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Profile of Women's Projects

UNFPA activities in the field of women, population and development expanded considerably in recent years. In the two-year period of 1986 and 1987, 63 projects were under way in all regions of the world, compared with 90 such projects undertaken in the six years between January 1979 and December 1984. In addition, a considerable number of the Fund's other projects had components related specifically to women.

The Fund's commitment to women was also manifested in the increased budget for women's special projects. Whereas $US 9.2 million had been committed to these projects in the 10- year period between 1969 and 1979, $9.7 million was committed to these programmes in the five-year period 1979-1984. In 1986 and 1987 alone, the amount allocated was approximately $4 million. For the five years 1986-1991, approximately $8.8 million was allocated. (Because the Fund considers projects for approval on an ongoing basis, this last figure does not represent the total allocation to be made for special women's projects.)

A. Regional distribution of projects

In 1986 and 1987, UNFPA supported 17 projects in Africa, 11 in Asia and the Pacific, 10 in the Arab States, 9 in Latin America and the Caribbean, and 2 in Europe (1 of these for Third World leaders) (see table 1). In addition, 14 interregional and global programmes received UNFPA support, with 13 per cent of total funds for the five-year period extended for these activities.

B. Size of projects

During 1986 and 1987, a total of 63 women's projects were approved and allocated or continued to receive funding (table 1). The budget of 1986 and 1987 was $4,068,242. For the period 1986-1991, the figures shown in table 1 represent only a portion of the funds that will eventually be allocated. This is because project proposals are reviewed and funded on a bi-weekly basis.

As table 1 shows, most of the special projects for women were implemented in Africa. However, for 1986-1991, the largest proportion of total funds was allocated to projects in the Arab States, where UNFPA supported fewer but larger projects demanding greater financial resources. Three projects in Asia and the Arab States were allocated budgets of more than $500,000 each for 1986-1991, whereas no projects in Africa or in Latin America and the Caribbean received such high levels of funding for the same period.

Table 1. Projects and allocations, 1986-1987 and 1986-1991, by region

Region	Number of Projects	Dollars Allocated 1986-1987	%	1986-1991	%
Africa	17	$956,103	24	1,776,457	20
Asia and the Pacific	11	814,625	20	1,863,517	21
Arab States	10	690,375	17	2,372,034	27
Latin America and the Caribbean	9	955,628	23	1,372,069	16
Europe	2	92,500	2	212,500	3
Interregional & Global	14	559,011	14	1,175,858	13
Total	63	$4,068,242	100	$8,772,435	100

Interregional and global projects placed second in the number of special projects--14--receiving UNFPA support. Most of these efforts were designed to bring people across nations and regions together to promote activities aimed at improving the situation of women. The projects were concerned with support and communication of information on women and development, population education and health training, and included some innovative United Nations staff development projects for promoting gender awareness.

A review of budget allocations shows that, compared with projects approved in other sectors, the Women, Population and Development projects fell into the small - and medium - scale funding category. Two-thirds of the projects were to receive less than $100,000 for the 1986-1991 period. Many of these smaller projects were training or information-gathering activities to be completed in a short period of time.

A sizeable proportion of women's projects had funding ranges between $100,000 and $500,000. These programmes usually involved training and institution-building activities conducted through a project cycle.

The three large projects that received more than $500,000 each in the five-year period, along with a few projects at slightly less than $500,000, were multidisciplinary projects encompassing education, training, skill development and economic activities. The pattern of funding was

consistent with the high priority given to training, institution-building and income-generating activities in the UNFPA Guidelines.

C. Types of activities

Most of the special projects for women undertaken in this period were classified as Women, Population and Development Projects (UNFPA Work Plan category 710), although this analysis includes a few programmes in other work-plan categories.

The UNFPA programme of assistance encompassed five broad areas of activity:

(a) Action, programmes concerned primarily with institution-building and income generation;

(b) Training, which includes training at the national and regional level, at the international and inter-organizational level, and at the local level;

(c) Support, Communication and Dissemination of Information;

(d) Research; and

(e) General

Many projects did not fall strictly into one or another of these categories, but incorporated elements of the various activities. For example, many projects included the categories of Support, Communication and Dissemination of Information; Research; and General activities. Thus the labels should not be viewed as exclusive programme definitions.

Table 2 lists the number of projects and the funds allocated within each of the five categories of projects.

Table 2. Projects and allocations, 1986-1987 and 1986-1991, by type of activity

Project Activity	Number of Projects	Funds Allocated 1986-1987	%	1986-1991	%
Action	27	$2,477,196	61	$5,150,839	59
Training	17	1,006,102	25	2,284,163	26
Support, communication and dissemination of information	10	131,049	3	598,258	7
Research	6	274,609	3	598,258	7
General	3	179,286	4	255,526	3
Total Projects	63	$4,068,242	100	$8,772,435	100

To help empower women, UNFPA has emphasized the training of women in non-traditional tasks, and staff development for those national organizations working for the advancement of women at various levels. Of the 63 special projects for women in the 1986-1987 period, 70 per cent were action or training oriented; 86 per cent of the funds were allocated to these programmes. This emphasis was consistent with the Guidelines and with the needs as identified by countries.

Programmes for research and support, communication and dissemination of information received less support in 1986-1987 than formerly. During the earlier stages of UNFPA work in this sector, considerable project support was set aside for research. However, as the information bases on women and development increased over the last several years, support for basic research gradually diminished. By the latter part of the 1980s, project-based and operation-specific research was being emphasized. Projects for support, communication and dissemination of information typically involved sponsorship of seminars and conferences and also data-collection activities.

D. Executing agencies

As shown below, the projects approved and allocated in 1986 and 1987 were executed by Governments and by United Nations specialized agencies and NGOs.

Executing Agency	Percentage of Projects
Government as sole executing agency	23%
UNFPA and other United Nations agencies (fairly equally)	32
Joint Government and United Nations programme execution	10
Non-governmental organizations	22
Other	13

Sixty-five per cent of UNFPA projects were executed by Governments and United Nations agencies. Many of these projects were collaboratively executed, as stipulated in the Guidelines. Of training projects for women executed by NGOs, almost half were being conducted by the Centre for Development and Population Activities (CEDPA) a private, non-profit international organization in Washington, D.C. The remaining 11 per cent were to be executed by other NGOs.

As impressive as the growth of activities in the sector of women, population and development was, these efforts should be viewed also in the context of all UNFPA activities. For all UNFPA projects supported during this period, the total amount of funds spent was $249,700,00. Thus special programmes for women represented only a small portion--though a significant one--of the Fund's overall work in ensuring that women's concerns were incorporated into all aspects of all projects.

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Maternal Mortality Statistics: what's in a number ?

The World Health Organisation has calculated that at least 500,000 women are dying each year round the world from causes related directly or indirectly to pregnancy. This figure is probably the best available using statistical methods but it is not an accurate calculation. Accurate calculations are not possible because accurate statistics are simply not available in the majority of the countries in the world. On the poster we produced for 28 May to launch the maternal mortality campaign, we put this figure at one million. This is not because we have done a better calculation, but because one study after another that we have looked at suggests that figures may be two to three times higher than current calculations indicate. We therefore doubled the accepted number, in order to call attention to how many women's deaths are almost certainly not included in the figure of half a million.

How Figures are Used

To find out about and include all the maternal deaths which are occurring, a complete definition of a maternal death is crucial. How thoroughly information is collected also makes an enormous difference. How figures and other information are interpreted then affects how they are used to prevent deaths. The number of deaths is broken down to show the different causes of death, and further broken down to indicate the amount of risk for each cause of death for women of different ages, social classes, parity, etc. This information should reveal which women are most at risk, affecting how services directed at these women are planned and altered. To do this accurately for every country in the world involves many complex problems and a lot of resources.

A Complete Definition

The currently accepted international definition of a maternal death is:

The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Maternal deaths should be subdivided into two groups:

(1) Direct obstetric deaths: those resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

(2) Indirect obstetric deaths: those resulting from previous existing disease that developed during pregnancy and which was not due to direct causes, but which was aggravated by physiologic effects of pregnancy. [International Classification of Diseases (ICD), 9th revision]

Haemorrhage, sepsis, obstructed labour, ruptured uterus and eclampsia are the most common direct causes of death; others include ectopic pregnancy and molar pregnancy (in which no fetus develops, which may result in cancer). Anaemia, hepatitis, malaria and other infectious diseases, diabetes, heart, liver and kidney failure, and effects of anaesthesia are among the most common indirect causes of death. It is unclear whether causes like suicide and murder of a woman because she is pregnant are also included as indirect causes, since these are not physiologic effects of pregnancy. Some countries do include them; most probably do not.

This definition excludes deaths from accidental or incidental causes, on the grounds that they are not pregnancy-related. In practice, these three categories--direct, indirect and accidental-- are not always distinct, and causes often fall into more than one of them. Some studies include accidental deaths as a separate category, in order to study them in depth and see why they happened. It may well be that some of them are more pregnancy-related than they at first seem.

Causes do not easily fall into one category because there is rarely only one cause of death. Yet certificates of death and hospital records may well list only one cause, when there were three or ten. Although the official definition calls for interventions, omissions and incorrect treatment to be identified, this may not be done in practice, because health care staff want to protect themselves from being blamed. Failure to record all causes distorts statistics and affects planning for intervention.

For this reason, autopsies at the time of death and enquiries which look more closely at individual deaths after they occur are needed to get a true picture of why women are dying. Autopsies may not be done because of lack of funds or staff, and may also be culturally unacceptable. Again, the medical establishment may oppose detailed enquiries because it exposes them to criticism, even if the enquiry is intended to be confidential. It may well be that in your country, attempts to set up enquiries have been tried and failed. If you plan to try and campaing for these to be done, it is worth trying to find out if someone has already tried.

Deaths during or following pregnancy, childbirth, miscarriage and induced abortion should all be included. However, abortion deaths are often excluded and may not have been studied at all, so it is important to check whether this is true.

In 1979, Dr Valerie Beral developed the concept of reproductive mortality, a concept which supercedes that of maternal mortality, in that it includes all causes of death related to women's

reproduction. [10] In particular, she included deaths related to sterilisation and the use of contraception. This concept has also been applied to mortality from cancer of the reproductive organs and from sexually transmitted diseases. [11] We might well also extend this concept to include infertility, since there may be deaths resulting from treatment for infertility, and indirect causes of death related to being infertile, e.g. suicide and murder. To date, few studies include these deaths, because the ICD definition has not incorporated them. In the same way, the definition of maternal morbidity, that is, temporary or permanent damage to health resulting directly or indirectly from causes related to pregnancy, can also be extended to encompass reproductive morbidity, from all the above-mentioned causes. [11]

We think that the reproductive rights movement should encourage the acceptance of this wider definition, since it looks at women in relation to reproduction and its associated health risks as a whole. Additions to the existing definition would be required, since pregnancy itself would no longer always be involved.

Causes of death in any one country do not remain fixed, but become more or less common with changing conditions, sometimes in a very short space of time. For example, the decriminalisation of induced abortion in a country greatly reduces the number of deaths from abortion within a few years, assuming that safe facilities become available. Or if conditions which lead to widespread sepsis in maternity hospitals are improved and drugs made available to fight infection, sepsis may be greatly reduced. In other words, specific causes of death will assume more or less importance when specific interventions are made. Without up to date information, intervention may lag behind reality and be less effective.

Age of women dying

The standard definition of "women of reproductive age" is 15-44 or 15-49 years old. Given the increased risks of pregnancy to those younger and older than this, we think separate figures should be kept for these groups, rather than none at all. Particularly in countries where early marriage is the custom, risks to young women under age 15 are likely to be high.

Period in which deaths occur

The current ICD definition includes only deaths during pregnancy and within 42 days after the pregnancy ends. The period of 42 days is a relatively recent restriction. In England & Wales, for example, records of maternal deaths within one year of the end of pregnancy have been kept since 1951, and in other countries the period of time has been 90 days.

A number of studies have clearly shown that deaths after 42 days do occur. At an international level, we have no idea how many. Studies done in the USA [1] showed that 16% of maternal deaths occurred between 42 days and one year after the end of pregnancy. It has been suggested that this is more of a problem in developed countries, where more available treatment can postpone a woman's death, so that she may well die after the 42-day interval. At least one study in a Third World country, Ethiopia, has shown that maternal deaths after 42 days were also excluded there. [2, p 28]

The potential for exclusion of "late" deaths is clearly shown by figures from England & Wales. Late deaths from direct and indirect causes increased from 5.6% to 13.3% of total maternal deaths within a ten-year period from 1967 to 1975 and then started to decrease. When deaths from accidental causes were included, the figures for late deaths continued to go up after 1975. [3]

"Late" deaths may well account for a considerable percentage of maternal deaths everywhere. We would strongly urge that those studying maternal deaths begin or continue to include "late" deaths, though as a separate category so that figures can be compared. We also feel it is important to lobby for the International Classification of Diseases definition to include these.

How statistics are presented

The officially accepted way of expressing the number of maternal deaths (MMR) is with the ratio: number of deaths per 100,000 live births. The denominator of live births was officially adopted because of the comparative lack of other available figures. For non-statisticians, this type of figure hides as much as it reveals, because to know how many women are actually dying you need first to know how many live births there are in each country. To complicate matters, some studies express this ratio as number of deaths per 1,000 or 10,000 or 1 million live births.

Other studies may use the ratio: number of deaths per 100,000 deliveries. This includes stillbirths in the denominator, but excludes the extra number of live birth resulting from multiple births. If there are more stillbirths than multiple births, an MMR expressed as deaths per 100,000 live births will appear to be higher than if it is expressed as deaths per 100,000 deliveries, and vice versa.

Yet other studies may use the rate: number of deaths per 100,000 women. It is absolutely impossible to compare figures expressed in this way with figures based on births or deliveries.

Depending on which denominator is used, the figures will be different and will make the number of deaths appear to be higher or lower. Hence, it is important to be aware of which denominator is being used when comparing figures from different studies. Some studies may

simply say "the ratio (or rate) is 20" without even supplying the denominator, forcing you to guess which denominator they used.

