

PJ - AAX - 136

ISN 50216

PROGRAMMING FOR WOMEN AND HEALTH

SUMMARY

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July, 1980

Prepared for the Office of Women in Development, Bureau of Programs and Policy Coordination, Agency for International Development by Equity Policy Center under contract number AID/OTR-c-1808.

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Summary

Health problems of Third World women fall roughly into three inter-related categories--those related to personal health, reproductive health, and occupational health.

A. Personal Health

Chronic malnutrition, perhaps the most important health problem affecting women in developing countries, compounding all other problems, affects women at each stage in their lives, but most severely once they start bearing children. By custom almost everywhere, women and girls tend to eat last and least of whatever is available to the family while they continue to carry heavy workloads. Women and girls are especially prone to nutritional anemia because of their relatively high requirements for iron, three times that of men. When not pregnant or lactating, they need nutrients to replace those lost in menstrual flow, while pregnancy increases the requirements of a woman's body to meet the needs of the growing fetus; during lactation, breastmilk passes iron and folate on to the newborn baby, to the detriment of the mother. An estimated 230 million women--i.e., about half the non-pregnant women and nearly two-thirds of pregnant women living in developing countries--are anemic.

Infections of the reproductive tract are numerous and widespread in women. They are caused by viruses, yeasts, bacteria, and other agents, and most are acquired through sexual intercourse. Pelvic inflammatory disease, involving inflammation of the fallopian tubes and/or ovaries and uterus, often follows, especially where the infection results from gonorrhea. The consequences can be serious enough to require hospital treatment for ectopic pregnancy, and genital tuberculosis; infertility is also a common result of genital infections.

Women are also at greater risk from other common diseases, in part because their maternal duties bring them into frequent contact with sick family members and household duties involve daily exposure to unsanitary conditions. Pregnancy heightens the risk. Malaria attacks are more severe during pregnancy, with greater risk of spontaneous abortion; where malaria is endemic, women lose their immunity during pregnancy and often die as a result. Tetanus, commonly associated with unhygienic methods of childbirth, is also a serious problem that affects both mothers and infants.

Mental stress among women is clearly a growing phenomenon. Traditional family and societal ties tend to weaken or break under the press of modernization, leaving older women particularly adrift. Migrant and refugee women are subject to a type of stress akin to culture shock, as well as that resulting from having to live, work, and care for children in conditions of poverty, alone and unsupported by the wider family.

Violence against women is encouraged by their lower status in the family and society. Notions of manliness, machismo, and honor in many Third World societies tend to support a system in which wife- and child-beating is condoned and rape goes unreported.

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Female circumcision affects as many as 10 to 30 million women in Africa and the Middle East. In its most extreme form (infibulation), female circumcision involves removal of all external genitalia and the virtual closing of the vagina. Girls are subject to extraordinary physical and psychological hazards from these crude operations, with damage that can last their lifetime. Despite its obvious implications for women's health, however, this practice persists, even in upper and middle class settings, because of its deep hold on the cultures concerned. Indeed, African women often insist that their daughters be circumcized in order to insure their marriageability. In December 1979, the regional Conference on the Integration of Women in Development at Lusaka went on record against infibulation, but condemned "international campaigns which do not take into account the complexity of African reality."

B. Reproductive Health

Childbearing, its prevention and its consequences, are the leading causes of death for women between 15 and 45 in many developing countries. Both maternal and infant mortality are higher when childbearing takes place below the age of 19, above the age of 35, and/or with the birth of the fifth and succeeding children. In these circumstances, complications of pregnancy (toxemia, hemorrhage, infection, etc.) result in maternal death rates as high as 8 per 1,000 (compared to less than 0.2 in the U.S.), especially when babies are born at home, in unsanitary surroundings, with help only from undertrained midwives.

Abortion--which is undergone by at least 35 million, and perhaps 55 million, women each year worldwide--is a health hazard of major proportions in the Third World. In Latin America, for example, it is thought to be the cause of 1/5 to 1/2 of all maternal deaths. Unsafe procedures abound, made even riskier when women try to abort themselves by methods that they have learnt only by hearsay. Tetanus is a particularly serious danger.

