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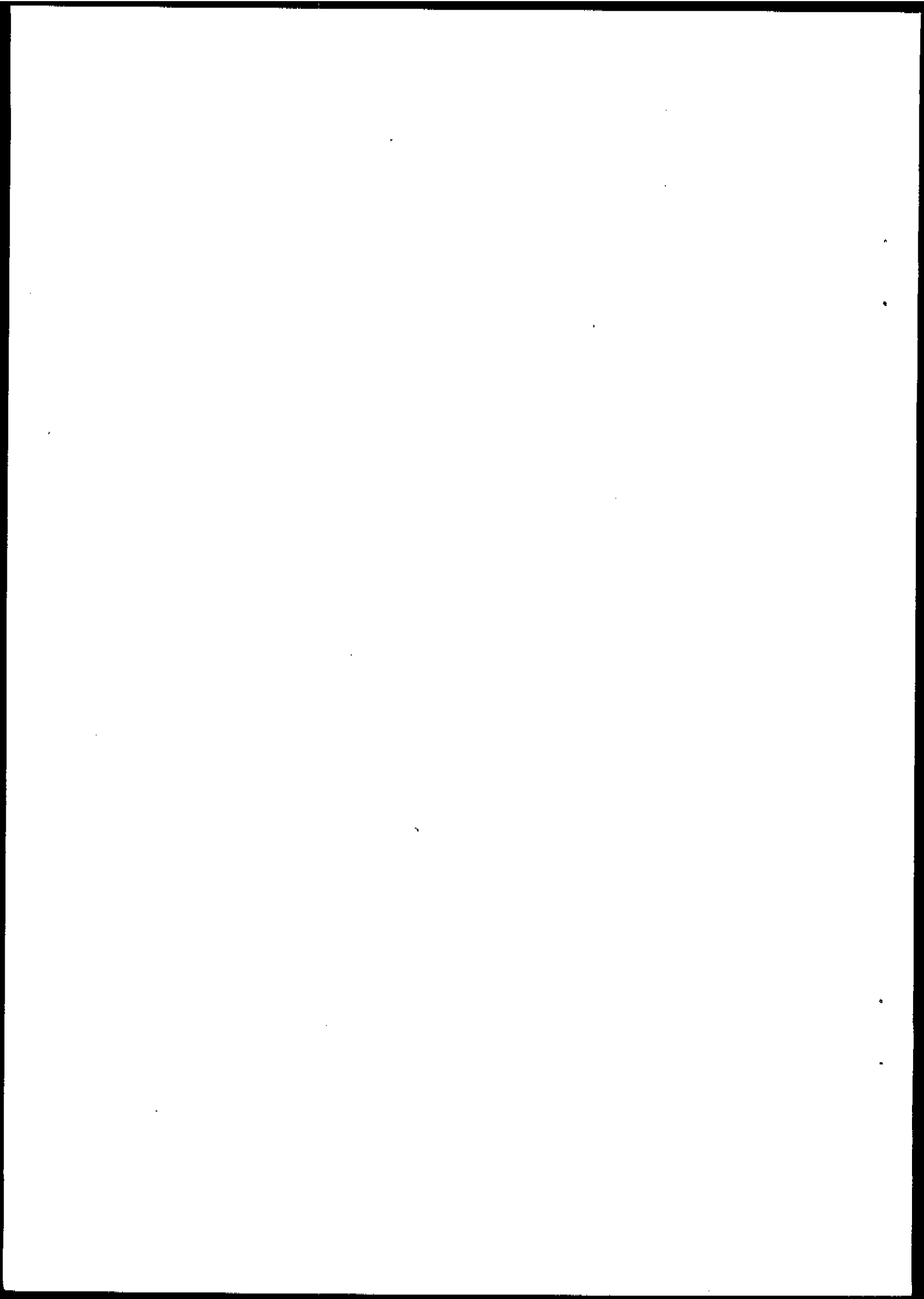
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1. Introduction

The WHO Regional Office for Europe and the Scottish Health Education Group (SHEG) jointly sponsored a three-day Conference on Women and Health. It was attended by approximately 150 participants from over 30 countries in the European Region and North America. They represented a wide range of disciplines and various positions in society from grassroots to ministries.

2. Scope and purpose

The Women and Health Conference was a concrete manifestation of the Regional Office's commitment to the United Nations Decade for Women. There has been a growing awareness among European Member States of the enormous part women play in maintaining the health care system, through their caring work at home, in the family, in the neighbourhood and in the health professions as nurses, midwives, physicians, etc. The health services depend on the caring work of women, and their skills and capacities, now more than ever. Yet this development has not been matched by women's participation in health care decision-making. This is particularly important as cutbacks in health services will have various effects on women's existing work-load in their role both as providers of health care and as users. Women's health may suffer if cuts in health services inadvertently add to their existing work load.

The status of women's health in the health care system today is important to the discussion of the WHO goal of health for all by the year 2000. Women are the majority of health care users but there is little input about their needs into the health care system. This makes the definition of women's priorities and health problems inadequate. Moreover, women have their own special area of health care - gynaecology and obstetrics - and it is particularly relevant who defines and takes the decisions about this strictly female concern. Further to this the increasing population of aging women in Europe raises particular questions, especially in countries where the retirement age has dropped and life expectancy has risen.

