WOMEN, HEALTH AND DEVELOPMENT

A Report by the Director-General

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PREFACE

This report has been prepared on the occasion of the ending of the United Nations Decade for Women and the 1985 World Conference to Review and Appraise the Achievements of the Decade with the three sub-themes of health, education and employment.

The report presents an analysis of the situation regarding women, health and development. It draws attention to the special health needs of women as well as to the key roles that women play in promoting health and development. Actions taken at various levels, with emphasis on the country level, to improve women's health and enhance their participation in health and development are summarized. The major obstacles and constraints to achieving full equity for women in the fields of health and development are considered, and forward-looking strategies for the future activities proposed.

The report was discussed in January 1985 by the WHO Executive Board, which endorsed the views and conclusions regarding women's special health needs and their roles in, and contribution to, health and socioeconomic development, emphasizing the need for further and more intense action. The report was discussed extensively by delegates at the Thirty-eighth World Health Assembly in May 1985. The Assembly unanimously supporting its content and the conclusions concerning forward-looking strategies, adopted resolution WHA38.27, which is reproduced on the following two pages. Operative paragraph 4 (1) of this resolution asks the Director-General to present this report to the World Conference.

RESOLUTION ADOPTED BY THE THIRTY-EIGHTH WORLD HEALTH ASSEMBLY, 17 MAY 1985

Resolution WHA38.27

WOMEN, HEALTH AND DEVELOPMENT

The Thirty-eighth World Health Assembly,

Taking note of the report of the Director-General and of the views of the Executive Board on the health situation of women and their role in health and development, and particularly in the implementation of the Global Strategy for Health for All by the Year 2000;

Noting the close relationship between equal rights for men and women and the participation of women in health activities and in the promotion of health for all, particularly as decision-makers;

Recalling previous resolutions of the Health Assembly on the role of women and, in particular, resolutions WHA28.40, WHA29.43 and WHA36.21;

Recognizing the great importance of the forthcoming World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace;

Concerned at the slow progress made by a number of countries in realizing the objectives of the United Nations Decade for Women, which are formulated in the reports of the World Conference of the International Women's Year, Mexico City (1975) and the World Conference of the United Nations Decade for Women, Copenhagen (1980), and recalling the report of the International Conference on Population, Mexico City (1984), particularly with regard to women's physical and mental health and also with regard to their social security and the safeguarding of their rights;

Concerned at the very high maternal mortality rates in many countries and at the frequency and severity of the repercussions on women's physical and mental health of certain practices, particularly during pregnancy or childbirth but also during puberty or childhood;

Concerned at the adverse effects on women's physical and mental health, and the risks for their children, of inadequate conditions of domestic work or paid employment;

Concerned at the frequency of nutritional anaemia in many countries, especially among pregnant women;

Concerned at the close spacing of pregnancies, particularly in the developing countries, and aware of the importance of adequate spacing of pregnancies as part of an appropriate family planning policy integrated within the general economic and social development programme of each country;

Bearing in mind with anxiety the prevalence in some countries of adolescent marriages and pregnancies;

Concerned at the increasing incidence and impact of family violence on women and children;

Aware that in some countries the general public does not know enough about the nature of the risk to the health or even the life of women presented by such factors as deficient or inadequate diet, lack of hygiene, excessive workloads, and pregnancy prior to full physical maturity and corresponding mental development - risks that may also have repercussions on the health of the children;

Recalling the correlation between the education of mothers and the reduction of child mortality levels;

1. THANKS the Director-General for his report;

2. CALLS UPON Member States to show greater concern, within the context of national activities and international cooperation, for the protection of women's physical and mental health, particularly as regards the nutrition of women, the health of pregnant women and young mothers and conditions of work; to assist women to carry out their functions as providers of primary health care; to strengthen their efforts to provide women with greater opportunities to pursue activities in the context of the realization of the objectives of the strategies for health for all; and to take an active part in the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women;

3. REQUESTS the Executive Board to monitor developments in the field of women, health and development;

4. REQUESTS the Director-General:

(1) to ensure the Organization's active participation in the World Conference and to present to it a report on the role of women in health and development, on the principal risks threatening women, and on the possibilities of guarding against those risks;

(2) to continue to pay close attention to cooperation with, and to provide expertise to, Member States in their activities both for promoting women's physical and mental health - including information and education of the public - and for intensifying the participation of women, particularly as decision-makers, in health and socioeconomic development, and to assist Member States to evaluate the effect of health development programmes and social services on the situation of women and on the protection and promotion of their physical and mental health;

(3) to strengthen coordination with the other United Nations agencies that pay special attention to the economic role of women;

(4) to evaluate the contribution made by WHO's programmes to the promotion and protection of women's physical and mental health and the effects of these programmes on the participation of women in health activities;

(5) to report periodically to the Executive Board and the Health Assembly on the progress achieved in this field.

