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WOMEN IN HEALTH

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At the WHO/UNICEF International Conference on Primary Health Care, held in Alma Ata, USSR, in 1978, recognition, implicit in the WHO goal of "Health for all by the year 2000" was given to the many elements - such as agriculture, sanitation, housing, water supplies and land ownership - having a direct bearing on health. It is, therefore, also realised today that health care means, in addition to strictly medical interventions, the need to develop these health-related areas. In other words, the interaction between health and development, if still imperfectly understood, has at least been identified. It would be equally fair to say, however, that the involvement of women in these health-related spheres, and thus their actual and potential contributions to health care, are not as yet being given their full due.

2. Many official statements, such as some made on the status of women's health at the Women's Mid-Decade Conference which took place in Copenhagen earlier this year, continue to assume that women's health problems will be solved by "someone else", and ignore the very real contribution which women have made and continue to make in the realm of health care, not only to their own health but also to the health of the family, the community and the nation.

3. The World Health Organisation, which has acknowledged the failure of the Western medical model to provide adequate health care for all, is now seeking new ways to combine traditional grass-roots health care with modern health techniques. It is in the former kind of care that women continue to make the major contribution, based, as stated above, on their deep involvement in all the spheres which influence health.

4. In a recent meeting with 40 young women, representing 36 countries and six continents, when asked what words came to mind when health was mentioned, it was significant that words like "mother", "grandmother", "sanitation", "housing", "environment", "nutrition", "agriculture", "food", "water" kept recurring. Words such as "hospital", "doctor", "nurse" and "medicine", which one might have expected to hear, were almost absent. This response may, however, have been the effect of the literature and a film to which the group was exposed during their meeting. For it is still rare for people to recognise women's role in health care through their involvement in all the areas vital to health, from agriculture and food growing, the preparation of food, fetching and using of water and care of the environment to home economics. All these activities are vital to the health of the family and the way in which they are done by the women responsible for them can have far-reaching effects on health, both positive and negative.

The gap between health services and health needs

5. From this failure to recognise women's role in health care stems a multitude of other ills. National health care services, being insensitive and unattuned to the realities of women's daily lives, may

do little to meet their real health needs. For example, although many countries claim to provide improved maternal and child health services, the lack of involvement of the women served is obvious: the providers or deliverers decide while the users have little choice or say. As a result, rural clinics for maternal and child welfare, for example, are often situated conveniently for health professionals or planners while the users must travel on foot for long distances, sometimes over difficult terrain, to reach them. Clinics for expecting mothers may be set on different days to those reserved for child welfare clinics. The fact that it is often the same woman who must lose working time twice over as well as travel considerable distances to attend both clinics is overlooked. Curative services for minor ailments may not be obtainable at the same time nor in the same place and the mother who fails to attend at the specified time is labelled delinquent.

6. The cost factor puts even geographically accessible maternal and child facilities out of the reach of most mothers, since even a nominal fee is beyond the scope of very low-income mothers. In addition, for those who are working, the problem is that of time, since clinic hours may be fixed to suit the providers of the care but do not take into account mothers' working hours. Many may thus miss out on programmes vital to their children's health, such as immunisation programmes.

7. Another example of the results of the failure to understand the realities of women's lives and their role in health-related areas concerns sanitation. A great deal of conventional health teaching about cleanliness of the environment and personal hygiene is given to rural women. Much of this totally ignores the difficulties involved in obtaining clean water - that commodity essential for good sanitation and health. Water sources may lie at a considerable distance from the village or settlement, or be polluted. The vessels used to carry water back to the village are necessarily limited in size. These days, the most popular pictures in literature on women in development seem to be those showing either women clustering around a water source or trudging over barren trails with water containers on their heads. In urban slums, sanitary conditions are no better and often worse than those in poor rural areas.

8. Added to the problems of inadequate and/or polluted water supplies are overcrowding, lack of food since none can be grown, and a scarcity of cash to buy what is sold in markets and shops. Such constraints make conventional health teaching at best irrelevant and at worst a slap in the face of the poor woman who is unable to follow the directions given. In addition, nutrition education is often inadequate to counteract the pressure of aggressive advertising and promotion for easily-prepared and pre-packaged foods. This has had deleterious effects upon both health and family income.

9. At the Women's Mid-Decade Meeting in Copenhagen, a paper on women's participation in the health services cited the following obstacles to health, common to developing countries:

(a) inaccessibility of rural areas where most of the people live;

(b) maldistribution of health services, especially hospital-based services, which tend to be located in big towns;

(c) lack of transportation facilities, medicines and financial resources;

(d) poor management and distribution of resources and lack of coordination between government departments and agencies;

and in industrialised countries:

(e) domination of the "medical model";

(f) paternalistic attitudes of medical doctors.

10. In the face of such obstacles, how do women survive? The figures on rural and urban disadvantaged women without adequate health care are staggering. The toll on the health and lives of infants and some groups of women denotes a crying need for a basic structural transformation in our societies - changes which will take into account not only women's health needs but their potential contribution to meeting these. The involvement of women in all the areas now considered important to health as a whole must be not only recognised but taken into serious consideration in attempting to formulate the answers. This will mean seeing women in a totally new role in which their energies and skills are utilised.