To be most accurate, maternal deaths should be expressed as the total number of deaths per the total number of pregnancies. Unfortunately, the total number of pregnancies is almost impossible to calculate, since for example, the majority of miscarriages are not reported as statistics anywhere unless the woman has attended a hospital for treatment after miscarriage. Clandestine abortions in which the woman did not require or seek treatment would also not be included. These pregnancies would be left out of the denominator. However, some studies are beginning to attempt to estimate the total pregnancies, by adding up live births, still births, ectopic and molar pregnancies treated in hospital, induced abortions, and miscarriages requiring hospital treatment [4] in order to get a truer maternal death rate. Miscarriages not requiring treatment would then be the only potentially large figure excluded. However, this is only possible where records are extremely accurate for all these categories, i.e. in some developed countries.

A World Health Organisation working group suggested that instead of live births, the 10th revision of the ICD definition should make the denominator all births, i.e. include multiple births and stillbirths. Such a half-way change, however, has a major disadvantage. Until more accurate collection of figures for the number of maternal deaths (the numerator) has been improved, such a change would make it look as if the number of deaths had decreased, even though the actual death rate had not improved.

Apart from the pros and cons of each of these ways of expressing the MMR, the real problem is that it can be difficult or impossible to compare across countries and even within countries, or to compare one year with another for the same country or region. Each time the definition of maternal mortality itself, or the official way in which it is expressed, is changed, figures are affected and are more difficult to compare. This fact has to be taken into account when definitions of maternal mortality or the MMR are broadened or narrowed, and should be carefully described by reports of studies.

Where information is collected from

All maternal deaths should be recorded on death certificates. In practice, deaths are not always registered in Africa or Asia at all, no matter what the cause of death. Even where they are registered, they may not indicate that the cause of death was maternal. Although Puerto Rico generally has excellent records of vital statistics, it was found that only 52% of maternal deaths were picked up from death certificates. [5] This is not simply a problem in Third World countries, however. Studies in the USA and France have also shown that only 46% to 85% of maternal deaths are identifiable from death certificates. [6] In order to prevent this underreporting, civil servants and doctors

responsible for death certificates would have to be instructed to ask for this information as a standard procedure and space would have to be made on the certificate to include this information. In cases where suicide, murder of the woman or illegal abortion are involved, police would also have to be instructed to indicate the link to maternity and pass this information on to the hospital or those filling out the death certificate.

Hospital studies are another means of collecting information. This requires studying the records of all the women who died while in hospital. Again, not all causes of death may have been recorded. Deaths may be excluded altogether if, for example, a woman has renal or heart failure during labour and is transferred to another specialist department to save her life. If she then dies, only renal or heart failure may be recorded. Hence, hospitals also have to allow for space on records and instruct doctors to note that the death was maternal. Hospital studies alone do not give an accurate picture of a whole country, or even the region they serve. If few women attend hospitals, even for complications, hospital records will underrepresent deaths in the region. One local study in Bangladesh, for example, showed that 53 of the 58 deaths identified ocurred outside the hospital. [2, p8] A study in a rural area of Anantapur District in Andhra Pradesh, India, showed that only 34.5% of maternal deaths were recorded in health facility records; others had to be identified by other means. [7] On the other hand, if attendance at a particular hospital for complications is high, and they handle the majority of cases of complications in the region, the hospital alone will register a higher rate of deaths than the region as a whole.

Community studies, which include deaths both in hospitals and in the community, are potentially the best way to conduct studies of numbers of deaths. These involve looking not only at death certificates and hospital records, but also going from door to door in a community and talking to each household to find out if any women have died and why. Obviously, this is quite expensive and time-consuming and can only be done easily in a restricted geographical area. A series of community studies in various parts of a country, however, which reflect the varying conditions of women, e.g. urban and rural, can then be used to estimate the total death rate in the country, as long as a large enough total sample has been collected. There are many ways in which such studies can and are conducted.

In general, studying death certificates and doing hospital and community studies, as outlined above, provide data about a whole population. Case histories, collected both in the community and from the hospital, can provide much more detailed information about deaths than looking at records. These are by far the most common studies of maternal deaths. They can range from a study done in one village covering a restricted period of time, to country-wide studies conducted on a regular basis to look at every death individually. Case/control studies are another means of studying deaths, of which unfortunately few have yet been done. These involve comparing the history of each

woman who has died with one who has not died, to see how the conditions of the women's life and health, as well as how they were cared for, differed.

Each of these types of studies has its uses and limitations. In the end, the information collected is only as good as the records that have been kept and the memories of the people who are interviewed. These, in turn, depend on the willingness to provide information. Finding out about deaths from clandestine abortion is particularly difficult because a woman's family or friends may be afraid to admit that she aborted herself, and a hospital may been unwilling to indicate this in records because of fear of prosecution. We have no idea how many abortion deaths have deliberately been hidden because of such fears. The fact that the estimate of the number of abortions internationally each year ranges from 30 to 55 million, gives some idea of how little we know about the number of abortion deaths. Half of abortions are estimated to be illegal, and for most there are no mortality statistics at all. In addition, there are still countries for which there is no maternal mortality information at all.

Interpreting who is most at risk

Some of the most commonly studied risk factors for maternal deaths are a woman's age, the number of children she has, the amount of education she has, and her social class. Many studies try to show which women are most at risk of dying in these categories by, for example, dividing the number of deaths of women with five or more children by the total number of maternal deaths. This gives a false picture of the actual risk. In order to calculate the real risk for women with 5 or more children, it is necessary to divide the number of deaths of women with 5 or more children by the total number of pregnancies of women with 5 or more children, etc. Even if the risk for a particular factor is calculated in this way, it still must take into account other variables, e.g. the women's general health, whether any of them had a caesarean section, whether sufficient blood supplies were available when needed, etc. Unless studies are able to do this, and it is not easy, their determination of risk factors for particular categories of women may not be very useful. In the end, individual case studies or case/control studies provide much more reliable information.

Morbidity

Many more women survive pregnancy, miscarriage, childbirth and abortion in spite of the complications which kill others. These can cause: vesicovaginal fistula which causes incontinence, chronic pelvic infection, infertility, uterine prolapse, anaemia, and chronic exhaustion and pain. [8] The social, as well as the health, consequences of these conditions can be enormous. Obviously, once a woman suffers complications, each time she gets pregnant the threat to her health is compounded. In 1931, it was estimated that in England & Wales at least 60,000 women (10% of all mothers) were "more or less crippled as the result of childbearing" and studies in two clinics

reported at the same time showed rates of 34% of women attending one clinic and 40-70% of women attending others with disabling damage of some kind. [13, p68] At the present time, one author has estimated that for every woman who dies, fifteen women experience chronic effects on their health, which means a minimum of 7.5 million women per year internationally. [8] In Kenya a Ministry of Health proposal to improve rural health services in 1972 indicated that problems connected with pregnancy and delivery accounted for over 500,000 spells of sickness, delivery accidents and related problems in 1969, a figure projected to rise by 1984 to 750,000 cases if nothing was done. [9] These figures give some idea of the magnitude of maternal morbidity internationally, for which statistics are even more difficult to collect. Many women may never turn up to a medical facility to ask for treatment from such conditions, so there is no way to count them all. If we then look further at all reproductive morbidity, the numbers become staggering.

Conclusion

Numbers can tell us a lot, even if they are incomplete. They only become meaningful to most of us, however, not as a series of statistics, but when we start to think about all the women we know and have heard about, both those who have died and those who are living with the after-effects of pregnancy and reproduction.

Doing research ourselves

Hundreds of studies already exist which may be of help to women's groups planning to campaign on this issue, or thinking about doing research on maternal mortality locally or nationally. The World Health Organisation, Division of Family Health, has offered to send information they have collected to groups involved in the maternal mortality campaign. Write to them at: Geneva 1227, Switzerland. Their guidebook for studying rates and causes [reference 2 below] is especially useful, and by the end of 1988 they will have published a fact-book compiling existing studies, and including statistics which have already been collected.

In addition, the WHO Safe Motherhood campaign has funds for operational research on maternal mortality, that is, research projects which not only seek information about maternal deaths, but also include practical projects to help reduce deaths. They are worth contacting if you are able to do this kind of research/project, but also for suggestions of where else to apply for funds.

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Women's Experiences

I

Negisti was 18, unmarried and a 12th grade student. She lived with her parents about 20 km outside the city. Negisti had become pregnant unintentionally and, afraid of her parents, had left home to hide her pregnancy. She came bak at the end of nine months and confided in her mother, who hid the fact from Negisiti's father. Negisti had no antenatal care. She had headaches and frequently vomited.

At 5 AM one morning, Negisti complained of lower abdominal pain. Her contractions increased in regularity and intensity. At 1 PM Negisti started convulsions. At this point her mother hid her in a little outhouse in the field. However, Negisti's convulsions worsened and late that afternoon her frightened mother told her husband everything. They arranged for transport and arrived at the city hospital at 9 PM.

On admission, Negisti was unconscious. Her breathing was loud and her tongue was bleeding from small wounds due to the seizures. Negisti was sedated and her full bladder was catheterised. Internal examination revealed that she was ready to deliver, but the baby was dead. Vacuum extraction was used. It now became clear that this was a twin pregnancy and the second child, also dead, was delivered.

Negisti went into an irreversible coma, probably due to a cerebral haemorrhage caused by the severe convulsions and died at 3 AM the next morning. [1]

II

Bizunesh, at 30 years old, had six children following seven pregnancies. She presented herself at the hospital's outpatient clinic at the beginning of the ninth month of her eighth pregnancy. She had a history of weakness for the past five days, had a fever, yellow eyes, discoloured urine and was vomiting. She could not be seen since the clinic was overcrowded. Two days later she was brought in at 6 AM bleeding profusely from the vagina. She was semi-conscious, confused and restless. She was immediately admitted to the medical ward with a diagnosis of viral hepatitis.

The routine treatment was started, but blood ordered for emergency transfusion was not available. She went into deep hepatic coma accompanied by shock due to continued profuse antepartum haemorrhage. Only plasma expanders were available to combat shock. However, even with massive blood transfusions, viral hepatitis in the presence of a compromised liver usually proves overwhelming in a pregnant woman.

At 3 AM the next morning, Bizunesh started contractions and was transferred to the labour ward. She gave birth at 6 AM to a dead baby girl. The birth was followed by a postpartum haemorrhage. The patient's blood pressure was undetectable and plasma expanders, together with oxytocic drugs were of no avail. She died two and a half hours after delivery.

The question of family planning was raised with the neighbours during the home visit five months after her death. Bizunesh had been aware of the services but could not avail herself of these since the husband, who was a driver and was not around most of the time, wanted to have more children. When Bizunesh was four months pregnant and bleeding vaginally, she was in hospital caring for one of her sick children. She could not be admitted because her husband was not around, either to relieve her in hospital to care for the sick child or to stay with the others at home. The neighbours could not be very supportive because of their own harsh living conditions. [1]

III

Lete and her husband were farmers with no formal education. They lived in a remote village and had their own house without electricity. The open field served for refuse and excreta disposal.

Lete was married at 13 years of age. Her first child was born dead in hospital following a labour which lasted for four days. Lete survived the ordeal, but the obstructed labour resulted in a fistula between bladder and vagina, so she had reconstructive surgery in a specialised hospital. Pregnant women who have had fistula surgery are carefully instructed to come for admission to hospital after the pregnancy has proceeded for eight months.

Lete became pregnant three years after fistula surgery and wanted the child very much. However, her home was too far from a health centre and she had no antenatal care. When she was seven months pregnant, she started to bleed suddenly from the genital tract after fetching water from the river. Labour started on that day and the membranes also ruptured. She was admitted to hospital at 8 PM after she had been in labour at home for three days.

Lete was in distress and had a high temperature and rapid pulse. Although the baby was small, birth could not progress because the vagina was severely scarred from the earlier surgery. The baby was dead. Lete now told us that she had not felt the baby move for a month. The baby had to be delivered with instruments (craniotomy): it weighed 1kg. By the third day after delivery, Lete was very ill. She was pale and her eyes were yellow. She had pneumonia and suffered from severe puerperal sepsis. The fistula repair had broken down and she was again incontinent. On the fourth day her condition worsened and she had an emergency laparotomy to ascertain if there was an incomplete rupture of the uterus and a possible bowel instruction.

Lete had a hysterectomy because of extensive septic necrosis of the ruptured uterus. Her outlook was poor. Two days after operation she went into renal failure and her condition became critical. On day four she was transferred to the Intensive Care Unit and on the seventh day she had haemodialysis for the first time. After the seventh haemodialysis on day 16, Lete's renal function started to improve, but she was still very ill.

Lete was given antibiotics and everything possible was done. However, she was poorly nourished and vomited frequently. In spite of repeated blood transfusions, the haemoglobin did not rise above 4.6G%. (Normal value above 12.0G%.) Vomiting continued and the possibility of a local gastro-intestinal lesion was considered.

Lete talked little. She tried to eat, but she was tired by vomiting. On the 23 rd day after surgery, she started to vomit blood and to pass blood from her rectum. She was very frightened of dying. She vomited blood intermittently until her death 27 days after the birth of her premature infant. [1]

IV

Asnakech was first admitted to a district hospital two weeks after an illegally induced abortion. She was 17 years old, and single. She lived and worked as a bar girl in a hotel, but attended ninth grade classes morning during the week. Her monthly earnings amouted to US$20. Asnakech was treated for a high fever and an intrauterine infection. This hospital admission lasted four days.

Three weeks following discharge Asnakech was again admitted, this time to a city hospital 45km away from her home. She had a high fever and abdominal pain. Asnakech had abdominal surgery for peritonitis. She also received medication and two units of blood. Three weeks following surgery, Asnakech was transferred to the intensive care unit of the University Teaching Hospital with congestive heart failure and severe anaemia from the septicaemia. An incision and drainage of the pelvic cavity through the genital tract indicated infection. She was treated with intravenous infusion, broad spectrum antibiotics and digoxin.

Asnakech improved slightly and was transferred to the gynaecological ward after 5 days in the Intensive Care Unit. In spite of the antibiotics, she continued to have high fever and rapid pulse with drainage from the surgical site. Six weeks after her initial operation, a second laparotomy was performed which revealed multiple abscesses in the abdominal cavity. In spite of vigorous antibiotic and intravenous fluid therapy, her condition deteriorated and she went into septic shock. She died 11 weeks after the illicitly induced abortion.