The purpose of the Conference was to create a dialogue among people with different expertise on issues of women and health in the European Region, to report on what is being done and to develop strategies for future action. The participants included policy-makers, researchers, health educators and representatives from consumer groups and grassroots projects.

To create this dialogue the method of networking was used. The health education programme at the Regional Office has used networking in much of its work: establishing lines of communication among people with similar interests and activities. In the planning stage, two newsletters were sent out announcing the Conference. They contained a brief questionnaire asking people involved in women and health activities to tell about themselves and their work. From the many responses, a directory was compiled listing these activities and projects by country, which was distributed at the Conference. Since participation at the Conference was limited, those not able to participate were urged to arrange their own women and health conferences nationally or locally. In fact, local Scottish women organized a women and health fair that immediately followed the Conference. Most Conference participants also had plans to disseminate information from the Conference. In an evaluation form distributed at the end of the Conference, the majority of participants said that they would share what they had learned at the Conference with others by writing articles for professional and other journals and by presenting written and oral reports to their reference groups.

3. Opening session

The Conference was opened by Dr J.E. Asvall, Director of Programme Management, on behalf of the WHO Regional Director for Europe. The opening addresses were given by Dr J.E. Asvall and Mr S.C. Mitchell, Director, SHEG. Dr J.J.A. Reid, Chief Medical Officer, Scottish Home and Health Department, then addressed the meeting. These speeches drew attention to how women and health has become a priority at the international, national and local level, as a result of the discussion generated by the United Nations Decade for Women.

The keynote address was then given by Dr A. Oakley, a research sociologist in the United Kingdom. She began by looking at what questions need to be asked and answered about women as users and providers of health care. Next she looked at the implications for women of the differences between two concepts of health: health as a medical product and health as a social product. Finally, she looked at the implications for health care systems of these two concepts of women.

Drawing on examples from literature, she focused on the medicalization of women's normal life and bodily functions and looked at the effects of marriage and motherhood on women's health. In conclusion she said:

....everyone has a stake in moving towards a more humane society where health and illness are not split off from the rest of experience, in which bodies are seen as connected to the environment, and minds and emotions are understood to shape the way bodies function; everyone also has a stake in appreciating the limits of science and in understanding the new technologies of our brave new world. What we want is a brave new world not a defunct, dispirited and depressing old one. What we want is a world in which women who ask for change are taken seriously.

4. Workshops

Through workshops the Conference provided an opportunity for small groups to work together and share information on women and health. There were over 50 workshops in all.

To create a basis for further discussions, workshops on the first day dealt with structures affecting women and health, which were discussed from five points of view based on eight background papers (see Annexes 2-9 for summaries).

Epidemiological: the importance of reputable and reliable data and the difficulties in quantifying women's experiences and access to medical care were stressed.

Demographic: some of the demographic factors that have an effect on the health of women were reviewed. One example was the progressive aging of the population, another was the decline in childbearing in the European Region.

Cultural: the importance was stressed of including the cultural dimension in an overall historical, economic and political analysis of women and health. A close look was taken at the dimension of continuity and change.

Political, social and economic: the position of women and vulnerable groups within society and how women make use of professional health care in Europe were analysed.

Health service structures: the ways in which the organization of health systems affect the equality of access to services were analysed. Also discussed were the discrepancies between the services that women themselves felt they needed and those that were actually provided.

Workshops on the second day were concerned with specific health issues, such as women and medicalization, fertility control, alcohol and drug abuse, sexuality, violence and women, employment, mental health, disabilities, and aging.

On the third day workshops developed plans for the future including new approaches in health promotion/education activities. Positive approaches to health and appropriate lifestyles were emphasized.

5. Workshop discussions

In this section there will be a summary of the 10 major concerns identified in the various workshops. Underlying the discussions was the basic assumption that health is not exclusively a medical issue but is interrelated with the broader issues of environment, housing, transport facilities, working conditions, sanitation, etc. Health services should therefore take into consideration the social and political aspects of health as well as the effects of different cultural backgrounds on women's health.

5.1 Women's work

Women's increased participation in the paid labour market has not been met by a decrease in their housework and family responsibilities. Women still nearly always have the sole responsibility for housework, even when employed full-time. The perpetuation of the double role of women as both homemakers and workers is having ill-effects on women's health. The traditional view in some cultures of women as housewives ignores the reality of women's lives.

The housework and private care that women carry out have been and continue to be largely unpaid labour throughout the European Region. Although housework represents a large proportion of the total work performed in most European countries, it does not appear in national labour and health statistics. Since official data do not reflect the true work-load of women, the consequences for women of reducing services in the health sector cannot accurately be estimated.

The characteristics of housework are long hours, a high rate of accidents and isolation. These are well known risks for women's physical and mental health. Housework is not included on

lists of work hazards or among risk factors of pregnancy, nor is it considered in maternity protection legislation or other legislative policies. Preventive measures and strategies rarely include the hazards and stress of housework. Consequently, little research takes into account the effect of housework on women's health. Women at the Conference emphasized the need to make housework visible to society.

Health professionals have the important task of recognizing and spreading a more accurate view of women's work. For instance, one of the workshops noted that in spite of the existence of legislation on maternity protection aspects, no progress can be achieved until there is a real sharing between women and men of domestic and family responsibilities. Men can play an important preventive role in the health of their wives and children by assuming housework and child-care responsibilities.

