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WOMEN, HEALTH AND DEVELOPMENT

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1. INTRODUCTION AND BACKGROUND

A World Conference was held at Mexico City in 1975 to mark International Women's Year. It adopted the World Plan of Action for the United Nations Decade for Women: Equality, Development and Peace. The Conference also recommended the holding of another international women's conference in the middle of the Decade. Accordingly, the World Conference of the UN Decade for Women: Equality, Development and Peace was held at Copenhagen in 1980 and it adopted a specific, action-oriented programme for the second half of the Decade (1980-1985) with specific emphasis on the areas of employment, health and education.

The World Health Organization is among the several UN organizations that are actively involved in promoting the cause for the equality of women. The World Health Assembly has given the highest priority to the commitment to achieve the goal of health for all by the year 2000. The strategy to be adopted is explicitly based on the principles of social justice, with emphasis on the primary health care approach. While many World Health Assembly resolutions have specific reference to women, three resolutions are particularly relevant in the context of the UN Decade for Women. These are:

WHA 28.40, which urges WHO's active involvement in the UN Decade for Women and increased actions by governments and the Director-General to ensure the full integration of women in all facets of the health programme.

WHA 29.43, which further endorses and encourages actions for improving women's health status and their participation at all levels of the health sector; and requests the Director-General to collaborate in activities related to the UN Decade for Women.

WHA 36.21, which urges the Director-General to contribute actively to the World Conference to review and appraise the achievements of the UN Decade for Women (to be held in 1985).

At the global level, women, health and development (WHD) activities aim at integrating women's issues into the total programme as part of HFA strategies. At the regional level, most Member States of the South-East Asia Region had initiated WHD activities much before the UN Conference in Mexico. However, the International Year and the follow-up Conference have helped to further sharpen the focus and intensify ongoing efforts.

The commitment of WHO has been further strengthened by the setting up of a WHD core group and an advisory group at the Regional Office in 1979 to translate the objectives of WHD into a plan of action including priority needs and problems, to outline innovative strategies and to strengthen specific existing WHD activities. WHD focal points at the country level were also established to identify needs and related programmes.

In December 1980, the South-East Asia Regional Office convened an inter-country meeting with the country representatives acting as foci in order to review various ongoing WHD programmes and formulate appropriate strategies to strengthen collaborative programmes at the country level. Several recommendations were made that urged WHO to review the current health status of women in the countries of South-East Asia, determine their health problems and needs, and formulate and promote specific activities as

well as to modify, where necessary, existing programmes in order to improve the health status and enhance the role of women.

Based on the recommendations of the above meeting, a regional programme on WHD for the South-East Asia Region was developed for the period 1982-1985 with the long-range objective of elevating women's status and role as providers, promoters as well as recipients of health care in order to achieve an optimum level of health and socio-economic development. This regional programme is not vertical but integrated in all existing WHO programmes, providing a sharper focus on women as providers and recipients of health care.

A follow-up meeting was held in November 1982 to review progress and to promote future development of WHD activities in the countries. The major recommendations of the meeting were: (1) WHO should play a leading role in the promotion of women's participation in all aspects of primary health care, (2) countries should increase the number of women in decision-making positions in the health sector, and (3) further coordination mechanisms should be developed in the countries among non-governmental organizations and between them and the governments.

2. STATUS OF WOMEN IN HEALTH AND DEVELOPMENT

It can be said that diversity is a constant variable in the Region. However, there are some features that influence the socio-economic and health status of women in most countries of the Region:

- The majority of women live in rural areas;

- The distances between home and modern health facilities in the countries of South-East Asia are relatively large and this affects the utilization of health service facilities by women;

- The Region is characterized by highly sex-segregated societies, which manifest cultural preferences for the male child and dominance of the male members of the family;

- In many countries, people's preference for indigenous and traditional medicine sometimes results in delays in providing modern health care even in critical situations, and

- The low level of general education and the high rate of illiteracy among women generally result in their poor understanding of health problems and needs, which in turn inhibits the work towards the improvement of their health status.

