WOMEN AS PROVIDERS OF HEALTH CARE

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The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this organization, which was created in 1948, the health professions of some 165 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

By means of direct technical cooperation with its Member States, and by stimulating such cooperation among them, WHO promotes the development of comprehensive health services, the prevention and control of diseases, the improvement of environmental conditions, the development of health manpower, the coordination and development of biomedical and health services research, and the planning and implementation of health programmes.

These broad fields of endeavour encompass a wide variety of activities, such as developing systems of primary health care that reach the whole population of Member countries; promoting the health of mothers and children; combating malnutrition; controlling malaria and other communicable diseases, including tuberculosis and leprosy; having achieved the eradication of smallpox, promoting mass immunization against a number of other preventable diseases; improving mental health; providing safe water supplies; and training health personnel of all categories.

Progress towards better health throughout the world also demands international cooperation in such matters as establishing international standards for biological substances, pesticides, and pharmaceuticals; formulating environmental health criteria; recommending international nonproprietary names for drugs; administering the International Health Regulations; revising the International Classification of Diseases, Injuries, and Causes of Death; and collecting and disseminating health statistical information.

Further information on many aspects of WHO’s work is presented in the Organization’s publications.
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ACKNOWLEDGEMENTS

This book is the result of an international cooperative effort in which a large number of countries, agencies, and individuals have been involved. The authors express their sincere thanks to all those — too numerous to mention — who have contributed to its preparation.

The text relies heavily on ideas and opinions put forward in the working papers, discussions, and reports of two multinational consultations on Women as Providers of Health Care, which took place in December 1980 and August 1982. The names of the participants in these two consultations are listed on pages 160-163. We are particularly indebted to Dr B. Grab and Dr Bui Dang Ha Doan who provided statistical input to Chapter 2, to Mrs Helga Morrow and Miss Ellen Cahill for their contributions to Chapter 3, and to Dr Beverley DuGas who revised Chapter 5.

Mrs Helena Pizurki devoted much effort and interest to this publication but sadly she passed away before the work was completed. Her intellectual input was considerable and her devotion encouraged the authors to maintain the momentum needed to complete the work.
INTRODUCTION

In conformity with the objectives of the United Nations Decade for Women (1975–85), which stressed the equitable participation of women in national development, WHO, with financial support from the United Nations Fund for Population Activities (UNFPA), has initiated a number of projects, including the Multinational Study on Women as Providers of Health Care. Although its title might give the impression that the project is limited to research, this is only one of its components. Essentially a country-based effort with an active, problem-solving approach, it began early in 1980. It was envisaged at the outset that national efforts would be promoted and supported by certain international activities, including consultations and workshops at which countries and agencies would be represented, and the production and dissemination of material designed to stimulate awareness and encourage appropriate action. The present publication is the first on the situation of women as providers of health care to be prepared by WHO, and the first in the world to provide a general survey and analysis of this situation and guidance for those entrusted with the development of programmes to deal with it. It represents both a result and an expansion of the earlier stages of the study.

The project that has led to the publication of this book consists of a set of interrelated activities organized and managed by WHO. These have included:

(a) the first WHO Consultation on Women as Providers of Health Care, at which priority issues were identified;

(b) the second WHO Consultation on Women as Providers of Health Care, at which participants identified and discussed the main constituents of a national strategy for achieving the long-term aims of the project, as specified below;

(c) the preparation of an annotated bibliography on women as health care providers in both formal and non-formal health systems; and

(d) the preparation of papers by participants from 17 different countries, each dealing analytically with a specific issue and containing broad proposals for action (see Annex 2).

1 Consultants to the project: Dr Irene Butter, Professor of Health Planning, School of Public Health, University of Michigan, Ann Arbor, MI, USA; and Dr Bui Dang Ha Doan, Director, Centre of Medical Sociology and Demography, Paris, France.
Women as providers of health care

Long-term aims

The general long-term aims of the WHO project are:

(a) to enhance the political, economic, and social status of women as health care providers in both formal and non-formal health systems;

(b) to ensure that all women receive education, training, and/or orientation that will enable them to provide health care for themselves, their families, and other members of the community;

(c) to ensure that, within the formal health care system, there is no discrimination against women employees as regards position, pay, responsibility, and authority; and

(d) to facilitate in other respects the participation of women in both national and international efforts to achieve “Health for all by the year 2000”.

Within this framework, the present publication aims more directly at:

(a) creating a broader awareness among people in general, and decision-makers in particular, of the extent of women’s contribution to national health development and the obstacles they face both inside and outside the formal health system;

(b) creating a broader awareness of the sources of the imbalance between men and women in the extent and nature of their participation in health care;

(c) providing information, particularly to women themselves and to decision-makers, concerning the basic factors to be considered in the development of a long-term strategy to improve the socioeconomic status of women health care providers; and

(d) guiding both women and men on the planning of relevant action and on the preparation of proposals for funding and other forms of support.

Why this publication is needed

It is paradoxical that, while societies depend so heavily on women to provide health care, their contribution to health development is frequently undervalued. As regards working conditions, women in most countries are discriminated against in terms of position, pay, responsibility, and authority. WHO’s growing emphasis on universal accessi-
bility to primary health care, and people's right and duty to participate individually and collectively in the management of their own health care, makes the role and status of women as health care providers an issue of critical importance in the context of the goal of "Health for all by the year 2000". In addition, in many countries, women's special needs for care in connection with their reproductive functions make it imperative that there should be more professional women health workers to care for those women who do not wish to be treated by men.

Evidence suggests that, in every country, there is a need to improve the status of women, relative to that of men, within the health care system. Even more important is the universal need for a general improvement in the physical, mental, and social well-being of men, women, and children alike. It is to this end that efforts to enhance, facilitate, and recompense the work of women in health development should be aimed. It is hoped that it will thus be possible to develop health care systems in which neither sex will have a monopoly in terms of control or financial profit, and in which the people in the community will exercise control and reap the reward of better health care.

The importance of women's contribution to the health and welfare of individuals, families, and societies as a whole, has gone largely unrecognized. More often than not women have been viewed as sources of health problems requiring and sometimes receiving special attention, mainly through programmes focusing on maternal and child care, family planning, and nutrition. In this book, however, they are viewed as resources for the solution of health problems—their own and those of others.

An underlying premise is that, if WHO and its Member States are to design and implement successfully a strategy whose cornerstone is primary health care and which aims at "Health for all by the year 2000", it is essential to concentrate on women as resources. At the same time, a kind of “chicken-or-egg” question arises, namely whether the relatively low status and prestige of primary health care is largely due to the fact that it is mainly provided by women, or whether it is mainly provided by women because it is still regarded by too many people, particularly men, as inferior work.

Whatever the answer to this question, it is essential to find ways of increasing the status and prestige of primary health care. One way might be to involve men and women to an equal extent in the provision of primary health care, with no discrimination between the sexes as regards tasks and rewards. Another might be to shift the greater proportion of the health budget and other resources to primary health care. Yet another might be to ensure that, if women are to continue to be the foundation on which primary health care rests, their work in this area is appropriately acknowledged and rewarded.
It should be noted that an increasing number of women are concerned about the fact that, when countries were busy establishing modern medical schools and new posts for physicians, in most of them there was little talk of the need for women applicants and instructors. With the advent of primary health care, on the other hand, it is women on whom countries appear to be depending. While the belated recognition of the need for women in health care is to be applauded, it can no longer be taken for granted that women will be content with a pat on the back as acknowledgement of their worth. It is hoped that this publication will contribute to reducing the discrimination against women in both the formal and non-formal systems of health care as regards education, training and orientation, employment, career development, and rewards.

In order to present as objective a picture as possible of the situation of women as health care providers throughout the world, a special effort has been made to obtain numerical data and other information relating to a variety of countries from a variety of sources. The authors are, however, aware that a significant proportion of the information and figures presented reflect a bias in the existing literature, in that they refer mainly to developed countries; in many cases, comparable data are simply not available for developing areas. Nevertheless, the data presented in this publication suggest a great diversity among the countries of the world as regards: how far and in what way women participate in health development; the position of women as health care providers; the measures taken (or not taken) to increase the knowledge and skills of women in order to enable them to participate more effectively in health development activities; and the measures taken (or not taken) to facilitate such participation in other respects.

While the authors of this book lay no claim to having proved anything, they have tried to stimulate thought and to remind readers, once again, that each country differs from others in a multitude of ways, including those relating to and affecting women as providers of health care. What may be a priority problem in one country may not be a priority in another. Moreover, even where several countries have a problem in common, its solution may require a different approach in each country.
Chapter I

THE CONTRIBUTION OF WOMEN TO NATIONAL HEALTH DEVELOPMENT

Women play a far greater role than men in the delivery of health care. This is true in most countries and is a relatively well established phenomenon, predating the emergence of modern health care systems. As mothers, grandmothers, wives, daughters and neighbours, they are the principal providers of informal health care in families and communities. In many developing countries, women act as traditional birth attendants for relatives and neighbours, often without financial reward, and still carry out the majority of deliveries. Outside the family, women lead the ranks of volunteers in hospitals, self-help clinics, and other community organizations. Also, in the elementary schools of many countries, the majority of teachers are women whose tasks include the teaching of health-sustaining attitudes and behaviour. Equally important is the role of women in the formal health systems of many countries, where they often constitute the majority of health care providers. Whether within or outside the family, whether in a formal or non-formal setting, women outnumber men as providers of health care.

The concept of division of labour by sex

There are many reasons why there is a tendency for women to play a relatively greater part in providing health care than men do. One explanation links it to patterns of gender-role differentiation instilled in individuals from the moment of birth through a process of learning and social conditioning. Such differentiation is not, for the most part, biologically conditioned or a social necessity, though it has been interpreted in this way by individuals and by institutional authorities in many cultures for a long time. Rather, gender-role differentiation is associated with reproductive differences between the sexes and is transmitted through habit, custom, and education, to perpetuate the notion that women are especially adept at “feminine” tasks and men at “masculine” ones.

Gender-role differentiation produces a sexual division of labour in the family as well as in the formal labour market. While every society practises a division of labour by gender there are considerable cross-cultural variations, so that what is considered to be proper work for women in one society may be typical men’s work in another. Both men and women
are conditioned from early on to have different functions, capabilities, and aspirations. For women in most societies, these functions include not only looking after the home and the family, but also more general caring, counselling, and nurturing functions extending into the neighbourhood and community.

It appears to be deeply embedded in social traditions and customs that the division of work between men and women within the family is complementary rather than competitive, and that fathers and mothers serve as role-models for sons and daughters respectively, thus perpetuating a pattern of role differentiation from generation to generation. One explanation given for the complementarity of the gender division of labour in families is the protection of marital relationships through the limitation of work-related competition between spouses. Although there is no reason why the culturally assigned domestic functions of women could not be assumed just as well by men, there are apparently no societies in which men have wholly replaced women in these functions. The pattern of complementarity is replicated in labour markets in the form of gender-typing of jobs and the development of non-competing worker groups. A further differentiation between the sexes within families is the assignment of subordinate roles to women and dominant roles to men, and this pattern too is frequently found in labour markets, both formal and informal.

One additional aspect of gender-role differentiation in both developing and developed societies is the distinction between market and extra-market functions and the relegation of men primarily to the former and women primarily to the latter. This form of specialization has often made women economically dependent on husbands and also has led to a general lack of recognition and undervaluation of household-related work. However, specialization in the production of goods and services for the family’s own consumption (extra-market work) has not necessarily precluded the production by women working at home of such goods as food, clothing, and handicrafts for sale on the market. Nor has it always prohibited women from working for pay outside the home. In view of the various types of work in which women around the world take part as home-based producers—paid employment, paid self-employment, work in family enterprises for which they do or do not earn individual wages, unpaid domestic work in the home, and contributions to the money-earning capacity of their husbands—the concept of extra-market work requires to be rethought and redefined.
Contribution of women to national health development

Women as providers of non-formal health care

Carpenter et al. (10) have described the responsibilities of women as providers of non-formal health care, including: (a) taking decisions concerning the health care of family members; (b) rearing children on healthy lines; (c) producing, selecting, preparing, and distributing the family’s food; and (d) providing health services at home for convalescent, chronically ill, and disabled members of the family. Other responsibilities of women include keeping family health histories, identifying illnesses (both their own and those of others); escorting the sick for necessary care; and providing nursing care, physical therapy, and first aid. Unfortunately, there is a universal dearth of information about the informal health care provided within the family, the preparation of women to provide such care effectively, how burdensome they find this aspect of their family responsibilities, and how much help they receive from their spouses. It is, however, clear that the bulk of informal health care in the home is provided by women. In fact, women hold a unique position as regards the provision of non-formal health care, both in the family and in the community.

Within the family, women are the main behavioural influence on the children of the household. While this applies in all countries, it has particular significance in countries or areas where certain behavioural factors contribute substantially to morbidity and mortality. Women in the home have the advantage of being in a position to alert the young, during their early formative years, to the adverse effects of specific forms of behaviour. By serving as positive role-models and by encouraging family members to assume greater responsibility for their own health, women can help to effect behavioural changes that may lead to a reduction in the risk of accidents, disease, mental illness, and early death.

In the community, women’s unique position with respect to health care stems from the special opportunities they enjoy for communicating and interacting with other women who have similar problems as regards their own health and that of their families. These opportunities arise, for example, around the water-pump and in the laundrette, in the paddy field and the tea plantation, in the outdoor vegetable market and the indoor supermarket, in the child-care centre and the health-care centre. As can be seen, most of these opportunities occur at places where, and times when, women are engaged in other tasks pertaining to the welfare of the household. It is the performance of these tasks that allows women to reach out to other women in the community and form a network, thus helping to enhance communal action.

1 The term “non-formal” is used in this publication to cover health care provided by, for example, family members in the home, lay health workers, traditional practitioners such as birth attendants, and self-help or mutual-help agencies, including clinics or dispensaries established and run by women (usually for women exclusively).
Women as providers of health care

Primary health care outside the formal health system

Primary health care is currently provided, for the most part, outside the formal health system and mainly by women. In general, women are involved in the following basic primary health care activities.

(a) Health education/family life education

Education for the promotion of health and the prevention of disease is the first of the eight essential components of primary health care. In most parts of the world, in both formal and non-formal health care systems, women are the health educators and foster the type of learning that will motivate people to want to be healthy and show them how to attain health and how to seek help on health matters when necessary.

(b) Nutrition

Nutrition is one of the most important factors influencing the quality of life in most parts of the world, and most nutrition-related activities take place within the family. Women are the primary processors, storers, and preparers of food and are responsible for proper nutrition. They help to increase and improve food supplies by processing and preserving food to the best advantage and distributing available provisions equitably within the family. They should, in addition, be oriented towards the early detection of malnutrition and the measures needed to reverse it.

(c) Supply of safe water and basic sanitation

Preventable diseases associated with contaminated water supplies and a lack of basic sanitation constitute a major health problem in developing countries. Safe, adequate, and accessible supplies of water, together with proper sanitation, are therefore foremost among basic health measures. In communities where piped water supplies have not yet been provided, women are the haulers, storers, and distributors of water and the managers of basic sanitation at the family level and often also at the community level. It is primarily women who have the responsibility for introducing sound personal hygiene practices, promoting the use of latrines, and ensuring that clean water is used for drinking and other domestic purposes.

(d) Immunization

Immunization programmes reduce morbidity and mortality due to preventable diseases, some of which are major killers of children. Women are the main users and promoters of immunization against the principal communicable diseases, for themselves and their children, playing an indispensable role in this connection, even when the
immunization is performed by men. They also help to limit the propa-
gation of communicable diseases.

(e) Maternal and child care, including family planning

In this area, as in those dealt with below, the work is at times shared
between men and women, but women still play a more or less predomi-
nant part. They are the main providers of maternal and child care,
including family planning, since most of the relevant actions and
decisions take place within the family. Women recognize the need for
preventive measures and the need to instil healthy behaviour. They also
take the initiative in such matters as first aid for childhood accidents;
they recognize the need for curative care; they take decisions about
using the health services, both for themselves and for other members of
the family; and they are aware of the nutritional needs of nursing
mothers.

(f) Management of illness

Women play a major role in the prevention and control of locally
prevalent diseases and are involved in preventive treatment, early
detection of symptoms, the decision to seek care, compliance with
prescribed treatment, and environmental activity aimed at prevention
and protection. Women usually predominate in the treatment of
common diseases and injuries inasmuch as this is often done at home in
the form of first aid. They are also the persons most likely to make the
decision to seek skilled help, or to be called upon to provide such help in
formal health care systems. Again, it is usually women who are respon-
sible for taking the necessary steps to prevent recurrence of an illness.

(g) Provision of essential drugs

Women frequently take part in producing and collecting the basic
ingredients for essential drugs. They also share with men the task of
distributing and administering drugs in health care systems. Keeping
drugs away from damp and heat, and out of reach of children, is
primarily a women’s function.

Since most of the activities just listed are in the more “feminized” areas
of health work, it should come as no surprise that primary health care is
delivered predominantly by women.

Women’s contribution to primary health care is not readily measurable
in terms of its impact on the health of society. The same applies,
however, to the contribution made by men and to other levels of health
care. What can and should be measured is the amount of time that is
devoted to health care by men and women respectively. Some idea of
the time women spend on primary health care may be gained by examining their activities in the areas of water supply, sanitation, and nutrition.

Water supply and sanitation

An adequate supply of clean water is fundamental to individual, family, and community health. Statistics show that roughly 2000 million men, women, and children—or almost half the world’s population—are without reasonable access to an adequate supply of water and that even more people are without proper means of sanitation. These two factors, together with poor personal and household hygiene, are directly responsible for innumerable cases of preventable diseases, such as gastroenteritis and parasitic infections. Those most severely affected are people living in rural areas and in poverty-stricken parts of urban areas.

The main obstacle to the use and maintenance of improved water and sanitation systems is not the quality of the technology but the failure “in qualified human resources and in management and organization techniques, including a failure to capture community interest” (26). Something that has been overlooked is that more than 50% of the adults in most communities are women, and that women play a major role in the building, use, operation, and management of water supplies in rural and urban areas in various parts of the world.

Women have four key roles in the field of domestic water supply and household sanitation, namely, as accepters of new technology, as users of improved facilities, as managers of water supply and sanitation programmes, and as agents of behavioural change regarding the use of facilities (17).

Women are the primary users of any domestic water system, whether new or traditional. Not only do they use it in preparing food and for washing and bathing, but they are the mediators between the water source and household demand. Women set the standards for the proper, economical use of water. It is they who decide on the choice of water for drinking, cooking, laundry, bathing, and other household functions, on the basis of what they have learned from their mothers and grandmothers and on their observation of the costs and benefits, both social and economic, of any change of system.

In subsistence-level communities the single task of water hauling can take 4–6 hours a day, to which queueing at water sites may add another hour or so. Surveys have confirmed that water collection and transport, especially when carried out on foot, are tasks undertaken primarily by women. However, when the trip to a water source is facilitated by other means of transport, more men tend to become involved. Table 1, based
on a survey carried out in Kenya, shows the unequal participation of men and women in the collection and transport of water.

Table 1. Mode of transporting water, according to sex of collector, Kibwezi, Kenya

<table>
<thead>
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<th>Mode of transport</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
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<tr>
<td>walking</td>
<td>116</td>
<td>693</td>
<td>809</td>
</tr>
<tr>
<td>bicycle</td>
<td>90</td>
<td>50</td>
<td>140</td>
</tr>
<tr>
<td>donkey</td>
<td>22</td>
<td>36</td>
<td>58</td>
</tr>
<tr>
<td>wheelbarrow</td>
<td>28</td>
<td>12</td>
<td>40</td>
</tr>
<tr>
<td>oxcart</td>
<td>17</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>all modes</td>
<td>273</td>
<td>794</td>
<td>1067</td>
</tr>
</tbody>
</table>

*Source: unpublished survey carried out by the African Medical Research Foundation, 1983.

As the primary users of water systems, women are also the main accepters of new technology in the areas of water supply and sanitation. Such technology needs to be geared to women's needs, and women need to be consulted when new water systems are being planned. Taboos and local customs concerning water use also need to be considered in the planning stages. Women are in the best position to explain local customs to planners.

Women have a strong potential role as managers of community water supplies. They not only select water sources but, in some instances, play a key role in seeing that funds and/or labour are available for their maintenance. Women thus make ideal candidates for training in tasks associated with the management and maintenance of community water supply and sanitation facilities. Once trained, they can plan for more accessible and more reliable water sources for their households and communities, helping the latter to acquire a greater awareness of the importance of having their own water supplies and sanitation. As a result, there may be more willingness to change from an old water source to a new one managed by the community, or from defecating in the bush to using a latrine unit maintained by the household.

The central role of women in the social conditioning of the young, in health education, and in non-formal health care networks makes them suitable as trainers in water and sanitation projects and as agents of behavioural change. Every effort should be made to recruit women for these tasks. To a large extent, the health and social standards of a household will depend on the ability of women to understand new facilities for water supply and sanitation and, through information and example, to ensure their proper use by other members of the household.

The full participation of women in water supply and sanitation projects has been a goal of international policy since 1980. To this end, an
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Interagency Task Force on Women and the International Drinking Water Supply and Sanitation Decade was formed in 1980. This task force meets regularly to develop strategies and monitor progress. Among the approaches recommended are:

— to ensure that, in the existing institutional framework for the improvement of water supply and sanitation, due consideration is given to meeting the needs and facilitating the participation of women;

— to increase the participation of women in management, policy-making, planning, and technical fields;

— in planning programmes to improve water supply and sanitation, to obtain the baseline data needed for an adequate picture of women’s needs and capabilities in these areas;

— to make judicious use of the information media to encourage women to take an active interest in water supply and sanitation;

— in choosing appropriate technology, to give careful consideration to women’s needs, and to the effect the choice may have on their participation.

This emphasis on the participation of women does not imply that the tasks involved should be carried out by women only. On the contrary, the task force stressed the need for the active involvement of men and women alike.

In 1983, the United Nations Development Programme (UNDP) launched an interregional project to promote and support the participation of women in the International Drinking Water Supply and Sanitation Decade. The broad objectives are to gather information on the subject, to spread awareness of the importance of sociocultural factors, to provide guidance on the involvement of women and of the community, and to strengthen national institutional capacity in the relevant areas, especially through the development of human resources. The specialized agencies in the United Nations family have developed country and global proposals that fit into the general framework of the interregional project.

In conclusion, there is no doubt that the involvement of women in activities to promote water supply and basic sanitation should be facilitated and encouraged to the utmost. It is important to gather, from every possible source, factual information on the subject and to make it available on as wide a scale as practicable. It is necessary to know what action has proved possible, where and in what cultural setting it has taken place, what obstacles were encountered and how they were over-
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come, what were the benefits, and to what extent the process can be successfully repeated elsewhere.

Food and agriculture

There is a tendency to view the role of women in nutrition as being limited to cooking and serving. The preparation of food for family consumption is almost universally recognized as a woman's task, and in most developing countries women do the major part of the farming as well. In Africa, for example, some 75% of all agricultural labour is performed by women. In Bangladesh, 90% of the female population is engaged in agriculture. In the Philippines, women work an average of 30 hours and men an average of 43 hours a week on the family farm. In the developing world generally, rural women account for at least 50% of food production.

Development researchers and planners tend to distinguish “farm work” or “field work” from “non-farm work”, the former including such work as preparing the ground, sowing, weeding, pest control, transplanting, harvesting, and associated operations. A great deal of effort and money is expended on research to discover exactly how much time is devoted to these tasks, which are viewed as being essentially “men’s work”. “Non-farm” work on the other hand, is not viewed, in economic terms, as essential to daily subsistence, even though families could not survive without the benefits deriving from such work, which is essentially performed by women.

The production of food in edible form involves an enormous amount of work after the harvest, i.e., the point at which the official measurement of “work” usually halts. Threshing, winnowing, drying, boiling (especially in the case of rice paddy), and other strenuous activities have to be undertaken between the harvesting and the storage of many staple foods. Correct storage is also a major concern, since post-harvest losses of food can mean the difference between survival and destitution. A study carried out in Africa showed that it takes about 13 hours just to pound enough maize to feed a family for between four and five days, where modern technology is not available for the purpose, and that the processing of tapioca and maize takes four times as long as all the working hours spent on the cultivation of these crops.

Before food can be cooked, an adequate supply of water and fuel has to be obtained. The work this involves can take up to several hours a day. Fuel may be obtained in the form of firewood, dried animal dung, and the residue of crops. In communities where such resources are becoming scarce, the search for them is increasingly time-consuming and difficult. Water and fuel (particularly wood) are very heavy, and it demands strenuous effort to carry them over long distances to places where food is prepared.
Women as providers of health care

In many cases, pigs, poultry, and other livestock are kept and have to be watered and cared for. Dairy animals need to be milked, and milk needs to be processed (the boiling of milk, the fermentation of yoghurt, and the production of butter—being part of the processing). Finally, of course, there is the cooking, which in the case of many staple foods takes a considerable time, especially if fuel supplies need to be gathered and conserved. Various relishes, spices, and vegetables are needed to make food palatable. These have to be either gathered from the wild or cultivated. In either case, the work involved is generally excluded from the statistics on agricultural production.

Apart from the preparation of food for home consumption, which constitutes the major part of subsistence agriculture, it is important that any surplus production should be marketed in order to produce some cash for the innumerable demands on, and needs of, a family, e.g., taxes, school fees, clothing, food in times of shortage, and other basic needs. Women in many developing countries engage in the trade of both processed and unprocessed agricultural commodities (both food and fibre) in order to meet needs such as those just indicated.

In addition to the above-mentioned activities, essential for the survival of the family, many women also take part in activities coming under the heading of “farm work”. Where the development process has resulted in the migration of large numbers of men to the cities and abroad, which is the case in many developing countries, the rural population consists mainly of women and children. Thus the small farmers producing food in these countries are increasingly women.

There are many striking instances of the failure of development planners to take into account the time and energy women spend in helping to ensure the health and welfare of their societies. A number of time-allocation studies have shown that rural women spend between 10 and 14 hours a day in productive work (including income-generating and expenditure-saving work), as opposed to the 10–11 hours spent by men. This obviously does not include the multitude of other activities that are also essential to the health and wellbeing of the family; these probably account for another four or five hours a day.

Programmes of social action that ignore the work and health of women are doomed to failure. Schemes for rural development that help to bring women together to pool and rationalize certain components of their work are most likely to be useful. For example, the provision of technological and other resources to facilitate cooperation in food processing will both help to reduce individual effort and enhance health potential for the family and the community as a whole. In any event, plans for community health development have little chance of success where women are excluded from the planning process.
The failure of planners to take women into account has had grave consequences for women and, as a result, for community development. New technology, in particular labour-saving devices (e.g., machines for land clearing, ploughing, harvesting, and threshing), is usually addressed to men. Development agencies are known to have given men, or sold to them on credit, small implements such as presses, grinders, or cutters, even when the work which these implements are expected to facilitate is traditionally done by women. Where such work represents an income-generating activity for women, the implications are obvious—women lose a source of income as a result of the introduction of a machine which they have not been taught to use and which, in any case, belongs to and will be used by men. In addition, it has been observed that men who have been provided with advanced agricultural technology have, in many cases, taken over land previously farmed by women and converted it to the production of cash crops. Where this occurs, it generally leads to a deterioration in the family’s nutrition. While non-nutritive cash crops may increase income, evidence suggests that this income is less likely to be used for the common good of the family than income generated by women.

Failure to reduce women’s overburdensome workload has had disastrous effects on the health of women in the societies concerned and, in turn, on the capacity of women for work. Unless it is broken this vicious circle bodes “ill for all” rather than “health for all”. It is hoped that decision-makers, whether in national institutions, in international development agencies, in bilateral aid agencies, or elsewhere, will begin to pay more than lip-service to the importance of women in national development, including the promotion of health for all.

Problem areas

Virtually every component of any programme for primary health care is based on the assumption that women, particularly mothers, will be the most important front-line providers of health care, particularly to children. Furthermore, it is well established that, of all the correlates of infant health, none is as strong or as consistent as the mother’s level of education. This is illustrated by the data presented in Table 2. The sex differential in literacy and in school enrolment rates (columns 1, 5, and 6) in relation to development is clear. Around 1982, the male/female literacy differential was 1% in developed countries (i.e., 98% of male adults and 97% of female adults were literate), in contrast to 20% in developing countries. The table further shows that the literacy and school enrolment rates are inversely related to the indicators in columns 2, 3, and 4 (proportion of births attended by trained personnel, proportion of infants with low birth weights, and infant mortality rate).

The ability of women to carry out the complex and demanding tasks assigned to them in primary health care programmes depends on four
<table>
<thead>
<tr>
<th>Region</th>
<th>WHO &quot;Health for all&quot; indicators</th>
<th>Other indicators</th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of adults literate (male/female)</td>
<td>Percentage of births attended by trained personnel</td>
<td>Percentage of infants with low birth weights (male/female)</td>
<td>Infant mortality rate (male/female)</td>
<td>Percentage enrolled in school aged 6-11 years (male/female)</td>
<td>Percentage enrolled in school aged 12-17 years (male/female)</td>
<td>Percentage of women aged 15-19 who are married</td>
<td>Average number of children per woman</td>
</tr>
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<td>56</td>
<td>16</td>
<td>103/92</td>
<td>76/64/55</td>
<td>55/46/30</td>
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<td>98</td>
<td>7</td>
<td>24/18</td>
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<td>49</td>
<td>18</td>
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<td>70/53/42</td>
<td>52/39/39</td>
<td>4.4</td>
<td></td>
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<td>33</td>
<td>14</td>
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<td>59/43/39</td>
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<td>44/30/29</td>
<td>29/16/29</td>
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<td>16</td>
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<td>12</td>
<td>78/68</td>
<td>85/87/60</td>
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<td>70</td>
<td>9</td>
<td>104/92</td>
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<td>56/15/45</td>
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<td>88</td>
<td>7</td>
<td>47/41</td>
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</tr>
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<td>51</td>
<td>20</td>
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<td>73/54/42</td>
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<td>78/57/54</td>
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<tr>
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<td>24</td>
<td>31</td>
<td>136/135</td>
<td>70/44/35</td>
<td>35/17/54</td>
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<td>88/87/75</td>
<td>75/71/10</td>
<td>2.8</td>
<td></td>
</tr>
</tbody>
</table>

*Sources: Columns 1, 5, and 6 – UNESCO; columns 2 and 3 – WHO estimates; columns 4, 7, and 8 – Population Reference Bureau and United Nations Population Division.

*bDeaths per 1000 live births.
Contribution of women to national health development

equally important factors, namely health technology, knowledge, resources, and time. Few programmes, if any, involve all four factors simultaneously. Health technology is perhaps the one most often involved, and time the least. While there is no doubt that the transmission of technology, such as improved methods of immunization and oral rehydration therapy, opens up new vistas for child health, the provision of improved technology alone is insufficient. Usually the effective implementation of this technology requires simultaneous inputs of knowledge, resources, and time on the part of the key providers of primary health care, namely the women.

The following are examples of how these factors, time in particular, affect certain programmes, especially in rural areas.

*Expanded immunization programmes for infants (diphtheria/pertussis/tetanus).* These programmes provide for three injections at intervals of 4–8 weeks, beginning early in life. Even if the problem of maintaining the cold chain during transportation of the vaccines and the shortage of trained personnel could be overcome, and even if mothers could be adequately informed of the advantages and availability of vaccines, the limited time at their disposal would seriously affect coverage, since in many cases the trips with the child, to the nearest health centre, could take as much as a day apiece, in view of the distance to be covered. In this situation, few women can be expected to have either the time or the resources to participate in the programme. The use of mobile vaccination teams or the delivery of vaccines to the villages will be needed to overcome this difficulty.

*Tetanus toxoid for pregnant women.* The same time constraints apply in the case of this immunization, which requires at least two and preferably three injections during pregnancy, at intervals of 4–6 weeks.

*Treatment for febrile malaria.* Where there are not enough appropriately trained health personnel to bring diagnostic techniques and chemotherapeutic agents directly to the areas where people live, mortality from malaria will continue to be high among young children, simply because mothers lack the time, money, and even the energy to get their children to a health facility that very often is more than 10 km away. Also to be taken into account are the time needed to continue therapy through the course of the illness and the financial resources needed to be able to buy a particular drug if the health centre does not have it.

*Oral rehydration therapy.* Aside from the need to instruct women in the techniques of oral rehydration therapy, and aside from the shortage of money for purchasing rehydration packages wherever these are not distributed free of charge, the major obstacle is, once again, time. Continually giving a sick infant large volumes of liquid by spoon or cup is not only time-consuming but also tiring and inconvenient for a
Women as providers of health care

mother who may have other children to attend to, in addition to house­hold tasks and farm work.

Breast-feeding. Studies throughout the world have shown that, where women work outside the home, their employers may not allow them sufficient time to breast-feed their babies, with the result that the teachings of the primary health care programme cannot be translated into improved child-feeding practices.

Clinic-based supplementary feeding and other programmes. Perhaps the simplest of all such programmes is, in principle, one in which the mother comes to the clinic or the distribution centre to collect food for her children and to have them weighed and immunized. However, as many studies show, attendance at a clinic drops dramatically as the distance to the clinic increases.

Food preparation and storage. Recent longitudinal studies in Bangladesh and the Gambia have shown that food contamination leading to diarrhoeal diseases is particularly marked when great demands are made on the time of the mother. The seasonal variations of gastroenteritis in developing countries are well known: epidemics recur annually when climatic conditions favour the proliferation of the housefly (Musca domestica), which contaminates food, including babies' bottles. In the Gambia, for instance, the peak seasons for diarrhoeal diseases coincide with the peak seasons during which women are most busy outside the home. During such times, the feeding of small children is particularly haphazard. They are often left, with a supply of porridge or gruel to spend as many as eight or nine hours in the compound in the care of young nursemaids or older siblings. Food for the evening meal is often prepared the night before and stored for 24 hours without refrigeration, becoming contaminated as a result.

From the above it can readily be seen that, if women are to participate effectively in primary health care, particular attention must be given to ensuring that they have enough time to do so. Not only should efforts be made to bring water sources closer to the home, but high priority should be given to the introduction of labour- and time-saving devices into the home.

