Women's Health

Fourth World Conference on Women
Beijing, China
4 – 15 September 1995

World Health Organization
Geneva, 1995
Acknowledgements

This document is based on contributions from WHO Regional Offices, WHO Headquarters, and experts in the field of women’s health and development around the world. WHO would like to thank the numerous colleagues who contributed to, and critically reviewed, the document at different stages.

WHO wishes to express its gratitude for the generous contribution of the Carnegie Corporation which made the development of this document possible.

General Editor: Dr A J Waddell, B.Sc., Ph.D.
Design: Threefold Design, Oxfordshire, UK.
Printer: Lynx Offset Limited, Oxfordshire, UK.
This document has been printed on 5-star ecofriendly paper which is totally chlorine-free.
Photo credits: see page 62.

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Preface

We are not asking for privileges for women. All we are saying is that equitable care is not identical care, particularly where physiological differences obviously call for specialized health services.

Sustainable progress will be achieved when women are finally empowered to make free, informed and responsible choices, and assert themselves as leaders in their own right within their societies.

Women's health is the surest road to health for all.

Dr Hiroshi Nakajima
Director-General of the World Health Organization

The 1995 Fourth World Conference on Women provides us with an opportunity to draw attention to the challenges now facing the health community as it strives towards promoting – and ensuring – the health of women everywhere. In many ways we have come a long way since the beginning of the United Nations Decade for Women (1976–85). And yet we find ourselves faced with the same obstacles to progress recognized then. Poverty, inequitable relationships between women and men, women's unequal access to health care and education, and social and cultural factors that discriminate against girls and women still prevent the attaining – and maintaining – of health for millions of women around the world.

Part I of this paper – Women's health – outlines the reasons why promoting and ensuring women's health is so important.

Part II – The social and cultural agenda – deals with a range of economic, social and cultural factors that threaten women's health, and shows how far we have yet to go in achieving health for women throughout the world.

Part III – What are the major issues in women's health? – moves on to consider some major health problems and issues which particularly – and in many cases exclusively – affect women.

In Part IV – How is WHO involved? – WHO provides a vision of its role in promoting and ensuring the health of women, and presents a summary of how the programmes being implemented by WHO are contributing towards closing the gap between rhetoric and reality in women's health.
Introduction

People generally accept the level of health and well-being that their society defines as appropriate for them. This has implications for women, who often consider themselves “healthy” as long as they can fulfil the roles expected of them. Millions of women around the globe, suffering from malnutrition, anaemia, extreme fatigue, chronic pelvic inflammations, and much more, will describe themselves as being “in good health” as long as they can get up in the morning, do a day’s work, and cope with household chores and family obligations.

Historically, women’s health has been largely defined by family and community interpretations of culture and tradition, and by a medical profession in which men are the main decision-makers. In addition, the resources required to achieve and maintain health have for too long been denied to individual women. The definition of health applied to a woman – and the resources allocated for this – have been influenced by social perceptions of women’s status and role, which in turn interact with class, caste, race and ethnicity.

Many women accept ill-health as their lot in life, often ignoring painful and debilitating symptoms because in their culture a woman is expected to endure without complaint; or because taboos and myths have led them to believe that their health problems stem from some sort of reproachable behaviour on their part; or simply because they have no alternative.

Such views are by no means universal, however. Women and women’s groups in all parts of the world, increasingly supported by men, are formulating their own interpretations of what health means in the context of their own lives. For many women it means not only physical well-being, but also exercising more control over their lives and relationships, and having the information and resources to take responsibility for their own health and that of their family – in short, it means having choices. When women themselves are asked about health what they have to say comes as a challenge to health system planners. The needs women express at first may seem only indirectly related to health – see Box 1.

Box 1: Women speak out on health

“What we need most for our health,” said a group of women in a village not far from Bangalore, “is a rabbit-raising project. We could sell the meat and pelts and have a few rupees to spend the way we want – for food, or a daughter’s school fees”. In a Nepalese village, the women had another idea: “What we really need for our health is a bridge across that gorge. It would cut two hours off the trip for firewood.”

With a nudge from women themselves, many societies are getting better at listening to women and looking at the world through women’s eyes, to paraphrase the theme of the 1995 NGO Forum on Women. This is a healthy addition to the long-prevailing predominantly male viewpoint, which has often been accepted as applying to all. To look at the world through the eyes of women is to bring hidden issues into the open. It suggests different priorities and alternative solutions.

But if they say they want resources of their own to use as they wish, or if they want a better work environment then they are in fact defining health in their own terms, and explaining what is important to their physical, mental and social well-being.

When WHO adopted the goal of Health for All by the year 2000, it again underscored its commitment to working for the health and well-being of all people, especially those most in need and in danger of being marginalized. We need to reaffirm that human rights and the goal of Health for All apply equally to women.

For many years it was assumed that the differences between men’s and women’s health must flow from the biological differences between women and men. Consequently, attention was focused on this aspect of women’s health, namely pregnancy, childbirth and women’s role as mothers. Other major differences
in the lives of men and women received little attention from the health sector.

In fact, women have health needs above and beyond those related to pregnancy and motherhood. Their health problems take different forms at different stages of their lives, and in different parts of the world. In some areas, women may die because they do not have access to services, or because services cannot provide the basic skills, technology and equipment they need, while in other areas they may suffer from over-medicalization and inappropriate use of sophisticated technologies. In both cases the needs and well-being of the women concerned are not being given adequate consideration.

Although the problems are different, many of the dynamics that lead to inequities in health for women are much the same everywhere. These are derived from the generally low status of women legally, economically and socially; from the imbalance of power in relationships which limits women’s choices and ability to protect their own health; and from the world’s indifference to the abuse and neglect of women.

Progress in some areas of women’s health has been mixed with setbacks in others. There have been three very positive developments with regard to women’s health since the Nairobi conference on women in 1985:

- a return to the emphasis on health as a human right, and renewed interest in the broad definition of health
- increasing use of gender analysis in health issues
- intensified activism on women’s health, to the point that one now finds groups of people everywhere, men and women, advocating and working for the fundamental changes in society that will lead to better health for women.

Two overall developments in the past decade have however had a significant and adverse impact on women’s health:

- First, the late 1980s and early 1990s brought severe economic difficulties and painful economic transitions in several areas of the world. In many countries, the already meagre health and social service budgets, including those allocated for women’s needs, were slashed. As a consequence, the quality and accessibility of services deteriorated even further.

- Secondly, the past decade has been marked in many places by violence, ethnic conflict, civil wars and uprisings. This has further disrupted health and social service systems, and the violence has often been directed at civilians, especially women. The extent of this large-scale public violence – and the domestic violence that many women experience in their daily lives – is only now becoming apparent. Violence is one of the major health concerns for women today.

The primary health care approach (PHC) – with its emphasis on community participation – enabled many women to take part in discussions of local health issues for the first time. The United Nations Decade for Women (1976–85) spurred an increase in local women’s groups, including those addressing health issues. These groups have grown in number and size, become more organized, and are now in touch with one another through various national and international networks. Today the women’s health movement, in all its diversity from the grassroots level to international gatherings, has a significant influence on policies and programmes affecting health and development.

In any review of women’s health, the spread of the HIV/AIDS pandemic must also be taken into account. The pandemic has had a truly disastrous effect on the lives of both men and women. However, it has made possible a far more public discussion of topics that have previously been difficult to address in a frank and open manner: for example, sexuality, human rights issues related to sexual and reproductive health, and the inequality between women and men in relationships. The rapid spread of HIV infection has forced the world to look more carefully at the differences in men’s and women’s experience with health and illness, and to look at the many different factors limiting women’s ability to protect themselves from ill-health. HIV/AIDS provides many insights into the ways in which gender issues can interact with biological factors to the detriment of women’s health.

Women’s health is a fundamental human right, and must clearly be promoted as such. The health of women is moreover a crucial determinant of social and economic development – a point that the World Health Organization continuously emphasizes.
Women are the cornerstones of the family and assume responsibility for many of its most vital functions, not only in regard to health and education, but also in food production and income generation. Therefore, the health of women is a prerequisite for the health of the whole family and, by extension, of communities and societies.

Human development, indeed human survival, would be impossible without the contributions that women make, often at the expense of their own health. Women and men both could make additional contributions to human development if they were to enjoy full health. Women are more likely to develop diseases that women are more likely to develop; diseases that are more likely to develop in communities and societies, and communities and societies that are more likely to develop.

Investing in programmes that benefit women is one of the most effective ways to improve the health of women and their children, improving their income-generating abilities. There is a synergy in these investments: they not only benefit women's personal health and well-being, but also contribute to the development of families, communities, and societies.

Women – when provided with a supportive and enabling environment – can improve their own health and that of their families and communities, often in the face of many hardships and constraints. The time is long overdue for an acceleration of action on policies and programmes that are truly supportive of women in this endeavour.

Why women’s health?

1. Women’s health matters – to women themselves, to their children and families, to their communities, and to society as a whole. The pervasive neglect of women, their inferior social, economic and cultural status, their exclusion from so many aspects of human development – education, access to resources, political power – and their specific biological needs and functions, have historically meant that women could not take good health as a given. For many women in large parts of the world, life is conditioned by poor health and inadequate access to the benefits health care can bring.

2. In addition to the adverse effects on women themselves, women’s ill-health has a broader societal impact: on children and families – malnutrition and ill-health in mothers can initiate a cycle of ill-health in the next generation, as many of these women will bear low-birthweight babies whose future growth and development will be jeopardized from the start. In addition, the nutrition and well-being of babies and young children is to a large extent the result of their mother’s health, nutrition and education.

3. Collecting information on women’s health permits a better understanding of their needs and concerns. It is not enough, however, to simply collect data – women’s health problems need to be analyzed from the perspective of women because they suffer from diseases and social ills that affect women differently. They have unique patterns of disease, their health is more serious in women than among some groups of men, they have different risk factors or different exposure to risk factors, and they require different interventions for women.
In many cases women's ill-health leads to disability, and even to premature death which in the prime of life is a tragedy in itself, and can have a catastrophic effect on the health and well-being of surviving family members. This disintegration of the family is compounded even further by the reduction (or loss) of the extended family networks which in the past were able to care for and support the very young and the old.

During the last few decades there has been an evolution in programmes addressing women and health, due in large part to a significant shift which is occurring in the way women are viewed:

**Women as childbearers** – initially, women were viewed primarily as beneficiaries in need of specific services for themselves and their babies during pregnancy and childbirth. Maternal and child health clinics have been the most common means for delivering pre and postnatal care, and preventive and curative health care for children. Another area of attention was family planning primarily as a means of reducing fertility and thereby slowing population growth. In both cases, women's health tended to be seen as a means to an end rather than an objective in itself.

**Women as mothers and care givers** – women have been seen as guardians of family health and health-care givers, with the emphasis on primary health care. As mothers and community health workers, women are recognized as a target group who, given the right information and support, can do much to improve family and community health. This perspective puts the emphasis on women as people in need of information, training and support so that they can contribute to the health of others.

**Women as individuals with multiple roles, needs and potential** – this more holistic, gender-oriented approach looks at women in all their roles and relationships, across the life span, in all the contexts that may affect their health. It helps identify the social and cultural determinants of health, notably relations between the sexes. This type of analysis has already provided new insights as to why good health eludes so many women. However, there is much still to be done, both to learn more and to translate the knowledge into programmes and action that will make a difference in the lives of women.

Women's role as mothers and care givers who deserve to be listened to and given information and support is important. But this information-giving needs to take into account women's own knowledge, and the constraints they face, such as limited time. It must be combined with action on a broader front – action to raise the status of women in general.

Often women are held responsible for the health and nutritional well-being of their children and blamed for family ill-health, even when they have no control over the family resources that may be required for good health. Women can be well-informed, know how to care for minor illnesses, and recognize the signs of serious illness, but still not have the autonomy to decide when to go for treatment for themselves or for a child. If such a decision must await the return of the husband or a decision of elders, it may be too late. Thus in some situations health information alone is not enough if nothing is done to change decision-making patterns in families.

Improving women's access to information in general, raising their educational level and ensuring literacy is an important process in its own right. It is also an effective way of reducing infant mortality and improving family health. Research suggests that this happens not just because women have acquired specific knowledge about health, but because women with even a few years of schooling have more self-confidence, they are better able to assume responsibility, they tend to communicate more with their husbands, and they may have a higher status in the family, giving them more say in health decisions.

Women's health is a societal issue. Improving women's health and well-being improves not only their own lives but also those of their children, and contributes to improved household and community welfare. As food producers and processors they play a key role in determining the nutritional status of family members. They are educators and carers of their children, carers and health providers in the household and the community, and income earners. In short they have multiple roles and double or triple work shifts; in the formal and informal workforce as well as in a variety of household tasks. By investing in women's health and nutrition, unnecessary suffering and premature death can be prevented among women, and among those who depend upon...
them – for no other reason than this, investing in women’s health should be a priority in its own right.

There is another overwhelming reason why women’s health must become a priority issue for the world community. There has been increasing awareness – and documentation – of the roles that women play in social and economic development. Yet in spite of growing recognition that women are a primary resource in any society, and that their health and socioeconomic well-being is a prerequisite of sustainable development, progress has remained slow and a wide range of health indicators show millions of women suffering unnecessary and preventable deaths, injuries and disabilities – not surprisingly, poor women are particularly disadvantaged.

Recently, WHO in collaboration with the World Bank documented the importance of investing in health, and identified interventions to promote women’s health as being among the most cost-effective. Investments in women give high returns and contribute significantly to poverty reduction. By improving women’s health, governments can therefore make essential contributions to economic and social development.

Although infant and child mortality are most often used as proxy indicators for social development, maternal mortality is in fact the indicator that shows the widest discrepancy between developed and developing countries (Fig. 1). Of the 500 000 maternal deaths that occur every year, 99% occur in developing countries and most of these are preventable through interventions within primary health care.

**Figure 1: Maternal deaths per 100 000 live births by region (1988)**

<table>
<thead>
<tr>
<th>Region</th>
<th>Deaths per 100 000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>300</td>
</tr>
<tr>
<td>Asia</td>
<td>200</td>
</tr>
<tr>
<td>Latin America</td>
<td>120</td>
</tr>
<tr>
<td>Northern America</td>
<td>100</td>
</tr>
<tr>
<td>Pacific</td>
<td>150</td>
</tr>
<tr>
<td>USSR</td>
<td>45</td>
</tr>
</tbody>
</table>

*Existing Australia, Japan, New Zealand WHO/MSM database, early 1990s

Box 2: Spotlight on gender

WHO, in applying a gender approach to health, moves beyond describing women and women’s health in isolation, but rather brings into the analysis differences between women and men. It examines how these differences determine differential exposure to risk, access to the benefits of technology and health care, rights and responsibilities, and control over their lives. In practice, a gender approach leads to:

- More consideration of all the factors that affect women’s health, not only biological factors, but social and economic status, cultural, environmental, familial, occupational and political factors.
- More attention to all of women’s roles, not only as wives and mothers.
- More attention to the roles and responsibilities of men, and the inequalities between men and women, with an examination of men’s roles, perspectives and beliefs in relation to women’s health concerns.
- More involvement of men in bringing about change.
- Listening to what women have to say about health and what they would like to know about it, rather than simply transferring information to women.
- Stronger measures to ensure that the voices of women are heard in identifying health issues and in researching, planning, carrying out, and monitoring the responses to them.
- More attention to the entire duration of a woman’s life, from birth to death – health for everyone is a cumulative matter.
- Greater recognition and support of women as active participants in the development of health care for themselves, their families and communities.

Alongside the political, social and economic changes of the late 20th century there have been significant developments in women’s own understanding of their health and the way it is affected by factors beyond the health sphere. Increasingly women are demanding that their own perspectives be taken into account in evaluating their health, assessing their needs and developing responses to those needs.

Due largely to action on the part of women themselves, the decade since the previous world conference on women held in Nairobi in 1985 has brought an increased public awareness of women’s health issues. Perhaps even more important is the widening of perspective from looking at women and health in isolation to a wider appreciation of “gender issues” – see Box 2. In the health sector such widening of
perspective has contributed to an improved understanding of the many interactions between women's health and socioeconomic development. It has also helped to reveal the diversity of needs amongst women, and the constraints that they face in addressing them.