Three days before her death, she confided in us about the events leading up to her desperate situation in the hope that this would somehow help to save her life. She had procured an abortion from an ambulance driver who had put her to sleep with an intravenous injection and induced the abortion with a pair of scissors. She aborted three days later. She paid him by giving him her gold cross, worth US$80, which she would redeem in installment payments over several months. She also told us that she had a two year old girl who was living with her elderly grandmother. Although she did not want another child and knew about family planning, she had not used any method of contraception. [1]

V

I had five abortions between the ages of 18 and 23. Although my experiences are typical for Roumanian women, I must add that if I remain healthy and alive, it is because I have a somewhat privileged position.

I got pregnant for the first time during the summer of 1966. I hadn't been careful. At the time, as now, we only had the most simple forms of birth control: condoms, rhythm method, taking one's temperature, douching with lemon juice or vinegar, or simply coitus interruptus.

My first abortion took place in the period before it became illegal. All I had to do was go to the hospital and pay 30 lei (average monthly income 1500 lei). I was put to sleep, and when I awoke the world was again in order. That same year the right to abortion was repealed.

In the first few months it was even difficult to find condoms. It was illegal to import the pill. Travellers entering Roumania were heavily searched by customs for contraceptives. It got so bad that women who wanted to travel abroad first had to undergo a gynaecological exam to ascertain whether they were pregnant. Upon return, the women were again examined to check if they had broken the law and had an abortion outside the country.

I got pregnant again in the spring of 1969. I began to discover the different ways one could get rid of this "thing" without having an abortion. I learned about lifting heavy objects and taking hot baths, in fact, so hot one must get drunk beforehand. There are also horrible attempts that sometimes end tragically. One young woman tried to perform a primitive suction method with a vacuum cleaner. She died of internal bleeding.

The hot baths, large quantities of vodka, heavy lifting and overdose of quinine did not help. Since neither my friend nor I had the money for an illegal abortion (3-5000 lei) I was forced to tell my parents. My mother was friends with a gynaecologist who performed the abortion for free after hours in his office. In case something unforeseen might happen, I only received a local anaesthetic.

The operation hurt a lot but only lasted five minutes and went well. I promised myself and my mother that the next time I would really be careful.

I got pregnant again in the spring of 1970. My mother had left the country. I went to a doctor at a special clinic and begged him for help. He gave me hormone shots which I had already used during my second pregnancy, and radiation in the abdominal area. After three weeks of daily radiation and shots, I lost the baby. As feared, the radiation caused a severe inflammation in my ovaries. Until today I suffer from chronic inflammations.

I got pregnant for the fourth time only three months later. I decided to go back to my mother's friend who had performed the second abortion. This time he did not dare to do the operation in his office. Instead, he tried to provoke bleeding by sticking a long needle up my uterus. He sent me home and said I should wait a few days. If I started to bleed or get feverish, I should go to the clinic since I was then eligible for a legal abortion for health reasons.

The fever came. I checked into a clinic and was sent on to the hospital with the diagnosis "endangered pregnancy". The doctor could not recommend an abortion since he was obligated to try to save the baby. My fever climbed and I started to haemorrhage severely. The next morning I received a "legal" abortion.

It seems impossible that I got pregnant again that same year. I was too tired to search for a free abortion and too embarrassed to go back to any of the former doctors.

Four years had passed since the anti-abortion law was passed. Doctors and patients had adjusted; it was now easier to get an illegal abortion. Everyone knew someone--a doctor, a midwife, a medical student--for a price. I knew of a doctor some of my friends had gone to and my aunt lent me the 4000 lei. Twice the doctor postponed the operation. The day came. I had to go alone. I was not allowed to know the doctor's name and the abortion was performed in somebody's apartment. At the door I had to use a special signal.

I received a sedative and local anaesthetic. A long low coffee table, with books placed under two of its legs to create a tilt, served as an operating table. A tape recorder was turned up loud. Two unknown men, only one of whom was a doctor, performed the operation. This time it hurt more [than in the past]. The doctor was swearing, the assistant held my hand attempting to calm me, but the music couldn't drown my moans. After half an hour, it was over. I was allowed to rest on the couch first. The pains continued and the next morning I had fever. The next day I went to my doctor. He examined me and found that half the fetus was still in me. He sent me to the hospital and I was lucky to get Dr X again. On the next day I had my second curettage, during

which the doctor discovered my uterus had been punctured and I was bleeding internally. I was operated on immediately and after ten days was released from the hospital.

There had been no time to conceal the matter and the doctor was forced to inform the police. I had to report to the police about every 3 days, always with the same tiresome questions. My whole family and all my friends had been informed. I was threatened with 3 years in prison. It was only because friends of my parents knew one of the highest judges that a new official was put on the case. A medical explanation of the perforation was patched together, and the case dropped. My new investigator still wanted to know whether I was really innocent. I reassured him that I was. [2]

VI

In 1983 my husband and I were involved in a car crash. I was 22 weeks pregnant with our first child and sustained serious injuries, both internal and skeletal. In the emergency ward, an obstetrician found the baby's heart beat with a fetal heart detector. He told me I would need an epidural at delivery, as my pelvis was fractured. I was then transferred to the surgical ward. In the middle of the night I started to have contractions. With all the X-rays I was having I already feared for my child's health. No heart was heard and his shape lay still on the ultrasound scan. My condition pointed to a hysterotomy. Surgery corrected most of my major injuries, but my baby son was removed dead from a previously intact uterus.

After 6 months of sadness, readjustment and crutches, I wanted to be pregnant again. The operation obstetrician told us I could get pregnant after 3 months of normal menstruation. I had a pelvic X-ray; my pelvic dimensions were good and an active birth would be possible if no complications were present. Three months later I was pregnant. At 6 weeks I had a pregnancy test and while I was waiting for the result to return, I had a threatened miscarriage, which thankfully did not happen. At 12 weeks I had a scan and the baby appeared to be large and healthy. The consultant thought I might have a low-lying placenta and suggested another scan at 28 weeks. I felt in good health and continued working.

At 28 weeks I had another scan. The placenta was found to be anterior. I thought that the placenta must be attached to the uterine scar [from the previous hysterotomy]. My medical attendants did not mention that this would or could cause problems. One was relieved that it wasn't placenta praevia. I went to the antenatal clinic every week starting at 33 weeks of pregnancy. The clinic is 29km from my home; the hospital 115km. At 35 weeks I had another scan and was told that my original dates were right. I felt she had not done a very thorough scan. I also expected the uterine scar to be scanned, as I have seen photographs of weakening scars detected by ultrasound, in obstetric books. We talked of active birth, which seemed possible, but a caesarean if labour was

not successful. I was given a return date one day before the expected date of delivery. I left saying I was sure I would be in hospital before that. I was.

I felt the baby engage at 36 weeks. I was very pleased as this meant my pelvis would be adequate. At 38 weeks I woke at 6:25AM with a need to empty my bladder. Afterwards, I still had an uncomfortable feeling in the lower abdomen. A pain started; I thought it was labour. I watched the clock waiting for the contraction to finish; instead the pain intensified. I quickly realised some complication had arisen. My mother phoned the midwife. I had asked for a doctor, but my mother assumed it was labour and that the pain was not as severe as I said. When the midwife arrived (from 11km away) I was in shock, had no blood pressure and the baby's heart could not be heard. The hospital, the doctor and an ambulance were called. The doctor came from 15km away and the ambulance from 29km away. The doctor gave me morphine and I left home at 8:10AM in the ambulance on the 115km journey to the maternity hospital.

It was thought that I had a concealed haemorrhage and it was decided that I should have a caesarean. I was very relieved as I was in tremendous pain and although the baby's heart could not be heard, I hoped that if he was alive he could be saved. After the operation I was told that he was stillborn.

I was on an intravenous drip, blood transfusion and strapped to an automatic blood pressure monitor. The consultant told us the uterus had ruptured at the site of the hysterotomy scar, where the placenta was sited. The haemorrhage was concealed, adding to the problems. The baby had no chance of survival.

I am told I will be able to have another child, with hospital care. At 24, I am given the impression that I have plenty of time.[3]

SOURCES

[1] Barbara Kwast, 'Roads to Maternal Death: Case Histories' Paper presented to the Safe Motherhood Conference, Nairobi 1987. Some shortened for space reasons.

[2] Anonymous, in Connexions No5, 1982, translated from sozialistisches Osteuropakomitee, W Germany, Aug 79. Shortened for space reasons.

[3] Letter from Elma Harrington to AIMS Newsletter UK Winter 85/86. This letter was as much about the way stillbirths are handled by hospitals, and coping with a stillbirth emotionally, as it is about this woman's own experiences. Only those parts about her experiences are included here.

From: Maternal mortality: A call to women for action, Isis International (Santiago de Chile) 1988 pp5-13.

A New Strategy For Ensuring the Integration of Women, Population and Development

A. Introduction

To correct the problems encountered in the execution and implementation of UNFPA-funded population programmes and projects in this area, as indicated by UNFPA-sponsored in-depth evaluations, special reviews by UNFPA's Special Unit for Women and Youth and independent consultants, UNFPA is proposing a new four-year, all-encompassing implementation strategy involving every aspect of the work of the Fund and its headquarters and field staff. The objective is the complete and total integration of women's concerns into all population activities and the increased participation of women in projects supported by the Fund.

Key words in regard to the strategy are flexibility and adaptability. Since decision-making in this area rests finally with Governments and such decisions will invariably take into account differing political and socio-economic conditions and commitments, cultural and traditional attitudes, availability of resources and national capability to implement such decisions, UNFPA believes that its proposed strategy should be considered only as a framework for action. Governments are invited to adapt the strategy to their local conditions and needs in a flexible manner. In the time-frame outlined, UNFPA will ensure that all measures that it can take and implement both at headquarters and in the field will in fact be taken and implemented.

At the same time, the Fund plans to initiate an active dialogue with Governments to enhance their understanding of the importance of women's involvement for the success of their population policies and programmes, of the effects of those policies on women and of the Fund's willingness to assist in the development of appropriate policies and the provision of means to implement them.

The Fund will also ensure closer collaboration between and among Governments, other United Nations agencies and UNFPA, as well as non-governmental organizations.

B. Activities to be undertaken

1. Revision of UNFPA project and programme procedures and guidelines

Needs assessment guidelines. Needs assessment reports will in the future include a situation analysis relating to women in all substantive chapters in addition to the specific chapter on women, population and development. Each needs assessment report will include, in relevant sections, information on the following:

(a) National policies as well as structures and organizations and their professional capacities and responsibilities with regard to women, population and development;

(b) National technical capacities to plan, co-ordinate and carry out programmes concerning women;

(c) National programmes and projects to enhance women's participation in population and other development-related programmes and the structural changes required to carry out programmes;

(d) Activities that should be given priority in the context of country programmes;

(e) Training capacity and institution-building in urban and rural areas;

(f) Accuracy and reliability of the national data base needed for project formulation and evaluation.

Programme development. When a country programme is being formulated, those areas which are of special benefit to women such as health, education, training, economic activities, institutional support and strengthening the capacities of non-governmental organizations, including women's groups, and which require UNFPA support will be identified.

Project formulation. Most development assistance affects both men and women, either directly or indirectly. However, experience has shown that some development activities have a different impact on men and women and may even affect women adversely. Therefore, at the project design stage, special attention is needed to ensure that both men and women participate in, and derive benefits from, project activities.

Questions which must be dealt with at the project design stage include what will be the benefits of project results to women; how women can participate; what education and training will be necessary to enhance the participation of women; and how such participation will benefit women. Each project document should include information concerning women in the sections dealing with background, justification, project objectives and output, the relation of the output to national policies, project budget and project monitoring and evaluation.

Project appraisal and approval. It will be the responsibility of the UNFPA field office as part of its project appraisal task to ensure that all project documents reflect relevant UNFPA policy guidelines. In those cases where guidelines have not been followed, the reasons should be explained in the project document. Compliance with these requirements will constitute the first step in the appraisal process of every project in the field. Projects in which women's concerns have not been adequately covered or where there is a potential for adverse effects on women will not be approved without prior consultations and possible modification.

Project execution. Adequate attention to the needs of women in all stages of project development and appraisal should ensure that women are brought into the project whenever possible both as beneficiaries and as participants. In the past, the implementation of some projects has been held up because the necessary technical and managerial expertise was not available. Since the emphasis on women's concerns is a new element in development work, it will be necessary to provide training for those staff and experts involved in various aspects of project work. Special training will also be necessary for women to enable them to participate at all levels. UNFPA's Special Unit for Women and Youth will develop, as a matter of priority, an inventory of individuals, institutions, United Nations agencies and non-governmental organizations, including women's groups, which are able to participate in training as well as the actual implementation of project activities. Whenever possible organizations with responsibility for the execution of projects should be closely involved in project design.

Project monitoring and evaluation. The recently revised UNFPA instructions for monitoring and evaluation include specific references to the areas in which issues concerning women should be examined and, if necessary, modifications made. In addition, specific guidelines for evaluating the women's dimension in regular projects have been developed. Therefore, in the task of monitoring and evaluation, all aspects of those guidelines will be taken into account and acted on accordingly. Irrespective of the nature of the population programmes or projects, the monitoring and evaluation guidelines require that all information be reported on a gender basis. However, some ongoing projects were originally designed without giving special attention to women's interests. To some extent these deficiencies and oversights can be corrected as part of the monitoring practices. For example, most UNFPA-supported projects include training components. If some project designs do not include women as trainees or trainers, appropriate changes should be introduced for the remaining phase of the project at the time of monitoring.

2. Training

It will be necessary to sensitize staff at all levels, both national and international, to the importance of women in population and development. Special emphasis will need to be given to education and training as a priority. This should include:

(a) Specific training courses for UNFPA staff to provide them with an analytical framework to ensure that UNFPA policy is taken into account in the basic planning of programme and project activities, to provide technical knowledge on how, in the context of their work, issues concerning women should be dealt with and to show how various guidelines and check-lists should be assessed and put into practice;

(b) Similar training courses will be conducted for staff members of other United Nations agencies and consultants who participate in UNFPA-sponsored programming missions. Regional advisers providing technical support in different substantive areas will also participate in such training;

(c) Special training for national programme officers, policy-makers and planners will also be supported.