Sharing the burden

Not only have women always played the major role in health care, especially preventive health care, but many health developments have affected women primarily and required their compliance. Immunization programmes have been aimed primarily at mothers, pregnant women, and children. The responsibility for birth control, fertility regulation, clean water, and waste disposal has been placed mainly on women, who also provide most of the information for statistical surveys on morbidity
Contribution of women to national health development

and on health care in the home. What, then, is the role of men in the non-formal provision of primary health care both in the family and in the community? Health workers will have to examine this role and take action to change men's attitudes and increase their health knowledge, so that health care responsibilities, especially within the family, may be shared by both sexes. In the interests of the democratization of health and the solidarity and equality of the sexes, attempts will have to be made to lessen the burden on women and to see that they are not expected to perform even more health care chores on their own.

Self-care/self-help

Self-care refers to health-related activities and decisions by individuals and families. It is the primary resource in the health care system. Self-help refers to an organized group—formal or informal—of people with a common health objective. Self-care and self-help encompass activities related to health promotion, disease prevention, treatment of illness and injury, management of chronic diseases, rehabilitation and the utilization or non-utilization of the formal health care system (23).

Self-care, in which the family functions as a health care unit within a particular system of traditional beliefs and procedures, is the most significant form of health care for most of the rural population in the developing world.1 In almost all instances, it is the women who are the frontline providers of this type of care. Self-care and self-help groups need to be appreciated and strengthened while being complemented by professional care. This would maximize the benefits of scarce and costly technical resources.

International information networks

There exist at least three networks that collect, prepare, and disseminate information on women and health throughout the world. One is the Boston Women's Health Book Collective, in Boston, MA, USA. This body assembles and issues, on a regular bimonthly basis, a packet of photocopies of material on women and health which it selects from a variety of periodicals and other publications. The packet is sent to about 600 women's health groups in the USA and elsewhere.

A second network is the Women's International Information and Communication Service (ISIS) in Geneva, Switzerland. ISIS deals with all areas of the women's movement, including health. It has assembled extensive information on women and health in different parts of the world. Moreover, it has an international network of contacts and the resources needed to put people and groups in touch with each other and to distribute information on request. It publishes the ISIS-International

**Women as providers of health care**

*Bulletin*, of which, to date, four issues (three in English, one in Spanish) have been devoted exclusively to women and health. It also published, jointly with the above-mentioned Boston Women's Health Book Collective, the *International Women and Health Resource Guide* (67), which includes annotated lists of groups, literature, films, etc. concerned with women and health internationally and is the only guide of its kind to date.

A third network is the International Contraception, Abortion and Sterilization Campaign (ICASC) in England. ICASC was set up to share information internationally on questions relating to abortion, contraception, and sterilization. It publishes a quarterly newsletter which brings together information from all over the world. It is made up primarily of national groups directly involved in action and research on questions relating to reproduction.

**Women and "Health for all by the year 2000"**

By now it is becoming increasingly recognized that women constitute a key resource for attaining the goal of health for all by the year 2000. Moreover, the attainment of this goal will bring about positive changes in the state of women's health and other aspects of their lives. Countries can only benefit from supporting women in their many primary health care functions and increasing their share of the rewards. At the same time it is important that women's movements and organizations should take advantage of the opportunities presented by the goal of health for all for effective action to improve the health level and social conditions of all people in all countries.

Given the major contributions that women make, and always have made, to people's health, education, and wellbeing, a change in social attitudes is indicated: instead of being concealed, denied, and trivialized, the accomplishments of women should be recognized, valued, and rewarded. Governments and communities would then be in the best position to achieve the goal of health for all. At the same time women would benefit greatly, not only because improvements in their own health level will provide them with the strength and energy to fulfil their aspirations and responsibilities, both within and outside the family, more constructively, but also because an essential part of the strategy for the achievement of health for all requires a higher value to be placed on women's position in society.

In the past, women especially have made large commitments to primary health care. Their special contribution to the attainment of health for all derives from two factors already discussed—their central role in the family and their central role in the community. However, the role of men in the provision of primary health care must also be acknowledged, and it is expected that men will progressively develop a better understanding of the need for a more equitable partnership in this area.
CHAPTER 2

THE SITUATION OF WOMEN WORKING IN THE FORMAL HEALTH CARE SYSTEM

Women in the formal health care system

It is difficult to describe the contribution of women to a country's formal health system except in terms of the relative numbers of men and women workers in the system as a whole and/or in each of its component parts. This chapter will review the extent of women's participation in the various branches of health care, their career patterns and incomes as health workers, and their position in the managerial structure.

In the following pages, the term female rate is used to indicate the number of women out of every 100 workers in a given branch of health care. The female rate varies from one branch of health care to another, from one country to another, and with time. The variations follow certain patterns, are conditioned by societal factors, and have some effect on the health system itself. By studying the female rate, it is possible to gain some idea of the extent of women's participation in health care, and of related trends and differentials. This may be helpful in ensuring that both sexes have equal opportunities for social and individual achievement. It may also show how the delivery of health services can be made more efficient.

Sources and quality of data

The statistical data used here were drawn mainly from WHO's health manpower data bank, which is fed with information from an annual survey by questionnaire. The main section of the questionnaire, which is sent out to all Member States, deals with the numerical strength of each category of health manpower (e.g., dentists, physicians, professional nurses, X-ray technicians, practitioners of indigenous medicine, etc.). To this are added other sections which can vary from one year to another and are concerned with such subjects as urban-rural patterns, distribution by nationals/non-nationals, distribution by speciality (for physicians), age and/or sex distribution, etc. In a great many countries, data on the age and/or sex distribution of health manpower is available only from population censuses, carried out around 1960 or 1970.

1 Data gathered in WHO's annual survey of health manpower are published each year in the World health statistics annual (Geneva, World Health Organization).
Women as providers of health care

The present study also makes use of other sources of information, notably the various national statistical yearbooks. For some countries, data on the numbers of persons in the different categories of health manpower, as well as their age and/or sex distribution, can be obtained from these statistical yearbooks for recent years. The main problem is the lack of consistency characterizing data taken from a number of different sources. However, by comparison and elimination of the more striking divergences, it is possible to obtain a coherent picture of the situation.

While an attempt has naturally been made to gather as much information as possible on the sex distribution of health manpower, such information is unfortunately not always available from the sources mentioned above or is available only for remote dates in the past. This problem was partly overcome by recourse to other sources (government reports, professional publications, etc.), but a number of countries nevertheless had to be excluded. Thus, the present study is not totally exhaustive. It may, however, be considered as giving a fairly representative picture of the present situation of women in the various national health systems, at least within the limits imposed on it.

Scope of the study

The aim of the study is to examine and analyse the representation of women in the various categories of health personnel in different countries. It is concerned only with the situation in formal health systems, because of the lack of relevant and accurate data on women providing health care informally. It must, therefore, be considered only as a first step in assessing the part played by women in health care. It is hoped, however, that it will also pave the way for a reorganization of information systems so that they cover the various types of informal health care.

The present study is primarily concerned with the relative numbers of men and women in the different branches of health care in each country and cannot deal directly with the crucial issues of autonomy, equity, authority or power, although some closely related matters such as types of practice, decision-making capacity, and wages are covered. However, the other chapters, though differing in approach and confined to specific areas, may furnish an empirical basis for a consideration of these broader issues.

Participation of women in health work and in the labour force as a whole

That the female rate is higher in the health system than in the economically active population as a whole is apparent in nearly every country. In Belgium, for example, out of every 100 health workers, 63 are women,
whereas out of every 100 workers in the labour force as a whole, only 30 are women (see Table 3, which is based on data from a sample of 16 countries). In Costa Rica, 64% of health workers are women, compared with 19.5% of all workers. In Czechoslovakia, 79% of health workers are women, whereas only 48% of all workers are women. In Jordan, the corresponding proportions are 24% and 6%. In practically every country, whatever its level of economic and social development, the majority of health workers are women whereas the bulk of the economically active population consists of men. In fact, women play a crucial role in the functioning of the formally organized sector of health care in every country of the world. If the non-formal sector is also taken into account, women’s contribution to health care is overwhelmingly greater than that of men.

Table 3. Female rates for health workers and the labour force as a whole, in selected countries

<table>
<thead>
<tr>
<th>Health workers</th>
<th>Female rate for labour force as a whole in 1975 (%)</th>
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<tbody>
<tr>
<td></td>
<td>Number of rate in 1975 (%)</td>
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<tr>
<td></td>
<td>Total number</td>
</tr>
<tr>
<td>Developing countries</td>
<td></td>
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<tr>
<td>Bolivia</td>
<td>1974</td>
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<td>Costa Rica</td>
<td>1973</td>
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<tr>
<td>Dominican Republic</td>
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<td>1974</td>
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<td>Jordan</td>
<td>1977</td>
</tr>
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<td>Republic of Korea</td>
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<tr>
<td>Developed countries</td>
<td></td>
</tr>
<tr>
<td>Austria</td>
<td>1971</td>
</tr>
<tr>
<td>Belgium</td>
<td>1970</td>
</tr>
<tr>
<td>Canada</td>
<td>1971</td>
</tr>
<tr>
<td>Czechoslovakia</td>
<td>1970</td>
</tr>
<tr>
<td>Germany, Federal Republic of Japan</td>
<td>1978</td>
</tr>
<tr>
<td>Japan</td>
<td>1973</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1971</td>
</tr>
<tr>
<td>Poland</td>
<td>1970</td>
</tr>
<tr>
<td>USA</td>
<td>1970</td>
</tr>
</tbody>
</table>

Representation of women in the different branches of health care

It is known that the proportion of women among workers in the formal health system varies greatly from one branch of health care to another and, within each branch, from one level to another and from one point in time to another. Table 4 shows overall trends with regard to physicians, dentists, pharmacists, nurses, and veterinarians from the early 1960s to the early 1970s. In the early 1970s, women constituted approximately 95% of the world’s nurses, 39% of its physicians, 33% of
Women as providers of health care

its pharmacists, 15% of its dentists, and 6% of its veterinarians. Compared with those for the early 1960s, these figures show an overall increase in the representation of women in each group.

It can be seen that there were increases of three percentage points for physicians and for dentists, of over six per cent for pharmacists, and of only a fraction of a percentage point for nurses.

It should be noted that the composition of the sample of countries on which the table is based varied from one occupational group to another

| Table 4. Changes between early 1960s and early 1970s in female rates for specific categories of health worker in the formal health system |
|---|---|---|---|
| | Total | Male | Female | Female rate (%) |
| Physicians (32 countries or territories)a | | | | |
| early 1960s | 1 166 796 | 741 791 | 425 005 | 36.4 |
| early 1970s | 1 589 589 | 963 539 | 626 050 | 39.4 |
| increase | 422 793 (36.2%) | 221 748 (29.9%) | 201 045 (47.3%) |
| Dentists (24 countries or territories)b | | | | |
| early 1960s | 216 547 | 189 919 | 26 628 | 12.3 |
| early 1970s | 243 875 | 206 505 | 37 370 | 15.3 |
| increase | 27 328 (12.6%) | 16 586 (8.7%) | 10 742 (40.3%) |
| Pharmacists (18 countries or territories)c | | | | |
| early 1960s | 216 783 | 160 088 | 56 695 | 26.2 |
| early 1970s | 261 929 | 176 351 | 85 578 | 32.7 |
| increase | 45 146 (20.8%) | 16 263 (10.2%) | 28 883 (50.9%) |
| Nurses (18 countries or territories)d | | | | |
| early 1960s | 1 168 897 | 65 801 | 1 103 096 | 94.4 |
| early 1970s | 1 609 151 | 87 342 | 1 521 809 | 94.6 |
| increase | 440 254 (37.7%) | 21 541 (32.7%) | 418 713 (40.0%) |
| Veterinarians (12 countries or territories)e | | | | |
| early 1960s | 45 145 | 43 999 | 1 146 | 2.5 |
| early 1970s | 54 280 | 51 034 | 3 246 | 6.0 |
| increase | 9 135 (20.2%) | 7 035 (16.0%) | 2 100 (183.2%) |

a Australia, Austria, Bahrain, Bermuda, Canada, Czechoslovakia, Denmark, Fiji, Finland, Federal Republic of Germany, Hungary, Ireland, Japan, Republic of Korea, Malta, the Netherlands, Norway, Pakistan, Poland, Portugal, Romania, Rwanda, Spain, Sweden, Switzerland, Thailand, United Kingdom (England, Northern Ireland, Scotland, separately), USA, USSR, and Yugoslavia.
b Austria, Bahrain, Bermuda, Canada, Czechoslovakia, Finland, France, Federal Republic of Germany, Hungary, Ireland, Japan, Republic of Korea, Norway, Poland, Portugal, Spain, Sweden, Switzerland, Thailand, United Kingdom (England, Northern Ireland, Scotland, separately), USA, and Yugoslavia.
c Austria, Canada, Czechoslovakia, Finland, France, Hungary, Ireland, Japan, Malta, Norway, Poland, Portugal, Spain, Switzerland, Thailand, United Kingdom (Northern Ireland only), USA, and Yugoslavia.
d Australia, Austria, Bahrain, Canada, Czechoslovakia, Fiji, Finland, Federal Republic of Germany, Hungary, Ireland, Republic of Korea, Northern Ireland, Norway, Saudi Arabia, Scotland, Switzerland, USA, and Yugoslavia.
e Austria, Canada, Czechoslovakia, Finland, France, Federal Republic of Germany, Hungary, Ireland, Norway, Spain, Switzerland, and USA.
and, as indicated in the table, the total number of countries on which the data were calculated was relatively small. Thus, the global figures for one occupation are not strictly comparable with those for another. They are indicative only of a trend within the specified occupation. Each of the five groups is considered separately below.

Physicians

In a sample of 32 countries or territories for which data were available for two points in time (e.g., 1960 and 1970, 1961 and 1971, or 1962 and 1972), there were about 200 000 more female physicians in the early 1970s than in the early 1960s (see Table 4), a rise of about 47% in the number of female physicians. At the same time, there were about 220 000 more male physicians in the early 1970s than in the early 1960s representing a rise of about 30%. Overall, the proportion of physicians who were women increased by three percentage points, i.e., from 36.4% in the early 1960s to 39.4% in the early 1970s. This shows that in general women have been gaining considerable ground in the medical profession.

Nurses

Because nursing has been traditionally viewed as a woman’s occupation, it may be interesting to note how many men entered the nursing profession during the period 1960–70. In the 18 countries or territories for which data were available, there were over 87 000 male nurses in the early 1970s. This represented a 33% increase over the number of male nurses in those countries in the early 1960s. Despite the considerable numerical increase, however, the proportion of male nurses remained very low and even declined slightly (from 5.6% to 5.4%).

Dentists

For dentists, as for physicians, the picture is blurred by the fact that, in several European countries, “physicians practising dentistry” and “university-level dentists” are counted among physicians. It is thus impossible to determine exactly the proportion of “physicians” in such countries who are dental practitioners and the proportion who are medical practitioners. It is equally impossible to ascertain the proportions of medical practitioners and of dental practitioners, respectively, who are women. It has been suggested that, in the countries in question, women constitute a higher proportion of dentists than of doctors. A separation of the data would shed more light on the matter and would be valuable for planning purposes.

Data in Table 4 suggest that between the early 1960s and the early 1970s, women entered the dental profession at a much faster rate than
Women as providers of health care

The number of women dentists increased by 40.3%, as compared with an increase of 8.7% in the number of men dentists. The net result of this was a rise of three percentage points in the proportion of dentists who were women. This fact notwithstanding, the proportion of women among dentists (15%) remained far smaller than the proportion of women among, respectively, physicians, pharmacists, or nurses.

Pharmacists

Of the professions examined, pharmacy experienced the greatest change in male/female ratios. Data for 18 countries show that the proportion of pharmacists who were women increased from 26.2% to 32.7%—a rise of 6.5% (see Table 4). This rise was still not high enough, however, to bring the proportion of women among pharmacists into line with the proportion of women among physicians (39.4%).

Over the decade, in the 18 countries as a whole the number of women pharmacists rose by 60% and the number of men pharmacists by 10%.

Veterinarians

Of the five branches of professional health care discussed in this report, that of veterinary medicine appears to be the one with the lowest proportion of women practitioners (6% in the early 1970s according to data from 12 countries), although their number increased almost threefold during the decade (see Table 4).

Midwives

The picture regarding midwives is relatively clear in the sense that, in the early 1970s, 100% of midwives in nearly all countries were women.

Women and specialization

Of the various branches of health care, medicine and nursing are those with the greatest scope for specialization. As regards nursing, however, there appears to be little information on the distribution of staff by sex and/or speciality. In countries where all or nearly all nurses are women, this is no problem; in others, it would be important to have such information. The following observations concern physicians.

It has been suggested that women physicians are particularly attracted to certain specialities, notably anaesthesiology, paediatrics, public health, and psychiatry. From the following examples the reader may gain some idea of the extent to which those specialities are, or are not, attractive to women in different countries. As the relevant data are
Women in the formal health care system

presented differently from country to country, it was not possible to develop a single table giving internationally comparable rates. Thus, data are presented separately for each of a few countries for which information was readily available. Moreover, in some cases, the data refer only to the proportion of all physicians in a specified specialist group who were women, while in others the data refer only to the proportion of all women physicians practising a given speciality.

In Czechoslovakia in 1970, women practitioners were represented in the specialities named below as follows:

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Female rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>paediatrics</td>
<td>69.9</td>
</tr>
<tr>
<td>ophthalmology</td>
<td>61.3</td>
</tr>
<tr>
<td>anaesthesiology</td>
<td>51.0</td>
</tr>
<tr>
<td>psychiatry</td>
<td>46.6</td>
</tr>
<tr>
<td>obstetrics</td>
<td>26.8</td>
</tr>
<tr>
<td>general surgery</td>
<td>19.8</td>
</tr>
<tr>
<td>orthopaedics</td>
<td>16.8</td>
</tr>
</tbody>
</table>

The data for Finland in 1973 are presented from two angles:

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Percentage distribution of female and male physicians among specialities</th>
<th>Number of women physicians and female rate per speciality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Females (N=659)</td>
<td>Males (N=2100)</td>
</tr>
<tr>
<td>paediatrics</td>
<td>16.5</td>
<td>4.5</td>
</tr>
<tr>
<td>neurology/psychiatry</td>
<td>10.0</td>
<td>9.2</td>
</tr>
<tr>
<td>ophthalmology</td>
<td>9.6</td>
<td>4.1</td>
</tr>
<tr>
<td>pulmonary diseases, tuberculosis</td>
<td>8.8</td>
<td>4.1</td>
</tr>
<tr>
<td>internal diseases</td>
<td>8.5</td>
<td>16.6</td>
</tr>
<tr>
<td>radiology</td>
<td>7.0</td>
<td>8.2</td>
</tr>
<tr>
<td>anaesthesiology</td>
<td>6.7</td>
<td>3.6</td>
</tr>
<tr>
<td>obstetrics and gynaecology</td>
<td>6.7</td>
<td>8.9</td>
</tr>
<tr>
<td>public health work and medicine</td>
<td>6.4</td>
<td>6.0</td>
</tr>
<tr>
<td>dermatology and venereal diseases</td>
<td>5.3</td>
<td>1.2</td>
</tr>
<tr>
<td>child psychiatry</td>
<td>5.2</td>
<td>0.2</td>
</tr>
<tr>
<td>ear, nose, throat diseases</td>
<td>2.0</td>
<td>4.7</td>
</tr>
<tr>
<td>surgery</td>
<td>1.5</td>
<td>20.1</td>
</tr>
<tr>
<td>other</td>
<td>5.8</td>
<td>8.6</td>
</tr>
</tbody>
</table>

Source: Haavio-Mannila (22).

From one angle (i.e., the proportion of all female physicians practising a particular speciality) paediatrics ranks first, neurology/psychiatry second, and child psychiatry eleventh. From the other (i.e., the proportion of all practitioners of a particular speciality who are women), child psychiatry ranks first, paediatrics third, and neurology/psychiatry seventh.
Women as providers of health care

In Jamaica, the female rates among those practising particular specialities in 1982 were as follows:

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Female rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>dermatology</td>
<td>100.0</td>
</tr>
<tr>
<td>anaesthesiology</td>
<td>52.9</td>
</tr>
<tr>
<td>radiology</td>
<td>44.4</td>
</tr>
<tr>
<td>obstetrics and gynaecology</td>
<td>44.0</td>
</tr>
<tr>
<td>ophthalmology</td>
<td>33.3</td>
</tr>
<tr>
<td>paediatrics</td>
<td>26.3</td>
</tr>
<tr>
<td>psychiatry</td>
<td>23.9</td>
</tr>
<tr>
<td>pathology</td>
<td>20.0</td>
</tr>
<tr>
<td>surgery</td>
<td>12.3</td>
</tr>
</tbody>
</table>

Source: International Labour Office (29)

For the USA, data for 1973 are also presented from two angles.

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Percentage distribution of female and male physicians among specialities</th>
<th>Number of women physicians and female rate per speciality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Females (N=24 354)</td>
<td>Males (N=300 013)</td>
</tr>
<tr>
<td>paediatrics</td>
<td>18.8</td>
<td>5.4</td>
</tr>
<tr>
<td>psychiatry</td>
<td>14.4</td>
<td>7.2</td>
</tr>
<tr>
<td>internal medicine</td>
<td>13.3</td>
<td>15.6</td>
</tr>
<tr>
<td>general (family) practice</td>
<td>10.5</td>
<td>17.1</td>
</tr>
<tr>
<td>anaesthesiology</td>
<td>7.2</td>
<td>3.5</td>
</tr>
<tr>
<td>pathology</td>
<td>6.6</td>
<td>3.3</td>
</tr>
<tr>
<td>obstetrics and gynaecology</td>
<td>6.3</td>
<td>6.3</td>
</tr>
<tr>
<td>radiology</td>
<td>3.6</td>
<td>4.8</td>
</tr>
<tr>
<td>public health</td>
<td>2.6</td>
<td>1.0</td>
</tr>
<tr>
<td>general surgery</td>
<td>1.7</td>
<td>10.1</td>
</tr>
<tr>
<td>ophthalmology</td>
<td>1.5</td>
<td>3.4</td>
</tr>
<tr>
<td>dermatology</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>neurology</td>
<td>1.2</td>
<td>1.1</td>
</tr>
<tr>
<td>physical medicine</td>
<td>1.2</td>
<td>0.4</td>
</tr>
<tr>
<td>other</td>
<td>5.4</td>
<td>16.6</td>
</tr>
<tr>
<td>unspecified</td>
<td>4.7</td>
<td>2.8</td>
</tr>
<tr>
<td>total</td>
<td>100.3</td>
<td>99.9</td>
</tr>
</tbody>
</table>

Source: Pennell & Showell (43). Percentages add to more or less than 100 because of rounding off.
The data for Poland show some interesting features. The table below refers to women who prepared doctoral and *døsent* dissertations in selected medical specialities during the period 1960–69.

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Doctoral dissertations</th>
<th></th>
<th>Døsent dissertations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of women</td>
<td>Percentage choosing the</td>
<td>Percentage of</td>
<td>Number of women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>speciality</td>
<td>dissertations</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>in each speciality</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>prepared by women</td>
<td></td>
</tr>
<tr>
<td>pediatrics</td>
<td>293</td>
<td>12.6</td>
<td>74.1</td>
<td>39</td>
</tr>
<tr>
<td>ophthalmology</td>
<td>93</td>
<td>4.0</td>
<td>66.6</td>
<td>27</td>
</tr>
<tr>
<td>microbiology</td>
<td>129</td>
<td>5.6</td>
<td>62.7</td>
<td>33</td>
</tr>
<tr>
<td>biochemistry and biophysics</td>
<td>139</td>
<td>6.0</td>
<td>46.7</td>
<td>41</td>
</tr>
<tr>
<td>medicine</td>
<td>723</td>
<td>31.2</td>
<td>38.8</td>
<td>135</td>
</tr>
<tr>
<td>obstetrics and gynaecology</td>
<td>276</td>
<td>11.9</td>
<td>20.2</td>
<td>48</td>
</tr>
<tr>
<td>surgery</td>
<td>666</td>
<td>28.7</td>
<td>16.6</td>
<td>129</td>
</tr>
<tr>
<td>total</td>
<td>2314</td>
<td>100.0</td>
<td></td>
<td>452</td>
</tr>
</tbody>
</table>

Source: International Labour Office (29).

What is interesting about the above data is the large proportion (nearly 29%) of the female students who specialized in surgery as compared with pediatrics (12.6%) and with obstetrics and gynaecology (11.9%). This fact notwithstanding, pediatrics is largely a women’s speciality in Poland (female rate, 74%), while most specialists in obstetrics and gynaecology and particularly in surgery are men (female rates, just over 20% and a little under 17%, respectively). In countries such as Finland and the USA, the proportion of women physicians who specialize in surgery is not only very low, but is not much different from the proportion of specialists in surgery who are women (roughly 2% either way in each of the two countries).
Women as providers of health care

A survey (date unknown, but before 1975) in the largest republic of the USSR (the RSFSR), where more than 50% of all USSR physicians work, showed that paediatrics was the speciality most widely chosen by women physicians, followed by obstetrics and gynaecology.

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Percentage distribution of women physicians by speciality</th>
</tr>
</thead>
<tbody>
<tr>
<td>paediatrics</td>
<td>17.7</td>
</tr>
<tr>
<td>obstetrics and gynaecology</td>
<td>9.0</td>
</tr>
<tr>
<td>stomatology (dentistry)</td>
<td>6.2</td>
</tr>
<tr>
<td>surgery</td>
<td>6.0</td>
</tr>
<tr>
<td>phthisiology</td>
<td>3.7</td>
</tr>
<tr>
<td>radiology</td>
<td>3.3</td>
</tr>
<tr>
<td>ophthalmology</td>
<td>3.2</td>
</tr>
<tr>
<td>neuropathology</td>
<td>3.0</td>
</tr>
<tr>
<td>otolaryngology</td>
<td>2.7</td>
</tr>
<tr>
<td>psychiatry</td>
<td>2.4</td>
</tr>
<tr>
<td>dermato-venereology</td>
<td>1.9</td>
</tr>
<tr>
<td>bacteriology</td>
<td>1.9</td>
</tr>
<tr>
<td>epidemiology</td>
<td>1.8</td>
</tr>
<tr>
<td>others</td>
<td>37.2</td>
</tr>
<tr>
<td>total</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Piradova (44).

The others consist of: specialists in therapy (therapists, infectionists, cardiorheumatologists, endocrinologists, haematologists, physiotherapists, gastroenterologists, etc.), 30% of the overall total; laboratory physicians, 3.3%; medically qualified sanitarians, 2.2%; and public health administrators, almost 2%.

One question that has been raised is the extent to which women's "choice" of speciality is influenced by the opinions of male physicians about the suitability of various medical specialities for women physicians. Although there is no way of answering this question, it cannot be ignored, particularly in the case of countries where speciality boards are dominated by male physicians. In the USA a study (15) has been carried out to determine the attitude of a sample of 84 male physicians on a medical school faculty regarding the suitability of certain specialities for women physicians. The field most highly recommended was child psychiatry, followed by paediatrics, psychiatry, and anaesthesiology. The field viewed as least suitable was urology, followed by orthopaedics, neurosurgery, and general surgery. In other words, with only a few exceptions, the fields that the male physicians thought to be most suitable for women are those in which, in the USA, women specialists already predominate, while the fields considered least suitable are those in which only a small proportion of specialists are women. Paediatrics was viewed as being more suitable for women than for men because it is non-competitive (presumably meaning that men are not much interested in it), because women are sensitive to the problems involved and can
relate well to the patients, and because it is a field in which women will be well accepted. Surgery was seen as particularly disadvantageous for women because of the great irregularity in working hours. Otolaryngology was seen as being too competitive, and both it and surgery were seen as fields in which women would encounter prejudice (the source of the prejudice presumably being male physicians).

Professional activities of women in the health system

The data below refer only to the USA and thus should not be interpreted as necessarily indicating a similar situation in other countries. As noted earlier, the situation of women in the health field varies greatly from country to country and over time.

The table below shows the distribution of male and female physicians in the USA in 1963 and 1973, by type and place of activity.

<table>
<thead>
<tr>
<th>Professional activity</th>
<th>Percentage distribution of physicians, 1963</th>
<th>Percentage distribution of physicians, 1973</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males (N=257 818)</td>
<td>Females (N=17 322)</td>
</tr>
<tr>
<td></td>
<td>Males (N=335 811)</td>
<td>Females (N=30 568)</td>
</tr>
<tr>
<td>patient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>office-based practice</td>
<td>90.5</td>
<td>81.5</td>
</tr>
<tr>
<td></td>
<td>78.6</td>
<td>70.4</td>
</tr>
<tr>
<td>intern/resident programmes</td>
<td>66.3</td>
<td>56.8</td>
</tr>
<tr>
<td></td>
<td>49.5</td>
<td>35.3</td>
</tr>
<tr>
<td>full-time hospital staff</td>
<td>13.7</td>
<td>15.3</td>
</tr>
<tr>
<td></td>
<td>17.8</td>
<td>22.3</td>
</tr>
<tr>
<td>other:</td>
<td>10.5</td>
<td>9.4</td>
</tr>
<tr>
<td>medical school faculty</td>
<td>5.2</td>
<td>1.6</td>
</tr>
<tr>
<td></td>
<td>7.7</td>
<td>2.5</td>
</tr>
<tr>
<td>administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10.5</td>
<td>9.2</td>
</tr>
<tr>
<td>research</td>
<td>2.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>other</td>
<td>0.7</td>
<td>1.0</td>
</tr>
<tr>
<td>none</td>
<td>4.3</td>
<td>10.7</td>
</tr>
<tr>
<td></td>
<td>13.7</td>
<td>20.4</td>
</tr>
<tr>
<td>total</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Based on data in Pennell & Showell (43).

The data in the above table show that, between the years 1963 and 1973, there was an increasing tendency on the part of both female and male physicians in the USA to engage in professional activities other than patient care. Female physicians, like male physicians, preferred office-based practice to hospital practice, although this tendency was greater among male physicians. At the same time, there was a marked decline, between 1963 and 1973, in the proportions of both male and female physicians who were in office-based practice. This is partly accounted for by a shift towards internship and residency programmes, partly by a shift towards activities other than direct patient care, and partly by an increase in the proportions of both male and female physicians who became inactive during the 10-year period. It is also noteworthy that
Women as providers of health care

proportionately as many of the female physicians as of the male physicians were in administration. The same applies to research.

In the USA, the representation of women on the faculties of medical schools is about what one would expect, considering the proportion of physicians in that country who are women. The following table shows a slight rise between 1975 and 1978 in the proportion of women among salaried faculty in medical schools.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>Female rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>40 578</td>
<td>34 459</td>
<td>6 119</td>
<td>15.1</td>
</tr>
<tr>
<td>1978</td>
<td>47 140</td>
<td>39 987</td>
<td>7 153</td>
<td>15.2</td>
</tr>
<tr>
<td>increase</td>
<td>6 562 (16.2%)</td>
<td>5 528 (16.0%)</td>
<td>1 034 (16.9%)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Higgins (25).

The representation of women in various faculty departments was as follows in 1978:

<table>
<thead>
<tr>
<th>Faculty department</th>
<th>Female rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>physical medicine</td>
<td>29.9</td>
</tr>
<tr>
<td>paediatrics</td>
<td>27.2</td>
</tr>
<tr>
<td>psychiatry</td>
<td>19.9</td>
</tr>
<tr>
<td>pathology</td>
<td>18.2</td>
</tr>
<tr>
<td>microbiology</td>
<td>17.2</td>
</tr>
<tr>
<td>anatomy</td>
<td>16.5</td>
</tr>
<tr>
<td>surgery</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Source: Higgins (25).

Data for 1971 show the distribution of women faculty members in medical schools in the USA by academic rank:

<table>
<thead>
<tr>
<th>Academic rank</th>
<th>Female rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>professor</td>
<td>4.0</td>
</tr>
<tr>
<td>associate professor</td>
<td>9.0</td>
</tr>
<tr>
<td>assistant professor</td>
<td>16.0</td>
</tr>
<tr>
<td>instructor</td>
<td>31.0</td>
</tr>
<tr>
<td>associate</td>
<td>32.0</td>
</tr>
<tr>
<td>assistant</td>
<td>39.0</td>
</tr>
<tr>
<td>lecturer</td>
<td>37.0</td>
</tr>
<tr>
<td>no academic rank</td>
<td>12.0</td>
</tr>
</tbody>
</table>

Source: Pennell & Showell (43).
Women in the formal health care system

There are also data from the USA on place and type of employment of registered nurses. The table below shows the percentages of nurses of each sex engaged in specified fields of nursing activity during the year 1972:

<table>
<thead>
<tr>
<th>Place/type of employment</th>
<th>Males (N=10 998) (%)</th>
<th>Females (N=766 416) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>hospital</td>
<td>78.7</td>
<td>64.1</td>
</tr>
<tr>
<td>nursing home</td>
<td>4.2</td>
<td>7.0</td>
</tr>
<tr>
<td>school of nursing</td>
<td>3.3</td>
<td>3.7</td>
</tr>
<tr>
<td>private nursing</td>
<td>3.3</td>
<td>5.0</td>
</tr>
<tr>
<td>public health</td>
<td>2.9</td>
<td>5.1</td>
</tr>
<tr>
<td>school nursing</td>
<td>0.9</td>
<td>3.9</td>
</tr>
<tr>
<td>industrial health</td>
<td>2.4</td>
<td>2.5</td>
</tr>
<tr>
<td>office (of physician or dentist)</td>
<td>1.5</td>
<td>6.8</td>
</tr>
<tr>
<td>other specified fields</td>
<td>1.1</td>
<td>0.5</td>
</tr>
<tr>
<td>not reported</td>
<td>1.7</td>
<td>1.6</td>
</tr>
<tr>
<td>total</td>
<td>100.0</td>
<td>100.2</td>
</tr>
</tbody>
</table>

Source: Based on data in Pennell & Showell (43).
The figures for females add up to more than 100% because of rounding off.