11. At Copenhagen, all the regions and countries identifying the above-cited obstacles to health set themselves targets for the forthcoming five-year period (1980-85). In the area of health care, targets and priorities included: "nutrition and family planning services which emphasise both preventive and therapeutic aspects. In general, these include increased training facilities for nurses, paramedical and technical staff, midwives, nursing assistants and traditional birth attendants; expansion of maternal, pre-natal and child health services; extension of public health and immunisation programmes; nutrition and health education. The national food and nutrition policy aims to reduce nutritional problems and increase domestic production such that there will be no further rise in the volume of food imports".

12. Other priorities included plans to increase the coverage and impact of nutritional programmes, better food production and processing and research into all aspects of women's health and nutrition. Belatedly, at the end of this shopping list are mentioned "other priorities and extension of programmes to reach people in socially and geographically isolated areas, and to increase community participation". Will efforts to implement these targets be successful in meeting the needs which are apparent?

Participation

13. At Copenhagen and in other international fora, concern has been generated over women's health needs. However, targets and priorities set mostly relate to research programmes and still fail to focus on the people concerned - the women themselves. The solutions offered to health problems come mainly "from above" and continue to look at the situation in general and prescribe solutions to be done _for_ others. Instead, what is needed is an approach which enables women - long the providers of health care in its wider sense - to search for solutions to their health problems, seek answers to the needs and do what they have always done, better. Once women are recognised as the providers of health care, changes will begin where they are, will take them into account at the decision-making level and will reveal what large or small inputs are required of them.

14. Overcoming the kinds of obstacles to health cited above really means applying the basic principle of primary health care - i.e. the principle of people's involvement in the policy-making, planning and implementation of health care. The need for education is often cited in the context of participation. But education per se, without a focus related to people's needs at all levels, is irrelevant. When directly related to people's needs, however, the positive effect of education on the effectiveness of people's participation in the decision-making process is evident. Education which does not take cultural and social factors into account is also doomed to failure. This has been clearly seen, for example, in efforts made to educate people in family planning.

15. Who is being educated is yet another element needing careful consideration. A simple increase in the number of prepared professional personnel does not, in itself, answer all health needs. Experience and research have shown that, in the areas where the need for health care is greatest - the village, the urban slum, and among "people in socially and geographically isolated areas" - it is the woman on the spot who is often closest to that need. The traditional birth attendant is such a woman. She is to be found wherever the human cycle of birth and death occurs. Education aimed at improving her skills has proved of inestimable benefit to the health of the community everywhere it has been given.

16. In one area where neonatal tetanus accounted for 90 per cent of the deaths of newborn infants, all deliveries were carried out by traditional birth attendants. In this rural, agricultural and very inaccessible zone, professional medical help was available only at several days' walking distance. A graduate nurse-midwife assigned to open a small clinic in the area, discovering the high rate of tetanus, found that a multi-purpose bamboo knife was being used, often without washing, to cut the cord. In her contact with the community, the nurse concentrated on re-educating the traditional birth attendants in the use of a razor blade, fixed to a bamboo handle and sterilised very simply between deliveries. Over a six-months' period, the incidence of neonatal tetanus was sharply reduced in the area.

17. Women in rural areas are the pivot of family life. Every day they must take many decisions affecting the welfare of the family. From the family to the community is a natural step. Education on hygiene, safe water and good nutrition, and their effect upon the health of the family, if appropriate to the realities of rural women's lives, relates naturally to their concern for their families' welfare. Their concern can be built upon, and women's knowledge and skills increased, as a means both of improving the health of the community and of securing the involvement of people in their own health care and the decision-making process.

18. Women's work in growing the food which feeds the family and provides part of the family income through selling some of the crop has been widely recognised as being as time-consuming as it is physically demanding. Growing knowledge of agricultural technologies appropriate to varying geographical conditions and climates could make food-growing not only far less time-consuming and physically wearing, but also a more lucrative form of employment for women. The time saved could also be spent learning about better nutrition and utilisation of the food grown for the family's health.

19. However, care needs to be taken in assessing what will really help women in agriculture. In the past, improvements in agricultural technology were mostly based on machinery operated by men. Although

sometimes appropriate, these technologies often removed women from their original role. The crops grown by these methods were sold for profit and the woman's ability to feed her family as well as to gain some additional income was severely reduced. The effect on the family's nutrition and general health was predictable. The woman's morale also suffered, especially when no attempt was made to use the free time she gained to improve her knowledge and skills in other areas so that her own and her family's health would not deteriorate.

20. The example of how appropriate education can build on women's involvement in food-growing and nutrition to increase their contribution to health is but one of many which can be cited. The education of children is another area of family life which, in isolated rural areas, devolves very heavily upon women. It is the mother who initially "transmits the culture" to her children and who teaches them all the customs, knowledge and techniques for living common to the community and the society. Women's responsibility for, and involvement in, this sphere is another asset which appropriate health education can build upon. What the mother learns in the areas of sanitation, food-growing, nutrition and health care she passes on to her children and thus to the future community.

21. If women's existing knowledge and skills are adequately assessed and effectively utilised as a basis for further learning, the human resources thus released for improved health become almost limitless. Official recognition of this potential offers the hope of the goal of health for all becoming a reality. For, while the other partners in the health team - professionals and staff with other levels of medical training - can ensure medical and other interventions, it is the first level of care, with its combination of curative, preventive and promotive health activities, which women - 50 per cent of the world's population - could contribute to a complete health care system for all