From this study, the authors have developed more sensitive verbal screening and follow-up tools for service providers. In addition, they have gained a fuller understanding of the meaning of different terms used and their correlation with "clinical syndromes" in order to facilitate broader 'incidence' studies in the near future.

Statement of Purpose. This paper presents a series of studies conducted as part of the development of an international research initiative in women's health. This initiative in women's health for midlife women was developed and administered within a framework that fostered international collaboration of nurse researchers. The research focused on the self-care responses of perimenopausal women in Bahrain, Botswana, Brazil, Thailand, and the United States. Self-care is defined as health promoting actions and cognitive behaviors. The women's perspective on self-care includes the use of medical care and other therapies. For women, the menopause and the time around the menopause are universal phenomena that lend themselves to crosscultural study.

Description of the design and methodology. Perimenopausal women between the ages of 35-54 were surveyed or interviewed using the Self-Care Response Questionnaire (SCRQ) which has been translated into Arabic, Setswana, Portuguese, Thai, and Korean languages. The (SCRQ) is a 41-item Likert-type scale with 5 points, 1=Never, 2-Sometimes, 3-Usually, 4-Often, and 5-Always. The questionnaire was completed in the United States by 186 perimenopausal women in the Chicago Metropolitan Area, including a group of Brazilian immigrant women (n=10), Korean immigrant women (n=30), and by 10 perimenopausal women each in Bahrain, Botswana, and Thailand. In addition, the SCRQ was completed by 25 women in Brazil.

Analysis of major findings. Perimenopausal women use similar self-care responses in Bahrain, Botswana, Brazil, Thailand and the United States. Cultural differences suggest the need to develop a pool of culturally appropriate self-care responses along with more general responses that can be used in any culture. The similarities and differences between the women are discussed in detail.

Implication for The Action Agenda: Subtheme I, The Status and Determinants of Women's Health--Factors that directly affect the health of women. With adequate knowledge about themselves and their bodies women can use self-care to manage the health concerns that they experience in their day-to-day lives. This knowledge allows perimenopausal women to appropriately select health actions and behaviors including medical care if needed. With the limited resources for health care in the United States and other countries, self-care is an ideal means of promoting and maintaining women's health.

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Theme II Roundtables

THE INFLUENCE OF REPRODUCTIVE STATUS ON RURAL KENYAN WOMEN'S TIME USE

Michael Baksh, Charlotte Neumann, Michael Paolisso, Richard Trostle, School of Public Health, University of California, Los Angeles.

To determine the effects that pregnancy and infant care have on Embu women's productive work activities, time use patterns were calculated for women at different stages of pregnancy and lactation, as well as for women who were neither pregnant nor lactating.

Time allocation data were collected from 169 households, from March 1985 through February 1986 by use of the spot observations technique. Households were visited approximately six times, at random intervals over the year. Detailed reproductive data were collected monthly, and household socioeconomic status (SES) data, quarterly. The 169 households are a subsample of the 247 that participated in the Nutrition Collaborative Research Support Program.

Results demonstrate that when women become pregnant, considerable "productive work" time that otherwise would be spent performing commercial activities, subsistence agriculture, housework, and tending animals gives way to a significant amount of time caring for children, and, to a lesser extent, being inactive and socializing. Work activities are curtailed especially in the 3rd trimester of pregnancy and the 1st period of lactation. Over the two-year pregnancy and lactation cycle, the pregnant/lactating woman devotes about 53 fewer days to commercial, subsistence agricultural, and other "productive work" activities than the non-pregnant/non-lactating woman. Low and medium-low SES women in their 3rd trimester of pregnancy work less (50-52% of daily time) than high and medium-high SES women (61%). Rest during pregnancy and child care responsibilities during lactation are the major factors accounting for these time use patterns.

These findings highlight the economic "losses" due to continuous cycles of pregnancy and childbearing. The loss of 53 work days over two years by a pregnant/lactating woman places considerable stress on household food production and income generation, particularly among those households that are already in poor economic condition. Longer birth spacing intervals would enable rural women to devote more time to economically productive activities.

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Women's Health Training: What do we mean?

R. Rodriguez-Garcia, Assistant Professor
Director, Education and Communication, Georgetown University, IISNFP

A key component of an action strategy for women's health is to encourage the education and training of health professionals to support, protect and promote the health of women and to provide appropriate women-centered health services.

But what do we mean by women's health? What main areas ought to be included in a women's health course?

This roundtable will attempt to move beyond the label "women's health" and analyze the underlying values and principles that guide the teaching of women's health issues. Participants will 1) identify the core areas of a women's health course; 2) discuss the rationale for inclusion and exclusion of topics; and, 3) propose a theoretical and empirical framework for women-centered rather than provider-centered teaching and service interventions.

Planning Drug Treatment for Pregnant/Parenting Women Through Interviewing Treatment Experts and Drug-Using Women Themselves

Authors:
Denise Paone, MS, Jane McPherson, BA & Wendy Chavkin, MD, MPH

Alarm has been expressed widely about the widespread use of crack by young United States' women who are bearing and raising children. Both the nature of crack/cocaine, and its popularity among childbearing women represent new phenomena. Currently, attention is focused upon the lack of available treatment designed for these women, and especially upon the exclusion of pregnant women from existing programs. Available data indicate that the services offered by traditional drug treatment models have not effectively engaged these women in recovery.

In order to determine what would constitute appropriate and effective treatment for this population, we have employed a two-tiered study design: Part One consists of a survey of 51 national experts from the fields of drug treatment, child welfare, criminal justice, research, evaluation and advocacy; Part Two includes interviews with 150 New York City women who use or have a history of using crack/cocaine. This sample is drawn from women in treatment (N=75) and women not in treatment (N=75) in order to reflect the range of life experience.

Preliminary data reveal that the majority of women report: homelessness during the past two years; history of sexual abuse; guilt or embarrassment associated with seeking prenatal care as a drug-using pregnant woman; and that their children are motivational factors in their seeking drug treatment. Similarly, the experts surveyed report that the woman's life problems --such as homelessness, domestic violence and poor health status-- must be addressed as part of drug treatment. Experts concurred that in order to engage and retain women, drug treatment must be supportive, women-centered and provide services to children. Experts identified lack of access and lack of child care as the two major barriers to drug treatment for pregnant and parenting women.

The results of this study have been used to design a comprehensive drug treatment intervention. Only from such a triangulated approach, which draws on the self-knowledge of the target population as well as the professional wisdom of experts in the field, can exemplary services be developed. This study has important implications for program design, practice, research, and for the Women's Action Agenda. We recommend that health services for women be sensitive to women's histories, and their child care responsibilities, and further that program design should draw upon the opinions of the target population.

Reaching Highest Risk Pregnant Women: Experiences and Lessons from New York City

Zell Rosenberg, M.D., M.P.H., Marta Baez, Robert Gatti

Pregnant low income and minority women in New York City have been documented to receive very late or no prenatal care (20% citywide and over 40% in selected communities). These women often have additional risk factors in their medical profiles (e.g. polysubstance abuse, homelessness, risk for AIDS). It is not surprising that infant mortality rates (e.g. 13.1/1000 live births citywide and 20.9/1000 in East Harlem) continue to remain much higher than N.Y. State (10.7/1000) and U.S. National (10.1/1000) averages.

In order to reach the hardest to reach poor pregnant women, two approaches have been vigorously implemented in the New York City Metropolitan Region: (a) increased financial access to services through the statewide Prenatal Care Assistance Program (PCAP) with expanded Medicaid eligibility and (b) development of model "community health worker" cadres, employed and supervised by grassroots community organizations, bringing health services to target women's homes.

For PCAP we report program utilization estimates following first year implementation of streamlined eligibility criteria to include women with incomes up to 185% of the poverty line notwithstanding legal residency status as well as results from a series of in-depth, on-site case reviews. These reviews highlight current barriers for bringing high quality services to ethnically diverse inner city populations as well as proposed solutions.

For community health workers, we detail how the special approaches used to select, train and supervise these workers in eight distinct high risk target geographic areas relate to the unique health needs found in the communities themselves.

Lessons learned in serving these highest risk, low income pregnant women-- common to developing and developed urban settings-- in urban areas are summarized. Issues involving community mobilization, social marketing, integrated service delivery by community based workers, overcoming language and cultural barriers, and ensuring program quality through monitoring are highlighted.

Theme II Roundtables

IMPROVING ACCESS TO HEALTH CARE BY INTEGRATING GENDER ANALYSIS WITH INSTITUTIONAL DEVELOPMENT

Authors: Pat Krackov and Ralph Stone

CEDPA has designed a series of training modules on gender issues to facilitate women's access to health care in developing countries. These modules have been designed to enable:

- a) individuals to gain new awareness of gender issues;
- b) organizations to institutionalize gender specific policies and guidelines;
- c) project teams to incorporate gender variables as standard components of the planning, implementation and evaluation process.

Key components of the training modules include: discriminatory practices, male-female power relationships, networking, access to resources and institutional management. CEDPA will outline the processes used to transfer this information from the individual to the organization to the project.

CEDPA will describe how, by focussing on all three levels, it bridges the gaps between individual awareness and institutionalization of gender analysis in the programming process.

The implication for The Action Agenda is that organizations should examine the impact of gender issues on institutional management. This process will commit organizations to improve access to health care by removing gender barriers.

Prevailing Patterns and Policy Issues in the Use of Public Prenatal Care Services in Jamaica

Mrs. Joan Rawlins, Research Associate, University West Indies
Carolyn Sargent, Department of Anthropology, Southern Methodist University

Government health policy in Jamaica encourages prenatal care from the first trimester of pregnancy. However, low-income women continue to obtain prenatal care late in pregnancy or not at all. This research analyzed prevailing patterns of prenatal care in Kingston, the capital of Jamaica. Women attending prenatal clinics (N=200) and postpartum patients (N=50) at the primary maternity hospital in Kingston, as well as 50 pregnant women in two low-income neighborhoods in the Kingston environs were interviewed to determine factors influencing their use of prenatal care services. Research methodology included structured interviewing of clinic patients and neighborhood women as well as participant observation in clinics, the hospital labor ward, and in a low-income neighborhood, over a one-year period. In addition, nurses in the prenatal clinic, neighborhood clinic, and on the maternity hospital wards were interviewed regarding attitudes and behavior that might affect women's use of prenatal care services. Nurses also offered interpretations of observed patterns of patient behavior. Pregnant women in both clinic and neighborhood samples were aware that prenatal care was necessary but for many women, an occasional visit served as sufficient assessment. Neither financial constraints nor an unpopular blood donation requirement constrained women from seeking early prenatal care; in the absence of alternative low cost maternity care options, the widespread dissatisfaction with conditions at the public maternity hospital did not affect women's use of hospital prenatal or delivery services. Contrary to expectations, multiparous women had more prenatal visits than did primiparas. The cultural construction of pregnancy as life cycle event rather than pathological condition may account for expressed indifference to medical surveillance during pregnancy. Policy recommendations based on this research address the need for modifications in health educator agendas, for urgent attention to structural conditions affecting delivery of services at the public maternity hospital, and for the development of alternative approaches to the delivery of maternity care to low-income women.

Role Reversal: Why Women in a Developing Country Use Less Hospital Care Than Men, In Contrast to Women in Developed Countries

Marcia Weaver, Ph.D.

One of the more important stylized facts about health services use in developed countries is that women are more likely to use health services than men (Fuchs 1974). This fact is true even after controlling for gynecological and obstetric care. In the United States, it is estimated that 63 percent of hospital patients are women and 37 percent are men. Although women are more likely to enter a hospital than men, among men who enter a hospital, the length of their hospital stay is on average longer than that of women (nine days for men and 16 days for women) (Sindalar 1982).

Data from the 1988 patient surveys at Mifamey National Hospital in Niger are used to calculate comparable statistics for a developing country. In contrast to developed countries, at Mifamey National Hospital about 45 percent of the adult patients are women and 55 percent are men. In addition, the average length of stay for men (18 days) is not statistically different from the average for women (15 days).

The presentation examines an analysis of four hypotheses for why women's use of hospital care in Niger is so strikingly different. The hypotheses are that there are sexual differences in the following four types of factors (Sindalar 1982):

- 1) the opportunity cost of time, i.e. wage rate, education and number of children,
- 2) access to home health care provided by a spouse,
- 3) externalities in the use of health care and health, e.g. men in the labor force may receive paid sick leave whereas women who work at home are not compensated for time that they are ill,
- 4) riskiness of lifestyle, i.e. amount of drinking, smoking and occupational risk.

The presentation also proposes important questions concerning the use of health services by women that should be addressed in future surveys in developing countries. The presentation will include a discussion of practical sampling and questionnaire design issues.

Empowerment: The Link between Women's Health and Development

Jane Stein, M.S.
Cecilia Zapata, Ph.D.

This paper links the *Women's Development* and the *Women's Health* movements through the concept of *empowerment*. The evidence accumulates that empowerment, the goal of women's development, is the road to health. Major health improvements for populations are related to increased education, improved status, better access to resources, and better socio-economic conditions; medical care and access to health services are secondary determinants at best. Empowerment, "a process aimed at consolidating, maintaining or changing the nature and distribution of power in a particular cultural context", may be the mechanism through which these changes affect health. Empowerment provides a sense of control, confidence, competence, self-esteem, participation, community; it enables one to "get around" in "modern" society. There is no single road to empowerment. There are many starting points—economic development projects, community organizations, social movements, desperation and survival—and many directions. Power is to be had on the individual level, in the home, in the community, in the state, and internationally. Each domain is a battleground and successes in one do not necessarily lead to successes in another.

The women's health literature often either addresses discrete health problems—maternal mortality, ovarian cancer—or provides evidence from aggregate studies that improved status is associated with improved health. We need to be looking for explicit links between empowerment and health. To that end, several different types of research are needed. The most pressing need is for more group measurements of women's and children's health, morbidity as well as mortality. We need to be able to compare "empowered" groups of women to more isolated women. For that we need good measures of health status, something as reliable as the overall self-perceived health status and functional status measures that we use in developed countries.