The word "gender" is used to describe those characteristics of men and women which are socially constructed, in contrast to those which are biologically determined.

People are born female or male, but learn to be girls and boys who grow into women and men. They are taught what the appropriate behaviour and attitudes, roles and activities are for them, and how they should relate to other people. This learned behaviour is what makes up gender identity and determines gender roles.4

16. Gender is a dynamic concept which looks at the system formed by the interrelations between men and women. These vary from one culture to another, and from one social group to another within a culture. But in practically all cultures the role of women is subordinate to that of men. The gender approach highlights the need for more equal relationships between men and women in all matters, in order to fully address women's health problems.

17. The empowerment of women is a fundamental prerequisite for their health. This means promoting increased access for women to resources, education and employment and the protection and promotion of their human rights and fundamental freedoms so that they are enabled to make choices free from coercion or discrimination. Women will necessarily remain at the focus of health activities, but efforts should be increased to facilitate their involvement in programme development so that they become participants in, rather than objects of, health interventions. Women's contribution to human development must be reflected in their ability to share equally in the benefits development can bring. Women's health is an issue that concerns everyone — women and men and the generations of tomorrow.

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Part II
What factors affect women's health?

Poverty and other economic factors

18. The statistics about women and poverty are all too familiar by now – the majority of the 1.3 billion people living in extreme poverty are women; women are more likely to be poor than men; in all areas of the world, households headed by women (between 10% and 27% in developing countries) are more likely to be poor than those headed by men.

19. The relationship between women and poverty tends to be the same, whether one looks at urban or rural women, or whether the data come from developed or developing nations. People living in countries with a low ranking on the scale of human development invariably suffer from several combined forms of vulnerability in relation to health, knowledge and education, purchasing power and income-earning capacity.

20. Poverty often means that people exist on insufficient food or the wrong kinds of food. For women, when this is combined with childbearing and a staggering workload, it often leads to serious malnutrition. Poor women are more likely to live in crowded, unsanitary housing with an inadequate water supply. Poverty and gender-defined roles limit access to education, especially for girls, narrowing their possibilities for future employment and denying them the opportunity to break out of the cycle of poverty and ill-health. Poverty limits access even to free health care if a family cannot afford the costs of medication or transport, or if a woman cannot afford to take time off from paid work to visit a health facility.

21. Still, the correlation between poverty and poor health for women is not a direct one. Economic growth does not necessarily guarantee better health or higher status for all women because the benefits are not equitably distributed. Indeed in general the health gap between rich and poor appears to be widening. A deteriorating economic situation can create severe health risks for women even when they do not live in extreme poverty. As the world has learned in recent years, women remain more vulnerable to adverse economic trends than men, especially in times of rapid social, economic and political change – see Box 9 in Part IV.

Lack of personal and social status and opportunities

22. The status of girls and women in society, and how they are treated or mistreated, is a crucial determinant of their health. Educational opportunities for girls and women affect their status and the control they have over their own lives, their health and their fertility in a powerful way. Equal opportunities for women in other areas of their lives – for example in the judicial, legislative, educational and employment sectors – would also directly promote and protect their health and well-being.

23. The generally subordinate status of women has an impact on their health in many ways:

Legal status – laws and customs about land ownership, inheritance, marriage or divorce that discriminate against women need to be revisited. Women should not be economically dependent upon men or left entirely without resources of their own since this would have a very negative effect on their health and nutrition, and that of their children, and other family members for whom they are responsible. Even when laws have been made more equitable, millions of women continue to be disadvantaged because custom prevails over law, laws are not enforced, or women are unaware of their rights.

Son preference – the high value placed on sons in some regions leads to discrimination with serious health consequences for girls and women. In extreme cases it may lead to prenatal sex selection in favour of boys, or infanticide. In areas with a strong preference for sons, patterns of food distribution within a household may contribute to malnutrition for girls. Young girls are more likely to be malnourished but less likely to receive treatment for malnutrition or any other problem. The woman who has many
daughters may be under pressure to keep on having more children until she produces sons. Women are often caught in circular patterns of inequity. Young girls who are treated as if they are inferior to their brothers come to believe it, live their lives as if it was true, and then pass on their low self-esteem to their daughters.

Lack of decision-making power and participation – there is often a hierarchy within households based on age and gender. The older women in some families are quite influential, but younger women may have little autonomy and little weight in family decisions. This becomes important to women’s health if they cannot, for example, take part with their husbands in decisions on family planning, or make decisions on their own about the emergency referral of children to a health facility.

Stains through childhood – many of the roles traditionally assigned to women are those of lesser value in a society, which tends to keep women’s social status low. On the other hand, the bearing of children is a role that is symbolically highly valued and respected almost universally. It may also be the only way for women to gain status or to survive in a given society. However, women receive little support in this role in terms of policies or resource allocation.

Lack of education – when illiteracy rates are considered, the gap between women and men becomes even wider. Globally, more than 960 million adults are illiterate, two-thirds of whom are women. In many parts of the developing world, girls are simply not expected to attend school. Sixty million of the 100 million children who have no access to primary schooling are girls. Findings prepared
for the World Conference on Education for All suggest that the more education girls and women receive, the greater the likelihood that they will seek prenatal care during pregnancy and that they will be attended by trained health personnel during the births of their children (Figure 2). Although the relationship is not uniform, fertility rates generally decrease as the proportion of women who attend school increases – women with secondary and tertiary education are particularly likely to adopt a modern method of family planning. Improving the health and well-being of children and mothers cannot be sustained and cannot be advanced further without primary education, literacy and basic knowledge for better living for girls and women.

![Figure 2: More education: better health care](chart)

* ventilation & nutrition
* ventilation & hygiene

% of births* with trained assistance

<table>
<thead>
<tr>
<th>Country</th>
<th>% of Births with Trained Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana</td>
<td>100</td>
</tr>
<tr>
<td>Mali</td>
<td>90</td>
</tr>
<tr>
<td>Tunisia</td>
<td>80</td>
</tr>
<tr>
<td>Peru</td>
<td>60</td>
</tr>
<tr>
<td>Indonesia</td>
<td>40</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>20</td>
</tr>
</tbody>
</table>

*Births in the five years before survey
Demographic and Health Survey, World Conference on Education for All

Demographic factors

Population dynamics reflect the life events of people – birth, growth, maturation, migration, family formation, aging, illness and death. Such events are the driving forces of changing demographic and health profiles, and are inextricably linked to the health status of a population. Therefore, the health of individual men, women and children remains of paramount importance at each level of population change.

But demographic, epidemiological and socioeconomic factors in developing and developed countries alike are combining to create new patterns of mortality and morbidity for both women and men, and to force a redefinition of the determinants of women's health. Such factors – discussed in greater detail below – include marriage and childbearing in adolescence in some parts of the world, contrasted with falling fertility rates in others as women are tending to have fewer children and to have them later in life; increased exposure of women to occupational hazards both within and outside the formal work economy; the particular problems faced by women as they grow older often without any personal or societal support networks; and the stark realities faced by women in refugee or other displaced populations.

It is estimated that by the year 2000 there will be 590 million children under the age of 5 in developing countries. Even though infant and under-5 mortality rates continue to decline worldwide, nearly 9 million infants still die each year in developing countries. Underlying these figures is the day-to-day reality of life in the least developed countries of the world where the most deprived mothers and their infants must struggle to survive – a struggle depicted in Box 3.

Against this background, girls in some countries receive less care than boys, and as a result more girls in these countries are dying than boys even though females are more resistant to infection during infancy than males – it is a sad fact that discrimination exists even in childhood:

- girls often have less to eat than boys
- girls receive less education than boys
- girls receive less care than boys
- girls work for longer hours than their brothers.
A baby girl born in one of the least developed countries in 1993 can expect to live barely 44 years—2 years more than a baby boy born in the same year. Her problems begin before birth since her mother is likely to be in poor health. If she is born in southern Asia, she has a 1 in 3 chance of being underweight, a greater chance of dying in infancy and a high probability of being malnourished throughout childhood. She has a 1 in 10 chance of dying before her first birthday and a 1 in 5 chance of dying before her fifth. In some African countries her chance of being vaccinated is less than 1 in 2. She will be brought up in inadequate housing under insanitary conditions contributing to diarrhoeal disease, cholera and tuberculosis. She will have a 1 in 3 chance of ever getting enough schooling to learn how to read and write. She may be subjected to female genital mutilation with consequent effects on her life as a woman and a mother. She will marry in her teens and may have 7 or more children close together unless she dies in childbirth before that. Traditions will prevent her from eating certain nutritious foods during her pregnancies, when she most needs them, and dangerous practices such as using an unsterile knife to cut the umbilical cord and placing cow-dung on the stump may kill some of her babies with tetanus.

She will be in constant danger from infectious disease from contaminated water at the place where she bathes, washes clothes and collects her drinking water. She will be chronically anaemic from poor nutrition, malaria and intestinal parasites. As well as caring for her family, she will work hard in the fields, suffering from repeated attacks of fever, fatigue and infected cuts. If she survives into old age she will be exposed to the same afflictions as women in the rich countries: cardiovascular disease and cancer. To these she will succumb quickly, having no access to proper medical care and rehabilitation. She will not be able to pay anything herself. Her country currently has less than USD 9 a year to spend on her health.


Figure 3: Percentage of first births to women under 20 years of age (selected countries)

More than 50% of the world’s population is currently below the age of 25 years. By the year 2000 approximately 86% of them will be living in developing countries. At present, one-fifth of the world’s population — more than 1000 million people — are adolescents between the ages of 10 and 19. Many girls are already married and are mothers by the end of adolescence. For example, in 15 of 19 countries studied in the Demographic and Health Surveys in Sub-Saharan Africa, more than half of women were married in adolescence, and in 14 of those countries a large proportion of first births occurred in adolescence. In Latin American and Caribbean countries studied, the level of adolescent marriage ranged from 31% to 60% of the female population.

The total fertility rate for women has fallen by 40% in the last 30 years and the percentage of contraceptive users has increased from around 14% in 1960–65 to an estimated 57% of women of reproductive age in 1994. This has contributed to a reduction in pregnancy-related risks as well as giving women more control over their fertility and their lives. Elsewhere, pregnancy and motherhood –

\[\text{State of the World’s Population. UNFPA, 1994.}\]
planned and unplanned – continue to be factors affecting women’s health, and in many areas the gap between unmet needs and availability still remains large – particularly for adolescents and the unmarried – for example in the area of family planning (Figure 4).

Figure 4: Unmet family planning needs
Married women who want no more children but do not use any contraceptive method

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>40%</td>
</tr>
<tr>
<td>Asia</td>
<td>30%</td>
</tr>
<tr>
<td>Latin America/Caribbean</td>
<td>20%</td>
</tr>
<tr>
<td>Middle East</td>
<td>10%</td>
</tr>
</tbody>
</table>

In areas where the fertility rate has fallen, however, women are having fewer children and are thus less exposed to the hazards of childbearing. On the other hand, the rapid changes occurring in women’s economic roles will create additional health risks for women and raise issues about how women are to cope with their dual roles and increased workload. The officially registered working population constitutes 60–70% of the adult male and 30–60% of the adult female population of the world. The average global participation rate in the formal workforce is 73% of all male workers, the corresponding figure for female workers being 43%. However, it is well documented that women contribute disproportionately to overall household income through their unpaid and unrecognized work in the home, in the family enterprises, and in the informal sector.

31 Life expectancy for women is highest in developed regions (for example, 75–79 years in Europe) and lowest in sub-Saharan Africa where the corresponding figure is 54 years for women – and 51 for men. In the last twenty
years, life expectancy for both men and women has increased, with the lowest increase recorded in Eastern Europe. Gains in life expectancy are related to a decrease in infant mortality and in the case of women to a reduction in maternal mortality. Almost everywhere in the world, women live longer than men, although the differences are smaller in Africa and parts of Asia. In some countries in southern Asia the life expectancy of women is equal to that of men despite the fact that girls are born with a biological advantage which makes them more resistant to infection and malnutrition than boys. In a number of countries this biological advantage is cancelled out by the social disadvantages that girls and women go on to experience. Despite their greater life expectancy women do not necessarily lead more healthy or disability-free lives.

The proportion of the population over 65 is increasing in all parts of the world. The majority of people over 65 in the years to come will be women – the older the population group, the higher will be the percentage of women in the group. Although on the whole women live longer than men, they are more likely to live their later years with noncommunicable diseases and consequent disabilities. Older women have different health needs to those of men, and younger women, and their socioeconomic disadvantages increase their susceptibility to deprivation and diminished access to health care.

Because women also tend to marry men who are older than they are, a large number of these women will be widows. Already about 25% of all adult women in Africa are widows. This percentage increases dramatically in older age groups, and in parts of the developing world up to 80% of women aged 65 or over are widows. In today's world of family instability and mobility among the young, widowhood often puts a woman at increased risk of poverty, ill-health and isolation.

Many older women live with their families (usually with a married daughter) and are well supported, returning that support by actively contributing to the household in a number of ways. However, particularly in the developing world, many old women become destitute towards the end of their lives – some because they are widows and poor, others despite the fact that they live with their families.

Whereas armed conflict is one evident driving force behind refugee population movements, large flows of people within and between countries also occur as a result of other man-made or natural disasters. About 80% of all refugees are women and children, and worldwide the refugee population has grown from 2.5 million in 1970 to over 18 million today. An additional 24 million people at least are displaced within their countries of origin and residence.

Physical and psychological violence are extreme examples of the health risks faced by refugees and displaced populations. In particular, women may be exposed to sexual abuse and violence. In addition, the risks of sexually transmitted diseases, unwanted pregnancies and unsafe abortion become significant, and the psychological well-being of women becomes threatened. Despite all of this, there is an almost complete neglect of the maternity care, family planning and reproductive health needs of refugees and displaced people.

All of these – and other – demographic factors bring inevitable sociocultural and epidemiological changes, and challenge health and social service systems. One such challenge is to prepare for changing health-care needs as the proportion of older women increases. Another challenge is to reach young women now with information that will help them avoid the preventable disabilities and illnesses of old age. To meet these and other challenges, it will be necessary to study the physical, economic and social situation of women in their locality, and to be prepared to respond. Attention must be given to listening to what women of all ages in the community are saying about themselves, and their health concerns.
Harmful practices – female genital mutilation

38. There are a significant number of practices that have a distinctly negative impact on women’s health and well-being. Some examples are dowry and bride price that may in some circumstances lead to physical abuse, intimidation, or even death; and the practice of marriage and childbearing before girls have reached physical and psychosocial maturity, which creates many health risks for young women. Most of the young women in these situations are powerless to resist. The social sanctions for doing so would be severe, and they have few alternatives.

39. Another traditional practice with serious health risks for women is female genital mutilation (FGM) – sometimes locally known as female circumcision. FGM is a tradition deeply embedded in patriarchal power structures and the desire to control women’s lives. Over time, however, both men and women in societies where it is practised have come to believe that FGM is necessary and in the best interests of the girl concerned. Many reasons are given to support its continuation:

Nobody will marry a girl who is not circumcised. Circumcision makes a girl more mature. It prepares her for the later pain of childbirth. Circumcised girls have self-respect and the respect of their husbands and communities. It increases their marriage opportunities. Uncircumcised women cannot control their sexual behaviour.

40. An estimated 2 million young girls are subjected to FGM each year. Most of these girls live in Africa, some in the Middle East, a few in Asia, and an increasing number among immigrant communities in Australia, Canada, Europe and the United States of America (Figure 5).

41. Women’s groups, health professionals, human rights activists, governments and international agencies have all taken firm stands against FGM, considering it a violation of children’s – and women’s – human rights. At the international level, the Convention on the Rights of the Child explicitly requires States to take all appropriate measures to abolish traditional practices prejudicial to the health of children. In 1994, the World Health Assembly again called the attention of the world to the detrimental health consequences of FGM, and has called for the elimination of FGM while according full respect and encouragement for all that is positive in local culture and traditions. In addition, the World Health Assembly has declared that medicalization of the procedure should not be allowed under any circumstances.

42. There are already some signs of change in the regions where it is most prevalent, especially among many younger parents, who are beginning to discuss the issue and may even decide to abandon FGM in spite of social pressures. Sometimes, women and families may be convinced of the harm of FGM when the health risks are fully explained to them. Many women who have undergone FGM are now realizing that the health problems they have experienced are connected to the genital mutilation they underwent in childhood.