Abortion laws have not kept pace with medical developments. In Bangladesh, for example, a total of three medical practitioners is supposed to be involved in the abortion decision--a requirement unrealistic to the point of fantasy. Furthermore, the majority of developing countries permit abortion only if the life (not the health) of the mother is threatened. Even where laws are liberal, as in India, lack of facilities renders legal abortion effectively unobtainable for most women.

Contraception is increasingly seen as a health issue of special interest to women, in view of the hazards of frequent childbearing and illegal abortion. Not that the contraceptive techniques central to modern family planning are without risk. But uncontrolled fertility is, statistically, many times riskier. Some doctors suggest that the pill may actually be safer for women in poor than in rich countries, because the former are less susceptible to cardiovascular problems that are aggravated by smoking and cholesterol-rich diets. Studies by WHO and others appear to show that fears expressed regarding the injectible contraceptive, Depo-Provera (that it may induce cancer, infertility, etc.) have been exaggerated, and WHO has twice announced that its experts saw "no toxicological reasons for discontinuing its use," even though the U.S. government has yet to

approve it for domestic distribution and AID does not finance its distribution under U.S. aid programs.

C. Occupational Health

Toxic substances used in agriculture are of particular concern to women because of their need to protect the fetus. Some commonly used pesticides and fungicides are known to cause cancer, miscarriage, birth defects, and genetic mutations. Pregnant women and prepubescent children are particularly susceptible, especially in developing countries where overspraying by untrained workers is common and protective clothing largely unknown. WHO estimates that 500,000 people worldwide are poisoned by pesticides each year, and 5,000 die of them. In Guatemala, studies have shown that mothers' milk is contaminated with DDT.

In addition to chemicals, one must ask whether women's household tasks expose them to health risks from daily contact with polluted water and excreta, whether carrying heavy loads of wood, water, and produce produces backstrain and other low-grade ailments, whether women are likely to contract hookworm or schistosomiasis from working in the fields, and whether these risks are greater for women than for men.

Industrialization in the Third World may provide female workers with more income, but it also exposes them to the occupational hazards and diseases from which men have traditionally suffered the most: stress-related heart diseases, accidents related to the use of machinery, exposure to toxic substances. Textile workers, for example, are subject to "brown lung" from exposure to cotton dust. Skin disorders are common among workers in food processing, textiles, and hospitals. Hair dyes used by beauticians have been shown to be carcinogenic. In the electronics industry, workers often get serious eyestrain after a year or two. Women are prominent in all these industries in the Third World.

Overwork is probably the most common occupational hazard of all for women. Studies in any number of countries have shown that women in poor households work full days in economically productive activities in addition to taking care of their children and households. This "double-day phenomenon" produces almost constant fatigue. It clearly cuts into women's productivity and doubtless lowers their resistance to various health hazards.

In order to move much beyond generalization and speculation, however, research on women's health needs--individual and occupational as well as reproductive--will have to be given much higher priority. A first need is to keep much more careful track of the differential impact of various health problems and health interventions on women and men. Most of the areas covered above might well receive higher priority in development programming if more were known about them. But at the moment there appears to be a severe shortage of solid data and analysis.

Toward More Equitable Programming

Equity and practical development considerations suggest the need for giving higher priority to women's health needs in development programming. Programs oriented toward mothers can further both development and equity, for examples by averting early infant death. A recent review of ten health and nutrition projects

by the Overseas Development Council notes that providing nutritional supplements to mothers "seems to have been a particularly effective means of averting early infant deaths." Immunizing mothers against tetanus averted "at least 80 percent of the potential deaths from neonatal tetanus" among infants, and the women were protected as well.