Secondly, we need some "basic" research into the processes of empowerment. The word is losing its impact through overuse. We need to define its components, much as we have done for the now useless concepts of *stress* and *social support*. After we establish its components, we need to investigate the multiple pathways to empowerment. Then we need to understand its relationship to health. What attitudes and what behaviors change? What resources become available? Does the immune system respond in understandable ways? We must look at empowerment in context. Do the roads that women are following survive the extreme deprivation we now see in Peru, Brazil, Zaire, and Ethiopia? When and where is empowerment dangerous? What happens to cultures and social structures as women become empowered and what happens to men? Are we in a zero sum game?

Thirdly, we need to do policy analysis—we must constantly see what works and what doesn't. We cannot assume that what works in one place can be packaged, reborned, and delivered somewhere else with a set of numbered instructions. The *Women in Development* literature is replete with case studies and individual interviews. We must continue to work on this scale which we can understand. As economic conditions get worse, we must readdress questions that were answered in more optimistic times. A recent interview with Domitila de Chungara from Bolivia reinforces the tragic impact of forced urban migration on empowered rural women.

Finally, researchers must take their findings and begin the difficult task of convincing those whose lives, whose careers, whose skills are in the field of health that resources and energies will accomplish more if put into women's development and women's empowerment than directly into health—whether women's health or child survival.

Theme II Roundtables

A Research Agenda for Women and AIDS: Expanding Prevention Options

Krystn R. Wagner and Jeffrey R. Harris

U.S. Agency for International Development

WOMENS STUDIES AND HEALTH SCIENCES IN ASIA -- GETTING TOGETHER OR FURTHER APART? by Soon-Young Yoon

Purpose: Women in many developing countries are at increasingly high risk of HIV infection while their options for AIDS prevention remain limited. This paper will demonstrate the need for additional research to identify biological and behavioral risk factors for HIV transmission to women in order to expand HIV/AIDS prevention strategies for women.

Methods and Findings: The paper will summarize the epidemiological data demonstrating that women in many developing countries are at increasingly high risk of HIV infection and therefore require targeted education and prevention programs. The assumption that women in developing countries have limited options for AIDS prevention will be examined by surveying findings on women's ability to control their sexual behavior and women's access to and use of health services and prevention technologies. The paper will review available experimental data on risk factors for HIV transmission to women, including concurrent sexually transmitted diseases (STDs). The significant association between STDs and HIV transmission indicates a need for improved diagnosis and treatment of STDs in women as one viable strategy for AIDS prevention. The paper will highlight information which remains essential to our understanding of other potential biological and behavioral risk factors and to our ability to provide women with appropriate and effective prevention options. Research is urgently needed to determine whether there is an association between HIV transmission and oral contraceptives, intrauterine devices, and/or spermicides and whether sexual practices such as the use of vaginal tightening agents contribute to women's risk of HIV infection.

Implications: A research agenda for women and HIV/AIDS will be proposed and will include risk factor studies and the development and testing of woman-controlled barrier methods for AIDS prevention. The paper will briefly describe the U.S. Agency for International Development's current research activities in support of this agenda. Among these activities is the new Women and AIDS Research Program funded through the International Center for Research on Women (ICRW) to support behavioral, ethnographic, and operations research. The objective of this program is to identify determinants of women's risk of HIV infection and women's options for AIDS prevention.

In Asia, many women researchers are beginning to take up health issues and breaking down barriers between womens studies and health sciences. But there is much more to be done. This paper takes a critical look at the role which research plays in current women and health trends and focuses on how various Asian feminist perspectives are brought into the complex arena of action.

Theme II Posters

DEVELOPMENT OF A SAFE BIRTH KIT IN BANGLADESH USING QUALITATIVE RESEARCH

Barbara Crook and Donna Robinett, PATH

Concerned about the high rates of neonatal tetanus in Bangladesh, in 1987 UNICEF asked a local NGO, the Christian Commission for Development in Bangladesh (CCDB) to develop a simple, inexpensive delivery kit that could be sold without subsidy to families in rural areas of Bangladesh. Technical assistance for this project was provided by the Program for Appropriate Technology in Health (PATH). The development and testing of the delivery kit took two years, involving input from potential buyers and users at every step of the development process. This participatory process, carried out through the use of qualitative research including focus groups (FGDs), insured the kit was appropriate for people in rural Bangladesh. At the end of the project, CCDB made recommendations to the Government of Bangladesh about kit contents, container design, price, and promotion and distribution strategies. This paper describes the key factors in the developmental process including: interviews with traditional midwives, FGDs with rural women and men regarding birth practices, design and assembling of prototype kits, development of an instructional insert, field trials with pregnant women, and test marketing of the kit. The interactive methodology used to develop this kit is an important tool for the development of any product or program. Consulting the end-user before implementation is critical to insuring the success of such interventions.

Increasing Access and Patient Satisfaction: Utilizing Mid-Level Practitioners in the Delivery of Women's Health Services

Ellen Dorsch, M.A., M.S.
Consultant for Special Projects,
Planned Parenthood of Northern New England

In the early 1970's, Planned Parenthood of Vermont (now Planned Parenthood of Northern New England - PPNNE) and the Vermont Women's Health Center dramatically improved the delivery of health care in a rural, poor state which lacked physicians trained in women-centered gynecological care. This paper reviews the history that led to the development of mid-level practitioner based services at these two organizations. In addition, it shows how the successful development of the role of these practitioners, as clinic managers and providers of women's health care and abortion services, has increased the accessibility of services. Finally, it proposes the promotion of the use of mid-level practitioners, both in the U.S. and in developing countries, as a means to make high quality contraceptive and abortion services accessible to all women.

Both program statistics and data from the Vermont Department of Health prove the effectiveness and appropriateness of mid-level practitioners particularly in rural areas. Using mid-levels almost exclusively as providers of routine gyn care, PPNNE has increased its service area from one clinic in 1970 to 22 (in VT and NH) in 1990, with plans to provide care in Maine in the near future. Physician's Assistants at the VMHC perform over 2000 abortions a year. Only 5 percent of all their services are delivered by an M.D. Without the support of the Vermont Board of Medical Practice, supervising physicians and the encouragement of women to pursue these professions, many Vermont women would have limited access to contraceptive and abortion services.

Vermont's success can be replicated in other states and countries. PPNNE has produced this model in training programs with family planners from Central America, Africa and the Middle East. In each situation, this model of care was a new idea, but one seen as having potential for eliminating many of the problems of access and patient dissatisfaction. In particular, the use of mid-levels as abortion providers will increase the availability of service greatly needed to reduce the high incidence of maternal mortality in developing countries.

To promote this model, donor agencies and international family planning organizations must understand the importance of mid-level practitioners. Second, they must fund training of local women who can take on the responsibility of providing care in their communities, managing programs, and advocating for safe abortion and women's health programs. PPNNE and the VMHC serve as models for the provision of quality, women-centered health care.

"Analysis of Missed Opportunities as a Tool to Improve Program Services"

Rebecca Fields, M.P.H.

This presentation will examine the link between quality (and efficiency) of Expanded Programme on Immunization (EPI) services, as indicated by missed opportunities for immunization (MOI), and utilization of vaccination services. For EPI, a standard measure of service delivery is vaccination coverage. However, routine coverage statistics are frequently inaccurate and cannot give details on the completeness and efficiency of the services provided. Different techniques, such as exit interviews and observational studies, can be applied to obtain information on whether a child or woman received all vaccinations for which she was eligible during a given visit. Computerized analysis of standard thirty-cluster coverage surveys can quickly detect when vaccination has been incomplete or administered at improper age intervals. MOI data collected by WHO in 15 African and Asian countries indicate MOI on the order of 50%, due mostly to failure to execute procedures already in place. The impact of MOI may include higher costs to achieve full coverage, reduced and delayed protection, loss of confidence in EPI, and dropping out from the system. If all opportunities to immunize were properly exploited, global immunization coverage could be dramatically improved. While MOI pertains specifically to immunization, this general approach could be adapted and used to some extent to address antenatal care. Questions pertaining to delivery, already included in EPI coverage surveys, could be expanded to maximize the amount of information gathered on delivery, thereby serving both EPI and maternal health program needs and strengthening the link between the two.

Tetanus: An Opportunity to Link EPI with MCH

Holly Ann Fluty

Although increased attention has been placed on the 750,000 newborns that die each year from tetanus, recent estimates indicate that tetanus is an important, easily preventable cause of maternal mortality. Coverage of women with tetanus toxoid still remains significantly lower than the dramatic increases in child immunizations. Not only does low coverage of women place them at unnecessary risk of death, but tetanus toxoid coverage is an indication of the poor health status of women. Every maternal and infant death from tetanus represents a health system that has failed to reach those at greatest need.

Despite an available vaccine as well as the hygienic practices known to prevent tetanus, large obstacles exist that threaten to prevent successful tetanus elimination programs. While collaboration between immunization and MCH programs is often cited as essential to any strategy, collaboration is easy to discuss -- and difficult to accomplish.

Several service delivery components can be identified as being critical for a tetanus control program. Not only is knowledge of the clinical and epidemiological facts of tetanus necessary, but there are several components needed to create the environment required to achieve results. While women can be reached through MCH services and/or EPI, either program must address the same operational issues:

- o **policy:** setting goals and targets with enough resources committed;
- o **management:** adequate personnel with competency training, supervision, and support;
- o **communication:** not only information for - but also information from - health workers, women and the community;
- o **logistics:** supplies of potent vaccines, syringes, delivery kits; and,
- o **monitoring:** coverage, program reviews, feedback mechanisms.

As there are limited resources for health, and even less for women's health, planning and managing a tetanus program must take advantage of existing services. Neither an excellent EPI nor a superb MCH program can exclude the other: both have much to learn - and gain - from each other.

Theme II Posters

Determinants of Non-Compliance With Iron Supplementation: A Review of the Literature

Rae Galloway

Iron deficiency anemia affects over 1 billion people. Particularly at risk are pregnant women and young children. Although distribution of iron supplements is practiced in many antenatal care programs in developing countries, it has been assumed that pregnant women do not take them. Non-compliance arises not only because of patient behavior but also from factors out of the patient's control. While the consequences of iron deficiency anemia persist (low birthweight babies, high maternal mortality, lethargy, etc.), little has been done either to monitor program effectiveness or to determine ways to increase compliance with iron therapy. A literature review was conducted to compare, with respect to compliance, iron supplementation with other long-term medical regimes; to determine specific reasons for non-compliance with iron therapy; and to suggest how compliance might be improved.

The review showed that the reasons for non-compliance with iron therapy generally do not deviate from non-compliance with other long-term drug programs. Reasons for non-compliance with iron deficiency treatment include: inadequate program support (lack of political commitment and financial support); insufficient service delivery (poor provider-user dynamics; lack of supplies, access, training, and motivation of health care professionals); and patient behavior (misunderstanding instructions, side effects, frustration about the frequency and number of pills taken, migration, fear of having big babies, personal problems, sickness that accompanies pregnancy, and the subtlety of the disease which makes demand for treatment low). Much has been made about the side effects (nausea, constipation, etc.) that women might experience during iron therapy as the cause of non-compliance with iron supplementation. In fact, the few studies that quantified the reasons for non-compliance with iron therapy show that only 5-10% of women stated that side effects were the reason they stopped taking iron tablets. In several studies women complained about side effects but this did not reduce compliance, especially when women were warned beforehand and reassured that side effects were temporary. A recent review of current programs in developing countries concluded that lack of iron supplements was the most common reason for non-compliance with iron supplementation.

Women continue to suffer from iron deficiency anemia even though the technology exists to address the problem at low cost. Governments and health care professionals must renew their commitment to iron therapy by monitoring and improving compliance. We can significantly improve compliance by: making sure that iron supplements are available at all times; providing advanced warning about the possibility of side effects; involving the patient in the therapeutic strategy; and providing reminders, such as posters and calendars, about taking supplements.

PLANNING MATERNAL MORTALITY INTERVENTIONS THROUGH SITUATIONAL ANALYSIS

Martha Campbell
Magda Ghanma

CARE began addressing the health problems of children in the Bara District of Sudan's North Kordofan Region in 1986 with co-financing from an AID Child Survival grant. During the course of this project, the unmet health needs of women were identified as a major impediment to improving the health of their children and more serious problems per se. Maternal mortality studies in Sudan demonstrate figures ranging between 540 and 2,000 deaths per 100,000 live births. In order to fill this void, CARE-Sudan developed the Bara Maternal Health Project. The first phase was a situational analysis, designed to provide information for the planning of appropriate project interventions with district and regional Ministry of Health counterparts. At the village level, the study identified maternal health problems and health-seeking behaviors among women of childbearing age and assessed the appropriateness of the training of traditional birth attendants conducted in Bara District in 1989.

The study was based on four strata relating to health service delivery: village; health post; rural dispensary; and health center/hospital. For each strata, one or several target groups were identified for information collection purposes. The target groups were health service providers, health service users and decision-makers in the communities.

The information obtained from the situational analysis was presented at a one-day workshop conducted by CARE with the district and regional MOH counterparts. Factors contributing to maternal mortality were identified from the study and decisions were made regarding appropriate interventions to reduce maternal mortality. Details concerning the study results and how interventions were developed will be presented in the paper.

Implications for the Action Agenda relate to the process of planning and managing women's health programs in a participatory manner in the rural sector of a country with serious food shortages, poor infrastructure and long-term civil strife.

MOTIVATING DEVELOPMENT AGENCIES TO COOPERATE WITH THE COMMUNITY (tackling community barriers to Health Education)

Nancy Hammond, director
HEAL Project, Adult Basic Literacy Society
Punjab, Pakistan

INTRODUCTION

The literacy rate for poor women in Pakistan is as low as 8%, symptomatic of their vulnerability to social and economic deprivation. Adult Basic Education Society (ABES) has found such women to be acutely aware of their problems and interested in development but few development agencies have faith or real experience in true community based development.