1. INTRODUCTION

1. 1985 sees the close of the United Nations Decade for Women. For 10 years, advocacy for women, their needs and their roles has captured attention all over the world and progress has been achieved in this regard. So why does this report end with a focus on the future? Why are we not consolidating general gains instead of redirecting our attention to women, health and development?

2. One reason is that much of the general progress has been patchy. Even women in industrial countries who led the drive for women's rights have made gains that are at best limited. Although both men and women in many developing countries continue to suffer from the consequences of underdevelopment and poverty, under these conditions it is women and children who bear the largest burden of extreme disadvantage. At the 1980 United Nations Conference on Women, the Global Plan of Action noted the major obstacles to progress, and for the second half of the Decade urged Member Governments to focus their activities on alleviating women's problems regarding employment, education and health.

3. Regardless of whether women's lot is improving in one country or another, concrete strategies and plans to achieve greater gains are badly needed. Awareness of the need for further action is no mere byproduct of the general women's movement; it is the result of a growing realization that women's health and involvement in health care are essential keys to health for <u>all</u>. For women not only have their own special health problems related to pregnancy and childbirth, but customarily do most of the caring for their families. So if they are ignorant, malnourished, overworked, and bearing large numbers of children beginning at an early age, the health of their families as well as their own health will suffer. This is especially true for the many millions of women who confront illiteracy, poverty, poor sanitation, and medical facilities that are inadequate, and physically and economically inaccessible.

4. It is a paradox that, while societies depend so heavily on women to provide health care, women's own health needs are frequently neglected. Women's contribution to health and development is underestimated (and often completely disregarded in official statistics); furthermore, their potential is grossly underutilized.

5. Clearly, if the goal of health-for-all is to be attained, more attention must be given to women's health and their roles in health and development. This report and the forward-looking strategies are based on the recognition that women's health and roles depend on broad considerations - including employment, education and social status. Ultimately, they may even depend on equitable access to economic resources and political power. It is therefore imperative not to view the health aspects in isolation.

Background and collaboration with the United Nations system

6. The integration of the principles and goals of the United Nations Decade for Women into WHO's activities has passed through three roughly defined stages in the last 10 years: policy and programme development, establishment of mechanisms, and action in support of Member States in their efforts regarding women, health and development.

7. The first stage was marked by policy statements and resolutions, and aimed at increasing awareness at all levels of the need to integrate the principles into WHO's programmes, with women as both beneficiaries and participants, and by efforts to make women's participation in overall development more effective. In accordance with resolution WHA28.40 (May 1975) the Director-General reported to the fifty-seventh session of the Executive Board (January 1976) on WHO activities in collaboration with the International Women's Year and outlined future WHO activities to promote the health and status of women. The report was transmitted to the Twenty-ninth World Health Assembly (May 1976), which adopted resolution WHA29.43.

8. These resolutions were consistent with the general trend in the Organization, which led Member States at the Thirtieth World Health Assembly (May 1977) to decide that the main social target of governments and of WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

9. A further landmark was the Declaration of Alma-Ata (1978) which clearly defined primary health care as the key to attaining this goal. Two years later, at the United Nations Conference on Women, in Copenhagen, a resolution on the integrated approach to the health and welfare of women, based on the provision of the essential elements of primary health care, was unanimously approved by delegates, marking the union of the principles of the United Nations Decade for Women with those of the international and national health communities.

10. In the second stage, mechanisms for the promotion and coordination of activities regarding women, health and development were established at all levels of WHO. Focal points and working groups were appointed at regional and global levels, and proposals were drawn up for general approaches as well as specific action. National focal points were identified in the South-East Asia Region and the Americas, and in the latter Region a special sub-committee of the Executive Committee meets twice yearly to monitor progress with the five-year plan of action.

