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Priority health issues affecting women

Address by

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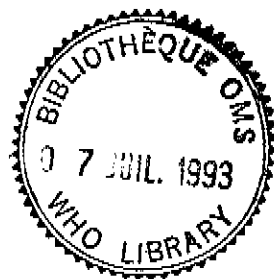
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Women are the world's greatest unused natural resource. They represent a potential for development that is often ignored. Most of the world's 2,500 million women cannot make their rightful contribution to social and economic development simply because they are denied access to health, education, economic resources and decision-making. This denial is seen clearly in the attribution of male and female roles and in gender discrimination.

By gender discrimination we mean the socially constructed relationships between men and women which are linked to the state, the economy, and to all micro and macro processes and institutions. Gender is a fundamental organizing principle of human society yet it is also a source of inequality. Promoting gender equality will have a profound effect on the organization of societies and implies major changes in the way women and men live, work and care for each other and for their families.

The imbalance of power between men and women has a negative effect on women's lives and health. As a result, women's health is characterized by the **absence** of physical, mental and social wellbeing and by the **presence** of disease and infirmity.

Women generally live longer than men, but they do not necessarily live healthier lives. In many societies girls are, even from conception, subject to discrimination in terms of being born, allocation of family resources and access to health care. Where women's status is low, their health, education and emotional needs take second place to those of

men. Relegated to subordination from birth, girls eat last and eat least, are overworked and under-educated, and can prove their worth only by bearing many children from an early age.

Women's health status is too often typified by neglect, abuse and victimization. Female infanticide, genital mutilation, malnutrition and anaemia, early marriage, high fertility, abortion, sexually transmitted diseases, HIV/AIDS, maternal mortality and morbidity, violence, rape and incest are all conditions which either affect only women or which hit women hardest.

At the same time, society's expectations of women are immense. Women bear an overwhelming responsibility as producers and reproducers. Their contribution to the wealth of nations through paid and unpaid work in agriculture, industry and services, though often uncounted, is enormous. At the same time, women assume special responsibility for bearing and bringing up the next generation. Yet the human reproduction activities which are borne exclusively by women are looked on as free goods and services. These multiple roles put stress on women's physical and mental wellbeing in industrialized and developing countries alike.

Development strategies show that investment in women's health yields high returns, both economically and socially. If we wish to unlock women's potential we must put an end to discrimination.

The health problems women face indicate a failure to recognize and take account of women's unique health needs. Women have different needs from men both because of physiological differences and also because of culturally

determined attributes that lead to social and economic inequalities between the sexes.

Gender differences reduce women's health status and access to health services by depriving them of education, economic opportunities, decision-making powers and legal status. Where such discrimination is most severe, life expectancy for girls may be the same as, or even lower, than for boys - a remarkable finding given the innate biological superiority of the female.

The health of women matters because women's health is synonymous with the health of society. Women are a resource in which it is essential to invest if society is to grow and develop. Not only do women nurture the next generation, but they also provide the bulk of health care available to the sick, the infirm and the needy. Women also have a unique role in transmitting health promoting behaviours - such as hygiene, food preparation and nutrition - to children and other members of the family or social unit.

Women's health will assume its proper place on the international health agenda only when the social and the biomedical construction of women's health needs are interlinked. This means placing women's core perceptions and needs at the centre of analysis and focusing on the diversity of women's health requirements over the life span. It also means consideration of women's health within the larger context of their lives.

Women, more than men, suffer from poverty and powerlessness. Their voices are not heard and their demands are not represented in the overall struggle for scarce

resources. As a result, women's perceptions of, need for and contribution to health are overlooked. This neglect is manifest in different, but mutually reinforcing, forms. The formal health services have not addressed the unique health concerns of women. Women's health issues, especially those concerned with their reproductive health and wellbeing, are quite simply neglected.

Neglect is also manifest in the failure of health research to examine the impact that physical and biological differences between men and women have on the epidemiology and aetiology of disease. Findings of clinical research on males have been generalized for both sexes. Such gender blindness has been noted in both communicable and non-communicable diseases. Although in many countries women spend up to half their reproductive lives either pregnant or lactating, they are denied access to drug treatment for a range of diseases because drug trials have not been evaluated for them.