As can be seen from the above table, by far the largest proportions of both male and female registered nurses work in hospitals, although proportionately more of the male than of the female nurses do so. Of the female nurses who work outside the hospital, the largest number work in nursing homes and the offices of physicians and dentists. It is also noteworthy that proportionately more of the female than of the male nurses are attracted to private nursing and to public health.

Decision-making opportunities for women in a formal health system

In a formal health system, there are many levels of decision-making, each responsible to the one above it. At one of the levels, the decisions concern direct patient care. The skills of those involved in such decisions have usually been well tested and demonstrated beforehand, and the process is designed so as to ensure accountability for the decisions made. This applies to all members of what is referred to as the “health team”. Within this team, which is usually hierarchically structured, the physician (whether male or female) is usually the “top” decision-maker in the sense that the decisions made by other members of the team are usually subject to “the doctor’s orders”, i.e., where a doctor happens to be around. Thus, in a country where most physicians are men, it follows that most of the decision-makers in the formal health system are men. The opposite holds, of course, where most physicians are women.
In this section, the focus is on what may be called "managerial" positions. These include positions that involve such matters as policy-making, planning, programming, and budgeting at national and institutional levels.

The examples below give some idea of the place of women in certain types of decision-making post in four different countries.

In Poland in 1973, the representation of women in selected managerial positions in the health system was as follows:

<table>
<thead>
<tr>
<th>Managerial position</th>
<th>Female rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health and Social Welfare</td>
<td></td>
</tr>
<tr>
<td>Secretary of State</td>
<td>0.0</td>
</tr>
<tr>
<td>deputy Secretaries of State</td>
<td>0.0</td>
</tr>
<tr>
<td>directors of divisions</td>
<td>0.0</td>
</tr>
<tr>
<td>heads of departments of health</td>
<td>0.0</td>
</tr>
<tr>
<td>directors of community health centres</td>
<td>6.5</td>
</tr>
<tr>
<td>deputy directors of community health centres</td>
<td>15.4</td>
</tr>
<tr>
<td>directors of hospitals and outpatient clinics</td>
<td>38.6</td>
</tr>
<tr>
<td>deputy directors of hospitals and outpatient clinics</td>
<td>25.7</td>
</tr>
<tr>
<td>chief physicians and deputy chiefs in hospitals</td>
<td>36.9</td>
</tr>
</tbody>
</table>

Source: Sokolowska (52)

The above data should be viewed in the context of the female rates for physicians (50.2%), nurses (98.5%), dentists (81.3%), and pharmacists (83.1%) in 1973. In this context, the table shows clearly that in Poland there is little gender relationship between the composition of the health labour force and that of the managerial force in the health sector. At the same time, although none of the highest posts was occupied by a woman in 1973, the female rate for the managerial staff of health establishments was quite high, but still not what it should have been in relation to the above-cited figures.

Data from Austria, for 1973 and 1974, indicate that there was not a single woman among the 65 heads of department in the various ministries, not even in the field of education, in which women unquestionably play a major part. In 1974, only 21 (or 2.3%) of a total of 920 established university professors and only 12 (or 7.6%) of the 157 unestablished professors were women. Not a single university clinic in the whole of Austria had a woman director, and in the hospitals and welfare centres of Vienna only 6 (or 5%) of 118 chief physicians were women, even though nearly 40% of the physicians in Vienna in 1974 were women (32).

Data for the USSR show that, while the number of women in decision-making positions is relatively high, here too it is not commensurate with
the number of women working in the health sector and particularly in the medical field, where over 70% of the work force in the early 1970s consisted of women. For example, in the course of more than half a century of socialized medicine, only one woman has ever occupied the top national position in health, i.e., Minister of Health (19).

On the other hand it has also been reported (44) that, in the USSR, women are leaders in public health establishments at all levels, that more than half of the curative-prophylactic establishments are headed by women, and that hundreds of women hold leading posts as heads of regional, city, and district health care departments and as administrators of large hospitals, sanitary epidemiological stations, dispensaries, ambulance stations, etc.

In the USA, the proportion of health administrators who are women is surprisingly high (44.6% in 1970), considering the position of women generally in that country's health system. This may be partly explained by the fact that, in earlier times, the administration of health establishments was usually entrusted to nurses, along with the task of nursing, feeding, housekeeping, taking care of supplies, etc. in these establishments. Also, because many of these institutions were under church jurisdiction, religious figures were often placed in positions of responsibility. In fact, according to one observer (54), over 70% of hospitals sponsored by the Catholic church in the USA in 1972 were administered by women. At that time, such hospitals represented about 25% of the short-term, non-governmental hospitals in the USA.

An unpublished study of a sample of both male and female graduates of 30 graduate courses in health and hospital administration in the USA in 1973 and 1974 has yielded the following important findings:

(a) Female graduates are more likely than male graduates to be found in non-hospital settings (5 out of 10 female graduates secured hospital positions, compared with 7 out of 10 male graduates).

(b) Of the graduates from the 30 courses in 1973 – 74, 7.6% of the women were unemployed, compared with 0.6% of the men.

(c) While nearly 64% of the men had direct administrative responsibilities as administrators, associate/assistant administrators, or department heads, only about 44% of the women did. Proportionately more of the women were found in posts involving research, programme analysis, and planning.

(d) Half of the women, compared with 70% of the men, sought executive positions in hospitals and/or nursing homes.

(e) Female graduates tended to be older than their male counterparts (while nearly 17% of the women were over 40 years of age, only 3% of
Women as providers of health care

the men were). They were also less likely than their male counterparts to be married.

(j) Women were as likely as men to be found in full-time positions.

It has already been noted that, in the USA, a higher proportion of male nurses than of female nurses are attracted to hospital service perhaps because it offers them a better chance of working in a decision-making capacity. The following table shows the posts held by male and female registered nurses respectively, in the USA in 1972. In order to bring out the relatively advantageous position in which male registered nurses found themselves in 1972, the table also shows the sex distribution for each type of post.

<table>
<thead>
<tr>
<th>Post</th>
<th>Male (N = 10 989)</th>
<th>Female (N = 766 416)</th>
<th>Female rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>administrator or assistant</td>
<td>8.2</td>
<td>3.7</td>
<td>97.0</td>
</tr>
<tr>
<td>consultant</td>
<td>1.1</td>
<td>0.8</td>
<td>98.1</td>
</tr>
<tr>
<td>supervisor or assistant</td>
<td>15.8</td>
<td>10.3</td>
<td>97.8</td>
</tr>
<tr>
<td>instructor</td>
<td>4.4</td>
<td>4.2</td>
<td>98.5</td>
</tr>
<tr>
<td>head nurse or assistant</td>
<td>15.0</td>
<td>15.4</td>
<td>98.6</td>
</tr>
<tr>
<td>general duty or staff</td>
<td>31.5</td>
<td>56.0</td>
<td>99.3</td>
</tr>
<tr>
<td>other specified type</td>
<td>19.4</td>
<td>6.9</td>
<td>96.1</td>
</tr>
<tr>
<td>not reported</td>
<td>4.6</td>
<td>2.7</td>
<td>97.6</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>98.6</td>
</tr>
</tbody>
</table>

Source: Based on data in Pennell & Showell (43).

From the above, it can be readily seen that, although it represented only a small proportion (1.4%) of all registered nurses, the male element has the opportunities for higher-level positions that are denied, under similar circumstances, to female physicians, whose relative strength in their profession is much greater than that of male nurses in theirs.

It is a matter of concern to men and women alike that policy-making and planning bodies are not sufficiently representative of the providers of health care, particularly women. In a study carried out in the USA (12), for example, the representation of health care providers on such bodies was analysed in terms of the absolute number and relative strength of each of a variety of occupational groups on the governing boards of health system agencies. It was found that, in a sample of nearly 1000 providers on 55 boards, fewer than 20% were women, even though women constituted 75% of the agencies' active work force and over 50% of the general population.
Income of women in a formal health system

To judge from data on the USA, the income of women health workers is generally lower than that of men. In a study covering 106 499 workers employed in branches of health care in 1973, 61 518 (57.8%) of the study population were women, and 44 981 (42.2%) men. The following table shows the distribution of those workers by sex, grade, and starting salary per annum.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Starting salary per annum (US$)</th>
<th>Males</th>
<th>Females</th>
<th>Percentage distribution of males by grade</th>
<th>Percentage distribution of females by grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>GS 1-3</td>
<td>5 017</td>
<td>27.6</td>
<td>62.4</td>
<td>9.1</td>
<td>11.1</td>
</tr>
<tr>
<td>GS 4</td>
<td>7 198</td>
<td>43.4</td>
<td>56.6</td>
<td>19.2</td>
<td>18.3</td>
</tr>
<tr>
<td>GS 5-6</td>
<td>8 055</td>
<td>48.9</td>
<td>51.1</td>
<td>24.7</td>
<td>19.0</td>
</tr>
<tr>
<td>GS 7-8</td>
<td>9 969</td>
<td>24.2</td>
<td>75.8</td>
<td>7.6</td>
<td>17.4</td>
</tr>
<tr>
<td>GS 9</td>
<td>12 167</td>
<td>14.2</td>
<td>85.8</td>
<td>5.4</td>
<td>23.6</td>
</tr>
<tr>
<td>GS 10-11</td>
<td>13 379</td>
<td>42.8</td>
<td>57.2</td>
<td>6.4</td>
<td>6.2</td>
</tr>
<tr>
<td>GS 12</td>
<td>17 497</td>
<td>70.0</td>
<td>30.0</td>
<td>6.6</td>
<td>2.1</td>
</tr>
<tr>
<td>GS 13-14</td>
<td>20 677</td>
<td>81.9</td>
<td>18.1</td>
<td>8.6</td>
<td>1.4</td>
</tr>
<tr>
<td>GS 15</td>
<td>28 263</td>
<td>90.0</td>
<td>10.0</td>
<td>10.7</td>
<td>0.9</td>
</tr>
<tr>
<td>GS 16 and over</td>
<td>32 806</td>
<td>95.9</td>
<td>4.1</td>
<td>1.7</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Pennell & Showell (43).

While men constitute only 42% of the study population, it can be seen from the table that their representation in the high-income groups is over twice as great, e.g., they constitute 90% of those earning over $28 000 and nearly 96% of those earning over $32 000. Conversely, although women constitute nearly 58% of the study population, they represent only 10% of those earning $28 000 and only 4% of the those earning over $32 000. What is not shown is the extent to which women whose qualifications are equal to those of men are slotted into positions that pay less. Nevertheless, it is obvious from the table that there is one health labour market for men and another, with lower salaries and inferior career opportunities, for women.

In the USSR, the picture is viewed from another angle, given that women not only constitute the largest proportion of the country’s health workers but also the largest proportion of those at professional level (e.g., about 70% of physicians and dentists are women). An observer (19) notes that, of 24 occupational groups covered in a Soviet statistical yearbook for 1973, that labelled “health, physical culture, and social welfare” and that labelled “art” were listed as receiving the lowest average monthly pay of all. At the same time, of all the groups covered, the “health, physical culture, and social welfare” group contained the highest percentage of women (85%). The average income figure for this group was 99 roubles per month as against a national average of 134.9 roubles for all occupations. Thus, the average for all employed persons.
was one-third higher than that for persons employed in the field of "health, physical culture, and social welfare".

In certain countries where the representation of women in the more prestigious branches of health care is relatively high, the women in question naturally stand to benefit from relatively high incomes. Among such countries are: the Philippines, where women constituted about 32% of the country's physicians in 1971 and where the average income of physicians at that time was nearly 17 times higher than the average income of the population as a whole; Sri Lanka, where the corresponding proportion was 22% and the corresponding income 42 times higher than the average; and Thailand (30% and 35 times higher). These figures suggest, if anything, the inability of the poor in such countries to afford the cost of medical care, regardless of the sex of the person providing such care. It is interesting to compare the incomes of physicians in the above-mentioned countries with those of physicians in certain countries that had a much lower proportion of women physicians during the early 1970s. For example, the proportion of women physicians and the average income of physicians relative to the national average was 9% and 8 times higher, respectively, in the USA, 13% and almost 7 times higher in Australia, and 17% and about 5 times higher in Sweden (36).

It has been suggested that, in the formal health system, the annual income of women is less than that of men largely because they work fewer hours. From data on the average net annual incomes of male and of female physicians in the USA in 1972 and on the average number of hours per week of direct patient care provided by each group (43), it was possible to ascertain the extent to which the income of male physicians would have exceeded that of female physicians even if, other factors being equal, each group had worked the same number of hours per week and of weeks per year.

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Amount (US$) by which the income of male physicians would have exceeded that of female physicians in the USA in 1972, if both had worked an equal amount of time</th>
<th>Annual income of male physicians as a percentage of that of female physicians for equal time</th>
</tr>
</thead>
<tbody>
<tr>
<td>specialities</td>
<td>Per year</td>
<td>Per hour</td>
</tr>
<tr>
<td>all specialities</td>
<td>9 381</td>
<td>6.54</td>
</tr>
<tr>
<td>obstetrics and gynaecology</td>
<td>12 937</td>
<td>4.83</td>
</tr>
<tr>
<td>psychiatry</td>
<td>8 622</td>
<td>4.86</td>
</tr>
<tr>
<td>surgery</td>
<td>11 981</td>
<td>2.58</td>
</tr>
<tr>
<td>paediatrics</td>
<td>8 057</td>
<td>5.52</td>
</tr>
<tr>
<td>general (family) practice</td>
<td>7 562</td>
<td>6.70</td>
</tr>
<tr>
<td>radiology</td>
<td>9 839</td>
<td>10.02</td>
</tr>
<tr>
<td>internal medicine</td>
<td>6 449</td>
<td>9.10</td>
</tr>
<tr>
<td>anaesthesiology</td>
<td>5 058</td>
<td>5.26</td>
</tr>
<tr>
<td>all others</td>
<td>4 412</td>
<td>7.94</td>
</tr>
</tbody>
</table>
From the foregoing table, it can be seen that in all medical specialities, collectively and individually, the income of men is considerably higher than that of women, even when the factor of time worked is taken into account. In terms of income per hour, the greatest difference is in radiology, followed closely by internal medicine. In terms of annual income the greatest difference is in obstetrics and gynaecology, followed closely by surgery. In terms of the income of male physicians as a percentage of the income of female physicians, the greatest difference is again in obstetrics and gynaecology, followed closely by surgery and psychiatry.

While discrimination against women may play a significant role in the observed income differences, other factors need to be considered as well. One of these is age and, by implication, seniority. In this regard, it is possible that, within each speciality, proportionately more male than female physicians had reached the better-paid senior positions. To the questions of why this may be so, a partial response is that opportunities for women to reach these positions are affected to a considerable extent by temporary interruptions in their practice and in their continuing education as a result of domestic responsibilities. This in itself constitutes a form of discrimination in the sense that male physicians (like men generally) are not expected to interrupt their practice or education for the reasons for which women are expected to interrupt them, quite apart from pregnancy and childbirth. Another factor is that lower incomes tend to be associated with salaried positions rather than fee-for-service positions.

Admission of women to medical schools

According to data collected by WHO for the World Directory of Medical Schools (62), an increasingly high proportion of entrants into medical schools are women, even in regions where total enrolment is declining.

The following analysis covers 59 countries and territories for which complete data were available for both the academic years 1979–80 and 1984–85. These have been divided into five regions as follows: Africa (Burkina Faso, Ghana, Libya, Madagascar, Mali, Morocco, Nigeria, Rwanda, Sudan, Tunisia, Uganda, United Republic of Tanzania, and Zambia); America (Brazil, Canada, Chile, Colombia, Costa Rica, Dominican Republic, Guatemala, Jamaica, Mexico, Nicaragua, Peru, Uruguay, and Venezuela); Asia (Hong Kong, Iraq, Israel, Japan, Jordan, Kuwait, Lao People's Democratic Republic, Lebanon, Malaysia, Mongolia, Nepal, Pakistan, Philippines, Republic of Korea, Saudi Arabia, Sri Lanka, Syrian Arab Republic, Turkey, and Yemen); Europe (Bulgaria, Finland, German Democratic Republic, Greece, Hungary, Iceland, Malta, Norway, Portugal, Sweden, and Switzerland); and Oceania (Australia, New Zealand, and Papua New Guinea).

During the academic year 1979–80 total medical school enrolment in the countries covered was 178 233 persons, of whom 53 898 (30.2%) were
Women as providers of health care

women (see Table 5). In the same academic year there were 37,544 admissions and 21,157 graduates, of whom 30.3% and 27.6%, respectively, were women. By the academic year 1984–85 the female rates had increased to 34.7% for enrolment, to 36.0% for admissions and to 32.4% for graduates.

From these figures it is clear that women are gradually constituting a greater proportion of the total student population in medical schools all over the world. However, it should be pointed out that in 1984–85 men still accounted for more than half the admissions with a rate of 64%. Between 1979–80 and 1984–85, admissions of women increased by 5.7%; at this rate it would take more than 10 years for women to constitute even 50% of admissions, and even longer for them to constitute 50% of overall enrolment and of the number of graduates.

Trends by region

While the female rates in all five regions show an upward trend, the admissions in two regions fell by more than 25% (see Table 5), with a decline in the actual figures for women as well as men. The situation in each region is shown graphically in Fig. 1–5. The figures on which the graphs are based will be found in Table 5.

Of the five regions, Africa showed the greatest increase in female enrolment over the earlier period (145%). Total enrolment increased by 68.3%, while male enrolment increased by 47.2%. The same pattern was found in America and Asia.

Total enrolment increased in America by 78.3% and in Asia by 71.9%, while male enrolment in these regions increased by 63.4% and 55.4%, respectively. Although female enrolment increased by 107.9% in America and 135.9% in Asia, it accounted for only 38.9% and 27.9%, respectively, of total enrolment for the 1984–85 academic year. At the current growth rates of 5.5% and 7.7% respectively, it would take roughly 15 years before females constitute 50% of the enrolment in medical schools in these regions.

Europe and Oceania, in contrast to the other regions, showed a decline in medical school enrolment. Although the net enrolment in Oceania was down by 1.1%, the number of women medical students increased from 2282 to 2801, i.e., by 22.7%, while the proportion of men among medical students dropped by 11.1%. Nevertheless, women still constituted only 36.8% of the total enrolment.

In Europe, enrolment had decreased by 19.1% between 1979–80 and 1984–85. However, if the eastern European countries covered (Bulgaria, Hungary, and the German Democratic Republic) are analysed separately, they show trends differing from those of the region as a whole.
Table 5. Medical schools: enrolment, admissions, and graduates 1979–80 and 1984–85

<table>
<thead>
<tr>
<th></th>
<th>Both sexes</th>
<th>Males</th>
<th>Females</th>
<th>Female rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrolment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>World total</td>
<td>178 233</td>
<td>261 597</td>
<td>+ 46.8</td>
<td>124 335</td>
</tr>
<tr>
<td>Africa</td>
<td>12 668</td>
<td>21 321</td>
<td>+ 68.3</td>
<td>9 935</td>
</tr>
<tr>
<td>America</td>
<td>45 408</td>
<td>80 948</td>
<td>+ 78.3</td>
<td>30 255</td>
</tr>
<tr>
<td>Asia</td>
<td>66 751</td>
<td>114 725</td>
<td>+ 71.9</td>
<td>52 235</td>
</tr>
<tr>
<td>Europe (total)</td>
<td>45 702</td>
<td>36 983</td>
<td>- 19.1</td>
<td>25 488</td>
</tr>
<tr>
<td>east</td>
<td>15 410</td>
<td>15 663</td>
<td>+ 1.6</td>
<td>6 357</td>
</tr>
<tr>
<td>west</td>
<td>30 292</td>
<td>21 320</td>
<td>- 29.6</td>
<td>19 131</td>
</tr>
<tr>
<td>Oceania</td>
<td>7 704</td>
<td>7 620</td>
<td>- 1.1</td>
<td>5 422</td>
</tr>
<tr>
<td><strong>Admissions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>World total</td>
<td>37 544</td>
<td>50 371</td>
<td>+ 34.2</td>
<td>26 178</td>
</tr>
<tr>
<td>Africa</td>
<td>3 129</td>
<td>4 018</td>
<td>+ 28.4</td>
<td>2 416</td>
</tr>
<tr>
<td>America</td>
<td>9 070</td>
<td>14 366</td>
<td>+ 58.4</td>
<td>6 259</td>
</tr>
<tr>
<td>Asia</td>
<td>14 048</td>
<td>24 027</td>
<td>+ 71.0</td>
<td>11 923</td>
</tr>
<tr>
<td>Europe (total)</td>
<td>9 487</td>
<td>6 644</td>
<td>- 30.0</td>
<td>5 025</td>
</tr>
<tr>
<td>east</td>
<td>3 073</td>
<td>3 044</td>
<td>- 0.6</td>
<td>1 261</td>
</tr>
<tr>
<td>west</td>
<td>6 414</td>
<td>3 590</td>
<td>- 44.0</td>
<td>3 764</td>
</tr>
<tr>
<td>Oceania</td>
<td>7 704</td>
<td>7 620</td>
<td>- 1.1</td>
<td>5 422</td>
</tr>
<tr>
<td><strong>Graduates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>World total</td>
<td>21 157</td>
<td>38 366</td>
<td>+ 81.4</td>
<td>15 321</td>
</tr>
<tr>
<td>Africa</td>
<td>375</td>
<td>2 152</td>
<td>+ 73.9</td>
<td>320</td>
</tr>
<tr>
<td>America</td>
<td>5 473</td>
<td>8 456</td>
<td>+ 54.5</td>
<td>4 108</td>
</tr>
<tr>
<td>Asia</td>
<td>8 317</td>
<td>20 820</td>
<td>+150.3</td>
<td>6 522</td>
</tr>
<tr>
<td>Europe (total)</td>
<td>5 693</td>
<td>5 591</td>
<td>- 1.8</td>
<td>3 356</td>
</tr>
<tr>
<td>east</td>
<td>2 107</td>
<td>2 875</td>
<td>+ 36.5</td>
<td>833</td>
</tr>
<tr>
<td>west</td>
<td>3 586</td>
<td>2 716</td>
<td>- 24.3</td>
<td>2 523</td>
</tr>
<tr>
<td>Oceania</td>
<td>1 299</td>
<td>1 367</td>
<td>+ 5.2</td>
<td>1 015</td>
</tr>
</tbody>
</table>
Fig. 1. Medical schools in Africa: trends as regards enrolment, admissions, and graduates, from 1979–80 to 1984–85
Fig. 2. Medical schools in America: trends as regards enrolment, admissions, and graduates, from 1979–80 to 1984–85

<table>
<thead>
<tr>
<th>Period</th>
<th>Enrolment</th>
<th>Admissions</th>
<th>Graduates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979-80</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1984-85</td>
<td>61.1%</td>
<td>40.6%</td>
<td>35.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Period</th>
<th>Number of students (thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979-80</td>
<td>Males 33.4% Female 68.6%</td>
</tr>
<tr>
<td>1984-85</td>
<td>Males 38.9% Female 61.1%</td>
</tr>
</tbody>
</table>
Fig. 3. Medical schools in America: trends as regards enrolment, admissions, and graduates, from 1979-80 to 1984-85.
Fig. 4. Medical schools in Europe: trends as regards enrolment, admissions, and graduates, from 1979–80 to 1984–85.

- **Total Europe**
  - **Enrolment**: 55.8% (1979-80) to 51.6% (1984-85)
  - **Admissions**: 47.0% (1979-80) to 49.8% (1984-85)
  - **Graduates**: 41.1% (1979-80) to 52.0% (1984-85)

- **Western Europe**
  - **Enrolment**: 36.8% (1979-80) to 43.9% (1984-85)
  - **Admissions**: 41.3% (1979-80) to 47.9% (1984-85)
  - **Graduates**: 29.6% (1979-80) to 38.7% (1984-85)

- **Eastern Europe**
  - **Enrolment**: 58.7% (1979-80) to 54.1% (1984-85)
  - **Admissions**: 59.0% (1979-80) to 52.0% (1984-85)
  - **Graduates**: 60.5% (1979-80) to 56.8% (1984-85)
Fig. 5. Medical schools in Oceania: trends as regards enrolment, admissions, and graduates, from 1979–80 to 1984–85.
These countries with centrally planned economies showed a 1.6% increase in enrolment. The enrolment of men also showed an increase of 13.2% over the previous period and, although there was a net decline of 6.5% in the enrolment of women, they still represented 54.1% of the total enrolment.

In western European countries, on the other hand, enrolment declined by 29.6% (by 37.5% for men, and by 16.1% for women). The proportion of women in the total enrolment for those countries increased by 7.1 percentage points over the 1979–80 figure, rising to 43.9%.

Admissions followed basically the same pattern. In Africa admissions of females rose by 85%, and admissions of males by only 11.7%; in America the corresponding rates were 107.5% and 36.3%, respectively. Similarly, in Asia, admissions of females rose by 159.2%, and admissions of males by only 49.5%. This development resulted in a substantial increase in the female rate for admissions in these regions (see Table 5), while, in regions where overall admission dropped (Europe and Oceania), there was still an increase in the rate although it was much lower.

The percentage-point increase in the female rate for admissions was 10 in Africa, 9.6 in America, 10.1 in Asia, 2.8 in Europe, and 7.6 in Oceania. In Europe, where not only was enrolment dropping but a relatively high proportion of admissions (47% in 1979–80) were of women, the increase in the rate was low. However, in regions with increasing enrolment and where women accounted for a relatively small proportion of admissions (e.g., Asia with a rate of 19.6% in 1979–80), the increase was greater.

In all the regions, except Europe, the actual number of graduates increased, and even in Europe there was only a 1.8% drop. The proportion of female graduates relative to male graduates also increased in all the regions. The figures for Africa are extremely high and somewhat misleading, since many of the countries that had not reported figures for graduates for the academic year 1979–80 reported them for 1984–85.

Even in regions where countries reported figures for both periods, the increase in the number of women graduates was considerably higher than the corresponding increases in enrolment or admissions; this was also true for male graduates in some cases. In America, for example, the increase since 1979–80 was 119.8% for women, and 32.8% for men. Women accounted for 35.5% of the graduates in the region in 1984–85, a percentage-point increase of 10.6 over the figure for 1979–80.

The number of female graduates increased by 221.3% in Asia, 14.9% in Europe, and 58.8% in Oceania, the gains in the female rate being 6.1%,
Women as providers of health care

6.9% and 11.1%, respectively. In countries with centrally planned economies, the number of men graduates increased by 49.1%, and that of women graduates by 28.2%. However, women still constitute 56.8% of the graduates, slightly less than in 1979–80 (60.5%).

To sum up, even in regions where enrolment is declining, statistics on enrolment, admissions, and graduates all show an increased percentage of females relative to males. The only exception to this trend is in the countries with centrally planned economies, and even in these, although there was a drop in the percentage of females relative to males as regards enrolment (from 58.7% to 54.1%) and admissions (from 59% to 52%), females still constituted more than half of the total medical school population. As for graduates, the female rate was already 60.5% in 1979–80, but decreased to 56.8%.

If current trends continue women should account for 50% or more of admissions to medical schools, and of medical students and graduates, in every region within 15 years.

Generational differences

Broadly speaking, the female rate shows a markedly upward trend in the younger generation of health workers (65). In Thailand, for instance, out of every 100 dentists aged 50–54 in 1970, 32 were women; at the same date, out of every 100 dentists aged 25–29, 64 were women. In other words, the female rate had doubled in a quarter of a century. In Hungary, out of every 100 physicians aged 45–49 in 1977, 30 were women; at the same date, the female rate for physicians aged 25–29 was 57%. A similar doubling of the rate from one generation to the next was observed among Belgian pharmacists: in 1970, the female rate was 20.5% for those aged 55–59, but 43.1% for those 25 years younger. Data on inter-generational variations in the female rate are presented in Table 6 for a sample of four types of health worker, each selected from a different country.

Data from a broader sample of countries are presented in Fig. 6 (dentists), Fig. 7 (nurses) and Fig. 8 (physicians); all show an upward trend. In fact, in nearly all countries a steady increase in the proportion of women in nearly all branches of health care may be observed when older and younger generations are compared. In certain developed countries, the increase is more striking in the traditionally male-dominated branches (e.g., medicine, dentistry) than in the branches where women largely predominate (e.g., nursing, midwifery). As regards the latter, the female rate is already nearly 100% in the older generation, so that no increase appears possible in the younger one. Nevertheless, this is simply a global impression. Data on nursing personnel in Australia (see Table 6 and Fig. 7) and Belgium (see Fig. 7), among other countries, suggest that, even for those branches where women largely predominate,
there can be a sizeable increase in the female rate in the younger, as compared with the older, generation. As for the developing countries, such an increase is clearly apparent in nearly all branches of health care, whether or not traditionally provided by women.

The upward trend in the female rate among younger health workers has coincided with an upsurge in women’s participation in economic activities. The International Labour Office has estimated that between 1950 and 1975, at world level, the activity rate for men decreased from 60.4% to 53.8%, whereas that for women increased from 27.5% to 29.1%. The number of economically active women in the world rose from 344.3 million in 1950 to 575.7 million in 1975 (28).

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Female rate (%) for:</th>
<th>nurses (Australia, 1971)</th>
<th>pharmacists (Belgium, 1970)</th>
<th>physicians (Hungary, 1977)</th>
<th>dentists (Thailand, 1970)</th>
</tr>
</thead>
<tbody>
<tr>
<td>under 20</td>
<td>97.6</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20–24</td>
<td>95.9</td>
<td>77.6</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>25–29</td>
<td>93.9</td>
<td>52.1</td>
<td>57.0</td>
<td>64.6</td>
<td></td>
</tr>
<tr>
<td>30–34</td>
<td>92.3</td>
<td>43.1</td>
<td>51.0</td>
<td>57.0</td>
<td></td>
</tr>
<tr>
<td>35–39</td>
<td>91.2</td>
<td>39.1</td>
<td>44.1</td>
<td>51.9</td>
<td></td>
</tr>
<tr>
<td>40–44</td>
<td>89.7</td>
<td>25.7</td>
<td>41.6</td>
<td>52.5</td>
<td></td>
</tr>
<tr>
<td>45–49</td>
<td>90.4</td>
<td>20.5</td>
<td>30.2</td>
<td>36.6</td>
<td></td>
</tr>
<tr>
<td>50–54</td>
<td>88.0</td>
<td>18.4</td>
<td>27.1</td>
<td>32.1</td>
<td></td>
</tr>
<tr>
<td>55–59</td>
<td>89.7</td>
<td>17.1</td>
<td>21.3</td>
<td>11.1</td>
<td></td>
</tr>
<tr>
<td>60–64</td>
<td>88.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

*From: World health statistics annual (65).

General observations

This analysis has been confined to factors that are of reasonably wide application and for which statistical information is available. In the circumstances, it can hardly be considered as presenting a complete picture of the situation of women health workers in the world today. However, a statistical study has its own merits. One is that it replaces intuitive feelings or subjective deductions by firm and objective observation and measurement. Another is that it permits the identification of facts or relationships that could not otherwise be apprehended. Moreover, the statistical approach may give the lie to some commonly accepted ideas. For instance, in the USA, “a comparison of the practice

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1 The term “economic activities”, as used here, means participation in the production of goods and services only. Housework is not considered as an economic activity, unless it is performed for remuneration or to facilitate the economic activities of the head of the household.
Women as providers of health care

Fig. 6. Female rate for dentists, by age group, selected countries

Women in the formal health care system

Fig. 7. Female rate for nurses, by age group, selected countries

Czechoslovakia 1970
Belgium 1970
Australia 1971
Thailand 1970
Yugoslavia
Jordan 1972

Number of women per 100 nurses of both sexes (female rate)

Age group (years)

Women as providers of health care

Fig. 8. Female rate for physicians, by age group, selected countries

Number of women per 100 physicians of both sexes (female rate)

Age group (years)

Hungary 1977
Austria 1971
Netherlands 1971
Japan 1973
Jordan 1972
patterns of men and women physicians graduating between 1931 and 1956 showed that almost 9 percent of the women were inactive, in contrast to less than 1 percent of the men” (34). Such observations, reported in other countries too, have been used as an argument against training women as physicians since they suggest that a woman’s working life is so short compared to that of a man that the economic return for the national health system would be too small. This issue is not discussed here, but it must be pointed out that the premise just cited is not supported by the facts. A study published in 1979 (3) gives values for the working-life and inactive-life expectancies of American physicians at age 35 in 1969–73. While, in the conditions prevailing at the time, the inactive-life expectancy was 8.6 years for female physicians and only 5.9 years for their male colleagues, the working-life expectancy was 34.1 years for men and as much as 36.3 years for women—a finding that seems contrary to “common sense”. The explanation lies in the greater longevity of women: at the time of the study life expectancy at age 35 was 40 years for male American doctors, but nearly 45 years for their female counterparts. This longevity factor should have been taken into account in the study quoted above, but was effectively ignored.
The nursing profession has been singled out for special consideration in this publication because the situation of women in nursing epitomizes that of all women who provide health care. Of all branches of health care and of all professions traditionally associated with women, nursing has the largest membership and the greatest concentration of women. About 90% of the world's nurses are women. In formal health care systems, the nursing component (i.e., nurses, nurse-midwives, and auxiliary nurse-midwives) outnumbers all others combined. Because of this and because nurses are already in close contact with individuals, families, and communities, nursing is potentially capable of making the most significant contribution of any branch of health care to the achievement of health for all. Yet the nursing profession is still viewed largely as secondary, supportive, and subordinate to the medical profession.

Of all professions subject to sex-role stereotyping, nursing seems the most severely handicapped in that nurses are doubly conditioned into playing a subservient role: first by society generally, and secondly by the medical establishment (55).

The degree to which nurses and nursing practice are affected by sex-role stereotyping is so acute that concerted action will be required to overcome the resulting disadvantages, notably the fact that the nursing profession is completely controlled by the medical profession. This situation has continually limited efforts on the part of nursing leaders to establish nursing as a profession that is complementary, and not subordinate, to the medical profession.