Another theme of several of the workshops was low pay and poverty, especially among migrant women (but also among older and disabled women). The man of the family may be well off, but the woman and children can be poor if the man controls the resources. Even when a woman is earning money, it is usually at the lowest pay scales. In addition, women often receive lower pay than men, for the same work (this pay gap is even more extreme for migrant, older or disabled women). In conclusion we can say that women's work (both paid and unpaid) is essential to society but it is often not taken seriously in official statistics. Women as individuals have little opportunity to change this situation. Women have to work outside the home to support themselves and their families, and they have to work inside the home because who else will do this work that is essential to the survival of the family?

5.2 Provision of lay care

Studies show that most health care is provided by lay people, privately at home and in the neighbourhood, and mainly by women. There is an increasing trend towards new social forms of health care, i.e. people are forming self-help groups to provide mutual support and aid for others (and their families) with similar health problems. The fact that these people actively participate in finding solutions to their own (or their families') health problems has been very beneficial. Many examples were given of the success of the self-help/self-care movement, particularly the women's health movement.

In some Member States professional health services and mutual aid groups are beginning to work together. This is being done by sharing knowledge and devising more effective ways of disseminating information that helps the patient to make informed choices about health care services. This cooperation is spreading the latest information on caring and coping with chronic conditions and is giving enormous benefits to the chronically ill.

At the same time in some countries, professional associations are still struggling to prevent self-help groups practising what they see as an illegal kind of medicine. In other countries, doctors encourage and promote only those mutual and self-help groups that might tend to remove from their practices problem patients such as alcoholics, drug abusers, chronically disabled people and depressed women. Participants warned against the dangers of integrating self help into the medical system in such a way that it is robbed of its special method of work which is the reason for its success.

Many women at the Conference recognized that self help/self care can be promoted as a way of saving on health expenditure (which in some industrialized countries represents up to 10% of the gross national product). When official services for the young, sick, old and disabled are being cut back, women must not support efforts that relegate these caring functions to the home to be assumed by women as unpaid work, but rather promote new solutions for quality care not based on the serving role of women.

5.3 Medicalization of women's health needs

Medicalization occurs when normal biological functions or social issues are seen as medical problems requiring medical solutions. In one workshop it was pointed out that medicine is one of the most important ideological forces of society since it is one of the key institutions that defines what a "normal" woman should be. This results in a shift of control from the individual to the medical profession. When this happens, for example in the case of childbirth, it means a serious loss of control over and confidence in women's own capacities and in their own bodies.

Medicalization has had unfortunate results for women especially in cases where daily coping problems have been diagnosed as "psychological" or "psychosomatic" disorders. In many countries this has resulted in a high prescription rate of tranquillizers or mood-altering drugs.

Often several complex factors are the cause of physical symptoms, but once energy goes into finding a medical solution the focus shifts and is often deflected from prevention. An example of this today is in vitro fertilization. This treatment for infertility is the current vogue, while little attention is paid to preventing the causes of infertility such as pelvic inflammations caused by IUDs and sexually transmitted diseases.

To prevent medicalization, health must be seen in the context of women's lives. This means the recognition of factors that influence health, such as the double work-load, the occupational health hazards of housework, women's life cycles (menstruation, pregnancy, menopause) and the fact that the economic and social conditions influencing women's lifestyles are very different from those that affect men.

Workshops cautioned that there is a tendency for medicalization to be exported from developed to developing countries. They also pointed out that not all solutions to health problems are medical and that often a change in social conditions (for example better housing) is a necessary prerequisite.

5.4 Decision-making in health care and health services

Workshop discussions kept coming back to the central issue of power and decision-making in health care. Women have always been responsible for the care of others: what they want now is to make decisions about this care. This includes decisions about the standards of health care, the priorities to be given in health services, the curricula, the training of health professionals and the research in this field. It was felt strongly that medical services for women needed clear evaluation, as certain medical procedures were regarded as being followed often more for the convenience of professionals than for the health of women.

Establishing the legal framework for making decisions is an important step. Appropriate legislation supporting maternity benefits and a breakdown of the sex-segregation in the labour market are ways in which society can relieve the increasing pressures on women's lives. Women coming from countries with "progressive" legislation, however, felt that legislation alone is not enough to change sex roles. For example, the provision of paternity leave in one Member State is underused. In another Member State, women do not have maternity leave and can lose their job when they become pregnant. It was emphasized that while legislation is not enough, it is necessary in supporting the changes desired by women. For example, in Member States where abortion is still illegal, women are forced to terminate unwanted pregnancies by clandestine and often dangerous means.

5.5 The status of women in the health professions

Although most health care providers are women, only a very tiny proportion of women in the health professions reach levels of important decision-making where the priorities in the health care system are set. Examples were given of countries where men hold almost all nursing management positions even though they represent only a small minority of nurses. On the other hand, even in countries where women make up over a quarter of the medical profession, only 1% have positions of decision-making and authority.

The role and authority of midwives has been threatened in the past 50 years by many different factors including the medicalization of birth, the increasing professionalization by the medical profession resulting in the rise of obstetrics as a specialty, and most recently the new technology that is being used in the screening of pregnant women and during the birth itself. These developments have undermined and de-skilled the work traditionally done by midwives. In many European countries they have been replaced by nurse-midwives.