11. In the third, current stage there has been an increase in action and awareness of women's conditions and roles, and of the interrelationships between the status of women and health and development. However, despite successes, by 1983 it had become clear that progress had been too slow, and that greater efforts were needed if a real impact was to be made. Accordingly, in May of that year the Thirty-sixth World Health Assembly adopted resolution WHA36.21, requesting the Director-General (1) to give high priority, in the implementation of WHO's Global Strategy, to well oriented and appropriate measures aimed at strengthening the provision of

health care for women and enhancing their state of health; (2) to ensure the Organization's active participation in the preparations for the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women; and (3) to work towards the full integration of women and their cooperation on an equal basis in the activities of health services in Member States.

12. Momentum was considerably strengthened in 1984 when all the regional committees included in their agendas an item on women, health and development, and resolutions were adopted.

13. WHO has participated in all stages of the preparations for the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women, to be held in July 1985 in Nairobi. It has collaborated in preparatory meetings, and contributed to the following:

- A review and appraisal of the progress achieved and obstacles encountered by the United Nations system in pursuit of the goals and objectives of the Decade. A questionnaire drafted by the United Nations Branch for the Advancement of Women was completed, including detailed answers to questions on (i) WHO activities and resources devoted to the advancement of women since 1976; (ii) programmes and projects into which activities for the advancement of women have been integrated; and (iii) the status of women staff in WHO.

- A review and appraisal of the progress achieved and obstacles encountered at the national level. WHO prepared a paper on health and nutrition, based on government replies to a questionnaire from the United Nations Branch for the Advancement of Women; it covered health policies and strategies, health care, health research, and the participation of women in the health sector.

- The forward-looking strategies (health aspects).

2. SITUATION ANALYSIS: WOMEN, HEALTH AND DEVELOPMENT

14. The status of women in a society is a significant reflection of the level of social justice in that society, and involves a complex set of interrelated factors. Woman's status is often described in terms of her level of income, employment, education, health and fertility, as well as the roles she plays within the family, the community and society. It also involves society's perception of these roles and the value it places upon them. What women do (their work in agriculture or industry; their contribution to the family income, household maintenance, community organization and development; and their role in the family and the bearing and rearing of children) not only affects their health but is also affected by it.

15. The significance of women's reproductive and nurturing roles for health and development as a whole is undeniable. The biological and social realities of their maternal role are closely linked to their health status and are major factors in the problems they face in health, employment, education, and many other areas.

16. Considering that the value society attaches to the woman's maternal role is one of the crucial factors influencing the status of women, how can we say that a high value is attributed to a woman if she dies needlessly in childbirth? If her child is born too small to survive the first week because her nutrition was so poor and her workload so great during pregnancy? If she is unable to breast-feed because she cannot devote enough time or leave her job? If she is not given access to effective, safe and acceptable methods to regulate her fertility? If she is bypassed by education and technological advances and isolated from the mainstream of community action while she is trying to prepare her children for healthy, productive lives in the community? In short, how do we assess the social value accorded to reproduction and nurturing if women are denied the support needed to carry out these roles?

17. The sex differentials in morbidity and mortality in infants and children show that in many countries a lower value is indeed given to girls than to boys. In one country a study of intrafamilial sex bias in the allocation of food and health care showed that for children under 5 the calorific consumption was on average 16% higher for boys than for girls. This was reflected in a significantly higher prevalence of malnutrition among the female children, 14% of them being severely malnourished, as compared with 5% of the males. Between the end of the first month and the end of the first year of life, when parental care is critical for a child's survival, the death rate of the females was 21% higher than that of the males, despite the innate biological advantage of the female. In another study in a rural area it was found that treatment, when sought, was delayed for more than 24 hours for 44% of the female children, as compared with 23% of the males.

Special health needs of women

18. The majority of populations in developing countries as well as those in the poorer sectors of developed countries suffer from high levels of communicable and noncommunicable diseases and other health problems and live in environmental conditions that are hazardous to health. The overall health needs of men and women are the same in this regard. Beyond these, however, men and women each have their special problems. Men are at greater risk than women for a number of health problems often associated with their work and with changing lifestyles or stress - such as accidents, lung cancer, alcoholism, and cardiovascular diseases. However, women's changing lifestyles may soon place them at equal risk for stress- and lifestyle-related problems. In the USA, for example, lung cancer is second only to breast cancer as the leading cause of cancer mortality in women in the 1980s.