43. Yet the social and cultural factors that keep it alive are still strong, and it is clear that there are long years of work ahead before the practice is entirely eliminated. Women’s groups in the countries concerned will continue to work towards the elimination of FGM, with international networks and organizations supporting these efforts.
FGM is a deeply rooted traditional practice that adversely affects the health of girls and women. It is a form of violence against them that has serious physical and psychosocial consequences, and is a reflection of discrimination against girls and women.

**Definition of FGM**
All procedures which involve partial or total removal of the external female genitalia and/or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons.

**Classification of FGM**
I. Excision of the prepuce; and all or part of the clitoris.
II. Excision of the clitoris with partial or total excision of labia minora.
III. Excision of all or part of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
IV. Unclassified: includes introcision, piercing or incising of clitoris and/or labia; stretching of clitoris and/or labia; scraping and/or cutting of vagina; introduction of corrosive substances or herbs into the vagina; other forms.

**Lack of access to health care**

It has been found that women are grossly under-represented in statistics relating to the use of health services. Although they suffer from levels of disease comparable to those of men – and even higher in the area of reproductive health – many do not get the care they need. They wait longer than men before seeking treatment and have difficulty leaving their families and household duties behind if long hospitalization is required. Such delays add to the risk of treatment failure.

Of all the factors influencing women’s health, access to health care ranks among the most important. Several factors combine to produce inequities in access that directly undermine the ability of women to maintain good health.

Time – the amount of time needed to use health services poses a greater obstacle for people who have relatively little “free” (non-work) time. Women are more “time-poor” than men. Ironically, a high implicit valuation of women’s time may be coexisting with gender bias against women. It may be more costly (and less replaceable) to a household to lose the domestic and agricultural services provided by a woman than to lose a day’s wages of a man. Because it is difficult for most women to be away from their homes for long periods, distant facilities and long waiting times are greater deterrents to service use for women than for men. In most developing countries, the demands of work both outside and inside the household lead women to spend nearly all of their waking hours working – workdays of 16, 18 or even 20 hours have been recorded in a number of studies.

**Deficiencies in the health system** – services are not provided in an integrated manner and often emphasize one phase of women’s lives – childbearing – neglecting other important ones that arise across the life course. Furthermore, urban bias in resource allocation has severe consequences for poor people in rural areas. Wherever women’s capacity to travel is limited, lack of high-quality care in local facilities or outreach programmes is a severe constraint on their access to care. The existence of urban bias in resource allocation should not however be allowed to disguise the fact that women in urban areas – especially poor women – also face enormous problems caused directly by health system deficiencies.

**Socio-cultural facets** – women’s absolute and relative poverty, their lack of control over the family cash resources, and the undervaluation of girls relative to boys suggests that, on average, health service user charges pose a greater obstacle to service access for women or girls than for men or boys. The privatization of health services in many parts of the world will accentuate this problem. However, there is also evidence that women are prepared to pay more for services that they perceive to be of better quality.

**Differential factors** – some women cannot or will not seek treatment from male health-care providers because of the belief that they should not be seen by any male other than a close relative. Women may need permission from their husband or other male guardian in order to seek care, even in emergencies. These women have little experience in communicating with men, and this may have negative consequences for the patient–provider relationship and thus the quality of care.

In order to address – and redress – these imbalances, health systems are taking action in several pressing areas – see Section in Part IV. Nevertheless, the long-term, more effective solution has to be to reduce the social, economic and cultural inequities that are at the origin of women’s unequal and inadequate access to health care.
What are the major issues in women's health today?

Nutrition

Malnutrition is undoubtedly the most widespread and disabling health problem among women in developing countries. It is often the result of two inequities: poverty and the status of women. These inequities lead, among other outcomes, to the unfair distribution of food within the family, and to the lack of money to buy good food. All of this is exacerbated by factors such as ignorance of nutritional requirements, illnesses and parasites (such as hookworm) that interfere with the body's utilization of food, improper food storage or preparation, and taboos against eating certain foods. Malnutrition is, moreover, a contributing factor in many other health problems that prevent women enjoying physical, mental and social well-being.

Malnutrition has a cumulative effect during an individual's lifetime, and this can lead to adverse effects on the health of the next generation. During pregnancy, deficiencies of such micronutrients as iron, iodine and folate—as well as of essential fatty acids—result in intrauterine growth retardation, mental retardation and congenital diseases. Infants affected by intrauterine growth retardation and low birthweight are more vulnerable to infectious disease, are more likely to have learning difficulties, and appear to be at greater risk of cardiovascular diseases and diabetes in adult life. During childhood, particularly during periods of social, economic and environmental stress, girls frequently receive an insufficient intake of proteins, calories and micronutrients with the result that, as an adult, the woman is underweight, often stunted and frequently anaemic. In turn, both of these last two conditions will complicate her pregnancies, add to the risk of bearing a low-birthweight baby, and thus perpetuate the cycle.

Although both men and women are affected by nutritional factors, women, for biological reasons, have a higher risk of suffering from the health-impairing nutritional deficiencies shown in Figure 6. Women and girls need more iron than men because of menstruation, pregnancy, lactation and other demands on their body's iron supply. Insufficient iron in the diet leads to anaemia, a condition that causes extreme fatigue and lower resistance to disease, and in women to difficulties in pregnancy and childbirth. In developing countries, about 55% of pregnant women and 44% of all women suffer from anaemia (Table 1). Significant disparities exist not only between developed and developing countries but also between different areas of the world. In some settings there is a dangerous interaction between anaemia and malaria that greatly increases the risks for both mother and child in pregnancy.

Figure 6: Women and nutrition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Estimated number of women suffering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaemia</td>
<td></td>
</tr>
<tr>
<td>Stunting</td>
<td></td>
</tr>
<tr>
<td>Iodine deficiency</td>
<td></td>
</tr>
<tr>
<td>Goitre</td>
<td></td>
</tr>
<tr>
<td>Blindness</td>
<td></td>
</tr>
</tbody>
</table>

Source: WHO, mid-1980s, EHS/94.11

Table 1: Estimated prevalence of nutritional anaemia in women, around 1980

An estimated 44% of women in developing countries suffer from nutritional anaemia, compared with 12% of women in developed countries. This is both a direct and indirect cause of maternal mortality. In addition it reduces work capacity, increases fatigue and increases susceptibility to health problems.

<table>
<thead>
<tr>
<th>Region</th>
<th>Prevalence of women</th>
<th>Prevalence of men</th>
<th>Prevalence of all women</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>51%</td>
<td>26%</td>
<td>36%</td>
</tr>
<tr>
<td>Developing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>countries</td>
<td>60%</td>
<td>32%</td>
<td>44%</td>
</tr>
<tr>
<td>Developed</td>
<td>77%</td>
<td>66%</td>
<td>12%</td>
</tr>
<tr>
<td>Africa</td>
<td>91%</td>
<td>44%</td>
<td>42%</td>
</tr>
<tr>
<td>Asia</td>
<td>75%</td>
<td>34%</td>
<td>45%</td>
</tr>
<tr>
<td>Latin America</td>
<td>41%</td>
<td>30%</td>
<td>34%</td>
</tr>
<tr>
<td>North America</td>
<td>24%</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td>Europe</td>
<td>17%</td>
<td>16%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Other micronutrient deficiencies, such as lack of iodine or vitamin A, also cause health problems. Iodine deficiency in a pregnant woman can lead to severe mental retardation in the child. Iodizing salt is a safe, efficient way to correct iodine deficiency. The role that vitamin A plays in health – particularly in women’s health – needs further elucidation. However, aside from its role in preventing blindness due to nutritional deficiency, vitamin A also appears to have a synergistic effect with other micronutrients. For example, small doses of vitamin A increase the absorption of iron and could play a significant role in reducing iron-deficiency anaemia in women.

In the area of ensuring food safety, women as the principal food managers in families in most cultures are a priority target group for education efforts. Women play an important role in ensuring hygienic food preparation, and in preventing and managing diarrhoea among family members, particularly preschool-age children.

While some people struggle to get the bare minimum of calories and nutrients they need to survive, the health of other women and men is threatened because of inappropriate diets containing an excess of calories. Obesity is increasing rapidly in many developed countries, and in certain sectors of the population in developing countries too. It leads to increased risk of diabetes, cardiovascular disorders and other chronic diseases.

**Breast-feeding**

Breast-feeding, besides promoting child growth by providing the best possible nutrition for both physical and mental development, also benefits maternal health in several important ways. Breast-feeding, by strengthening maternal-infant bonding and reducing the risks and severity of infections, greatly enhances the quality of infant care and the woman’s satisfaction. These effects are even seen among premature infants from socially deprived environments – maternal abandonment is reduced and the subsequent school performance of such children is improved. For the mother, breast-feeding immediately after delivery may reduce the risk of postpartum haemorrhage – and of anaemia. Breast-feeding also lowers the risk of ovarian and breast cancer, promotes child-spacing, and reduces fertility rates. Longer intervals between births allow women time to regain their strength and nutritional well-being before having another baby.

Although these benefits of breast-feeding for baby and mother have been recognized for a long time, there has been a lag in ensuring the practical support that breast-feeding mothers need in their daily lives, such as adequate nutrition and reduced workload. With more women going to work outside the home, supportive policies are also needed to ensure that working mothers who want to breast-feed can continue to do so, for example policies to permit women to take time off work to breast-feed, or the provision of child-care facilities near the workplace.

**Reproductive health**

WHO is committed to implementing the Programme of Action – especially in the area of reproductive health – agreed upon at the International Conference on Population and Development (ICPD) held in Cairo in September 1994. The definition of
Reproductive health agreed upon at Cairo represents an important widening of perspective, and contains many concepts that are of vital importance to the general health of women and men:

Reproductive health ...implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. ...[It implies] the right of access to appropriate information and services that will enable women to go safely through pregnancy and childbirth. ...It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.

Reproductive health is a crucial part of general health – not only is it a key element of health during adolescence and adulthood, it also sets the stage for health beyond the reproductive years for both women and men, and has pronounced intergenerational effects. The health of the newborn is largely a function of the mother's health status and of her previous access to health care. The reproductive health component of general health increases during adolescence and, particularly for women, during the reproductive years. In old age, although general health continues to reflect earlier reproductive life events, other health issues become more important. Even though at each stage of life an individual's needs differ, there is a cumulative effect across the life span – events at each phase having important implications for future well-being.

Many factors affect reproductive health, and its attainment is not limited to interventions by the health sector alone. Reproductive health affects, and is affected by, the broader context of people's lives, including their economic circumstances, education, employment, living conditions and family environment, social and gender relationships, and the traditional and legal structures within which they live.

Women bear by far the greatest burden of reproductive health problems (Figure 11). Women are at risk of complications from pregnancy and childbirth; they must deal with unwanted pregnancy, suffer the complications of unsafe abortion, bear most of the burden of contraception, and are more exposed to contracting, and suffering the complications of, reproductive tract infections, particularly sexually transmitted diseases (STDs).

According to the World Bank's Investing in health: world development report 1993, STDs (not including HIV infection) are the second largest cause of healthy life lost in women aged between 15-44 years in the developing world, second only to maternal causes. If HIV infection is combined with conventional STDs, sexually transmitted infections account for nearly 15% of all healthy life lost in this age group.
59. Biological factors alone do not explain women’s disparate burden. Their social, economic and political disadvantages have a hugely detrimental impact on their reproductive health. Young people of both sexes are also particularly vulnerable to reproductive health problems because of a lack of information and access to services.

60. Human sexuality and relationships between the sexes directly affect the ability of young people and adults – both women and men – to maintain good reproductive health. The rapid spread of HIV/AIDS particularly among young women, has demonstrated their vulnerability and the need for sensitive and responsive education messages, technologies and services that are appropriate and relevant to them.

61. Much of the violence against women occurs in the context of sexuality and reproduction – rape, sexual abuse, battery during pregnancy, and forced prostitution and human trafficking. The health consequences of violence are often in the realm of reproductive health and contribute substantially to the burden of disease in women and young people.

62. Reproductive health programmes must include, as a minimum, attention to the issues of family planning, maternal mortality, unwanted pregnancy, unsafe abortion, STDs (including HIV/AIDS), harmful traditional practices, gender and sexual violence, infertility, malnutrition and anaemia, and reproductive tract infections and cancers.

63. This concept of reproductive health, as promoted by WHO and its partners, is based upon principles of gender equity and human rights. Putting this concept into effect will require the involvement of those most directly concerned, with women themselves and young people. It will also involve a multisectoral effort to increase access to care and to improve quality so that no opportunity is missed to offer people a full range of reproductive health information and services.

Maternal mortality and morbidity

64. In the mid-1980s it was estimated that half a million women died each year from pregnancy-related causes – 99% of them in developing countries. Unfortunately, little has changed since then. Inadequate reporting in
the past (and today) makes it difficult to discern trends, but it appears that there has been very little reduction in global maternal mortality, in spite of the fact that almost all of these deaths could be prevented with existing knowledge and technology.

An estimated 80% of all maternal deaths are due to five major complications, namely haemorrhage, infections, hypertensive disorders of pregnancy, obstructed labour and unsafe abortions (Figure 7). The remaining 20% of deaths are caused by existing diseases which are aggravated by pregnancy such as malaria, tuberculosis and heart disease. Many of these deaths could be averted by early detection of complications, timely referral to a facility that has the personnel and equipment necessary for effective treatment, and greatly improved access to family planning information and services. According to the 1993 World Development Report, ensuring access to family planning, prenatal and delivery care is one of the most cost-effective health sector interventions, costing less than US$5 per capita in low-income settings.

Behind the immediate medical causes of maternal death are underlying factors such as:

- lack of family planning to help women avoid unwanted pregnancies
- a history of pregnancies that are too frequent or too numerous
- a birth that came too early or too late in a woman's life
- malnutrition or other pre-existing conditions like malaria, anaemia or tuberculosis that predispose to obstetrical complications
- traditional practices such as female genital mutilation, nutritional taboos and unsafe delivery practices.

And underlying these factors in turn are deeper economic and sociocultural issues such as:

- inaccessible or inappropriate health services
- inadequate resources to pay for needed care
- lack of education which enables women to make appropriate use of services
- insufficient knowledge of the signs and symptoms of pregnancy-related complications.

The unnecessary death of a woman in the prime of life is a tragedy in itself and a catastrophe for her family. Over 90% of the time, when a mother dies the child she was bearing either does not survive the mother's death or is dead within a year after the birth. Other young children in the family also have

Figure 7: Estimated percentages of all maternal deaths due to the main obstetric complications worldwide.

Haemorrhage 25%
Indirect causes 20%
Other direct causes 15%
Sepsis 15%
Hypertensive disorders of pregnancy & Eclampsia 12%
Unsafe abortion 13%
Obstructed labour 8%

an increased risk of dying within a year or two after the death of their mother, with daughters being more at risk than sons in areas with pronounced son preference – see Figure 10. In many cases, the main burden of caring for the family passes to the older children, especially to older girls.

**Figure 10:** What happens to the remaining children when the mother dies?

<table>
<thead>
<tr>
<th>SONS</th>
<th>DAUGHTERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child deaths per 1000</td>
<td>0</td>
</tr>
</tbody>
</table>

Reduced employment prospects, and having to assume the responsibilities of parenthood before they are ready for them. If they resort to unsafe abortion they run many more health risks.

77. Information campaigns and discussions related to HIV/AIDS have helped many people, especially young people, gain a better understanding of their own sexuality, of the options open to them, and of the need for responsible sexual behaviour. There is still, however, an acute lack of access to information and services for young people for many reasons, including their own lack of information about services (or of resources to use them), shame and embarrassment, the hostile reception they often receive or anticipate if it relates to sexuality, as well as a lack of training to provide service providers with the skills for dealing with young people. The same applies to policies and legislation which are often conflictual, undermine confidentiality and privacy, and require parental consent for the provision of services.

78. Whether they live in developing or developed countries, adolescent girls and boys are subject to many health risks in a rapidly changing world, but for adolescent girls, some of the biggest risks they face are related to reproductive health. Female children and adolescents (as well as young males) are highly vulnerable to pressure from older people to have sex – such pressures can be experienced both inside and outside their own family.

