3. SUMMARY OF ACTION BEING UNDERTAKEN

48. This section reviews selected activities that are indicative of trends.

49. Accurate and adequate information, relevant to local circumstances, is essential for appropriate action. Country averages for specific indicators often mask inequalities between population groups as well as between sexes. Thus it is important to have, as far as possible, data disaggregated according to sex and population group.

Information support and transfer

50. Despite the special importance of local data, countrywide information can be useful for assessing the general scope and nature of problems. However, the first round of monitoring progress towards health-for-all provided little information. For example, one of the global indicators endorsed by the Thirty-fourth World Health Assembly for the monitoring of the Global Strategy was the availability of trained personnel for attending pregnancy and childbirth. The Executive Board's report on the monitoring of progress showed that, when three-quarters of Member States reported, only 37 provided data on this indicator that could be included in calculations.

51. Some countries have done a great deal of research concerning women (particularly in the last five years), although others are just beginning their efforts in this direction. In the United Nations questionnaire to review progress at the national level, governments were asked if any inquiries or surveys had been carried out since 1975 on the health needs and priorities specific to women; 47 of the 76 who responded said that this had been done. In addition, a number of studies were reported on problems of special groups of women - working women, adolescents, older women, and refugees.

52. Information on particular topics related to women's health is also increasing, governments reported studies on the prevalence of anaemia and other nutritional deficiency diseases, low pregnancy weight gain, and the distribution of food within the family and its effect on the nutritional status of women and girls.

53. The WHO regional offices have been actively involved in collecting information about women in the various countries, either as the requisite first step towards action recently taken, or as part of longer-term efforts to develop a data base. For example, an extensive review of the health status of women in the Western Pacific Region has been prepared, largely on the basis of replies to a questionnaire sent to 32 countries and areas; in the Region of the Americas information from governments about sex-segregated data collection and country activities has been collated and analysed, and annotated bibliographies (e.g. on cancer of the

cervix) have been prepared; in the South-East Asia Region a study on women's health status has been initiated, and information received from countries has been compiled.

54. At the global level, information has been gathered on a variety of specific topics such as female mortality and the prevalence of nutritional anaemia, and support has been provided to some countries to strengthen their data base on women. A meeting on sex differentials in mortality, co-sponsored by the United Nations, WHO and the Australian National University, was held in Canberra in 1983.

55. To share the information gathered and use it as a means of advocating action, meetings have been held in all regions. In the Eastern Mediterranean Region WHO organized a seminar on traditional practices affecting the health of women and children. In the Western Pacific Region it recently convened a meeting of countries to discuss the role of women in health education, and collaborated with the Korean Women's Development Institute in conducting a meeting on women's health. Two inter-country seminar/workshops concerning women, health and development were organized in the Region of the Americas, and at the national level similar meetings took place in Colombia and Cuba and a workshop was held in Mexico. In the European Region a major conference on women and health, held in 1983, was attended by 150 participants from 30 countries. Village coordinators for women, health and development in 17 countries in the African Region met in Brazzaville to further develop their plan of work.

56. With regard to promotional activities, in the Region of the Americas a popular booklet (Mandate for change: women, health and development in the Americas) and a more detailed publication (Women in health and development) have been issued. In the European Region WHO collaborates with the Women's Health Information Centre in the United Kingdom, which is a source of literature and information on women and health, maintains a directory of relevant self-help women's health groups, and organizes meetings on women's health.

57. At the global level a clearing-house has been established to collect and provide information and material for WHO programmes and women's organizations throughout the world. Publications are prepared which (a) highlight specific women's issues within a programme area; (b) describe women's health issues as a whole, combining existing information from all programme areas; and (c) describe certain health problems from a woman's perspective. Through this mechanism a large number of key persons and institutions regularly receive these and other information.

58. Other activities have included the preparation and distribution of an information kit on women, health and development, in collaboration with the Joint United Nations Information Committee, and several radio programmes and special issues of World Health magazine.