The profile of the health status of women in the South-East Asia Region is as follows:

- The female:male ratio in the Region was approximately equal, with a noteworthy decline registered in India from a ratio of 972:1000 in 1961 to 933:1000 in 1981[1]. Only in Thailand do females exceed males because of their longer life expectancy.

[1] Country report on "Women, Health and Development", India, 1984.

- Infant mortality rates, life expectancy at birth, mortality and morbidity in the reproductive age group were generally found to be significantly higher among females than males.

- Maternal mortality rates differ widely in the countries of the Region. In Indonesia, Mongolia, Sri Lanka and Thailand, the rates are close to 1 per 1 000 live births, while in Burma they range from .5 to 4.6 and in Maldives the rate is 6 per 1 000. In Bangladesh, the rate is 30 per 1 000 live births. In India, the rate ranges between 0.4 to 13.4 in different States[1].

3. ISSUES

The basic issue, of course, is to determine what action is required to achieve equity between the sexes in the society but other sub-issues relating to women's health and development have been identified on the basis of an analysis of country reports. These reports exemplify the need to develop programmes, strategies and approaches on a long-term basis in order to achieve a measurable impact on the role of women in health and development. Information obtained would help stimulate discussion and assist in the further development of WHD activities in Member Countries of South-East Asia beyond the end of the UN Decade for Women.

3.1 Women as Consumers of Health Care

All Member States have developed a health system oriented and structured in line with the primary health care approach. Such health care consists of a combination of promotive, preventive, curative and rehabilitative measures. Women should share equitably in the benefits of primary health care. Maternal and child health, nutrition and family planning form the broad base of health and related activities for women in all the Member Countries. However, there are many important areas where problems remain. The situation of women in rural areas remains a major concern. Such women are overburdened with the responsibilities of collecting fuel and water, domestic functions, and the need to work along with men in agricultural production and take care of children. Their living accommodation is generally unhygienic. The promotion of the health status of women would not be realistic unless their workload is reduced.

Two components alone would alleviate the workload of women: making water supply readily available would reduce the burden of carrying heavy loads over long distances and would promote a healthier life-style; and the control of communicable diseases would lower the incidence of children's illness.

All WHD activities in existing and future national and international health programmes should thus incorporate the particular needs and requirements of women into their current activities. This would encourage the integration of women in health and development into general health promotion. Financial resources should be allocated for this purpose.

According to data available, the life expectancy of women is generally longer than that of men. But the mortality rate for women

[1]Bulletin of Regional Health Information, 1982, WHO SEARO pp. 24-25.

continues to be high. The major problems affecting pregnant and lactating women are anaemia and malnutrition. These conditions arise from chronic malnourishment, and are aggravated by lack of knowledge on health and nutrition and of money and time to care for themselves properly or seek health care when needed.

The maternal and child health programme should be comprehensive and delivered as a total package including well-baby care. Since a large majority of women still give birth with the help of traditional birth attendants (TBAs), mechanisms should be developed to integrate the functions of TBAs into the health care system.

Women, as consumers of health care, need to be provided with appropriate knowledge. The important role that women play in self-care has not been fully developed. Women need information, such as how to recognize and care for the common symptoms of colds, fever, diarrhoea, and where to go for assistance when it is required.

Health education programmes seeking to help women should engage in a broad spectrum of activities. They should develop a collection of learning packages designed to provide functional literacy, educate women on how to protect their own health and their crucial role in health and development, as well as impart training in selected aspects of maternal and child health. All health workers have a responsibility to share health information with consumers.

Issues

(a) What steps should be taken to ensure that adequate resources are provided to implement appropriate WHD activities in all health programmes?

(b) What further action is required to provide a comprehensive maternal and child health package to women and children?

(c) What group of ailments or health needs can be specially identified as those particularly common to women?

(d) What efforts must be made in order to implement health education programmes that promote the involvement of women in self-reliant, self-care activities?

3.2 Women as Providers of Health Services

The role of women in health and development is unquestionable. Their contributions are recognized in both formal and informal health systems. The available data on health professions show that women tend to constitute the lower and middle-levels of health workers. For example, in India, 72.7 per cent of paramedical workers are women while only 25 per cent of medical doctors are women[1].