19. Women's special health needs are primarily related to their reproductive role. The process of gestation, birth, breast-feeding and child nurturing is in itself a healthy and normal process. It is when crucial elements in the environment are lacking or inadequate that this process becomes problematic, and evidence suggests that this occurs with startling frequency. At certain more critical stages lack of care can have fatal effects.

20. Maternal mortality accounts for the largest or near-largest proportion of deaths among women of reproductive age in most of the developing world, although its importance is not always evident from official statistics. In areas where the problem is most severe, most maternal deaths simply go unrecorded, or else the cause of death is not specified. Hence the tendency to underestimate the gravity of the situation. Only 75 of WHO's 164 Member States are able to measure maternal mortality. Of the 117 developing countries, 73 are unable to provide the rate, and a number of the figures that are provided by governments are gross underestimates.

21. From other indicators, one can hazard a rough guess that some 500 000 women die of pregnancy-related causes each year, most of them preventable. Maternal mortality rates in countries where the problem is most acute are as much as 200 times higher than the lowest rates in industrialized countries. The tragedy is not only the woman's untimely death, but the consequences for the family she leaves behind.

22. The chief causes of maternal deaths in such countries are haemorrhage, often with anaemia as an underlying cause, and sepsis. In some Latin American countries 50% of maternal deaths are due to illegal abortion. In the developed countries, where the overall levels of maternal mortality are much lower, the proportion of maternal deaths due to haemorrhage and sepsis is much smaller, but toxaemia of pregnancy accounts for over 20% of maternal deaths in most countries.

23. Appropriate care during pregnancy and childbirth is crucial to women's health and well-being, as well as to that of future generations. Failure to obtain such care can lead not only to death - of the woman and/or her child - but also to debilitating conditions such as incontinence, uterine prolapse and genital tract infections that add to

the burden, suffering and low quality of life of women for the rest of their lives. Vaginal fistulae, resulting from inadequate care in childbirth, often lead to the victim's complete social isolation. A hospital study in Africa revealed that 30% of gynaecological admissions were for fistula repair. Such conditions, which are preventable, come to be accepted as part of a woman's lot.

TABLE 1. LIVE BIRTHS AND MATERNAL MORTALITY RATES - RANGE OF COUNTRY VALUES

Region	Live births (thousands)	Maternal mortality rates (per 100 000 live births)	
	1982	Lowest	Highest
Africa	23 100	108	1 100
Asia - South	51 700	5	1 000
- East	23 200	8	100
North America	4 400	6	10
Latin America	12 500	8	470
Europe + USSR	12 000	2	140
Oceania	500	14	900
WORLD	127 400	6	1 100

Sources: United Nations Population Division and WHO estimates based on a variety of sources.

24. Despite the unnecessary suffering and deaths caused by lack of appropriate care during pregnancy and childbirth, only about 60% of births in the world are assisted by trained attendants (see the table in Annex 1 for more detailed information).

25. Malnutrition, including anaemia, is a serious health problem, especially in women who have too many pregnancies too closely spaced. The woman's nutritional status, in turn, influences her chances of having a normal delivery and a child with an adequate birth weight as well as her ability to breast-feed without detriment to her own health.

26. Nutritional anaemia is widespread among women of child-bearing age and contributes significantly to maternal morbidity and mortality - particularly, but not only, in developing countries. It is estimated that nearly two-thirds of pregnant and one-half of non-pregnant women in developing countries are affected. The high prevalence of anaemia among women is particularly serious in view of their heavy workloads: anaemia has a profound effect on psychological and physical health; it lowers resistance to fatigue and disease and affects working capacity under conditions of stress; and it greatly increases the risk of ill health and death in childbirth. Obesity and undernutrition - both signs of malnutrition - are seen in peri-urban areas of developing countries.

27. Closely connected with malnutrition and anaemia during pregnancy are the hazards of diseases and infections, including intestinal parasites and malaria. In areas where malaria is endemic, women lose their immunity during their first pregnancy (with greater risks of spontaneous abortion and fetal death), and malaria of the placenta increases the risk of low birth weight. Pregnant women are also more susceptible to poliomyelitis; and pregnancy may precipitate the development of overt leprosy or diabetes. Other infections aggravated by pregnancy - such as infectious hepatitis (where case fatality increases dramatically), genital tract infections and pulmonary tuberculosis, especially when combined with malnutrition - are widespread problems contributing to maternal mortality and morbidity.