79. Having a child before reaching physical and psychological maturity can change the entire course of a young girl’s life. When girls give birth before their pelvic bones are fully developed, they run a high risk of obstructed labour, which can result in death or disability for them and the child. It can leave the mother with vesicovaginal fistulae that make her a social outcast, or with other painful and incapacitating health problems that will be with her for life.

80. Unless young people who are sexually active have appropriate information, skills and services, they risk very serious health problems, including sexually transmitted diseases (STDs) and HIV infection leading to AIDS. For girls, unprotected sex can also result in an unwanted pregnancy and childbirth. In addition to the physical dangers of early childbearing (inside or outside marriage) it can mean the end of their education, greatly.

**Sexuality and reproductive health in adolescence**

Family planning

81. Family planning services should provide information, education and universal access to the full range of safe and reliable methods, and be closely linked to, or integrated with, other reproductive health services. Family planning programmes must focus on enabling people to make informed choices about the timing.
number and spacing of their children, and on empowering women to manage their own fertility, while emphasizing men’s joint role and responsibilities in healthy sexuality and reproductive health.

Family planning was once seen primarily from the perspective of population control. However, in recent years and particularly since the International Conference on Population and Development in 1994, family planning has come to be recognized as much more than a solution to rapid population growth. Family planning is a preventive measure with a family and social dimension; a way of promoting optimal human development; and an intervention that leads to enormous gains in terms of women’s health and well-being.

If people were able to have only the number of children they wanted, and at the times they chose, an estimated 25–40% of maternal deaths could be averted, the number of abortions would be reduced, and the health of women and children would be improved.

Research with a gender perspective has helped uncover some of the reasons why people do not make greater use of family planning services. There are problems of access, including the times and costs of services, the number and types of contraceptives available, preconceived ideas and biases among healthcare providers, misconceptions and myths in the minds of users, alienation due to provider attitudes, and a lack of privacy and confidentiality. Many of these factors are particularly important barriers to women, and need to be addressed urgently by policymakers.

In addition, there are social factors such as family decision-making structures, traditions that insist on sons to carry on the family name or perform other functions, the idea that virility is demonstrated by fathering a maximum number of children, and lack of communication between spouses. Many of these social factors can be overcome through interventions to foster male responsibility and involvement in family planning.

Unsafe abortion

Each year there are about 20 million unsafe abortions performed worldwide. It is estimated that at least 70,000 women die as a result of these abortions, while millions more become infertile or are left with other lasting damage to their health. Unsafe abortions account for a sizable proportion of all maternal mortality and morbidity, and in some countries may be the cause of more than half the total number of all maternal deaths (Ch. 3). The complications of unsafe abortion lead to unnecessary health service costs in terms of money, personnel, drugs and other resources.

Table 2: Civil registration data: abortion deaths as a percentage of all maternal deaths

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>1980</td>
<td>15.5</td>
</tr>
<tr>
<td>Brazil</td>
<td>1985</td>
<td>12.3</td>
</tr>
<tr>
<td>China</td>
<td>1980</td>
<td>18.2</td>
</tr>
<tr>
<td>Colombia</td>
<td>1985</td>
<td>11.1</td>
</tr>
<tr>
<td>India</td>
<td>1980</td>
<td>17.0</td>
</tr>
<tr>
<td>Indonesia</td>
<td>1985</td>
<td>13.7</td>
</tr>
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<td>United States</td>
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<td>1980</td>
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</tr>
<tr>
<td>Venezuela</td>
<td>1985</td>
<td>14.1</td>
</tr>
</tbody>
</table>


Because adolescents are more likely to hide a pregnancy, are unwilling or unable to seek appropriate health care, wait longer into the gestation period before getting help, and are more desperate not to have the baby, induced abortion, or pregnancy termination, generally presents a greater risk to the health and life of the adolescent than to an adult woman. This may lead her to try and self-abort or to go to unqualified people in clandestine and dangerous circumstances, even when she might have had legal access to abortion. Programmes to prevent unwanted and unplanned pregnancies are needed, particularly for young people.

Unsafe abortion is a major public health issue and a clear indication of unmet needs for contraception. The health consequences of unsafe abortion should be recognized and managed, and counselling and care provided for all complications. Where abortion is legal it should be safe. All women should have access to high-quality and affordable counselling and services, including post-abortion family planning.
Sexually transmitted diseases (STDs) including HIV/AIDS

STDs constitute a major public health problem throughout the world. It is estimated that 315 million curable STDs occur globally each year, most of them in developing countries and among young people. Worldwide, one in every 20 adolescents is affected by STDs. A summary of the global extent of STDs and the ways in which they affect women is shown in Box 4. STDs have been a neglected area in public health despite overwhelming evidence of their impact on health, particularly for adolescents, women and newborns. Women, especially young women, are more vulnerable to STDs (including HIV infection) than men because of the existence of biological, cultural and socioeconomic disadvantages.

Biologically women are more susceptible to most sexually transmitted diseases than men, at least in part because of the greater mucosal surface exposed to a greater quantity of pathogens during sexual intercourse. In addition, the risk of transmission of STDs, including HIV infection, is greater whenever the vaginal mucosa is damaged. As a result of such factors most STDs, including HIV infection, are transmitted more readily from men to women than from women to men. Women with STDs are more likely than men to be asymptomatic, and therefore are less likely to seek treatment for STDs, resulting in chronic infections with more long-term complications. Untreated STDs increase the likelihood of HIV infection occurring during unprotected sex with an HIV-infected partner.

These biological factors are compounded by sociocultural ones. In many parts of the world women have little or no control over decisions relating to sexuality, nor do they have control over the sexual behaviour of their male partners or the use of condoms for the prevention of STD/HIV infection or pregnancy. The symptoms of STDs may not be recognized as needing treatment. Stigmatization, which is particularly acute for women with STDs, keeps women from seeking treatment, or services and facilities suitable for women may not be available. In most cultures, women tend to have sexual partners who are older, who are usually sexually more experienced, and who have had more partners and thus are more likely to have become infected. This plays a particularly important role when adolescent women have sex with older men. The HIV/AIDS pandemic provides some dramatic illustrations of these issues, and of the need for sex- and age-specific analysis of data. Figure 11 shows the relative distribution of AIDS cases in Africa by age in both men and women – in many places, young women are becoming infected with HIV and progressing to AIDS at much earlier ages than men.
Women are affected by AIDS at a much younger age than men. The peak age for women is 20–24 years compared with 30–34 years for men.

The influence of socioeconomic factors is evident in the spread of STDs. Poverty and urbanization drive men to cities for work, which takes them away from their families and can lead to men seeking other sexual partners, which in turn increases the risk of STDs. Their visits home may put women there at risk of STD/HIV. Poverty and urbanization also drive women into prostitution as a survival strategy.

It is women who pay the highest toll for untreated STDs, which can result in pelvic inflammatory diseases (PID), infertility, ectopic pregnancy, complications in pregnancy and childbirth, and cervical cancer. PID is the most common cause of admission to gynaecology wards in many developing countries. Infertility with its serious marital and social consequences is attributed to prior STD infection in 50-80% of affected women. The rate of ectopic pregnancy is some three times that found in developed countries and remains an important cause of maternal mortality. Spontaneous abortions, puerperal sepsis, premature births, and stillbirths can all be caused by STDs.

Certain STDs, in particular, human papilloma virus, increase the risk of cervical cancer – now one of the fastest growing and most serious cancers among women in the developing world. Cervical cancer is the commonest form of cancer in women in most developing countries – see Figure 11 – and the second most common form of cancer in women in the world. Globally, there are an estimated 450 000 new cases each year, and an annual death toll of 300 000. If the number of undiagnosed early cases were taken into account, the figures would be nearer to 900 000 new cases each year. An estimated 75% of all cases occur in the developing countries where only 5% of the global resources for cancer control are available.

Early detection and screening have been successful in reducing the morbidity and mortality due to cervical cancer in some developed countries, but not in others – the reasons being the poor level of management, and the implementation of inappropriate policies, such as screening mainly young women without sufficient coverage of older women. In most developing countries, 80% of cervical cancer cases are diagnosed at an advanced, incurable stage, the reasons being: lack of knowledge among women of the symptoms of the disease, a fatalistic attitude towards cancer generally; a lack of awareness of the possibility of a cure; lack of, or disorganized, screening programmes; and a
lack of health care facilities in the rural areas, combined with a low priority for women’s health issues.

90. Information programmes can help prevent the spread of STDs, and can encourage people to seek treatment, especially in settings where women are free to make their own decisions. Information which is precise, forthright and tailored to the local culture and conditions can be used to show why, for example, preventive behaviours (such as mutual fidelity to one partner, abstinence or use of condoms) are so important. Women and girls need to be informed about the damage that STDs can do, and need to know how to protect themselves – this means acquiring skills to refuse unwanted sexual relations, or to negotiate safer sex. To promote safe sexual behaviour does not encourage promiscuity. On the contrary, it encourages individuals to respect the integrity of their own body and life, and to have a better understanding of their responsibilities towards other people.

91. It is essential to address the power relationships between men and women and provide women, especially young women, with the personal skills and confidence to refuse sexual relations when they so wish. This will be possible, however, only when women have sufficient status and economic opportunities to reduce their dependence on men for survival and relative well-being.

92. It is critically important to include young men and women, boys and girls, in these information and skill-building programmes, not only as “recipients” but as responsible partners in planning and carrying them out. Reaching young people at an early age is crucial, before they become sexually active. Many STD clinics find that the average age of the clients is falling steadily. It would be difficult to say how much of this drop is due to consensual sexual activity and how much should be termed “sexual abuse”.

93. The rise of the HIV/AIDS pandemic has confirmed what women’s health advocates have long been saying: women’s poor health is linked to their relative powerlessness in relations with men, stemming in part from an inferior social status and economic dependence, and in part from society’s tolerance of human rights violations against women.

94. Women continue to have unprotected sex even when they know or suspect that their husband or partner is HIV-infected. The use of a condom can in some cases be interpreted as a sign of unfaithfulness on the woman’s part, or as an insult to the man. In some circumstances, for a wife to insist on condoms would be to invite a beating or abandonment. Many husbands do not want to use condoms because they want more children or want a son – a desire that their wives may share.

95. As the awareness of HIV/AIDS spread, older men in some areas began to look for ever-younger girls as wives or sex partners, hoping that this would increase the chances of having a partner who was not infected. For the girls, it had the opposite effect, as described above in relation to other STDs; it increased the chances that they would be having sexual relations with someone who was already infected. Few young girls in these situations have the status,
or the economic independence, to insist that an older man use a condom — the current global extent of HIV infection among women is shown in Figure 13.

Women bear much of the burden of the HIV/AIDS pandemic in other ways. In HIV-infected women, the virus can pass on to their children during delivery or through breastfeeding. Women are also likely to be the care providers when their husband or someone in the family or community is sick with AIDS. When sick themselves, they may not get support or care. Many older women in the areas hardest hit by the pandemic find themselves taking care of a number of children orphaned by AIDS. It is to be hoped that the growing understanding of how HIV/AIDS affects women will lead to more effective interventions to help them protect themselves against it, and to more support for those who are affected.

Work-related and environmental health hazards

WHO promotes a definition of occupation which includes all women’s paid and unpaid tasks, performed inside or outside the home. Women are more likely than men to work in situations where they are not protected against exposure to potential health hazards. Outside the home, women tend to work in the informal sector or in smaller, less-regulated enterprises. In rural areas women and men are frequently exposed to pesticides and other toxins. Whether in the formal or informal sector, the health hazards relating to women’s work have been inadequately studied, and as a result are poorly addressed.

Figure 13: Estimated distribution of HIV-infected women alive as of late 1994

The special occupational health problems of working women are recognized in both developing and developed countries. In the former, heavy physical work, the double work burden of job and family, and traditional social roles increase the burden of female workers. Machinery and work tools are often designed according to male anthropometry even though female workers have to use such equipment. In many service occupations, the female workers may be exposed to the threat of violence from clients or to sexual harassment from fellow workers. Some studies indicate a higher than average risk of unemployment among low-paid female workers which may also have negative social and health consequences on families. Equal job opportunities for women and men and equal payment for the same job are still rarely seen around the world.
In some developing countries, working women are concentrated in labour-intensive factories (for example, textile work, garment sewing, and electronic assembling). Poor conditions in these workplaces lead to health risks ranging from exposure to carcinogenic chemicals to excessive noise, heat, humidity, physical strain, eye strain and allergic reactions.

Women may also face additional problems due to occupational exposure to hazardous substances, particularly during pregnancy – a fact illustrated in Figure 14. A number of industrial or agricultural chemicals, as well as ionizing radiation, may lead to infertility, abortions, stillbirths, congenital malformations and inherited diseases.

Women’s work is not confined to the formal and informal sectors. In most cultures, women continue to carry the main responsibility for maintaining the household, including caring for the children, the sick and the elderly. Furthermore, in many countries they are also responsible for food production and processing, much of which is done manually and can require large amounts of energy. When women’s increased participation in wage-labour is added to their household responsibilities, the resulting “double or triple burden” means that women work far longer hours than men.

In many developing countries, the time, work and sheer physical burden involved in satisfying basic requirements for food, water and fuel can be enormous. Women may walk up to 10 kilometres for water and/or fuel and can carry loads of 20 kilograms or more on their heads – the high prevalence of back pain is not surprising. In addition to the time spent obtaining these basic necessities, where distances are long, women may be at risk of assault or abuse, as has been documented in some refugee situations. In urban areas, the distance may not be so great, but waiting times at water pumps can be long. The more difficult it is to obtain water, the less likely it is that water will be available for washing dishes, washing hands or other hygiene requirements.

Despite their responsibility for water collection (Figure 15) and sanitation management, women rarely participate in decision-making when the construction of facilities is planned. All too often they have no say about the location of a pump or the design of latrines. In order to improve health and quality of life for women, water and sanitation programmes must concentrate on:

- reducing the time and energy women expend in water collection
- increasing women’s participation in community decision-making regarding water and sanitation.

A major environmental concern is the use of biomass fuel and coal for domestic cooking and heating. These fuels are used by about one-half of the world’s population, often in poorly ventilated dwellings. Possible effects
Figure 15: Proportion of men and women who collect water, by age, Kenya, 1983.

Fetching water is the responsibility of women in most parts of the world. The health implications include skeletal damage, accidents, energy depletion and miscarriage.

<table>
<thead>
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<td>5-9</td>
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</tbody>
</table>

![Percentage Graph](image)

Source: Ferguson A. Women's health in a marginal area of Kenya. Social science and medicine, 1990, 30(10), 23.

In recent years, more importance has been given to the gender approach in tropical diseases. As a consequence, there is a better appreciation of how such disease in women differs from that in men, and the following issues must now be emphasized.

105. Women have a different risk of exposure to certain tropical diseases than men. This is as a consequence of their traditional roles related to water (schistosomiasis), cultivation (malaria, filariasis), domestic roles (dengue, Chagas' disease, and leishmaniasis) and certain biological characteristics (for example, during pregnancy when malaria is an important cause of maternal death, abortion, miscarriage, stillbirth and neonatal death).

106. Women frequently do not seek care for themselves or for their children following infection with tropical diseases. Women are grossly under-represented in the statistics of health services, indicating that they may not be receiving the care that they need. Studies have shown that far fewer women than men attend clinics (though they suffer comparably) or they wait longer than men before seeking treatment. One reason for such delays is that men may be reluctant to have women leave their household responsibilities behind, particularly where long hospitalization is required such as in the case of visceral leishmaniasis. Sick mothers who do not seek care for themselves may also not seek it for their children. One study in Africa has shown that some women incapacitated with guinea worm were not able to bring their children to the health clinics for the necessary care, including immunization.

107. Certain conditions, resulting from tropical diseases, interfere with women's social and economic activities. Leishmaniasis, schistosomiasis, lymphatic filariasis and onchocerciasis cause profound incapacity and disfigurement. Women are particularly affected by these diseases, especially in relation to their marriage prospects.

108. Urinary schistosomiasis causes genital lesions with significant consequences for women. The passing of blood in the urine (caused by Schistosoma haematobium) carries social stigmatization for girls in many countries, while for boys it may be considered a sign of
virility. The effects on quality of life include ostracism by the family and community for assumed premarital sexual relations, and marital conflict after appearance of lesions in married women, while young girls may be forced into prostitution.