This situation is found in many of the Member Countries of the South-East Asian Region. There is also evidence that women's participation

[1] Country report on "Women, Health and Development", India, 1984.

in leadership positions in health care systems is relatively insignificant. Thus, support should be provided for activities designed to promote the involvement of women in the planning and development of national health manpower. Equal access should be given to employment opportunities, and to education and training facilities. The lack of opportunities for women to receive management training has also been documented.

In informal health systems, women play varied roles: they are health care providers to their children, families, neighbours,and to the community. In addition to being the first person to be looked to for physical assistance, women also provide emotional and spiritual support. As mothers women have a great influence within a social structure. This influence should be exploited for the benefit of improving the health status of the community.

Issues

(a) What specific policies and mechanisms are required to facilitate a greater participation by women in decision-making/leadership positions at all levels of the health care system?

(b) Is it possible and desirable to identify or delineate certain categories of professionals or para-professionals best suited for women as providers of health care?

(c) How can the role of women in providing informal health care be enhanced?

3.3 Support Services for Women

All Member States have legislation, rules and regulations providing for maternity leave for working mothers varying from 30 to 90 days, but many still need to establish such facilities as day-care centres and health services at the workplace. In addition, health services should be flexible enough to respond to the needs of working women. Working hours should be such that women and children do not have to forego health care because of scheduling conflicts. Only a few countries have specific rules and regulations for protecting the health of women workers, and these generally cover those working in mining, underground work, construction work and other hazardous occupations. It has been calculated that 33.8 per cent of the official labour force consists of women and that these contribute nearly 66.6 per cent of the total working hours. However, women receive only 10 per cent of the world income and own less than one per cent of the world property[1]. These factors provide a strong motive for the mobilization of women for the improvement of their situation, which can come only through social changes.

The development and provision of appropriate support services for women are the responsibility of the countries; consequently, there must be clear national policies to integrate women in health development. This concept should also be reflected in the socio-economic development policy. Most Member Countries of the South-East Asian Region have established a special office or national committee to act as an advocate for women's development. While these efforts are laudable, unless the health and other sectors accept women's goals and provide financial support, the implementation of the programme will be slow.

[1]H. Sipila: The Status of the World's Women, 1979.

Issues

(a) What further measures should be enacted to protect women in hazardous occupations?

(b) What further steps should be taken in a given country to ensure that continuity and adequate support are provided to the special office or national committee dealing with women, health and development?

3.4 Women's Non-Governmental Organizations

In most Member Countries of the South-East Asia Region, there has been an appreciable increase in the number of women's organizations. Several activities are undertaken by non-governmental organizations in supporting the achievement of Health For All goals, including health education campaigns, training programmes related to health, sanitation and nutrition, particularly for women in rural or isolated areas. The major constraints faced by these organizations are (1) the lack of any linkage with the formal health structure, (2) the lack of understanding and support from health workers, (3) limited financial resources, and (4) the lack of appropriate technical inputs.

Issue

What are the roles and functions of these organizations in relation to the health care delivery system? How can these organizations be actively utilized in support of the development of national health services.

4. CONCLUSION

In reviewing the reports on women, health and development provided by Member Countries of the South-East Asia Region, it is clear that WHD activities have progressed and that considerable changes have been made. However, a great deal still remains to be done. The improvement of women's knowledge and skills in the field of health is essential so that they can contribute to maintaining their own health and that of their families and communities. A high rate of illiteracy among women is found in villages and it is toward this group that special education programmes need to be directed. Policies and regulations should be reviewed and revised to ensure that women participate actively in policy and decision-making in the health development system.

WHD activities should be further strengthened in all existing WHO programmes with adequate budgetary and other resources provided to ensure implementation of the activities. Coordinating mechanisms between non-governmental organizations and government and other inter-sectoral organizations should be enhanced. In view of the need to develop a long-term plan in consonance with strategies for "health for all by the year 2000", WHD activities should continue beyond the end of the UN Decade for Women. All future efforts should be directed towards attaining positive benefits for women to offset past disadvantages.