**Aim of this chapter**

The aim of this chapter is to give examples from nursing education and practice of the type of discrimination to which women are subjected generally. It is hoped that it will lead to a better and broader understanding of the problems faced by women as health care providers and that, by portraying the present situation of nurses as women, it will also point to ways in which the full potential of the nursing profession can be realized.
Nursing and the condition of women

First, there will be a brief review of the development of nursing practice and education, including the efforts of the profession to establish its role and status in the society it serves. Next, factors influencing the role and status of nursing will be examined and there will be an account of the efforts made by nursing leaders, in particular through participation in decision-making at policy-making level, to increase the relevance of nursing to the needs of the community.

It is assumed at the outset that, in formally organized health systems throughout the world, there has always been a definite professional hierarchy. In these systems, the physician is supreme, while the nurse occupies an intermediate or lowly position, particularly if she is working in a hospital. While nurses are subordinate to physicians, they are often in charge of various categories of auxiliary personnel and the management of patient care. They stand midway between the physician and the auxiliary in the administrative hierarchy of the health system, and are also placed between the physician and the patient. Thus, in her relations with the patient, the physician, and the auxiliary health personnel, the nurse plays a triple role. The origin of this role dates back to the era of Florence Nightingale, when the nurse was defined by her character rather than her skills, the model being the upper-class Victorian lady in her roles as wife, mother, and housekeeper. In fulfilling her duties the nurse was, and in many countries still is, expected to bring to the patient the selfless devotion of a mother, to the physician the wifely virtue of absolute obedience, and to the auxiliary personnel the firm but kindly discipline of a household manager.

This pattern has, with slight variations, persisted over the years, despite the high level of education many nurses have attained, despite the broad range of skills they have acquired, and despite the efforts of nursing leaders to establish nursing as an autonomous profession.

The full potential of the profession will not be realized until the nurses themselves are in control, until the doctor-centred pattern of medical care is replaced by a “health team” approach, and, most important, until governments recognize the crucial role of nursing and midwifery personnel within a formal health service.

However, in some countries, certain factors have already produced a significant change. These include increased educational opportunities for nurses, the women’s movement, the demedicalization of society, and increasing opportunities for nurses to participate in decision-making at policy-making level within the health system.
Women as providers of health care

The development of nursing practice and education

Women have always been the care providers in society, nurturing and nourishing children and other family members and, by extension, friends, neighbours and the community. In most cultures these important activities are stereotyped as feminine, i.e., society assumes that female characteristics and traits are required by those who carry them out.

When nurturing functions became institutionalized as work to be paid for, women were expected to perform it, but usually for little pay, or for payment in kind in suboptimal working conditions. Probably more than any other highly feminized profession, nursing represents the epitome of the institutionalization of what was once considered socially to be solely a women’s function.

In western countries, where it was first institutionalized as a paid occupation in early health systems, nursing was basically of two types: that practised in the homes of those who could afford it by private, fee-for-service, live-in nurses, and that provided in institutions and workhouses by women of religious orders or by domestic servants. In many parts of Europe, it was not until the turn of the twentieth century that nuns were replaced by lay nurses, owing to a falling-off in the number of adherents to religious orders (11).

Formal nursing training was nonexistent: nurses were expected to use the basic homemaking and caring skills that they had learned from either their mothers or other women in the family, from domestic service, or from their experience on the job. The duties of the nurse were essentially those of housewife-cum-servant, and this was reflected in the doctor/nurse relationship. Doctors were male, well-educated, and generally from the more prosperous classes, while nurses were female, poorly educated, without formal training, and from the lowest social class. Until 1860, the relationship between doctor and nurse was quite unequivocal: the nurse was to be “the skilled servant of medicine” operating “in strict obedience to the physician’s or surgeon’s power” (14).

The emergence of modern nursing

The introduction of formal training for nurses marked the emergence of modern nursing. The reform of nursing in the latter half of the nineteenth century involved training, changes in recruitment, changes in organization, and changes in hospital administration (2). It came as a response to a wider knowledge of medical care and to the recognition by doctors and others of the importance of bedside care.

The year 1860 marked the beginning of modern nursing in England, with the enrolment of the first students at the Nightingale School of
Nursing at St Thomas’s Hospital, London. This first nursing training school was not, however, under the control of the hospital, but functioned as a separate institution with its own funds and governing body. It admitted women students of two distinct kinds: probationers who received a small salary, and “lady pupils”, who received no salary and actually paid for their tuition. The probationers were of working-class origin and the lady pupils drawn from the upper classes. Nightingale had hoped to attract middle-class women to nursing, but was almost entirely unsuccessful. Abel-Smith (2) suggests that this was because of the fundamental conservatism of the middle class. For the working class, nursing represented an alternative to domestic service. For the lady pupils, however, it offered a rare opportunity to be in a position where they were not totally subservient to men and had some decision-making power (42).

Nightingale conceived nursing as an independent, autonomous, dignified profession, allied to the medical profession rather than subordinate to it. She wrote in 1867, “the whole reform in nursing both at home and abroad has consisted in this: to take all power over nursing out of the hands of men, and put it into the hands of one female trained head and make her responsible for everything” (42). She thus objected to the archaic and sentimental notions of nurses as martyrs, penitents, or ministering angels, and to the concept of the “born nurse”. She saw nursing as a dignified, necessary, responsible profession, demanding moral and physical stamina and intelligence in the face of complex situations (56), and consequently she rejected ignorant and untrained nurses.

Nightingale also believed that health care should be based on the provision of a healthy physical and psychosocial environment which she considered an essential component of the process of care and thus complementary to the physician’s chemotherapeutic and surgical cures.

The registration of nurses

Throughout the world the apprenticeship method was long believed to be the only way a nurse could learn (39), but, with the increasing institutionalization of medical care and the corresponding need for skilled nursing personnel around the turn of the twentieth century, nurses in several countries began campaigning actively for the registration of trained nurses. This trend appeared in Latin America by the middle of the century. Such a development was inevitable because chaotic educational systems had created a situation in which no distinction was made between trained and untrained nurses (8).

In some countries, there was opposition from several quarters to the registration of nurses. Physicians opposed registration and the elevation of nursing into an established profession on the ground that such an act would narrow the field of recruitment and lead to a shortage of nurses.
Women as providers of health care

There was still a great demand for private, domiciliary care, which competed with health institutions for the limited supply of nurses. It seems likely that physicians were not unwilling to recruit and employ untrained nurses and to train them on the job. This was probably because most physicians at the time considered nursing practice as consisting of little more than housekeeping and hand-holding. Registration also had its opponents within the nursing profession: matrons feared that their power would be reduced and their prestige lost if all trained nurses were registered.

To promote the registration campaign in the USA, two national nursing organizations proceeded to set up constituent groups in the different states. The local membership did the necessary lobbying, and in 1903 the nurses of North Carolina were the first to succeed in having a nurse registration act passed. One by one, the other states followed suit, and by 1923 all states had nurse licensure laws. In England and Wales, registration of nurses became law in 1919. It is interesting to note that the original registration acts did not include any definition of the scope of nursing practice. According to Bullough (8): “The term ‘registered nurse’ was defined as someone who had completed an acceptable nursing programme and passed a board examination, rather than someone engaged in a specific type of practice. This placed emphasis on the educational process, and early reform efforts tended to be focused on upgrading the educational background of registered nurses.”

The nurse’s role: a reflection of the sociocultural environment

It has been said that Florence Nightingale’s concept of nursing as an autonomous profession closely allied to the medical profession was intentionally misconstrued by those with vested interests in the health structures of the time, who sought to perpetuate the notion of the nurse as subordinate to the physician. At the same time, nurses were called upon to subordinate self-interest to the care of others (11). The need for the nurse to be seen as a subordinate reflected a social system in which women were considered inferior and the nursing profession was exploited commercially in order to protect male mobility and prestige, socially, professionally, financially, and politically. Furthermore, the idea of nurses as subordinates was propagated through the medium of nursing education in order to provide low-cost hospital staff for the benefit of the health industry, whose subjugation of nursing simply reflected the general cultural mores of the years prior to the First World War and women’s suffrage.

In insisting that control over nursing must be vested in nurses, Florence Nightingale did not intend to challenge the doctor’s authority vis-à-vis the patient (8). The independent functions of the nurse remained essentially those of a housemaid. In their delivery of patient care, they were entirely under the jurisdiction of the doctor.
Nursing and the condition of women

But as the movement for the emancipation of women grew, women agitated to have access to medical training although Florence Nightingale herself spoke disparagingly of those who entered the medical profession: “They have attempted to become men and succeeded only in becoming third-rate men” (16).

The International Council of Nurses (ICN)

Before the death of Florence Nightingale in 1910, trained nurses all over the world formed self-governing organizations which came together in the International Council of Nurses (ICN), soon to become an effective medium for promoting the modern nursing movement. In July 1900, the ICN established its charter, which included the following words:

We nurses of all nations, sincerely believing that the best good of our Profession will be advanced by greater unity of thought, sympathy and purpose, do hereby band ourselves in a confederation to further the efficient care of the sick and to secure the honor and interests of the Nursing Profession.

Other objectives were added as the organization developed and as the leaders recognized more fully the standards and responsibilities implied by the word “profession”.

The Council’s aims and membership requirements further emphasized the principles of self-government under nurse leadership, the determination to develop the nurse as a professional person, an articulate, self-directing human being, and a citizen, to improve the quality of nursing service and education, and to raise the ethical, social, and economic status of nurses.

The report of the 1901 ICN Congress in Buffalo revealed the spirit and ideals of these pioneers of the profession when it stated:

The essential spirit of the International Council of Nurses is that of self-government. Nurses who appreciate their profession and take themselves seriously begin to realize that the period of tutelage is past, and that women are now fitted to take up such positions in the world as are now held by many of those here present, and are also capable of governing themselves. We also realize that in professions as well as in individuals the highest and greatest point of perfection is only attained when we do govern ourselves. Under tutelage no one ever attains to the best that is in him. Further, these congresses bring together nurses of all nations and they form a means of communication which widens the nurses’ views, deepens sympathy and makes them greater human beings.

It is interesting to note that, in the early ICN documents, it was the recognition (presumably by the health system and by society generally) of nursing as a profession in its own right that was stressed rather than any explicit challenge, either to the authority of physicians or
the effectiveness of contemporary medical care. It would take several decades of advances in health care and improvements in the status of women before nurses voiced such challenges.

Epidemiological changes and technological development

Throughout the decades following the emergence of institutionalized health care and modern nursing practice, nursing education continued to follow the hospital-based, disease-oriented model. Medical technology and social and epidemiological changes made the nurse essential, but the physician diagnosed and prescribed, while the nurse treated and observed. The body of knowledge constituting the nursing curriculum increased as advances were made in medicine, and nursing has gradually become more specialized and task-oriented in response to the complexity of caring functions. However, the profession continues to be dominated by medicine and by the wide array of specialized medical personnel that have sprung up in response to technological advances.

What is nursing?

Perhaps the best-known definition of nursing is that given by Virginia Henderson (24):

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. In addition, she (the nurse) helps the patient to carry out the therapeutic plan as indicated by the physician.

Who should be called a nurse?

The ICN defines a nurse as follows:

A nurse is a person who has completed a programme of basic nursing education and is qualified and authorized in her/his country to practise nursing. Basic nursing education is a formally recognized programme of study which provides a broad and sound foundation for the practice of nursing and for post-basic education which develops specific competency. At the first level, the educational programme prepares the nurse, through study of behavioural, life and nursing sciences and clinical experience, for effective practice and direction of nursing care, and for the leadership role. The first level nurse is responsible for planning, providing and evaluating nursing care in all settings for the promotion of health, prevention of illness, care of the sick and rehabilitation; and functions as a member of the health team. In countries with more than one level of nursing personnel, the second level programme prepares the nurse, through study of nursing theory and clinical practice, to give nursing care in cooperation with and under the supervision of a first level nurse.
Nursing leaders have recently been trying to clarify who is and who is not a “nurse” and to explain what constitutes “nursing”. In some countries, only the nurses who have graduated from a university course are considered professional nurses, while graduates from hospital-based schools of nursing are considered technical nurses. In other countries, a professional nurse is a person with at least twelve years’ general education plus three years’ nursing education, while those with nine years’ school education plus three years’ nursing education are called auxiliary nurses (though a nurse with the same level of education may be called a professional nurse elsewhere). As is frequently the case in countries with many levels of nursing personnel, all levels have similar functions and roles. Although performance is likely to differ in quality at the various levels, the general public is rarely aware who is doing what. Since, according to the public, a nurse is a nurse, regardless of educational preparation, the nurse’s general reputation hinges on the level of performance of the majority—the majority often being auxiliary-level personnel.¹

Current notions about nurses and nursing

A variety of studies have dealt with the image of the nurse in relation to social class, the status of nursing as a profession, and how the public sees nursing education and the nurse’s expanded role. The findings tend to support the traditional view of nursing, emphasizing the subservient role of nurses to that of physicians, their alliance with hospitals, and the technical nature of their work.

A study undertaken in Queensland, Australia, has sought to determine what nurses and non-nurses know and believe about nurses and nursing (66). It was found that there was no significant difference between the two groups as regards nurses’ more obvious activities such as washing patients, giving medication, dressing wounds, taking vital signs, and giving first aid. But, among those who were not nurses, there was a lack of understanding of nurses’ autonomous activities, such as planning patient care, discussing care with patients and other professional health workers, and teaching patients. The other activities perceived differently by the two groups were either technical and/or of a kind generally associated with doctors.

The public image of the nurse appears to be particularly negative in countries where strong cultural traditions severely restrict the participation of women in paid occupations outside the home. As a result, nursing functions in these countries are performed by women of the lowest social class—a situation reminiscent of the earliest days of nursing. For example, a serious problem for nurses and nursing teachers in Egypt is the low status of the profession. “In Cairo and Alexandria,

¹ The levels referred to here are those based on degree of training and not the different institutional levels of health care.
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where baccalauréat, master’s, and doctoral degree programmes in nursing have been developed within the universities, there has been some advance in social acceptability of the nursing profession. Still, few young women study nursing by choice. If their grades are not high enough to allow them to choose other professions such as medicine or law, which have high status, they enter the school of nursing in order to gain a university degree, not because they wish to become nurses” (51). Similar problems are found throughout the Arab countries with the result that the nursing profession is unable to attract an adequate number of women.

The great progress made by the nursing profession in line with the growing complexity of health care today has not yet been acknowledged or adequately recompensed and evaluated by either the public or the formal health care systems.

Nursing and the women’s movement

The upsurge of feminism in developed countries in the 1960s challenged the medical dominance of the nursing profession. Women are, by and large, better educated than in the past and have greater occupational and personal expectations. Moreover, nurses are challenging training on medical lines and questioning the tradition of deference to physicians. Nurses as women have begun to seek a reappraisal of both the contribution of nursing to the health system and the contribution of women to a healthy society. In the opinion of one nurse-feminist, this does not mean that nurses are abandoning compassion by challenging health system structures, “it does mean we have compassion for our own legitimate needs. By prostituting those needs, concerns and talents to those of others, by persisting in taking secondary roles, we have helped to perpetuate social, economic and political systems, which we know very well are inadequate. Thus have nurses, by default, contributed to the appalling inadequate health care system” (50).

Margaret Sovie (53) relates the protracted development of nursing as a profession directly to its traditional image as a profession for women: “Nurses are now cognizant of the past societal conditioning and collectively are acting to exert their power. They have organized for political action; collective bargaining is becoming commonplace; conditions of employment as well as essentials for implementing standards of care are negotiated; achievable goals are delineated; strategies outlined and timetables set. Nurses are learning that a profession undergoing change requires creative courage.”

It appears that the feminist movement has indeed had a profound influence on the nursing profession in some countries, although in others, for cultural, social, and political reasons, nurses have been unable or unwilling to align themselves with this movement.
Where nursing leaders are in a position to link up with the women's movement but have hesitated to do so, one can only speculate on the reasons for their hesitation. It may be that they are not fully aware of the present and potential strength of the movement or, perhaps, that they remain wary of, and uncertain about, its objectives and direction. They may fear that, by becoming participants in the movement, they will alienate themselves still further from the medical profession and from their own potential supporters, or that they will provoke retaliation and retribution from the medical establishment.

A dilemma faced by nursing leaders today is the need to integrate the apparently conflicting strategies required to develop the nurturing—i.e., the "feminine"—side of their work and, at the same time, to encourage the accession of nursing to the area of high-level decision-making, traditionally characterized as "masculine".

In this connection, one may point to the sincere concern expressed by nurses and nursing leaders about what is seen to be a movement away from care. There have, in fact, been many articles in the nursing literature questioning the nature of care, with titles such as "Care in nursing—are we being side-tracked?" (37). There is also M.-F. Colièrè's contention that "the caring function has become a subordinate function stripped of all social and economic value" and that "under the impact of medical pressure, it has been transformed into the 'treatment' function" (13).

Again, in order to gain equal status with medicine, nursing would appear to be moving towards an acceptance of judgement by male standards, an increased emphasis on the managerial and administrative nature of nursing practice, and a denial of the "feminine" nature of nursing care.

In the final analysis, it would seem that nursing leaders, as well as women generally, should no longer allow themselves to be victims of an "either/or" situation. They should not choose, nor be forced to choose, either one strategy or the other, but should strive instead to achieve a synthesis of the two.

**Nursing and primary health care**

A much debated question, at both the national and the international levels, is that of the respective roles of various categories of health personnel in the development of health systems based on primary health care. Of particular interest in this respect is the role of nurses, since nursing personnel of all categories comprise the largest group of health care providers throughout the world.
A challenge for nursing

Primary health care may prove to be the nursing profession’s greatest challenge. Among other things, it offers nursing leaders an opportunity to combine the various strategies that have been developed with the aim of reforming nursing. Although early nursing practice concentrated mainly on individual needs within the family and the community, the spectacular rise of medical technology, the increasing emphasis on sophisticated equipment and techniques, and the glorification of hospital work have all contributed to shifting the focus of nursing practice to the patient in the hospital, where, of course, most nurses have received their education. Nurses, by and large, have failed to recognize that, by medicalizing nursing practice, they were in fact changing the fundamental nature of nursing, and in so doing reinforcing the medical profession’s grip on nursing.

Primary health care, by stressing teamwork and the need to match the best qualified and most readily available personnel with essential primary health care activities, has given the nursing profession the chance to prove its worth. The “caring” nature of nursing has been revitalized by the goal that governments have set themselves of achieving health for all by the year 2000 through primary health care. Many assumptions can be made about this development, not the least being that nurses, as a result of the demedicalization of health care, are now more confident that nursing will be able to contribute significantly to improving the health of individuals, families, and communities. It can also be assumed that the increased and improved educational preparation of nurses, together with the women’s movement, has helped nurses gain that confidence.

The challenge for nursing will be to ensure: that primary health care is accorded its proper status in the health care sector; that nurses are adequately prepared in attitudes, skills, and knowledge to carry out, in addition to their traditional functions, more demanding tasks such as examining the sick and disabled, determining the source of health problems, and treating acute conditions as well as the major preventable diseases in the community; and that resources—human, material, and economic—will be allocated according to priority needs.

There is considerable evidence that nurses all over the world are taking up the challenge. In Malaysia, contact between rural and isolated communities and the formal health system has been mainly through nurses. Nursing as a profession for women had been well established under British rule and, because of the large rural population and the unwillingness of doctors to practise in rural areas, nurses found themselves forced into a wider role—one often expected of them, but rarely recognized. The Malaysian example is not unique.
Many Latin American countries, e.g., Brazil, Chile, Colombia, Costa Rica, Ecuador, Honduras, Mexico, and Panama, have already begun to change nursing curricula in accordance with the following principles:

- that the predominant goal of nursing education is community health and not personal health;
- that the natural setting for the training of health personnel is the community health facility;
- that the training of nursing students should be based as much as possible on the concepts of problem-solving and learning-by-doing (35).

In Colombia, a pilot health project for the integration of health services, which was carried out by the Ministry of Health from 1956 to 1963 under the sponsorship of UNICEF and WHO, trained and made extensive use of professional nurses in the fields of public health and midwifery (A. Mejía, unpublished report, 1958). These nurses were subsequently used in the training and supervision of auxiliary nursing personnel and in the orientation of traditional birth attendants. The project involved 40 pilot health centres, which were the forerunners of today's health districts, now the basic operational units of the Colombian health system.

In Europe, the role of nursing was clearly spelled out in a document prepared by the WHO Regional Office for Europe in 1982. Further evidence that nurses are taking the challenge of primary health care seriously comes from the Philippine Nurses' Association which has been actively involved in promoting primary health care in the Philippines. In 1971 it adopted an underserved and depressed community with a population of approximately 8000. The project started in a structure that was no more than a roof supported by four poles, with a staff consisting only of one full-time nurse paid by the association, but with the full support and cooperation of the community. Within a year the premises had developed into the Barangay health centre and the community's multipurpose hall. By 1981, the nurses had trained 16 health workers, some of whom have already trained others. The health workers take turns to staff the health centre. They provide basic health services including simple health screening examinations and laboratory procedures, e.g., sputum microscopy (41).

The International Council of Nurses has prepared a report (38) on activities recently undertaken by nurses in their own countries, following six regional workshops on the subject of mobilizing nursing leadership for primary health care. A total of 253 nurses (members of

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national nurses' associations and others) from 75 countries participated in the six two-week sessions. One commitment made by the participants was to conduct projects in their own countries that would be relevant to the topics discussed during the workshops. Sixty per cent of the participants have reported on these post-workshop projects. They range from conducting workshops on primary health care for nurses (as in Ghana, Guyana, India, Lesotho, Liberia, Malawi, Nigeria, Paraguay, Peru, Puerto Rico, Sierra Leone, Sri Lanka, United Republic of Tanzania, Zaire, and Zimbabwe) to finding out what changes are needed in nursing education and nursing practice (as in Benin, Costa Rica, Ecuador, Panama, Togo, and Uganda) and establishing closer working relationships with ministries of health (as in the Bahamas, Honduras, Mauritius, the Seychelles, and Swaziland).

Constraints

Nurses have provided, and will continue to provide, the greater part of health care in most health systems. In 1983, a resolution of the Thirty-sixth World Health Assembly (WHA36.11) noted that, in all countries, nursing/midwifery personnel play an important role in providing health services and in mobilizing public opinion for the effective development of primary health care. It also noted that, in many countries, they play a vitally important part in the training and supervision of primary health care workers, thus providing an effective example of health team work and health team development that could be used as a basis for even more vigorous efforts in that direction (64). Yet, although both national and international bodies have declared their recognition of the crucial role played by nursing, it has too often remained only words on paper. Little is done by governments actually to implement recommendations to improve the situation of nurses and nursing. Moreover, such recommendations have most frequently referred to changes required within and on the part of nursing, rarely mentioning the fact that society generally needs to change its values, notably as regards women's work.

The constraints most frequently mentioned in documents and reports as preventing the nursing profession from contributing fully to the goal of health for all relate to nursing education, nursing practice, and legislation. In both nursing education and practice over the last few decades, an increased emphasis on curative functions has led to the neglect of certain abilities nurses need to function effectively in the primary health care team. For example, they must be able: to identify, define, and solve problems; to work in collaboration with other health workers and with members of the community; to apply epidemiological methods in determining health needs; to delegate tasks; to supervise, train, and evaluate other health workers; to determine analytically the cost-effectiveness of services; and to assume leadership.

Another major constraint, and one that is rarely mentioned in reports on the role of nursing in primary health care, relates to policies and
legislation governing nurses’ registration and licensing. The regulation of the different branches of health care is essential in order to safeguard the public. Yet, throughout the world, national regulatory policies for nursing are often outdated, inadequate, or altogether lacking. Information available from the WHO Regional Office for the Eastern Mediterranean reveals that, of the 23 countries in the Region, only Cyprus and Pakistan have specific regulatory bodies for nursing training and practice. The report of a WHO working group on legislation for nursing/midwifery services and education in Europe (63) concludes that the existing legislation impedes the development of nursing in the Region. The impediments are said to be the following:

1. Nursing legislation is concerned with the support of curative medicine, rather than the provision of nursing services, and assigns a subordinate role to the nursing/midwifery component of the health service.

2. The legal control of nursing services and education in almost all countries is vested in bodies containing few or no nurses. Nursing education remains outside the national education systems, so that the relevant diplomas have no academic standing, and professional commitment to inquiry and excellence goes by the board.

3. The legislation is detailed and specific, leaving little or no provision for studies in nursing per se. Emphasis is placed on postbasic studies in medical specialities rather than on nursing, while different categories of first-level nursing practitioner are maintained, as well as variations in the general educational requirements for admission to the basic nursing education programme. In some countries a much clearer distinction is needed between courses for first-level and courses for second-level nursing personnel, as regards entry requirements and duration.

4. In almost all countries of the Region, there are no requirements for the updating of register entries and the licence to practise is awarded for life with no requirement to produce evidence, at specified intervals, that minimum standards of competence continue to be maintained. Non-observance of legal provisions also hampers the development of services, as in the use of the title “nurse” to designate different categories of auxiliary nursing personnel. Failure to protect the title has implications for the quality of nursing services and the public image of the nurse, as well as being an infringement of the law.

The points mentioned in the report can be applied to the situation of nursing throughout the world. Without control over their own profession, nurses will not be able to change their educational preparation and their orientation in practice. It is precisely the question of who has control that governments need to review.
A pertinent example is to be found in Austria, where the law states that every school of nursing must be under the direction of a physician and, depending on the training to be given, must be connected with a hospital or psychiatric institution. Since the great majority of physicians in Austria are men and the great majority of nurses women, and since the laws are made mainly by men, the reluctance to make any changes is not surprising. It is ironic that governments that have supported the concept of self-reliance by signing the Alma-Ata Declaration are either unconcerned about extending this principle to the nursing profession or unwilling to do so.

The performance of all health workers is also affected by prevailing living and working conditions, which, particularly in rural and isolated areas, are often inadequate. ILO dealt specifically with the employment and conditions of work of nurses in Convention 149 adopted by the International Labour Conference in 1977. It includes recommendations on, inter alia, the practice of nursing, participation, career development, remuneration, working time and rest periods, social security, nursing students, and international cooperation (31). Only 19 governments have ratified the Convention since its adoption. One must ask why governments have been so reluctant to ratify a Convention that does no more than prescribe for the nursing force the same conditions as prevail in other branches of health work.

Efforts by the profession to overcome constraints

Nursing leaders recognize that many of the constraints in their profession require intervention at the national and international levels where policies and decisions about nursing and health care in general are made. They are therefore making determined efforts to promote the placing of competent nurses at all administrative levels of the relevant international, national, district, provincial, and local bodies. An example of an attempt by nursing leaders to exert influence on a government comes from Canada, where in 1980 the Canadian National Nurses’ Association presented the Government with a 72-page brief putting forward suggestions for changes in the health system. Among the recommendations were the following (5):

— Legislation should be changed to allow the emergence of a health insurance programme that would stimulate the development of primary health care services, permit the introduction of new entry points, and promote the appropriate utilization of qualified health personnel.

— Better community-based preventive, diagnostic, and ambulatory care programmes should be made available, and access should be through nurses as well as physicians.
— Health insurance should be “portable” so that equivalent insured services can be obtained when out-of-province health care is needed.

In spite of pressure on the Government by the Association, the recommendations have not been adequately recognized, let alone implemented.

Nurses are making great efforts to identify the constraining and driving forces that influence their profession. A survey of its readership was conducted by the nursing journal RN. More than 6000 nurses from Canada, Guam, Ireland, Puerto Rico, and the USA took part, and their answers to the questions asked revealed that nurses view professionalism as essentially an amalgam of competence, high ethical standards, medical knowledge, and compassion. The survey further revealed that nurses rank their profession high on a scale of 1 to 10, that what they value most is recognition from patients, and that they feel that hospital management and (in the USA) the American Medical Association, have hindered the development of nursing (21).

Perhaps the most comprehensive report on nursing and primary health care is one prepared by WHO following a meeting held in 1981.1 The participants agreed that primary health care is both a guide to action and a philosophy that must permeate the whole of nursing practice in the health system, and that it must be seen not as a separate entity but as an integral part of the total health care of the community. The meeting drew up the following Declaration on Nursing in Primary Health Care, based on the principle that the provision of primary health care is a natural extension of nursing practice:

Many people in all countries are at present deprived of their fundamental right to health and social well-being. Nurses, working as a unified force in primary health care, can effect changes in the health system to correct these deficiencies and enable all people of the world to attain a healthful productive life. To this end it is imperative that the nursing profession should take immediate steps to:

— introduce the concepts of primary health care into all components of nursing practice and education;

— increase the relevance of nursing to the urgent needs of the community;

— actively promote the involvement of those to be served, in the identification of their health needs and in the planning, delivery, and evaluation of their health care;

1 Nursing in support of the goal Health for All by the Year 2000. Unpublished WHO document, HMD/NUR/82.2, 1982.
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— demonstrate social responsibility and imagination in making primary health care available, accessible and acceptable to all people in the community;

— be active in policy-making for health, influencing governments, nongovernmental organizations, and other health-related groups at all levels to allocate funds, set priorities, and take appropriate decisions;

— act assertively to bring about a rational balance in health care, especially in the distribution and integration of nursing personnel;

— accelerate the coordination, integration and expansion of community health services;

— stimulate research into health services development and administration both to strengthen nursing practice and education and to develop cost-effective evaluation methods for testing innovative patterns of service and education to provide alternative methods for primary health care.

Five basic strategies were put forward at the meeting:

— the development in each country of a corps of nurses that is well informed about primary health care and ready to expedite the necessary changes in the nursing system;

— the inclusion of nursing personnel at all levels of policy-making and administration so that the profession can contribute to determining the action to be taken;

— the involvement of nurses, and the use of their skills, in initiating or extending primary health care;

— fundamental changes at all levels of nursing education to ensure that the priority needs of populations are functionally integrated into that education and into nursing practice;

— research into nursing administration, practice, and education that will demonstrate the need for nursing's contribution to primary health care, clarify the implications and evaluate the results.

More recently, the Director-General of WHO, discussing the report of a WHO Expert Committee on Education and Training of Nurse Teachers and Managers with special regard to Primary Health Care (61), at the 75th session of the WHO Executive Board in January 1986, outlined some of the new ways in which WHO sees nurses and nursing, as follows:

As WHO's Member States began to implement their policies and strategies to achieve the goal of health for all through primary health care, it became more evident that successful implementation would depend strongly on dedicated people, for what is sorely needed to
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practise primary care is love for one's fellow man. I consider that nurses, by their very vocation, must have just this kind of love.

...

If the millions of nurses in a thousand different places articulate the same ideas and convictions about primary health care and come together as one force, then they could act as a powerhouse for change. I believe that such a change is coming, and that nurses around the globe, whose work touches each of us intimately, will greatly help to bring it about. WHO will certainly support nurses in their efforts to become agents of change in the move towards health for all.

In order to realize the full potential of this powerhouse, nurses will need to be organized and equipped to break down resistance to change, to sustain the initial effort, and then to develop strategies and action plans. What is very clear is that the nursing profession is more than ready to respond to this challenge.

...

Given the potential of nurses to take their place in the forefront of the health for all movement, the members of the Executive Board and myself foresee the following things taking place:

— The role of nurses will change; more of them will move from the hospital to the everyday life of the community, where they are badly needed.

— Nurses will become resources to people rather than resources to physicians; they will become more active in educating people on health matters.

— Nurse leaders will increasingly innovate and participate in programme planning and evaluation.

— Nurses will participate more actively in interprofessional and intersectoral teams for health development.

— More and more nurses will become leaders and managers of primary health care teams; this will include guiding and supervising non-professional community health workers.

— Nurses will thus assume greater responsibility for taking decisions within health care teams.
Previous chapters have made several comparisons between men and women regarding their roles and status in society generally and as providers of health care. The gender divisions in society have led to discrepancies between the sexes in such matters as opportunity, autonomy, authority, and power. Women have had less access than men to the types and levels of education leading to high-ranking, well-paid occupations. Inequality of opportunity also channels women into dependent jobs in which they work in a subordinate capacity with little autonomy. Sex bias is also reflected in the access to authority and power enjoyed by those holding positions in management, leadership, decision-making, and policy formulation—areas in which women are notably underrepresented. In enabling women to realize their full potential as health care providers, the first step is to examine the factors responsible for their secondary status and see what types of action are likely to foster greater sex equality. Such is the aim of this chapter, which will consider four sets of relevant factors and ways of dealing with them in both developing and developed countries. These factors will be discussed in the following order:

- gender-role differentiation
- structure and values of modern health care systems
- polarization of branches of health care
- women’s multiple role and the structures of society at large

**Gender-role differentiation**

Gender-role differentiation begins in early childhood when the behaviour and personality characteristics of boys and girls are modified according to parental and societal expectations. Different conditioning agents predominate at different stages of a person’s life. During childhood, parents and other family members play a leading role, to be followed by teachers, other adult counsellors, and communication media. During adolescence the influence of peers may be dominant, while at a still later stage the working environment may be the principal factor in sex-role training. Gender-role differentiation is a powerful and subtle process, whereby gender stereotypes are transmitted within families, in educational systems, and by the media and most other social institutions.
It has been observed that parents treat male and female infants differently from birth onwards, and that this influences sex-role development in fundamental ways. Preschool conditioning takes the form of reinforcement or discouragement of particular forms of behaviour by providing boys and girls with different toys and encouraging them in different activities, and by sex-typed role-modelling within the family. This early conditioning of children is believed to affect their interests, aspirations, and capabilities later in life.

Sex-role stereotyping is based on two sets of personality traits, one set considered as typically masculine, the other as typically feminine. The male stereotype in western societies comprises such traits as ambition, competitiveness, aggressiveness, dominance, rationality, and objectivity. While male children generally are seen as dominant and explorative, female children receive an upbringing that is more confining and that associates femininity with submissiveness, passivity, dependence, nurturing, emotionality, and subjectivity. Note that the two sets of traits tend to place males and females at opposite ends of a continuum. Sex-role stereotyping exists in all cultures, and everywhere the male stereotype is apparently the stronger and more dominant one. While sex-role differentiation tends to inhibit both men and women from fully developing their attributes and capabilities, women are usually brought up to see themselves as less self-confident and less competent than men, probably because “male” traits are generally considered to be relatively more important and of greater value to society.