A recent review of research studies on AIDS found that most failed to mention the sex of the subjects, or applied results of studies inappropriately to both sexes. Yet it is known that women have different risk factors for HIV and appear to respond differently to infection. Women's vulnerability to HIV infection and to other sexually transmitted diseases is directly related to their status in society. Women's economic dependence on men makes it difficult for them to protect themselves against infection, and their relative poverty means that they have less access to health education about prevention and treatment. In addition they carry a much greater burden in terms of the impact of

epidemics, not least due to their traditional role as care givers.

Low social and economic status prevent women from articulating their health concerns. Many women accept chronic fatigue and ill health as normal and inevitable. Women need to see that change is possible, that their health is not immutably fixed but can be bettered, that good health is an option open to them. Indeed, good health is surely a woman's right.

Women need information in order to define their concerns. They also need ways of bringing their perceptions and concerns to the attention of health care providers and planners. In other words, women need to be able to participate actively in formulating their own health concerns and in developing strategies to address them.

Much will depend on the capacity of the formal health care system to respond to women's health needs in a gender sensitive, appropriate and effective way. Flexibility and gender responsiveness must be incorporated into health planning systems in both industrialized and developing countries.

The World Health Organization, as the technical agency responsible for global public health, has a special responsibility to bring women and health care providers - needs and services - together in a functional relationship. Too often women seek health care only when their symptoms become overwhelming. Health care providers must encourage women to think of their health in positive terms, rather than as a series of acute episodes marking a lifetime of constant

and chronic discomfort. Yet a narrow epidemiological model of women's health which defines women simply as victims of discrimination, as inert recipients of treatment for disease, cannot hope to do this.

In defining women's priority health needs, our objective should be to break the cycle of neglect that afflicts women across the generations. It is time to move from advocacy to action - action that recognizes women's rights and autonomy and that enhances women's participation in the development process. This means we must take practical steps to ensure that women are able to exercise choice in their lives. Choice in the number and spacing of children, in contraceptive method, in reproductive life style - these are essential first steps towards exercising choice in other areas of life. Reproductive rights and reproductive health are the foundation on which improvement in women's health and other aspects of women's lives can be built.

Reproductive and sexual health implies the ability to reproduce safely and with a successful outcome and to bear wanted children. It also means the right to regulate reproduction without risk and to have sexual relations that are safe.

In many societies women remain trapped by a tradition that assigns high value to their role as reproducers but takes little note of anything else they are able to do. We must develop interventions that offer girls and women alternative ways of expressing themselves and achieving fulfilment, while still recognizing the importance of their role as mothers. We can do this only by addressing the needs of girls and women

from birth, though childhood and adolescence, to adulthood and into old age.

There are many views about what women's health needs are. But in the context of such widespread need it is imperative to develop priority interventions that will improve women's health status rapidly and sustain that improvement. For this reason, I propose to single out for priority action three indicators which reflect the unequal health status of women and which it is possible to improve substantially even in the short term. These are nutrition, fertility and maternal mortality.

First, as a highest priority, let us deal with the nutritional needs of girls and women throughout their lives. Let us develop strategies to end discrimination in food allocation and nutrition. Malnutrition brings with it an enormous burden of ill health - wasting, blindness from vitamin A deficiency, mental retardation from iodine deficiency, and the widespread iron deficiency anaemia. Malnutrition affects girls and women more than boys and men firstly because of discrimination in feeding and health care and secondly because of the female's need for extra energy and iron to make up for losses during menstruation, childbearing and lactation. Malnutrition also contributes to increased morbidity and death from infectious and chronic diseases.

Women, suffer from malnutrition more than men do even though they produce more than half the food in the developing world and play a major role in storing, processing and marketing food.

Some 450 million women between 15 and 49 years suffer from anaemia, the most widespread and neglected nutritional deficiency disease in the world today. Anaemia affects women more than men and is a major problem during pregnancy and lactation. Anaemia remains a public health problem because efforts to provide oral supplementation have not focused on women's needs and perceptions. As a result, distribution systems have been unreliable, training of providers has been inadequate and health education has been either lacking or inappropriate.

Improving women's nutritional status - in particular, removing the burden of chronic fatigue that accompanies anaemia - will be a vital first step in breaking the cycle of neglect and ill health. It will demonstrate to women that ill health is not an immutable state. It will show that simple interventions exist which can bring real changes to women's everyday lives.

Fertility control also aims to change women's daily lives. Access to family planning information and services will lead to a vast improvement in women's health. More importantly, a woman who controls her fertility can control other aspects of her life too. The fatalistic acceptance of childbearing well beyond the limits of safety has been forced on women and their families simply by the lack of an alternative. When women are given the power to take free and informed decisions about when to start and stop childbearing, and how many children to have, they are free to take better care of themselves and their families. The benefits of family planning on the health of women and children are well established.