Owing to women's double work-load, the career of the female physician is often interrupted, and young female doctors are often unable to practise for several years because of family commitments.

There are specific health hazards in the health profession that relate to the status of female workers. The double burden of caring for a family and pursuing a career have definite consequences for health. One study shows that male doctors live on average five years longer than female doctors. The incidence of abortion and malformed children in women doctors has increased. In anaesthetics, one study showed that the incidence of liver disease in both male and female staff has doubled. These results are being challenged and research is currently being conducted into the influence of stress factors in anaesthetics and intensive care wards. Female laboratory staff have been shown to have children with an above-average incidence of chromosomal abnormalities, and they also suffer a higher incidence of abortion. Nurses suffer a high incidence of back pain, related in part to injury, but also to stress factors.

It was also suggested that the higher mortality and morbidity rates in women are related to their relatively low positions in the hierarchy, and that stress-related diseases are generated by long working hours with a lot of shift work and accompanied by a loss of autonomy.

5.6 The role of health education

Prevention has been and still is a key issue in health education, but in today's complex society it is not enough. Health education should be instrumental in promoting healthy lifestyles. A part of its approach includes analysing the effects of the unhealthy messages often put across by advertising that condone smoking and alcohol abuse among young people and women (there has been an increase in both smoking and alcohol in both groups).

Health education has a key role to play in the improvement of women's health. There is a gap between how the medical profession and lay people perceive illness and the terminology and language used in communication between the patient and the health worker. In highly technical societies, lay people define their problems in terms of disease because it is the easiest way to communicate with the medical system. Experience from women's health groups have shown that when women have the opportunity to discuss health issues with non-medical people they are better able to express themselves. It is therefore an important step in the prevention of health problems that health workers should attempt to understand the lay perception of health and of illness, both of which are cultural phenomena. This is especially important in the case of migrant women who are often the most poorly informed users of the health system, owing to a high illiteracy rate both in their own language and in the language of the host country.

Several workshops encouraged the support of lay initiatives in health education. For example, there is a growth in the Region of documentation centres on women and health. These centres are collecting, evaluating and disseminating the available information that women need to make informed choices about health issues. In one workshop a presentation was made by a representative from a London-based group that has developed a Women's Health Information Centre. Other women and health documentation centres are celebrating ten-year anniversaries, for example DO.RI.S. in Rome and ISIS in Geneva. These groups began by collecting information for their own purposes and by means of publishing newsletters have been disseminating this wealth of material to other women. Several examples of "non-sexist" health education were given.

Health education and training should not be only for the lay public but also for professionals. Physicians (for lack of other options) are often forced to rely only on literature produced by drug manufacturers. An approach to health education that puts the consumer's needs and wellbeing in focus is preferable and should be aimed at groups such as health professionals, government decision-makers and health planners.

5.7 The increasing population of old women

As living standards in the Region have improved, retirement age has dropped and life expectancy has risen. The problems associated with old age are of increasing concern, especially for women who in most countries live longer than men and therefore make up the majority of the older population. The fact that most old people are women is often ignored in research and social programmes.

The economic and social subordination that women live under most of their lives is intensified in old age, making poverty one of their major problems. There also appears to be a double standard imposed on the elderly that includes stereotyping as to what women/men can do at various ages and gives men easier access to social services: for example, men have an easier time getting home help services, on the assumption that men need more help with domestic chores than do women.

The traditional stages of a woman's life - as daughter, wife, mother - and the emphasis women put on social contact leave them ill prepared for coping alone in old age. This often leads to feelings of loneliness and depression which, in turn, affect their health. Whereas former generations could rely on the help and companionship of younger family members, the changes in family patterns, work patterns and housing/physical planning leave little possibility of an extended family structure and social network.

Strategies for planning for the increased aging population and the specific problems for women stressed the importance of looking to the future and beginning to prepare for it now. Important areas are:

- the role trade unions can play in preparing people for retirement through courses and planning activities for their retired members;

- the role the media can play in presenting a positive image of old age;
- how to keep the elderly out of institutions and in their own homes for as long as possible;
- to take into consideration the millions of European immigrants who will be retiring in the near future.

Old people have resources and skills that should not be wasted. It was emphasized that even in the face of a poor economic situation, priority should be given to "adding life to years" particularly among women.

5.8 The special health needs of migrant women

The problems and special needs of migrant women were an important issue at the Conference. In the European Region most migrants have to cope with hard social and economic conditions (doing the hardest work for the lowest pay). The prerequisites for health (i.e. good housing, environment, nutrition, etc.) are often more scarce among migrant women than among other groups. Sexism and racism add to their problems and these prejudices also exist in the health services.

Besides the health problems they share with other women, migrant women have other problems. They often get contradictory messages, for example while indigenous women are encouraged to have more children, the fertility of their own migrant group is seen to be a problem. Specific female conditions such as giving birth, gynecological disorders and female-related cancer are particularly a problem for these women who not only have language problems, but are caught in the conflict between deep-rooted religious taboos and the modern, Western medical system.

There is also the danger in times of economic crisis that migrant women will be the first to be forced out of the labour market, since they have jobs with little security. Mass unemployment for migrant women will create even more poverty and isolation.