Primary health care for women's special needs

59. The principles of primary health care and total coverage provide a framework for reaching women in greatest need. Of particular relevance is maternal and child care, including family planning. Evidence indicates

that, although the situation may be improving, there is still a long way to go. Countries are increasingly recognizing the need for more active measures to make such care available, and this is reflected by the fact that all WHO regions have emphasized the particular importance of adequate coverage of women during pregnancy and childbirth. A review of international financial and technical resources currently being applied to the improvement of the health of women and children in developing countries indicated that 30% of funds allotted to health are devoted to various aspects of maternal and child health, including family planning. WHO is supporting such activities in more than 90 developing countries, in most cases in collaboration with UNFPA.

60. A study on the training and utilization of traditional birth attendants was carried out in the Eastern Mediterranean Region following two workshops, and three Member States were subsequently assisted in launching national training programmes. In the South-East Asia Region all Member countries reviewed their policies and training programmes, and a framework for the evaluation of performance - designed in 1981 during an intercountry meeting - was adapted to meet countries' specific needs. Studies on the delivery of services were undertaken in Burma and Thailand. Following an interregional workshop (New Delhi, 1981) WHO developed a traditional birth attendant trainer kit, and has encouraged the production of teaching and learning materials in a number of countries.

61. Preparations for a consultation on the role of women's organizations in family planning included a review of the coverage of women's issues in UNFPA needs assessment reports, a comprehensive report on women's particular concerns in family planning programmes and methodologies for assessing them, and a paper on work by women's organizations in this area. The consultation will be followed by research and development activities in at least five countries. In the European Region a study was made of family planning legislation in selected Mediterranean countries, and another is currently being carried out on alternative approaches to the development of family planning programmes.

62. In the Eastern Mediterranean Region WHO collaborated with countries in pilot projects for the early detection and treatment of cervical and breast cancers. To promote the development of effective cervical cancer control in the Region of the Americas, as part of Member governments' public health programmes, the Organization co-sponsored with the American Cancer Society a meeting (Mexico, 1984) at which the PAHO manual of norms and procedures for cervical cancer control was reviewed.

63. Following the recommendation of a group of experts in 1981 that careful consideration be given to further testing of the efficacy of screening for breast cancer, particularly breast self-examination, a consultation on the subject was held in 1983.

64. Over-utilization of technology and over-medicalization of pregnancy and childbirth has become a major problem in developed as well as in urban areas of some developing countries. For example, fetal monitoring in some countries has resulted in an increase in the number of caesarian births owing to overreadings. The Region of the Americas and the European

Region, in particular, are involved in a review of these problems. Sociocultural relevance as well as women's perceptions are important considerations for the appropriate and successful use of technologies.

Social support measures for women

65. Recent studies on breast-feeding highlight the importance of women's living conditions for children's nutrition and health, and recent research on women's roles indicates the complexity of the situation everywhere for poor women who have to work in order to ensure family survival. The relationship between women's income-earning work and child care has to be considered in terms of: the level and use of women's income; the mother's time-use (especially for infant and child care); the type, location and conditions of women's work; the cost and availability of childcarers other than the mother; the effects on socioeconomic development. These are only some aspects of the whole range of infant and child rearing functions; a woman's time and status, particularly her access to and control of resources, are critical to these functions. Social support measures form an important part of these resources.

66. In traditional societies women have relied on each other and their extended families for informal social support. However, considerable unmet needs are arising where family structures are changing, increasing numbers of families are depending on women's incomes for survival, and women are losing their traditional means of support.

67. Initially particular attention was paid to day care alternatives for children, and women's roles in infant and young child feeding. A report on alternative approaches to day care for children was prepared in 1981, followed by an annotated bibliography in 1982. WHO and UNICEF co-sponsored an interregional meeting on day care in Nairobi in November 1982, and this aspect has become an important component of the programme on women in health and development in the African Region. Following the completion in Kenya of a study on the conditions of women who work away from home, and their time- and resource-use with particular reference to the way they manage child care while working, a framework was designed for carrying out similar country case studies in various parts of the world.