HEALTH EDUCATION AND ADULT LITERACY (HEAL) PROJECT

ABES established HEAL to enable women to have access to information and resources for self development as well as to motivate government and NGO's to share responsibility and cooperate with communities in their own development. Materials and methods were developed and piloted with 4 NGOs and 90 women resulting in literacy equal to standard programs, high retention of key health issues and strong motivation to form action groups for self help. Success was heavily dependent on the attitude of project/ field management staff. Existing health education materials were not relevant to the women's perceived or actual issues.

In phases 2 and 3 work expanded to 35 new classes and 60 follow up groups in cooperation with 12 NGO's and 2 semi government groups. HEAL techniques for motivation development have been used by a number of groups including the College of Community Medicine, Lahore; the Family Planning Association of Pakistan and UNICEF. New literates are encouraged to use their experiences and ideas to produce teaching and resource materials. Training programs for field staff and project organizers have been found to be essential.

CONCLUSION

The results of the HEAL project show clearly that the attitude and lack of commitment of development organizations can be a major barrier to effective implementation of development initiative which with careful project planning based on trust can be overcome.

WORK AND WOMEN'S MENTAL HEALTH IN DEVELOPING COUNTRIES GUIDELINES FOR AN EPIDEMIOLOGICAL APPROACH

V. S. Santana, and S. Harlow. S. of Public Health, Dept. of Epidemiology, University of N. Carolina at Chapel Hill. Epidemiological research of mental disorders traditionally have considered work only as a mediator of socioeconomic status and examine the relationships between occupational classification and various disorders. Recently, researchers have been trying to understand how work itself may operate by as risk factor. Work environments, the organization of work processes, employment and unemployment thus have become areas of interest for psychosocial research. Stress models have been utilized as the theoretical framework and most of the available data addresses occupational stress. However, despite of methodological and theoretical advances, there is no clear understanding of potential causal pathways, nor of the work related determinants of mental disorders. Most of the data currently available comes from economically developed countries. Consequently, industrial work or characteristics of the work process and organization of these countries have been the focus of this research. There are only few studies on work and mental health from developing countries, most of which use the same theoretical and empirical approach, regardless of the economic, social, cultural and historical differences between them. Our aim is to highlight aspects of the relationship between work and women's mental health, defining some departures from the prevailing models utilized in industrialized contexts. First, in most of Latin American countries, economic production is largely based on intensive utilization of the labor force at low cost. Consequently, as job are not sufficient to cover basic needs, people develop strategies to increase income which are determined by cultural, geographical and social factors. Frequently, the strategy is to increase the length of the work day. Once time work is visible evidence of this strategy, but supplemental jobs, specially informal jobs are the hidden dominant features in developing countries. This additional work creates a particular kind of exploitation, where physical and mental overexertion, and long-term fatigue, along with a scarcity of available resources to rest and to obtain personal relief may play an especial role in the determination of a large range of health outcomes. For women this overexertion is their "natural" way of life, since the extension of the work time with the housework and child care activities are dominant features of their work life. Consequently, as the health is worn down, especially in their midlife period when the domestic demands are high, health problems are expected also to be high, particular those related to psychological distress.

Theme II Posters

A Tetanus Toxoid Immunization Coverage Survey in the Gorkha District of Nepal

Dr. Sunita Acharya, Chief, Expanded Immunization Project, Nepal
Dr. Beth Hennings, Johns Hopkins School of Hygiene and Public Health
Ms. Mary Taylor, INTERCEPT, John Snow Public Health Group
Dr. Marie Diener-West, Johns Hopkins School of Hygiene and P.H.
Mr. Lok Raj Bhatta, Save the Children/USA, Nepal
Mr. Ramesh Neupane, District Public Health Officer, Nepal

In Nepal, neonatal tetanus continues to be a significant contributor to infant mortality. In the Gorkha District of Nepal, the government's Expanded Immunization Project (EIP), and Save the Children/USA (SCF), have collaborated since 1986 on an immunization program which included providing tetanus toxoid immunization (TT) to all women at risk of childbearing (aged 15 to 44 years) in order to provide adequate coverage of pregnancies and births. However, observations in the field raised the possibility that women under age 30 and first pregnancies were not covered in the same proportion as the overall population of women.

The standard World Health Organization (WHO) cluster survey methodology for measuring childhood coverage, was modified to measure TT coverage of women 15 to 29, and 30 to 44 years, and to determine coverage of births occurring in the previous 12 months; standard WHO definitions of fully immunized were used. Program managers and field workers worked together to test and culturally adapt the survey methodology to increase data quality and to strengthen feedback into program implementation.

The coverage in both age groups was significantly different ($P < .01$), 57.7% for 15 to 29, and 45.1% for 30 to 44 year olds, and coverage of pregnancies was lower in both groups. In addition, a significant number of 15 to 29 year old women and first pregnancies were inadequately protected. Many women were first immunized at the time of their children's immunizations. Field program workers have used this information to restructure motivation, education, and service delivery in Gorkha. At the national level, five lifetime TT series begun at earlier ages is being considered by the EIP.

This exercise illustrates the feasibility of identifying problems at the field level, using rigorous methods to quantify and verify the problems, and ultimately enacting change in both program implementation and policy.

QUALITY OF CARE IN SIX OPERATIONS RESEARCH PROJECTS IN LATIN AMERICA AND THE CARIBBEAN

Antonietta Martin, John Townsend, Laura Bani

Quality of care in family planning services as defined by the desires and needs of clients was the focus of several operations research projects conducted by the Population Council's INOPAL Project in Latin America and the Caribbean. This presentation will review the effects of improving the quality of family planning services in different settings, i.e. indigenous groups, urban clinics and rural environments. Quality of care is defined according to certain basic elements such as choice of methods, information given to clients, technical competence of the provider, interpersonal relations, follow-up and continuity mechanisms, and appropriate constellation of services.

Specific strategies tested included: a) new counselling and information strategies in the Dominican Republic. b) The provision of appropriate services in indigenous areas in Guatemala based on cultural and personal perceived needs. c) Training and supervision strategies to improve quality of information given to clients, and technical competence of CBD providers in Guatemala and Peru. And, d) the perceptions of the quality of care of reproductive health services in MOH clinics in Barbados.

COST-EFFECTIVENESS OF A NUTRITION INTERVENTION PROGRAM FOR PREGNANT WOMEN. Francisco Mardones-Santander, M.D., M.Sc. (1); Pedro Rosso, M.D. (2); Rafael Zamora, M.Sc. (1); Francisco Mardones-Restat, M.D., M.Sc. (1); Nicolás González, M.D. (1); and Dick Uiterwaal, M.Sc. (3). (1) Institute of Nutrition and Food Technology (INTA), University of Chile, Casilla 138, Santiago 11, Chile; (2) Faculty of Medicine, Catholic University of Chile; (3) Melkumie Holland, The Netherlands.

Although costs of supplementary foods distributed to pregnant mothers by the Ministry of Health in Chile are over US\$ 5 millions for 1990, its socio-economic impact has not been analyzed with experimental data. Food supplements are distributed free of cost to pregnant women through public primary health care services. Recently we have studied the effect on birth weight and maternal nutritional status of a milk based nutrient mixture ("Vita-Nova"), given to underweight Chilean mothers (Am J Clin Nutr 1988; 47: 413-9). A marked reduction in the proportions of both under 3,001 g and small-for-date infants was observed in the mothers receiving "Vita-Nova" compared with those who received the powdered milk supplement ("Purita"). In addition, mothers receiving "Vita-Nova" had greater weight gains and better iron nutritional status. The overall conclusion of the study was that the introduction of well accepted foods or nutrient mixtures, such as "Vita-Nova", could substantially improve both maternal and fetal outcomes. Using the results of that experimental comparison, the effects and public costs that "Vita-Nova" would have if introduced in Chile as a replacement of powdered milk were analyzed using the cost-effectiveness methodology. Target population were all low weight/height pregnant women served by the Ministry of Health in 1987. Based on the assumed favorable change in the birth weight distribution associated with the introduction of "Vita-Nova", the change in variables such as infant deaths, hospitalizations, and malnutrition rates was estimated; their new public costs were also calculated when relevant. Results of this evaluation indicate that an improvement of food products nutritional composition (i.e. "Vita-Nova") can favorably modify national health and nutrition infant indexes. Economical advantages would be also obtained with this type of preventive intervention. The resulting lower number of immature or growth retarded births would allow savings over 5% of the present public costs (e.g. savings of approximately US\$ 500,000 in hospital care of neonates would result); this fact is very important for the small budget of the Ministry of Health and supports the idea that this type of programs are extremely beneficial from a cost-effectiveness point of view (Partially supported by FONDECYT-CHILE (Project Nr. 986/89) and Melkumie Holland, The Netherlands).

THE EFFECTS OF PROTEIN-ENERGY SUPPLEMENTATION IN EARLY INFANCY ON THE ANTHROPOMETRY AND BODY COMPOSITION OF GUATEMALAN WOMEN AT ADOLESCENCE

Rivera, J. Ruel, M.T. and Martorell R

Statement of purpose. Maternal anthropometry has been shown to be a strong predictor of pregnancy outcomes such as fetal growth and length of gestation. Although less well documented, a positive association between maternal anthropometry and maternal health throughout the perinatal period has been suggested in recent literature.

An analysis was done to assess the impact of nutritional supplementation during early infancy on the anthropometry and body composition of women at adolescence and young adulthood, with an emphasis on predictors of reproductive performance, namely height, weight, fat-free mass and biall diameter.

Design and methodology. The data used were collected in 4 rural Guatemalan villages during a longitudinal supplementation trial that took place between 1969 and 1977 and during a follow-up study conducted in 1988-1989. In the supplementation study, two of the villages received a high protein-energy drink (Atole) made available to all pregnant and lactating mothers and children under 7 years. The other two communities received a non-protein, low calorie drink (Fresco). The follow-up, cross-sectional study was undertaken to evaluate the effects of improved nutrition during early childhood on physical and psychosocial status at adolescence. The subsample used for the present analysis ($n = 248$) included all girls who resided in the study villages from birth to three years, during the supplementation years, and for whom anthropometric measurements were available at 3 years of age and at the time of follow-up, when they were between 13 and 20 years of age.

Multivariate analysis was used to compare the anthropometry and body composition of the Atole and Fresco groups, controlling for skeletal age and other independent variables. One-tailed tests were used to assess the statistical significance of differences between groups ($p < .05$).

Major findings. Statistically significant differences in favor of the Atole group were found in height (+ 1.66 cm), weight (+ 1.81 kg) and fat-free mass (+ 1.50 kg), after controlling for skeletal age and maternal height. Biall diameter did not differ between the Atole and Fresco groups. When height was controlled for, the difference in weight between the groups disappeared, suggesting that the difference in weight was attributable to a higher stature in Atole women. When controlling for height in the fat-free mass model, however, the difference in favor of the Atole group remained statistically significant, although the size of the difference was slightly reduced (+ 1.00). This latter result indicates that the increased level of fat-free mass found in Atole women was not uniquely due to their increased height.

Implications for the "Action Agenda". These results suggest that moderate levels of protein-energy supplementation (12% RDI) given to girls with inadequate dietary intakes during their first three years of life have significant long-term effects on their height and fat-free mass at adolescence and young adulthood. The importance of these differences in terms of reproductive performance and maternal health are now under investigation in this same population.

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Theme II Posters

THE ELDERLY WOMAN: ADDING LIFE TO YEARS

Gopal Sankaran, M.D., Dr.P.H., West Chester University, PA

This paper addresses the health and interrelated social, economic, and psychological needs of elderly women in different cultures and focuses on strategies and policies to effectively meet them. With the rising life expectancy for women both in the developing and the developed nations, elderly women constitute an increasing proportion of the population throughout the world. However, as compared to men of similar age, elderly women often suffer from multiple handicaps resulting from cumulative and synergistic effects of biological, social, and cultural factors. Using a cross-cultural perspective, similarities and differences in the health status and health needs of elderly women in different cultural contexts are analyzed. Gender-specific health and social risk factors and their influence on the health status and health needs of the elderly women are documented. Strategies to strengthen the health care and the social support systems for elderly women are highlighted. Relevant policy changes to improve the health status of elderly women are presented.

Nursing interactions-exploring underprivileged ethnic women's preventive health habits.
Bilkijs VISSARDJEE, M.Sc.N., Marie Elisabeth TAGGART, Ph.D.

Based on Leimenger's transcultural care theory, this exploratory study's purposes are to generate cultural sensitivity within health care providers, as well as to identify and bring attention to specific preventive health needs of ethnocultural minority groups.

Consistently with Public Health Unit's, the project will be collecting data using the observation/participatory approach; theories of pain and discomfort; observation notes will be discussed during the interactive session preventive health care providers (nurses) and the underprivileged ethnic women.

Reports in fields as varied as economics, sociology, anthropology, psychiatry, and law have recognized women's unequal status in western societies. They statistically help to illustrate this. The National Council of Welfare reports that in 1986, about 50 percent of single mothers in Canada were living below the poverty line. For a woman, single parenthood can be a sentence to poverty. A 1986 study conducted by the Canadian Advisory Council on the Status of Women found that 75 percent of women see themselves as having sole responsibility for their family's health care in the home. Moreover, the study confirms that it is the women who usually health-related choices for their family members.

In the area of preventive care, several biological and cultural factors appear to enhance women's potential for well-being. A woman's ability to take health choices is profoundly influenced by not only their cultural background but by the ease and complexity of the options available to them as well.

In Canada and the USA, immigration is a major demographic cause, most of the immigrants go to the large urban centres, ability to survive with difficult economic conditions. Health care providers need to be facilitators of positive health in women.

In this study, the target population is constituted by a group of underprivileged women with various ethnic backgrounds.

The results will help health care providers to become more knowledgeable about preventive care for these specific women of color, especially in regard to their unique needs and behaviors; perhaps positive health actions may be encouraged not only for the prevention of disease but also for the joy of being healthy.