Outside the home and immediate family, a variety of agents are involved in the gender-role conditioning of children. They include television and other communication media, interaction with peers, schooling, and environment, all of which give children a set of expectations about themselves. Educational and vocational systems are especially adept at exercising sex bias, both overt and covert, and imposing cumulative constraints on both men and women. Thus, in western countries, sex stereotyping is often displayed in: (a) textbooks and other instructional material; (b) teacher–pupil interactions; (c) curricular options and educational streaming; (d) educational and vocational guidance; and (e) organizational structures. These examples were identified in a recent UNESCO publication (57), together with ways of ending such stereotyping in educational institutions and practices. A particularly striking point made by the author is that, while there is increasing recognition that the inequality of the sexes has negative effects on both men and women, the question of gender inequality continues to be considered mainly as a woman’s affair and is raised and researched most often by women. Moreover, it is mostly women who are making the innovations that can change the situation. If greater equity is to be achieved in both private and public dealings, men and women alike must regard the matter as one of some urgency.
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Consequences

It follows from the preceding section that the sex-role training and social conditioning of boys and girls prepare them for, and channel them into, different functions in their adult lives. Men and women are offered different sets of opportunities with respect to types, levels, and content of education. Women, who are expected to centre their lives round marriage and family responsibilities, frequently receive fewer years of schooling and a less career-oriented education than men. Some of the educational avenues open to men at an early stage are considered to be irrelevant to the contribution society expects from women. Consequently women frequently find themselves relatively less qualified and inappropriately prepared to enter the more prestigious branches of health care. Two tendencies have been observed: (a) in the past, gender role differentiation led women to shun the higher-ranking positions in the health system, so that for a long time medical and dental schools in a number of countries had few female applicants; and (b) by comparison with men, women had much more limited access to medical and dental schools in some countries, and in some cases women were barred from admission altogether. As a result, women medical school graduates in some countries still have great difficulty in obtaining specialized postgraduate training, as most vacancies seem to be reserved for men. Women health providers thus tend to be in such occupations as are not barred to them by a narrower education than that of their male counterparts, i.e., in relatively low-level, dependent sectors of health care, often subject to the control of the higher-ranking more powerful sectors that are the preserve of the male.

The stereotyping of masculinity and femininity, combined with the belief that men’s and women’s lives are centred in different domains, also leads to gender-role specialization in the household. Women’s lives are generally concentrated in the domestic domain, whereas men are oriented to the public domain, i.e., to political and economic activities involving the control of persons and things. There is evidence that activities in the public domain are almost everywhere accorded more authority and prestige than those in the private domain.

Gender-based division of household responsibilities is a fundamental feature of families in subsistence economies. As Chapter 1 has shown, the work of women in subsistence economies includes child-bearing and -rearing, household provisioning and management (including fuel gathering and the provision of water), and some farming and income-generating tasks (68). Rural women in different regions have taken part in a variety of activities, including: boiling palm sugar in South-East Asia; brewing beer in West Africa; making pottery and selling surplus foods in Latin America (58). With the modernization of economies and the development of markets, there is frequently an erosion of women’s previous roles and a need for new income-generating opportunities for women if they are to maintain family well-being. If traditional roles are
superseded, women become dependent on the wages of husbands or relatives to meet family and personal needs. Yet the genuine complementarity of sex roles in the rural family is frequently ignored by development planners when their employment programmes concentrate on generating jobs (in the public domain) for rural men and ignore the dependence of rural families on the earnings of women in the private domain (68). As noted by Blumberg, "women's relative economic power is the main determinant of their relative equality as people, regarding a wide variety of life options and aspects of well-being" (7).

In Western industrial societies likewise, the traditional idea of the family was based on two premises: (a) the woman's place is the home, and (b) the man is responsible for the economic support of the family. Given these premises, women were not completely restricted to household-based activities, but when they were employed in the formal labour market, their job commitment was expected to be secondary to their domestic duties. Moreover, when women worked outside the home, they were expected to engage in work of lower status than that of their husbands and to make only marginal contributions to the family income (48).

Throughout the world, there is an increasing tendency for women, at least at some stage in their lives, to expand their sphere of economically productive work beyond the household and join the paid work force. In some countries, jobs are held only by young and single women; in others, married women enter and re-enter the labour force, for example, when an addition to the family income is needed, when they find that their children, husbands, and homes are making fewer demands on their time, or when they become the sole breadwinners for their children. In most of the developed world, the female labour force, which includes both married and unmarried women of all ages, has expanded steadily during the second half of the twentieth century. In recent years, participation in the labour force has grown at a faster rate for married women with children than for any other group of women. The proportion of women who hold a paid job varies widely between countries and regions, ranging from more than 80% in socialist countries such as the USSR and about 70% in Scandinavian countries to almost 50% in Western European countries and North America, 40% in Africa, 45% in Asia, and approximately 24% in Latin American countries (30).

Recent calculations, based on ILO and United Nations data, show that, in terms of working hours, women conduct one-third of all market-type work throughout the world, although they receive only 5% of world income, and that 46 out of every 100 women between 15 and 64 years of age are employed (29). There is also evidence that women, at least in some countries, now tend to follow continuous patterns of work, rather than the intermittent type more commonly observed in the past.
Another consequence of gender-role differentiation, namely the gender-based authority structure, also originates in the family and is then transplanted into broader social contexts. The masculine traits cited earlier in this chapter included aggressiveness and dominance in contrast to the feminine traits of compliance and submissiveness. Early conditioning of the sexes leads to stratification systems that systematically place males in the more highly valued roles \(^{(33)}\). These roles are usually associated with economic power, with authority to make choices, and with the exercise of control in the public domain. It has been observed that "until very recently [in Western societies] the stratification system located men in such a way that they had virtually total access to the entire range of resources available within the society" \(^{(33)}\). Male dominance in family structures seems closely linked to women's confinement to the private or domestic domain. But even where women take up roles in the public domain and are in control of means of production, it will be found that there is a replication of patriarchal authority structures in extra-familial spheres of activity and that a gender-balanced and more equitable distribution of power has yet to appear.

Policy measures

To counter sex-role stereotyping and its results, action is required in three areas: education, employment, and the authority structures of social institutions.

1. In *education* the following types of action are called for:

   — education of parents, teachers, employers, and the general public to expect and encourage men and women to pay equal parts in all spheres of activity and to shed traditional attitudes based on gender bias;

   — elimination of sex-role stereotyping from all educational institutions, curricula, and teaching material, and promotion of the same kind of educational guidance for both sexes, with equal access of men and women to all streams and types of education.

For health-training institutions the following policy changes are recommended:

   — adoption of admission policies ensuring equal access for men and women;

   — equal representation of men and women among teaching staff, curriculum review boards, and other policy- and decision-making bodies;

   — equality of access for men and women to continuing education programmes;
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1. Consideration of men and women for financial aid and fellowships on an equal basis;

2. Equality of access for men and women to training in management and leadership skills;

3. Equal participation of men and women in leadership of professional associations.

2. In the area of employment, the provision of income-generating activities for women is of crucial importance where there has been an erosion of women’s traditional economic roles, and more generally to protect the economic independence of women and the well-being of women and their families.

Men should be motivated and encouraged to share the responsibility for informal health care in the family on a more equitable basis. This is a matter of high priority since, because of their growing participation in the formal labour market, women may not have sufficient time and energy to continue to meet almost all the extra-market primary health care needs of family members.

3. As for the authority structures of social institutions, the prevailing pattern of male dominance should be replaced by one free from gender bias.

Everything possible should be done, through legislation and other means, to ensure the access of women to all levels and spheres of influence and encourage their participation in establishing values and making choices.

Polarization of health work

Here “polarization” means the assignment of health workers according to their sex, so that some types of health care are largely entrusted to men and others to women, while few, if any, are gender-balanced. Polarization, segregation, and sex-typing are parallel terms for the process of channelling men and women selectively into fields of work on the basis of gender. Occupations have been described as sex-typed “when a very large majority of those in them are one sex and when there is an associated expectation that this is as it should be” (18). Because of this expectation, the sex-typing of jobs and occupations tends to be a self-perpetuating process. As shown in Table 4 (page 28), many men and women work in sectors of health care in which 80–90% of their colleagues are of the same sex. In a number of countries it is found that most sectors of health care are segregated, even though the same sector may consist mainly of women in one country and mainly of men in another.
Notable examples of polarization are nursing, which is usually preponderantly an occupation for women, and medicine, which in many countries is practised preponderantly by men. Reference has been made to the recent tendency of women in many countries to enter occupations traditionally reserved for men. This suggests that the gender composition of high-ranking occupations is gradually becoming more balanced. A less polarized, more integrated employment pattern in health requires not only the entry of women into traditionally male fields, but also the entry of men into traditionally female ones. As indicated in Chapter 2, the situation is changing to some extent, but so far the latter process has occurred at a far slower pace than the former.

It has also been observed that men and women working in the same branch of health care tend to be segregated into different roles, specialities, or types of job. Examples of this are the clustering of women doctors in paediatrics, psychiatry, and public health, and the concentration of male nurses in administrative and supervisory jobs.

Gender-based occupational segregation in health care has several facets, as male and female workers are set apart according to the status of the occupation, the functions or roles performed, and the level of autonomy. For example, women are generally vastly under-represented in top-ranking autonomous occupations (medicine, dentistry, optometry, veterinary medicine) in which remuneration is high, working conditions are favourable, and male domination is the expected norm. Occupations that rely heavily on women are those in the so-called semi-professional and allied sectors (nursing, dietetics, dental hygienics, and social work) associated with lower status, less autonomy, and lower pay (see Chapter 2, pages 35–43). An example of limited autonomy is offered by the circumscribed role of hospital nurses, who know considerably more about patients’ conditions and responses to treatment than the physicians do. It has been alleged that 95% of the care patients receive in hospitals is given by nurses, yet nurses have little opportunity to participate in decision- and policy-making with regard to patient care and the development of their profession (see also Chapter 3).

Functional segregation places women primarily into the nurturing, caring, and support functions associated with femininity, and men into the more masculine functions of curative and interventionary treatment, using exclusive procedures and technology. Moreover, in many countries, the male-dominated sectors are much more likely than the female-dominated ones to obtain legal authorization for their members to engage in independent private practice.

The effects of gender segregation on status, roles, and levels of autonomy are repeated within sectors. Even though larger numbers of women are working in the more prestigious sectors of health care, they still seem to come up against barriers in these traditionally male
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preserves. One study suggests that the entry of a growing number of women into medicine, instead of eradicating differences between men and women doctors as regards choice of specialty, may actually compound these differences (45). Another study (9) pointed out that women in male-dominated branches of health care are inclined to seek employment in institutions and bureaucratic organizations rather than independent private practice (see also pages 35–37). Another constraint on women’s work in traditionally male sectors is the difficulty of advancing to executive and directorial positions. They thus remain disproportionately concentrated in the lower echelons of the hierarchy.

Consequences

Even though it is now easier for women to enter the more highly regarded branches of health work, there is still an overall gender imbalance in the health labour market. Almost everywhere, women outnumber men as health workers, but the male minority consistently outranks the female majority, thus creating a discrepancy between the status and decision-making power of women and their numerical preponderance. While only limited data are available in this area, there is some evidence that, in addition to occupational status, degrees of autonomy in health practice and decision-making authority are also gender-associated.

In conformity with the relatively low status of female-dominated occupations, women workers typically function in dependent, supportive roles with limited autonomy, under the supervision and control of members of the opposite sex. It follows that women are consistently under-represented in influential decision-making posts and rarely supervise activities and services performed by male health providers. Moreover, when women do occupy managerial or decision-making jobs, these tend to be in female-dominated fields like primary care, nursing, or nutrition. It has also been found that women in upper managerial positions are more frequently involved in research, planning, and policy evaluation than their male counterparts, who tend to work in financial and decision- and policy-making capacities.

Compounding the consequences of occupational segregation is the fact that it is also at the root of the gender earnings gap, a critical disadvantage for women health care providers. Occupational segregation can lower women’s wages in two ways: first, as a result of the cramming of women into traditionally feminine occupations, workers in male-dominated occupations are protected from female competition, thus commanding relatively higher wages; secondly, because employers perceive women as being generally less productive or more “suitable” for female-stereotyped, lower-paying jobs, women are offered lower salaries. Accordingly, men consistently outearn women. As reported in a study carried out in the USA in 1981, “Not only do women do different
work than men, but also the work women do is paid less and the more an occupation is dominated by women the less it pays” (59).

Because occupational segregation leads to different rates of job and career advancement for men and women, the gender earnings gap is reinforced over time. Thus gender segregation according to the type of health work performed has a whole range of adverse consequences for women, including subordinate occupational status, restricted upward mobility, limited autonomy, and inferior pay.

Policy measures

Among the principal types of policy measure employed to reduce occupational segregation are equal opportunity and equal pay laws, and governmental and private initiatives aimed at removing gender bias in recruitment practices in all areas of health care.

Equal opportunity laws. Various laws designed to bring about equality in educational and employment opportunities, including antidiscrimination measures and regulations specifying positive action, have been drawn up in many countries during the last decade, with varying degrees of success. While this type of legislation is needed everywhere, a variety of technical, attitudinal, and political barriers still need to be overcome, and monitoring and enforcement procedures will be required.

Equal pay laws. Many countries already have this type of legislation, but, without substantial commitment and an overall endorsement of sexual equality by society, even the most promising equal opportunity and equal pay laws are not likely to produce substantial change. In several countries, recognition of the consequences of occupational segregation has led to the interest that was once focused on equal pay for equal work being shifted to equal pay for work of comparable worth, and a basis for appropriate comparisons between the earnings of men and women in different jobs is being sought. Here “comparable worth” means blend of skill, effort and responsibility demanded by a particular job under equivalent working conditions. Policies designed to achieve equity in pay involve a number of complex issues. To be successful, these policies should aim at helping women to acquire suitable work qualifications (developed skills, productivity, career mobility) and to realize their full potential.

Governmental and private initiatives. There are a number of ways of ensuring equal opportunities in educational institutions, training programmes, and the labour market. These include:

— collective agreements between trade unions and employers aimed at eliminating gender bias in hiring and pay; and
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— efforts to achieve the proportional representation of men and women in all policy- and decision-making areas, so that the barriers hindering the integration of women into the health labour force will be broken down.

Women's multiple role and the structures of society at large

In comparing the roles and status of men and women in formal health care systems, it is important to acknowledge one very basic difference: most male health care workers are responsible solely for the job, while most female health care workers combine their work on the job with child care and a variety of time-consuming household tasks. Thus women's work as health care providers must allow them to deal with the many demands made on them by these additional responsibilities. As long as men have basically one role and women a variety of roles, this initial gender imbalance will predispose them differently for work in the formal health system.

Historically, the issue of multiple roles has not always been relevant. In pre-industrial societies, men and women tend to share the burden of household work and the production of the goods needed for sustenance. In agrarian societies, both men and women tend to be involved in a variety of household and farming activities, all geared to the subsistence of the family unit.

The splitting-away of industrial production from home production and the channelling of men and women into separate market and household roles produced what Jessie Bernard has called the "one-role ideology" for women—an ideology that denied the legitimacy of women's work outside the household, except in dire economic circumstances (6). The "one-role ideology" persisted even as women's roles in the formal labour market evolved, starting with the early phases of industrialization when women were recruited for certain types of job and households started to become dependent on women's wages. However, as long as there were relatively few women in the labour market and most of them were single, and as long as the employment of married women was episodic and intermittent, market work continued to be viewed as marginal and secondary to woman's pivotal domestic role. Because the idea of the primacy of this role was so deeply rooted, the contribution of women to market production was often denied, obscured, and undervalued.

The twentieth century is the century of the "two-role ideology" for women. The underlying rationale varies between cultures and with time. Antinatalists have advocated it as a way of reducing fertility in developing countries. It has also been proposed as a means of ending the exclusion of women in developing countries from the development process and reversing its adverse effects on them, through their
integration into development and modernization, i.e., participation in mainstream market activities (4).

In developed countries the following reasons for extending women’s participation in economic activities have been put forward:

— the value of the contribution women can make to the economy in general, and during wars and periods of labour shortage in particular;

— the fact that women experience a post-maternal period of increasing length, during which they may desire, and should not be barred from, paid employment;

— the belief that women dependent on welfare or public assistance should be enabled to be self-supporting; and

— the belief that women, like men, should be assured opportunities to realize their potential and achieve self-fulfilment.

The “two-role ideology” allows women to explore new opportunities, particularly paid employment outside the family. With these new opportunities come new challenges such as those involved in combining work with family. A variety of patterns are still evolving; they range from various combinations of full responsibility for family tasks, combined with part-time, temporary full-time, or continuous full-time employment, to new divisions of labour within the family in order to free women for more substantial formal employment. New roles also can create new stresses and strains within families. When a woman’s employment is considered secondary and her market work is limited in type and amount to be compatible with her domestic work, the strains may be minimal. Unfortunately temporary or part-time status in the labour market is frequently associated with low pay, limited opportunities for advancement, and a dearth of fringe benefits.

Achieving the delicate balance between family and work roles is particularly difficult for women health care providers, since professional jobs in health care often entail extremely long working hours. When professional women work part-time or cannot guarantee a commitment to the job equal to that of their full-time male colleagues, they run the risk of being debarred from the responsible, high-level positions to which they may aspire (18). The fact that they must devote a relatively large number of hours to household and family may deaden their ambition and limit the time and energy they can spare to further their careers.

Time-budget studies show that in many countries husbands enjoy far more leisure than working wives do (33), and that, on the average,
employed women work at least 26 hours in the home, over and above the usual 40-hour working week. It has been observed that "while one social convention—that against mothers working—has broken down, another social convention—one that labels most household tasks ‘women’s work’—leaves women doubly burdened" (60).

This conflict between work and family is believed to be less severe in developing countries where the extended family still exists and grandmothers and other relatives can help with the housework and look after the children. In such circumstances, wives may enjoy the same upward mobility in their jobs as their husbands do. In developed societies, where nuclear families predominate, domestic help is expensive, and adequate child care facilities are scarce, women’s multiple role can be a major source of family stress. Given the traditional division of work within the family, women inevitably tend to lag behind their more single-minded spouses in their pursuit of careers. This can be a source of strain between spouses, between colleagues, and between women and their employers. The alleviation of strains and pressures of this kind demands major structural changes in the family, the world of work, and society at large.

Consequences

Consequences of the dichotomy between men’s single role and women’s multiple role include: (a) a potential reduction in the informal work performed by women; (b) role conflicts in women; (c) the penalties inherent in a multiple role.

A growing number of women are making larger and more continuous commitments to employment with the possible result that as they engage in more paid work they may cut back their unpaid work, i.e., health care, child care, and family care. It has been reported that the time spent by working wives on housework is only half that spent by non-working wives, but that their working week nevertheless averages about 65 hours (60). What is the likelihood that the informal family health services provided by women will also receive less attention? This possibility deserves serious attention, as it poses a threat to the health status of the family and its members. In addition, it is unlikely that women will continue to devote their time and energies to voluntary work in schools, churches, charitable organizations, health care facilities, etc. on the same scale as in the past. How will this affect health institutions and health programmes in particular, and how dependent have these programmes become on women’s spare-time work? If their contribution is important, how can it be replaced?

Women participants in the delivery of formal health care may experience several types of role conflict. Difficult choices have to be made regarding the compatibility of family responsibilities with the demands of a career, choices that until recently have rarely confronted male
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workers. Examples include choosing to be employed by others rather than self-employed, as women doctors and dentists tend to do, thus ensuring standardized working hours; opting for part-time employment as nurses, therapists, or dental hygienists; choosing jobs that allow a timetable compatible with domestic duties; and rejecting managerial or other leadership positions that demand overtime, long-distance travel, and work at weekends, all of which could conflict with marital and family commitments. Because the careers of the men in the family are usually given priority, women have had to transfer from one place of education to another or to interrupt their own careers because their husbands have been moved to jobs elsewhere. Both within and outside the health field, there have been countless cases in which the responsibilities associated with marriage and/or parenthood or commitment to putting a husband’s career first have inhibited women from realizing their full potential. The same type of inhibition appears to apply to men only in exceptional cases.

The fact of women’s multiple role has influenced the attitudes and behaviour of employers and colleagues, regarding their recruitment and assignment in the health field. Women are disproportionately channelled into less skilled jobs (e.g., as nurse aides, laboratory technicians, occupational therapists, or physical therapists), in which educational requirements are relatively limited, the investment risk is low, individuals are replaceable, and there is no career ladder to jobs with autonomy, status, and power. Because of a belief that women’s multiple role is associated with unreliability and limited job commitment compared with that displayed by male workers, employers are reluctant to hire and train women for jobs requiring a high level of expertise, responsibility, or autonomy. To give women extensive on-the-job training or groom them for higher-level jobs is considered as a poor investment. Despite (or because of) the fact that the labour force includes a substantial and constantly growing number of women, whose work commitments increasingly resemble those of men, employers still persist in attitudes and behaviour based on myths and stereotyped ideas of “women’s work instability” and “female motivational deficit”. It is important to point out that most organizations, including those concerned with health, use criteria and standards for the recruitment, evaluation, and promotion of workers that are based essentially on “male” norms, i.e., norms established for workers with only one role, thus creating obstacles for both male and female workers with multiple roles.

A further consequence is that women are penalized for having a multiple role, as may be seen from their over-representation in part-time employment, usually characterized by underskilled, badly paid jobs without benefits; by the disproportionate extent to which they are assigned to jobs for which they are overqualified and which offer little hope of promotion; by their exclusion from career channels leading to
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prestigious high-level jobs. The penalizing attitudes on the part of employers and colleagues arise from various misconceptions about women’s motivations, aspirations, commitment, and competence, prompting discriminatory treatment of women workers with results calculated to bear out the initial assumptions. Because societies have been slow in responding to needs arising from the intersection of work and family, men who have assumed a multiple role, either because of single parenthood or because they share household and child-care responsibilities with their spouses, are also penalized by employers, colleagues, and the custodians of high-level positions.

Another type of role conflict that women experience in male-dominated health sectors stems from the masculine image associated with the top jobs, which drives women to subordinate their feminine personality traits to professionally acceptable behaviour based on male role-models (46). This problem overlaps with the conflicts caused by women’s multiple role, and in some cases it can result in a serious identity crisis. Deeply embedded cultural values regarding the role of the male as breadwinner and the role of the female as the family “nurturer” appear to be at the root of discriminatory employment practices and account for the slowness of society to respond to a changing reality. True gender balance in the family requires a “shared role ideology” that allows both spouses to play more or less equal parts in being provider/breadwinner as well as “nurturer” and fosters a more balanced allocation of responsibilities (6).

Policy measures

Given the imbalance between men and women in the acceptance of family obligations, societies may adopt one of the following courses of action:

1. One approach would be to equalize the family division of labour so that men and women could enter the labour market from an equal level of nonmarket commitment. Because wider family obligations would be imposed on men, work structures and patterns would have to be adapted to the “shared role ideology”.

2. Alternatively a series of programmes or mechanisms might be developed whereby women would be largely replaced in the performance of family tasks and thus be able to match men with respect to workloads, work commitments, and work continuity. This would require, as a minimum, programmes of child care, care of the elderly, and household support.

Two types of measure are called for: labour market changes, and social infrastructure changes.
(a) Labour market changes

The following changes are needed in the labour market:

— new and more flexible types of work structure;

— flexitime (enabling workers to choose hours compatible with their family life);

— flexiplace (permitting work to be done at home or elsewhere);

— shared jobs (allowing two workers to share one post);

— part-time jobs (in which workers could choose to work less than full time, without being penalized in pay or fringe benefits);

— multiple-benefit options (allowing workers to choose between benefit packages: sabbatical, parenting leave, alternative wage and retirement options);

— re-entry arrangements for workers whose employment has been interrupted.

These types of flexibility are essential for workers whose family responsibilities will vary in extent over their working lives. Criteria for career progression and promotion should also be adapted to family demands on workers. With more gender symmetry in people's roles, both within and outside the family, men will also be called upon to make occasional sacrifices to facilitate a spouse's career. The ideal model might be that of a two-career family, in which both spouses would take turns in accommodating each other's self-development and join in making the most of both careers.

If, on the other hand, imbalance in the sharing of family obligations is maintained, the course of action suggested is to support and replace women in their informal, family-sustaining roles. The ILO first addressed the matter in 1965, but stated in 1980 that, even though nearly all countries had adopted measures in these areas, "it is most unusual for governments to have adopted a specific policy defining objectives and providing for the appropriate resources whereby women workers with family responsibilities would be effectively helped to cope smoothly with their double duties" (27).

(b) Social infrastructure changes

The following is a list of preliminary steps towards the development of a social infrastructure permitting women to enter the labour market.
Maternity protection:
• maternity leave (the ILO standard is 12 weeks);
• parental leave to be shared by both parents;
• cash benefits (25–100% of prior income);
• prohibition of dismissal from job;
• nursing breaks;
• special leave in the event of sickness in the family;
• reduced working hours for women with at least two children, or one housework day per month.

Comprehensive child care:
• creches, nurseries, kindergarten programmes;
• after-school care programmes;
• child-care programmes during school vacations.

Programmes for the elderly:
• nursing home and foster-care programmes;
• day-care programmes.

Household support systems:
• networks for domestic services;
• canteens, food shops, and laundries at factories and other places of work;
• cleaning and apartment maintenance services;
• appropriate technology for home-based activities, including household provision of water and sanitation.

That services such as the above should be available, accessible, and affordable is more important than whether they are sponsored by the public or the private sector.

Structure and values of modern health care systems

Earlier sections of this chapter have dealt with gender divisions as they apply in most societies. Wherever possible an attempt has been made to relate male/female dichotomies to health care delivery. In this section it will be shown how the structure of modern health care systems reinforces, and in some respects exacerbates, gender differentiation in general and the secondary status of women health care providers in particular. Both the institutional structures and the dominant value orientations of health care systems are of relevance here.

The advent of scientific medicine in the twentieth century and the resulting transformation in the organization of health care have had a far-reaching influence on the functions and status of women health care providers. The transformation has been manifested in the institutionalization of health care delivery, the professionalization of various types of health work, and the development of increasingly hierarchical systems based on uneven distributions of power.
Rapid advances in medical knowledge and technology have prompted the segmentation of the health labour force and the shift of an increasing proportion of health care from small-scale practitioners' offices to larger and better-equipped health care facilities. These trends are quite obvious in developed countries, but, even in the majority of developing countries, the construction and operation of health facilities absorb a major part of the health budget. This growth in institutionalization has been accompanied by a tendency to make hospitals and medical centres the nucleus of delivery systems, sometimes with a disproportionate emphasis on clinical research and the treatment of rare diseases affecting only a few people, at the expense of more basic health services needed by the entire population. Spectacular advances in medical science encouraged the professionalization of medical practice (i.e., the process whereby medical practitioners as a group attained legal autonomy and control over the provision of a wide range of medical services). Scientific progress also stimulated more and more specialization, fragmentation, and subdivision in the various branches of health care.

Consequences

The health systems in many countries are notorious for their hierarchical nature and highly concentrated power structure. The uniqueness of health systems in contrast to other social systems lies in: (a) the near-absence of a "middle class" among health workers, in that the health work force consists largely of low-level and high-level workers with little in between; (b) severe impediments to both horizontal and vertical occupational mobility, reinforced by separate, occupation-specific educational programmes often precluding transfer between fields; and (c) wide disparities between health workers with respect to income and power. Inasmuch as the gender-linking that selectively channels men and women into different occupations, then into separate jobs within these occupations, is so pervasive in the area of health care, a gender hierarchy becomes superimposed upon the occupational one. Gender is used as a criterion for the level of the occupation, and the occupations where women predominate are clustered at the lower levels of the hierarchy. In other words, while both male- and female-dominated occupations span the whole range of levels within the hierarchy, the upper end of the range for male-dominated occupations is at the apex of the hierarchy, whereas the upper end of the range for female-dominated occupations tends to be in the middle. Moreover, as already indicated, men and women tend to have different promotion and mobility patterns in that men entering the hierarchy at a lower level seem to have better access to the path leading to the top than women, who are for the most part precluded from rising in the hierarchy. The path followed by the men is the familiar one leading to managerial slots, supervisory positions, control over resources, and decision-making power. This topic has already been amply discussed, but the point to be
emphasized here is that the marked hierarchical structure and highly biased distribution of power found in health systems accentuate the gender inequality found in other sectors of society.

Health systems have a strong tendency towards specialization and fragmentation, which are sometimes considered as obstacles to women health care providers, because they are likely to reinforce the segregation of the sexes. Advances in treatment methods and the diversification of technology encourage specialization and sub-specialization within the different fields of health care and the proliferation of occupational categories across these fields.

As for the dominant values and priorities of health systems, these have not usually enhanced the position of women health workers. First there is a tendency in many countries for health systems to be physician-centred rather than consumer-oriented. Secondly, the values implicit in decisions on the allocation of resources undermine the position of women health workers. These values are those of a small elite of largely self-interested decision-makers and are reflected in: disproportionate investment in large hospitals and medical schools in urban areas, at the expense of more evenly distributed comprehensive health care; the allocation of higher priority to secondary and tertiary care facilities than to community-based primary care programmes; and the provision of invasive treatment for a minority of very sick people rather than disease prevention and health promotion for the entire population. Women health workers are further disadvantaged by the emphasis placed on dependency rather than self-reliance, monopolized as opposed to shared knowledge, and concentrated rather than decentralized authority. Whether the same priorities would be chosen if the women concerned participated in decision- and policy-making is a question that cannot be answered as yet. One has a strong impression, however, that most health care systems, as constituted at present, are designed mainly by men and oriented to predominantly male values.

Policy measures

The priorities of health care systems need to change, not only because in current schemes the role of women and the services they provide are considered peripheral and are therefore undervalued, but also because resources are not used in the ways most likely to improve public health. Typically the orientation of health care systems is such that preventive and promotive measures tend to be perceived as marginal to medical practice and are consequently slighted as regards resources and prestige. This has traditionally been the case with health education and environmental health and, in general, with most aspects of primary health care. By and large, these are female-dominated areas of health care, and by and large the women employed in them are excluded from decisions about societal needs. It is the contention here that a better integration in
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health systems of female workers and the alternative approaches they offer is essential not only to raise the status of women but also to ensure the achievement of health for all through primary health care. The decentralization of authority and the redistribution of power are potential ways of giving women a more central role, which would include decision-making and resource allocation. The following are among the measures that would facilitate the necessary changes:

1. The dominant orientation of health delivery should be shifted from serving the interests of providers to serving those of consumers.

2. The development of more horizontal and more democratic organizational structures should be encouraged as a way of toning down the hierarchical nature of the system.

3. The better utilization of all health workers should be promoted by:

   (a) removing the barriers to horizontal and vertical mobility, and

   (b) fostering cooperative team relationships and cooperative partnerships among workers in different branches of health care.

4. The involvement of women in all important health care activities and particularly in high-level decision-making should be promoted.

5. It must be recognized that those who engage in nurturing and the provision of psychosocial support are precious human resources for health care.

6. The roles of non-professional and lay health workers and of health advocates should be expanded and upgraded.

7. Information and health-related knowledge should be shared with communities and health care clientele, and individuals and communities should be encouraged to become more self-reliant and cooperative in enhancing their own and others' health and well-being. This policy, if implemented, should eventually enable communities to take part in planning, priority-setting, and resource allocation for health care.
Earlier chapters have outlined women's contribution to health development, as well as their unsatisfactory situation as health care providers and the various factors contributing to it. Measures to improve this situation have also been discussed. The present chapter is intended to provide guidance on positive action to this end.

In most countries of the world, there has been growing concern about the status of women generally in society. Yet to date little attention has been paid to the status of women in national health care systems. That something needs to be done is obvious. That something can be done is evident from recent WHO-sponsored projects.

The WHO-sponsored project on women as providers of health care, of which this publication is a part, has included two consultations and various activities in individual countries. Thirteen developing countries and four developed countries took part in the project. Papers were submitted on specific aspects of the situation in each country, together with broad proposals for action (see Annex 2). In four of the developing countries—Colombia, Indonesia, Jamaica, and Thailand—the papers resulted in specific projects to initiate action on one or more issues.

This chapter is addressed primarily, but not exclusively, to women—women who have an interest in change and feel a need for the type of guidance provided here; women with or without managerial competence, but with a propensity to leadership, whether in an institutional community setting, in town or country; women from all social and economic strata.

For a person seeking to initiate the formulation of a plan for a project or programme, a big problem is how to get things started in the absence of the necessary funds and organization, when the only resource so far available is the person herself (or himself). Often the person may, because of other work commitments, have only a small amount of time to devote to having her or his idea transformed into a well developed, comprehensive plan of action. In such cases it is difficult to give appropriate guidance on how to go about obtaining the requisite seed money or other forms of support. The approach will depend to a large extent on the person's position within, or in relation to, the decision-making
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hierarchy. Other factors, too, are involved, particularly cultural factors relating to communication between people of differing social, economic, or political levels. For example, in some countries it seems perfectly feasible for the ordinary citizen to approach a high-level decision-maker directly. In others access to high-level authorities can be gained, if at all, only via a rather tortuous route, starting with officials at a relatively low level. In either case, the individual seeking support for the formulation of a plan will need to estimate the amount and type of resources required.

A long-term strategy for action in individual countries

Basic features

In the course of the WHO-sponsored project on women as health care providers, it has become evident that, regardless of the particular concerns of individual countries, a comprehensive strategy geared to the achievement of the long-term aims of the project must include at least the following six basic features: education and training, health education, support systems, actions to change people's attitudes about women, employment policies (and opportunities), and infrastructure development. While each of those will be described separately below, it must be borne in mind that they are interdependent. For example, the need to earn a living underlies most people's desire for education and training, and the productive employment of a society's members should be a major aim of its collective investment in education and training. Thus, in order to ensure the society's social and economic goals, the formulation of employment policies and the establishment of jobs for those to be educated and trained are essential. Similarly, support systems, particularly for women, are essential for several reasons, e.g., to enable women to undertake education and training; to ease the burden of their domestic responsibilities during the years they are employed outside the home; and to enable them to interrupt employment for certain periods of time in order to bear children (i.e., to produce the future labour force), if they so desire.