In the next few years, many migrants will be reaching retirement age. Many of them will be women who have never worked outside their own home, do not know the language of the host country and may not even read or write in their own language. They are not prepared for institutional life in the host country because they have food taboos and other customs from their own cultures.

5.9 Technology

Developments in technology greatly affect women's health both positively and negatively. It was pointed out that technology is a male-dominated field, often influenced strongly by economic considerations. Women must begin to influence technology and to develop it according to their needs.

In the field of medicine, the technology developed is often expensive and not necessarily rational. An example is in vitro fertilization, which is a highly expensive technique, that may lead to dangerous genetic manipulation and does not solve any great health problems. The money invested could be better spent preventing infertility problems and taking care of the needs of children already born.

There has also, in recent years, been an increase in the use of technological devices in uncomplicated births. This includes various prenatal screening techniques that in many countries have become such a part of the medical routine that a woman has no choice.

During childbirth, technology such as electronic fetal monitors are supposed to improve safety levels and reduce risk. Often the result is that the medical staff pays more attention to the machine that is monitoring the birth than to the woman. Learning to interpret monitor readings is slowly replacing the skills health workers had in identifying symptomatic changes in the woman's body and in the fetus. Controlled scientific research almost always shows that the technology used in uncomplicated births does not improve either the safety or the outcome. In fact, the introduction of electronic fetal monitors in some Member States has increased the number of caesarian births owing to misinterpretation of the readings.

The overall question is how can women influence the development of new technology and how can they become a part of the decision-making process that controls the existing technology?

In the case of medical technology, there is a need to investigate how and why capital-intensive technological care is accorded higher status and commands such a large proportion of resources in developed countries.

5.10 Research needs and priorities

The workshops stressed that more controlled research is needed. This includes research that looks at "alternative" approaches to health care and research to test medical practices that are carried out but never evaluated. Moreover, in the European Region, it is vital to evaluate legislation related to work and the health of women, especially occupational health, including the effect of the double work-load on women's health in general and especially during pregnancy.

Women attending the Conference recognized the limits of analysing issues related to health in isolation and independent from the other aspects of women's lives (including the social, political and economic aspects). A true analysis of women's health needs must include some of the alternative strategies and supplementary services that exist (and that women use) but that are often "hidden" because they occur outside the established system.

To achieve these goals it was argued, the purpose of the research and the criteria used should be redefined from women's point of view and in the context of women's lives. This means including such issues as housework and the effect of motherhood on health as well as physical, psychological and social influences. Not to consider these issues makes the research inadequate as far as strategy and action are concerned.

6. The outlook for the future

The Conference gave participants an opportunity to appreciate the complexity of women and health issues in the Region. In a Region as large and diversified as Europe, there are problems of quantity and quality of service. In some areas there is a serious lack of medical services of any kind and in others women criticize the health services for not meeting their needs. For example, in some countries more childbirth services are needed, whereas in other countries an important point for women is the right to choose between birth at home or in a hospital.

One recurring theme was the need to re-examine and reformulate the "reality" of women's lives. This redefinition is necessary to make visible some of the hidden aspects of women's lives (such as their double work-load) and how this affects not only their own health but that of their families. Another much repeated theme was women's role as providers of health care.

In many of the workshops, regardless of the specific issue, freedom of informed choice was considered a basic right for all women. Participants were unwilling to allow the pursuit of health to become a luxury for only privileged groups, women or others. They underlined that health services must be available to all people, in a form that allows an informed choice of preventive and curative options, and with user involvement in their planning and evaluation. In the end the discussions kept coming back to the central issue of power: Women have always been responsible for the care of others; what they want now is to make decisions about this care.

In the workshops on the third day dealing with action to be taken the following suggestions for improving health services for women included:

- support of alternative systems that expand the range of choices in the existing health care system (such as alternative birth centres in addition to existing hospital services); and
- representation of women in decision-making bodies at all levels of the existing health care system.

7. The final plenary session

The final plenary session summarized the results of the Conference and looked towards the future. This included a review of the social and cultural structures influencing women's health presented under the theme "The way ahead".

The risks of medicalization and medical management of all sorts of social problems (such as unhappiness) were reviewed. Self help and self care can be valuable, but women were warned of falling into the trap of taking on the total care of the sick and disabled at a time when most governments are trying to reduce health care costs. The role of female health professionals was discussed and women were urged to participate in the decision-making process.

A representative from WHO headquarters spoke on the United Nations Decade for Women and how the Conference related to the Decade. The Decade began after the Mexico Conference in 1975, and is to end in 1985 with a conference in Nairobi. This Conference was part of the Decade and hopefully one sign of a worldwide movement. The United Nations system recognizes this growing trend in its support of the United Nations Decade for Women.

The French Minister of Women's Affairs, Mrs Y. Roudy, spoke of the changes she desires for women and the campaigns she is working on, including equal employment for women; making information a priority so women will be aware of their rights and be stimulated to work for new rights; easily accessible contraception and abortion; and courses to teach policemen to cope with battered and raped women, which are a must in dealing with the problem of violence against women. She described plans to forbid clitoridectomies on young migrant girls and to improve conditions of childbirth. She stated that the Government does a part of the work necessary to improve the conditions of women; the women's movement and individual women must also push for change if these efforts are to have any effect.

Representatives from the Regional Office and SHEG summed up the main recommendations of the workshops and described programmes and activities in their respective organizations that promote women's health.