Some of the training courses will be designed specifically for UNFPA, while others, particularly at the regional and national levels, will be organized in co-operation with, and drawing upon the experience of, other United Nations organizations. Efforts will be made to ensure that similar training is include in all other training activities organized either by the Fund or jointly with other United Nations agencies.

3. Closer co-ordination with United Nations agencies

Strong co-ordination and collaboration in these efforts with other agencies within the United Nations system is considered essential for the success of the strategy. The reason for this emphasis is the fact that most UNFPA-supported programmes are designed, implemented and monitored with the participation of staff of United Nations agencies and/or regional advisers. The areas requiring closer co-ordination will include joint organization of, and participation in, training activities, consultative meetings and joint programme development and project formulation, implementation and monitoring.

4. Technical support

In the past, implementation of some projects has been delayed because of the lack of technical and managerial expertise. Therefore, one of the priority areas for UNFPA will be the identification of the expertise required as well as of individuals or institutions to assist in the work of project development, formulation and implementation. Recently, the Fund initiated a computerized roster of consultants in this field. However, additional efforts are needed to include in this list individuals with substantive and practical experience in women's concerns, theoretical knowledge, familiarity with the work of UNFPA and the capability of working in different cultural and political environments. In addition, increased involvement of UNFPA's Technical Branch in implementation of the strategy will be encouraged.

5. Strengthening the role of non-governmental organizations

Efforts will also be made to identify suitable non-governmental organizations, including women's organizations at the regional and local levels, which are involved or could become involved in activities concerning women in population and development. These groups could be helpful in identifying and advocating priority areas for action at the field level, in developing project designs, in facilitating the implementation and evaluation of projects promoting the participation of women, in providing information and training at the grass-roots level and in carrying on the work after the initial project stage is completed.

6. Information support system

Special efforts are needed to ensure that the new procedures and guidelines are brought to the attention of all individuals and executing agencies of UNFPA-funded programmes and projects. For wider dissemination of information, the following measures will be introduced:

(a) A computerized information retrieval system will be developed to provide easy access to information on the scope and nature of UNFPA's support to projects specifically designed to benefit women as well as on women's aspects in all other projects;

(b) More systematic and periodic information on activities will be produced in published form and disseminated widely, using the information support system of UNFPA. This will include activities to enlist the interest and active participation of the broadcast and print media;

(c) In the preparation of all reports, documents and statements concerning UNFPA's work, efforts will be made to ensure that women's aspects are dealt with satisfactorily; and

(d) Similar efforts will be undertaken in the preparation of statements and briefings for top management in their contacts with Governments and organizations both within and outside the United Nations.

C. Monitoring the implementation of the strategy

As indicated above, a comprehensive monitoring system will be established. A mid-term review of the implementation of the strategy will be conducted during the first half of 1989. Another review will take place in late 1990 or early 1991. In addition, the impact of the strategy will be measured, that is, adherence to the guidelines and to their practical effectiveness in the context of project development, appraisal, implementation and evaluation. The outcome of all these exercises will be reported to the Governing Council.

From: UNFPA: An implementation strategy to strengthen the capacity of the fund to deal with issues concerning women population and development, 5 March 1987 (New York) pp 8-12.

PART I. UNFPA AND WOMEN

A. Background

1. In 1976 UNFPA Women and Youth Section issued a paper on "Policies and Programmes in the Field of Women, Population and Development" (hereafter called "Guidelines on Women") which included (a) suggestions on how to incorporate the specific needs of women in regular population projects, and (b) a description of the kind of special "Women, Population an Development" projects likely to be supported by UNFPA. This paper was revised in 1980 and endorsed by the Policy Committee (PC).

2. In February 1979, UNFPA issued its "Interim Guidelines for Needs Assessment and Programme Development", which include technical guidelines for the inclusion of a chapter on "Women, Population and Development" in the Population Needs Assessment reports. A 1985 update of these Guidelines emphasizes the need to look into the women's dimension of all projects: data collection and analysis, population education, etc.

3. In May 1982 the Evaluation Branch (EB) proposed to the PC that all evaluations conducted by EB "as far as possible take into account the role of women." This principle was approved on 19 October 1982. The evaluations conducted by EB since then have in fact, in varying but increasing degrees, looked into women's role and status.

4. The Governing Council, at its Thirtieth Session of June 1983, requested the UNFPA Executive Director to provide to the Council at its thirty-third session a report on results of past evaluations according to the major workplan categories, "including activities related to women."

5. During 1984, UNFPA participated in the UNDP-coordinated "Inter-organizational assessment of women's participation in development". ILO and UNIDO had proposed a questionnaire for this study. UNFPA revised and adapted this questionnaire to fit its needs, and the present Guidelines are an outcome of that exercise. The checklist for projects in the various work plan categories (pages 5-8) has been derived from the 1980 "Guidelines on Women" mentioned in paragraph 1.

B. Mandate

6. In reviewing the UNFPA Guidelines on Women, the PC recommended that the paper would "serve as internal guidelines for UNFPA funding in the areas concerned, until the Governing Council (GC) clarifies UNFPA's mandate in this regard". It further recommended that "the

following be established as criteria for UNFPA support to programmes relating to women, population and development:

(a) the proposed project/activity must be within the general framework of national population plans and policies;

(b) the proposed project/activity should have some bearing on increasing the effectiveness of population programmes in the country; and

(c) the proposed project/activity should be of the nature of a pilot or demonstration project the outcome of which may influence or facilitate policy-making."

7. The PC also recommended that support be provided for the following types of projects and/or activities:

(a) formal as well as non-formal education programmes for women, including functional literacy, family life education and programmes to promote educational and vocational aspirations of women;

(b) population and women employment programmes, aimed at increasing the access of women to employment, career guidance and training, for example involvement of women in rural industries and in extension services;

(c) programmes aimed at promoting the participation of women in decision-making in family and public life;

(d) activities in support of institutional development at the local grass roots as well as governmental levels, to ensure adequate attention to the status and role of women in population and development;

(e) activities aimed at improving the health of women and children as part of an integrated approach to MCH/family planning in health policies. In this regard, special attention should be given to the employment of women as providers of health care; and

(f) population and development projects in which special attention is given to increasing the role of women in development.

8. The Governing Council in June 1981 discussed UNFPA's mandate related to women. On the basis of this discussion UNFPA issued a circular to its staff, stating that the Fund should endeavour to integrate women's aspects in all its programme areas, and that the above-mentioned criteria for funding as well as the UNFPA "Guidelines on Women" remained valid.

9. In June 1985, the Governing Council (Decision 85/19) requested "that the Fund further strengthen its activities directed both to special women's projects and to the role of women in all population programmes and activities".

C. Goals

10. The goal of UNFPA within the field of women, population, and development is to improve the status of women, and especially to increase the participation of women in population and development activities and programmes and the benefits accrued to women from these programmes.

D. Institutional strategy

11. In order to pursue the goal mentioned in paragraph 10, UNFPA's strategy is to:

(a) Ensure that all UNFPA-supported programmes:

— consider and include in their design the specific needs and concerns of women,

— maximize benefits to women while ensuring that no detrimental effects on women derive from their implementation,

— maximize the possibilities for women's active participation in different stages of project planning, preparation and implementation,

(b) Support "Status of Women" projects ("Special Programmes", Work Plan Category 710). In supporting these projects, UNFPA's aim is not limited to advancing activities with immediate and direct demographic objectives, but also to improve conditions which influence population factors indirectly and over the long run.

(c) Direct particular attention to the needs of the less-privileged female population living in rural areas and in urban peripheries while also encouraging the involvement of women at the policy-making and planning level. The latter may imply providing support for training of women in the professional and technical categories.

(d) Increase active participation of women leaders as well as women's organizations in population programmes supported by the Fund.

From: UNFPA: Guidelines for evaluation of the women's dimension in UNFPA assisted programmes (New York) April 1986, pp 1-3.

The Place of WID Guidelines/Checklists: Lessons Learnt from the Process of their Development and Use

Experiences at international Level

Representatives of several bilateral agencies, multilateral and interregional organizations, including the Canadian International Development Agency (CIDA), the Finnish International Development Agency (FINNIDA), the Netherlands Ministry of Foreign Affairs, the Norwegian Agency for International Development (NORAD), the Swedish International Development Authority (SIDA), the Swiss Development Co-operation and Humanitarian Aid (SDC), ILO, UNFPA, UNESCO, CIRDAP and CIRDAfrica, FAO and WFP described in detail their experiences in the development and application of WID Guidelines. This elicited useful commentary from the national participants. While some agencies are still in the early stages of developing guidelines, and they are expected to benefit in particular from the sharing of information and experience at the Meeting, most agencies have by now gained practical experience that permitted the group to arrive at certain conclusions and recommendations. It is interesting to note that multilateral agencies led the way in developing WID guidelines in the mid-1970's. In most cases the bilateral agencies made an analysis of the structure and priorities of their bilateral programmes and started developing applicable WID Guidelines. In addition, the multilateral and bilateral agencies derived valuable information from evaluation of selected ongoing projects in Third World countries which had been designed prior to the introduction of the Guidelines.

Relevance for National Level

National participants raised several issues and provided some concrete examples based on their experience with the application of donor agency WID Guidelines/Checklists in their countries.

Guidelines/Checklists cannot themselves solve, at the national level, problems of inequality in access to resources, such as land, education, credit, skills, nor can they resolve deeply ingrained socio-cultural obstacles.

In many countries there is an insufficient number of women experts capable of designing or implementing projects with WID objectives, especially in agricultural projects.

Participants pointed out that donor WID policies may contradict national WID policies. Furthermore, political factors and motives determine national priorities just as they do donor

priorities. Hence negotiation and implementation strategies of agencies need to be flexible enough to take these realities into account. Donors may provoke resentment if they are seen as unilaterally trying to impose their own values through rigid enforcement of guidelines.

In monitoring and evaluation of WID components, there must also be flexibility in taking unforeseeable factors into account. The example of a horticulture project for women not meeting its objectives due to severe drought was presented as example.

As a result of WID Guidelines, one participant had been involved in the analysis of a potential fishery project for women who traditionally processed and marketed fish on a small scale. Through consultation with the women themselves modifications were suggested that would help prevent their total dislocation.

Women's organizations have a role to play, especially in the consultative process and in helping to develop innovative pilot projects. However, they cannot substitute the national governments in terms of resources or national capacity; care should be taken in assessing their capacity and accountability when utilizing them in the implementation stage.

Applicability, Use and Lessons Learnt

Following is a summary of the assessments concerning the applicability of WID Guidelines/Checklists and lessons learnt regarding their development and use:

Terms used for WID Guidelines vary among agencies and include "guiding principles", "framework for constructive help", "directives", "strategy", etc. Their objectives, content and methodology vary considerably as well.

WID Guidelines/Checklists have been found to have multiple uses: a tool for developing project documents, monitoring and evaluation of plans and programmes; material for training and creating awareness; a policy statement and point of leverage in negotiations with national counterparts (nearly all governments have also issued WID policy statements since 1975); and, a policy statement legitimizing authority for action within an agency.

In developing Guidelines/Checklists, an agency must choose between a simplified approach and one that is more comprehensive and multidimensional. A common approach is development of different types of aids and methodologies for use at different levels and programme areas. Because WID objectives are complex and include social as well as economic goals, a more multidimensional and comprehensive approach was considered essential by most participants.

Except for women-specific projects, few of the projects evaluated took women's concerns into consideration. As a result, practically no data base was available against which to measure effects or change. 1/ Thus the purpose of developing and promoting the use of WID Guidelines/Checklists became clearer.

There is usually little that can be done to reorient or restructure ongoing projects once they are well established; therefore it was concluded that efforts to include WID concerns are more fruitfully spent on improving design and implementation of new projects.

Women's units are sometimes marginalized from the mainstream of project development, e.g. placed within the evaluation section, and are thus rendered less effective than when they are actively involved in project design from the very beginning.

It cannot be assumed that women-specific projects automatically benefit women since the methodology may be weak, women may be marginalized by being placed in special components attached to sectoral projects, and their resources may be inadequate or the first to be cut due to low priority. Major sectoral projects, especially those in agriculture, have the greatest potential impact on women and therefore should take priority over women-specific projects or components. Most agencies now stress the need of an integrated sectoral approach.

Many agencies have not instituted a system of checklists, viewing them too categorical and tending to provide an easy way out of thinking and analysis. Those that do use them to complement the guidelines tend to focus on technical aspects (e.g. fishery, agriculture) of project development. This is one way of combatting the strong, widespread reluctance of technicians to introduce a "human element" into what is seen as purely technical projects.

1/ Although "reconstructed" data sometimes indicated a positive impact, e.g. of drinking water projects, it was concluded that the positive impact could have been greater if WID Guidelines/Checklists had been used. However, analysis of assistance programmes indicate that a majority (60-90%) of many agencies' projects have no clear-cut target group (e.g. harbour development, direct financial assistance.)

Some agencies have developed guidelines as a means of starting a process in their organization, and the responsability for further specification and concrete plan of action are relegated to various other units of the agencies. This ensures that the entire organization becomes part of the process and that the guidelines are well integrated.

Some insights were gained and a few important lessons were learnt:

Incorporating economic analysis and arguments in the methodology of WID Guidelines is more convincing than equity or welfare objectives.

Using an integrated approach, training for the successful use of WID Guidelines should become an integral part of the programming process. Training can continuously be imparted in many forms, such as to programming officers at all levels; to national counterparts to enhance their awareness and receptivity; and for helping to formulate a common vocabulary and conceptual/analytical framework.

When a project proposal that gives inadequate attention to women's concerns is rejected at a high level of authority, it provides a positive incentive to programming officers to make efforts to promote women's issues. At this stage, resources should be provided to assist WID consultants in giving adequate coverage to women's issues.

It should be accepted that comprehensive WID approaches do require a time frame in the long-term work plan, human resources, and priority. They should also be perceived as an urgent matter for integration into an agency's programme. The methodology of the guideline should include analytical tools and statistical measures for short and long term goals and for measuring change across sectors. As in the case of credit, guidelines on cross-sectoral issues at times become necessary.

The participation of women through a systematic involvement of local women's groups, where feasible, should be encouraged at all steps of the programme cycle. However, establishing such targets should not become a substitute for commitment and analysis nor should they prevent conceptualization of WID issues on broader scale.