During their reproductive lives women will require a range of contraceptive methods, from the temporary and transient to the more or less permanent, from barrier to hormonal methods. Providing an appropriate mix of methods is the challenge facing health care providers. Women need to be able to take free and informed decisions about the risks and benefits of different methods of fertility control.

Family planning is much safer than bearing children in the conditions that many women face today. Poor nutrition and high risk fertility patterns both contribute to the chronic ill health suffered by millions of women who experience complications during pregnancy and delivery. Half a million of those women die from these complications each year.

The 16th century reformer Martin Luther wrote, "Women should remain at home, sit still, keep house, and bear and bring up children ... If a woman grows weary and at last, dies from childbearing, it matters not. Let her die from bearing - she is there to do it." Four hundred years on, the health community still fails to make inroads against maternal mortality, even though we know what needs to be done to prevent it. Such a situation is simply not tolerable.

Unsafe motherhood kills 1,400 women in the prime of life each day, 60 women every hour, one woman each minute. Surviving millions suffer illness ranging from chronic pelvic inflammatory disease to obstetric fistula for the rest of their lives.

Unsafe childbirth also causes the deaths of some 4.3 million newborn babies each year, 12,000 babies every day, 500 babies each hour, eight babies every minute. Many

babies who survive are so badly damaged by the trauma of delivery that they are unable to live economically and socially useful lives.

The deaths of these women and babies are avoidable. Women die from infection, high blood pressure, obstructed labour, unsafe abortion and a range of diseases that are aggravated by pregnancy such as malaria, hepatitis, rheumatic heart disease and diabetes. All can either be prevented or treated cost-effectively at the community or health centre.

There is no need to wait for further research and technological development before we define a practical strategy to improve women's health. The challenge is, rather, how to put available knowledge into practice in a way that meets women's own needs, and responds to their problems.

All pregnant women have the right to quality prenatal care. Complications must be detected before they turn into emergencies. Debilitating diseases such as diabetes, malaria and sexually transmitted diseases must be treated for they become more severe during pregnancy.

No pregnant woman should deliver without the assistance of someone who can provide basic care if complications develop and who knows when and where to seek the help of a more skilled health care provider. What is good for mothers is also good for their babies. Every mother has the right to expect that her baby will be born alive and healthy, just as every baby has the right to a living and healthy mother.

High quality services for pregnant women should be available as close as possible to where women live and work. Services must be welcoming, flexible and low cost. Health care personnel should collaborate with traditional health providers to ensure that cultural perceptions are given due consideration.

Women must have life saving operative delivery for obstructed labour. They need drugs to combat eclampsia, antibiotics for sepsis, drugs and blood replacement in cases of haemorrhage. Babies with birth asphyxia must be given immediate resuscitation. And the health care system should encourage immediate breast feeding and other practices known to be beneficial.

More than anything else, women wish the process of pregnancy and delivery to be a time of dignity and pride. A health care system that ignores the fundamental right to privacy, and respect for the person and cultural traditions, will not gain the confidence of the women it aims to reach. Public health workers have to make greater efforts to ensure that pregnancy and delivery - natural processes though not risk free - are not over medicalized.

The person best equipped to provide community based, low technology and cost-effective care to women during their reproductive lives is the person with midwifery skills who lives in the community alongside the women she treats. Such a person understands women's concerns and preoccupations. In many societies, women and their families wish this person to be a woman too. It is a tragedy that the number and status of midwives in the health services have been allowed to

decline in recent years. It is time to reassert the value of midwifery skills and make them available to all.

Family planning and obstetric care may be the woman's first and only contact with the formal health sector. As such, the person who provides them is in a position of great responsibility in dealing with a hidden plague that affects all women, from all walks of life, from all parts of the world. This is the person who must be alert to the issue of violence against women.

Violence, rape and incest represent another facet of the low status accorded to women and their subordination in a strongly masculine and aggressive society. Domestic violence is seldom seen as a public health issue yet it is a significant cause of female mortality and morbidity. Violence against women is widespread in all countries where studies have been conducted. And the most endemic form of violence against women is wife abuse. In parts of south Asia, suicide and violent deaths among pregnant women and those of reproductive age are linked to factors such as unwanted pregnancy, bride price and dowry. Elsewhere, domestic violence often increases during pregnancy and a significant proportion of perinatal morbidity is thought to result from the battering of pregnant women. We cannot afford to neglect the health implications of violence for women's mental and physical health and well being.