68. Relevant activities at the global level included meetings during 1983 and 1984 on determinants of infant and young child feeding and care; on the possibility of developing a cost/benefit framework for decision-making on investments regarding social support measures for women; and on social support for women in their multiple roles, with particular emphasis on informal measures.

69. Legislation and policy imperatives are social support measures that governments can take. Regarding maternity benefit legislation, WHO collaborated with ILO in the preparation of a publication on the protection of working mothers. It summarizes existing provisions of legislation on maternity benefits on a regional basis, and emphasizes the need to extend the coverage of such legislation - both in terms of the population covered and the extent of each provision (e.g. increases in time and facilities for breast-feeding).

70. Other important legislative measures are those governing minimum legal age of marriage; women's rights in marriage and in cases of divorce, rape and abortion; harmful traditional practices; access to credit; and basic constitutional guarantees of equality, including equal pay for equal work. Regional reviews and replies to the United Nations questionnaire to appraise progress during the Decade have shown that a number of countries have enacted or changed such laws in recent years.

71. Occupational health risks for women, particularly regarding reproductive health, were discussed at meetings organized by WHO in Budapest in 1982 and in Tbilisi (USSR) in 1983.

72. The crucial role that governments can play in providing social support to women is undeniable, but is not in itself sufficient. The main reason is that most women in developing countries are engaged in informal income-earning activities and are therefore not usually covered by the minimal social security laws (e.g. in one country in the South-East Asia Region it was estimated that protective maternity legislation covered only 1.6% of the women). But even in some developed countries the underlying assumption is that difficulties arising from the combination of motherhood and employment (formal and informal) are to be borne solely by the individual.

73. This is a familiar situation for women, who, having been excluded from most formal organizations and networks, have developed their own informal systems and approaches to problem-solving. The result is that in almost all countries there are women's networks which form a natural community-based mechanism for action. Governments are increasingly recognizing the contribution these groups and organizations make, as well as their potential, and are seeking their aid and advice.

Involvement of women's organizations

74. Women's organizations have special characteristics that make them a key factor in community involvement and an ideal entry-point and partner in primary health care activities:

- they are traditionally supportive, motivated and interested in health care (linked with socially prescribed roles of women as health care providers);
- they are able to understand and carry out intersectoral activities basic to primary health care;
- they have a positive attitude towards voluntary work;
- their work in primary health care is seen as positive action, acceptable both to the family and the community;
- they are based on, or form part of, long-standing networks, with family, cultural and inter-generation ties which are conducive to health promotion and disease prevention.

75. The grass-roots organizations are the main focus of WHO's strategy for involving women's organizations in primary health care. They serve poor and powerless populations in rural and urban settings, and their main

goal is usually to satisfy the immediate needs of their members, as they see them. They are rarely involved in planning or decision-making related to health development programmes, and have few established links with the organized health system. Nevertheless, they are currently carrying out a number of health and health-related activities on their own intitiative, often with WHO support. Where health services are supporting such groups the activities are more effective, and include: organizing children for visits of immunization teams; organizing mothers for maternal care; developing community mini-pharmacies to provide essential drugs at low cost; maintaining facilities for safe drinking-water and sanitation; providing information about family planning.

76. The purpose of intermediary organizations is to support local groups as well as their own membership. They often work from urban centres, and may be motivated by religion, profession, politics, or business. Some have branches or affiliates all over the country, or in regions of the country, and others are national associations or federations based in the capital city. Some receive the patronage of the government or major political parties, and some are backed by wives of high-level government officials. Funding is also received through members' contributions and donations from funding agencies or foundations.

77. Intermediary groups can facilitate collaboration with self-help groups that have little or no experience of working with national or international health and development institutions, enabling them to achieve greater effectiveness in planning and supervising local health activities, and managing the limited health resources.