8. Recommendations

All the workshops were asked to draw up recommendations based on their discussions. The following are a synthesis of these.

8.1 Women's work

The value and role of women's unpaid work in the home need to be acknowledged and adequately supported, especially in industrial societies where paid work is so well charted as the basis of status and society support.

There is a need for more and stronger legislation that promotes paternity leave as well as for programmes that re-evaluate domestic roles that at present create a heavy work-load for women.

Legislation should be promoted that encourages innovative approaches to family support services within the community.

Educational programmes should be supported for the entry and re-entry of women into the labour market.

8.2 Provision of lay care

Lay priorities and perceptions should be accepted and concepts of self help and self care should be introduced into the training of all health workers and self help should be supported through education and counselling.

Population policy in Member States should include input from the lay public.

Pilot studies should be carried out to test forms of health care, such as birthing centres, that offer an alternative to standard hospital care.

Guidelines should be produced for doctors and resources made available to other individuals dealing with women who are the victims of violence.

8.3 Medicalization of women's health needs

Member States should investigate the incidence of and discourage the existence of medicalization of normal biological functions, such as the menstrual cycle and pregnancy, and social-based conditions, such as stress, which has resulted in an increase in prescription rates of tranquillizers and mind-altering drugs for women.

8.4 Decision-making in health care and health services

Member States and international organizations are urged to adopt policies that support and encourage the involvement of women in all levels of policy development. Research programmes and priorities in all aspects of health and medical care that affect women should be re-evaluated.

It is important that wherever possible women have freedom of choice in the health services (in terms of type of provider, treatment, and institution). To make this a reality, women health care providers should be involved in presenting the available choices in an easy to understand way and women health consumers must be involved in defining the available choices, within the formal and informal systems.

8.5 The status of women in the health professions

Member States should work towards strengthening the role of women health professionals. This includes supporting the expansion and enhancement of the status of midwifery in developed as well as industrialized Member States.

Member States are encouraged to recognize and give attention to the content and organization of the primary health care that is provided by women, particularly midwives and community health workers, to women. It should focus on communication, emotional support, and the social and psychological aspects of health. These aspects of care must be strengthened and higher status accorded to the health workers who provide it.

8.6 The role of health education

Access to health education materials must be made available to lay people as well as to health professionals as it is necessary for effective health care.

Health education materials should promote equality between the sexes.

Health education is not only a question of promoting health through the media, it should also analyse the negative messages being delivered by advertising.

The arbitrary censorship of health education material written by lay and professional women for other women should be eliminated.

Separate fertility regulation services and materials should be designed that are appropriate to the particular needs of adolescents.

8.7 The increasing population of old women

Studies of the elderly often ignore the fact that most of them are women and that throughout their lives women have had different economic and social opportunities than men. Further research is needed into the huge variety of physical and social factors affecting the health of aging women.

8.8 The special health needs of migrant women

Recommendations should be made to combat racism in the health services in Europe and make the special health education needs of migrant workers, especially women, a priority.

Programmes should be set up that encourage the training of ethnic minority health providers to ensure better service in the communities where they live.

Information on health care and services should be collected and disseminated for women migrants informing them of their rights, status, etc.

8.9 Technology

There is a need to look at how and why capital-intensive technological care is accorded higher status and commands such a large proportion of resources in developed countries, and attempts should be made to curb this tendency in the Member States.

A closer evaluation should be made of the actual contribution of high technology to health, through research and the systematic evaluation of existing research in different countries.

8.10 Research needs

The goal of research should be to re-examine and reformulate the "reality" of women's lives. This redefinition is necessary to make visible some of the hidden aspects of women's lives such as their double work-load and how this affects not only their own health but also that of their families.

Research should be carried out into the long-term effects on women of various obstetric and other medical interventions.

Funds should be made available for women's groups to research and analyse female sexuality.

Annex 1

CONFERENCE EVALUATION FORMS

On the third day evaluation forms were distributed asking the participants for their impressions of the Conference. Seventy-one participants filled out and handed in the forms (15 in French). The following is a short summary of the result of this evaluation form.

Over three quarters of the participants who answered felt that the size of the Conference was satisfactory, only nine people thought it too big and two thought it too small.

More than a half felt that there were a satisfactory number of plenary sessions, while a quarter found them too few. A little over a third felt that the plenary sessions were long enough.

Approximately a half thought that the workshop topics were too specific and a little over a half felt that there were too many. Over a third found the workshop topics too general.

Over a half had no suggestions for important topics that had been left out of the workshops. Those who did feel that important topics had been left out mentioned the problems of migrant women, the possibility of war/nuclear war and the peace movement.

More than a third thought that the structure of the workshops was too loose and several indicated that the role of the workshop leader was a determining factor in the success of a workshop.

More than three quarters felt that the size of the workshop groups enabled them to express their views.

Two thirds felt that there was enough time for both formal and informal discussion.

Two thirds felt that they learned something new, primarily as a result of having met participants from other countries and learnt to appreciate the differences between countries and the complexity of their systems.

When asked what expectations they had that were not met, more than a half had no suggestions. Of those that had suggestions, the thing they missed most was the promotion of action and of strategies for achieving goals.

When asked if they had learned anything that would modify their ideas or practices, a third said no and a quarter did not answer. Those who did elaborate mentioned that they now felt better informed, that they had had their ideas reconfirmed or that they had had their ideas challenged.