Education and training of women for work in the health sector

Education and training—both formal and non-formal—are among the most important determinants of the extent and nature of women's involvement in development, including the development of a nation's health. The question of education and training for women as health care providers, whether in the formal or non-formal sector, cannot be viewed in isolation from the amount and type of general education that women receive. In this regard it is noteworthy that, although the law in most countries gives boys and girls equal access to education and training programmes, boys are generally given preference over girls for many cultural and economic reasons. In many countries, large numbers of
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girls complete the equivalent of only two or three years of schooling—hardly an adequate basis for retaining the ability to read, write, and do simple arithmetic. In such countries, literacy rates are, therefore, understandably lower among women than among men. Current estimates for Pakistan, for example, indicate that 89% of females over five years of age are illiterate (compared with 64% of males). In the 5–9-years age group, only 33% of the girls are enrolled in primary school, compared with 75% of the boys. Only 15% of the girls, compared with 40% of the boys, complete primary education. In some countries the illiteracy rate for the female population is increasing. Their more limited opportunities for schooling at the primary and intermediate levels make it much more difficult for women to attend and benefit from vocational and other types of education and training programmes that would enable them to compete with men in the employment market or in other productive efforts.

Aside from the differences between females and males as regards the proportion of each receiving education, there are also differences in the content of their education. Girls are generally directed toward courses that emphasize household or domestic activities, while boys are directed toward general academic subjects and vocational training that leads to gainful employment. Thus, even in schools that are open to boys and girls equally, a form of sex-role segregation and discrimination that starts even before children enter schools is reinforced. This will not be readily overcome in programmes of higher education unless there are radical changes in the rearing of children, in their early schooling, and in their education at secondary level. The last-mentioned stage of education is particularly decisive for the future of young women, since it is the stage during which boys and girls receive vocational training or decide to go on to higher education.

It is apparent that, aside from the imperative need for a radical reform in programmes of general education (to which WHO could contribute in the area of health education), programmes of education and training geared to the production of health workers, will have to pay special attention to the needs of the women enrolled in such programmes, since most of them will already have been strongly influenced by the stereotyping of their early years.

Education and training for health work falls into two broad categories, basic and continuing, the first being the initial education and training required to be able to provide some aspect of health care, while the second is education and training that continues throughout a health worker's career from the time of initial qualification to retirement; in the present report, this is taken to include postgraduate education. Each of these categories will be discussed as it applies to women health workers.
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(a) Basic education of women for work in the health sector

As far as basic education for health work is concerned, women are in a much less favourable position than men, particularly as regards their distribution among the different types of course or school. In programmes geared to the production of what are called "professional" health workers, there is an overall preponderance of men, except in those for the training of nurses and midwives. There are, of course, variations between countries. In most eastern European countries, for example, women outnumber men in medical education programmes, while, in certain African countries, men outnumber women in nursing education programmes.

As regards the basic education and/or training of other levels of health worker (usually referred to by a term such as "assistants", "auxiliaries", or "aides"), women predominate in programmes for the preparation of auxiliary personnel in nursing and midwifery, while men predominate in programmes for the preparation of medical assistants and veterinary assistants. As regards assistants in pharmacy and dentistry, the global picture is very unclear.

What is important about the type of education and/or training women pursue in the health field is that, for most of the women concerned, it leads to jobs that command relatively low incomes. As a general rule, the lower the income of a person, the lower that person's prestige in the eyes of a society even though her or his work may be indispensable to the achievement of the society's objectives or those of a respected institution. In the field of health, there are various ways of attacking this problem. One of them is to recruit and train as many women as men for each type of job, and to ensure that men and women have equal access to, and payment for, the types of job for which they were trained. While this will not solve the problem of the low pay offered certain categories of health worker, it should at least give women the satisfaction of feeling that the low-income work is being shared equally by men and women. If primary health care is truly to be the basic approach to health for all, a larger proportion of each nation's health budget must be diverted to such care, the providers of which should be reasonably well paid. As far as it now exists, primary health care in the formal system is being provided largely by poorly paid categories of health worker. Outside the formal system, it is generally provided by women as part of their unpaid labour as mothers, wives, and daughters.

An alternative is to institute measures that will aim at obliterating the gross differences in salaries and fees between those categories of health worker in which women predominate (e.g., nurses, midwives, and nursing/midwifery personnel) and those in which men predominate (e.g., physicians and physicians' assistants). The net effect of this might be the type of equilibrium mentioned above as desirable with respect to recruitment for education and training and employment. There is also
the possibility, however, that such a course of action would lead to the main areas in which women predominate (nursing and midwifery) becoming sufficiently attractive financially to induce large numbers of men to enter them and crowd the women out. This could be acceptable if the reverse situation were to develop in areas of health work where men now predominate. This, however, is unlikely to happen unless very serious and systematic efforts are made to enable women to receive the necessary education and training to obtain and maintain jobs in these areas.

The possibility of women being crowded out of a highly feminized area of health work should not be ignored. Midwifery is a good example. In many countries, including the United Kingdom and the USA, this profession was practically obliterated by that known as obstetrics. This profession is largely dominated by men and is highly paid, even when it is not combined with gynaecology. In recent years, there has been some revival of interest in midwifery and its practitioners, including traditional birth attendants, but they are not nearly as well paid as obstetricians.

The recruitment of women for basic education and training programmes, particularly those in which students or trainees have traditionally consisted mainly of men, will require a special effort. This is so partly because of the negative image women have of themselves as a result of social conditioning, partly because of their domestic responsibilities, and partly because in many countries far fewer women than men have the schooling required for admission to basic education and training programmes, particularly those for preparing "professional" as opposed to "auxiliary" personnel. It may be necessary to launch campaigns to find women meeting the admission requirements and to persuade them to enter training.

To help women to enter and complete education and training programmes, enabling and support mechanisms will be needed. These will be described in a separate subsection, since they are needed with regard not only to basic education and training but also to continuing education and to employment.

Measures will also need to be taken to help eliminate discriminatory attitudes and practices on the part of the men in the education programmes, whether they are administrators, students or trainees, or teaching staff. Discrimination can take many forms and come from various quarters. For example, an institution as such can be discriminatory, particularly with respect to such matters as recruitment, admissions, women students with children, financial aid, lodging, athletic facilities, day-care, and health services for students. Within an institution, male staff and students have a variety of ways of showing discrimination, sometimes overtly and sometimes subtly. While women
can and do devise personal ways of coping with discrimination, it is essential for efforts to combat it to be made on a collective and impersonal basis. In this regard, it is essential to stress the need for teaching and learning material reflecting a conscious effort to do away with the very stereotyped image of female and male roles that continues to mark much of such material. Particular attention will need to be paid to the type of message conveyed by photographs, sketches, illustrations, and examples.

Other important propagators of stereotyped images of female and male roles are the teachers and trainers themselves. The extent and nature of the differences, if any, between male and female teachers and trainers in this regard are not known. This could be an important area of research with the broader aim of developing appropriate education and training programmes for the preparation of teachers and trainers. Where and how to start in this direction are major questions, since the instructors of future teachers and trainers are themselves products of their own social conditioning.

(b) Continuing education for women in health work

Various circumstances give rise to the need for continuing education, including the following (1):

— developments in knowledge, resources, or approaches regarding health care, e.g., the introduction of a new drug or piece of equipment, or increased concentration on primary health care;

— changing health needs, e.g., demographic changes and changes in patterns of morbidity, mortality, or demand for services;

— inadequate or inappropriate initial training for the job assigned to the health worker;

— changes in the role of health workers as a result of changes in the objectives and organization of the health services;

— deterioration in the quality of care provided by individual workers, particularly those working in isolated situations where the means for sustaining motivation and standards are lacking;

— promotion or change of job, which is likely to require additional types of competence, e.g., management skills; and,

— the health worker's own need to learn.

While all of the above are equally applicable to men and women health workers, special considerations apply in the case of the women. One of these is the fact that, unlike most men health workers, most women
health workers have to devote a large proportion of the day to domestic responsibilities. This makes it much more difficult for them to take advantage of opportunities for continuing education, except, perhaps, for those available on the job site during working hours. Another is that, because upper-level managerial posts are seldom occupied by women, in spite of the fact that women constitute the larger part of the formal health labour force and are the main providers of care in the home, a special effort will need to be made, through continuing education, to prepare many more women for positions of leadership. Yet another consideration is the fact that large numbers of women are obliged to interrupt their careers in order to bear and rear children and/or to care for disabled members of their families. If they are to re-enter the system, they will need special consideration as regards continuing education.

Practically everything that was noted earlier about women's basic education for health work applies to continuing education as well, e.g., the need to allow more women to have access to education programmes and to enable them, through support systems, to take advantage of the opportunities provided; the need to ensure that learning material is free from sex-role stereotyping; and the need to ensure that teaching and supervisory staff refrain from discriminating against women either overtly or covertly, through ignorance or arrogance.

Beyond the above-cited factors is the need to ensure that continuing education for women health workers will make up for those aspects of, or deficiencies in, basic education and training programmes that reinforce women's tendency to shy away from certain specialized areas of health work and from decision-making positions. There is evidence that, for one reason or another, women have a greater tendency than men to enter such fields as paediatrics, psychiatry, anaesthesiology, and public health. This raises the question of how much speciality boards (which are usually dominated by men) influence women's choice of speciality. On the assumption that they do influence it to some extent and that—as some (but not all) aver—specialization in the health field forms a part of continuing education, it follows that those responsible for designing and managing continuing education programmes should devise ways of combating or circumventing the tendency towards stereotyping manifested by the members of such boards. The same applies to anyone entrusted with guiding applicants for education and training programmes, whether basic or continuing, in the various branches of health care. One of the problems is that the designers and managers of education and training programmes (largely men) have themselves been conditioned towards stereotyping, thus tending to organize programmes in ways that are convenient to men in terms of time, location, methods, etc. This seems to apply even when those in charge of the programmes are women, which is usually the case with education and training programmes for nursing and midwifery personnel.
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This last observation is of particular importance, since nursing and midwifery personnel constitute by far the largest single component of the labour force in the formal health system. As matters stand now, the education and training of such personnel is geared essentially to the provision of a support system for physicians in the clinical setting, (e.g., in hospitals, clinics, and the offices of physicians in the private sector). The fact that, in the majority of countries, most physicians are men while most nurses and midwives are women is less important than the fact that the orientation of the education and training of a physician (i.e., towards clinical work) largely determines the orientation of nursing and midwifery education (i.e., also towards clinical work—but with the very important and arduous work of nurses and midwives serving as a support system designed to enhance the productivity and, effectively, the income of physicians).

In countries committed to primary health care as the basic approach to health for all, many things have to change, not least among them the orientation of nursing and midwifery education and training. A big question is whether nursing and midwifery personnel who are already well entrenched in the clinical setting (where the focus is essentially on secondary and tertiary care) can be persuaded, through continuing education, to play a greater role in primary health care, which takes place largely outside the clinical setting. (A similar question arises, of course, with regard to physicians.) This question is particularly important in the light of one of the main reasons for continuing education as noted above, namely, changes in the role of health workers (as the result, for example of an increased concentration on primary health care as the basic means of achieving health for all). In this context, there is a need for a serious assessment of continuing education as a potential means of converting members of the “medical care team” to the new concept of health care and to a pattern of behaviour concomitant with that concept.

No discussion on continuing education for women in health work can be complete without mentioning the importance of ensuring that the development of leadership skills is an integral part of continuing education in both the formal and the non-formal health sectors. In the formal sector there are many levels of decision-making, each responsive to the one above it. At one of the levels, the decisions concern direct patient care. The skills of the decision-makers involved have usually been well tested and demonstrated beforehand, and there are ways of ensuring accountability for the decisions made. Apart from a desire to have a greater number of women among physicians, who are usually the top decision-makers as regards direct patient care, participants in the WHO-sponsored Consultations on Women as Providers of Health Care stressed the need for: more women in higher-level “managerial” positions (i.e., those involving such functions as policy-making, planning, programming, budgeting, and evaluation at the national,
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subnational, and institutional levels) and more women directors and teachers in education and training programmes for health workers.

For the types of managerial position noted above, there is usually no clear test of performance as there is in the case of decision-makers in the area of direct patient care. Many managers become managers on the basis of skill demonstrated in another field plus, in some cases, a short course in management, often in an environment that in no way reflects the learner’s work situation. In some instances, accession to managerial positions may be purely a matter of politics or nepotism, and thus may have little to do with skill in management. While such a state of affairs should work equally well for men and women, it seems to work better for men, regardless of the sex composition of the health labour force as a whole or of its various component parts. This seems to hold true for countries of widely different social and economic structure.

Regarding ways of developing leadership skills in women in the health labour force, women themselves seem to differ. Some suggest that special programmes of continuing education should be established in which women alone would participate as trainees and the instructors (also women) would serve as role-models for those aspiring to positions of leadership. The reasoning behind this suggestion is that, since women are generally overlooked in the recruitment process for management training programmes that are supposedly open to men and women alike, women-only programmes would be a way of circumventing this problem. Moreover, in programmes open to both men and women, there is little chance that the few women with access to them will have a female role-model to support and guide them.

Those who object to a separate programme for women only, and with women role-models, do so on the reasoning that women will never be able to compete with men in the market for managerial positions unless they learn to compete with men in management-training programmes. This reasoning would be sound if there were not such a gross imbalance in the sex composition of both trainee and trainer groups in such programmes.

A compromise solution to the problem would be one in which the management training programme would be open to both men and women but a special effort would be made to recruit women and accommodate their particular needs and to balance the sex composition of the trainer group. This may be more readily possible in off-the-job programmes than in those forming part of the process of supervision on the job—in which, in most countries, the supervisors more often than not are men.

Considerable concern has been expressed about leadership training for women engaged in non-formal health care, particularly at village level, to enable them:
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- to take charge of local health care activities in which women are the main participants;
- to organize groups for community action;
- to participate in assessing needs and determining action to be taken;
- to manage water supply and basic sanitation programmes;
- to gain access to existing and potential resources and use them more effectively in carrying out village-level activities in primary health care; and
- to strengthen links between the non-formal and the formal sectors.

For the development of a system of continuing education in which women will be able to participate equally with men as both trainees and trainers, it is essential that women should be equal partners with men in formulating plans for such a system and taking charge of their implementation.

Changing people's attitudes about women

At the beginning of this book, it was pointed out that, while women's contribution to health development is far greater and more direct than that of men, for the most part this contribution is neither perceived by people generally nor properly acknowledged in social and economic terms. The implications of this situation for the future of primary health care were also pointed out.

Participants in the second WHO-sponsored Consultation on Women as Providers of Health Care emphasized the need for action to increase people's awareness of the importance of women's work in general, and their health work in particular, and thus promote a change in attitudes and behaviour both towards and on the part of women. Three areas in which such changes are essential were identified: (a) the attitudes of men and women in general towards women's contribution to health care; (b) the attitudes of both female and male staff in the formal health system towards women health care providers in the non-formal health system; and (c) the attitudes of top-level decision-makers.

(a) Attitudes of men and women generally about women

The participants felt that, until women's image of themselves changes, there is little likelihood that changes will occur in women's image of men and men's image of women and thus in men's attitudes and behaviour towards women. These three factors are inextricably linked and reinforce one another.
As a result of the social conditioning of both women and men over many generations, a number of women have a relatively low level of self-respect and self-confidence. This applies to women in all fields of endeavour and, more particularly perhaps, in the field of health care, where few people—women or men—are fully appreciative of the many-sided contribution of women to health development. Where women’s own awareness of their contribution is lacking, there is little chance that others will place a positive value on it. In a survey of certain African villages, for example, it was found that women are providing the bulk of primary health care without realizing that they are doing so. They simply never viewed themselves as health care providers. The survey has helped them to a greater appreciation of their own worth.

Once women begin to develop their self-esteem, men are more likely to develop a positive image of them and deal with them on an equal footing. For this to happen, women will have to support one another, not only in meetings among themselves but through channels that reach men as well. They will have to extol their own qualities, as men do theirs. As regards their role in health care, women must devise ways of making their primary health care activities more visible and ensuring that women’s self-help groups, as well as the many other health-related services women provide in the non-formal system, project an image of credibility and worth. Participants in the consultation stressed the importance of revising systems for the collection and analysis of statistical data in every country so that they cover all kinds of labour in the health field, both paid (including work for payment in kind) and unpaid (including volunteer work). The rationale of this proposal is that, until the vast amount of health services provided in the non-formal sector (predominantly by women) is identified and measured (along with the work women perform in the formal sector), it will be difficult to increase the visibility of women’s total contribution to health care, particularly primary health care.

Hand-in-hand with women’s reassessment of themselves will come changes in their views of, and behaviour towards, men. In practical terms, women will have to stop submerging their own aspirations in deference to some unfounded societal notion that only the types of work performed by men are important and that only men can perform them. To this end, many women have to demonstrate their determination to train for and accept positions hitherto denied them, either as a result of discrimination or because their low assessment of themselves by comparison with men made them reluctant to apply. Moreover, the drive by women to have men share more equally in family responsibilities, including health care, will help to initiate and reinforce much-needed changes in the way that labour in the health field and in society as a whole is divided between the sexes. Crucial areas include opportunities for training and work, roles, levels of participation, workloads, recognition, and rewards.
Adult men and women should not only seek equality with one another, they should also strive to ensure that their children, regardless of sex, are cherished, supported, and challenged equally from the very start of their lives. In this regard, parents still have a great deal to learn, since most of them are not even aware that they are discriminatory as regards their daughters and sons. Few parents realize that some of the traditional ways in which daughters and sons, respectively, are reared may, in the long run, be detrimental to both sexes. This is because neither parent has received, during childhood, the experience he or she would need, during adulthood, to appreciate fully either the positive or the negative aspects of the other parent’s role. This lack of appreciation leads to conflicts between the sexes—a conflict that inflicts hardships on both sexes, since it disrupts both family life and social life. Moreover, it extends to the market-place, where mutual resentment has an adverse effect on the individual and collective productivity of the work force.

(b) Attitudes of staff in formal health care systems towards the non-formal sector

Formal and non-formal systems of health care exist in all countries, usually isolated from, and often disdaining and mistrusting one another. One is accused of focusing only on “high-quality medical services” for a small minority of the population, and the other is accused of not having a clue about “standards of excellence”, a phrase much used by professionals to establish their monopoly on high-cost health services. Participants in the WHO Consultation repeatedly stressed the importance of forging stronger links between the two systems, particularly with respect to the planning, implementation, and evaluation of primary health care programmes.

The forging of such links will require changed attitudes all round. Staff in the formal health sector, men and women alike should be made aware, through reorientation programmes, of the contribution of the non-formal sector, and particularly of its women members. (It is estimated that women provide close to 95% of health care in the non-formal sector.) The staff in the formal health sector can help to enrich this contribution by providing health education to women in general in the community, training traditional birth attendants, providing training in primary health care for women who act as child-minders, and helping women to plan and implement projects aimed at improving community health.

Action such as that just noted will require an approach that is acceptable to the communities concerned. These will have their own culture and could easily be alienated by an approach imposed from outside.

(c) Attitudes of top-level decision-makers towards women

It is difficult to ascertain what top-level decision-makers really think about women and national development, including health development.
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Many of them issue statements (both oral and written) giving the impression that they understand that a nation’s health and welfare, in the broadest sense of these terms, is as dependent on women as it is on men. However, in many cases these “political” statements are not followed by any significant practical effort to ensure a more rapid progress towards equality between the sexes. This applies even in countries that have enacted laws and drawn up policies supporting such equality. Machinery to enforce and monitor the implementation of such laws and policies is imperative if a society is to make significant progress towards the goal of health for all.

Participants in the consultation felt that some means should be devised whereby politicians and decision-makers could be more fully apprised of women's contribution to health care, the problems they face in this regard, and ways in which their contribution could be enhanced and rewarded. Regional workshops were suggested as one means to this end.

Efforts to bring about changes in a society’s attitudes and behaviour regarding women should form an integral part of all education and training programmes, both inside and outside the health field. They should also form part of family-health education programmes. It must be remembered that education may be carried out not only through words, but also through photographs, drawings, games, and other learning aids. It involves such media as books, periodicals, radio, television, and exhibitions. The media in all countries should be scrutinized with a view to eliminating portrayals of women as useful only for work that men deem unimportant.

Health education

Health education has been defined as any combination of activities leading to a situation in which people want to be healthy, know how to attain health, do what they can, individually and collectively, to attain it, and seek help when they need it.

 Everybody needs health education, females and males alike, both as children and as adults. However, because women are the principal providers of health care in their families and communities, the development of a massive health education programme for women, particularly in villages and urban slum areas, is a matter of the highest priority. The objective of such a programme would be to enhance the capacity of women to improve their own health and to provide more effective health care to their families and communities. The dual aspect of this objective needs to be emphasized, since a family's state of health is strongly affected by the health of the wife/mother, which can deteriorate in her struggle to take care of sick children or other relatives and deal with her many other responsibilities, not least of which is childbearing. This vicious circle has to be broken in the drive towards health for all.
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Precisely because many women living in villages and urban slums are already so heavily burdened and have little time to spare, health education programmes for them must be held at convenient times and places. In addition, it must be remembered that, while all women need health education, those likely to need it most are also likely to be, for the most part, illiterate. This will call for special teaching and learning methods. Indeed, health education should be integrated with literacy development programmes, and vice versa, since illiteracy is in itself an obstacle to the achievement of better health.

Inasmuch as women socially condition the young and orient them towards behaviour they consider as conducive to health, they function as health educators. However, much of the behaviour they themselves engage in and teach to others may be detrimental to health. One of the tasks of a health education programme should be to sort out the various practices existing within a culture, to promote those that are known to be conducive to health, to discourage those that are known to be detrimental, and not to interfere in either way with those that appear to be neither harmful, nor harmless.

Given that the health of families, not least the women in them, is adversely affected by the negative image women have of themselves, another task of a health education programme should be to encourage women to see themselves in a different light, particularly as regards matters related to their reproductive cycle and the roles of females and males in the home and in society. As noted above, as women's image of themselves changes, their image of men and the image men have of them are also likely to change. Although the task of changing images may come more appropriately under the heading of "education for family life", the definition of "health education" provided above is broad enough to include this aspect of health development as well. Among the types of knowledge often noted as being essential for the members of a family, is how health contributes to family welfare. Although reference is also frequently made to the other side of the coin, i.e., a need for knowledge of factors contributing to health (e.g., cleanliness, immunization, proper nutrition, rest, sleep, etc.), only rarely is mention made of the importance of reciprocal understanding and respect between the female and male members of a family or the importance of an arrangement between them to share work in the home, including the rearing of children, especially where women have to work outside, as well as inside, the home. Health education programmes ought to deal with these very important health-conditioning factors.

The health education of women is one way of training community health educators. This notion is succinctly expressed in the following proverb: "Teach a mother to be healthy and she will teach the rest of mankind". Appropriate health education will enable women to become positive role-models, thereby promoting behavioural changes that will result in
healthier life-styles and, ultimately, higher levels of health in their communities.

Employment

No plan for national development, including health development, can be considered of any value without a coherent and enforceable strategy for employment, backed by appropriate support systems. Such a strategy would need to take two essential factors into account. The first is the need to ensure jobs for those in whom a society has invested, or plans to invest, resources for education and training—jobs that are consonant, in terms of content and remuneration, with the type and level of education and/or training received. The second is the need for policies and structures that will enable women to participate effectively in the labour force.

In practically every country, policies and practices with regard to education and training and to employment are geared to a norm based on the time available to men. This is as true of the health sector as of any other. For men, such features of their lives as marriage, birth of children, or divorce, constitute events and, as such, have little influence on their decision to pursue their education or participate in the paid labour force. In the lives of women, on the other hand, they usually constitute transitional periods (marriage being the time spent taking care of home and husband, childbirth the time spent being pregnant and rearing children, etc.). Thus, in the course of the life cycle, the time available for education and for participation in the paid labour force remains relatively constant for men, but can be greatly reduced for women.

Under the system of employment most prevalent today, any person unable to work full-time during rigidly fixed hours for 5–6 days a week, without major interruptions in employment, risks being discriminated against and penalized. With a view to rectifying the situation, various expedients have been tried, mainly in industrialized countries. These include: the unbroken working day in which employees may choose the set of hours (i.e., shift) most convenient to them: variable or flexible working hours; a shorter working week; and part-time work.

The majority of part-time workers are women. While part-time work offers women a convenient means of dividing their time between family responsibilities and paid employment, it has serious implications in that it generally condemns them to second-rate jobs, low earnings, poor working conditions, and the deprivation of social security and other benefits. Part-time work, for both men and women, needs to be made more attractive in every sense, so that those holding part-time jobs are not penalized in the ways just mentioned.

Other needs of workers with heavy family commitments include such things as parental leave, sick leave, and child-care programmes. While
these go beyond employment policy as such, they do have a bearing on the participation in the labour force of persons with families and should feature in any employment strategy dealing with women as health care providers.

One of the principal factors conditioning the employment status of women is lack of continuity in their working lives. It is fairly well established that job continuity is an important factor in earnings, since it allows the acquisition of seniority, on-the-job training, and promotion. Research on the consequences of dropping out of the labour force is important for assessing the extent of sex-based discrimination as regards earnings. Research is also needed to find out why women drop out and what changes might ensure their retention in the labour force. For instance, it is possible that higher wages for women would strengthen their attachment to the labour force. The results of such research might help to change the attitudes of employers, whose reluctance to hire women for certain positions stems in some cases from a genuine concern about the interruptions in women’s employment. If the “expected” job turnover rate for women is high, employers will consider it wasteful to provide them with on-the-job training or to promote them to managerial and supervisory positions. This, of course, produces a vicious circle in the sense that it results in women being employed in jobs that offer them little incentive to stay. If it could be shown that the job turnover rate for women could be reduced substantially by higher wages, employers might revise their attitudes, thus giving more women career opportunities and increasing the pool of candidates for managerial positions.

Much more information is needed on the effects of discrimination as it pertains to the employment of women. The health sector is particularly short of data, classified by sex, with respect to the following: the distribution of employees by occupation; unemployment rates; wages and incomes; the characteristics of employees in terms of educational level, labour market attachment, experience, etc; and job turnover rates (separations, accessions, and promotions). Information based on an analysis of such data would be useful for several purposes, e.g., for planning the development and management of human resources in the formal health system, and for showing employers and decision-makers the true situation.

Support systems

Three types of national policy are emerging with respect to workers with family responsibilities. One type involves legal and administrative measures designed to eliminate certain forms of discrimination against women in employment. These include measures to enable women to alternate their roles in the family and at work, e.g., maternity leave, long-term leave, and reduced working hours. The second type involves
measures to support women workers, e.g., child-care facilities and household support systems in the form of domestic services, and collective facilities such as canteens for take-away meals and food shops at the place of work. The third type is concerned with workers who have interrupted employment because of family responsibilities and wish to return to work. It includes vocational guidance, additional training as required, and job placement services directed at re-employment.

As regards policies of the first type, it is essential to ensure that such measures as special leave provisions and reduced working hours do not deprive the worker of future employment or of status related to the accumulation of pension rights, health insurance coverage, and similar benefits. Greater flexibility should be built into policies based on such measures. This is likely to occur, however, only after employers and social institutions have accepted, as a norm, the concept of intermittent work (i.e., work that alternates with time spent on education and family-related responsibilities).

In the second type of support system referred to above, child-care facilities are of paramount importance, both for mothers at work and for those taking part in education and training programmes. Such facilities have been established in many countries and are of various kinds. One takes the form of a central building within a block of houses that offers such communal facilities as creches, kindergartens, and leisure-time centres for schoolchildren, as well as hobby rooms, workshops, etc. Another is the “day-mother” system in which one mother takes care of a group of small children of local working mothers in her own home. Some of the problems that need to be tackled with respect to collective day-care are:

- the shortage of facilities for the care of pre-school children;
- the shortage of facilities for school-age children after school hours, during holidays, or at other times when parents have to work;
- transport problems, especially where there are long distances between the place of work, the home, and the day-care facility;
- the effects of day-care on children; and
- the training of child-minders, especially with regard to the health care needs of children in their charge.

To date, the dominant trend in the provision of day-care has been to meet the needs of one-parent families or families where both parents wish to enter or remain in the labour force, or to fill the gap when people are unable to care for their children (as, for example, during ill health).
Women as providers of health care

Day-care, however, can be seen as more than just a support system for working parents. It should also be viewed as an opportunity for providing children with relationships outside the immediate family and a stimulating positive environment, for health promotion and disease prevention, and for educational activities.

The advantages of affiliating day-care to the health sector are many. Each would reinforce the other. Infancy and early childhood are periods when the child is at particular risk of malnutrition and impaired growth and development. Good day-care facilities can provide an excellent starting-point for health and nutrition surveillance, the monitoring of growth and development, and the prevention and early detection of physical and psychosocial problems. Children in day-care are a readily accessible group for immunization, supplementary feeding programmes, and health education. In addition, the link with the health sector would facilitate the direct referral of children to health care services and, simultaneously, provide a means of communication between health services and families. Such communication is important, particularly since, in many of the communities where the need for day-care is high, not enough use is made of available health services and there is a correspondingly high incidence of child morbidity. Furthermore, it can help in making parents more aware of good hygienic and nutritional practices.

Child-care facilities can also help to stimulate community participation. A suitably flexible approach will encourage different kinds of parental and community involvement, thereby helping to provide a forum for community interaction on relatively neutral ground.

At present, there is a shortage of information, especially from developing countries, on the staffing of day-care facilities and the training of the staff. It would appear, however, that health promotion among children in day-care is more effectively carried out by persons with at least some training in the matter. In many communities with limited resources, local people are recruited as child carers and given a minimal amount of training. This is certainly useful from the standpoints of cost-effectiveness and keeping the children in touch with local environment. In addition, an attempt should be made, wherever possible, to involve both sexes, as well as older people, in the provision of day-care facilities.

A common problem in the developed countries, and in the more formal institutions in developing countries, is the high turnover of day-care staff. This is a result of low remuneration, poor working conditions, and long working hours. In many ways, the situation reflects the low status generally assigned to women and particularly mothers, whose "only job" is to care for children and maintain a home. It would appear that such caring is as undervalued when it is performed within the labour
force as it is when it remains an unremunerated function of women in their homes. Moreover, the rapid turnover of staff is detrimental to the children since it means that they constantly have to break off relationships with their carer(s) and establish new ones.

The third type of support system, referred to above, applies particularly to women who wish to resume employment after a prolonged absence. Such women often face a variety of problems, including economic problems as well as uncertainties about how they will fit in with younger colleagues, whether they can adjust to a new hierarchic structure, follow a new rhythm of work, and meet the demands of a new job, and, of course, whether and how they will be able to reconcile employment with domestic responsibilities. Vocational guidance and job-placement services have been established in several countries to assist women re-entering employment. Evidence suggests, however, that most of these services leave much to be desired. As regards continuing education for re-entry, much of what has already been noted under the section on continuing education applies, the main difference being that established staff have a better chance than potential re-entrants of receiving additional training at the place of work.

Infrastructure development

Participants in the WHO Consultation spoke of the need for a means whereby national resources could be planned, mobilized, organized, and used in the most effective way for achieving the long-term aims of the WHO-sponsored project on women as providers of health care, i.e., an infrastructure. Their concern was expressed in terms such as these:

"Steps should be taken to establish or strengthen links between the national machinery for the integration of women in development on the one hand and the main decision-making institutions within the health sector on the other."

"Governmental machinery should be created for coordinating and monitoring women's activities from the national to the village level."

"Existing organizations and mechanisms involving women as health care providers should be coordinated."

From the various group discussions it became obvious that, in certain countries, there are many activities relevant to the project, but they often fail to lead anywhere because they neither fit into a concerted plan of action nor receive continuing support. Many of these activities are conducted by women's organizations, each working in isolation from others, with no link to a high-level decision-making body or support from the government or any other institution. For example, it was
pointed out that in Jamaica there was no formal channel of communication between the Bureau of Women’s Affairs and the two major organizations for providers of health care with a largely female membership, namely, the Nurses’ Association of Jamaica and the Midwives’ Association of Jamaica. Examination of the issues being tackled by these two groups shows that they are more concerned with the problems of nursing and midwifery as professions than with nurses and midwives as groups consisting mainly of women. Neither organization appears to have much knowledge of, or concern about, women’s role in development. While both organizations are aware of the existence of the country’s Bureau of Women’s Affairs, they seem to have no conception of how links with the Bureau could be established or of the possible outcome of such links. While the Bureau of Women’s Affairs has been entrusted with drawing up policies and strategies for the integration of women in national development activities, its effectiveness is limited by a number of obstacles, including a shortage of personnel and funds.

These observations probably apply to a large number of other countries as well as Jamaica. Moreover, there are some countries without any special bureau or department dealing with women’s affairs at the top level of government. From replies to a questionnaire sent out by the United Nations, it appears that about a third of its Member States have not yet set up any kind of body to deal with the task of implementing the World Plan of Action formulated by the World Conference of the United Nations Decade for Women (Mexico, 1975).

The national bodies dealing with women’s affairs (where they exist) vary from country to country as regards structure, size, nature of membership, and material resources, and are known under a variety of names. Some of them consist of only one or two people; others are well staffed. Some limit their membership strictly to women and deal only with women’s affairs. In others, both men and women are included as members and as subjects of concern. In several countries, the body is a bona fide component of the government, and its actions and decisions imply government approval and support. It may constitute a ministry on its own, e.g., the Ministry for the Promotion of Women, in Togo, and the Ministry for the Status of Women, in France, or a subdivision of a ministry, e.g., the Women’s Division in the Ministry of Social Development, in Nigeria, and the Women’s Development Bureau in the Department of Social Welfare, in India. In Spain, women’s organizations are represented in all ministries. In the USA there are over 150 commissions on the status of women.