Losses to development in the form of lowered productivity result from the chronic ill-health of women in general, yet health services reach Third World women, if at all, primarily in their roles as bearers and nurturers of children. Even though major problems for women occur at or around the time of child birth, health programs should not be limited to providing these services exclusively. The great majority of women over 15 years of age are neither pregnant nor mothers of small children, however. Initial World Fertility Survey (WFS) data suggest that, conservatively speaking, over 70% of women in the Asian and Latin America countries surveyed are neither pregnant nor lactating. (See Fig. 1 attached. Figures for Africa are not yet available.) In other words, maternal and child care programs that focus on mothers and children under 2 are not necessarily appropriate for more than two-thirds of the women in the countries of Asia and Latin America surveyed by WFS, and family planning services are irrelevant to more than 1/4 of them.

Women are the targets of maternal and child health programs because they are interested in improving the health of their children--and because their cooperation is essential to any program directed to this end. It is they who must be taught to seek prenatal care, to prepare more nutritious foods for their children, to treat childhood diarrhea, to store and use water safely, to keep their children's excreta from polluting the family home and water supplies. It is they who form the broad base of the primary health care system, as providers of family self-care.

Women may well be eager to make an added effort if the health of their children is involved, but the facts of their existence may make it difficult for them to do so. A WHO-sponsored conference on women and family health warned in 1978 that "in the existing definition of primary health care, and in the way women's roles were described, there was the danger that women's already heavy workload would be increased and that the 'voluntary' nature of their traditional work in health would be exploited." In the absence of compensating efforts to reduce women's workloads, or to involve men more closely in family responsibilities, women may lose still more ground to fatigue, stress, and lowered resistance to disease.

The reality of women's lives also has implications for the accessibility of primary health care facilities. Among the factors that may render these facilities effectively inaccessible to women are:

--cost, including the costs of transportation for themselves, their children, and, often an accompanying adult family member, as well as for drugs or other medicines.

--convenience. The effective service area for health clinics typically has a radius of only three to five kilometers, and even this much of a trip can be difficult for a woman with small children in tow; clinic hours often conflict with women's other work responsibilities.

--compatibility with their own needs and preferences. Rural women are particularly likely to be illiterate or unable even to speak the language of urban-trained providers. In some areas, women are uncomfortable with male health providers. Doctors and nurses may be cold and unsympathetic.

The attitudes of men and male-dominated society may also inhibit women's access to health care for themselves and their children. It is always said that women, as mothers, are key to the family's health, nutrition, and education. But women alone cannot make the changes needed to improve the health of the family without the resources, information, and authority which so commonly remain with men.

The basic contention of this paper, however, is that women's health needs will not be met if programming continues to focus narrowly on the health sector alone. Such problems as malnutrition, fatigue, excessive fertility, to say nothing of various forms of violence against women, are intimately bound up with women's generally low status and lack of opportunity for education and employment. Programs to improve the status of women, along with literacy, income generation, and the like deserve priority in their own right; they can also be expected to improve the outlook for successful family planning programs and in general help to improve women's chances for a healthy life.

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

(1) Expand the number of women in decisionmaking positions. As in other fields, it is questionable whether health development programs will ever reflect women's needs and concerns adequately in the absence of women at all levels of the health system, particularly where these systems continue to be dominated by male physicians.

It is crucial that women "consumers" of health services be included in community consultations and that they be well represented among health workers at the community level. The new thrust toward primary care in international health programming is likely to provide greater opportunities for training women as midwives, community health workers, and other physician extenders. The importance of upgrading the skills of traditional birth attendants, used by up to 90% of rural women, is also increasingly well-recognized, though too little attention is yet paid to the wider roles of traditional attendants in providing abortions, female circumcision, marriage counseling, and help for menstrual disorders, infertility, and the like.

Nursing and other health occupations will remain an important source of independent income and status for women for a long time to come and the number of women in these occupations needs to be expanded especially in countries where health providers are overwhelmingly male. It should be remembered, however, that these women, no less than factory workers, are subject to the problems that attend working a double day. They may not be able to perform their functions adequately without supporting arrangements such as child care and maternity leave; in the case of single women, housing may be a special problem.

Women are most seriously underrepresented at higher levels in health management and research. With rare exceptions, health systems in developing countries, as in the U.S., continue to be administered and policies set by men, often physicians insensitive to women's needs. The number of women scientists involved in biomedical research and decisionmaking may be even smaller than the number in the management of health care systems.