In areas of malaria, the disease is a major contributor to the development of chronic anaemia, particularly during pregnancy, which can be severe. This complication has a direct causal association with infant and maternal mortality.

Women are important providers of care for certain communicable tropical diseases. For example, women are usually the ones to identify malaria signs in their children, and often treat them with drugs obtained locally. It is important that women receive appropriate information on managing the most common fevers, recognizing signs of severity and seeking prompt treatment.

Tuberculosis

Tuberculosis – seldom a prominent item on the agenda of women’s health advocates – is responsible for the deaths of around one million women each year. For reasons not fully understood, women seem to be most vulnerable to tuberculosis in their early and reproductive years. The biological changes that occur in those years may make women more likely to progress to tuberculosis once infected. Tuberculosis is an indirect or contributory cause of many maternal deaths.

Tuberculosis in women causes great loss of productivity and disrupts the socioeconomic well-being of families and communities. Failure to prevent and treat tuberculosis in women puts their children at risk for tuberculosis infection, illness and death. When women die from tuberculosis the families suffer all the hardships and increased risks that accompany women’s deaths from any cause.

In countries severely affected by the HIV pandemic, substantial increases in tuberculosis are being seen. Younger age groups are most severely affected, and the increase in young women is greater than in young men.

Globally, twice as many men are reported to have tuberculosis as women. But it is not known if this is due to biological differences or if there is under-reporting of tuberculosis in women. Women face many barriers to getting care, including limited resources, stigmatization, and preference for traditional healers.

There is a need to better understand the differences between men and women in: risk of tuberculosis infection; risk of progression from infection to tuberculosis disease; barriers to access to tuberculosis care; and the socioeconomic impact of tuberculosis. With this knowledge it should be possible to recommend changes in tuberculosis control programmes to ensure optimal tuberculosis control for both men and women.

Noncommunicable diseases

As infectious and parasitic diseases are brought under control, and as populations age, noncommunicable diseases become more prominent. Women now spend a much greater proportion of their lives in the post-reproductive, post-menopausal years. Even if the problems are similar – for instance, breast cancer or cervical cancer – the strategies for dealing with them differ for younger and for older women. Older women are more vulnerable to cardiovascular disease, diabetes and cancers – noncommunicable diseases will therefore play a larger role in women’s health in coming years. In addition, the problems of older women often differ from those of older men, for example in the higher morbidity rates associated with incapacitating osteomuscular diseases, such as osteoporosis and arthritis, and the higher levels of depressive illness among women. Not enough is known about how noncommunicable diseases and conditions are manifested in women.

Heart disease is a case in point. Much of the research done on this major cause of death among women was based on long-term studies of men. It was assumed that the findings would apply equally to women heart patients, but experience is showing that this is not the case – cardiologists are learning that currently derived rules about diagnosis and treatment do not apply to women, for example:

- Half of all women who have a heart attack die within a year, compared with only 31% of men. If a woman has bypass surgery, she has a greater risk of dying during the surgery.
- Heart disease is not recognized in women as early as it is in men. A woman with chest
pain is less likely to be referred for an angiogram.

Clot-dissolving drugs have been studied in men but not in women. Standard dosages are based on the studies of men. Women are more likely than men to have bleeding problems while on clot-dissolving drugs.

These examples, related to heart disease, point to a broader phenomenon: women have often been excluded from research studies on issues outside of reproduction, or if they did participate, the results were not analysed to reveal possible sex differences. Women were absent from the clinical trials of many medications that are routinely used by women today. As a result, there is very little data on hormonal interactions with these drugs, or on the effects of metabolic differences between men and women.

Many more gender-sensitive studies are now being undertaken, but some questions can only be answered by long-term research. As a result, women will be some twenty years behind men in getting answers to some of the pressing questions about their health. Longitudinal studies on women and health are needed, particularly in the developing world.

Meanwhile heart disease, diabetes, and cancers not linked to reproduction (for example, lung cancer) are increasing among women in many developed and developing countries. Since these are all diseases often linked to "life-style", there are measures that women can take to reduce their risk, if they have good information, and if they are supported in making the necessary behaviour changes. For example, they can avoid smoking and drinking too much alcohol, and can try to get enough exercise. Women and men can also try to guide their children towards a healthy lifestyle.

Substance abuse

Gender-sensitive research has uncovered many differences between men and women in their experiences with substance abuse. For example, the rates of tobacco smoking among men have levelled off or declined in many developed countries, while the rates among women are still climbing and climbing fastest among young women. An estimated 21% of women in the developed world are smokers, whereas in the developing world the corresponding female smoking prevalence is estimated at 8%. In some developed countries the numbers of male and female smokers are currently converging. In many of these countries fewer men than women are taking up smoking and, in addition, the prevalence of female smoking is not declining as rapidly as it is among men.
The alarming increase in the prevalence of tobacco smoking among women is inevitably leading to large increases in female morbidity, and — as shown in Figure 17 — is fuelling in some developed countries an increase in smoking-related female mortality. In developed countries, the lung cancer death rates among women have in some cases doubled or even tripled in the past twenty years. In such settings, the percentage of all smoking-related female deaths due to lung cancer is around 23.4% — this means of course that a massive 76.6% of smoking-related deaths are due to other causes, a point graphically illustrated in Figure 18.

Figure 17: Woman increasingly die from smoking
Deaths from smoking at ages 35–69, United States of America, 1955–1995

In addition, when pregnant women smoke they are not only harming themselves but their babies — smoking increases the risk of miscarriage, low-birthweight, and sudden infant death syndrome.

In spite of such devastating and well-known health hazards, tobacco products continue to be aggressively marketed among women, and especially in developing countries. The health community has a responsibility to counter this trend. The general lack of published studies and research on women and substance use in most countries must now be addressed, and data collection and research into effective prevention/treatment measures for women must be improved and promoted.

There are also marked male/female differences in the effects of alcohol consumption. A woman absorbs more of the alcohol she drinks into her bloodstream as a result of several factors, including biochemical differences in the stomach lining, and differences in the proportion of body fat to muscle tissue. Women who drink heavily are more likely than men to develop cirrhosis of the liver. The babies of women who drink excessively when they are pregnant are at risk of foetal alcohol syndrome, which can cause physical deformity, mental retardation and other serious birth defects.

Socially, women drinkers are more likely to become isolated. They are less likely than men to seek treatment. A study in one Latin America country found that nine out of ten husbands leave their alcohol-addicted wives, whereas one out of ten wives leaves her alcohol-addicted husband.

Little is known about the consumption of alcohol by women in developing countries, but it is certain that the production of alcohol there has increased many times in the last few years — regardless of whether the increase is being consumed by men or women, the trend is disturbing: first because alcohol use in men is associated with domestic violence, and secondly because it is clear that alcohol producers, like cigarette producers, are targeting women and young people in their promotion campaigns in developing countries.

When men and women report similar psychological or psychosomatic symptoms, men are more likely to be given physical and laboratory tests, and women are more likely to be given drugs. This has led, in many parts of

Women took up smoking later than men in most countries, so the full impact on their health is just beginning to be realized. It is known however that smoking increases the risk of early menopause, and of osteoporosis.
the world, to increasing levels of dependency on prescription drugs among women. In developed countries, women in older age groups who are abusing drugs usually use minor tranquilizers originally prescribed by a doctor, sometimes mixing them with alcohol.

131 A significant number of younger women in developed countries use tranquillizers, crack cocaine, heroin and cannabis, while in developing countries opium and cannabis tend to be used. In both developed and developing countries, the use of glue, organic inhalants, and cannabis is increasing among teenagers, and this is often associated with cigarette smoking and beer drinking. The use of so-called "recreational" drugs by women during pregnancy – especially crack cocaine and heroin – increases the risks for mother and child and can cause major impairments and long-term developmental difficulties in the child.

132 There are disturbing reports about women and drug abuse coming from many parts of the world. In some rural areas of Africa the use of cannabis by adolescent girls is considered a major community health problem. More women and girls are getting involved in the drug trade as "pushers" and couriers. More women who use drugs are resorting to sex work to finance the habit.

133 Women who inject drugs have been found to have a higher incidence of HIV infection compared to their male counterparts. Women tend to stop men when they are sharing needles just as they do when sharing food. The drug paraphernalia is usually passed around and used by the men first, then by the women, so that the women are more likely to be using contaminated needles.

134 The rehabilitation and treatment needs of women drug abusers differ from those of men. However, very few rehabilitation facilities specifically address women's needs, and there is a general lack of information on how to deal with drug abuse among women.

135 While quite a bit is known about the patterns and effects of substance abuse among women, less is known about the underlying causes. The work that has been done in this area links women's substance abuse with low self-esteem, escape from repressive life situations, peer pressure, a desire to "belong", and the need to find a way to gain status within the group.

A few decades ago much of the research on women's mental health involved a search for biological causes of mental illness in women. Later there was a search for correlations between women's mental health and socioeconomic and cultural factors. More recently a gender perspective has been applied to mental health, taking into account men's and women's status, roles and positions in society.

137 In developing countries, community surveys usually find more women than men suffering from some form of mental illness, but more men getting treatment. In some developing countries, many women with mental disorders are treated by general practitioners and are usually given tranquilizers or sedatives, while men are more likely to be referred to specialists.

138 Depression is the most common mental disorder among women in developed countries. Although adequate data are lacking in developing countries, it appears that the same is true there. A multicountry study coordinated by WHO showed that female depression rates are almost double the male rates in both developed and developing countries. More women than men attempt suicide (Figure 19) but more men actually kill themselves.

139 Many reasons have been put forward to explain the higher incidence of depressive disorders in women: biological or physiological factors; women's greater readiness to admit distress and seek help; possibility of the diagnosis being influenced by cultural expectations of women and

Figure 19: Attempted suicide
Age-specific rates per 100,000 population in 16 European cities, 1989–92

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<tr>
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<td>235</td>
<td>517</td>
</tr>
</tbody>
</table>

Age groups
55+ | 50+ | 40+ | 30+ | 20+ | 10+ | 0

(Revised Nordic epidemiological study, 1984)
stereotypes about what is “normal” for a woman; the stress brought about by discrimination against women in employment and other areas; the fact that women are more likely to be in lower socioeconomic levels; and demands made on women by their sometimes conflicting roles.

Depression in women has also been found to be associated with infertility, an unhappy marital situation, heading a single-parent household, physical violence or sexual abuse, poverty, and isolation in old age. A recent WHO publication on women’s mental health concludes:

When women’s position in society is examined, it is clear that there are sufficient causes in current social arrangements to account for the surfeit of depression and anxiety experienced by women.

The gender perspective has been a useful addition to the work on women’s mental health. But there is still much to be done in order to understand the origins of mental illness in women; to help women find ways to protect their mental health and avoid illness; and to develop and disseminate more effective treatment strategies for women.

Violence against women

In a world where violence seems endemic, both men and women experience it in many forms and both suffer considerable damage to their health and well-being because of it. But the nature of the violence they are exposed to is almost always different, the causes of it are usually different, and the impact on their lives is different.

Women are exposed to a continuum of violence. It goes from domestic violence taking place in the home, where the woman or girl usually knows the assailant; to settings outside the home where women are subject to random violence by people unknown to them; to the large-scale, systematic violence against women found in situations of conflict and mass movements of people.

All these types of violence directed against women are linked to the same familiar causes – the lower social status of women; the notion that women are the “property” of men and that it is acceptable for men to exercise control over them, by physical force if necessary; and the societal tolerance of human rights abuses against women.

Domestic violence has been called “the hidden epidemic”. There is a certain reluctance to take action on human rights violations against women when they occur in the privacy of the home and family. Yet the statistics gathered in the last decade have forced the world to face up to the true nature and dimensions of the problem – see Box 5 – and to recognize domestic violence as an urgent public health issue.

The selected examples shown here indicate the extent of domestic violence and its impact on women:

- Worldwide, studies indicate that from 20% to over 50% of women have been beaten by an intimate male partner.
- In South America, one study found that 70% of all crimes reported to the police were of women beaten by their husbands.
- In the USA, up to one-third of women patients in hospital emergency departments are there because of injuries sustained in domestic violence.
- In Papua New Guinea a survey found that over half of married women in cities had been battered; and almost one in five of these women had gone to a hospital after being beaten.
- A study in Alexandria, Egypt, showed domestic violence as the leading cause of injury to women, accounting for 25% of all visits by women to trauma units.
- In a survey in the Kisii District of Kenya, 42% of women reported being “beaten regularly” by their partners.
- In Jamaica, a study among girls aged 11–15 years found that 40% reported the reasons for their first sexual intercourse as “forced”.
- In a nationally representative sample of Canadian women, 29% of those ever married reported being physically assaulted by their current or former partners.

Domestic violence is found in all societies, in countries at all levels of development, in all socioeconomic groups and cultures. It includes physical battering, incest, rape, sexual abuse, and psychological bullying and exploitation. The victims are overwhelmingly women and girls, although women too can be batterers. Children too, boys and girls, are victims of domestic violence in the form of battering, sexual abuse and incest. Victims of violence can then go on to experience serious physical and psychological consequences. Battered women have a higher rate of depression, attempted suicides and other psychiatric morbidities and are also reported to have more pelvic pain and increased somatic complaints, in addition to serious injuries.

Various factors make women reluctant to report domestic violence: threats from the assailant; belief by the women that her husband or partner has the right to do it or that she “deserved” it; economic insecurity and fear of what might happen if she were left to fend for herself. Police and legal systems have not, as a rule, made it easy for women to report domestic violence, nor have they been very effective in deterring or punishing it. Some women make repeated trips to emergency rooms and clinics, each time with more serious injuries. Their injuries are often not recognized or reported as deliberate violence until they end in homicide.

Most health systems and health planners at all levels have been slow to respond to this “hidden epidemic”. Women in many countries are demanding that the health sector:

1. regard domestic violence as a serious public health issue
2. undertake more specific research on its causes, consequences and ways to prevent it
3. disseminate information about domestic violence to health workers or conduct training to strengthen their ability to recognize the signs of domestic violence.

Promoting violence-free families and societies is a long-term task. But at least recognition of the problem is increasing. The health sector has an opportunity at this point to play a key role in exposing domestic violence for what it is, and making known the damage it does to women's physical and mental health.

Outside the home women are subject to violence in the form of rape, forced prostitution and other exploitation. Although more rapes are reported now, it is estimated that 9 out of 10 still go unreported. Women's groups in many countries have set up centres to help rape victims with counselling, support and assistance in reporting rape and bringing the offender to justice. They help women get the physical and psychological health care they need.

The damage to women's health caused by rape can be extensive. Women are often beaten by the rapist. They are potentially exposed to sexually transmitted diseases (including HIV/AIDS) suffer damage to their reproductive organs, and may even be killed. They may be left with an unwanted pregnancy, and most women experience short- or long-term adverse psychological effects. Assault and battery during pregnancy appears to be tragically more common than once thought, and is apparently associated with poverty, extreme youth and unwanted pregnancy.

Women are especially vulnerable in situations of armed conflict or mass population movements. Women forced to leave their homes as refugees or displaced persons are often separated from the men in their families and have few means to protect themselves from violence. A refugee woman who has children or other dependents with her is vulnerable to sexual exploitation. Her only means of assuring their food and safety may be to accede to the demands for sexual favours made by soldiers, border guards or camp administrators.

In recent hostilities, there have been many examples of violence against women being used as a punitive measure against the enemy. This systematic rape and brutal sexual abuse destroys the dignity of women and violates many of their human rights, including their right to physical integrity; to survive, and to lead full and fulfilled lives.
The role of WHO in women's health

Towards better health for women

Almost 50 years ago the International Health Conference defined health as:

a state of complete physical, mental and social well-being; and not merely the absence of disease.

This definition is embodied in the WHO Constitution which also affirms that

everyone has the right to the highest attainable standard of health.

In the same period, the Universal Declaration of Human Rights was adopted by the General Assembly, proclaiming the right of all human beings to live in conditions that enable them to enjoy good health and health care, and stipulating that:

Everyone is entitled to all the rights and freedoms set forth in this Declaration without distinction of any kind, such as race, colour, sex...