From: FAO/INSTRAW: Report of the Meeting Evaluating Bilateral and Multilateral experiences in the development and use of Women in Development Guidelines/Checklists implications for national use in formulating agricultural projects for women (Helsinki) 1985, pp 18-22.

Population Policy Overview

DEMOGRAPHIC INDICATORS			CURRENT PERCEPTION
SIZE / AGE STRUCTURE / GROWTH			The rate of growth is considered satisfactory.
Population:	1985	2025	
(thousands)	135 564	245 809	
0-14 years(%)	36.4	24.6	
60+ years (%)	6.6	13.8	
Rate of:	1980-85	2020-25	
growth	2.2	1.0	
natural increase	22.2	10.0	
MORTALITY / MORBIDITY			Levels and trends of mortality are viewed as unacceptable.
	1980-85	2020-25	
Life expectancy	63.4	72.1	
Crude death rate	8.4	7.6	
Infant mortality	70.6	29.8	
FERTILITY / NUPTIALITY / FAMILY			Levels and trends of fertility are satisfactory, both in relation to population growth and family well-being
	1980-85	2020-25	
Fertility rate	3.8	2.3	
Crude birth rate	30.6	17.6	
Contraceptive prevalence rate	65.3	(1986)	
Female mean age at first marriage	22.6	(1980)	
INTERNATIONAL MIGRATION			Levels and trends of immigration and emigration are considered not significant and satisfactory.
	1980-85	2020-25	
Net migration rate	0.0	0.0	
Foreign-born population (%)	1.0	(1980)	
SPATIAL DISTRIBUTION / URBANIZATION			Patterns of spatial distribution are perceived as partially appropriate. Major concerns are the concentration of population in large metropolises, e.g., Sao Paulo and Rio de Janciro, and the absence of growth centres to stimulate development in peripheral regions.
Urban	1985	2025	
populalion (%)	72.7	89.0	
Growth rate:	1980-85	2020-25	
urban	3.7	1.2	
rural	-1.3	-0.7	

Population Policy overview - Brazil

GENERAL POLICY FRAMEWORK

Overall approach to population problems: The Government has not adopted an explicit policy to modify fertility or population growth. Initially, this related to the Government's positive perception of the benefits of population growth and a large population size. Now, it is largely related to Brazil's gradual transition to more moderate levels of fertility and population growth. The Government desires to restrict immigration, although not for demographic reasons, and to modify population distribution, largely as a means of achieving national integration.

Importance of population policy in achieving development objectives: While the topic of population has not been overlooked by the Government, which has included detailed population projections in its sectoral plans, population policy has been regarded as a sensitive issue. Although there was a new round of policy discussions in 1981, the Government remains cautious in regard to population issues. In 1984, a decree establishing a National Population Commission had been drafted, but no action had been taken as of late 1985. The appointment of a Commission for the Study of Human Reproductive Rights in 1985 may herald the beginnings of a major commitment to a national population programme.

INSTITUTIONAL FRAMEWORK

Population data systems and development planning: The main sources of demographic data are the nine censuses, the most recent of which was conducted in 1980. A nationwide system of vital registration was not established until 1974. Since comprehensive vital registration data are still lacking in many areas, researchers have relied on indirect techniques to derive estimates of fertility and mortality. The Brazilian Institute of Geography and Statistics (Fundaçao Instituto Brasileiro de Geografiá e Estatistíca) is the major organization responsible for collecting and analysing demographic data. Over the years, however, other government entities and agencies, including the State Government of Sao Paulo, the North-East Development Agency, and the Amazon Development Agency, have studied demographic matters. The most recent available development plan is the Third National Development Plan (III Plano Nacional de Desenvolvimento), 1980-1985. In late 1985 the National Development Plan for the period 1986-1990 had not yet been formally approved.

Integration of population within development planning: Although the National Planning Agency has integrated population factors in development planning in Brazil through the use of economic-demographic models, there is no formal institutional arrangement to ensure such integration.

Population Policy overview - Brazil

POLICIES AND MEASURES

Changes in population size and age structure: The Government has no policy to influence natural increase or population growth, although socio-economic policies such as employment creation, export growth, revitalization of agriculture and development of new energy resources are expected to affect growth. Of primary concern are the regional differentials in rates of population growth. The Government has set no numerical goals, as it believes that the appropriate growth rate to be that which corresponds to the sum total of the free and well-informed decision of those couples and individuals who aim at planning their reproductive life. The results of the 1980 census - indicating a gradual slowdown of population growth are likely to reinforce this position. Nevertheless, Brazil recently implemented programmes to provide information and the means to exercise individual decisions with respect to family size, which are being incorporated into public health services at federal, state, and municipal levels. Concerning social security legislation, a national pension scheme covers employed persons in industry and commerce, domestic servants, and the urban self-employed, while special systems exist for students, public employees, rural workers and employers.

Mortality and morbidity: The Government has expressed concern over mortality differentials among different income groups and geographic areas, as well as over infant mortality, infectious and parasitic diseases and malnutrition. The Government seeks to redress inequalities in the health care system. Attempts are being made to improve resource use and allocation, and service coverage. Recently, the Government's policy has been to decentralize health services while expanding the national programme and integrating federal, state and municipal programmes. The Northeast has been chosen as a priority area both for implementing the national programme and for the establishment of local centres. National strategies already implemented include the establishment of mini-health posts and health centres to bring basic health and sanitation activities to communities in the Northeast of less than 20,000 inhabitants. In 1979 the extension of these centres to the rest of the country was legally established as a national objective. Programmes are also underway to promote maximum utilization of existing public sector facilities and to extend coverage to rural and semi-urban areas. Basic nutrition is also of considerable concern. The Government considers that improved nutritional status depends largely on reducing the cost of basic foods and on a better income distribution. Family planning and child-spacing are encouraged through programmes of maternal and child health.

Fertility and the family: In a dramatic shift from its previous position of neutrality regarding family planning, and its earlier pro-natalism, the first Government-promoted family planning programme was announced in 1984. While not viewed as a panacea for social and economic

Population Policy overview - Brazil

problems, it is seen as an indispensable tool of development policy. The family planning programme, which is a component of a maternal and child health programme, will be implemented initially in the Northeast and then gradually extended to other areas. Currently all forms of birth control are legal, including sterilization. It is no longer illegal to advertise contraceptives. Abortion is illegal except to save the mother's life.

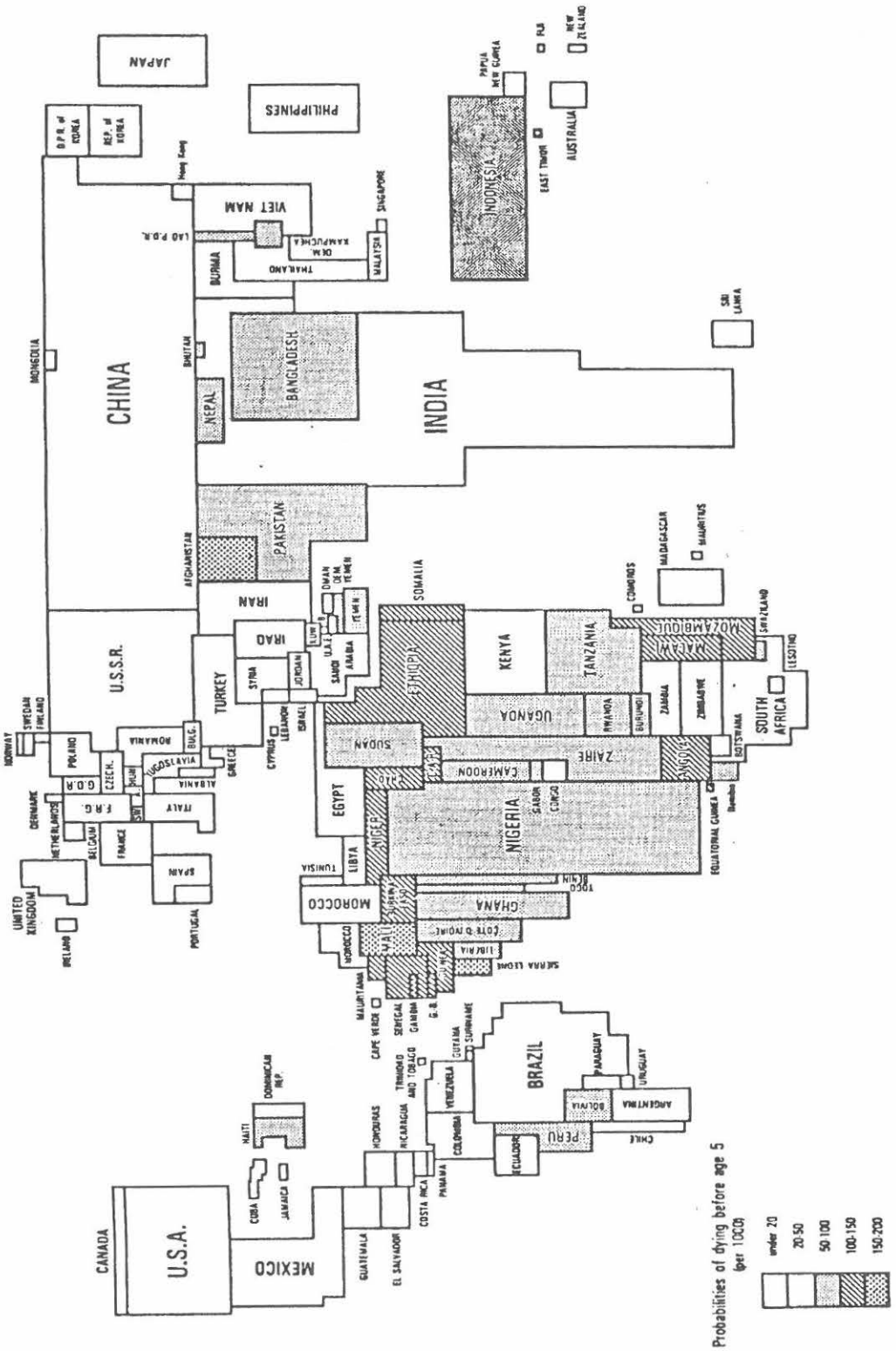
International migration: In 1980 the Government enacted a strict new immigration law, chiefly in response to concern over the presence of political exiles from neighbouring countries. In 1978, the Government changed its position on refugees and withdrew from the Geneva-based Intergovernmental Committee for Migration (ICM), citing Brazil's lack of need for immigrants and ICM's shift in focus from resettling European migrants to placing Southeast Asian refugees. The country has never experienced large-scale emigration.

Spatial distribution/Urbanization: Since the mid 1970s Brazil has stated the objective of deconcentrating the population of its large metropolitan areas and stimulating economic growth in peripheral regions. The National Urban Development Council mapped out a national urban development policy for the 1980-85 period. Guidelines included: reducing uncontrolled growth in some metropolitan areas; guiding investment to medium-sized cities in order to raise their relative growth rates and initiate a process of urban deconcentration; stimulating economic activity and job creation in small and medium-sized cities; alleviating urban poverty; and increasing accessibility to urban services. In late 1986, citing both national security and development objectives, the Government decided to set up small army bases along its borders as a way of drawing settlers to those remote regions.

Status of women and population: The minimum legal age at marriage for women is 16.

From: United Nations: Case studies in population policy: Brazil. New York, 1988, pp 1-4.

Projections of probabilities of dying before age 5, 2020-2025 with the size of countries proportional to the projected average annual number of births, 2020-2025



From: United Nations: Mortality of children under 5. World estimates and projections 1950-2025, 1988 (New York) pp 18.

UNFPA calls for international action to balance population growth and resources

As part of its commitment to sustainable development, the United Nations Population Fund (UNFPA) is calling on Governments, international organizations and non-governmental agencies to adopt specific goals for the twenty-first century and to work together towards balancing population and resources.

The suggested goals would help to extend family planning and health programmes to the urban poor and to rural areas, reduce maternal and infant mortality, bring women into the development mainstream reduce levels of illiteracy and relieve population pressures on the environment.

The Population Fund, which is celebrating its twentieth anniversary this year, says that while much progress has been made in population efforts over the past two decades the uneven way population is growing and its inequitable distribution in combination with other factors is now posing grave threats to the economic, social and environmental health of the planet.

With world population expected to reach the six billion mark by 1998, UNFPA says it is imperative to provide more health care and family planing programmes to poor and rural areas, reduce maternal and infant mortality, reduce illiteracy and give more women access to education and remunerate them for the work they do.

"What we do in the next decade will determine the patterns of world population growth for much of the next century", said Dr. Nafis Sadik, UNFPA Executive Director. "If present trends continue, (the global population) will stop growing at 10 billion about a hundred years from now, but this could be speeded up or delayed. If population programmes succeed, we may be able to limit total population to 8 billion. If we fail, there could be 14 billion people on the earth in the year 2100."

Dr. Sadik said that the uneven patterns of population growth - nearly all of it in the poorest countries - and economic growth - with real growth confined to a fortunate handful - posed grave threats to the environment, to the international economy and to international security.

UNFPA has recently concluded a review of the key achievements in the population field over the past two decades.

That review clearly shows that sustainable development can become a reality only if the population, environment and development linkages are adequately translated into policies and social sectors - health and education - are given equal value with economic growth.

"This will take awareness and commitment of national political leaders; the creation, where they do not already exist, of governmental units to direct population efforts and resources; and strong population institutions to conduct research and train population managers", Dr. Sadik said.

Governments of high-fertility countries are being forced to spend increasing amounts on essentials and have little left over for investment. Because of the increasing outflow of capital from the developing countries for essential imports and for debt service, Governments are spending proportionately less on this kind of "social investment" - education and health.

Necessity is driving the poor in the developing world to conduct a ferocious assault on their environment, she continued.

"Increased demand from growing populations has already outstripped many countries' ability to supply basic needs. Nutrition levels are dropping and infant mortality may be once again on the rise."

Urban growth in many developing countries is twice the national rate of developed countries. Moreover, there is a clear-cut relationship between high fertility rates, crowded urban conditions, poverty and violence.

An important factor in the success or failure of population and development programmes will be the international community's efforts to improve the status of women.