If employment of women at policymaking levels is to be encouraged, more women will need training in management skills, as well as in confidence building, assertiveness, and nuts-and-bolts things like record-keeping, project preparation, and fund-raising.

(2) Made better use of women's organizations, both grass roots and voluntary. The impetus for starting some of the oldest and best organized groups was health related--homemaking, family planning, clean water supplies, etc. Women's groups that seek to encourage late marriage, modernize abortion laws, start rape crisis centers, call attention to hazardous working conditions, and generally raise the status of women can also have important health effects.

(3) Recognize women's need for time and money in order to be able to follow desirable new health practices. One promising approach would be to look for projects that can do double duty--that would, say, generate income for women while improving family nutrition, or save women time while making more water available for family hygiene. (Two important caveats are that women need to have control over allocating any time saved from traditional tasks and that they be taught to maintain and repair any machinery involved.) Until greater interchange takes place between those whose primary concern is health for all, and those whose primary concern is the welfare and status of women, certain kinds of programs are in danger of falling between the slats in development programming, and these are most likely to involve programs affecting the underserved aspects of women's individual and occupational health and status.

Reproductive Status of Third World Women¹
(Derived from World Fertility Survey)

Country	Reproductive Status of Third World Women ¹ (Derived from World Fertility Survey)						Est. % Lactating ² +	% Pregnant (a)	=	Est. % Pregnant & Lactating	Est. % Not Pregnant & Lactating
	(a)	(b)	(c)	(d)	(e)	(f)					
Bangladesh	11.1%	11.4%	.7%	6.2%	11.2%	3.4%	18.7	11.1	29.8	70.2	
Fiji	10.8	5.5	14.9	9.9	6.5	7.0 ³	15.1	10.8	25.9	74.1	
Indonesia	10.3	13.8	0	14.4	7.5	5.5	16.2	10.3	26.5	73.5	
Korea	9.9	6.8	4.7	12.3	3.1	2.3	20.3	9.9	30.2	69.8	
Malaysia	10.5	8.0	3.5	10.5	4.0	4.7	19.6	10.5	30.1	69.9	
Nepal	9.8	7.4	1.5	10.0	15.9	2.1	17.8	9.8	27.6	72.4	
Pakistan	16.0	6.0	1.0	11.0	10.5	3.0	17.5	16.0	33.5	66.5	
Sri Lanka	9.4	9.0	8.9	11.8	5.3	5.0	16.9	9.4	26.3	73.7	
Thailand	9.7	7.7	7.6	15.3	4.5	2.6	17.5	9.7	27.2	72.8	
		Average: 24.4							Average: 28.6	Average: 71.4	
Colombia	10.9	13.4	3.6	4.8	4.1	5.5	19.2	10.9	30.1	69.9	
Costa Rica	7.9	11.2	11.7	7.8	3.0	12.3 ³	15.4	7.9	23.3	76.7	
Dom. Republic	14.5	18.4	9.9	5.7	5.7	4.1	13.9	14.5	28.4	71.6	
Panama	8.7	14.6	18.3	6.2	3.2	8.6	13.5	8.7	22.2	77.8	
Peru	11.9	10.0	2.5	9.7	2.3	5.2	19.5	11.9	31.4	68.6	
		Average: 29.6							Average: 27.1	Average: 72.9	

Averages

- (a) % pregnant (World Fertility Survey data)
- (b) % widowed, divorced, separated (WFS data)
- (c) % sterilized (WFS data)
- (d) % infecund (WFS data)
- (e) % exposed with no living children (WFS data)
- (f) % exposed older than 45 (WFS data)

1/ WFS data includes all ever-married women, including consensual unions, but not spinsters

2/ Estimated % lactating women; assumes that mothers breastfeed 5 children on average of 2 years each between the ages of 15 and 45--i.e., 10 years, or 1/3 of the time--clearly an overgenerous assumption for countries with successful family planning programs. In other words: $\frac{100 - (a)}{3}$ through (f)

3/- data is for women over 40