An Evaluation of a Nurses' Training Program on Child Spacing in Egypt

Approximately one third of all infant mortality in Egypt occurs in the neonatal period. A large proportion of this mortality results from complications of pregnancy and childbirth as well as poor childbirth practices. In May, 1990, the USAID, with the assistance of Clark Atlanta University, subcontractors, implemented a training program for the training of maternal child health nurses working in the health centers. The program, which was seventeen weeks long, included content related to maternal child health, care of the neonate, community health nursing, public health administration and nutrition. An evaluation team consisting of three members (two nurses and one physician) were responsible for evaluating the training during a three week period. The purpose of the final evaluation was two-fold: 1) To assess the effectiveness of the nurses program on their knowledge, skills and attitudes. 2) To review the training syllabus and make recommendations for future training programs.

A quasi-experimental method was used to conduct the study. Data collection procedures included comparisons of test scores, surveys of mothers' opinions, observations of nurses' interactions and performances, and surveys of faculty as well as participants' opinions of the training.

Data revealed that the mean score of the trained group of nurses was higher than the untrained group. In addition, trainees were able to assess maternal child health needs, intervene, using health promotion skills and appropriate technical skills. They also made referrals for various health problems. Recommendations for future training included more emphasis on clinical practice in maternal child health clinics, reducing the training period from seventeen weeks to eight weeks, choosing better clinical sites as role models, and including more content related to family planning, and OB complications instead of public health administration.

by Anqad Farag Wahba, Ph.D., R.N.

Theme II Videos/Films

WIBANGBE: TRADITIONAL BIRTH ATTENDANTS, THEIR TRAINING AND SUPERVISION

Grace Jensen, Juste Samba, Franklin Baer,
Ralph and Florence Galloway

SWIRU Basic Rural Health Project
c/o Dr. Franklin C. Baer
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Title: NGO Fieldstaff Conduct Focus Group Pretests of a Regional Training Video

Authors: Jose Romero Diaz, PhD and Valerie Uccellani, MS
Nutrition Communication Project of the Academy for Educational Development

WIBANGBE: Traditional Birth Attendants, their Training and Supervision is a documentary film made in the Karawa rural health zone of Zaïre where the training of traditional birth attendants (TBAs) has been in progress since 1982. The film demonstrates that health care for rural women can be improved through the services of the TBAs who can provide a crucial link between Western and traditional health care. The film shows how TBAs are chosen by their communities, trained by health personnel and supervised after training. These TBAs are providing maternal and child care, teaching child spacing and referring high risk women to health centers.

The film also provides a good overview of the decentralized health zone structure that has been the key to the national primary health care strategy. Today some 170 of the 306 planned health zones have become functional and have dramatically increased access to primary health care services especially for women and children. The film provides glimpses of primary health care in action not only with traditional birth attendants and village development committees but also describes the role of health centers and reference hospitals.

The film was made by a Zaïrian team from the National Radio/Television and financed by USAID through the SANRU I Basic Rural Health Project (660-0086). The film is 16 mm, 23 minutes in length and available in English or French soundtrack. It is distributed within the U.S. on behalf of the SANRU project by ACNM (American College of Nurse-Midwives) who served as a technical consultant during the production of the film.

Any organization that has tried its hand at developing training materials for regional use appreciates the pivotal role that pretesting plays in the production process. Nonetheless, many organizations shortcut the critical step of pretesting as few fieldstaff are adequately trained in the design, implementation, and analysis of qualitative audience research.

In response to requests from CARE fieldstaff in six LAC countries, AED designed and conducted a series of three, cross-country workshops in September, 1990. Each two-day workshop trained participants in the fundamentals of pretesting health education/promotion materials and in the use of FGDs to collect qualitative data. During the workshop, participants ran a practice FGD to pretest a regional training video on interpersonal communications in Growth Monitoring/Promotion (CMP). They critiqued their own performance as animators and observers, and practiced organizing/analyzing FGD results. Following this intensive training, each participant team conducted FGD pretests of the video in their own country, and prepared an FGD report. The data contained in the reports guided the decisions how to revise the video script for maximum acceptability, appropriateness, and comprehension on a regional scale.

The workshop showed that fieldstaff are highly motivated to become skilled in effective FGD research, and see many applications of FGD research to their program activities. While two days is insufficient for fieldstaff to become skilled FGD animators and observers, formal guidelines and participatory exercises form a solid base on which fieldstaff can sharpen their skills. The implications of the workshops are that effective qualitative research can be incorporated into health communication activities of NGOs, and that the research can help to ensure that these activities be of maximum benefit to the communities.

ENCOURAGING AFRICAN WOMEN An African feature film that presents a positive role model

by Steve Smith

Development through Self-Reliance, Inc. and its sister Zimbabwean non-profit agency, Media for Development Trust have produced a full-length feature film in Zimbabwe that presents a role model of a typical middle-class African woman who finds herself done out by the traditional cultural system that she has always believed in. By necessity she is slowly awakened to the modern methods to remedy the wrongs she has suffered, and eventually wins back her rights in a way that yields a happy ending for all. If African women are ever to improve their health status, they will need to find the strength to take actions for their own betterment. The film presents a case of a woman who takes strong positive action in a socially acceptable, non-militant way.

The woman is a character viewers can identify with. Her story develops in a very normal way and she is pushed into action in a way viewers can relate to. Audiences get to live through her experience with her and see how things work out well. Viewers are encouraged to follow her example.

This entertaining and educational film has a working title of *Winds of Change*. The story is beautifully written by Tsitsi Dangaremba based on focus group discussion research and the help of a panel of Zimbabwean experts. It is directed by Godwin Mawuru and produced by John Riber. It has been shot in Zimbabwe in October 1990 and will be released in early 1991. Financial support has been received from CIDA, SIDA and NORAD. The film will be distributed throughout Africa via television broadcasting, and small group showings put on by NGOs, etc. Also it will be distributed via cinema halls and video rental clubs. We anticipate a very wide distribution.

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Theme IIb Concurrent Session: Appropriate Technology for Life Threatening Situations
Session Chair: William Dolan
Esperança

WOMEN DON'T HAVE TO DIE: AN UNDERUTILIZED TECHNOLOGY CAN MAKE A DIFFERENCE

Janie Benson, M.P.H.; Francine Coeytaux, M.P.H.; Ann Leonard, R.N., M.S.P.H.; Ayse Akin Dervisoglu, M.D.; Khama Rogo, M.D.; Virginia Chambers, M.P.H.; Lisette Silva, B.A.

Abortion-related complications are among the most common causes of maternal mortality in the developing world. An estimated 250,000 women die each year from the complications of unsafe abortions. In addition, ten times this many suffer severe injury as a result of poorly performed abortion procedures. Four major factors influence the mortality and morbidity associated with abortion: the method of the abortion; the skill of the provider; the accessibility and quality of medical facilities to treat abortion complications; and the duration of the pregnancy. A long-standing, appropriate technology, manual vacuum aspiration (MVA), exists which affects these factors and thus could reduce the deaths and injury caused by unsafe abortions.

Manual vacuum aspiration is a simple, safe and effective technique for the treatment of abortion complications and the provision of early abortions. It is especially appropriate for the developing world because unlike dilation and curettage (D&C), the commonly used technique for the treatment of women presenting at hospitals with the complications of unsafe abortions, MVA does not require the use of anesthesia, an operating room or an overnight stay. These advantages, plus the fact that non-physicians can be trained to utilize MVA, could result in major benefits to health systems overwhelmed by the demands of caring for a large number of women with abortion complications.

This paper will discuss the implications of the adoption of MVA training and services on both women's health and on health systems. Its potential for decentralizing the treatment of abortion complications to lower levels of the health system and increasing women's access to safe care will be described. Also presented will be the effect of MVA services on resource consumption on developing world health systems. Case studies in Latin America, Asia and Africa where policy changes have resulted in the implementation of MVA training and services will be highlighted.

**IMMUNIZING AGAINST LIVER CANCER:
TRAINING AND IEC FOR THE INTRODUCTION OF HEPATITIS B VACCINE**

Scott Wittet, Program for Appropriate Technology in Health
Dr. James Maynard, International Task Force for Hepatitis B Immunization
Nancy Muller, Program for Appropriate Technology in Health

Liver cancer and cirrhosis are primary killers of both women and men in much of the developing world. These adult conditions usually result from infection by the hepatitis B virus during infancy. Losing a mother or father to liver disease during their most productive years has important implications for the health and well-being of the children left behind. A vaccine against hepatitis B has been available for some time, but due to high cost it has been reserved mainly for the rich. Recently, special programs initiated by the International Task Force for Hepatitis B Immunization have been able to procure the vaccine at under US\$1 per pediatric dose, bringing it into line with other EPI vaccines. It is expected that global reductions in pricing will soon follow.

Now that the cost barrier has been overcome, other challenges must be faced. In Cameroon, Indonesia, Kenya, Philippines, and Thailand efforts are underway to strengthen existing EPI programs through addition of hepatitis B vaccine. Difficult policy issues must be faced when using a phased approach to introduction and only certain infants are offered the vaccine. Provision of the new vaccine can require doubling of cold chain capacity and a 50% increase in sterile needles and syringes. Communication activities are another important aspect of these programs, including training health staff and raising the awareness of parents and community leaders about hepatitis B and its control.

Qualitative research data have been used to develop appropriate training materials and effective public IEC campaigns. These programs are designed to reinforce information and skills needed for EPI overall. Confusion among health service providers is rampant and must be addressed. The materials mix responses to fascinating cultural data with standard medical information. Examples chosen from each of the introductory countries illustrate the complexity of new vaccine introduction and the different sorts of challenges faced in a variety of situations.

CONJUNCTIONAL PALLOP CATEGORIZATION AND ANEMIA IN PREGNANCY

Derrick B. Jelliffe
Population & Family Health Division, School of Public Health, UCLA

Anemia in pregnancy is a widespread and serious complication, especially if associated with hemorrhage during child birth. A new low cost, appropriate technology "conjunctival pallor categorizer" using Munsell color chips is under investigation. Results and the device will be presented for discussion, concerning (a) methods of selecting colors, (b) definition of categories according to ecological constraints, etc.

**GOABLE STRATEGIES FOR THE CONTROL OF
CERVICAL CANCER (CaCx) IN INDIA**
ASHOK SEHGAL, MEERA ROY, L.SATYANARAYANA &
USHA K. LUTHRA

Statement of Purpose - CaCx is the leading malignancy among Indian women with about 90,000 new cases being added every year. In the absence of any organized control programme the load is expected to increase by 1.6 fold by the turn of the century. The paper deals with the goable strategies for the control of cervical cancer in Indian situation.

Description of the design and methodology - The necessary data were analysed from 3 sources: (i) A prospective cohort study (1976-87), (ii) A nested case-control study within the cohort (1976-87) and (iii) Community-Control of CaCx at Alipur PHC, New Delhi.

Analysis of major findings -

1. **COHORT STUDY** - The natural history of CaCx and the biological behaviour of uterine cervix dysplasia has been established for the first time among Indian women.
2. **NESTED CASE-CONTROL STUDY** - Several risk factors have been delineated such as: a) age at consummation of marriage (RR=2.5), b) HPV 16 & 18 (RR=5), c) Sexual promiscuity (RR=5), d) Multiparity (RR=1.5 with more than 5 children), e) Cervical erosions (RR=1.5), f) genital infections (RR=1.3).
3. **COMMUNITY BASED Intervention study** - The preliminary results of the "Clinical down-staging" with selective cytology screening have shown that by visual examination of the cervix and referring the "high risk" lesions (erosions bleeding on touch, unhealthy cervix and suspicious cervix) that accounted for 16% of the screened population for further evaluation, resulted in a yield of 66% of early cancers (stage 0-IIA). Further, it has been shown that these lesions can be detected by the trained Auxiliary-Nurse-Midwife (ANM) to an accuracy of over 80% (4).

Implications for the Action Agenda - In India it is not possible to undertake nationwide cytology screening. The alternative strategy of clinical downstaging with selective cytology may be tried. In addition control of pelvic infections and ablative treatment of erosions may be an important aspect of primary prevention.

Theme IIb Concurrent Session: Barefoot Doctors and Midwives

Session Chair: Michele Andina

MIDWIFERY EDUCATION AMONG DISPLACED CAMBODIANS

IN Thailand: A COMPETENCY BASED APPROACH

BY

DENISE CALLAGHAN F.N.P. C.N.M. M.P.H.

This paper discusses a project to develop and implement a culturally appropriate curriculum to train midwives. The curriculum is based on the existing needs of Cambodian women who have been living in camps for displaced persons in Thailand since 1979. The process by which the competency based curriculum was developed and implemented is discussed. This process included; assessing the health needs of the Cambodian women, identifying human and material resources available, developing job descriptions in all areas a midwife would potentially provide services, analyzing the tasks by identifying the knowledge skills and attitudes which are necessary to perform each task, and finally organizing the tasks into objectives, units and lessons. The process of implementing the curriculum in a pilot project over a ten month period is shared.

The effect of a comprehensive education program on the existing health care system is presented. This includes the impact of trained midwives providing services in all areas of women's health; the increased coordination of services among the Cambodian providers and non-governmental organizations; the decrease in dependency upon the presence of foreign nurse midwives from non-governmental organizations; the empowerment of Cambodian midwives to manage their educational and clinical services and ultimately function independently.

Implications for international health care workers in refugee and development situations is discussed including the importance of designing programs which are culturally appropriate and meet the needs of the population to be served.

Developing a Model Maternity Unit Through Continuing Education: A Sister Cities Approach to Safe Motherhood (Rochester-Bamako). Charlene Pope, CNM, Jo Wrona, MSN, Mamadou Kante, M.D. Fantimata Dicko, M.D., Fantimata Traore, M.D., Lynn Bickley, M.D.

We report on the development of a workshop model for continuing education in Bamako, Mali to: (1) improve intrapartum services, (2) create training resources for practicing midwives; and (3) set standards for safe care of mothers.