28. There are also serious occupational health hazards for women. Studies clearly show that women engaged in heavy labour during pregnancy have a mean pregnancy weight gain several kilograms less than other women who have a similar food intake. The birth weights of their babies are similarly lower, thus diminishing the babies' chances of survival and healthy growth and development. Moreover, women are increasingly undertaking work in industries that manufacture and use new chemical substances giving rise to serious concern as to possible toxic, carcinogenic or mutagenic effects.

29. Traditional practices can affect the health of mothers and children, both positively and negatively. A negative example is the circumcision of girls. The harmful health effects, especially of the most radical form of circumcision, include the immediate problems of infection, bleeding and shock, and the subsequent problems experienced when initiating sexual intercourse and during childbirth.

30. Uncontrolled fertility aggravates many of the above-mentioned health problems. Too many or too closely spaced pregnancies give rise to health risks both for the mother and the infants and higher maternal and infant mortality rates. The health of other children in the family is also affected, especially very young ones who may still be dependent on maternal feeding and care. The ability of couples to plan the timing, spacing and number of children, in addition to being an important health promotive measure for all members of the family, allows women to fulfil their other roles more effectively.

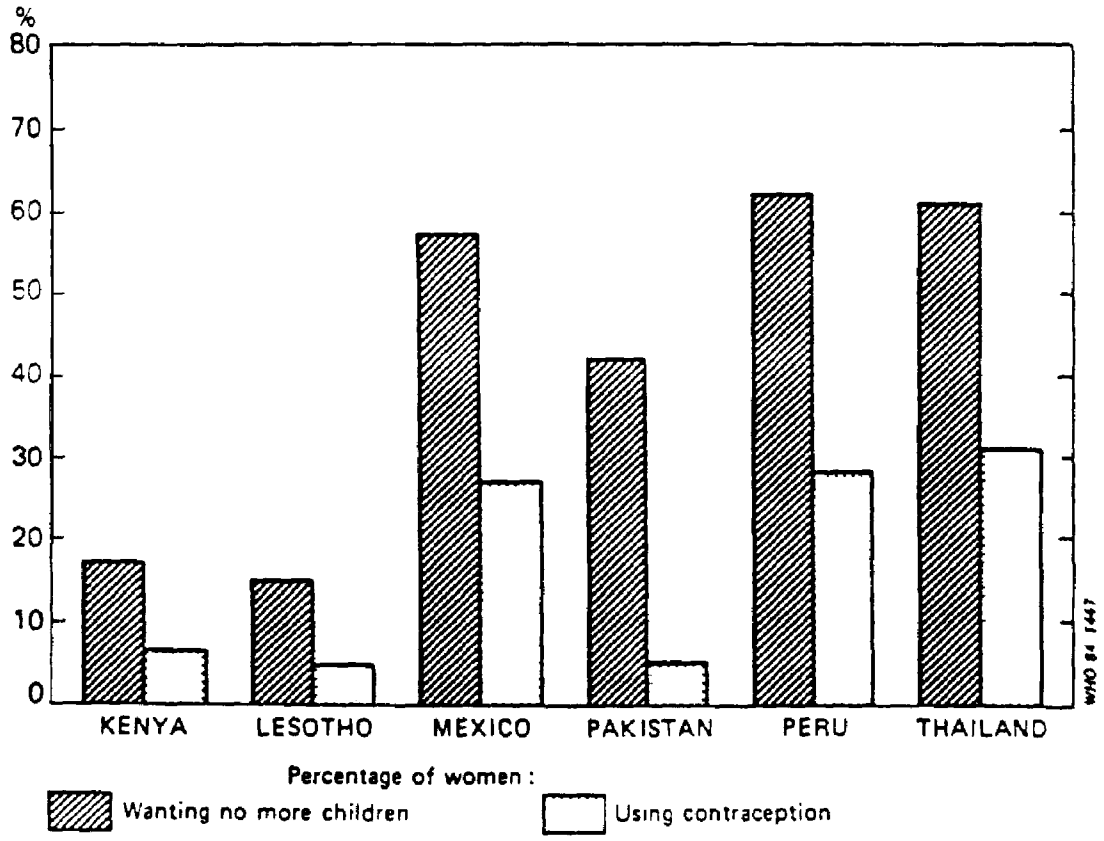
31. Age at childbearing is also important. Although the age of marriage and first pregnancy is rising in many developing countries, there are still many in which over 50% of the first births are to women aged less than 19 years. Births to women who are not fully mature can permanently injure their health, and the maternal mortality rate in this age-group is often three times that in the 20-24 year age-group. Many developing countries, particularly in the rapidly expanding urban areas, are beginning to experience the adolescent reproductive health problems of many industrialized societies: early onset of sexual activity, increased numbers of out-of-wedlock pregnancies and abortions, and an increased incidence of sexually transmitted diseases with their high risk of subsequent infertility. At the other extreme, when children are born to women over 35 years of age there is a higher risk of infant and maternal mortality and morbidity, including congenital malformations.