1 The names of these bodies are given, by country, in a wall-chart published in English, French, and Spanish in Vol. 7, No. 3 (1980) of People (the quarterly journal of the International Planned Parenthood Federation). The chart also contains other information on women and society. Copies of the chart can be obtained from the Federation’s Distribution Unit, 18–20 Lower Regent Street, London SW1Y 4PW, England.
While not every country has a national body dealing with women’s affairs, all have a variety of non-governmental women’s organizations (associations, groups, clubs). They differ from each other in a number of ways. Some consist of women interested only in recreational activities while others have rather wider objectives. Some consist of women with a common profession (e.g., women lawyers, women physicians, women executives). Some consist of poor women, some of rich women, some of both. Some are urban, others rural. Some are in the form of what are popularly referred to as “women’s cooperatives”. Others consist of mothers and are referred to as “mothers’ unions”. All of them should be encouraged to participate in national health development.

In countries where there is as yet no body specifically dealing with women’s affairs at the top level of government (provided these countries are interested in ensuring equality for women in both the process and outcomes of national development, including health development), the creation of such a body would be the first step towards an appropriate infrastructure.

In countries where there is a such a body but it is weak in human and material resources, a first step would be to strengthen it so that it can perform the tasks expected of it, notably those relating to women’s participation in national health development, for unfortunately top-level bodies for women’s affairs often tend to ignore or otherwise neglect the health component. This may be due to the fact that, until recently, “health” has not been considered an essential component of national development.

If the top-level body is to be effective in its role as coordinator of the health-related work of women’s organizations, a survey of such organizations in each country will be essential. In each case, the aim should be to identify the leaders (not only the titular head) of the organization and ascertain: its main objectives and functions; its willingness to collaborate in action to achieve specific objectives relating to women as health care providers; the resources actually or potentially available to it for this purpose; and the additional support it might require. A report on the survey should be prepared and distributed to the organizations surveyed and to other groups and individuals as appropriate. The survey itself and the report on it should aim at paving the way towards the development of functional links between the various organizations (horizontal links) and between each organization and the top-level body dealing with women’s affairs (vertical links). The link to the top level may be through a series of coordinating mechanisms at intermediate levels (e.g., district, provincial, regional).
Women as providers of health care

The process of change

The nature of change

Improvements imply change. Even if women were not concerned with improvements in their educational and job opportunities, and in their employment and working conditions as health care providers, the environment within which the health system operates is constantly changing. A pragmatic yet creative approach is needed to bring about changes leading to improvements in the condition of women—a process that, in turn, requires changes in individual and organizational attitudes and behaviour, often in the face of resistance.

The process of change has, in fact, been the subject of a considerable amount of study in recent years, and numerous descriptions of the process and theories about its mode of operation have been published. Our purpose here is not, therefore, to repeat what has already been written but, rather, to apply one of the most commonly cited theories to the task of improving the position of women as health care providers.

According to this theory—Rogers' theory of change (47)—there are five basic steps in the process:

— *awareness*, in which the individual, or group, becomes aware of the need for change;

— *interest*, in which further information and possible solutions are sought;

— *evaluation*, in which possible solutions are considered for their relative merits, and one is selected;

— *trial*, in which the selected solution is tried out on a small scale; and

— *adoption*, in which the change is incorporated into the whole of the system concerned.

If the process of bringing about change in the status of women in the health field is examined in the light of Rogers' theory, it is clear that it is important, first of all, for women to become aware (if they are not already) of the need to change certain features of the health care system. While there is increasing awareness—not only among women, but among most people in the system—of inequities that need to be righted, a great deal still remains to be done to sensitize all women to the need for change. Next, women must devise, and carefully examine, possible ways of overcoming their problems. Only after thoughtful evaluation of all possible solutions, should one strategy be selected and tried. Wherever possible, changes should be introduced slowly—in stages, or on a trial basis—so that they can be re-evaluated before being implemented on a massive scale.
A catalyst is often needed to get the process started. In the language of change theory, the person who acts as a catalyst is called a “change agent”. The change agent is usually an outsider who has been asked to come in and help a group to identify their problems and to work through possible solutions. Sometimes, however, the change agent may be someone within an organization or group who has leadership ability and the knowledge and skills needed to get things done and who has been asked to undertake the job of initiating change.

Table 7 shows the factors conducive to the successful implementation of change, including the characteristics needed by change agents, the target groups for whom change needs to be brought about, and the basic factors that need to be changed to improve the status of women in the health field.

<table>
<thead>
<tr>
<th>Change agent</th>
<th>Target groups</th>
<th>Changes needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>a person specifically delegated with the responsibility for initiating change, e.g., - Director of Women’s Bureau - Head of civil service section on equal opportunities for women - President/Chairman of women’s groups, e.g., National Action Committee on Status of Women - Consultant</td>
<td>women in the health professions women in auxiliary/assistant categories of health worker traditional birth attendants and other traditional healers, e.g., herbalists organized women’s groups in villages</td>
<td>in education and training in people’s attitudes about women in health education in employment in support systems in infrastructure development</td>
</tr>
</tbody>
</table>

**Characteristics:**
- knowledgeable about situation in country
- can communicate well in speaking and writing
- has credibility, i.e., is accepted as leader
- is committed to improving the status of women as health care providers

**Characteristics:**
- aware that something is wrong
- feel need to improve situation
- able to deal with change, flexibility
- want to change
- see the value of change agent
- have available channels for communication, e.g., regular meetings
- have support for change from the top

**Characteristics:**
- perceived benefit (is it worthwhile?)
- simple, understandable, easy to administer
- does not involve radical changes, can be implemented in stages
- does not require a great deal of time or money
- non-threatening

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*a Adapted from Schulz (49).*
WHO’s strategy for the achievement of “Health for all by the year 2000”, with its emphasis on primary health care, offers women special opportunities—but it is up to women themselves to seize these opportunities. The process described here is intended to provide guidance in this respect, leading to concrete plans which, if successfully implemented, will allow women to benefit from, and contribute to, health development.

It is not meant as a comprehensive guide to orthodox planning. A lack of awareness, resources, tradition, support, assistance, and political backing in regard to women in health and development makes it impossible to adopt sophisticated and highly technical planning techniques like those used, for example, in large-scale government planning departments. For this reason, we believe that the most realistic approach to the problems of womanpower in the health field is the problem-solving one outlined in this chapter.

Identification of leaders

The process of change in any country usually begins with the identification, or emergence, of one or more potential leaders. In the area with which we are concerned here, these potential leaders will probably, though not necessarily, be women. They must, however, be deeply convinced of the need for change in the status of women as health care providers and strongly committed to achieving this end. Those who have emerged as leaders have often been active in women’s organizations; some have been working full-time, some part-time, and some on a purely voluntary basis. Whatever their employment status, it is essential that they should be able to devote a major part of their time and energy to the task at hand.

These leaders serve as the “change agents” referred to in the previous section, i.e., as persons specifically delegated with the task of initiating change. Other change agents may subsequently be selected and trained to work with other groups; these are usually drawn from the initial core group established by the leader to get the process started.

Establishment of a core group

The person who is appointed (or who is self-selected) as leader of a “women in health” movement in a country usually accepts responsibility for coordinating activities within that country. Unless this person already has a considerable amount of power and prestige, however, she or he, working alone, cannot usually accomplish a great deal in the way of bringing about changes in a well-established system. It is essential, then, to gather together a group of interested persons to serve as a core group to help with the work.
The core group should include people in decision-making positions in key government departments, such as ministries of health, of planning and/or economic development and of education, as well as representatives of major women's groups who have evinced concern about health matters.

The involvement of the community is just as important as the involvement of high-level decision-makers. In their own way, local institutions that represent and are accountable to the local community can be as "political" as the politicians in government. With both, involvement can lead to understanding, and understanding can lead to participation and support. The key word here is understanding—hence the need, in some cases, to educate those whose participation is essential.

Participation is, by implication, an active process. It includes involvement in decision-making, in formulating and implementing programmes, in sharing in the benefits of these programmes, and in evaluating them. Participation helps to enhance people's receptivity and ability to respond to development programmes, as well as encouraging local initiatives (40).

The core group should meet regularly, with a formal agenda for its meetings and minutes of the proceedings, so that a record is kept of the decisions made and action taken.

Provision of a learning opportunity

In most instances, the members of the core group need an opportunity to improve their own leadership skills and to "learn by doing", using a problem-solving approach in order to identify and start tackling some of the major problems with which they are faced.

One of the best ways of providing people with an opportunity to use the problem-solving approach is by means of a workshop. There is no need to elaborate on the organization and conduct of a workshop at this point, since WHO has already issued guidelines on this subject (20). We will thus concentrate in subsequent sections on the steps involved in the problem-solving approach to the initiation of changes in the status of women as health care providers.

These include:

— getting a consensus on what the main problems are;
— gathering facts about these problems;

— choosing one problem to tackle;
— looking at ways of overcoming the problem;
— working out a plan for the purpose; and
— selling the plan to others.

(a) Getting a consensus

Mention has been made of six major areas of concern about women as health care providers that were identified in the course of the project, namely: education and training, health education, support systems, changing people's attitudes about women, employment policies and opportunities and infrastructure development.

Within these broad areas of concern lie a multitude of specific problems and issues, whose relative importance varies from country to country. Even within the same country, problems often differ widely from one region to another, and often, too, the women in one village will have different concerns from those in a neighbouring village. It is important that people should have the opportunity and time to talk about things that are bothering them, to explore areas of mutual concern together, and to reach agreement on the matters that are most important.

Group discussions provide an excellent forum for this purpose and, in every workshop, ample time should be provided for them. The groups should be small, so that everyone feels free to express an opinion. It is only through open discussion that people become aware that others have problems similar to their own, or have similar feelings about problems and situations. Group discussions give people an opportunity to voice their concerns, to identify problems, and to work out solutions and gain the necessary support for concerted action to implement them.

From discussions held during the second WHO Consultation on Women as Providers of Health Care, the following issues have emerged as being of paramount concern in various countries:

— the training of women to provide certain health care services to preschool children in informal day-care units in poor areas and metropolitan regions;
— features of education systems that effectively bar women from filling certain vacancies in the country's health system;
— the differing systems of reward for various categories of health care provider (salaried and volunteer, male and female, including those who provide family planning services);
Challenge to countries

- women's participation (or lack of it) in decisions at policy-making level about health care;

- the promotion of women's efficiency and effectiveness as health care providers;

- the use of women's organizations in efforts to develop community health;

- the integration of family planning and primary health care into the work of nursing personnel, village health workers, and other women providers of health care; and

- the training and utilization of illiterate and semi-literate women as providers of certain types of health care in villages.

(b) Fact-gathering

In order to ascertain the nature of the problem (how big it is, how serious it is, what are its causes, and whether anything can be done about it) the group will need some facts. For example, if it is generally agreed to be a major problem that women have very little say in decisions at policy-making level about health care (one of the issues raised above), the group will be more likely to be able to do something about the problem if it has a few facts, such as:

- the number of women in each of the major groups of professional health care workers (e.g., doctors, nurses, dentists, pharmacists, laboratory workers, public health inspectors);

- the sex composition of the main policy- and decision-making health boards and committees;

- the sex distribution of persons in managerial and executive positions in the health care system;

- the influence of professional organizations that are mainly composed of women (such as nursing and midwifery associations) on policies related to health care delivery and benefits for their members;

- formal relationships of women's groups in the country with the professional organizations just referred to.

Someone will need to be entrusted with the responsibility for gathering the facts, assembling them, and presenting them to the group as a whole. Small subcommittees of two or three persons are sometimes helpful in this respect.
When all the facts are in, it is usually obvious that there are a number of problems, rather than just one. In a follow-up to the example used above, namely that women have little say in decisions in the health field at policy-making level, the problems that emerge may include the following:

- there were few women on policy-making and decision-making boards dealing with health matters, such as hospital boards, district health councils, health centre boards, and the like;

- there were few women in managerial and leadership positions in the health care system;

- there were more men than women in the professional and technical categories of health workers, except in nursing and midwifery where women predominated;

- the nursing and midwifery association had a minimal influence on health policy, not being consulted on major policy issues;

- there was a lack of communication between the country's women's bureau and its nursing and midwifery associations;

- the women's bureau had no influence on the formal health sector and no communication with it.

All these problems are important, but it is usually neither possible nor feasible to try to tackle all of them at once. Generally, it is wise to select one problem to start with. The question is, which one? Here it is helpful to have some criteria, or yardsticks, to assist with the decision. The following questions may usefully be asked:

- Which problem can something be done about?

- Which is most serious?

- Is it growing or decreasing?

- What are the long-term benefits of altering the situation?

- What may happen if the problem is not solved shortly?

- What repercussions will there be if changes are made? On whom? On what?

Let us suppose that the group looking at the particular set of problems listed above decided that the first it would like to tackle was that of the lack of women in managerial and leadership positions in the health care
system. This decision would be based on the reasoning that the greater the number of women in senior positions in the health care system, the easier they would be able to bring about changes in it. Rectifying the existing situation would, then, have long-term benefits that would appear to justify the group's selection of that particular problem as a priority.

(d) Looking at ways of overcoming the problem

The next step, of course, is to consider what can be done about the problem. How can the situation be changed? It is helpful here to try to identify some of the factors causing the problem, which, in turn, may suggest some of the things that need to be done to correct it.

Among factors contributing to the problem of "too few women in managerial positions" for example, may be the following:

— the number of managerial positions available is small (in which case, special efforts should be made to identify suitable women candidates for any posts that fall vacant);

— women may not have the necessary education and/or training to assume managerial positions (in which case, a management training course for such women would be in order);

— there is discrimination against women on the part of employers (in which case, action aimed at eliminating the discriminatory practices of the employers is needed);

— women's self-esteem is low (in which case, the whole social conditioning process needs to be changed, so that both men and women see the importance of family responsibilities and learn to share them).

All these factors will have to be tackled at some point if the problem is to be permanently resolved. However, major changes in the customs and conventions of most present-day societies will be needed before the social conditioning process is adjusted so as to increase women's self-esteem, and before family responsibilities are shared between husband and wife to free women for responsible jobs in the labour force. To bring these changes about, massive national campaigns to reorient child-rearing practices in families will have to be launched. In addition, changes will be needed in education systems, and notably in the counseling and guidance of students. These changes will take a long time, and the results may not be apparent until a new generation has grown up and taken its place in society.
A group interested in initiating changes may be well advised, then, to start with a factor that is conducive to a short-term, concrete solution, and to tackle changes in the social conditioning process as a long-term project.

In considering possible courses of action to solve a problem, some questions that may be helpful are:

— What specifically needs to be done?

— How long will it take?

— Who will do it?

— What resources are needed to do it (e.g., people, money, equipment, etc.)?

— What might prevent it from being done?

— Are there policies that need to be changed before something can be done?

— Is the proposed action acceptable, culturally, politically, and socially:
  • to the target population?
  • to decision-makers?
  • to potential co-sponsoring agencies?

— Could the proposed action be integrated into ongoing health programmes?

(e) Working out a plan of action

To return to our example, the group might choose to initiate action to overcome the problem of women not having the necessary education and training to assume managerial positions in primary health care. They might decide that, to improve the situation, all categories of health worker needed to be trained in management, leadership, and communication skills.

Specific action that might be taken includes:

(i) appointment of an “action team” to get in touch with training institutions and analyse the management, leadership, and communications components of their curricula;
(ii) development of such components as needed;

(iii) development and issue of guidelines on the inclusion of such components in the curricula for various categories of worker; and

(iv) organization of workshops to develop the management, leadership, and communications skills of various categories of trained workers.

For each of these activities:

— a time-frame would need to be worked out;

— the responsibility for carrying out the activities would need to be delegated;

— the resources needed would have to be estimated;

— problems, or potential "road-blocks", would need to be identified;

— some method of checking on progress would need to be devised.

In connection with each activity, too, it would be necessary to see if any policy changes were required, and whether more facts were needed.

It is useful to have the action plan in writing, so that everyone can have a copy. A written plan also constitutes a helpful check-list. A form could be drawn up, provided there was general agreement on what should be included in the plan of action.

A work-sheet developed for a project in Jamaica on women as providers of health care is given as an example (Table 8). This work-sheet may be useful to others, or each group may wish to develop one to suit its specific needs.
Table 8. Plan of action for Jamaican project on women as providers of health care

**Objective 1. To facilitate the advancement of women into managerial positions**

<table>
<thead>
<tr>
<th>Specific activities</th>
<th>Time frame</th>
<th>Organization(s) responsible</th>
<th>Resources</th>
<th>Constraints</th>
<th>Monitoring and evaluation indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clarification of job roles and functions through planned and documented orientation for new workers</td>
<td>ongoing</td>
<td>Ministry of Health</td>
<td>planning unit of Ministry of Health</td>
<td>lack of resources</td>
<td>number of workers included in orientation sessions</td>
</tr>
<tr>
<td>2. Provision of organizational charts for workers at all levels</td>
<td>1 year</td>
<td>Ministry of Health</td>
<td>Ministry of the Public Service</td>
<td>manpower shortage</td>
<td>organizational chart revised</td>
</tr>
<tr>
<td>3. Review of the present system in order to create a performance appraisal system based on merit that will be objective and allow for appropriate action (positive and negative)</td>
<td>ongoing</td>
<td>Ministry of Health</td>
<td>Ministry of the Public Service personnel department</td>
<td>inadequate peer evaluation</td>
<td>development of system</td>
</tr>
<tr>
<td>4. Course on how to “navigate” the system (informal measures)</td>
<td>6 months</td>
<td>Bureau of Women’s Affairs</td>
<td></td>
<td>lack of funding</td>
<td>course conducted</td>
</tr>
<tr>
<td>5. Implementation of administrative arrangements for primary health care in all regions of the island</td>
<td>1 year</td>
<td>Ministry of Health</td>
<td></td>
<td>lack of resources</td>
<td>assessment of progress towards objective after 6 months</td>
</tr>
<tr>
<td>6. Feasibility study on how to deal with the need for child care facilities for women, especially those working on varying shifts</td>
<td>12 months</td>
<td>Ministry of Youth (Child Care Division) nongovernmental organizations Bureau of Women’s Affairs regional preschool system</td>
<td>data/information on other day-care programmes such as that of the YMCA and “backyard nurseries”</td>
<td>lack of funding</td>
<td>built into study and project proposal</td>
</tr>
<tr>
<td>7. Development of a programme in which the participants “understudy” successful managers</td>
<td>ongoing</td>
<td>Ministry of Health</td>
<td>known successful leaders and managers</td>
<td>lack of resources</td>
<td>pre- and post-testing of participants on skills developed</td>
</tr>
</tbody>
</table>
### Objective 2. To promote a change of attitudes towards women in managerial positions as providers of health care

<table>
<thead>
<tr>
<th>Specific activities</th>
<th>Time frame</th>
<th>Organization(s) responsible</th>
<th>Resources</th>
<th>Constraints</th>
<th>Monitoring and evaluation indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dissemination of report on workshop</td>
<td>1 October 1984</td>
<td>Bureau of Women's Affairs, Ministry of Health, Department of Social and Preventive Medicine</td>
<td>funding technical assistance</td>
<td>lack of commitment</td>
<td>report disseminated</td>
</tr>
<tr>
<td>2. Establishment of forum to meet regularly and discuss issues pertaining to women's specific needs</td>
<td>ongoing</td>
<td>Bureau of Women's Affairs, nongovernmental organizations, Ministry of Health, Department of Social and Preventive Medicine</td>
<td>funding technical assistance</td>
<td>manpower shortage, lack of finance</td>
<td>meeting held, documentation of meeting, evaluation forms</td>
</tr>
<tr>
<td>3. Interdisciplinary research study on attitudes helping women to move to the top</td>
<td>1 year</td>
<td>Bureau of Women's Affairs, Ministry of Health</td>
<td>local technical assistance through University of the West Indies (women's studies, Departments of Sociology, Social and Preventive Medicine, and Psychiatry)</td>
<td>lack of funding, inadequate data base</td>
<td>study conducted</td>
</tr>
<tr>
<td>4. Development of mass media programme</td>
<td>ongoing</td>
<td>Bureau of Women's Affairs</td>
<td>audiovisual aids technical assistance</td>
<td>budgetary constraints, budget cuts</td>
<td>mass media programme in progress</td>
</tr>
</tbody>
</table>
Objective 3. To ensure training of all categories of health care workers in management, leadership, and communication (MLC) skills

<table>
<thead>
<tr>
<th>Specific activities</th>
<th>Time frame</th>
<th>Organization(s) responsible</th>
<th>Resources</th>
<th>Constraints</th>
<th>Monitoring and evaluation indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Appointment of an action team to join with training institutions in analysing the MLC component of their curricula, and to issue and develop guidelines</td>
<td>7 weeks (by mid-October 1984)</td>
<td>Bureau of Women's Affairs, training institutions: - University of the West Indies - University Hospital of the West Indies - Ministry of the Public Service - Ministry of Health</td>
<td>Ministry of Health, Ministry of the Public Service, University of the West Indies, College of Arts, Science and Technology, community colleges</td>
<td>general economic situation, lack of finance, low level of individual training, low staff/student ratio, inadequacy of available teachers, unavailability of hardware and software</td>
<td>constitution of action team, inclusion of MLC component in curricula, development and issue of guidelines</td>
</tr>
<tr>
<td>2. Identification of resources available for the programme</td>
<td>1 year</td>
<td>as above</td>
<td>as above</td>
<td>as above</td>
<td>resources identified</td>
</tr>
<tr>
<td>3. Development of an MLC component as needed</td>
<td>1 year</td>
<td>as above</td>
<td>as above</td>
<td>as above</td>
<td>relevant MLC component developed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Workshops to develop MLC skills of various categories of workers</td>
<td>1 year</td>
<td>as above</td>
<td>as above</td>
<td>as above</td>
</tr>
<tr>
<td>5.</td>
<td>Provision of fellowships and other opportunities for graduates and postbasic courses for able candidates</td>
<td>1 year</td>
<td>as above</td>
<td>as above</td>
<td>as above</td>
</tr>
<tr>
<td>6.</td>
<td>Decentralization of management training programmes to parish level</td>
<td>ongoing</td>
<td>Ministry of Health</td>
<td>Ministry of the Public Service</td>
<td>PAHO, World Bank, USAID</td>
</tr>
<tr>
<td>7.</td>
<td>Development of curricula for multidisciplinary training in management at all levels</td>
<td>2–5 years</td>
<td>Ministry of Health, Ministry of the Public Service, University of the West Indies, Department of Social and Preventive Medicine</td>
<td>International funding agencies</td>
<td>University of the West Indies, College of Arts, Science, and Technology</td>
</tr>
<tr>
<td>8.</td>
<td>Development of an MLC skills bank</td>
<td>2–5 years</td>
<td>Ministry of Health, Ministry of the Public Service</td>
<td>International funding agencies</td>
<td>lack of finance</td>
</tr>
<tr>
<td>9.</td>
<td>Strengthening of coordinating mechanisms for training programme</td>
<td>2 years</td>
<td>Ministry of Health</td>
<td>Ministry of the Public Service, PIJ (manpower)</td>
<td>shortage of manpower</td>
</tr>
</tbody>
</table>
### Objective 4. To promote the dissemination and exchange of information on women's health

<table>
<thead>
<tr>
<th>Specific activities</th>
<th>Time frame</th>
<th>Organization(s)</th>
<th>Resources</th>
<th>Constraints</th>
<th>Monitoring and evaluation indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establishment of formal links with the Ministry of Health and other Ministries through the Permanent Secretaries</td>
<td>ongoing</td>
<td>Bureau of Women's Affairs research officer</td>
<td></td>
<td>lack of staff time involved</td>
<td>successful joint activities between the Bureau of Women's Affairs and Ministries attendance and participation</td>
</tr>
<tr>
<td>2. Holding of regular meetings with the Ministry of Health and nongovernmental organizations for the exchange of information on women in health work</td>
<td>ongoing</td>
<td>Bureau of Women's Affairs staff available data</td>
<td></td>
<td>difficulty in motivating people to come problems of data collection</td>
<td></td>
</tr>
<tr>
<td>3. Development of a newsletter on the subject of women in health work</td>
<td>ongoing</td>
<td>Bureau of Women's Affairs and other women's organizations Ministry of Health</td>
<td>information</td>
<td>lack of finance shortage of manpower</td>
<td>production of newsletter</td>
</tr>
<tr>
<td>4. Development of a documentation centre providing information on health and other issues relating to women</td>
<td>1 year</td>
<td>Bureau of Women's Affairs National Library</td>
<td>Department of Social and Preventive Medicine</td>
<td>need for funding</td>
<td>centre established</td>
</tr>
<tr>
<td>5. Holding of a health fair on women in health work</td>
<td>3 days</td>
<td>Bureau of Women's Affairs Bureau of Health</td>
<td>Education churches schools PAHO PSOJ nongovernmental organizations</td>
<td>lack of finance shortage of manpower</td>
<td>participation evaluation by participants</td>
</tr>
</tbody>
</table>
Challenge to countries

(f) Selling the plan

Plans that clearly define the objective the group has in mind and the way they visualize reaching it are much more likely to be implemented. There is an old saying: “If you know where you want to go, people are more likely to help you along the way.”

Plans, particularly those for large-scale programmes, have little chance of being implemented unless high-level decision-makers are somehow brought into the planning process. Where the planning effort is initiated by government officials, there is less need for the planners to be concerned about government support. Where this is not the case, those wishing to plan an undertaking and ensure its implementation will need to inform the relevant authorities about it and ask for their reaction. In certain cases the reaction may be favourable, and sometimes the authorities may even offer financial or other forms of support for the planning process. Whatever the potential reaction of the authorities concerned, it is essential for the would-be planners to know beforehand whom to approach, and how, and to learn where these authorities stand with respect to the undertaking for which planning is being considered. When their reaction is favourable in the first instance, it is quite likely that they will become progressively involved and will help in procuring funds, facilities, equipment, personnel, etc. for the planning process. In any case, it is important to identify the relevant decision-makers, to assess their approachability, to make contact with them at an early stage, to keep them informed throughout the planning process, and to solicit their advice on matters that impinge on their particular areas of concern. Obviously, the greatest problem will be presented by the unconvinced and/or threatened decision-makers. Methods need to be devised either to persuade them to give their support or to circumvent their opposition.

Proposal writing

Some of the following guidelines are taken from an information kit for women in Africa jointly prepared by the staff of the African Training and Research Centre for Women based in Addis Ababa, Ethiopia and the staff of the International Women’s Tribune Center, New York, NY, USA.¹ Although the kit is intended for Africa, most of the material in it is also suitable for use in other regions. We recommend this kit to our readers as an excellent source of ideas for the writing of proposals, as a guide to potential resources for projects or programmes, and as a guide for the development of a similar kit for other regions.

¹ This kit is available from: The African Training and Research Centre for Women, United Nations Economic Commission for Africa, P.O. Box 3001, Addis Ababa, Ethiopia.
If you have decided to go ahead with your project, and have also determined that you need outside assistance, the next step is to define the project.

Defining the project

Before exploring outside sources of funding, it is necessary to define the project in terms that potential funding sources will find easy to understand. Also, in researching potential sources, it will be helpful for you to have a clear idea of what your needs are, so that you can match them with funding agency priorities.

For instance, are you seeking funds for a training project? A conference or seminar? A research project? A publication? Does your project fall under the broad category of community development? Education? Agriculture? Will you need money? Technical assistance and training? Equipment?

Selecting a source of assistance

It is best to look first for sources of assistance in your own country or community. Two possibilities are government services and local community services and businesses.

(a) Government services

Government or local authority staff, such as community development officers, schoolteachers, health and social workers, etc., can give valuable advice as to suitable government contacts, available resources, existing and future projects, etc.

Apply to the government department most likely to be dealing with the subject of your request, e.g., education, rural development, etc. Address the letter or application to the Women's Programme Officer if there is one. As the work of the various interested departments frequently overlaps, it may be necessary to send copies of your letter to all the departments concerned. This should help to ensure that the right people learn about your request.

Send a copy of your letter to the government agency for promoting women's interests, if such an agency exists.

Keep people in the interested government services in your area informed of your plan and programme activities. In this way, you can often get additional help and support.
(b) Local community services and businesses

When looking for fairly small amounts of money, facilities, equipment, or technical assistance, it might be possible to generate support from community service organizations or local businesses. Business people's clubs will sometimes organize campaigns for various projects.

If neither your government nor local sources seem sufficient, you should then begin exploring outside sources, of which the most important are:

— the United Nations;
— government agencies;
— private agencies and foundations; and
— multinational corporations.

These sources assist nongovernmental projects in various ways. Extensive research into the priorities of potential funding agencies and the relevant application procedures is crucial. Once you have found several suitable sources, you should send each of them a brief description of your project and ask for information on its procedures, its concern with women and development, and its application requirements. The information you collect will help you to plan a proposal strategy.

To obtain outside funding or assistance, organization, persistence, and creativity are required, and funding agencies will appreciate your doing the necessary homework before submitting a formal application. If a local representative of the agency to be approached is available, get in touch with him/her to discuss the correct procedure. Guidelines on the preparation of proposals will be found in Annex 1, together with some of the criteria of funding agencies and a short list of publications on sources of funding.
REFERENCES

4. ANAND, A. Rethinking women and development: the case for feminism. Washington, DC, Population Department, Board of Church and Society, The United Methodist Church, 1980.
References


Women as providers of health care


References


PREPARATION AND PRESENTATION OF PROPOSALS TO FUNDING AGENCIES

1. Preparation of proposals for the funding of country projects: guidelines on data required

Introduction

A. Major programme area
B. Title of the project
C. Aims and objectives of the project
D. Country or area of execution
E. Duration of the project. Indicate the number of years, e.g., a minimum of 3 years and a maximum of 5 years.
F. Summary budget. Prepare a table on the following lines, showing the amounts required annually and over the project period to meet recurrent and capital costs respectively.

<table>
<thead>
<tr>
<th>Type of expenditure</th>
<th>1983</th>
<th>1984</th>
<th>1985</th>
<th>Total 1983–85</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In addition, detailed annual budgets must be prepared according to the model indicated by the potential funding agency.

G. Requesting agency. Indicate the name of the body requesting the funds (e.g., Ministry of Health, National Council of Women’s Organizations) and describe its relationship to, or position in, the country’s organizational structure (an organogram or chart may be useful for this purpose).

1 These guidelines were developed in the course of the second WHO Consultation on Women as Providers of Health Care (August 1982).
H. Problem(s) addressed by the project. The problem(s) to be addressed by the project should be defined in the context of the broad aims of the WHO Multinational Study on Women as Providers of Health Care. For example, one of the aims is to provide women the education, training, and/or orientation they need in order to participate effectively in health development work. Presumably, the problem here is that too few women have the necessary training. The reasons why this is so constitute further problems that need to be addressed in the process of planning and implementing the necessary training programmes. Problems should be stated simply, clearly, and comprehensively. They can be stated in quantitative and/or other terms. In some cases, a problem can be defined by means of a contrast, e.g., when a particular situation exists in two or more different environments at the same time or at two or more different points in time in the same environment.

I. Target group to be served. Since the basic aim of the WHO project is to enhance the status and role of women as health care providers, it follows that one or another group of women will be a target group. The target group should be specified, e.g., a group of mothers requiring health education, a group of women health workers requiring management training, a group of women requiring training in a medical speciality, and so on. The number of women involved in each case should be specified, together, where necessary, with the geographical location of the group and any other characteristics.

J. Relationship (if any) with other projects. The purpose here is to demonstrate to potential sponsors that the project is not relying exclusively on external funds, since certain existing projects and programmes in the country have an infrastructure that may be used for the project on women. The subjects of some related projects and/or programmes may lie outside the health sector's main area of responsibility, e.g., literacy education, employment, home economics and nutrition. In all cases, an effort should be made to explain how the project is expected to be linked to the other projects or programmes specified and/or which of their resources are likely to be used and how. It may also be useful to indicate that the project is a follow-up of the WHO Multinational Study on Women as Providers of Health Care and that, as such, it will be linked to future activities that may be organized by WHO with respect to women as health care providers, e.g., regional and interregional workshops, consultations, or study tours, publications, and exchanges of information.

K. Relationship with national socioeconomic and/or health plans. It may be useful to indicate that the project requiring funding is part of the overall national effort to promote and implement activities aimed at the achievement of the goal of “Health for all by the year 2000”, and that it
Women as providers of health care

will enable countries to remove certain obstacles that hinder women (the most numerous group of health care providers) from contributing more efficiently and effectively to national health development. It would be important to indicate the problem(s) with which the particular project is concerned, e.g., inadequate education, training, and/or orientation of women for primary health care, for policy-level decision-making, for teaching, or for programme and personnel management; inadequate support facilities (e.g., day-care, maternity benefits); or an inadequate system of recruitment for training or employment.

L. Degree of priority. Funding agencies will be interested in knowing how much importance is attached by the government and the public of the country concerned to the problem cited, and how it is proposed to tackle it. Some idea of this will need to be obtained beforehand and noted in this part of the proposal. To a certain extent, the importance that is likely to be attached to the project can be gauged by the degree of priority being accorded to efforts to improve the situation of women generally in the country. It may be useful to present a summary of such efforts, including the adoption of legislation, the activation of committees, etc. In addition, it may be of interest to potential funding agencies to know that a project similar to the one being proposed has been successfully carried out elsewhere, either inside or outside the country. Factual information to this effect should help potential funding agencies to determine whether or not it may be worth while to fund the proposed project.

M. Expected impact. An effort should be made to foresee and describe how far, and in what way, the project will effect changes in the status and role of women as health care providers in the health system and/or in the family and the community. Particularly important factors to be taken into account are improvements in the employment and career patterns of women in the formal health system and improvements in facilities to increase the efficiency and effectiveness of women's health-related work in the home and the community. If it is possible to do so, an effort should also be made to indicate how far, and in what way the project will influence people's health for the better.

Background

A. National commitment. Summarize the indications that national commitment exists, emphasizing legislation and other official support for women, and decisions or actions involving the allocation of funds, or other forms of support, to actions aimed at improving the situation of women socially, economically, and politically.
Annex 1

B. The present status of women as providers of health care. Provide a brief account of the status of women as health care providers, using information from your own country study where applicable.