Several other United Nations declarations, documents and human rights instruments also make provision for the promotion and protection of the health of girls and women – see Box.

WHO is guided by the following operational principles, which are fundamental in promoting the centrality of human health and well-being to the process of development. The application of these principles is central to WHO’s activities in the area of women’s health.

- Health is a fundamental human right
- The highest attainable standard must be maintained
- Equitable relationships between women and men and equality of opportunities must be achieved
- Services must be accessible

1948 Universal Declaration on Human Rights
1966 International Covenant on Civil and Political Rights
International Covenant on Economic, Social and Cultural Rights
Condemned discrimination on the grounds of sex, and recognized the universal right to the highest attainable standard of physical and mental health
1979 Convention on the Elimination of All Forms of Discrimination against Women
Called for the elimination of all forms of discrimination against women, including in access to education, health care and family planning
1990 Convention on the Rights of the Child
Protected the rights of children with special attention to girls
Expanded the international human rights agenda to include gender-specific violations
1993 Declaration on Violence against Women
Elaborated the definition of gender-based violence against women and defined it as a crucial human rights issue
1994 Programme of Action of the International Conference on Population and Development
Emphasized gender equity, equality and empowerment of women as central and placed family planning in a broader reproductive health framework
quality of care must be assured
individuals, families and communities must be fully involved in the promotion and protection of their own health
a life-cycle approach to health
partnerships must be established between health care providers and clients and with sectors other than health
health services should be integrated to promote a holistic approach to health care provision
to invest in human resources is to invest in social and economic development
optimal use should be made of human and material resources
interventions must be sustainable.

Women do not perceive their bodies as separate groups of organs each requiring a different set of interventions. Nor do they see their lives as a series of discrete periods with the ages around pregnancy and childbearing as being the only ones of significance. And women are concerned not only with their own health needs but also with those of their children and other family members.

Yet the way health systems have been set up around the world is such that it is almost impossible to find a single facility that can address simultaneously the needs of young and older women, their children, or different concerns such as reproductive tract infections and tropical diseases. Clearly, not every facility should be able to offer every kind of care. But every facility should be able to direct women effectively to the most appropriate place for care, and that place should be accessible, available, affordable and able to offer a high quality service. Research will be needed to develop alternative models providing such integrated services in different socioeconomic and cultural settings.

Improving women’s health and eliminating inequalities requires partnerships of many kinds: women and men; old and young; international agencies, governments and NGOs; researchers in many disciplines; health professionals, women’s health advocates, and programme planners in many fields. All of these groups need to work in close partnership with community members and users of health services.

In its own activities and in these partnerships WHO will continue to:
advocate for greater allocation of resources to programmes that effectively address the health needs of women.
promote preventive strategies and programmes.
promote and expand the use of gender-sensitive approaches in all health programmes, through staff orientation, expansion of training activities in the regions and support for national training activities.
ensure that the voices of women are heard in identifying health issues, planning and carrying out interventions, and evaluating the results.
advocate for a greater proportion of women in decision-making and leadership positions in the health sector at all levels, from local and district health offices, to national ministries, to the highest levels of international organizations.
work for improved sex- and age-disaggregated data collection and analysis to sensitize policy-makers and lead to more effective action in the health sector.

For WHO, one of its most valued partnerships is with women health care providers – those millions of women who work day in and day out in health systems around the globe – see Box 7. In looking at women and health, there is a tendency to concentrate on women in need of health care or women as users of health services. However, WHO is mindful, too, of the inestimable contribution made to health by the women who provide health care to others – despite the often poor salaries and limited career opportunities available to women in largely male-dominated health-system hierarchies.

At the end of the 20th century, global economic, social and political shifts make it imperative for the perspectives and contributions of women to be brought more forcefully into the health and development arena. WHO has an opportunity and a responsibility to address women’s health and quality of life issues in all of its activities. Women’s health must now assume its rightful place high on all social, economic and development agendas.
Women form the backbone of the health system in almost every country. They give long years of dedicated service as community health workers, nurses, midwives, doctors, pharmacists, nutritionists, health educators, and in many other capacities. Their contribution to the community and nation goes far beyond professional functions and office hours. They are health advocates, health promoters in the community, health care providers and carers for their children, the elderly and the infirm.

In some countries, women have served with distinction at the highest levels of national health systems. In general, however, women have been under-represented at the top decision-making levels of health systems, a situation that WHO is working to correct.

Gender issues affect women health care providers at all levels. Gender discrimination, combined with the age hierarchy in some societies, means that young female health workers face increased hardships and discrimination in job conditions and promotion, and may be subject to harassment at work.

In areas where women do not use health services unless they can be seen by women health workers, it is particularly urgent to recruit and train more women. However, the same cultural factors that block women’s use of health care facilities may make it difficult to recruit women health workers unless their special needs are met. It is important that women in the health professions receive good training, are not discriminated against in pay or career opportunities, and have the support of more experienced workers in their first years at work. They should also have access to housing and transport, and working arrangements should be safe and culturally appropriate.

The work of WHO

Part of WHO’s commitment to improving women’s health is to make sure that the voices of women are heard wherever decisions are made about health. Particular attention is being paid to incorporating a gender perspective and addressing women’s concerns in the work of WHO at both Headquarters and Regional levels.

Many programmes across the range of WHO’s activities have made efforts to increase the emphasis placed upon women’s health as an issue in its own right, and have attempted to ensure that this is reflected in programme activities. A selection of these activities across the broad spectrum of WHO’s work are presented below.
WHO has strengthened the emphasis given to women's health issues by creating the unit of Women, Health and Development (WHD) within the Division of Family Health (FHE). The objective is to accelerate activities in women's health, and develop and consolidate a coherent and comprehensive strategy. At the regional level, focal points on women, health and development work to strengthen and coordinate activities for women in all WHO programmes, and to liaise with other organizations of the United Nations system concerned with women's health and development.

WHO has declared reproductive health to be a priority and allocated more resources to it. WHO will continue to work with governments to implement integrated reproductive health programmes reflecting the broader approach to reproductive health, the empowerment of women and equitable gender relations recently endorsed by the International Conference on Population and Development (ICPD). WHO is devoting new energies to developing practical and appropriate methodologies in this area. Priority will be given to involving women in the identification of needs, and the development and evaluation of policies and programmes.

In order to address the continuing concern about maternal mortality and morbidity, WHO has developed the Mother–Baby Package (see 10:079) as a practical way in which to accelerate action at country level. This brings together several priority components of reproductive health – family planning, safe motherhood and STD management – around a core of maternity care, and promotes the decentralization of care and the delegation of responsibilities to people with midwifery skills in order to ensure that care is available as close as possible to where women live.

The Division of Family Health sets norms and standards, and develops guidelines on the technical and managerial aspects of the whole range of contraceptive methods. WHO recognizes the importance of integrating women's perspectives to improve the design of information and services in family planning. In recent years, WHO has promoted dialogue on fertility regulation technologies between researchers, policy-makers, and women's health groups in an effort to ensure that research and service activities reflect the needs and perspectives of the women who are the primary users of these technologies. Dialogue meetings have been held in several regions – Asia, Africa and Latin America. In addition, women's health advocates serve on various committees and sub-committees of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP). They take part in the design, monitoring and evaluation of both clinical and introductory trials and are

The Mother–Baby Package recommends a basic set of simple interventions focused on the main causes of maternal and newborn mortality:

- before and during pregnancy – information and services for family planning; STD/HIV prevention and management; antenatal registration, check-ups; treatment of existing conditions (for example, malaria, hookworm); advice regarding nutrition and diet; recognition, early detection and management of complications such as eclampsia, bleeding, abortion and anaemia; tetanus toxoid immunization; iron/folate supplementation.

- during pregnancy – clean and safe delivery; access to essential care at a health centre or hospital for bleeding, eclampsia, prolonged obstructed labour and other complications.

- after delivery (mother) – prevention and early detection of postpartum haemorrhage, sepsis and eclampsia; postpartum care including support for breast-feeding, family planning and STD/HIV prevention services; tetanus toxoid immunization.

- after delivery (newborn) – resuscitation when necessary; keeping the baby warm; early and exclusive breast-feeding; prevention, early detection and treatment of infections including ophthalmia neonatorum and cord infections.

If properly applied, the Mother–Baby Package could avert approximately 50% of the estimated total of 500,000 maternal deaths per year, and reduce neonatal mortality by a third. It would also lead to significant improvements in the health and well-being of mothers and newborns.
involved in developing ethical guidelines for research.

Increasing awareness of the extent of violence against women is resulting in greater momentum on this public health and human rights issue. WHO is seeking to cooperate with health workers and professional associations in order to raise awareness and improve skills for management and referral of the health problems resulting from violence against women. Preventive strategies need to be developed and tested. There is a need to agree definitions and methodologies to better assess the magnitude of the problem and to evaluate the effectiveness of different interventions. WHO is initiating work in this area.

WHO is working towards the elimination of female genital mutilation (FGM) through its efforts in advocacy and normative technical guidance. Emphasis has been given to the development of a standardized system of classification of different types of FGM, and recommendations on research priorities including common methodologies, and to providing technical input to countries, NGOs and other international organizations to support efforts to eliminate the practice.

Ten years ago, women were regarded as being on the periphery of the HIV/AIDS pandemic – now they are at the centre of WHO’s AIDS agenda – a shift apparent in the research activities now being supported by WHO which include:

- clinical research and development studies into vaginal microbicides and the “female condom” both of which are female-controlled methods to prevent the sexual transmission of HIV
- research into the prevention of mother-to-infant transmission of HIV using antiretroviral drugs, with an emphasis on approaches that would be feasible in resource-poor settings.
- social and behavioural research on gender relations in the area of high-risk sexual behaviour, particularly among young people.

Among its many activities in the area of care WHO has supported the integration of HIV/STD prevention services into MCH/FP programmes, a move which would greatly increase the accessibility of such services to women. In order to identify approaches and interventions which have been particularly successful in reducing HIV transmission among women, WHO recently convened a meeting on “success stories” in this area. WHO, in collaboration with an NGO, has also developed a resource pack on women and AIDS to be used by national AIDS programmes (NAPs) as well as NGOs working at country level.

WHO is working to provide guidance to countries on appropriate prevention, detection and treatment strategies for cervical cancer. In most developing countries a meaningful coverage of all at risk women through cytological screening will not be possible for decades to come because of lack of economic and human resources. WHO has created a Study Group on control of cervical cancer in developing countries to analyse and evaluate the feasibility and effectiveness of alternative low-cost strategies in resource-poor settings with special emphasis on visual inspection of the cervix in asymptomatic women to detect cervical cancer at an earlier, curable stage. These approaches will be used as interim alternatives to mass screening, which remains the most effective technique for early detection and management of cancer of the cervix.

The health and social status of women have a direct impact on the health and nutrition of the family, particularly infants and young children. This important principle was underscored in the Plan of Action for Nutrition adopted at the International Conference on Nutrition:

*Women are inherently entitled to adequate nutrition in their own right as individuals. They need to constantly balance their reproductive, nurturing, educational and economic roles, which are so important to the health and nutritional well-being of the household and of the entire community ... Special attention should be given to the nutrition of women during pregnancy and lactation. Equity in the allocation of food between girls and boys must be promoted.*

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The World Declaration and Plan of Action for Nutrition – which represent a global consensus on the nature and causes of nutritional problems – serve as the platform for WHO's continuing technical support to countries, including those with high levels of malnutrition. Meeting the health and nutrition needs of the family, particularly of women, infants and young children, is a key aspect of WHO's support for food and nutrition activities at all levels. WHO has developed collaborative activities with the International Food Policy Research Institute (IFPRI) examining for example intrahousehold resource allocation, and whether sex and age biases exist.

A large proportion of the severely iodine-deficient are women in their reproductive years whose babies are at high risk of irreversible mental retardation unless they receive adequate amounts of iodine. WHO's primary focus in preventing and controlling iodine deficiency disorders continues to be on achieving sustainable universal salt iodization. Pending the successful establishment of salt iodization in iodine-deficient areas, WHO recommends giving women iodized oil, which is safe at any point during pregnancy for purposes of preventing and controlling moderate and severe deficiency.

WHO provides information on the worldwide distribution of protein-energy malnutrition in developing countries through its Global Database on Child Growth. An analysis of maternal anthropometry and pregnancy outcomes describes to what extent anthropometric measurements are useful and efficient in predicting maternal and child outcomes of pregnancy in different country settings. One objective is to develop specific reference curves for maternal weight gain in different populations for use as tools for monitoring pregnancy in the community and home.

Iron deficiency remains a global problem of massive dimensions, particularly iron deficiency anaemia in women, infants and children. The WHO database on anaemia in women monitors anaemia prevalence among pregnant and non-pregnant women worldwide. WHO is supporting research on different iron supplementation strategies, in order to overcome problems such as lack of compliance and logistic difficulties.

In some areas, women's susceptibility to nutritional anaemia is compounded by infection with intestinal parasites, particularly hookworm. Although certain drugs are known to be effective against hookworm there has been debate as to the appropriateness of using them during pregnancy because of possible effects on the fetus. In 1994, therefore, WHO organized an Informal Consultation on Hookworm in Women which developed guidelines on treatment strategies, particularly during pregnancy.

Because WHO's entire food safety programme contributes to disease prevention and health promotion, it is also directly conducive to promoting women's health. Two specific diseases, toxoplasmosis and listeriosis, are of particular importance to women. Both can be prevented by applying elementary food safety measures. The programme's activities aimed at reducing or eliminating chemical food contamination help to reduce women's exposure to a number of environmental pollutants, for example polychlorinated biphenyls (PCBs), dioxins and mycotoxins, thereby protecting their health and reducing or preventing altogether chemical contamination of their breast milk.

To increase worldwide protection, promotion and support for breast-feeding, WHO and UNICEF launched the Baby-Friendly Hospital Initiative in June 1991. These efforts aim at ensuring that health services become more woman-friendly, and more welcoming to families. WHO and UNICEF are supporting national authorities responsible for designating maternity wards and hospitals “baby-friendly”, by using international assessment criteria, providing programme guidelines, developing training manual and other materials, and supporting related training activities.

WHO is currently synthesizing existing research and data on women, health and environment and has prepared training materials on these issues that can be used in a variety of disciplines and settings. Specific activities in this area include recommendations for research, and interdisciplinary action on the use of domestic fuels for heating and cooking in developing country settings. WHO is working on country projects in Ethiopia and Vietnam to improve women's health through increasing fuel security, enhancing income, and promoting home
and other substance abuse – action now could prevent millions of young people, especially young women, from starting to use addictive substances, thereby saving them from a lifetime of health-destructive behaviour. WHO has carried out a project on “Women and Substance Abuse”, supported by the United Nations International Drug Control Programme (UNDCP).

WHO’s work on women and substance abuse includes a project on the victimization of women substance users, which aims to sensitize drug treatment agencies to gender issues, particularly the special needs of women. Another project will investigate the relationship between substance use and high-risk sexual behaviour in different cultural contexts. A report – *Preventing fetal effects of substance abuse* – will include guidelines for the selection of appropriate educational messages on psychoactive substance use and pregnancy, for the dissemination of these messages and evaluation of campaigns. The ongoing Street Children Project is considering the specific concerns and needs of street girls.

Many developing countries are at a critical point in time on the issues of tobacco, alcohol improvements to decrease the health risks of dependence on traditional, low-grade fuels. As larger numbers of women enter the labour market, both formal and informal, more will be done to identify and address the specific concerns of women in their working environment – similar concerns can also apply to household work. WHO has recently launched a new programme initiative entitled Promotion of Research and Training on Women, Health and Environment.

One essential objective of WHO’s activities in the area of adolescent health is to strengthen gender equity between the sexes as a crucial part of the healthy development of young people. Ways of achieving this include promoting healthy behaviour; preventing specific problems including STD/HIV.
infection and unplanned and unwanted pregnancy; and advocating and supporting the provision of information and care to those in need. Special attention has been given to the development of participatory methods which permit young people to contribute to the planning, implementation and evaluation of actions designed for their benefit. Another key activity is to provide technical support to key partners in the United Nations system, governments and NGOs to strengthen policy and programming at country level.