When asked how they planned to share the Conference experience with others, the majority intended to write articles for professional journals or reports for their group or funding agency, and/or planned to organize a meeting or discussion on the issues brought up at the Conference.

Annex 2

EPIDEMIOLOGY

by
Dr U. Maclean

This paper explores the uses of epidemiology in the field of women's health as a valuable tool to investigate women's life and health.

The first part of the paper looks at the nature of this branch of medical science and the importance of reputable, reliable data. It is pointed out that although women are clearly subject to the same diseases, disasters and disabilities as men, there are still differences and these differences can in some but not all cases be found in the diseases that are directly related to their reproductive functions and organs. If any progress is to be made with policy changes among health planners and official medical care providers, the argument must be substantiated with accessible and reputable data. Some examples are the causes of some cancers and cardiovascular diseases in women.

The second part of the paper deals with the limits of epidemiology, including the difficulty of quantifying women's experiences and their access to medical care. The importance of socioeconomic states of poverty and social class, and the difference they can make when combined with sex differences are discussed. In countries that have conquered the formerly common communicable diseases and where maternal mortality is very low, women can now expect to live longer than men. Surveys show the interesting paradox, however, that women report more illnesses than men. In other words, in epidemiological terms women experience higher morbidity, but lower mortality. The reasons for this are discussed.

A growing radical critique of epidemiology points out the limited causal assumptions inherent in this field and urges that much more attention be paid to the effect the organization of society has on the production of ill health.

Annex 3

DEMOGRAPHIC FACTORS AND WOMEN'S HEALTH

by
Population Activities Unit
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Demographic conditions and changes may affect the state and level of health of the female population in a number of ways. This paper does not attempt, however, to assess the specific relationships between all demographic factors and health. Although each factor may, by itself, have only a small effect on health, their cumulative effect may be significant.

One of the major developments in demographic trends in the region of the Economic Commission for Europe has been the progressive aging of the population. A fundamental characteristic of the aging process, that will have an impact on women's health, is the high proportion of women in the aged population, especially in the oldest age groups. A second demographic variable that affects women's health is associated with childbearing. The paper reviews briefly general fertility trends, in particular the decline in childbearing, as well as some more specific aspects of fertility related to health, such as the decline in the number of higher birth orders, fertility outside marriage, the age of the mother at birth, contraception and abortion.

Annex 4

CULTURAL FACTORS AT WORK

by
Professor L. Balbo

Two dimensions appear to be equally important as reference points in the discussion on women and health: the dimension of persistence and the dimension of change.

Persistence

We cannot afford to underestimate how much in contemporary society remains unchanged, how many interests and existing structures resist change, how much need there is to repeat, insist on and face the same issues again and again. What feminism, the women's movement and our own awareness as women who live in these times have made us understand, is in no way to be taken for granted. Thus, let us discuss traditional stereotypes and beliefs concerning women.

Change

Having said this, it is also true that much has actually changed in our conditions and lives as women. Change has been and is going to be a crucial element for us and we are concerned with and interested in change. This dimension, then, is a key in our analysis.

How are these underlying themes going to be addressed in a more detailed presentation? The value systems, normative patterns and stereotypes that define women's position in our society and characterize our "cultural heritage" as a whole ought to be reassessed. More important yet is to identify the institutions and social agencies that actively perpetuate and reinforce the existing system.

In doing this it seems important to focus not just on the traditional cultural agencies, such as the family, religion or the mass media, all of which are widely recognized as playing a key role in stereotyping women. What about the occupational system of contemporary society, what about the modern state? In other words, what roles do structural conditions and economic and political agencies play, by affecting "culture" and by shaping patriarchal/sexist values?

Having discussed these traits, I hope our analysis will allow us to move on to a second set of questions concerning the following issue: under what conditions do women become aware of, mobilize against, build up power to resist and change the existing order?

Annex 5

WOMEN'S SHARE IN GOVERNING THE COUNTRY:
THE CASE OF POLAND

by
Professor M. Sokolowska

In Poland (as in many other countries in the European Region) very few publications exist on the social status of women and official statistics are not divided by sex. This is the case for employment and occupational status, making it difficult to evaluate women's role in decision-making. Feminist studies are non-existent.

In this review of women's share in decision-making, Poland is an interesting example because it is a socialist country with a long history based on a vigorous national culture. It is interesting to see what effect the events of recent years have had on women and what role women have played in these developments.

This paper includes a description of:

- women's share in education, gainful employment and earnings;
- women's role in political, economic, academic and cultural elites;
- the impact of the Marxist-Leninist doctrine on women;
- the impact of national culture on women; and
- the social position of women from August 1980 to December 1984.

The author wrote years ago that women's access to power elites was merely a matter of time. Today she is inclined to believe that this is unlikely. The author concludes that although the existing structures occasionally co-opt women it is perhaps best that women do not have a real share in the contemporary systems of power: at least they bear no responsibility for the trend of events in the world.

Annex 6

SOCIOPOLITICAL AND ECONOMIC PERSPECTIVES ON WOMEN AND HEALTH

by
Ms C. Delphy and Dr D. Leonard

This paper argues that only by recognizing the position of women as one of subordination within a patriarchal capitalist society can we understand the use women make of professional health care in Europe, the use professionals make of women as lay care-givers, and the treatment women are offered when they are ill.