Women will be able to respond adequately to such aggression only from a position of strength - when they enjoy good health, have a measure of control over their lives and futures, and are secure in the knowledge that skilled and loving health care is available when they need it.

Focusing our initial efforts on interventions which relate to women's reproductive lives should not imply that women's health needs are seen solely, or even primarily, in terms of their roles as mothers. Nonetheless, in those parts of the world where most women live, between half and three quarters of a woman's life is spent either pregnant or breast feeding. We cannot continue to allow women to run risks that were the norm in the 16th century. The major killers of women during pregnancy and childbirth were the same then as they are today. But today we have simple and effective interventions to prevent them.

It is time that conditions such as malnutrition, unregulated fertility and maternal mortality were problems of the past. We must look to the future in order to anticipate the health needs of the women of tomorrow. Women's increasing life expectancy has not been accompanied by improved health. Yet more women than men, will be confronted with the health problems of old age.

As industrialization and urbanization proceed and life expectancies increase, women will face a different burden of ill health and disability. Health problems such as breast and cervical cancer are unique to women. Other problems are more prevalent in women than men - including cardiovascular disease, mental disorders, osteoporosis, immunologic disorders and Alzheimer's disease. Sexually transmitted diseases, HIV/AIDS and cancer affect men and women differently. Specific interventions must be devised to address each type of problem, bearing in mind that women are more likely than men to be poor, lacking social security coverage and health benefits.

Particular attention should be paid to adolescence. It is a time of growth and change, when many behavioural patterns are developed that set the stage for health or ill health in later life. Risk taking behaviours may leave young women vulnerable to accidents, to sexually transmitted diseases and HIV, to drug abuse and early childbearing. High rates of adolescent pregnancy in both developed and developing countries are not only risk factors for health but also reduce the prospects for continued education or employment.

More attention must be paid to women's health at the workplace. We must foster the conditions in which women and their partners can optimally share the responsibilities of production and reproduction.

As the end of the millennium approaches and environmental concerns become ever more urgent, the role that women play in the environment will increasingly be at the forefront of our concerns. Women are the primary victims of environmental degradation.

Growing recognition of women's health and development on the international agenda gives grounds for cautious optimism. Multisectoral strategies will be formulated and there will be sustained change for the better. But it must be acknowledged that policies and interventions that target only women cannot achieve the best results. Men must participate in social development as equal partners with women in a common undertaking. Together men and women will share in a process that will benefit them, their spouses, their children and future generations.

The priority of the World Health Organization is to foster and encourage this process. WHO will provide the best assistance that the medical field has to offer, while also recognizing the limits of medicine in the context of the social and economic determinants of health. While quality health services are primarily the responsibility of the health sector, health status is not. Redressing the inequalities that women face and improving their indicators of health status is a shared responsibility of all development sectors. Only by cooperation and determination will we be able to offer every woman the chance of a life of active participation in development and self respect.



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Geneva, March 1993

Further related reading

Health implications of sex discrimination in childhood.
WHO/UNICEF/FHE/86.2.

Maternal Mortality: A global factbook compiled by Carla AbouZahr and Erica Royston.
ISBN 92 4 159001 7. SwFr 50-
(Developing countries 35)

Preventing Maternal Deaths by Erica Royston & Sue Armstrong. ISBN 92 4 156128 9. SwFr 40-

The prevalence of anaemia in women: A tabulation of available information, Second Edition, 1992
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Bibliography, 1989.
WHO/MCH/89.5.

The role of women's organizations in primary health care with special reference to maternal and child health including family planning. WHO/FHE/WHO/88.1
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WHO, Geneva
and
Women, Water and Sanitation.
WHO, Geneva

Women, Health and Development. Progress report by the Director-General.
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AIDS and family planning,
WHO Geneva, May 1990,
WHO/MCH/GPA 90.1.

AIDS and maternal and child health, WHO Geneva, October 1990, WHO/MCH/GPA 90.2.

Safe Motherhood newsletter
Quarterly bulletin of the
Maternal Health and Safe
Motherhood programme.
Available on request in English
and French.

Unless otherwise stated, these documents are available free of charge from:
The Division of Family Health,
World Health Organization,
CH-1211 Geneva 27,
Switzerland