32. Abortions, both induced and spontaneous, are widespread. Induced abortion is probably the most widely used method of limiting the number of children. Illegal abortions kill up to 200 000 women a year and permanently injure the health of countless more. These facts illustrate the lengths to which women will go to limit the number of children they bear and must ultimately be responsible for; they are risking their lives to end unwanted pregnancies.

33. The high number of abortions provides a clear indication of the unmet needs and desire to practise family planning. About 95% of the people in the developing world live in countries which, at the policy level, provide some form of public support to family planning programmes. However, although as many as 30% - 40% of women of reproductive age may be using family planning methods in some developing countries, in many others the proportion is still only 5% - 7%. And yet, if women the world over were able to have only the number of children they say they want to have, the crude birth rate would range between 16 and 28 per 1000 population rather than the present range of between 28 and 40. In many cases, the problem is lack of access to family planning services in the developing world, especially in rural areas and urban slums. However, the significance of the contradiction between woman's stated desire to practise family planning and her reluctance to do so is enormous, and goes beyond the question of availability of services.

FIGURE 1. WOMEN AND FAMILY PLANNING

(in selected countries)



Source World Fertility Survey (1975+)

34. The major restraint on the practice of family planning by women is related to their status and stems from a number of social factors and attitudes. In many countries the value of a woman in the eyes of society is based on the number of children she has. Moreover, having no other means of adequately caring for herself in later years or attaining some status in society, she will eventually have to depend on her children for economic and moral support.

35. The situation is exacerbated by a preference for sons, a tendency that can be seen in many countries and, in its extreme form, is exemplified by abandonment of female infants. The milder manifestation of this is increased fertility and reduced spacing between births.

36. What is significant and promising is that, in spite of these and other social forces pressing women to have more children, and in spite of the discomforts, the continuous and active steps required of women to use most modern family planning methods, and the dangers of illegal abortions, women are increasingly choosing to limit the size of their families.

37. The implications for family planning programmes are great, and suggest that efforts should perhaps be geared less towards convincing the convinced (women) and more towards supporting social changes that will enable them to practise family planning - with emphasis on educating women and changing male attitudes about sharing responsibility for family planning.

38. Cancer is another major health problem for women. Cancer of the cervix is the main form of cancer in the developing world, with half a million new cases occurring annually. In Latin America approximately 1 in every 1000 women between the age of 30 and 55 develops cervical cancer every year. However, with simple screening cervical cancer can be detected and treated at an early stage - when the cure rate, with minimal treatment, is virtually 100%.

39. Breast cancer, the main form of cancer affecting women globally, is one of the commonest causes of death in many developed countries, and is becoming frequent in developing countries as well. Breast cancer mortality rates have increased in the past 60 years in every country reporting to WHO, although in most developing countries with overall high mortality rates they have been relatively stable over the past 10-20 years.

Women: a key health resource

40. In addition to having special health needs as discussed above, women carry extra responsibilities for health through their contribution to the health of their families and communities, both formally and informally. This preponderance of women in health care activities is true for most countries, developing and developed, and is a phenomenon which predates the emergence of modern health care systems. It is the women who are expected to be health educators; to teach sound health practices to future generations; to create a home environment that is conducive to health (from clean water to nutritious food); to limit family size; to ensure that children are immunized and cared for during crucial years and to take them to the formal health care services when necessary; and to

care for the elderly. Women often serve without monetary compensation as traditional birth attendants, who still deliver most of the babies in the developing world; and they constitute the majority of volunteers in hospitals, self-help clinics, and other community organizations. They are therefore already providing a giant's share of primary health care - particularly as the majority of the eight essential elements fall almost exclusively in the woman's domain at the family level. And yet women are expected to fulfil these multiple roles while being the least educated and informed.