"We have clear-cut, concrete evidence of linkages between female education and fertility and mortality, between gainful employment and patterns of family formation and between women's participation and the success of population programmes", Dr. Sadik said. Specific development goals involving the improvement of the status of women include:

- Extension of family planning services to 500 million women by the year 2000;
- Reduction of maternal mortality by at least 50 per cent by the year 2000, especially in those countries where such mortality is very high (higher than 100 maternal deaths per 100,000 births);

- Reduction of infant mortality to 50 per 1,000 live births by the year 2000, especially in those countries where infant mortality is high;
- Reduction in levels of illiteracy, especially female illiteracy which is almost 50 per cent in the developing countries where nearly 98 per cent the world's illiterates live;
- Expansion of girl's enrolment in school and their retention in the school system;
- Securing women's legal and social rights to free marriage, land ownership and paid employment;
- Increasing income-generation programmes for women;
- Strengthening the institutional structure and the capacity for research and training at national levels; and
- Establishment of a framework and appropriate policies and programmes which would integrate population trends and environmental considerations in development strategy.

Dr. Sadik said that it would take increased political commitment from Governments to improve the status of women, extend educational opportunities, increase family planning and health service, and provide a more equitable distribution of income to achieve the goals.

From: Population headlines, No. 168, March 1989. Economic and social commission for Asia and the Pacific (ESCAP), pp 13.

Female-headed households, 1970-80[1]

1970s[2]		%	1980s[3]		%
Argentina	1970	16.5	Buenos Aires	1982	18.4
Bolivia	1976	26.0	La Paz		n.a.
Brazil	1970	13.0	Brazil[4]	1980	18.5
Colombia		n.a	Bogotá	1982	19.3
Costa Rica	1973	16.4	San José	1982	17.0
Cuba	1970	18.3	Cuba[5]	1981	28.2
Mexico	1970	15.3	Mexico City		n.a.
Panama	1970	20.6	Panama City	1982	22.9
Peru	1972	22.3	Lima-Callao	1982	18.1
Venezuela		n.a	Caracas	1982	21.0

n.a.- Not available

[1] percentage of female heads of households of total number of heads of households. [2] Information obtained from population census. [3] Information obtained from studies of households. [4] Demographic census, 1980. [5] Population and household census, 1981.

Distribution according to civil status of women heads of households shows that in 1982 most of them were in the category of widowed, separated or divorced, followed by single women and then by married women and women living as married.

Available information indicates that the number of female heads of households is higher in the poorest social sectors in all cities except Bogotá and Buenos Aires where it is slightly lower than the average. On the basis of existing data it is difficult to ascertain if it is poverty in the first place which contributes to the formation of female heads of households or whether it is the fact that the households are headed by women which leads to poverty, as a result of women's lower

earning opportunities. It is possible that a combination of both factors determines a further decline in the standard of living of these households headed by women.

Data on the different forms of female-headed households are still very limited. Considerably more research is needed on the definition as well as the typology and location of these households within the different social sectors. This is crucial in order to differentiate between the variety of situations and conditions in which women are living and thus design appropriate development strategies which will take these differences into account.

From: ILO: Women at Work, 1/86 (Geneva). pp 50.

DIFFERENT POLICY APPROACHES TO THIRD WORLD WOMEN

"Women in Development" (WID)

ISSUES	WELFARE	EQUITY	ANTI-POVERTY	EFFICIENCY	EMPOWERMENT
Origins	Earliest approach: -residual model of social welfare under colonial administration -modernization/ accelerated growth economic development model.	Original WID approach: -failure of modernization development policy -influence of Boserup & First World feminist on Percy Amendment -Declaration of UN Decade for Women.	Second Wid approach: -toned down equity because of criticism -linked to Redistribution with Growth and Basic Needs.	3rd and now predominant: WID approach: -deterioration in world economy - policies of economic stabilization and adjustment rely on women's economic contribution to development.	Most recent approach: -arose out of failure equity approach -Third World women's feminist writing and grass-root organizations.
Period most popular	1950-70: but still widely used.	1975-85: attempts to adopt it during and since Women's Decade.	1970s onwards: still limited popularity.	Post 1980s: now most popular approach.	1975 onwards: accelerated during 1980s, still limited popularity.
Purpose	To bring women into development as better mothers: this is seen as their most important role in development.	To gain equity for women in the development process: women seen as active participants in development.	To ensure poor women increase their productivity: women's poverty seen as problem of underdevelopment not subordination.	To ensure development is more efficient and more effective: women's economic participation seen as associated with equity.	To empower women through greater self-reliance: women's subordination seen not only as problem of men but also of colonial and neo-colonial oppression.
Needs of women met and roles recognised	To meet PGN* in terms reproductive role, relating particularly to food aid, malnutrition and family planning.	To meet SGN** in terms of triple role - directly through state top down intervention, giving political and economic autonomy by	To meet PGN in productive role, to earn an income, particularly in small-scale income generating projects.	To meet PGN in context of declining social services by relying on all 3 roles of women and elasticity of women's time.	To reach SGN in terms of triple role - indirectly through bottom up mobilization around PGN as means to confront oppression.
Comment	Women seen as passive beneficiaries of development with focus on reproductive role. Non-challenging therefore still widely popular especially with government and traditional NGOs.	In identifying subordinate position of women in terms of relationship to men, challenging, criticized as Western feminism, considered threatening and not popular with government.	Poor women isolated as separate category with tendency only to recognise productive role; reluctance of government to give limited aid to women means popularity still at small scale NGO level.	Women seen entirely in terms of delivery capacity and ability to extend working day. Most popular approach both with governments and multilateral agencies.	Potentially challenging with emphasis on Third World and women's self-reliance. Largely unsupported by governments and agencies. Avoidance of Western feminism criticism, means slow significant growth of underfinanced voluntary organizations.

* PGN - Practical gender needs. ** SGN - Strategic gender needs.

Source: "Gender planning for women in development" World development 1988.

UNITED NATIONS INTERNATIONAL RESEARCH AND TRAINING INSTITUTE FOR THE ADVANCEMENT OF WOMEN INSTRAW

WOMEN, POPULATION AND DEVELOPMENT

Population Policies and Programmes

UNITED NATIONS FUND FOR POPULATION ACTIVITIES UNFPA

ADVANTAGES AND DISADVANTAGES OF THREE TYPES OF WOMEN'S PROJECTS

Tipe of Project	Advantages	Disadvantages
WID-Specific	Women receive all of the project's resources and benefits. Beneficiaries may acquire leadership skills and greater self-confidence in a sex-segregated environment. Skills training in nontraditional areas may be much easier without male competition.	These projects tend to be small scale and underfunded. Implementing agencies often lack technical expertise in raising productivity or income. WID-specific income generation projects rarely take marketability of goods or services into account and thus fail to generate income. Women beneficiaries may be required to contribute their time and labour with no compensation. Women may become further marginalized or isolated from mainstream development.
Women's Component in a larger project	The project as a whole enjoys more resources and higher priority than WID-specific projects, which can benefit the WID component. Women are ensured of receiving at least a part of the project's resources. Women can "catch up" to men through WID components.	The WID component usually receives far less funding and priority than do the other components.These components have tended to respond to women's social roles rather than their economic roles; for this reason, domestic activities may be emphasized to the exclusion of any others. Awareness of the importance of gender in the project's other components may be missing.
Integrated Project	Women can take full advantage of the resources and high priority that integrated projects receive. If women form a large proportion of the pool of eligibles, their participation will probably be high, even without detailed attention given to WID issues.	Unless information on women's activities and time use is introduced at the design stage, these projects may inadvertently exclude women through choices of promotion mechanism, location and timing of projects resources, etc. If women form only a small proportion of the pool of eligibles, they may not be included in the project. Women may be competing with men for scarce project resources and lose out because of their lack of experience in integrated group setting and their relatively low status in the family and community.

Sex Disaggregation of Data

In general, all project designs should be based upon knowledge and consideration of women's roles relevant to the project. Erroneous assumptions regarding "male" and "female" roles and activities are one of the key factors not only in the failure to reach women but in overall project failure.

Ideally, project design should be based upon sex-disaggregated data. In many cases, this can be collected by simply adding a question on gender to the standard baseline data questionnaire. Project officers in the microenterprise area who include gender as a variable in their baseline data collection, for instance, will be able to answer the following questions:

- Do women predominate in certain informal sector occupations? Are their incomes and savings lower or higher than those of men? Are their business smaller or larger? Do women have lower or higher fixed assets and sales? Do women have differential access to credit and technical assistance?

In other cases, the project planner may wish to add more detailed questions on gender. For instance, project officers in the agricultural sector might want to add questions on the following points to their baseline data collection:

- sexual division of labour
- daily and seasonal time use by sex
- income sources and expenditures by sex
- access to productive resources such as credit, land, etc.

Sometimes, however, such detailed data collection will not be practical and less precise or complete information will have to be relied upon. In this case, it may be possible to locate microstudies by local research institutes on the participation of women in various sectors.

Use of Sex-Disaggregated Data

Sixteen percent of the borrowers of a loan fund for microenterprises in Lima, Peru in 1984 were women. Analysis of a random sample of loans to 148 female and male borrowers in the programme revealed that 62 percent of the loans in the bottom quintile of the loan distribution were awarded to women, while 62 percent of the largest loans were granted to men. Additional analysis revealed that it was the nature of female borrowers' occupations, rather than the fact that they were women, that explained the variance in the loan sizes granted. Women received smaller loans because they predominated in low-earning occupations, such as commerce or sewing that are related to small loans, not because the loan institution discriminated against women on the basis of sex. Men, on the other hand, predominated in the higher earning occupations of bakeries, leather and shoe repair services, and nontraditional manufacture.

The importance of Technical Competence: The Bolivia Ulla Ulla Rural Development Program

The purpose of the Ulla Ulla Rural Development Program, undertaken by the World Bank in the late 1970s, was to raise the productivity and incomes of Bolivian peasants by modernizing all phases of alpaca and wool production. Through baseline research, project planners discovered that peasant women are heavily engaged in herding and shearing; the project design therefore included a specific productive women's component. During the implementation stage, however, the implementing agency hired a female coordinator with no technical qualifications to run the women's component. Under her direction, the component consisted of "traditionally feminine" activities, such as cookie-making and papier-mache, with no productive potential. This project demonstrates the importance of using technically qualified staff to implement women's components in integrated projects.

Institutional Selection

Choice of implementing agency is one of the most important elements in project design. One may assume that women's organizations are the best suited to implement projects that include women. However, **experience with projects designed to reach women indicates that the failure of productive programmes can often be traced to lack of technical expertise on the part of the implementing agency.** That is, agencies with the capacity to reach women are not necessarily capable of implementing successful productive projects for women due to lack of technical expertise.

On the other hand, **technically implementing institutions may be incapable of reaching women and may not even consider the participation of women to be important.** These institutions may not have the expertise to recognize which aspects of their programmes potentially pose problems for women's access. Even with the best intentions, such institutions may still exclude women from opportunities to significantly improve their economic situation.

Project designers can enhance the chances of reaching women by choosing implementing agencies with appropriate technical expertise, as well as a commitment to developing or recruiting expertise on women's issues relevant to the project. Naturally, the choice of an institution will not be made on the basis of its expertise in reaching women in their productive roles. In cases where the best technical institution lacks experience in reaching women, project design should make provision for technical assistance from outside consultants or organizations in regard to improving women's participation.

Target Population

Project designers should consider the following issues:

1. **Possible constraints to women's participation in project activities should be considered in the design of all projects.** Projects designed in such a way as to minimize the restrictions that the poor face in gaining access to resources will increase the chances of reaching poor women as productive agents. Additional project features to be considered in order to enhance women's participation include the location of activities and services and the timing and duration of activities. If, for instance, agricultural training programs involve long-term, residential training, there is little chance that women will be able to participate, given their household responsibilities and societal norms that typically restrict rural women's travel away from home.

2. **When there is a low proportion of women in the pool of eligibles, women's participation tends to be low, in spite of active efforts to include them.** If this is the case, three steps can be taken:

- Expand the eligibility criteria;
- Consider developing a special women's component designed to respond to the constraints that render women ineligible;
- Institute an active recruitment programme for women (particularly effective when implicit exclusion, on the basis of cultural perceptions, has reduced the number of eligible women, rather than explicit exclusion).

3. **The distinction between increasing women's activities or work and improving the returns to women's activities or work** must be considered when planning project components and expected outcomes.

- In agricultural projects, for example, the involvement of women in soil preparation and weeding of certain crops increases the demands upon women's time and labour, yet women may not share in the proceeds of crops sold through male-based co-operatives.

Women may refuse to participate in components that increases their work without increasing their returns; this factor enormously increases the potential for project failure if such components depend on women's labour for their viability (see box next page).

4. Targetting resources to women has advantages and disadvantages which should be weighed in the design phase. In some sectors, such as agriculture and energy, **targetting does seem to ensure that project benefits reach women** and introduces an element of accountability in the project. In other areas, notably microenterprise development and credit programmes, resources are usually delivered to women without **targetting and targetting may, in fact, create tension within the project, result in lower quality of services to women, and further segregate women from the mainstream.** Overall, the broader approach of relying on knowledge of gender roles to determine whether women are likely to participate in each project component is a more useful strategy.

Women's Labour/Women's Returns

The Guatemala ALCOSA Agribusiness Project provides insight into the importance of the distinction between increasing women's labour and increasing women's returns. In one of the project sites__Chimachoy--the town's (male) farmers heeded the ALCOSA processing company's calls for larger amounts of vegetables by cutting back on traditional food crops to increase the production of cauliflower. Women, who previously had helped in the fields only during planting, were pulled into 2-3 days of horticultural labor each week on top of their normally overburdened shedules. As a result they had to cut back on their marketing trips to town, the source of their only independent income. (ALCOSA payments came in the form of a check made out solely to their husbands.) Women's financial independence was therefore diminished as their workloads increased.

In another project site, San Jose Pinula, the ALCOSA processing plant provided women the opportunity to work for wages paid directly to them. Shifts were long during peak periods--up to 16 hours--but female employees made 100 to 300 percent as much as they could have made in market selling and domestic work, their two main alternatives. Women retained ultimate control over their incomes and gained in self-reliance and financial independence from their husbands.