78. International women's organizations - associations or federations of national nongovernmental organizations - usually "represent" national organizations from approximately 100 countries, and reflect the social or political biases of their national affiliates. Many carry out activities at the national level, working through the national body. Because of their international standing and prestige they provide important links between the community organizations and the government.

79. In all the WHO regions women's organizations have been identified as a major resource with which stronger links should be made. In the African Region an innovative and comprehensive programme on the participation of women in health development was launched in 1980, its basic approach being the use of village women's organizations as entry-points for primary health care at the community level. By the end of 1983, 26 such organizations in 17 countries were participating; each village chooses various health and development activities which are then implemented by the community, with technical support from governments and WHO. Special leadership training courses for women from the villages are being given at the WHO Regional Training Centre for Maternal and Child Health and Family Planning in Mauritius. An evaluation of the programme, using the WHO health programme evaluation principles, showed very promising results, including the following:

- Through revolving funds nine villages established mini-pharmacies of essential drugs in health centres and posts. The community chose trusted people to staff these, and each village opened a bank account for safe-keeping of the proceeds.

- Some of the people chosen have since been trained as village health workers in Angola, Cameroon, Congo, Gambia, Ghana, Liberia, Nigeria, Uganda, and Zambia.

- Statistics for Ngogwugwu village (Nigeria) show that no deaths of mothers during childbirth were reported in the last two years, as compared with six other villages under the same local government authority. Apart from one death at Somo (Mali) due to neonatal tetanus, no deaths from any of the six target diseases of the Expanded Programme on Immunization have been reported in the participating villages during the past 12 months.

- The multiplier effect was seen in four cases: neighbouring villages, impressed with the results, sought to participate in the programme. Moreover, groups that had become self-motivated and self-reliant initiated activities themselves, with their own human material and resources, and within a few months new activities - or expanded scope of the old ones - had outstripped the original plans.

80. In the Region of the Americas a survey was carried out in several countries on the types and functions of women's organizations involved in health work at all levels in both urban and rural areas. This was followed by an in-depth review of health activities of women's organizations in Barbados, Colombia, Honduras, and Peru. Subsequently, a Technical Working Group met in 1983 to discuss how organized groups of women could become more effectively involved in primary health care. In a number of countries steps have been taken towards closer collaboration with local groups to follow up regional activities: in Honduras, for example, a total of 72 leaders of women's organizations attended three seminars held with the aim of increasing the participation of women's organizations in maternal and child care activities.

81. In the South-East Asia Region support was given to Thailand for the strengthening of policies and plans for the involvement of self-help women's organizations in primary health care, emphasizing nutrition and family planning. In the Eastern Mediterranean Region a questionnaire was sent to women's organizations to collect information on their roles in primary health care. In the Western Pacific Region an in-depth review of women's organizations was undertaken in two countries, with focus on the interaction of the health care system and voluntary groups; technical cooperation was provided to the Governments of Fiji, Papua New Guinea, and Samoa to support the work of women's committees in primary health care activities.

82. At the global level, a working group met in Geneva in 1983 to discuss WHO's support to women's organizations with regard to primary health care; it considered the roles of women in health promotion and the problems inherent in existing health services which affect their ability to meet women's needs adequately.

Women as health care providers

83. In an effort to better understand and improve the status of women as health professionals, WHO has initiated a number of projects, including a multinational study on women as providers of health care. From its very

start, in early 1980, the study was conceived as essentially a country-based, action-oriented, and problem-solving effort. The aim was to promote and support national efforts through consultations and workshops including representatives from various countries and agencies, and through the production and dissemination of materials useful for stimulating awareness and promoting action regarding women as health care providers. The project has included a number of activities such as:

- two WHO-sponsored consultations, the first to identify priority issues, and the second to discuss the main elements that should constitute a national strategy for achieving the long-term aims of the project;

- the preparation of an annotated bibliography;

- the preparation, in the 17 participating countries, of papers providing country- and issue-specific analyses and broad proposals for action;

- the preparation of a paper on the participation of women in the health system.