We describe the results of an observational assessment tool for existing intrapartum and postpartum services in Bamako's six maternal-child health centers which showed that the practices targeted by the continuing education workshop were implemented less than 25% of the time. Site visits by a Rochester-Bamako supervisory team established relationships with practicing midwives, confirmed areas of practice needing improvement, and obtained feedback on protocols for problems of daily practice. The Sister Cities team subsequently developed a continuing education workshop based on existing knowledge, attitudes, and practice which featured demonstrations, on-site role modeling, and midwife peer-group discussions to develop new patterns of safe care for mothers. The workshop produced a supervisory checklist for on-going learning and motivation of midwives. The workshop emphasized use of locally available technology and current midwifery practice standards from WHO and the International Confederation of Midwives (e.g., risk assessment, partographs for safe labor, problem-solving exercises for improved consultation and referrals, and improved neonatal care). Project outcome data will be reported.

MIDWIVES WORKING WITH MIDWIVES TO IMPROVE THE HEALTH OF WOMEN INNOVATIVE APPROACHES

LIFE SAVING SKILLS WORKSHOPS FOR GHANAIAN MIDWIVES

Margaret Marshall, CNM, EdD, MPH, Project Coordinator, American College of Nurse-Midwives (ACNM), 1522 K Street, N.W., Suite 1000, Washington, D.C. 20005

STATEMENT OF PURPOSE

This presentation will discuss how information from two studies helped identify factors contributing to maternal mortality in the Greater Accra Region (GAR) of Ghana. This information was used to develop a risk assessment/assessment tool for midwives and carry out a life-saving skills course for very rural midwives in an effort to avert unnecessary maternal and neonatal deaths.

DESCRIPTION OF DESIGN AND METHODOLOGY

The American College of Nurse-Midwives and the Ghanaian Ministry of Health (MOH) collaborated on a project to determine important causes of maternal mortality through two maternal mortality studies in the GAR of Ghana. A risk assessment/assessment tool was developed based on the findings of the maternal mortality studies and midwives in the GAR were taught to use it. A second project has been funded to train 120 very rural private midwives and midwifery tutors in life-saving skills.

ANALYSIS OF MAJOR FINDINGS

1. The major causes of death noted on the record and/or autopsy note were, hemorrhage, infection, pregnancy induced hypertension, tetanus, and other ailments.
2. The private sector midwives have been in practice on average more than 25 years with no to minimal continuing education.
3. The use of the risk assessment tool improved the ability of the midwife to identify high risk women. It is not clear that they then did a better job with complex decision making skills regarding preventative treatment, and/or referral.
4. Presentation of information to the MCH/FP Policy Committee of the MOH and the policy making body for nurses and midwives led to a request for an assessment of the midwifery schools in Ghana and support for a number of the recommendations made by the assessment. The life-saving skills workshops are an outgrowth of the assessment and its recommendations.

IMPLICATIONS FOR ACTION AGENDA

The providers on the front line need appropriate knowledge and skills to save women's lives. The use of studies to determine the needs of the population is an effective way of identifying the problems faced by women and the needs of the caregivers. Presentation of this information to policy makers can lead to a reevaluation of current policies and positive steps to alleviate the identified problems.

Inservice Training for Womens' and Childrens' Health Services in Three Hundred Poor Counties in China

Dr. Qin Xiao Chun, Deputy Director, Project Office, MCH Dept. Ministry of Public Health;

Ms. Judith Standley, UNFPA-UNICEF MCH-FP Adviser, Beijing, China

The Maternal Child Health (MCH) Department of the Chinese Ministry of Public Health is currently implementing a project entitled "Strengthening MCH-FP Services at the Grassroots Level". This project is jointly funded by UNICEF and UNFPA with two subcontracts, one to Programs for Appropriate Technology in Health (PATH) to assist in the communication component, and one to WHO to provide technical assistance to three project components including a major project evaluation.

This project is designed to improve MCH services to women and children in 300 poor, remote, and high mortality counties throughout China. It is one of the largest externally funded projects in the Ministry of Public Health and will promote MCH activities nationwide. It has received both national as well as worldwide recognition for its explicit focus on high mortality areas.

The key link in providing appropriate MCH services to mothers and children are the village and township doctors. A needs assessment at the beginning of the project showed these grassroots workers required extensive additional training. Traditionally China has relied heavily on the lecture method and the use of training materials that were often too difficult and inappropriate for the township and village doctors.

To meet this challenge, the MCH Department took the lead in designing a participatory training plan which integrates a variety of training activities based on project objectives. New training methods are being introduced which will be used along with newly developed MCH training materials specifically designed and pretested to reflect the real needs at the grassroots level. This was accomplished using a well planned and complex process involving national and regional experts, special workshops, module development groups, training of trainers and pretests. The involvement of multiple individuals and institutes in developing and implementing a unified training plan in a country the size of China is a remarkable achievement. In addition, with assistance from PATH, emphasis is being given to improve the inter-personal communication skills of health workers so they can better serve the community. Development of improved health education materials is an integral part of this effort.

An overview of the training component will be given including the details of the planning process, results of implementation to date, and evaluation. Slides illustrating these themes will accompany the presentation.

Theme IIb Concurrent Session: Controlling Infection

Session Chair: Peter Berman

BIRTH-LINKED TETANUS AND SEPSIS MUST STOP

Dr François Gasse and Dr Stuart Kingma, Medical Officers, Expanded Programme on Immunization, World Health Organization, Geneva, Switzerland

The continuing, tragic toll of disease and death from unsafe and dirty deliveries in developing countries can be drastically reduced. In these countries, women will watch over a million of their newborn children get neonatal tetanus (NNT) this year, well over half of whom will die. Countless women will have post-partum infections that could easily be avoided, and up to 100,000 of those will die of sepsis or tetanus.

Two viable strategies of remarkable simplicity and of modest resource requirements are ready for global implementation to combat this on-going tragedy, and these must be made available to all women of the developing world: immunization with tetanus toxoid and improved delivery practices.

WHO has resolved to eliminate neonatal tetanus by 1995 with these two simple expedients. However, present coverage of pregnant women in developing countries with the minimum two doses of tetanus toxoid (TT) is only 27%. This is all the more tragic when it is seen that their children are protected with their standard immunizations to the 70% level. International support should help ministries of health develop systems which link maternal immunizations with those of their children and which take advantage of all possible "missed opportunities" - immunization of women against tetanus must consistently be done at each child care clinic, at every antenatal clinic, at family planning clinics, at all medical service points, and also at the time of delivery.

Clean delivery and cord care practice is the crucial complementary strategy to immunization. When properly implemented, clean delivery practices alone can be highly effective at NNT elimination and at reducing overall maternal and neonatal mortality and morbidity due to sepsis. New teaching approaches and single-use cord care kits can help.

All of this means that neonatal tetanus and post-partum maternal sepsis must become priority issues for national action in health care, and, even more importantly, must become issues that are fully understood by women for their own action.

Syphilis-Associated Perinatal Mortality - A Quantifiable Problem with an Effective Intervention - Where is the Program?

J. McDermott, J. Wirima, R. Steketee, S. Larsen

Reported prevalence of reactive syphilis screens in women attending antenatal clinics in Africa range from 4% to 15% with estimates of 20% to 40% of women with untreated syphilis experiencing a perinatal death. This high perinatal mortality has serious psychological and cultural implications for these women experiencing unsuccessful childbearing. Although a low technology screening test exists and penicillin remains an effective drug for treatment, syphilis remains an ignored maternal and perinatal health problem in many developing countries. The implementation of this intervention requires a functioning health care delivery system in which blood specimens can be obtained, tested and reported so that reactive women can be promptly treated. Currently, this is considered beyond the capability of many health care delivery systems in Africa. We investigated the syphilis sero-reactivity rate among pregnant women to assess the implications of this non-intervention policy on the perinatal mortality rate among Malawian women.

Among consecutive attendees at first antenatal clinic visit in a rural community, blood specimens were obtained and stored on filter paper. Subsequently, samples were eluted from the filter paper for use in sensitized (RPR) venereal disease research lab (VDRL) antigen and microhemagglutination assay for antibodies to *Treponema pallidum* (MHA-TP) tests. Twenty-three (29%) of the 78 women tested who had a stillbirth had reactive VDRL and MHA-TP syphilis screening as compared to 12 (3%) of the 384 women tested with liveborn infants. Extrapolation to the entire study population results in a reactive syphilis screen rate of 4.1%. By eliminating syphilis in this population, the stillbirth rate could be reduced by 26%. This would result in a 16% reduction of the perinatal mortality rate from 68 per 1000 births to 57 per 1000 births.

The combination of a quantifiable impact of untreated syphilis on perinatal mortality and the availability of a low cost, effective intervention justifies the urgent need to address this problem. To implement this intervention, improvements in the basic infrastructure of the health care delivery system that provide effective management of a testing and treatment program are absolutely necessary.

Infection Prevention Guidelines: Effectiveness of Instruments and Equipment Processing Procedures

Authors:
Wendy Cronin, MS
Noel McIntosh, MD, ScD
Linda Tietjen, BSN

Providing a safe environment for the delivery of family planning services, regardless of a facility's size and location, is essential. In developing countries, health care workers - especially those responsible for performing/assisting surgical procedures, processing instruments and equipment, housekeeping and waste disposal - are increasingly at risk of contracting AIDS (HIV) and hepatitis B (HBV). Protective measures for pre-treating contaminated (used) surgical instruments, needles and syringes, and reusable gloves prior to either high-level disinfection (HLD) by boiling or sterilization include:

- decontamination by brief exposure to 0.5% chlorine (bleach) solution, and
- thorough cleaning (washing with soap and water).

Decontamination is the first step in handling instruments and objects which may be contaminated with HBV or HIV. Soaking these items for 10 minutes in 0.5% chlorine solution immediately after use and before leaving the examining, procedure or operating room, kills HBV and HIV.

Cleaning with soap and water is the most effective way of reducing the number of microorganisms (up to 80%) on contaminated instruments and objects. Moreover, neither HLD or sterilization procedures are effective without prior cleaning.

Simple-to-do, inexpensive decontamination and cleaning guidelines are discussed which can help ensure that clients and staff never become infected from contaminated instruments or objects.

Maternal Mortality Due to Tetanus: Prevention or Backstreet and Backcountry Neglect

Vincent Fauveau, M.D., M.P.H.
Robert Steinglass, M.P.H.
Masuma Hamdani, M.P.H.
Marjorie Koblinsky, Ph.D.

WHO estimates that 500,000 women in developing countries die annually from complications of pregnancy, abortion attempts, and childbirth. Tetanus represents an important cause of preventable maternal mortality, although it is mentioned, if at all, only in passing in standard references on safe motherhood. A review of the magnitude of the problem, based on community data, is seriously overdue. A preliminary estimate by the authors as part of a World Bank review of health sector priorities for the 1990s indicates that 30,000 deaths due to postpartum and postabortal tetanus occur annually, accounting for 10% to 25% of total non-neonatal mortality due to tetanus.

Attention of public health workers involved in child survival has largely been directed towards immunizing women with tetanus toxoid (TT) as a means of protecting future unborn babies against neonatal tetanus (NNT). That women need to be protected in their own right against the septic risks associated with pregnancy and childbirth is often overlooked.

Trends and epidemiological risk factors for non-neonatal tetanus incidence are reviewed. Historical experience in developed countries is not germane to the situation prevailing in developing countries. Unless significant resources are allocated to its rapid reduction, declines in tetanus will occur slowly despite the availability of an inexpensive, heat-stable and highly immunogenic vaccine. The proportion of births delivered with clean cutting and care of the umbilical cord is not expected to improve quickly.

On behalf of A.I.D., REACH has been involved in all facets of tetanus control. Lessons learned have included:

- Increased awareness is needed by health planners, providers, women and their families about prevention of tetanus through TT and clean delivery;
- communication and mobilization strategies aimed at both providers and consumers are needed to overcome barriers;
- within the EPI, equal emphasis must be given to TT immunization of women;
- EPI and MCH staff have a joint role in reducing tetanus;
- girls and women of childbearing age are targets for TT immunization;
- every service contact with women should be used to increase TT coverage;
- improved indicators of TT coverage and clean deliveries are needed.

Integration of EPI with MCH services is needed. TT coverage should be a performance indicator for quality/quantity of MCH services. Definition of "fully immunized child" should include the concept of a baby born protected against NNT by virtue of the TT immunizations received by its mother.

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Theme IIB Concurrent Session: Enhancing Family Planning Programs

Session Chair: Andrew Fisher

WOMEN'S REPRODUCTIVE HEALTH IN URBAN SQUATTER SETTLEMENTS: A NEEDS ASSESSMENT

Dr. Rennie D'Souza, Dr. Inayat Thaver
Department of Community Health Sciences
Aga Khan University, Karachi

The findings from two independent cross-sectional studies in the squatter settlements ('Katchi Abadis') of Karachi are presented. The first (1988) involved interviewing 471 women of reproductive age from five katchi abadis (Katchi Abadi's study). The second (1989) involved interviewing 502 women from one katchi abadi Essa Nagri. (Essa Nagri study). In all other respects the populations and reproductive health findings in these five katchi abadis are fairly similar and the findings are presented together.

Of 502 women from Essa Nagri study, the mean age at marriage was 18 years and the mean number of pregnancies per woman 4.6. Of all gravidae, 34.5% of women had more than five pregnancies, 48.6% of married women experienced either an abortion, still birth or child death, 23% experienced at least one or more abortion, 3.6% had a still birth, and 37.3% of had at least one child death.

Although 63.8% of 471 women from Katchi Abadis study had some hospital-based antenatal care, 69.2% were delivered at home. Of these, 43.7% were delivered by untrained traditional birth attendants, and 41% had no immunization against tetanus in the last pregnancy.

The reproductive health of women in Karachi katchi abadis is poor. Even modern health facilities have had no effect in providing basic essential antenatal and birthing care for nearly half of those that utilize it. Our findings show increased pregnancy wastage and child deaths, associated with poor ante-natal care. Primary Health Care Programmes can address these issues in squatter settlements. Training and incorporating traditional birth attendants and (female) Community Health Workers in a domiciliary midwifery programme will ensure better pregnancy outcome and child survival.