5. **Cultural mores, determined by tradition and religion, may affect such behaviors as the gender-based division of labour, and can have a critical impact on project success.** There are wide variations in behavior across countries and even from community to community. Some cultural constraints can be addressed through programme or project interventions. Resistance to involving women in new productive programmes seems to decrease when the programme increases household income.

- In a village in rural Guatemala, women were accustomed to helping in the fields only during the planting season. However, the introduction of contract farming on horticultural crops, with its promise of increased income, influenced women to contribute 2-3 days/week of labour on the vegetable crops.

6. **In most LAC countries, women--particularly those who are the sole economic support of their households--are over-represented among the poorest low-income groups.** Project interventions that identify the poorest of the poor as the target group will therefore automatically include a great many women.

General Guidelines for Project Implementation

Project designs that successfully incorporate women do not in themselves guarantee successful implementation. A number of features can be built into project implementation that will help ensure that women will receive project benefits and resources as planned.

1. **When sex-disaggregated information is provided by the monitoring system and the project allows for revisions in the design, it is more likely that project benefits will successfully reach women.** Ongoing evaluation teams should have scopes of work that explicitly include the gathering of sex-disaggregated data. Project planners cannot always foresee and make provisions for obstacles to women's participation that may arise during implementation. Therefore, the greater,the flexibility of the design and the adaptability of the process, the greater the chances that implementors can adapt the project to unforeseen circumstances.

2. **Consideration of the degree to which women retain project benefits should be undertaken during the implementation phase** since effective evaluation of the impact of the project may require such information.

• One of the goals of the Solanda hosing project in Quito, Ecuador, for example, was to provide equal housing opportunities for households headed by women. Project designers decided to lower the down payment requirement, which meant that many more women would qualify as applicants to the project. However, the selection process, if left unchecked, can still favor men over women within any applicants in all categories. This situation exemplifies the need for monitoring during selection of project applicants.

General Guidelines for Evaluation

Indicators of progress are important in keeping the implementation of any development strategy on track. In the case of women in development strategy, the best indicators of progress can be gleaned from sex-disaggregated data on the nature of women's participation in programmes and projects.

Levels of Analysis

Indicators at three levels can be used to evaluate whether projects have included women. Project officers must decide on a case-by-case basis which level of evaluation is warranted, given the funds available and the importance of including women in the project.

1. At the first level are overall indicators. A technical office may want to look at its project portfolio to determine whether it is likely reaching women or not. Use of overall indicators is the simplest and cheapest way of evaluating a project portfolio, as it relies on data that is already available. It should be noted, however, that these indicators can demonstrate only the potential of the project portfolio to reach women. Determination of whether the projects actually include women can be reached only through sex-disaggregated project data.

An overall picture of the likely opportunities a strategy is providing for women, can be obtained by assessing whether the strategy focuses on areas likely to benefit women.

Three main indicators can be used in these comparisons:

First, **what are the percentages of projects focused on areas likely to benefit women?**

Second, **what are the budgetary allocations to areas likely to benefit women?**

Third, **what are the relative numbers of consultants' and contractors' scopes of work that explicitly require the consideration of gender roles in the areas of concern?**

2. The second level of indicators are sector-specific indicators. These require little or no sex-specific data yet can increase our understanding of whether the necessary conditions exist for reaching women and provide more depth than the overall indicators.

In the microenterprise sector, for instance, analysis of certain features of the project, such as the target group, average loan size, collateral requirements, and financing mechanism can give a fair indication of the extent to which women are being reached. Analysis of these project features is relatively inexpensive and easy.

3. At the third level of analysis, sex-disaggregated indicators can be used to pinpoint problems in implementing a development strategy for women or to highlight areas in which successful approaches have been found. These indicators are the most difficult to collect and the most costly; however, it is only at this level of analysis that the participation of women in a particular project can come to light. Sector-specific and sex-disaggregated indicators are suggested at the end of each of the four sector sections.

From: Gender Issues in Latin America and the Caribbean, in the gender manual series (Washington) 1986 pp 31-37

Migration

Worldwide, policymakers are giving increasing attention to the effects of outmigration, particularly from the small farm sector, on declining food production. Perhaps the most startling consequence of the migratory process in Jamaica is the fact that about one-third of agricultural land is not presently under cultivation. This phenomenon is common today in many world areas where discouraged small farmers have left their own enterprises to seek work on commercial farms or in the cities, as well as overseas.

Moreover, because historically emphasis has been put on export crops in Jamaica, only about 6 percent of the cultivated land currently produces food for local consumption (U.S. Agency for International Development 1975: 122). Jamaica can ill afford to lose any more land devoted to domestic food crops or any more small farmers to outmigration.

Why do farmers leave the land in such large numbers? First, Jamaicans have a long tradition--going back to the attraction of the $5.00 a day "Panama money" West Indians could earn constructing the Panama Railroad--of "goin' a foreign" as a survival strategy. On a small island, the continued high birth rate and rapidly declining death rate would have meant even more restricted job opportunities if the rate of population growth had not been "masked and tempered" by migration.

Second, as in many former colonial and slave societies, farming is associated with a status that many people prefer to leave behind. Young people in particular do not want to stay on the land, and the median age of the farmers has moved constantly upward. In the II Integrated Rural Development Project (II IRDP) at Christiana, Jamaica, for example, more than one-half the farmers are 50 years of age or older (except on the smallest parcels); women farmers, who make up one-quarter of the total, tend to be somewhat older (U.S. Dept. of Agriculture 1978: 94; Chaney and Lewis 1980b).

A third reason for abandoning farming among small farmers is the meagre economic return to farming. A base-line survey carried out before the II IRDP began (Jamaica, Ministry of Agriculture 1981) confirms that income earned from farming is very low; only 30 percent of the farmers in the IRDP grossed more than J$1500 per year, and about one-quarter of all farmers earned less than J$300 per year in gross value product. Experts argue that if farm incomes were improved, there would be a greater willingness on the part of young people to remain in the rural areas and farm the family land.

Fourth, many members are "displaced" from farming by the need or desire to earn cash. As a rural economy moves from a subsistence to a cash basis, many seek off-farm employment to pay

taxes and to buy consumer goods that are perceived not only as desirable but as "necessary". Yet there are few income-earning opportunities in the countryside; according to the 1979 survey mentioned above (ibid.: 19), only 13 percent of reporting farmers earned income of their own farms; 5 percent worked on other farms as labourers, and only 8 percent found work that was non-agricultural. People, therefore, migrate to areas where they perceive better job possibilities may exist--to the towns or cities of Jamaica or abroad.

Decline of the Small-Farm Sector

Increasing outmigration is by no means the only scenario associated with small farm sector deterioration, but it is an important ingredient in the acceleration of its decline. Indeed, migration is both a cause and an effect of the problems that beset the small farm. In Jamaica, this sector traditionally has provided much of the local food (eaten by the poor in the city and countryside alike), as well as many export crops--such as bananas, spices, citrus and coffee. At one time, about 25 percent of Jamaica's export crops were grown on small farms. About 60 percent of the Jamaican population lives in rural areas, and 30 percent of the total workforce is in agriculture (U.S. Dept. of Agriculture 1978: 74, 89, 94).

Now the agricultural sector's productivity has greatly declined with the grave damage inflicted by Hurricane Allen on citrus and banana, only the latest in a series of difficulties. Soil erosion on the hillsides where most small farms are located is perhaps the most serious problem. The small farmer always has suffered from an uncertain supply of high cost inputs and lack of credit. Agricultural extension services are geared to the kinds of crops grown on the large estate farms, as are research efforts, and small farmers have never competed successfully for the kinds of assistance and supports that might induce people to stay in the countryside.

Another factor in the decline of small holder agriculture--and the consequent decrease in amounts of local food available--is the growing discouragement of farmers because of what Jamaicans call "praedial larceny," that is, theft related to the land and its products. Such thievery is not confined to adventurous boys climbing over the hedges to steal mangoes but includes incidents of midnight rustlers coming in trucks to steal a farmer's entire stand of cabbages or other market crop.

Many farmers own small parcels of land at some distance from their houses, making it difficult to watch over their crops. Not every farmer loses an entire planting, but most must put up with continual petty pilfering. Praedial larceny is one of the major farm-related problems reported in the daily press and commented upon by nearly all the persons interviewed for this study. Growing numbers of small farmers apparently feel that their agricultural efforts are not worthwhile, and many seek off-farm employment instead of putting in crops, setting in motion the circular process

in which migration leads to the deterioration or abandonment of agricultural land. This deterioration, in turn, leads to further migration from the rural areas.

Feminization of Farming

The deterioration of the small farm sector is intimately linked to a third set of events: the feminization of agriculture. Similar trends have been observed both in developed country agriculture, as recent studies in such widely separated countries as Spain (Margolies 1980), Romania (Cernea 1978) and Japan (Shinpo 1973) attest, as well as in developing countries (Bukh 1979; Colvin, et al. 1981; Gordon 1978; Mueller 1977; Obbo 1980 and Smale 1980, among others).

Women have always played a large role in both commercial and subsistence agriculture in most world regions. This is true particularly for the former British colonies in the Caribbean (as it is in most of Africa today). In keeping with a worldwide trend, women in Jamaica probably are participating more in farming rather than less. The outmigration of men leaves behind one or more adult women who must continue to manage the household and care for the children, as well as cultivate the family food and produce the cash crops.

In Jamaica, 26 percent of the labour force in agriculture, forestry and fishing is female. Many women are actively engaged in farming, and many of them are heads-of-household. Women's holdings are, however, significantly smaller, on the average, than those of male farmers. The 1979 Agricultural Survey of the II IRDP areas (Tables 3A and 3B) reports that women's holdings are significantly smaller than men's. About 25 percent of the women farmers work less than one acre of land, and only 20 percent of the women farm operators cultivate more than five acres. In contrast, only 5 percent of male farmers work less than one acre, while 40 percent farm five acres or more. Naturally, with less land, women as a group earn significantly less than men from farming.

In addition to their work in cultivation, women also process,preserve, and prepare the food. They also spend many hours weekly in hauling water and foraging for firewood. And they continue to bear the children and to have the major responsibility for their care. If remittances from the migrant members are slow in coming or cease, the women left behind become economically responsible for young and old. They must find the means to provide food, clothing, school fees and supplies, medical attention,and all the other things their families need, with few opportunities for off-farm employment to supplement what they can earn (or conserve, by providing food for their families) from the land.

Sometimes women carry on with little or no drop in production when their menfolk migrate. But in other cases, women do not have access to credit, extension assistance, or agricultural inputs, because these are often available only through co-operatives or farmers associations to the person

who can show title to the land or has other tangible property for security. Since there are fewer and fewer men to clear and plow the land, traditionally male tasks, women are forced to plant the same land again and again. Burdened with both the cash crops and the family's food crops, women often become discouraged--and may cut back on agricultural activity or abandon it altogether. Indications are that agricultural activity is decreasing in some areas of large out-migration of men. Land goes out of production, terraces fall, irrigation systems deteriorate, and women fall back into just enough subsistence production to feed themselves and their families. This, in any event, is the pattern in many world areas (ICRW 1979: 116-18; Mueller 1977: 76-77; Birks and Sinclair 1980: 90-91; Myntti 1978: 42). There is good reason to believe that, if documented, the situation would not prove to be all that different in Jamaica-with the index of land being utilized constantly going down as first men, then their discouraged womenfolk, migrate in search of what they perceive as better opportunities in the towns or beyond.

Agricultural Marketing

The way in which domestic food crops are marketed also directly affects the availability of food and consequently people's diets. There is universal consensus that the marketing system in Jamaica is inadequate; without entering here into the controversy over the efficiency of higglers--women traders who handle at least 80 percent of the marketing of local fruits, vegetables and staples (Smikle and Taylor 1977: 32)-- there is little doubt that internal marketing could be greatly improved.

Sheer lack of transport often prevents the farmer from taking his/her produce even to the local market or nearby boxing plant. The hardworking, shrewd higglers often harvest the produce to be sold that day or the next from their own and their neighbors' fields, paying a better price than the government agricultural marketing corporation. But their lack of transport means that typically they carry relatively small amounts of produce long distances, often on the tops of buses or sitting astride their sacks in the back of open trucks. Post-harvest losses attributable to the marketing system and to the lack of proper storage facilities are estimated at about 30 percent of the crops produced. Further losses in nutrition occur because the produce is sometimes sold in a deteriorated state.

Price is another key factor in the marketing scenario. Cheap food policies for the urban population sometimes discourage small farmers who must pay high prices for planting materials and other inputs, yet may not make sufficient profit to pay their costs, much less realize a return to their labor. In recent months for example, low market prices offered for yam resulted in many of the farmers of the central region in Jamaica leaving their unharvested crops in the field. Peeled ginger, commanding only J$1 per pound, also was not worth taking to market.

Dependency on Food Imports

This situation leads directly to a fifth scenario associated with malnutrition: what many Jamaicans consider an overdependency on imported food. Adequate diet in Jamaica always has depended upon food imports. From the 17th century when salt fish was brought from the Newfoundland Banks as a cheap protein source for fieldhands, Jamaica has made up the shortfall in nutrients with imports. In times when sugar was king in Jamaica, it was more economical for planters to provide staple foods for their workers than to have them spend time in growing food. (Women, however, often grew some food items and were allowed to sell them in the market even before emancipation--the origin of the higgler system.)

In recent times, Jamaica has been hard put to come up with the foreign exchange necessary to purchase cereals on the world market to make up for domestic shortages. Few Jamaican officials advocate complete self-sufficiency in food; there is, however, a growing uneasiness among them about overdependency on imported food, linked to a high level of awareness that counting on the world food supply is dangerous at a time when the era of cheap food prices (which held for past two decades except for short periods of world drought) is about to end. The great surge in corn production achieved with the introduction of hybrid seed and short-season varieties has leveled off, and the promise of the Green Revolution has not been fulfilled. For developed-country agriculture, costs of all inputs are increasing, while the supply of good land and mineral fertilizers is decreasing. At the same time, increasing costs (and uncertainties) of transport because of the rise in oil prices and unrest in oil-producing regions already must be factored into the prices of food bought abroad. Most crucial of all, whatever constitutes an "adequate" world food reserve, there now are limits to what can be provided through food and disaster aid, concessional sales, and food-for-work-programs.