84. To date, the following Member States have joined the project: Brazil, Colombia, Egypt, Ethiopia, France, Hungary, India, Indonesia, Jamaica, Mali, Nigeria, Pakistan, the Philippines, Switzerland, Thailand, the USSR, and Zimbabwe. A start has been made on implementing relevant action in several of these countries.

85. In Colombia the focus is on a series of workshops to prepare female health workers for positions of leadership in the formal health system. In Indonesia, as a preliminary to the development of an action plan, steps have been taken to assess various studies carried out in the country in relation to women's role in health development. In Jamaica, a manual has been produced which can serve both as a tool for training health aides and as a handbook for use by such aides and by others (e.g. teachers in general education programmes, mothers' groups, and women's organizations). Efforts are being made to improve the health-related aspects of child-minding in a number of nurseries, the focus being on the immunization of children, the assessment of their nutritional status, and the identification and control of health hazards. In Thailand, a national seminar on the promotion of women's efficiency and effectiveness as health care providers, held in 1983, produced a general plan of action which includes proposals for: (i) the production and duplication of handbooks, slides, posters, etc., for trainees and housewives, on such subjects as nutrition, environmental sanitation, first aid and basic nursing care, family planning, child care, and personal hygiene; (ii) a public relations campaign about the project; (iii) the training of trainers; (iv) a regional meeting in each of the regions of Thailand, aiming at the distribution of responsibilities related to the plan of action; (v) meetings of community leaders in six provinces; and (vi) the training of target groups of women.

86. In the Region of the Americas the Organization has sponsored and actively participated in various conferences regarding women as health care providers, and in Europe, following the publication of Women and health - the lay component, it is carrying out a study on the role of women as the main providers of health care in the family.

Intersectoral activities

87. Reference is made in various parts of this report to intersectoral activities, but particular mention should be made of those relating to nutrition and safe water supply and sanitation. Many governments have established offices, commissions or ministries to serve as a coordinating mechanism for "women's affairs" or intersectoral programmes.

88. The Joint WHO/UNICEF Nutrition Support Programme was initiated in 1982 to support action that can be taken by the health sector for the improvement of the nutritional status of children and women. National programmes are currently being supported in Burma, Ethiopia, Mali, Mozambique, Nepal, Sudan, and the United Republic of Tanzania. The programme has a special women's component which is concerned with promoting activities to increase women's income; to improve their productivity; to increase their access to adequate dietary information; to reverse negative social and cultural attitudes affecting their dietary patterns. In each national programme the women's component varies, but the range of activities includes a search for solutions to problems of child care and women's other work roles; the education of men in family nutrition; the development of cooperatives for agriculture and small-scale industry.

89. WHO, together with other United Nations agencies participating in the International Drinking Water Supply and Sanitation Decade (IDWSSD), is collaborating in efforts to improve community water supply and sanitation through recognition of the role of women and promotion of women's participation in IDWSSD activities at national, regional and international levels. It has participated in the interagency task force on women and IDWSSD, and has initiated activities in relation to women's aspects of human resources development and planning and evaluation of programmes. The guide for the design of a national support programme for community education and participation in water supply and sanitation contains explicit references to women's issues throughout, and takes account of the differences between women's and men's situations and roles vis-à-vis water supply and sanitation.

90. In collaboration with UNDP, WHO is also helping countries to develop a women's component in IDWSSD activities. In Honduras three projects have been started to improve water and sanitation through new technology with the participation of women's groups. In the Dominican Republic a project is being developed to enable women's groups to disseminate information on improved sanitation and hygiene practices in their communities. In Barbados, Guyana, Jamaica, and Saint Lucia a survey of potential sanitation projects involving women was recently carried out. There are similar activities in Democratic Yemen, Egypt, and Sudan.