HOW AIDS PREVENTION TRAINING IS CONTRIBUTING TO IMPROVING QUALITY OF CARE IN FAMILY PLANNING PROGRAMS

Laura C. Smit
IPPF/WHR

Since mid 1988, IPPF/WHR has carried out a series of training activities to integrate AIDS prevention into existing family planning programs. The strategy has consisted of holding (1) separate subregional meetings for Latin America and the Caribbean for the Executive Directors of 39 family planning associations, (2) subregional training of trainers, and (3) country-specific sessions in selected countries for front-line family planning workers.

The areas that have been addressed which have an impact on quality of care include: counselling skills and process, facts and feelings about AIDS/sexually transmitted diseases (STDs), human sexuality, and infection control procedures. In the process of providing facts about STDs including AIDS, of soliciting feelings about AIDS, and of talking about how to prevent AIDS, the trainees themselves recognized the need for improvements if family planning workers are to play a role in AIDS prevention.

For example, during the training, the participants requested more exercises in values clarification, in differentiating between myths and reality in sexuality, and in understanding "safer sex." They realized that increasing staff comfort and capacity in talking about sexuality with clients would help not only with AIDS/STD prevention, but with their contraceptive counselling as well. They recognized that counselling is different from simply providing information, and that specific skills (such as reflecting feelings, asking questions, and paraphrasing) are necessary with clients. Trainees noted that they needed to improve their infection control procedures, and several have developed training materials for this purpose.

Numerous lessons have been learned, many of them applicable to the Action Agenda of the conference. Health care depends primarily of staff, and staff capacity depends primarily on training; the participatory nature of these training sessions is recommended for any activities designed to improve quality of care in women's health. A training manual for counselling skills has been developed which helps workers to acknowledge the importance of and learn the techniques involved. Using AIDS/STD prevention as the content of the training has not only given family planning workers the ability to talk about AIDS to their clients, but has also made them sensitive to the issues of sexuality that can arise in women's health care.

FALLING THROUGH THE CRACKS: POST-ABORTION FAMILY PLANNING

Janie Bensor, M.P.H.; Francine Coeytaux, M.P.H.; Ann Leonard, R.N., M.S.P.H.; Jose David Ortiz Mariscal, M.D.; Joan Healy, M.P.H.; Judith Winkler, M.Ed

Successful family planning programs in developing countries often design program strategies which focus on women at high risk of unwanted pregnancies. These population groups include adolescents, post-partum women and older, high-parity women. However, a large group of women, those who have sought clandestine abortions, has been ignored by most family planning programs.

A number of compelling reasons exist for addressing these women's needs. Thirty million or more abortions are performed in the developing world each year. These women risk their lives to avoid a birth; at least 250,000 women die annually from abortion-related complications. Studies have shown that women are highly motivated to use contraceptives following an abortion, especially more effective methods, if they are available. The provision of family planning information and methods is the most direct way to reduce the incidence of abortion and safeguard the health of women who otherwise would seek an unsafe abortion.

This paper will discuss the current obstacles to the provision of family planning services to post-abortion clients. These include health system divisions between the delivery of gynecological care and family planning services; misinformation among providers about appropriate contraceptive methods for post-abortion women; the hostile political environment toward abortion care; and a lack of recognition of the problem of unsafe abortion and the resulting need for contraceptive services. Strategies to meet the family planning needs of post-abortion women will be suggested.

CONTRACEPTION DURING THE POSTPARTUM PERIOD: Perspectives From Clients and Providers in Three Regions

Cynthia Steele Verma
Evie Landry

While there is renewed interest in postpartum contraception on the part of service providers and policymakers, little is known about the knowledge, attitudes and experience of women with regard to postpartum family planning. There are many assumptions and opinions about postpartum family planning (e.g. that women are especially receptive to contraception at this time), but few studies which reveal how pregnancy and its outcomes may influence women's interests in choices of contraception. This research was undertaken to gain insight into women's decision-making and preferences for postpartum contraception, as well as how education and services for postpartum family planning are provided.

A study of client attitudes regarding postpartum contraception was conducted in Africa, North Africa and Latin America. The research looks at the information women received about family planning during the prenatal, intrapartum and postpartum periods; what kind of information and services women would like; and reasons for choosing a postpartum contraceptive. This information was collected through focus group discussions with pregnant women, and structured interviews with women who had recently delivered a baby. Service providers were also interviewed to learn their views and concerns about postpartum contraception and family planning decision-making during the perinatal period. In addition, background information was collected about the organization of postpartum services.

The intent of this research was to determine whether providers' views and the way services and education are delivered match the women's expressed preferences and their actual experience. The results will help improve the delivery of family planning information and services at the maternity sites where the research was conducted. The research findings are being used to develop client education material for postpartum family planning, to orient services for postpartum family planning to women's needs and interests, and to design appropriate training for service providers.

More broadly, the research demonstrates that approaches to meeting women's health needs must be predicated on a valid understanding of what women want and why. Since women may be most likely to interact with the health system when they are pregnant or delivering a baby, the perinatal period is a critical opportunity to provide appropriate education and services for postpartum family planning.

**Theme IIb Concurrent Session: Female Circumcision
Session Chair: Gordon Wallace**

A Grassroots Project by Nurses in Nigeria to Eradicate Female Circumcision.
Mrs. Christine Adebajo, Project Director, National Association of Nigeria Nurses and Nurse-Midwives (NANNM), Lagos, Nigeria.

A baseline survey conducted by the Nurses' Association found that harmful traditional practices, including child marriage and female circumcision, are found in all areas of Nigeria. The Association decided to launch a health education campaign to eradicate these practices. They sought the collaboration of PATH (Program for Appropriate Technology in Health) to develop a community level campaign using the large network of nurses throughout the country. Mrs. Adebajo will outline the approach and the results of this project.

A WORLD REVIEW OF TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN - AND
ACTIONS FOR CHANGE *

by Fran P. Hosken / Women's International Network. **

WORLD REVIEW:

- Definition of Traditional Practices Affecting the Health of Women, - including Female Circumcision / Genital Mutilation (FC/GM), Food Tabus, Violence against women / Wife Abuse, Declusion, Child Marriage etc.
- Epidemiology and Background Facts - the Effects on Health & Development
- The Spread of FC/GM and Violence against Women - a Global Review
- The Economic Costs to National and Health Budgets of Traditional Practices
- The Human Rights Implications: United Nations Actions and Country Reports on Human Rights Practices

ACTIONS FOR CHANGE

- The WHO Seminar on Traditional Practices Affecting the Health of Women & Children: 1979 Khartoum - Recommendations
 - Foundation of IAC - Inter African Committee 1984 Dakar and Action Plan
 - Education for Change : The Childbirth Picture Books with Additions on FC/GM and other educational initiatives
 - Report from 1988 International Seminar in Mogadishu on "Strategies to Bring About Change" by SWDO and AIDoS with Africa wide participation
 - Second IAC - Inter African Committee - Conference Addis Ababa with 22 African Countries participating and other Affiliates - Recommendations for Actions and Health Education / Initiatives and review of activities.
 - Health Education / Preventive Actions in Europe, USA, world-wide - the link to AIDS.
- *) The author of this presentation was the temporary advisor on FC/GM to WHO at the Seminar on Traditional Practices Affecting the Health of Women and Children held with 13 African and Middle Eastern Countries participating and is the author of numerous research articles published in health journals on FC/GM as well as "The Hosken Report - Genital & Sexual Mutilations of Females" and author of the "UNIVERSAL CHILDBIRTH PICTURE BOOK" the most widely used teaching book on reproductive health used regardless of language or literacy and used in many languages world-wide. She is the publisher/editor of Women's International Network News (since 1975 / Quarterly) which reports in every issue on Women's Health and FC/GM world-wide, as well as on Violence, Development, the UN and more.
- **) WOMEN'S INTERNATIONAL NETWORK / NEWS / 187 Grant st. Lexington MA 02173 USA (617) 862-9431

Medical and Cultural Aspects of Female Circumcision in Somalia and Recent Efforts for Eradication
Dr. Asha A. Mohamud

Dr. Mohamud will discuss the medical aspects of the harmful traditional practice of female circumcision (FC) which has been undergone by over 90 million women and girls in 26 African countries. She will note the types of FC and medical consequences, both immediate and long-range. She will present the cultural background of the practice in Somalia and trace the present changing cultural attitudes and recent efforts to eradicate FC. She will discuss the role of various indigenous groups, both public and private, collaborating to bring about change in Somalia through different types of approaches and programs and also the role of international collaboration in supporting the efforts by Somali women.

STATEMENT OF PURPOSE

Deborah Ongewa and Joyce Naisho

To discourage female circumcision among selected Kenyan communities, thereby improving the health of the affected women.

Objectives

To determine the following:

The extent and nature of female circumcision among selected communities in Kenya; the impact of female circumcision on the physical, mental and social well-being of the affected women; the health care available to victims of female circumcision; the reasons for continued female circumcision despite the declared government policy against the practice; and the strategies for discouraging the practice.

Hypotheses

- that majority of household heads where the practice has discontinued understand the health effects and other consequences of female circumcision;
- that traditional beliefs and values are major factors in female circumcision practices;
- that environmental and religious factors re-inforce female circumcision practices.

DESIGN AND METHODOLOGY

- (i) Study Sites: Eastern, North Eastern, Rift Valley and Nyanza Provinces of Kenya, among the Somali, Maasai, Maru, and Kisii peoples respectively.
- (ii) Investigation: Population-based surveys, and secondary data.
- (iii) Sampling: In each province, three administrative divisions will be selected - two where the practice is still prevalent and the other where it has declined over the last 30 years. In each division, three villages will be selected for the study; with 15 households randomly selected from each village.
- (iv) Data Collection: Using structured questionnaires, discussion groups and observations. Interviewees to include household heads, community leaders, the youth, circumcisors, and health providers.
- (v) Variables will fall into the following categories: Socio economics, health, and KAP (Knowledge, Attitude and Practice).

ANALYSIS OF MAJOR FINDINGS

Use of computers to process and make comparative analysis of the data.

IMPLICATIONS FOR THE ACTION AGEND

Study will lead to better understanding of the nature and extent of the problem and possible strategies for discouraging the practice. This would enhance participatory policy development and to the design of effective information, education and communication programmes as well as focussed health programmes for the various target groups.

Theme IIB Concurrent Session: Preventing Maternal Deaths--What Works?

Session Chair: Deborah Maine

REGIONALIZATION OF PERINATAL HEALTH CARE IN A RURAL AREA IN INDONESIA

Anna Alisjahbana
Department of Epidemiology & Biostatistics, School of Medicine
Padjadjaran University, Bandung, Indonesia

An ongoing Risk Approach Study in Perinatal Health in Tangjursari, a rural area in West Java (Indonesia), shows that lack of appropriate care can be ascribed to the following factors:

- Lack of knowledge and motivation as well as acceptance of referral by the women result in delays in referral.
- Communication and transportation interfere with timely referral.
- Shortcomings and deficiencies at the health service provider level.

To improve the health care delivery system for maternal and perinatal care, an integrated and close collaboration between the informal, formal and intersectoral service systems is necessary. A regional care system links all sectors including hospital and primary care facilities into one system with the purpose of providing appropriate and immediate antenatal, intrapartum and postpartum care at the primary, secondary and hospital levels or care. A Maternal & Child Hut at the village level will act as the primary level to provide antenatal care and clean delivery while serving as a post for immunization and family planning. A nurse-midwife with a TBA will provide the services. The MCH Hut is supervised by the health center, while health center personnel are supervised by the specialist at the hospital. A network of referral and feedback as well as improved communication and transportation will complete the network to provide care during emergencies.

MORTALITY IMPACT OF A COMMUNITY-BASED MATERNITY CARE PROGRAMME IN RURAL BANGLADESH

By V. Fauveau et al.

INTERNATIONAL CENTRE FOR DIARRHOEAL DISEASE RESEARCH, BANGLADESH

A programme to reduce maternal mortality was implemented and evaluated as part of a primary health care project in a rural area of Bangladesh. The programme consisted in posting trained midwives at two decentralised health outposts, with the responsibility of attending as many home-deliveries as possible, detecting obstetrical complications at their onset, and managing these complications on the spot, or accompanying the patients to the project maternity centre for higher level care. The impact of the programme was evaluated by comparing obstetric maternal mortality ratios between the programme area and a neighbouring control area without midwives. Other characteristics, including coverage and utilisation of health services and family planning, were similar in both areas. Ratios per 1000 live births of maternal deaths due to obstetric complications were similar in both areas during the three years preceding the start of the programme (4.4 vs 3.8 per 1000 live births, ns). In contrast, the ratio became significantly lower in the programme area than in the control area during the three years following the start of the programme (1.4 vs 3.8 per 1000 live births, $p=0.02$). Ratios of deaths from causes other than obstetric were not different.

These results suggest that posting midwives in villages, and giving them the means to home treat common obstetrical problems at their onset or to refer them, have the potential to decrease direct obstetric mortality rates by as much as two-thirds. The inputs for such a programme to work and the constraints for its replication at a large scale, however, should not be underestimated.

MATERNITY CARE IN GRENADA, WEST INDIES: A COMPREHENSIVE STUDY

Virginia Laukaran, Dr.P.H. and Adity Bhattacharyya, M.D.

PURPOSE: To investigate maternal and perinatal mortality and to describe the content and organization of prenatal and maternity care in Grenada, a setting with limited resources. To identify the services needed to maintain relatively low levels of maternal and infant mortality and estimate the cost of such services.

METHODS: Vital statistics for the entire population, a chart review of hospital records from a probability sample of 258 complicated deliveries, clinical observations and interviews with health professionals were used.