While noting that the position of women in the labour market and their treatment by the media and other institutions are important in defining women's position within society, the paper focuses on the division of labour within the family and the conditions of women's work in the home as being of primary importance.

Within marriage, responsibility for domestic work continues to rest with the wife-mother (or, if there is no wife, a daughter). She is required to do routine housework and to care for her husband, her children, the elderly and the sick as the need arises. In return she receives maintenance. The demands upon her are open-ended, and consequently the pressure of work is unremitting. She feels harrassed and exhausted and that she is constantly failing to complete all that could be done. She is required to fit herself around other people's needs and convenience and always to put others first. She is expected to work as unobstrusively as possible, so that much of her work is invisible, and she has little status in society. She lacks companionship for most of her working life.

Health care workers view women's work in the home as unskilled (when they recognize it exists at all) and their time as valueless. They support the subordination of women's needs to those of the family. With regard to health, they hold women responsible for getting other people to do what is best, and/or to take on any extra work themselves. Women who fail to keep their family well are made to feel guilty and stupid. The rational reasons women have for sometimes going against professional advice are not investigated. The cure for a woman made ill by the nature of domestic work, consists in making her again content with her lot. The problems and illnesses endemic to the primary occupation of women are not taken seriously, and current methods of medical practice have themselves served to increase the stress women work under.

Annex 7

WHOSE NEEDS DO INDUSTRIALIZED HEALTH SYSTEMS MEET?

by
Dr S. Ruzek

Many factors influence the social organization of health care in industrialized societies. The population's age distribution, social class, ethnic and religious composition, and cultural history, along with its wealth, size and commitment to political ideologies all influence how health systems develop. Western industrialized health systems idealize objectivity and rationality and ignore or discount subjectivity. Quality of care as measured by scientific and professional values often differs from lay definitions. Whereas professionals emphasize the availability of advanced medical technology, women's definition of quality care means access to services to control and manage fertility, access to treatment that is known to be safe and effective, and opportunities to gain knowledge about health that is congruent with their personal and cultural values.

Many types of routine medical care could be provided by mid-level practitioners (nurses, midwives and health educators) more safely and effectively, and at lower cost than by the physicians who often provide these services. Rather than promote mid-level practice, however, many countries now attempt to promote more self care, a professionalized form of lay self help that makes care in the home by family members an official extension of the formal health care system. Self care, promoted by some as a solution to the fiscal crisis of the welfare state, is not a panacea and has some potentially harmful consequences for women. The state must take a stronger stand to make primary care a priority, to encourage the use of mid-level practitioners, and to limit the expansion of high technology specialty care.

Fee-for-service and state or prepaid health care systems offer different incentives for patients and providers to use or perform medical services. In fee-for-service systems, women are at risk of overmedicalization and overtreatment. In prepaid or state systems, services may be unavailable. In neither system are enough women in positions of authority to determine what services will be made available or reimbursable through insurance payments. Inequities based on social class are greater in fee-for-service than in prepaid or state systems. Mechanisms for involving more women in all levels of health care decision-making are needed.

Annex 8

WOMEN AND HEALTH: THE ISSUES

by
Scottish Health Education Group

The medicalization of women's health issues has resulted in passivity and dependency. Since health education is concerned with controlling modern diseases through taking responsibility for lifestyle, women cannot afford to be passive recipients of health care.

Women occupy key positions in society, as the major providers of health care for the young, the old and their menfolk. Outside their traditional family role, their own health and that of their families has been increasingly affected by economic hardship and unemployment.

Within health education there has been a shift of emphasis away from the individual. Health education is increasingly seen as an issue for the individual as part of the group and the community. Women in formal groups, such as professional and industrial bodies and patient representative bodies, have a major role to play in improving health systems and working and living environments. Women working in informal groups at the community level may need support in crossing the administrative barriers that divide health from education and social work.

Finally, those involved in health education clearly need to inform themselves about issues that affect women and to change some of their own entrenched attitudes.

Annex 9

WOMEN AND HEALTH: A PRIORITY

by
Health Education Unit, WHO Regional Office for Europe

It is essential that women's health be a priority if the target of health for all by the year 2000 is to be achieved. Though the role of women in society is changing, traditional views of the female role are kept alive by custom, legislation, social systems and education based on role model definitions of men, women and families.

In the European Region, women's increased participation in the paid labour market has not been met with a decrease in their unpaid labour in the home. Women may be damaging their own health and that of their families through the consequent increased stress and work-load. It is therefore essential for society in general and men in particular to accept their responsibilities and duties in the reproductive sphere. Not only do women make up half the world, but the maintenance of their health is crucial to the health of present and future generations.

This paper looks at the interplay between women's paid and unpaid work. It then gives some background to the proclamation of the United Nations Decade for Women including the World Plan of Action, which is a global consensus on what needs to be done to improve the conditions of women.

In the section on the role of health education, the theory of health promotion rather than health prescription is discussed, together with the importance of recognizing lay competence as an expression of consumer demands. This leads to a discussion of the impact the women's health movement has had, both as a reaction against traditional medicine and as an innovator of new concepts.

Next, in order to place the issue of women and health in its proper framework, women's roles as the providers and users of health care (including health promotion, disease prevention and treatment) are discussed.

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