41. Equally important is the role of women in the health professions - where, again, they often constitute the majority of health care providers. Available statistics suggest that in most countries, although the labour force in the formal health system tends to be predominantly female, women tend to fill the lower paid, less prestigious jobs, rather than those with status and decision-making power. The example provided by one country, where 73% of paramedical workers are women, but only 25% of medical doctors, constitutes a pattern that can be found in most countries of the world. Where this is not the case, the status and remuneration of the medical profession are comparatively low. In short, although the majority of medical doctors have traditionally been men, as many as 75% of health workers are women. This, added to the informal care provided by women, means that health care is predominantly a woman's field; it is the quality of their participation that has been limited, owing to less access to training, information, education and opportunities.

Women's health and their participation in development

42. Improved health and social status of women provide the key to their equitable and effective participation in overall socioeconomic development. Although women constitute half of the world's adult population and one-third of the official labour force, they perform nearly two-thirds of total working hours, receive only one-tenth of the world income, and own less that 1% of world property.

43. Women's contribution to the economy is grossly underestimated and is not reflected in labour force statistics. Globally, women are responsible for at least 50% of food production; in some countries and regions the figure is much higher - e.g. 60% - 90% of all agricultural work in Africa is done by women, and in Bangladesh 90% of the female population is engaged in agriculture. In addition to crop cultivation and harvesting, twice as much time can be taken by food-processing and preparation - tasks carried out almost exclusively by women. Similarly, the time and energy required for the fetching of fuel and water (often involving a walk of 10 km three days out of four) rarely figure in national labour statistics, and the many hours that women devote to housework are simply discounted. The implications of these issues for women's health and their potential for participation are tremendous.

44. The prevailing patterns of development are, in some cases, making women's socioeconomic situation worse. A striking example is the marginalization of women in agricultural development as a result of the introduction of modern technology: when labour-saving, cost-effective technology is made available, it is generally to men. Thus, even the development success story has costly implications for women.

45. The continuing breakdown of traditional societies also often aggravates the situation of women. As a result of urban-based development, migration of husbands, wars, and desertion, the proportion of women left to cope alone, with very few resources or skills, is increasing rapidly in many rural areas and among the urban poor in both developed and developing countries. This is reflected in the statistics available on female-headed households, which in some countries seem to form the large majority of the poorest families. For example, an analysis in a large developing country showed that 40% of all female-headed households were in the lowest income group; the corresponding figure for male-headed households was 21%. In addition, male heads of households often earned less than 50% of the household's total income and depend on women and children to contribute the rest by working in the informal sector without any kind of social or other benefits resulting from formal employment.

46. Women's situation vis-à-vis development has to be viewed in light of the amount and type of general education received. In many countries it is substantially less than that received by men. Although in most countries the law gives boys and girls equal access to education and training programmes, boys are given preference over girls for many cultural and economic reasons. In many countries large numbers of girls complete the equivalent of only two or three years of schooling - hardly an adequate basis for retaining the ability to read, write, and do simple arithmetic. The ratio of boys to girls enrolled in school is shown in the table in Annex 1.

47. And yet there is striking evidence that the woman's level of education is one of the most significant factors in the health of her children. Regarding infant mortality, the effects of the mother's education remain constant despite any variations in other factors. In countries where infant mortality levels are very high the male/female ratio of literate adults is 42/19; where they are low, it is 96/94 (see Table 2). As to family planning, it has been repeatedly shown that the higher the level of a woman's education, the fewer children she is likely to have and the later she will start childbearing. The reasons for this vary, and include the girl's choice to postpone marriage and the opportunity for paid employment, which will also raise her perceived value, because she is seen to be less burdensome by parents. Whatever the underlying reasons, the importance of the link between women's education and lowered fertility is paramount.

TABLE 2. PERCENTAGE OF ADULTS LITERATE, BY SEX, AND LEVEL OF INFANT MORTALITY

Countries with infant mortality rates (per 1000 live births) that are:	Percentage of adults literate	
	Male	Female
Very high (more than 100)	42	19
High (60-100)	68	55
Medium (26-59)	90	85
Low (25 or less)	96	94

Sources: UNESCO and United Nations Population Division, about 1980.