RESULTS: A highly accessible system of prenatal care given by nurse midwives with referral for women with signs of pre-eclampsia, hemorrhage, malpresentation, gestational diabetes and other complications has permitted Grenada to attain a comparatively low level of maternal mortality (12.0 per 10,000). Currently, efforts are underway to reduce perinatal mortality. Among General Hospital births in 1987-88 the perinatal mortality rate was 37.2 per 1,000. The proportion of institutional births was 90%, nurse midwives attended 87% of all births including hospital and home deliveries. Less than 4% of births were caesarian sections, performed only by obstetricians. Nurse midwives take considerable responsibility while acting on the basis of clearly defined protocols. Communication via telephone between the PHC and hospital clinics and lab and the use of a patient's prenatal record card are fundamental to the smooth functioning of the referral system and to adequate reception of incoming cases from the PHC. No attempt is made to use social criteria to define women for increased follow-up. PHC care is free to all and obstetric referral is made when and if there are signs of complications.

CONCLUSIONS: An accessible program of prenatal care with an effective referral network for complications and efficient second level treatment can bring about impressive reductions in maternal mortality with limited supplies and equipment.

THE QUETZALTENANGO MATERNAL NEONATAL HEALTH PROJECT

Barbara Schieber, M.D.
Principal Investigator

Guatemala occupies one of the worst positions in the hemisphere in regards to maternal and infant mortality (est. MMR: 100-144 per 100,000 live births, est. IMR: 73.4 per 1000 live births). The TBA is the primary provider of health care for women in Guatemala, with the estimated 20,000 TBAs attending 60% to 70% of all births and providing the majority of prenatal care. Despite their important role in maternal and infant health, TBAs rarely have an effective working relationship with the formal health system. TBA training has been carried out for over 30 years by the Government of Guatemala and the many NGOs working in the country, however, in most cases this training has been based on a western medical model, which is not only inappropriate for childbirth in the community but may also cause harm by discouraging beneficial traditional practices and introducing, through example, dangerous and unnecessary medical interventions.

A study of community, TBA, clinic and hospital response to "high risk" events during pregnancy and delivery was carried out from 1988-89 by INCAP (the Central American Health and Nutrition Institute) in the highland department of Quetzaltenango. This presentation will report on the findings of that study and the project started in 1990, in response to them. The Quetzaltenango Maternal and Neonatal Health Project is a joint effort between the AID MotherCare Project and INCAP. Using an operations research design, INCAP is working with local health authorities to develop and test an improved "case management" approach to prenatal, obstetric and postpartum care at all three levels of the health system (community/TBA, clinic and hospital). The case management approach relies on the early identification, referral and proper institutional management of high-risk events as they occur, rather than the referral of women based on broader and less sensitive predisposing "risk factors" such as age and parity. The project recognizes the TBA as a key element of the health system and as the primary channel of communication for the mothers, families and communities she serves. Improving the standard of care and attitudes towards the TBA at the institutional level, while at the same time increasing the knowledge and skill levels of the TBAs, is the focus of project interventions.

Theme IIB Concurrent Session: Women Working for Change
Session Chair: Mary Beth Moore

THE GONO GOBESHONA APPROACH IN IMPROVING WOMEN'S HEALTH. The
Case Study of Banche Sineha.

Angela Gomes

This paper aims at describing our experiment on participatory planning process which have creatively designed programs for and by the rural poor and destitute women by applying Gono Gobeshona (Mass research or Participatory Research) method. When we say Gono Gobeshona approach we emphasize that the target women must be equipped with data on micro-realities as a prerequisite in their empowerment process.

Village women collected & displayed health data in 100 villages. They used these data to analyze their health problems, formulate program strategies and develop viable plan. The GG (Gono Gobeshona) exercises empower them to mobilize internal as well as external resources ultimately evolving a participatory PNC (Primary health care) model. The target women are now militant to claim & realize services & inputs from the government since needs are quantified based on data. Education, skill development and subsequent increased income combined with health education enabled them to ^{maintain} income balanced ^{well}. Impacts are already visible in terms of 100% immunization of all the children & mothers, no mortality record during delivery, dramatic rise in school attendance by children from the poor category, collective rise of women against unjust male dominance, significant fall of malnourished children in the project area & women's collective contribution to treat malnourished children through giving improved diet, administering & managing rural health clinic by the rural women, developing a sound referral system, successfully resisting health frauds in the villages, ensuring timely supply of essential drugs in the remote village etc.

As an alternative to present doctor-dependent curative based health system they have undertaken short-term and long-term measures of developing a preventive health care system as well as preparing batches of trained midwives, health workers & paramedics who will be staying in the villages with them unlike urban minded affluent doctors.

Time is now to consolidate success, work out a time-plan to gradually overcome failures and formulate strategies to replicate through other NGOs in order to achieve Health for All (HFA) within the shortest possible time.

Our Projects, Ourselves: A Case Study in Haiti
M. Catherine Maternowska, Joan Haffey, and Yvette Menard

Based on seven years of field experience in urban and rural Haiti, this paper will detail how the idea of a family-planning program in an urban slum in Port-au-Prince has led to a comprehensive women's health project in the rural mountains of Haiti. Both the rural and urban counterparts advanced a radically novel proposition: to take poor women, most of them nonliterate, and invest them with the training and resources requisite to becoming active agents in the struggle to improve women's lives, and thereby the lives of the urban and rural poor.

Years of development experience have yielded an important but often forgotten lesson: projects work best when the people for whom they have been conceived are involved in the planning, implementation and evaluation of all initiatives. One small grant from a non-governmental organization, who was willing to believe this credo, has developed into seven separate but inter-related projects squarely addressing the needs of Haitian women including contraception, literacy and employment generation. This paper will trace the history of these projects and how Haitian women were integral to the success of what is now a country-wide model of health care provision.

The momentum generated was not without obstacles including initial disapproval from large federal and international bureaucracies as well as difficulties in finding funding agencies that embraced similar goals. Yet, steps were taken to protect the integrity of the projects and barriers were overcome. This country case study clearly demonstrates how the process of planning and managing women's health initiatives must reflect the concerns of the women they are designed for and above all must be accountable to the communities they serve.

Abstract Not Available for Publication

**WOMEN HELPING WOMEN IN WAR-TORN MOZAMBIQUE:
AN INTEGRATED APPROACH TO SELF HELP IN
HEALTH, AGRICULTURE AND EDUCATION INTERVENTIONS**

Gilles Rouillon, M.D.
Gail Snetro

This report demonstrates the role of women and their internal community structure in countering poverty and disease through self-reliance in a war affected area. The application of an integrated approach towards addressing women's health and lifestyle needs over a two-year period is described.

The development of a community-based nutrition demonstration center in Southern Gaza, Mozambique, provided the foundation through which village women trained other women to monitor growth in their children, reverse growth faltering trends, practice making appropriate weaning foods and exchange knowledge on preventative behavior against local health problems.

Volunteer women activists who practice their skills during training sessions at the center are a community resource in monitoring health conditions for families in their area, controlling vaccine coverage and women's needs. The center is part of an intervention which involves the agriculture sector, water, literacy training and small scale credit operations.

The skills women learn at the center and through the multi-sectorial approach can be taken with them in case of destabilization effects of the war.

Examples of specific training interventions and their results are provided to demonstrate the ability of indigenous women's groups to improve lifestyle conditions.

We conclude that an integrated sectorial approach to project planning relying on the indigenous organization of women plays an important role in survival for war-torn populations.

Theme IIb Concurrent Session: Women's Empowerment--Critical for Health Session Chair: Sidney Schuler

Woman's Health : An Empowering Process to Identify Needs and Access Services in Rural Nepal.

Beaton, Susan C.

One component of the Nepal Health Development Project has been a Community Development Process in a local community. Emerging from this is a strong emphasis on women's issues, including health.

Through a Participatory Research Process, common areas of concern to the villagers were identified. Appropriate plans of action were designed by the groups to provide solutions to the identified problems. These included the mobilization of local skills/resources in addition to increasing effective access to government services. The initial groups formed were the Women's and Health groups.

The Health group targeted clean drinking water and the building of "smokeless" cooking stoves. This was due to concerns regarding the high incidence of ARI, GI and eye diseases. The priority for the women's group was income generation, literacy and legal rights. Both groups co-operated in their action programs with the women taking a leading role.

As a result of the process, women have developed the skills to publically express their needs and concerns, which previously was socially and culturally unacceptable. A sensitized and responsive Health Post has responded to the women's demands with out-reach MCH clinics, and co-operation with Traditional Healers thus increasing the utilization of Health Services by the female population. The success of the smokeless stove building, using women to women peer education has resulted in approximately 25% of households using this new technology. It is too early to objectively assess the impact on health indices with regard to ARI, GI and eye diseases.

The women's group has been the most active in the development and implementing of their ideas. The use of a video project has aided their efforts in spreading their message of women's health issues within and outside their community. Women from neighbouring communities have visited to learn about the process and discuss common concerns.

With the experience gained, the women are now actively engaged in assisting in the formation of other special interest groups e.g. forestry. They are also active in the spread of this process to adjacent communities through expansion teams.

IMPACT OF WOMEN'S EMPOWERMENT THROUGH SAVINGS GROUPS ON WOMEN'S CONTRACEPTIVE BEHAVIOR IN SAVE THE CHILDREN, BANGLADESH

Sk. M.D. Aminul Islam

The Bangladesh Field Office of Save the Children (SC) has been organizing Women's Savings Groups (WSG) in 17 "old" villages since 1982 and in 11 "new" villages since 1989. The WSG members save a little money each month, meet regularly, discuss different issues relevant to their lives and invest their savings or take loans for small-scale income generating activities.

Some preliminary results from SC's Program Management Information System (PMIS) show that child survival is higher in WSG members' families than non-members, contraceptive prevalence is higher among members than non-members and fertility is lower among members than non-members.

The University Research Corporation, Bangladesh, designed and conducted a study to examine and document the impact of women's empowerment through WSG membership on contraceptive behavior.

The study was conducted in 5 "old" and 3 "new" SC project villages and 2 randomly selected comparison villages from the same geographical area. The characteristics of the experimental (SC) and comparison (non-SC) villages were largely similar in terms of household size, age, parity, etc. The methodology of the study included a baseline survey, comparison of selected variables from the PMIS with the baseline survey, two rounds of in-depth investigations and a mini-CPS.

Findings show that contraceptive use, both ever and current, is higher among the members than non-members (baseline current CPR in old villages among members 30.9, non-members 17.9), higher in the old than new villages (baseline current CPR 16.9 among members and 12.9 among non-members in the new villages). It is also higher in the experimental than comparison villages (baseline current CPR 7.3), suggesting that the SC program has not only contributed to raising contraceptive usage among the members but also among the non-members residing in the project villages.

The in-depth investigations show that participation in WSGs empowered the women in terms of gaining more control over sale of household products, control over cash proceeds from the sale of these products, increased mobility and higher self esteem. Consequently the women play a stronger role in household decision making, which in turn creates favorable fertility norms among them, and which eventually motivates them to contracept. It appears that WSGs are an effective means of improving women's status in rural Bangladesh, which when combined with birth spacing motivation and services can be used as an effective strategy for raising CPR. Increased CPR should contribute towards improvement of women's health and nutritional status.

USING 'OUR OWN RESOURCES' AS AN ALTERNATIVE WAY OF IMPROVING WOMEN'S HEALTH

Chief (Mrs.) Bisi Ogunleye

The Country Women's Association of Nigeria (COWAN) saw the need for people's participation in getting health education and services to the rural areas and embarked on its program of "Rural Integrated Health and Family Planning Education and Services." This program includes the following projects:

Family Planning Education and Services: This project trains selected members to serve as Community-Based Distributor Promoters (CBDBs); 300 CBDBs have already been trained. The CBDBs educate women and rural communities at large about the need for family planning. This type of education enables rural women to make their own choices, particularly that of whether or not to use family planning. The CBDBs also sell commodities to interested clients. At the present time, COWAN is operating in 102 communities in Ondo State.

Community Health Provision: In order to ensure rural women's access to maternity and pre-natal care, COWAN organizes consultative meetings annually for the Community Visiting Nurses and the Community Traditional Birth Attendants (TBAs), both of which are COWAN members. These kinds of meetings have resulted in numerous referrals to community clinics and hospitals. In addition, COWAN has established a health revolving loan fund to take care of referred cases and has a clinic center and a boat for a mobile clinic in the river-borne areas of Ondo State.

Nutrition: COWAN is very concerned with the poor nutritional intake of its members and rural communities. Thus, it provides training in the production, utilization and preservation of soybeans, vegetables and fruits. In addition, it is a "must" for every COWAN member to plant 2 orange trees, and over 32,000 have been planted since 1976.

By using available human and material resources at the community level, COWAN has been able to educate and service many in the rural areas about the need for good health. Future plans include additional community/mobile clinics and mini-pharmacies and the training of more community health promoters.

The Evolution of the Village Women's Development Program in the Kingdom of Tonga

Seini Vakasiuola

Statement of Purpose:

The evolution of the Tongan Village Women's Development Program, founded by the Foundation for the Peoples of the South Pacific (FSP), is examined in relation to its increasing independence and status as an indigenous NGO.

Design and Methodology:

FSP has worked in Tonga since 1978. The Village Women's Development Program has since then developed into one of the most active and effective non-government organizations working in rural development in Tonga. The members have received training in organization and leadership skills, how to identify needs and how to develop projects as a group. Leadership has been transferred to a Tongan National.

Primary activities of the group have been in the Village Food and Nutrition Program which focusses on promoting and protecting breastfeeding and improving maternal and infant feeding practices. The Village Women's Development Program has worked with the Village Food and Nutrition Program to train field workers and village groups and run workshops on family food production, good nutrition and health practices, breastfeeding and weaning foods. The Village Women's Development Program significantly contributes to the South Pacific Maternal and Infant Nutrition Newsletter.

Analysis of Major Findings:

The transfer of skills has resulted in a strong indigenous non-government organization which has the power to impact upon government policy. Women have been empowered with management skills and a sense of ownership and responsibility for their own health.