A new programme on aging and health was recently launched. Among its key perspectives (life course; health promotion/healthy aging; cultural; intergenerational; ethical; and gender) a strong emphasis is given to the differences in health and ways of living between men and women. A major review paper – Women, Aging and Health – has already been prepared in collaboration with the Global Commission on Women’s Health, and programme activities now planned will reflect the paramount importance of the “feminization of older age” not only because women live longer, often in poor health, but because most of the care givers for older people are themselves female.

In its efforts to combat tuberculosis, WHO is working to better understand the differences between men and women in terms of:

- risk of infection with tuberculosis
- risk of progression from infection to disease
- barriers to access for tuberculosis care
- socioeconomic impact of tuberculosis.

WHO is carrying out research which it will use to make recommendations for changes to tuberculosis programmes to ensure optimal interventions for both men and women, and will make recommendations on the cost-effectiveness of tuberculosis control interventions. The burden of death and disease due to tuberculosis among women is too great to be ignored, and tuberculosis now needs to be placed firmly on the women’s health agenda.

WHO recognizes the importance of gender issues in relation to tropical diseases. Two activities currently been coordinated by the Special Programme for Research and Training in Tropical Diseases (TDR), involve a women’s health NGO, and several WHO programmes working to develop a Healthy Women Counselling Guide, and a manual for health workers – Health Workers for Change.

TDR is also concerned that both biomedical and social research on the effects of tropical diseases on women has taken a narrow perspective, focusing primarily on differences related to pregnancy and reproduction. There has been little examination of the relationship between tropical diseases and the broader social roles and responsibilities of women. With the collaboration of the International Development Research Centre in Canada, TDR is promoting research on the determinants and consequences of tropical diseases for women.

Malaria in pregnancy is a major public health problem. The global malaria control strategy promoted by WHO incorporates technical advice in all training materials, and national control programmes are advised to make specific provision for this subject in their plans. Antimalarial services are advised to concentrate on providing appropriate information to women so that they can identify danger signs, seek prompt treatment and treat sickness with correct and adequate dosages of medicine. A major thrust is disease management at the most peripheral level possible – women and children should be the major beneficiaries of this strategy.

Based upon field experience, WHO has developed a set of guidelines on diarrhoea and acute respiratory disease to assist health workers working to provide mothers with the necessary knowledge and skills, and to build the mothers’ self-confidence so that they can give adequate care to children suffering from these conditions.

The health sector recognizes its limitations in responding to broad societal issues, but an intensified intersectoral effort can be effective. In Benin, for example, the Ministry of Public Health directs a programme of economic intervention that supports 200 small projects initiated by women and unemployed young people to earn money for financing community health facilities. The project is a collaborative effort with input from WHO, the International Labour Organisation, the World Bank, the United Nations Development Programme (UNDP), and several NGOs, including the Association des Femmes Béninoises pour le Développement.
WHO’s emergency and humanitarian activities include a rehabilitation programme for war-affected populations in former Yugoslavia with special services for women who are victims of rape. A WHO emergency mental health project in Tajikistan provides mental health counselling for conflict-affected populations, including widows and victims of rape. Health services set up for refugee women have traditionally been focused on maternal and child health needs. Now there is a growing demand for a broader range of health services, including all aspects of reproductive and sexual health for women and girls. WHO is collaborating with the Office of the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Population Fund (UNFPA) in the development of a manual on reproductive health in refugee situations. WHO is also preparing technical guidelines on reproductive health in refugee situations for field workers.

All of WHO’s work in women’s health is guided by the *Ninth General Programme of Work*, which draws attention to the risks of marginalization of vulnerable groups, particularly women, in overall development. It also emphasizes the human-rights basis for the protection of women’s health at all stages of life, noting their increased vulnerability in situations of economic hardship, violence, warfare and environmental degradation. Among the major intended results of the *Ninth General Programme of Work* are the removal of inequities and the meeting of the special needs of women.

**Regional achievements**

WHO Regional Offices actively promote women’s leadership and participation in health through consultations, through national and regional networks involving governmental and nongovernmental representatives, and through workshops and leadership training programmes. Although each Region has a different focus for its activities, a number of commonalities emerge, such as the need for improved data collection and analysis; for more research on women’s health; and a universal concern for reproductive health issues.

Regional Office for Africa

The African Region has been most affected in recent decades by environmental disaster and civil disturbances. In addition, Africa continues to experience the negative effects of debt, the terms of trade, and structural adjustment policies. All of these have had serious repercussions on the health status of disadvantaged segments of the population, especially women, and on health services throughout the Region.

It is in this context that the WHO Regional Office for Africa has made the health of women one of its top priorities. The Regional WHD programme was established within the WHO Regional Office for Africa (AFRO) in 1990 to give greater priority to addressing women’s health and development as well as to promote a more in-depth study of women’s situation in the Region.

Maternal and child health and family planning continues to be one of three priority programme areas for accelerating Health for All in the Region. However, a new orientation has gradually been emerging in recent years, characterised by a more holistic approach to women’s health.

Since 1990, a multisectoral team approach on “promoting women’s leadership and participation in MCH/FP has given rise to a
network of multidisciplinary teams in 11 countries of the Region. In five countries action research on women’s participation and leadership was conducted.

The Regional Committee for Africa, in its Forty-Third Session (1993) examined the position of women in overall development and passed a resolution entitled Women, Health and Development. This resolution puts emphasis on Member States developing an enabling legal framework for women in development, and making appropriate budgetary allocations to their WHD programmes. In addition 41 of the 46 countries in the Region have nominated focal points and a network has been created to identify priority issues affecting women’s health in the Region.

Promoting health through women’s functional literacy

An AFRO initiative is “promoting health through women’s functional literacy” which aims to improve the health and well-being of particularly vulnerable women through literacy linked to feasible and sustainable income-generating activities, health education, and community mobilization. Functional literacy has proved to be a key element in women’s empowerment by providing them with the skills which are crucial in helping them to overcome the myriad of health and other problems they face in their everyday life.

Activities to combat HIV/AIDS have been key in the Region. A “Women and AIDS Task Force” was established in 1992 within the Regional Office. Unfortunately, its activities were hampered by financial constraints, but AFRO continues to provide technical support to core groups of nurses working in the field of HIV infection and AIDS, and is supporting activities to increase the research capabilities of nursing and midwifery personnel. WHO has supported community networks that have been formed to fight against HIV/AIDS. Examples include the AIDS Support Organisation (TASO) in Uganda, and the Society for Women and AIDS in Africa (SWAA) in Zambia. AFRO is also advocating for changes in the provision of MCH/FP services, as well as for the establishment of policies that could reduce the socioeconomic and cultural factors that place women at increased risk of HIV/AIDS.

Support is being provided by the Regional office to three countries where female genital mutilation (FGM) is widely practised to establish national policies, guidelines and programmes for its elimination.

Activities to provide education to health planners on the importance of gender analysis and the collection of sex-disaggregated data are also being pursued.

Regional Office for the Americas

The Women’s Health and Development Programme (WHD) of the WHO Regional Office for the Americas (AMRO) is a fully fledged programme within the Division of Health and Human Development, with four full-time and one half-time professional staff and two support staff assigned to it. In addition, all country offices have a WHD focal point.

A gender approach forms the basis for the work on women’s health of the WHO Regional Office for the Americas. During 1995, all the Regional Office staff will participate in a series of seminars designed to help them incorporate a gender perspective into their work in a more systematic manner. For this, AMRO has developed gender and health-training manuals for training-of-trainers and for participants. Training seminars have already taken place with the WHD focal points from the region, and are ongoing at country level for AMRO staff, ministries of health staff, health personnel, and others dealing with health issues.

Another major activity of WHD is improving the level of information and knowledge available on gender gaps in health, and developing women’s health profiles at the regional and sub-regional levels, and in selected countries. WHD collaborates with other technical units to ensure that health and social-sector data are collected and reported with a gender perspective, and also focuses on strengthening the capacity of health systems to analyse health data accordingly.

Among its ongoing specific activities AMRO is initiating a 12-country action-research project on violence against women, carrying out advocacy and promotional activities for the legal equality of women. AMRO is also working with indigenous women in Central America with a focus on health promotion. A methodology to look at quality of care with a
Gender perspective is being piloted for use in the Region and worldwide. Strategies to mobilize, organize and develop women’s leadership abilities in promoting, protecting and monitoring their health is an area of work in which AMRO works closely with nongovernmental organizations (NGOs) in the region.

Regional Office for the Eastern Mediterranean

During the last decade there has been a growing trend in the Region for women to be seen not only as beneficiaries of health programmes, but as providers of health and as equal partners with men in national development. In the medical, health and nursing professions the number of women is increasing in several countries. There is also a growing awareness in many EMRO countries about various aspects of social discrimination against women. Female literacy, birth-spacing, and neglect of girls now appear as themes in television programmes and lay journals. Efforts are now being focused on creating awareness of the importance of women’s health, and on developing a holistic approach, with an emphasis on adolescence.

The WHO Regional Office for the Eastern Mediterranean (EMRO) gives particular attention to action to reduce maternal mortality through safe motherhood. It is working with several countries (Egypt, Iran, Pakistan, the Syrian Arab Republic, and Yemen) to undertake reliable assessments of maternal mortality through community studies and identify feasible measures to address this. Placing a trained birth attendant in each village is a high priority objective in the MCH programme in most countries of the region. Efforts have been made to implement the Mother–Baby Package as a step towards safe motherhood.
Advocacy on women’s issues at the highest administrative level has resulted in political commitment which was unthinkable even in the 1970s. There has been a growing acceptance of family planning for health as an essential requirement for the promotion of women’s health in EMRO countries – most of which have incorporated this as an integral part of maternal and child health programmes.

The promotion and protection of breast-feeding is a high priority for EMRO. A two-pronged approach involving the Baby-Friendly Hospital Initiative and adoption of the International Code for Regulating the Marketing of Breast-milk Substitutes is being promoted.

The emergence of noncommunicable disorders such as obesity, non-insulin dependent diabetes and hypertension in young women is of concern, especially in the economically affluent countries of the Arabian Peninsula. EMRO is taking action through the mass promotion of healthy lifestyles. In addition, the health of elderly women is a major concern for EMRO given the projected increases in the number of such women in the population. The issue of women and AIDS is seen as another priority.

**Regional Office for Europe**

The WHO Regional Office for Europe (EURO) set up the Women’s Health Counts initiative in 1993. This was motivated by the recognition that the changes regarding women’s health in the European Region have been largely negative – see Box 9. The gap in health indicators between the countries of Western and Eastern Europe – and between the rich and poor within Western European countries – has widened, and these trends have had particularly adverse effects on women’s health.

Women’s Health Counts was initiated to address these issues in a consolidated manner. It initially focused on women’s health in the countries of central and eastern Europe (CCEE) and the newly independent states of the former USSR (NIS). Countries selected national focal points for the coordination of data collection, and “women’s health profiles” were prepared for each country. The information gathered from 11 Eastern European countries was presented at a Conference in Vienna in February 1994. The Vienna Declaration, which resulted from this meeting, aims to put women’s health at the forefront, and recommends that countries establish systems to collect sex-disaggregated data in order to monitor women’s health. Since the conference, 25 more countries have joined the initiative and health profiles are being collected for all of them.

In 1993, the WHO Regional Office for Europe took steps to help countries in its region improve the monitoring of women’s health. In this time of many changes in the countries of central and eastern Europe (CCEE) and in the newly independent states of the former USSR (NIS), a study has been carried out to assess the impact of the change on the daily lives and health of women.

Some of the findings are cause for concern. In many places there is a serious lack of medicinal drugs, or they have become prohibitively expensive for most people. Once-strong state health systems have deteriorated. Indicators such as maternal mortality, infant mortality, and morbidity from circulatory diseases in women are rising. Other worrisome areas are women’s mental health and the lack of adequate nutrition, leading to increasing levels of anaemia, particularly among pregnant women. In some places many maternal deaths are linked to a high abortion rate, not a surprising development since contraceptives – if available at all – may cost up to one third of a woman’s income.

An increase in violence against women, often linked to the consumption of alcohol by men, has added physical insecurity to their other concerns. Domestic violence and certain other types of violence have increased in Western Europe as well, but in CCEE this is now combined in several places with the brutalities of war. The results have been particularly traumatic for women. WHO will continue to work with countries undergoing rapid political and economic changes to help them minimize the adverse effects on health.
EURO is collecting and analysing information to assess which are the health priorities, and to provide the basis for programmes to improve women’s health in the Region. The country profiles will be compiled in a comparative analysis of women’s health in east and west entitled *Highlights of Women’s Health in the European Region*.

Women’s health is also a component of the Multi-City Action Plan Project (MCAP). Participating cities have nominated coordinators to look at women’s health services in the cities. Some of the cities have produced Women’s Health City Profiles, for example St Petersburg and Glasgow.

Other specific women’s health interventions include projects related to reproductive health, and family planning services, such as technical assistance to central and eastern Europe and the former Soviet Union. This technical assistance includes training in contraceptive technology, counselling, sex education, STD prevention, and programme management and logistics. A European family planning quarterly magazine called Entre-Nous is published in five languages, including Russian, and has a circulation of 11 500. It aims to give counterparts in different countries a forum to discuss priority issues in women’s reproductive health.

Greater visibility has been given to women’s health and development at regional and country levels over the past few years. This has been accomplished largely through advocacy, information dissemination and the creation of opportunities for dialogue within countries, and within the WHO Regional Office for South-East Asia (SEARO).

Key specific activities include: national meetings on women, health and development held in four countries to bring together representatives of governments, institutions, NGOs and United Nations and donor agencies to identify priority issues and strategies and mobilize in-country expertise and resources. WHD focal points have been designated within ministries of health, and within many of the WHO Country Offices – in the Regional Office itself there is a WHD Core Group to facilitate information exchange, and action.

A Regional Consultation was held earlier this year and will form the basis for future action and specific interventions on women’s health in relation to advocacy, policy, programmes and research. The Regional Consultation identified as major health issues that need to addressed: malnutrition, anaemia and other nutritional deficiencies; early and unwanted pregnancies; unsafe abortion; high fertility and high maternal mortality; reproductive tract infections (RTIs); STDs and HIV/AIDS; and
work-related health concerns. Other issues were identified in which more data is necessary to assess the situation, such as cervical and breast cancer, substance abuse, and violence against women.

SEARO has produced a series of information kits on several health themes, three of which are related to women's health: safe childbirth, safe motherhood and promotion of women's health in South-East Asia. The Regional Office is also producing a series of issue papers on women's health, including one on reproductive tract infections, and one on the health of poor women in urban areas. A consultant has been engaged to assist in establishing a resource database on women health and development and a resource centre, and a proposal is under way to commission studies, involving three or four countries in the Region, on reproductive tract infections.

There are several activities on HIV/AIDS prevention, including greater involvement of women's groups in awareness raising, and the creation of a special task force on women and AIDS as a part of some of the national AIDS programmes (NAPs).

Regional Office for the Western Pacific

The WHO Regional Office for the Western Pacific (WPRO) has recently begun to place much more emphasis on women's issues. The aim is to ensure that all health programmes promoted by WPRO (whether they address mainly children's problems or the entire population) benefit both women and men — it is currently recognized however that it is not always possible to measure progress or success as data from countries are not always sex-specific, except in the case of maternal and reproductive health.

Specific activities include production of a Women's Health Series — the first one of which reviewed available information on reproductive health from countries of the Region. The second is a volume on women's experiences of aging in the Western Pacific Region. Other topics planned include: lifestyle changes and their impact on the health of women over recent decades; sex worker and reproductive health concerns; medical and psychological consequences of abortion; and the health cost of violence against women.

In preparation for the Beijing Conference, WPRO has identified a women's focal point in eight countries of the Region - China, Fiji, the Lao People's Democratic Republic, Papua New Guinea, the Philippines, the Republic of Korea, Samoa, and Viet Nam. They will be responsible for collecting information on gender-specific health and social indicators, and preparing a background country paper which will be presented in a workshop in Beijing on women's health in the Region. The data collected will be analysed in a publication which will also form part of the Women's Health Series.

Specific activities are being carried out in the area of adolescent health. A survey of adolescent health services was done in the Philippines which revealed that services are still very sporadic, uncoordinated and not supported by appropriate legislation. As a result, an "adolescent's health-policy formulation process" is now being planned which will involve various youth groups. In addition, workshops on adolescent health are planned in China, Malaysia and Viet Nam.