Work plan

A. Objectives, approaches, and activities. Formats for funding proposals usually have separate subheadings for these three factors. Here, they are discussed under a single heading in order to show the differences between them. An objective is viewed as the result envisaged as ensuing from the implementation of one or more planned activities. For example, a planned activity might be to conduct a series of workshops on management for a certain number of women during a certain period of time, the objective of this activity being that of having available, by a certain time, a number of qualified female managers. Thus, the training of the women is the activity, and their availability as managers the objective envisaged. Objectives are most meaningfully expressed in measurable terms. An approach, like an activity, is also a way of reaching an objective. However, it is less specific than an activity in terms of time, location, etc. For example, intersectoral collaboration might be considered as an approach. The manner in which such collaboration might be effected would need to be defined in the form of a set of activities specifically designed to ensure intersectoral collaboration (e.g., a meeting of representatives of different sectors) and/or a set of activities in which various sectors would play a role. For example, in a set of activities aimed at ensuring that a certain number of women will receive guidance on child care, nutrition, etc., intersectoral collaboration could be defined in terms of the roles to be played by various sectors, i.e., national or other bodies concerned with such matters as nutrition, literacy development, education through mass media, etc. Other broad approaches include research, information exchange, technical cooperation, network development. In the context of each of these, specific activities can be proposed.

B. Timing of activities. You may wish to include a table indicating each major activity and the period over which it is expected to take place.

C. Resources within the country mobilized for the project. Specify the in-country funds, staff, infrastructure, equipment, etc. available for the project.

D. Budget. Provide estimates, in US$ equivalents, of the cost of each activity, including travel costs where relevant. The example that follows is adapted from a proposal for a project in Thailand on women as providers of family and community health care.
Women as providers of health care

Sample budget

Budget request:

1. Project personnel

<table>
<thead>
<tr>
<th>Staff needed</th>
<th>% time</th>
<th>Cost year 1 (£)</th>
<th>Cost year 2 (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Project Director</td>
<td>50</td>
<td>3 600</td>
<td>3 600</td>
</tr>
<tr>
<td>(b) Project Coordinator</td>
<td>100</td>
<td>6 000</td>
<td>6 000</td>
</tr>
<tr>
<td>(c) Assistant Coordinators (2)</td>
<td>100</td>
<td>2 000</td>
<td>2 000</td>
</tr>
<tr>
<td>(d) Secretary (1)</td>
<td>100</td>
<td>2 000</td>
<td>2 000</td>
</tr>
<tr>
<td>(e) Typists (2)</td>
<td>100</td>
<td>3 200</td>
<td>3 200</td>
</tr>
<tr>
<td>(f) Driver (1)</td>
<td>100</td>
<td>1 600</td>
<td>1 600</td>
</tr>
</tbody>
</table>

2. Honoraria

<table>
<thead>
<tr>
<th>Honoraria</th>
<th>Cost year 1 (£)</th>
<th>Cost year 2 (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Director, organizers, and resource persons</td>
<td>10 000</td>
<td>10 000</td>
</tr>
<tr>
<td>(b) Project Committee</td>
<td>5 000</td>
<td>5 000</td>
</tr>
</tbody>
</table>

3. Operating expenditure

<table>
<thead>
<tr>
<th>Operating expenditure</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital</td>
<td>Current</td>
<td>Current</td>
</tr>
<tr>
<td>(a) Transport</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 station-wagon</td>
<td>9 000</td>
<td>5 000</td>
</tr>
<tr>
<td>3 bicycles</td>
<td>300</td>
<td>50</td>
</tr>
<tr>
<td>(b) Electric typewriters (2)</td>
<td>2 600</td>
<td>300</td>
</tr>
<tr>
<td>(c) Stencil duplicator</td>
<td>3 500</td>
<td>600</td>
</tr>
<tr>
<td>(d) Stationery and office supplies</td>
<td>1 200</td>
<td>1 200</td>
</tr>
</tbody>
</table>

4. Production of handbooks and other material

<table>
<thead>
<tr>
<th>Production of handbooks and other material</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10 000</td>
<td>10 000</td>
</tr>
</tbody>
</table>

5. Regional meetings

<table>
<thead>
<tr>
<th>Regional meetings</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4 meetings × 40 people × 3 days)</td>
<td>8 000</td>
<td>8 000</td>
</tr>
</tbody>
</table>

6. Contingencies

<table>
<thead>
<tr>
<th>Contingencies</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5 000</td>
<td>5 000</td>
</tr>
</tbody>
</table>

Monitoring and evaluation

Funding agencies are, with good reason, interested in ensuring that the funds they provide lead to the realization of the objectives of the project for which they are intended. For this reason, they will be interested in knowing about the plans envisaged for the day-to-day assessment of progress in the implementation of the project (monitoring) and for measuring its impact in relation to the objectives specified and, if possible, in relation to the country's broader goals concerning women and health development (evaluation). Monitoring will require systematic data-gathering, reporting, and analysis, with a view to making adjustments in the programme, if necessary, as regards organization, timetable, resource expenditure, etc. Funding agencies will be interested in having information on the manner in which monitoring will be carried out and may even wish to participate periodically in the monitoring scheme. As regards evaluation, funding agencies may be interested in
the criteria that will be used in measuring the value of the project, e.g., efficiency, effectiveness, and relevance, in relation to immediate objectives and to broader goals. They will also be interested in the organization of the human resources required for evaluation. Evaluation will depend largely on the data gathered through the monitoring system.

2. Sample format for proposals

Remember that each United Nations, government, or private agency may require a different proposal format. Nevertheless, the following suggested format will suit a number of agencies/organizations and is easily adaptable to the requirements of others.

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title page</td>
<td>This page can serve as both the title page and the cover sheet for your proposal. It should give the following information: (a) title of project; (b) name of person applying for funding; (c) name of organization sponsoring the proposal; (d) location and duration of project.</td>
</tr>
<tr>
<td>Summary or abstract</td>
<td>Although this section follows the title page, it is frequently the last to be drafted. The summary should give a concise description of the proposed project, not exceeding one page. It should briefly state the problem/need, the objectives, the methodology or programme plan, the expected duration of the project, and the amount of money requested.</td>
</tr>
<tr>
<td>Problem/need</td>
<td>Outline the specific problem or need your project seeks to deal with. When possible, document your statement with statistics or quotations.</td>
</tr>
</tbody>
</table>
Objectives

Provide a very specific description of the expected outcomes of the project. This should be written in terms of end results, not the methods you will use to achieve them. Be certain they relate to the statement in your “problem/need” section.

Organization profile

Briefly describe the history and function of your organization. Again, the experiences you describe should relate back to the “problem/need” and “objectives” sections, substantiating your abilities to undertake a project of the nature described.

Programme or project plan

Location. Where will the project take place? Why was that particular site chosen? What facilities and equipment are available?

Personnel. State the number of people required and their function in carrying out the project’s agenda. It is suggested that biographies or *curricula vitae* of key individuals involved in the project be included in the appendices to the proposal.

Work plan. This most important section will take some time to develop. You will want to describe the sequence of the activities you are planning, as well as specific methods and approaches. It is important to develop a specific and realistic work plan, which can be used as a guide once the project is operational.
**Evaluation**

You will want to discuss this component of the proposal with the prospective funding agency, since reporting and evaluation requirements vary widely. Evaluating your project while it is under way will help you and the funding people to see your progress and accomplishments, as well as the choices available for future action.

**Budget**

The budget should present a realistic estimate of all costs involved in implementing and operating the project. For ongoing projects, try to include a projected budget for several years ahead, demonstrating, if possible, eventual self-support.

Cost estimates should be broken down into logical categories, such as: salaries; supplies and equipment; rent; telephone; postage, etc.

Voluntary contributions made to the project by you and members of your organization should be listed and estimated as closely as possible in cash terms, or shown as “no charge”.

If you are applying for funds for a special project by an established organization, be sure to include funds for overheads. For example, if you are operating a day-care centre, but want to run a special training programme for one week, you should include a fraction of the charges for rent, electricity, etc., at the day-care centre during that time.
3. Sample letter to a funding agency

Name __________________________ 
Title __________________________
Organization _____________________
Address __________________________
Country ___________________________  Date ___________________

Dear ____________________________

It is my understanding that the [name of funding agency] administers funds [provides technical assistance] for [project category, i.e., training projects, seminars, etc.] in the field of [subject area, i.e., income-generating activities, family planning, etc.] for women. I am writing on behalf of [name of organization], an organization active in the field of [state area of activity]. We are planning to undertake a project to [provide a brief description of objectives, adding a short sentence or two highlighting unique features of the project].

If this project is one which could be considered for funding by the [name of funding agency], would you please send me the necessary forms and any other relevant information required for submitting a proposal?

If you think that this project is inappropriate for funds from your office, could you please refer me to a more appropriate source?

Thank you for your cooperation and assistance.

Sincerely,

[Name] ____________________________

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1 Adapted from Hall, M. Developing skills in proposal writing, 2nd ed. Portland, Continuing Education Publications, 1977, p. 60.
4. **Sample criteria of funding agencies**¹

The following is an example of the criteria that may be applied by a funding agency (in this case, the Dutch Co-Financing Programme) when deciding whether or not to support a particular project.

1. **The main criteria used when considering projects**

   (a) The objectives of the project should be clear and realistic and attainable within the limits of the resources and time available.

   (b) The project should be well defined as to cost, size, and duration.

   (c) In addition to a determination of the participation of this funding agency in the project, there should be, where appropriate, a plan for continuation of the project by the organization or country concerned.

   (d) The project should be managed by local people or come under local management as quickly as possible.

   (e) Those responsible for the project should possess the necessary competence, qualifications, and experience to ensure its sound management.

   (f) The project should be adaptable to conditions in the country concerned.

   (g) Local people should be involved in the planning, implementation, and financing of the project.

2. **Some aspects that are given priority**

   The types of projects that will receive priority consideration include:

   — those supporting initiatives by local groups;

   — those fostering self-reliance by encouraging local management, local financing, and local initiative;

   — grassroots projects that need small investments;

   — local community development activities aimed at promoting social justice and self-reliance, and directly linked to pre-existing activities. However, when the development process in a community has come to a deadlock, or when existing activities have too closed a character, preference will be given to entirely new activities.

¹ Adapted from: Mandate of the Dutch Co-Financing Programme, Interkerkelijke Coördinatie Commissie Ontwikkelingsprojekten (ICCO) [Interchurch Co-ordinating Committee for Development Projects], Utrecht, Netherlands.
3. Low-priority projects

Unlikely to be considered are:

— coverage of recurrent expenditure of large institutions, e.g., hospitals and schools;

— ongoing administrative expenses and running costs;

— projects for minority groups that place these groups in a privileged position and that may cause jealousy and competition.

4. Some types of project eligible for support

(a) Agriculture: farming, ranching, fertilizer/poultry-raising/fisheries cooperatives, rural credit development, cattle-dips, rain-water conservation, training, and agricultural implements.

(b) Education: preferably technical and vocational education, adult education, leadership training.

(c) Health and family planning: integrated rural health care, child-care and nutrition programmes, mobile clinics, training of community nurses, and mothercraft programmes.

(d) Human resources development: job-creating projects, projects that train people for employment, management development, e.g., development of cottage industries and handicrafts, marketing cooperatives, training in welding, plumbing, and carpentry.

(e) Social action: projects that introduce change and innovation, e.g., the utilization of mass media and other communications techniques, adult literacy programmes, youth projects, community centres, radio schools, audiovisual literacy programmes.

(f) Community development: overall community development programmes, i.e., projects combining two or more areas of concern for the development of a village or region, e.g. health, nutrition, and mothercraft programmes.
5. Publications on sources of funding


Prepared for the Ford Foundation's Coordinating Committee on Women's Affairs and its international division's Committee on Women's Programmes, this paper reviews US foundations, bilateral aid programmes, multilateral agencies of the United Nations system and selected nongovernmental agencies.


This is a compilation, dating from 1977, of information on the membership, resources, and activities of women's groups all over the world.


Both publications provide information on potential private foundations, government agencies, United Nations agencies, and private voluntary organizations, as well as a brief discussion of proposal writing.


1. Summaries

**Brazil.** The subject of the paper is the means whereby laywomen can be trained to provide certain health services to pre-school children in informal day-care units in poor areas of major cities. It presents an analysis of the effectiveness of traditional forms of child care (e.g., creches and day-care centres) as observed in the City of São Paulo, compared with non-traditional methods being developed in other areas of Brazil and certain other countries of Latin America (e.g., Venezuela). Of particular interest to the author is a project in Brasilia for the training of mothers, who do not engage in outside work, to take care, in their own homes, of the children of mothers who go out to work, as well as their own children. The programme is addressed essentially to economically poor families and constitutes a way of helping women to serve each other and their children at relatively small cost to the government.

**Colombia.** The paper analyses aspects of education that bar women from certain positions in the country's health system. The analysis concentrates on: (a) the social and cultural features of family and community life that influence the education of girls and women; (b) legislation and organization as these pertain to general education and education for professional health work, and the manner in which they affect the education of women; and (c) the employment of women, with particular reference to the legal framework conditioning women's employment generally and the occupational framework in the health sector as it pertains to women. The paper touches on a whole cluster of interrelated factors that condition the situation of women in Colombia and, thus, in the country's formal and non-formal health care systems. Action is proposed in areas ranging from family life education to general education, higher education, education for professional health work, general employment, and employment in the formal health system. Possible types of action include research, promotional activities, legislation, and training. As regards the health sector, particular emphasis is placed on: (a) continuing education/training/orientation

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1 The full papers are available on request from: Health Manpower Systems, Division of Health Manpower Development, World Health Organization, 1211 Geneva 27, Switzerland.
for women; (b) the need for better information regarding the distribution by sex, income, qualifications, etc., of personnel in the formal system, taking into account all categories and levels of personnel; and (c) the need to design, test, and apply indicators for measuring the unpaid work of women in family and community health care.

**Egypt.** The paper reviews the differing systems of rewards for various categories of health care provider (salaried and volunteer, male and female, those providing family planning services) in Egyptian villages. It was undertaken because evidence in some countries suggests that, with an increase in the tangible rewards (particularly financial) attached to a particular type and/or level of health work, there is a tendency for larger numbers of men to take up such work and slowly crowd women out, and that there is a point beyond which the level of rewards acts as a discriminatory factor against women. The paper notes that this does not seem to apply in Egypt, in that the men and women in the villages have relatively well-defined roles, with the domestic scene and "outreach" services constituting a "women's world, where men have no role". Of greater concern to the author is the question whether the reward systems operating at village level constitute "a problem or a solution". Her analysis stresses the need to raise the low income of certain categories of health care provider (regardless of sex) and the need to motivate rural health care providers within the framework of efforts to upgrade services.

**Ethiopia.** The subject of the paper is the integration of family planning and other aspects of primary health care into the work of nursing personnel, village health workers, and other women providing health care. The Government of Ethiopia, the paper notes, considers that raising the status of women is a prerequisite for the correction of the social injustice they suffer and for their integration into the country's development effort. To this end, women are being organized, on a nationwide basis, under the aegis of the national Revolutionary Ethiopian Women's Association. To date, over 18,000 local women's associations have been formed, each with about 200 members. Their main objectives are to fight for the rights of their members and to upgrade their skills through training, notably in the delivery of health care, in particular, primary health care. In her proposals for action, the author emphasizes the need for continuous in-service training oriented to primary health care, including family planning, for nurses and their instructors, health assistants and their instructors, village health workers, community health agents, and traditional birth attendants.

**France.** The paper considers ways and means of making it easier for women health care providers to remain in or re-enter the health labour force. It deals in particular with women physicians in France and is based on three studies, namely: a statistical review of the demographic characteristics of physicians in France in mid-1979; a survey made in 1977 regarding the hours per week worked by physicians in various
types of practice; and an opinion poll carried out in 1980 among a random sample of 3000 female physicians in France (2013 or 67.1% of whom responded to the mailed questionnaire). The analysis shows that in 1979 nearly 26% of women physicians in France were not practising medicine—a rate nearly four times higher than that for male physicians. Child-bearing and child-rearing combined constitute a major reason for the high inactivity rate among women physicians. Responses to the 1980 questionnaire reveal that women in private practice are concerned about not being entitled to paid maternity leave. On the other hand, women in salaried positions, although they have paid maternity leave, indicated that they feel obliged to cut this leave short because their supervisors (usually men) “had an obsession about maternity leave”. The women physicians interviewed had offered a variety of suggestions, including (for salaried physicians) flexible working hours, day-care for children, and tax reduction to compensate for the expense of hiring home-help.

**Hungary.** The paper is about the use of women’s organizations in efforts to develop community health. It provides, first of all, an analysis of major factors (social, cultural, economic) that condition the attitudes of specialists and lay persons in Hungary as regards health and health care. This is followed by a comprehensive analysis of the relationship between the women’s movement and health care in Hungary, covering: (a) the characteristics of the Hungarian women’s movement in terms of organization and functions, including health care activities; (b) general problems regarding the development of community health care, the possible role of the women’s movement in community health development, and the conditions necessary for the women’s movement to play that role effectively; and (c) an evaluation, based on experience, of the role of the women’s movement as regards primary health care. The last part of the paper suggests ways in which the women’s movement can play an active part in such care and help the women who provide it.

A considerable part of the paper is devoted to the role that women’s organizations can and should play in promoting the development of part-time child care facilities catering for the children of mothers who would like to return to work on a part-time basis. Women’s desire for part-time work stems from what the author refers to as the “child care allowance neurosis”, which manifests itself in many ways, including an escape into illness by an increasing number of women who receive allowances for child care. The intricacies of this phenomenon are explored by the author together with its interrelationship with the declining birth rate in Hungary, one of the few countries that have paid a great deal of attention to the provision of maternity and child-care benefits.

**India.** The issue studied was the training and utilization of illiterate and semi-literate women as providers of certain types of health care in villages. As regards India, this issue is particularly important because of
the high rate of illiteracy among women and the important role that women in India (as elsewhere) play as regards family and community health. On average, 75% of Indian women are illiterate. In certain areas, the proportion reaches 95% or more. The papers presented by the participants from India vividly portray the current health situation in the country, pointing out failures in the health system and the reasons for them, notably the failure to involve people in general, and women in particular, in a meaningful way, with the necessary training and support. The papers also show the role of women as members of the family, as members of the community, as community health volunteers or health guides, as traditional birth attendants, and as child-minders. Various programmes for the training and utilization of laywomen are described, the educational requirements for candidates for training varying from one programme to another. Proposals for action include: the expansion and systemization of programmes in health education, adult education, the training of traditional birth attendants and community health volunteers; the development and dissemination of relevant training materials; the training of instructors and supervisors; and the development of a reward system.

**Indonesia.** The subject is that of women’s participation in decision-making at policy-making level as regards health care. A variety of documents were examined and 45 individuals (19 men and 26 women) interviewed, including decision-makers in health services and family planning services, prominent women in the Government, in women’s organizations, in institutions of higher education, and prominent people in medical associations. In the course of the interviews, opinions were sought on such matters as: the appropriate role for women after marriage; appropriate occupations for working women; factors supporting or hindering the role of women as decision-makers; decision-making within the family as regards health care; and decision-making by women in formal health systems. It was noted that, while all respondents readily agreed about having more women participate in the provision of health services, their opinions varied greatly regarding the nature and extent of that participation.

Proposals for action covered a wide range, including: measures to change the image of women; measures to upgrade the skills of women, including managerial skills; measures to lighten the burden of working women (e.g., day-care); the introduction of technology designed to enable women to cope with their domestic responsibilities more efficiently; and the intensification of family-health education programmes. It was suggested that a start be made, as soon as possible, on a survey concerning factors in the family, particularly those relating to mothers (e.g., their level of education) that influence the health of children under the age of five. This would be helpful for designing training programmes for women as health agents in the family. In addition, steps should be taken immediately to develop appropriate
technology for training women as managers and leaders and as health agents in the family.

**Jamaica.** The paper discusses women’s participation in decision-making at policy-making level as regards health care. The findings are based on numerical and other data from a variety of documents and on information provided by individuals in response to a specially designed questionnaire. Data are presented on the work of women as health care providers in a technical and professional capacity. These form the basis for an analysis of the degree of women’s involvement in decision-making not only at the level where policies are determined, but also at that of implementation. Also examined are: (a) the sex composition of the main policy- and decision-making health boards and committees; (b) the two professional organizations in the health field that are composed mainly of women, i.e., the Nurses Association of Jamaica and the Midwives Association of Jamaica, in the context of their influence on policies related to health care delivery and benefits for their members; and (c) the relationship of the Bureau of Women’s Affairs with the above-mentioned professional organizations and with the formal health sector. Action suggested includes the strengthening of the technical and human resources of the Bureau of Women’s Affairs; the development of mechanisms to encourage changes of attitude in both men and women; the development of a register of women working in the health sector, indicating their qualifications and potential for further training and advancement; and the development of training programmes geared to the needs of women at the decision-making levels of health care.

**Mali.** The paper is concerned with the integration of family planning and other aspects of primary health care into the work of nurses, village health workers, and other women health care providers. In her introductory remarks, the author points out that, while “privileged positions” continue to be largely in the hands of men, official policy statements discourage discrimination against women. In view of this and of the fact that the Government of Mali had created a body called the National Commission on the Promotion of Women, the political terrain appears favourable for an intensification of action to ameliorate the situation of women. The National Union of Malian Women, a highly militant body, has spearheaded such action in the areas of maternal and child care and family planning, mobilizing vast numbers of women throughout the country to participate in efforts to help each other and their children to achieve better health. The far from negligible results of these efforts include the development of a considerable number of rural maternity centres, social centres, canteens for schoolchildren, a pilot centre for family planning, and collectives for raising food for home consumption. The paper also gives a detailed description of the training and responsibilities of women health agents employed by the Ministry of Public Health and Social Affairs.
Nigeria. The subject is the use of women’s organizations in efforts to develop community health. The paper is based largely on information gained by the author on the spot concerning a programme on women in health development, promoted by the WHO Regional Office for Africa with the participation of nine countries, including Nigeria. In Nigeria, the author: (a) visited selected communities and lived in them for periods ranging from 10 to 21 days, during which she worked closely with the women’s organization in each, observing its achievements, resources, and problems and inquiring into its relationship with the National Council of Women’s Societies, with government structures, and with other local organizations; (b) held discussions with members of other local organizations and with community leaders; (c) interviewed officials of relevant sectors at local, state, and national level to find out how to achieve the coordination between them and the women’s organization that is needed for the effective implementation of planned projects; (d) interviewed officials of the National Council of Women’s Societies at national and state level to learn about the organization and management of the Council and its place in the overall governmental system; and (e) collected relevant statistics.

The paper discusses, inter alia: the priority problems requiring the involvement of women; what women’s organizations are doing (or can do) to help solve these problems; and the obstacles faced by women’s organizations in their efforts to solve health problems. The author presents a number of proposals for facilitating the work of women’s organizations and making it more effective. Among these are a proposal to establish a statutory body (e.g., an Official Bureau for Women’s Affairs) that would have certain mandatory responsibilities with appropriate authority and resources.

Pakistan. The paper deals with the integration of family planning and primary health care into the work of nursing personnel, village health workers, and other women providers of health care. It provides a detailed description of what the author refers to as the “family welfare approach”—an approach that calls for “exclusive, focal, undiluted attention on women, both as health care providers and as recipients of it”. Presumably, this approach is already in process of being implemented in certain rural and peri-urban areas of Pakistan, although the author does not clearly indicate whether or not this is so. In any case, the approach envisages, as pivotal points, family welfare centres, each staffed by: a female family welfare worker; two family welfare assistants, one female and the other male; and a helper. The centres’ major activities are seen as: the provision of maternal and child care services; the training and supervision of traditional birth attendants; the education of local women in healthier living; and the recruitment and training of community volunteers (20–40 per centre). Each centre is intended to cover 25 000–30 000 inhabitants. The notion of career development for women is implicit in the family welfare approach in
that a woman with little schooling can join a centre as a helper and, with encouragement and support, pursue her formal education or receive additional technical training as a birth attendant and, from there on, move into training for midwifery.

**Philippines.** The subject studied is the use of women’s organizations in community health development. In the Philippines, as in many other countries, there are essentially two types of women’s organizations. The first consists of organizations whose members are from the more privileged classes living in urban areas and whose civic activities are usually (but not in all cases) sporadic and have the flavour of charity. About 70 such organizations, affiliated to the Civic Assembly of the Philippines, are briefly described by the author. The second type consists of groups whose members are generally poor women, mostly from rural areas who get together to help each other and the community generally. In the Philippines, a particular type of organized effort in which women, along with men and young people, participate, is the Balikatan Sa Kaunlaran (BSK), a “shoulder-to-shoulder” movement launched by the National Commission on the Role of Filipino Women to bring the public and private sectors together in common projects aimed at the fuller integration of women in the development of the nation. BSK groups have been organized in a large number of provinces and cities.

A pilot project to test the effectiveness of women’s groups in the delivery of primary health care has been proposed. It is expected to follow the lines of a previous project, which tested the feasibility of integrating family planning into ongoing projects of the BSK.

**Switzerland.** The subject of the paper from Switzerland is the Women’s Dispensary in Geneva. This dispensary is conceived, established, and run by women for women and their children. The author describes: the medical system in Geneva as the context in which the project took form and developed; the history of the women’s health movement in Geneva; the history of the women’s dispensary; the basic principles of the dispensary; and how the dispensary functions. She concludes by presenting an assessment of: the work of the dispensary; the attitudes of the staff; the rights of the staff and users; the impact of the dispensary on other institutions; and its suitability as a model.

**Thailand.** The paper, which deals with the promotion of women’s efficiency and effectiveness as health care providers, contains a great deal of information on the role of Thai women in the home and society generally and on the country’s health problems. Among the proposals made is one calling for the establishment of a national committee consisting of representatives from various Government ministries and from several nongovernmental organizations that have been (or are very likely to be) interested in improving the status of women and their role in Thai society. The committee would be responsible for: planning and
organizing projects; obtaining funds and other assistance for their implementation; considering requests for assistance from other nongovernmental organizations; and coordinating projects. Periodically, seminars would be conducted, in different regions, for policymakers in both governmental and nongovernmental bodies, in order to keep them informed of the situation of women. In addition, seminars and meetings among women at all levels would be arranged with a view to helping them realize the value of their actual and potential contribution to health development. The proposals also call for the coordination of existing women's groups and support for them in their efforts to improve their own health and that of their families and communities. Nongovernmental organizations, such as the Nurses Association, the Home Economics Association, the Girl Guides Association, and the Medical Women’s Association should be urged to take the lead in providing education and training for other groups of women.

**USSR.** The subject studied is that of women as decision-makers in the health system of the USSR. The author points out that, while women constitute between 69% and 80% of the health workers in the organized health system, only 25% of the decision-making positions in the system are held by women. (This percentage presumably refers to decision-making at the policy level, since, at the technical/operational level of the USSR’s health service there are a vast number of female decision-makers.) The author proposes the following measures to help increase the proportion of women in high-level managerial posts:

(a) modify the existing curricula at the Central Institute of Advanced Medical Studies in order to render them more suitable to the needs of women physicians, and undertake a study of the social and professional characteristics of the ‘target group’, i.e., the women holding the above-mentioned 25% of decision-making positions;

(b) test the modified curricula and follow up the work performance of the target group;

(c) develop advanced management training programmes for all women doctors.

**Zimbabwe.** The paper examines the relationship between the sex distribution of health care providers in the local health centres of Zimbabwe and the rates at which such centres are utilized by men and women respectively. It is based on a sample study of providers and recipients of health care in the capital city of Harare. Visits were paid to five local health centres, where interviews were conducted with 65 persons awaiting treatment (36 females and 29 males) and with the staff of the centres, i.e., 4 physicians (all male), an unspecified number of female medical assistants, 12 male medical assistants, and 14 nursing sisters.
The interviews aimed at eliciting responses that would show which type of health care provider (female or male) patients preferred to deal with as regards each of the following areas: family planning and gynaecology; sexually transmitted diseases; sanitation; malnutrition; minor illnesses; and serious illnesses including those requiring surgery.

The findings of the study suggest that:

(a) the provision of family planning advice and contraceptives should be largely the task of female staff, although a longer-term view suggests the need for male educators to arouse the interest of men in family planning;

(b) there is an obvious need for female gynaecologists;

(c) existing services with respect to sexually transmitted diseases are totally insensitive to the feelings of patients, there should be separate facilities for the treatment of male and female patients, and confidentiality should be ensured;

(d) many more women should be trained as surgeons.

2. Action taken

In several of the above-mentioned countries, appropriate action has already been started as follows.

In Colombia, the emphasis is on a series of workshops to prepare female health workers for positions of leadership in the formal health system. One objective is to help ensure that women's views regarding health and national health development are reflected, by women themselves, in bodies concerned with policy-making and planning in the areas of health care, education, and research. The workshops, which form a part of the extension programme of the National University of Colombia, are coordinated by the university's Faculty of Nursing.

In Indonesia, as a preliminary to developing a plan of action to improve the situation of women as health care providers, steps have been taken to assess various studies carried out in the country concerning women's role in development, particularly health development.

In Jamaica, a manual has been produced which can serve both as a tool for training health aides and as a handbook for use by such aides and others, e.g., teachers in general education programmes, mothers' groups, or women's organizations. In addition, efforts are being made to
improve the health-related aspects of child-minding in a number of nurseries, the emphasis being on the immunization of children, the assessment of their nutritional status, and the identification and management of health hazards.

In Thailand, a national seminar on the promotion of women's efficiency and effectiveness as health care providers (December 1983) produced a general plan of action envisaging: (a) the production and/or duplication of handbooks, slides, posters, etc., for trainees and housewives, on such subjects as nutrition, environmental sanitation, first aid and basic nursing care, family planning, child care, and personal hygiene; (b) a public relations campaign on the project; (c) the training of instructors; (d) a meeting in each of the five regions of Thailand, to discuss the distribution of responsibilities under the plan; (e) meetings of community leaders in each of six provinces; and (f) the training of target groups of women (e.g., housewives, women workers, young countrywomen, and female students).
Annex 3

WHO CONSULTATIONS ON WOMEN AS PROVIDERS OF HEALTH CARE

First Consultation

Geneva, 17–19 December 1980

Participants:

Dr M. Bekele, Social Development Planner, Ethiopian Planning Commission, Genolier, Switzerland (Rapporteur)
Dr M. R. Chalermslook Boonthai, Director of Health Statistics Division, Ministry of Public Health, Bangkok, Thailand
Dr B. Coyaji, Director, King Edward Memorial Hospital and Rural Health Projects, Pune, India (Chairperson)
Dr N. G. Alarcon, Assistant Director, Colombian Institute for the Encouragement of Higher Education, Bogotá, Colombia
Dr T. A. Gomez, Director, National Nutrition Service, Ministry of Health, Manila, Philippines
Ms P. Lawes, Parliamentary Secretary in Charge of Women's Affairs, Ministry of Youth and Community Development, Kingston, Jamaica
Ms A. Raikes, Health Researcher and Short-term Consultant, Danish International Development Agency, Copenhagen, Denmark
Dr E. R. Rosenberg, Department of Economics, University of São Paulo, São Paulo, Brazil
Ms T. Sumbung, Chairman, Education Team for Family Planning and Population Programme, Women's Committee, Jakarta, Indonesia
Dr I. Tinker, Director, Equity Policy Center, Washington, DC, USA (Rapporteur)

1 Unable to attend: Dr N. S. Kislijak, Vice-Minister of Public Health, RSFSR, Moscow, USSR; Dr A. El Said, Dar El Helal Journal, Cairo, Egypt; Professor M. Sokolowska, Head, Department of Medical Sociology, Polish Academy of Sciences, Warsaw, Poland; Dr R. Taufa, Assistant Secretary, Family Planning Section, Department of Health, Konedobu, Papua New Guinea; Dr M. Were, University of Nairobi Medical School, Nairobi, Kenya.
Representatives of other organizations

*International Labour Organisation*
Ms C. Cornwell, Salaried Employees and Professional Workers Branch, ILO, Geneva, Switzerland

*United Nations Fund for Population Activities*
Mr B. Muntasser, Liaison Officer UNFPA, c/o UNDP, Geneva, Switzerland

*United Nations Children’s Fund*
Ms D. Phillips, External Relations Division, UNICEF, Geneva, Switzerland

**Secretariat**

Dr Bui Dang Ha Doan, Director, Centre of Medical Sociology and Demography, Paris, France (*Temporary adviser*)
Ms D. Gibson, Audiovisual Communication, Division of Public Information, WHO, Geneva, Switzerland
Dr K. Giri, Family Health, WHO Regional Office for South-East Asia, New Delhi, India
Ms V. Hammer, Division of Family Health, WHO, Geneva, Switzerland
Dr I. Kickbusch, Consultant, WHO Regional Office for Europe, Copenhagen, Denmark
Dr B. Lockett, Human Resources and Research, WHO Regional Office for the Americas, Washington, DC, USA
Dr A. Mangay Maglacas, Chief Nursing Officer, Division of Health Manpower Development, WHO, Geneva, Switzerland
Dr J. Mather, Director, Affiliated Education Programs Service, Office of Academic Affairs, Department of Medicine and Surgery, Veterans Administration, Washington, DC, USA (*Temporary adviser*)
Dr A. Mejia, Chief Medical Officer, Health Manpower Systems, Division of Health Manpower Development, WHO, Geneva, Switzerland (*Secretary*)
Ms G. Nnenna Nzeribe, Consultant, WHO Regional Office for Africa, Brazzaville, Congo
Ms Z. Patey, Health Manpower Systems, Division of Health Manpower Development, WHO, Geneva, Switzerland
Ms H. Pizurki, Consultant, Health Manpower Systems, Division of Health Manpower Development, WHO, Geneva, Switzerland

**Observer**

Ms J. Van Hussen, Coordinator of International Women’s Affairs, Ministry of Foreign Affairs, The Hague, Netherlands.
Women as providers of health care

Second Consultation
Geneva, 16–20 August 1982

Participants

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