Implications for the Action Agenda:

FSP's activities in Tonga can serve as an example for the role of international PVOs in enabling women to become involved in activities, planning and policy which affect maternal and child health. In countries where the status of women is traditionally poor, providing women with the skills and desire to demand health care services can be the most sustainable role for a PVO.

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— *International Interdependence in Health* —
**IMPROVING THE HEALTH OF UNDERSERVED POPULATIONS:
A GLOBAL PARTNERSHIP**

June 14-17, 1992, Hyatt Regency Crystal City, Arlington, Virginia

The global health crisis continues to expand. Affordable care, including access to preventive services, eludes a growing segment of society. The disparity between actual needs of populations and national health policies to address these needs is growing. In developed countries, rapid industrialization and its consequences—including changing life styles and environmental degradation and pollution—have been detrimental to health. Developing countries continue to face problems of communicable disease and malnutrition, problems associated with environmental causes, and emerging problems with cancer and other life style related diseases. Health systems worldwide seem to be mired with increasing demands and diminishing resources. They are confronted with a number of formidable challenges, including access, quality, cost effectiveness and choice of technology.

It is under these conditions that the number of underserved people worldwide is dramatically increasing. In the United States approximately 37 million men, women and children have no health insurance at all, and millions more have only the barest coverage. In the developing world there are more than one billion underserved people. Thirty years of international health assistance from Western countries have helped, but other approaches are needed.

From this chaos, health and development professionals have found an increasing similarity between the health problems of the underserved in the United States and those of the developing world. Vaccine preventable diseases like measles have reached epidemic levels in some areas of the U.S. after years of control, and tuberculosis is on the rise. Adolescent pregnancy is increasing, and the U.S. infant mortality rate remains one of the highest among industrialized countries with pockets that rival developing countries. Weakened and constrained by such poor health, millions of people here and abroad will never attain an adequate education or reach their full productivity. Poor health has and will continue to be a drag on the economies of the U.S. and developing countries.

Emerging from these converging variables is the need for a new international health order for the next century; one in which the U.S. will shed its paternalistic approach to aiding developing countries. U.S. foreign assistance will become international assistance. Experts agree that the U.S. can learn much from successful health care approaches used in Africa, Asia, Europe and Latin America. Partnerships in which industrialized and developing countries work together to solve their similar health problems will be instrumental to improving the health of the underserved worldwide. Recognition of the human capabilities of people in developing countries will result in new forms of cooperation. It is in this context that the National Council for International Health is organizing its 1992 International Health Conference "Improving the Health of underserved Populations: A Global Partnership." The following are the conference goals:

- 1) To exchange information on approaches at community, state/district and national levels around the world to improve the health of underserved populations;
- 2) To examine and identify principles learned from these experiences which could be adapted for use in both industrialized and developing countries; and,
- 3) To target similar health problems among underserved populations in the United States, developing countries, and others which provide opportunities for collaborative solutions.

1992 CALL FOR ABSTRACTS

CONFERENCE THEMES

Theme I

Sharing Experiences for Improving the Health of Underserved Populations: International Perspectives

Abstracts should be designed to present specific case experiences of programs which have been implemented for at least one year, and which address one or more of the program aspects listed below:

- Targeted Population Approaches - used in reaching vulnerable groups, such as women, children, the elderly, homeless, ethnic minorities, etc.
- Settings Requiring Special Strategies - such as **urban** areas (eg. Healthy Cities) or **rural** areas (eg. outreach), etc.
- Problem Oriented Approaches - such as adolescent pregnancy, maternal nutrition, infant mortality, AIDS and sexually transmitted diseases (STDs), immunization, long-term care, addictions to drugs, alcohol and tobacco, etc.
- Geographic/Regional Approaches - such as Asia, including Japan and Australia; Africa, including South Africa; Middle East; Latin America, including the Caribbean, Central America and South America; United States, Canada and European countries
- Institutional Based Approaches - such as government initiatives (local, state/district, and national), voluntary organizations, foundations, universities, private enterprise institutions (eg. HMOs, insurance systems), etc.
- Intersectoral Approaches - such as programs which link employment and income generation to better health; and improved education to better health; etc.
- Approaches Which Emphasize Making Better Use of Existing Resources - traditional medicine, existing preventive and therapeutic approaches, appropriate use of available technologies, community based care, self-care, etc.

Theme II

Lessons Learned: Principles for Action

For more than 30 years the international development community in the U.S. and other countries has been focusing resources on improving the health of "the poor" overseas. At the same time considerably greater resources have been spent to improve the health of the underserved in the U.S.

What lessons have been learned in developing countries and in the U.S. from these experiences? And, what principles do they identify for future action?

Presentations from differing viewpoints, and from different countries, are strongly encouraged. Such perspectives may include community representatives, donor/recipient representatives (eg. government, foundations, voluntary organizations), technical/academic representatives, business representatives, media representatives, etc.

Abstracts should focus on one or more of the following areas:

A. Program Design - In relation to issues such as access, quality of care, cost, etc.

Which program strategies/designs appear to be the most or least effective in reaching the underserved? How is success best measured? Which programs are more likely to be sustainable? Replicable? Acceptable?

B. Policy Formulation

• How effective have primary health approaches been in improving the health of "the poor"? • What process results in the development of policies which most positively affect health improvements for underserved populations? • How critical is community involvement and "cultural sensitivity" in developing policies for the underserved? • What has been learned about the development of policies which protect the human rights, ethics and other special problems associated with underserved populations?

IMPROVING THE HEALTH OF UNDERSERVED POPULATIONS:

A GLOBAL PARTNERSHIP

June 14-17, Hyatt Regency Crystal City, Arlington, Virginia

CONFERENCE THEMES

Theme III

Targeting Opportunities for Future International Collaboration

International health has evolved from its traditional role of the wealthy donor nation aiding the Third World nation. The flow of assistance is no longer a one way street, but rather two way. The need now is for countries and people worldwide to share their experiences, adapting the appropriate strategies to their own circumstances. There is an imperative need to foster new relationships, strengthen old and existing ones, and work together in improving the health of the underserved.

It is time to enlarge our initiatives beyond the health profession, and to interact with other stakeholders in society — such as business and the private sector — to mobilize broader based alternatives and open new perspectives. It is equally important to look beyond the confines of national boundaries and to work with international health and development partners.

To move more aggressively toward this new goal, the Conference will develop a "Strategy for Partnerships."

Abstracts should focus on one or more of the following issues:

- What are the similar health issues of underserved populations which provide opportunities for collaborative problem solving between the U.S. and developing countries?
- How can meaningful alliances be developed both within and outside of the U.S. to meet these opportunities?
- What role can bilateral and multilateral international organizations (A.I.D., WHO, PAHO, UNICEF, UNFPA, UNDP and The World Bank, etc.) play in strengthening this collaborative process?
- How can information be shared more efficiently between people worldwide working on similar health problems?
- How can the **human leadership** necessary to achieve the goals embodied in this concept of a new international health order be established and supported?

PROGRAM TYPES

Panel Presentations

Individual papers are screened based on merit and grouped topically into panels by the Conference Advisory Committee. Each 90-minute panel session consists of four 15-minute presentations with half an hour for discussion. Slide projector and Overhead are standard AV equipment at each Concurrent Session. Session Chairs are recruited by the committee from the pool of abstract submitters.

Roundtables

This is an informal presentation type—the presenter makes a brief explanation of his/her research and then leads the discussion of up to nine other participants in a roundtable setting. No audio visual equipment is available but handouts are welcome. Roundtables take place in a one-hour time frame.

Posters

Participants display their graphic presentations throughout the conference and are available to answer questions during specified periods. Posters should be self-explanatory. The poster corkboards are 4'X8'. This program type is particularly appropriate for presenting data in graphic and tabular form.

Video/Films

These one-hour sessions include films, videos, and multi-media presentations.

IMPROVING THE HEALTH OF UNDERSERVED POPULATIONS:

A GLOBAL PARTNERSHIP

June 14-17, 1992, Hyatt Regency Crystal City, Arlington, Virginia

CRITERIA FOR SELECTION

1. **Significant**-Does the abstract relate to the conference theme? Does the abstract identify or illuminate key conceptual health or related issues?
2. **Methodologically Sound**-Does the abstract demonstrate a logical design? Are evidence or analysis presented clearly?
3. **Innovative**-Are principles and methods creatively applied? Does the abstract present new windows of discovery?
4. **Applicable**-Can the issues addressed be of value in other areas and in other health care situations?

ABSTRACT GUIDELINES

- ◆ **Do not submit** more than one abstract. Additional abstracts by the same presenter will not be processed.
- ◆ **Do not submit** complete panels or abstracts that describe panels. An abstract is a short version of a paper. It's not a list of presenters.
- ◆ **Complete the attached form (both sides)**. Incomplete submissions will not be processed. The information on this form will be used for the final program if the abstract is accepted.
- ◆ **Abstracts will be accepted in English, French, Spanish, and Portuguese**. If presentations are submitted in a language other than English and the paper is accepted, the presenter will be expected to provide either a translator at the conference or an English translation of the paper.
- ◆ **Type your abstract in the box provided, single-spaced, within the dotted border**. Abstracts should be camera-ready copy for production in the printed program. Abstracts that are not camera-ready will not be included. Standard abbreviations may be used by typing the whole word the first time followed by the abbreviation or acronym in parentheses.
- ◆ **Abstracts MUST BE postmarked no later than OCTOBER 15, 1991** to be considered.
- ◆ **All presenters must register for the conference and pay the discount registration fee**. A separate presenter registration form will be sent to accepted abstract presenters. NCIH cannot reimburse presenters for any conference expenses, including transportation, lodging, meals, etc.

Each submission must include the following

- ◆ Statement of purpose
- ◆ Description of the design and methodology
- ◆ Analysis of major findings

International Interdependence in Health

IMPROVING THE HEALTH OF UNDERSERVED POPULATIONS:

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Use one form for each abstract presenter. Please note: only one presenter per abstract. Do not submit complete panels. Please type or print legibly. This information will be used in the final program.

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Check one

- Theme I Sharing Experiences for Improving the Health of Underserved Populations: International Perspectives
- Theme II Lessons Learned: Principles for Action
- Theme III Targeting Opportunities for Future International Collaboration

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- Panel Presentation
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If your abstract is not accepted for the program type of your choice, would you accept the following type of presentation?

- Panel Presentation
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Nationality

Type of organization PVO/NGO Government Int'l Agency Consultant

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Conference Evaluation



Please fill out and drop this form off at any drop box location after the Closing Session.

1. Why did you attend the conference? On a scale between 1-6 (1-most important, 6-least important) please indicate in each box your rating.

- Interest in women's health
- Professional Development
- Presenter/Speaker

- Networking Opportunities
- Career Search
- Other _____

2. For each of the following program events, check (✓) if you attended and rate using a scale of 1-5, 1-excellent, 2-very good, 3-good, 4-fair, and 5-poor. Please state a reason for the rating.

Opening Session: _____ Attended

Rating _____

Theme I Plenary Session (Mahmud Fathalla and Barbara Torrey) _____ Attended

Rating _____

Theme I Forums (check one)

_____ Our Bodies, Our Perceptions _____ More than a Medical Issue _____ Beyond Reproductive Health

Rating _____

Theme I Concurrent Sessions (check one)

_____ Abortion _____ Access to Care _____ Female Morbidity _____ Listening to Women

_____ Nutrition _____ Reproductive Tract Infections _____ Socio-Economic Status

_____ Work and Women's Health

Rating _____

Theme II Plenary Session (Mary Racelis): _____ Attended

Rating _____

Theme II Forums (check one)

_____ Changing Priorities _____ Voices of the South _____ Initiatives in Women's Health

Rating _____

Conference Evaluation

Theme IIA Concurrent Sessions (check one)

- HIV/AIDS Innovative Models Obstetrical Risk
 Quality of Care Talking With Women TBA and Community Health Workers
 Women Helping Women Women's Rights

Theme IIB Concurrent Sessions (check one)

- Appropriate Technology Barefoot Doctors and Midwives Controlling Infection
 Enhancing Family Planning Programs Preventing Maternal Deaths
 Women Working for Change Female Circumcision Women's Empowerment

Rating _____

Awards Banquet (Antonia Novello): Attended

Rating _____

Public Policy Breakfast: Attended

Rating _____

Theme III Forums (check one)

- Women's Rights The Future of Activism Instruments of Change

Rating _____

Closing Session and Luncheon (Gabriella Bocec): Attended

Rating _____

Roundtables **Posters** **Videos/Films**

Comments _____

Exhibit **Career Center** **Receptions**

Comments _____

What type of organization are you affiliated with? (Ex. Gov't, PVO) _____

What is your major area of interest? (Ex. Population, Child Survival) _____

General Comments (Overall Program, Conference Operations, Registration, etc.) _____

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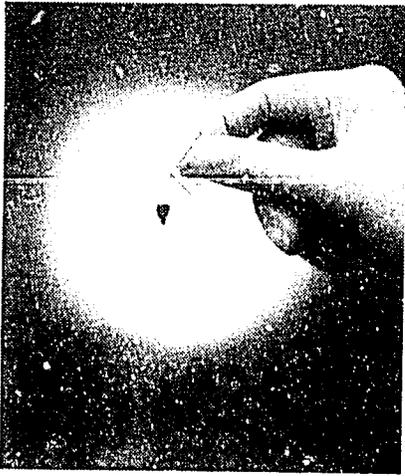
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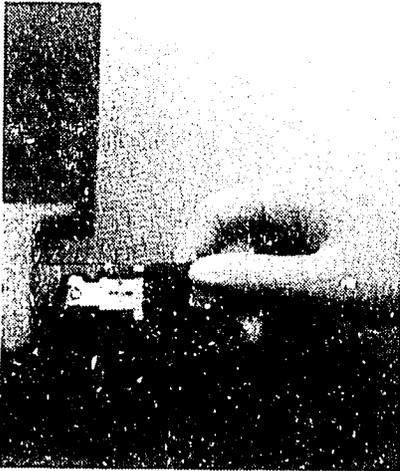
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- 3.** Results are displayed in 45 seconds.

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