Activities are also ongoing in various aspects of reproductive health, such as family planning, maternal health and safe motherhood. A review of cultural and traditional factors affecting reproductive health is planned. A very successful Health Workers' Manual on Family Planning Options was produced for the Region, and another one
is being prepared which will enable health workers to provide better counselling, and to educate/motivate couples and women during pregnancy, childbirth and postpartum.

Another area of concern is the increasing tobacco use among women, particularly young women. An awareness campaign on the issue of women and smoking is planned within the regional health promotion programme. The relationships between women and men and their roles in family life are also being addressed through a mass-media campaign on health promotion called Health for all begins at home. WHO has prepared and is supporting the adaptation of education material on “what to do to stay healthy” in five countries.

WHO – closing the gap

WHO’s future activities to improve women’s health will continue to include setting norms and developing guidelines, policy development, the provision of technical support, and research. Increased efforts will be directed towards:

- **Advocacy** for women’s health and gender-sensitive approaches
- **Promotion** of women’s health and prevention of ill-health
- **Making health systems more responsive to women’s needs**

**Advocacy** for the importance of women’s health, and for the need to develop effective policies and programmes to address it will continue to be needed. It was with such issues in mind that the Global Commission on Women’s Health was established in 1993 in response to resolution WHA45.25 on Women, health and development emanating from the 1992 Technical Discussions at the World Health Assembly. The purpose of the Global Commission on Women’s Health is to promote the adoption and implementation of effective measures at all levels for improving women’s health, and to carry out international and national advocacy in the area of women’s health concerns. For example, the Global Commission has put women’s health on the agenda of many international conferences, such as the World Conference on Human Rights (Vienna, 1993), the AIDS Summit (Paris, 1994), and the World Summit for Social Development (Copenhagen, 1995).

In looking at women’s health issues, the Global Commission takes a life-span perspective, since health conditions in one phase of a woman’s life not only affect subsequent phases of her own life, but also have an impact on future generations. The health of adolescents and of older women have been the focus of discussions in the last two meetings of the Global Commission. Based on this life-span approach, the Global Commission concentrates its efforts on six priority areas: nutrition; reproductive health – including HIV/AIDS and other STDs; the health consequences of violence; aging; health conditions related to life-style; and the working environment.

Prevention of women’s health and prevention of ill-health involves addressing the underlying socioeconomic and other factors that determine women’s health status and affect their access to information and services. It requires legal, regulatory and other mechanisms to promote and support improvements in women’s health. WHO has a role to play in the following key areas:

- **Legislation and health policies** – to ensure that discrimination against women is identified and that efforts are made to introduce required changes. Education, legislation, information and other measures can, for example, improve communication and shared responsibility between men and women on responsible parenthood, sexual and reproductive behaviours and prevention of STDs (including HIV/AIDS). Legislation to ban female genital mutilation, enforce criminal penalties for violence against women, or taxing and restricting the sale of harmful substances are other examples.

**Investment in female education** – including taking affirmative steps to keep girls and adolescents in school, developing
more gender-sensitive curricula, and sensitizing parents to the value of educating girls, ensuring access to and completion of secondary and higher levels of education for girls and women, as well as emphasizing wider access to vocational and technical training and non-formal education.

- **Improvement in women's economic status** – especially focusing on poor or vulnerable women. A good example is the WHO project “promoting health through women’s functional literacy and intersectoral action” in Africa which makes loans available to vulnerable groups focused on improvement of economic and health status, and functional literacy.

  2. Making health systems more responsive to women’s needs – is another major focus in which WHO has particular responsibilities, both because of its technical expertise and also because it can bring women’s health to the attention of those in a position to make changes. On the basis of its past experiences in the area of women’s health and in the light of newly emerging trends, WHO has identified a number of areas for immediate action. Change in these areas could bring about rapid yet lasting improvements in women’s health:

    1. Improving access to health care
    2. Improving quality of care
    3. Involving women in the planning and implementation of interventions
Improving access to health care

Women in developing countries, and poor women everywhere, tend to have less access to health inputs and services than do men. Underlying these inequitable patterns of access are social, cultural and economic factors which include practices that discriminate against women and girls; and a lack of women’s control over household resources. As a result, barriers to the use of health services – for example time and travel costs, and health system deficiencies – may pose greater obstacles for women than for men.

Changing the way services are provided within facilities – see Table 2 – can reduce the time needed to seek and use care. Where specialized facilities or different schedules for “clinics” within individual facilities exist for family planning, immunizations, and maternal care, for example, women must make several trips if they need each of the services. An alternative model offers a mix of curative and preventive services for women and children, enabling them to use one visit for more than a single purpose.

More women can be reached by health services if better use is made of peripheral services. It is less costly, in terms of both time and money, if people living in rural areas can get adequate care in facilities that are close by. But very often, the bulk of a country’s limited resources for health is directed to the tertiary facility in the urban area or capital city. Bringing health care closer to where people live, through known and trusted providers could do much to reduce the gap between women and health care services.

Not enough is known about the impact of the introduction of user fees or community financing on the accessibility of health services for women who generally have more limited access to financial resources than men. Where fees are accompanied by improvements in the service women may accept the price and may make greater use of what is perceived to be a better health care resource. Paying a flat fee for a “bundle” of services – antenatal, delivery and postpartum care, for example – can encourage women to seek care and the absence of additional fees encourages them to attend the health facility in good time if complications arise.

Sociocultural factors, often grounded in gender relations, are important in determining women’s access to services. For example, women may not have the freedom to travel, or they may be required to do so in the company of a male who may not be available during working hours of the health facility. Even where there are no such restrictions, women patients may be more responsive to women providers. Women may be unwilling to be examined by men or may be too shy to report the problems they are experiencing, especially where reproductive health problems are concerned.

Improving quality of care

Improving quality of care is critical to improving women’s health, to increasing access to and use of health services, and to using limited resources effectively. Therefore,
WHO is taking a leading role in working with other sectors, and with national authorities, to offer equitable and effective health care to children, adolescents, women, men and the elderly.

Women's perceptions of quality of care demand that a balance be struck between the technical and interpersonal elements of quality and what women want – the two do not necessarily coincide. The present model of health care focuses on discrete technology-based interventions. It does not take into account the experiences (their own or those of relatives, friends) that women themselves bring to health and disease. For example, during pregnancy and childbirth, health care is segmented according to the separate physical needs of mother and baby. Care for one is not necessarily given in conjunction with care for the other. Consideration of the stresses on the new mother – psychological, biological, social or economic – is not incorporated into the care offered, and no specific provision is made for family or community support.

Much of the difficulty of achieving the best balance can be resolved through a more gender-sensitive approach to the needs of women on the part of health-care providers, and a rethinking of the relationships between providers and clients, one that removes the aura of infallibility and power of the provider, and recognizes the skills and knowledge of the client in her own health care. Addressing quality of care also means addressing the fragmented way in which women's health needs are currently addressed. Research will be needed to develop alternative models providing such integrated services in different socioeconomic and cultural settings.

Involving women in the planning and implementation of interventions

One important mechanism to improve quality of care is to involve women in decision-making so that they become active participants in their own health care. This means that women participate as equals in planning, implementing and evaluating policies and programmes, and that interventions are developed in a holistic and integrated manner. WHO's primary health care approach has underscored the necessity of involving women.

For this to happen, women need to feel confident if they are to share their real concerns and experiences with health-care providers.

High quality of care is sometimes considered unattainable for programmes with limited financial resources. However, assuring quality care is more likely to result in a more efficient use of resources because the health benefits of interventions will be greater. The underlying philosophy for improving quality of care recognizes the need to ensure that health care providers have the appropriate knowledge, the necessary and relevant skills, and adequate resources in terms of supplies and equipment. Furthermore, health care providers must be responsive to the women's individual, social, cultural and medical needs, and must respect the right of individual women to make voluntary, coercion-free decisions about their own health care. A framework for ensuring quality of care in health services consists of at least the following elements:

- promotion and protection of health through preventive services including education, information and counselling
- accessibility and availability of services
- acceptability – including cultural acceptability – of services; women need privacy, may prefer to consult a female health worker, and should be assured of confidentiality
- technical competence of health care providers
- availability of essential supplies, equipment and medication, and the establishment of norms and standards for the equipment necessary at each level of care
- high-quality, responsive and respectful provision of health care during the client–provider interaction
- information and counselling for women
- involvement of women in decision-making
- comprehensiveness of care and integration of primary health care services
- continuous monitoring of services – involving women themselves – to assess quality of care.
It is through women’s empowerment that the mutual articulation and exchange of experiences between them and the health services targeted to them can be attained.

In order to stimulate open and participatory processes which permit the ideas and opinions of women and young people to be listened to and acted upon by programme managers and health planners, WHO is currently developing innovative approaches particularly for the identification of reproductive health needs.

Responding to the needs of women health care providers

Much of the discussion on women’s health uses language that defines women as needing care. However, to a large extent, women are also the main providers of health care – see Box 7 – particularly in the traditional health care systems and at the most peripheral levels of modern health-care structures. Yet little attention has been given to the constraints within which they work, to the difficulties faced by women in this role or to ways of improving their status and standing in the community. Efforts need to be made to improve their working conditions and promotion prospects, and to increase their access to the skills, supplies and equipment needed to fulfil their functions effectively.

A manual – Health Workers for Change – was collaboratively developed by WHO and a South African women’s health NGO in a number of African countries. This step-by-step guide shows how to run action-research meetings in health posts, which investigate the attitudes of health-care providers towards their women patients. As a result women’s health problems may be understood and approached in a more comprehensive way by health workers.

Providing information to women

A major constraint that women face is lack of information. Women need to know about danger signs and symptoms, and when to seek health care, whether for themselves, their children or for other members of their families. They also need information to make decisions about when to seek health care and from whom. In several programme areas (see The work of WHO above), efforts have been undertaken to improve the knowledge base women have so that they obtain better health care for themselves and for their families.

WHO promotes, for example, the use of home-based maternal records – simple charts that women themselves keep, that include health information, and a record of their own reproductive history and their children’s growth and development. Such records have been adapted for use among non-literate
women and studies have found that women themselves are less likely to lose or mislay their records than health services are. Women welcome the opportunity to discuss their health concerns with health-care providers, and feel that home-based records offer an opportunity for more equal partnerships with the health services.

The idea of a Healthy Women Counselling Guide (HWCG) was conceived by several programmes of the World Health Organization as a tool to be used by rural women. The guide is intended to provide information to women about their health, in a way that can be understood readily by both literate and illiterate women. The information given to women in the HWCG will be strengthened by more positive feedback and interaction with health workers.

Gathering and analysing information about women and their health

A significant constraint in dealing effectively with women’s health needs is the continuing lack of sex and age-differentiated data. Whereas WHO has long collected and analysed data on cause of death for males and females separately, the same has not been true in relation to the incidence and prevalence of specific diseases such as tuberculosis, and malaria and other tropical diseases. There is very little information on their differential impact on men and women.

It is not enough simply to collect data – it has to be analysed from a gender perspective. Do the data indicate differentials in incidence or prevalence? What are the possible sources of such differentials? Do they lie in biological factors such as different responses to disease or differences in reactions to treatment; or are they a reflection of social factors such as differences in exposure, in health-seeking behaviour, or coping mechanisms?

The needs for information must be seen in relation to health and health-care indicators and the policy development and managerial processes for health development, both within Member States and in the Organization. Member States have not been able to report consistently on the progress made in relation to women’s health; in part because of continuing weaknesses in management information systems for health, and the fact that registration of vital events is either inadequate or absent. Thus there is still a serious lack of high-quality information about matters of concern to women, including maternal mortality and morbidity, and access to quality maternal health care. Furthermore, information systems specifically designed to examine the sex-specific aspects of women’s health beyond reproductive health have not been established. In order for Member States to be able to use relevant information for policy development and management, and to include such information in their regular reporting on women’s health and health care, it will be necessary to ensure that health information systems collect and analyse sex-specific data as a matter of routine. Analysis and reporting of women’s health need to go beyond looking only at reproductive health issues in order to assess the effect of sex differences and attitudes on women’s health as a whole. Member States, in their commitment to a number of internationally recognized policies, plans and programmes of action7 have been sensitized and called upon to collect, analyse, report and act upon, to the extent possible, sex-specific data for mortality, morbidity, use of health services and other relevant parameters.

In the coming years WHO, its partners, and health systems globally must face up to the challenge of “closing the gap” between rhetoric and reality, and to give far greater attention to women’s health issues.

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7 These include the health-for-all strategy; the Plan of Action of the World Summit for Children; The Plan of Action of the International Conference on Nutrition; Agenda 21 of the United Nations Conference on Environment and Development; and the Programme of Action of the International Conference on Population and Development.
Conclusion

All individuals have the right to "the highest attainable standard of health". But when it comes to women, double standards, poverty, social discrimination and inequality, amongst other factors, militate against this. Many of the facts have been known for years. Yet health and well-being continue to elude millions of the world’s women.

The themes of the United Nations Decade for Women (1976–85) — equality, development, and peace — will be reiterated at the Fourth World Conference on Women in Beijing in September 1995. These are all crucial elements in women’s health, and in their personal and social development.

Quite simply, women will never enjoy the highest attainable level of health until they have equal access to resources and to the fruits of development — equality in access to education, to political power, and to the process of decision-making. This in turn means addressing inequitable gender relationships, and the underlying inequalities that currently stand in the way of women’s access to health. Such inequalities — enshrined in traditional, cultural and legal frameworks — perpetuate women’s lower social and economic status. All of this continues to limit the ability of women to make free and informed choices about their lives. In addition, to attain full health, women must have access to high-quality services, and the information and skills to use such services appropriately. Women — the primary care givers in the home and in the health system — must receive appropriate and acceptable care for themselves, and for their families.

To promote equality for women is not to favour identical approaches to health for women and men. Women and men are innately different and have differing needs. Promoting equitable access to health care implies recognizing these differences, and developing responses that address the varied needs of men and women throughout their lives. It also involves addressing the socioeconomic and cultural factors which discriminate against women and girls.

Ever since the start of the United Nations Decade for Women, the contribution that women make to health and human development has been recognized and awareness is now growing of the extent of that contribution and of the enormous toll it takes on women in terms of their own health. Human energy and creativity are the driving forces of development, yet for millions of women worldwide that vital energy is drained in the daily struggle to survive, and to protect the health and well-being of themselves and their families.

The achievement of peace at all levels — international, national, local and domestic — is a crucial step for the attainment of health for all. For women, it has a very special significance. Women and their children are most often on the receiving end of violence and aggression. Among the first to be affected by war and civil strife they are often the last to receive support and assistance.

Whether in the form of killing and maiming, ethnic cleansing, mass rape or forced prostitution, violence is all too often borne by women. Moreover, violence is not confined to the sphere of politics. Very often it is from within their own homes and families that girls and women have most to fear. Female genital mutilation, incest, sexual abuse, domestic assault and battery — these are the hidden faces of violence against women. For women, peace is a domestic as well as a societal issue.

For far too long women have been portrayed as powerless victims and have been seen as objects of health interventions. Undoubtedly women all over the world face enormous adversities that impact on their health and well-being. Yet women have power, are creative, can take and already have taken action. Women must be recognized as protagonists in their own health, and in the provision of health care.

The time has come when women all over the world are beginning to ask questions, take actions and demand resources, results and accountability. The time has come for health-care systems to listen to what women are saying, and to take every possible opportunity to improve women’s health and — by extension — the health of the world.
## Annex 1: Basic Demographic and Social Statistics

<table>
<thead>
<tr>
<th>Region</th>
<th>Life expectancy 1980-90 Male</th>
<th>Life expectancy 1990-95 Male</th>
<th>Ratio of male-female life expectancy 1990-95</th>
<th>Average number of children per woman 1900-95</th>
<th>Maternal mortality (deaths per 100,000 live births) 1988</th>
<th>Infant mortality (deaths per 1000 live births) 1990-95</th>
<th>Births attended by trained personnel %</th>
<th>Coverage of prenatal care 1990</th>
<th>Adult literacy rate M/F</th>
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<tr>
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</table>

Japan, Australia and New Zealand have been excluded from the regional estimates but are included in the total for developed countries. Figures may not add to totals due to rounding.

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