Unemployment and Poverty

Those who leave the countryside are not easily absorbed into the stagnant economies of the urban areas. Most often they join the ranks of casual labor in the informal sector, or the unemployed. Another scenario generating malnourished, displaced persons is revealed: lack of income. Not only must food be available either through local production or through purchase abroad if people are to eat, they must have money to buy food.

A related phenomenon is the high incidence of female-based household; in Jamaica, about 35 percent of households are headed by women, and there are estimates that in Kingston the number may be over 50 percent (U.S. Agency for International Development 1981: 19). Women either are left behind when their menfolk leave to find work in the cities of their own-or another country, or women themselves go to the city to seek work and establish a household there. Almost one-half

(47.1 percent) of the labor force in Jamaica is female (Jamaica, Dept. of Statistics 1982b: Table 6.1, p. 64). Among women 20 to 54 years of age, 86.5 percent were in the workforce in April of 1981 (ibid.: Table 6.2, p. 65).

Men may establish several families over a lifetime, sometimes having more than one simultaneously, while women generally live in a series of mating unions. Couples start out in a consensual or "visiting" union and may marry only late in life, often to other partners entirely. In 1970, as many women (31 percent) were living in consensual as in legal unions (U.S. Bureau of the Census 1977). While there is little or no stigma attached to mating patterns outside marriage, the situation nevertheless means that women often are economically responsible for large families, while men may cease any contribution to some of their children as the number of their dependents increases.

As job opportunities in the formal sector became scarcer in the late 1970s in Jamaica, there were marked increases in informal sector employment where wages are lower (Jamaica, Dept. of Statistics 1980: iv). The greatest increases were registered, however, in the unemployment indices, particularly among women. In Kingston, the real rate of unemployment was thought to approach 50 percent , although official statistics were lower. By April of 1981 (the latest date for which statistics are available), a startling 38.6 percent of women in the labor force were unemployed, compared to 15.1 percent of men (Jamaica, Dept. of Statistics 1982b: Table 6.10, p. 73). Among women heads-of-household, unemployment rates also were higher than those for men: 27.9 percent unemployed among female heads compared to 10.5 percent unemployed among male heads (Jamaica. Dept. of Statistics 1980: Table 4.3, p. 79).

Even for those who are employed, however,incomes may not provide sufficient resources for balanced diets. The lowest 10 percent of employed males earned a weekly wage of only J$10.04 in October of 1979, while the median income for men was J$40.05 and for women, J$33.33 (Jamaica, Dept. of Statistics 1980: Table vi, p. viii). The nutrition Advisory Council (1978: 11) estimates that Jamaican households spend an average of 70 percent of disposable income on food; but, for the 70 percent of lower-income households, food expenditures reach 80 percent of disposable income. The strategy for survival obviously indicates that most Jamaican households must have more than one wage earner. A recent study by Bolles (1981: Chapter 8) shows how women in 127 households in Kingston stretch their resources through cash generated by various household members, informal exchange of goods and services through networks of relatives and friends, and by tapping into informal labor market activities through "scuffling," i.e., hustling, pilfering, and petty commodity activities.

Income levels and employment statistics do not, of course, actually "measure" the nutrition/consumption situation in a society. There are families with income levels above the minimum to adequately nourish their members but with malnourished members; there are other families that fall below the minimum but with adequately-nourished members. Nevertheless, the high rate of poverty does indicate a high probability of malnutrition.

From: Elsa Chaney, Equity Policy Centre (Washington) 1983.

Mexico City Declaration on Population and Development

"...Improving the status of women and enhancing their role is an important goal in itself and will also influence family life and size in a positive way. Community support is essential to bring about the full integration and participation of women into all phases and functions of the development process. Institutional, economic and cultural barriers must be removed and broad and swift action taken to assist women in attaining full equality with men in the social, political and economic life of their communities. To achieve this goal, it is necessary for men and women to jointly share responsibilities in areas such as family life, child-caring and family planning. Governments should formulate and implement concrete policies which would enhance the status and role of women.

Unwanted high fertility adversely affects the health and welfare of individuals and families, especially among the poor, and seriously impedes social and economic progress in many countries. Women and children are the main victims of unregulated fertility. Too many, too close, too early and too late pregnancies are a major cause of maternal, infant and childhood mortality and morbidity..."

Source: Mexico Declaration on Population and Development, adopted by the International Conference on Population, Mexico City, 14 Aug. 1984.

From: ILO: Women at Work, 2/84 (Geneva) p 5.

MATERNITY PROTECTION: A SOCIAL RESPONSIBILITY

Every mother is a working mother,but women as workers and as mothers have a long history of struggle in the production and the reproduction processes. Although in production their economic and social contribution is slowly being recognised in many countries, there still remain complex problems in their work and life cycle. These need to be identified,reconsidered and re-examined in policy and legislation.

During the last three decades, demographic and economic trends have induced several governments to reorient social policies which reflect more clearly the needs of working women. This period has coincided with the increase in participation rates of women in the official labour force of many countries. The 1960s and 1970s have demonstrated that the economic performance of women in the economy is substantial- a major departure from the early part of the century when it was regarded as marginal. Towards the end of the nineteenth and the beginning of the twentieth century, when the first laws to "protect" working women were adopted-mainly focused on maternity-the number of working women outside the household was very low. It was estimated to be about 10 million in a few countries including the United Kingdom, France and Germany, where women were mainly employed in the textile industries. The improvement of conditions of work and life of women in that period of history has been the subject of literature in many countries. Their long hours in factories and workshops and miserable wages were so humiliating that they were regarded as a violation of human rights by trade union organisations. Such working conditions continue to be the normal life of women in the modern sector of many countries even today.

The first international standard -the Maternity Protection Convention, 1919 (No. 3)- laid down the basic principles of a women worker's right to maternity leave, cash benefits during absence from work, nursing breaks and, more importantly, the right to retain her job throughout pregnancy, confinement and childrearing. Over 30 years were to elapse before the need to re-examine this ILO instrument was considered. During its 35th Session, the International Labour Conference adopted the Maternity Protection Convention (Revised), 1952 (No. 103). This Convention widened the scope of maternity cash benefits to be paid by social insurance or public funds. Since many aspects of reproduction were not covered by the Convention, the Conference at the same time adopted the Maternity Protection Recommendation (No. 95) to further ameliorate conditions of working women. The Recommendation made various proposals including: a longer period of maternity leave, an increase in cash benefits of up to 100 per cent of previous earnings and the provision of additional benefits and facilities for nursing mothers.

The fact that since 1952 so many international instruments have referred to "maternity protection" is a reflection of the growing need to recognise that working mothers need financial

support and job security during all stages of reproduction: pregnancy, confinement, nursing and childrearing. It took more than three decades, several international decisions, many resolutions and standards to recognise that maternity is a "social function" and not a handicap in employment, a privilege for which working women should not be punished on an individual basis. This principle is the basis for introducing protective measures, policies and legislation in a large number of countries. Still the available information based on national sources indicates that marital status and maternity frequently act as obstacles in employment opportunities and have an adverse impact on the income of the working mother presenting special problems at all stages including recruitment, promotion and retirement. On this point, the United Nations Convention on the Elimination of All Forms of Discrimination against Women is explicit. According to its operational clauses, States Parties should take appropriate measures to prevent discrimination against women on the ground of marriage or maternity[2]. As we move toward the end of the UN Decade for Women and glance at the future horizon, we find that the number of working mothers has increased everywhere and that existing legislation has not always kept pace with this profound economic change. The global legal analysis in this issue clearly shows that in certain countries marital status or motherhood are not insurmountable barriers in the labour market in seeking, acquiring, retaining and advancing in jobs. This experience has been particularly noted at the national level during the last decade in some countries where anti-discrimination laws, equality policies or affirmative action regulations were introduced to improve material and social benefits and other facilities at the workplace. Still, in many countries working mothers continue to be the victim of de jure and de facto discrimination, often based on inherited social customs, beliefs and values.

Evidence from many countries reveals that the major stumbling block in recruitment practices, promotion procedures and social security schemes is the assumed economic cost of maternity protection. The notion of "economic cost" when hiring a woman worker or dismissing a pregnant woman or terminating the job of a working mother is based more on social mythology rather than economic reality. In countries where social insurance and not the individual enterprise has to bear the financial burden, the argument of economic cost is utilised in not hiring a woman. There are some signs that a shift of emphasis from economic cost to social function in reproduction is taking place. In public sector enterprises, for example, the degree of discrimination against working mothers is less visible, as the norms and regulations governing processes of recruitment, promotion and social facilities are enforced by th State. There, it is not profit and productivity which are the sole criteria in employment policy, but also the social responsibility of supporting the privilege of maternity.

There is a global trend towards smaller families - on women falls the shadow of maternity in several countries, pushing them off the job or the labour market for performing what is a social function for economy and society. They frequently do not get jobs, and, having got them, lose

them, even on the imagined threat of pregnancy and are assumed to be "unreliable workers" in their employment contracts.

This issue of Women at Work focuses attention on an ILO global survey of legislative provisions on maternity protection and the social responsibility to protect working mothers. This analysis, supported by economic evidence, reveals that as more women enter the labour market and become mothers, the workplace will have to transform to adapt to this changing economic scene and social reality.

In the following paragraphs, the health aspects of working mothers and the supporting facilities that they urgently need are discussed below by WHO.

From: ILO: Women at Work 2/84 (Geneva) pp 1-2.

WHO: Women workers and breastfeeding

Recent works from WHO's Divisions of Family Health attempt to establish how much is known about contemporary feeding patterns, clarify some of the issues involved and suggest ways in which women can be not only encouraged to breastfeed but given the necessary family and community support to do so. A study reviews and analyses over 200 studies on breastfeeding prevalence and duration carried out in 86 countries. Its purpose is threefold: to quantify patterns and trends; to indicate the gaps in current knowledge in the hope of encouraging countries to monitor their own trends; and to stimulate an understanding of the factors contributing to current changes.

There are still large parts of Africa, Asia and elsewhere where almost all children are breastfed. Most of 21 million infants born in Africa each year are breastfed, usually for a protracted period of time, as are most of the 38 million infants born in central and south-western Asia. In eastern and south-eastern Asia (34 million births annually), prevalence and duration are high in rural areas; in urban areas prevalence is also high, but duration is lower. In Latin America (12 million births a year) initial prevalence is generally high but average duration varies considerably.

From: ILO: Women at Work 2/84 (Geneva) pp 23-29.

Linking Women and Children (UNICEF)

From its earliest forays into health campaigns and feeding programmes in the villages of Asia and Africa, Unicef had accepted as a matter of course that the well-being of children was inseparable from the well-being of their mothers. In maternal and child-heath care, Unicef had a legitimate claim to have helped pioneer improvement in the lives of women; it had taken a lead in according due respect to the nurturing role of women, not only as mothers and home-makers, but also as healers and birth attendants.

From health care, Unicef assistance for women had broadened to training in what in the early days was described as "mothercraft" and "homecraft". The support which, at Charles Egger's initiative, had been first offered to women's groups in east Africa in the late 1950s had initially been provided as a means of improving child nutrition and family welfare. But before long, the women's group or women's association had been seen in a more potentially significant light. The ideas which, in parts of French-speaking Africa, found their expression in "animation rurale", suggested that the women's group not only provided a context in which women could learn new skills, but also gave them a new set of ideas about themselves, the kind of lives they were leading, and what to do about them.

Such awareness was the precondition of taking any kind of action to breach the rigid codes governing family and community life, most of which were designed to keep women in inferior and subservient roles, and in whose application women usually connived without question. Brought up in a narrow world of drudgery, male domination and constant childbearing, women's willpower was sapped. Before they could take a small step forward, they needed to be able to conceive of other relationships than the fixed ones of kin, and achieve new worth and dignity in their own eyes. Changing the attitudes of government officials and national leaders towards women in such a way as to open up more opportunities and more protection for the fulfilment of their domestic and maternal roles would not help women who had no sense of their advantage. In a telling statement, an observer wrote of the "bat women of Asia, clustered safely in the darkness of male domination and fluttering about fearfully when an opening door lets in some light".

The growing sense that attitudinal change was needed-both by women and about women-in order for them to profit from the development process on their families' behalf was one of the reasons for the stress on reaching women and out-of-school girls through the mechanisms of non-formal education. In some parts of Asia and many parts of Africa a female illiteracy rate of seventy per cent in rural areas was still common in the early 1980s, and in some places rose as high as ninety per cent. Families who appreciated the benefits of schooling often appreciated them on behalf of a boy, who might find a salaried job behind a desk in town and handsomely repay the

investment; but not on behalf of a girl. Her duties helping her mother in the house and in the fields were usually more economically important to the family. The disproportion between the numbers of boys and girls entering school reinforced the discriminatory process which kept men moving ahead while women remained in ignorance of the modern world. The theme that more girls should be in school was constantly repeated; but what ministries of education were actually doing, or able to do, to redress this balance was difficult to identify.

One study of village life undertaken in Africa in the early 1970s described the classic syndrome whereby the persistence of traditional education for girls reinforced women's marginalization: "According to tradition, the (village) community entrusts the education of girls to the mother. The training focuses on routine procedures which girls will be expected to perform as wives, mothers,agricultural workers...The mother participates with a deep sense of responsibility, eagerness, and real interest...She is interested in being a good educator because certain rewards accrue to her such as enhanced status in her community and emotional satisfaction...While the mother is found sufficient by the village community for educating girls, nonetheless she suffers from a major handicap in that role-namely, the education she imparts is greatly limited to her own ignorance, and inability, due to illiteracy and isolation, to gather further information developed on scientific lines. Thus she transmits to her daughter only those traditions, superstitions, and ways of living that she knows, many of which are nonconducive to socio-economic development of the community".

Although Unicef's view of the role of women in development widened over the years, there was a strong latent resistance to the idea that Unicef itself-which was after all created in the name of children rather than women -should be concerned with any other female role than that of the bearer and rearer of children. Resistance to picking up the cudgels on behalf of women "qua" women was reinforced by the fact that changes in the laws affecting women's status and employment -the primary goal of much of the women's right movement in the industrialized societies -would have little effect on the lot of rural women in developing countries. The kind of discrimination experienced by women caught in the trap of poverty, ignorance and life-long labour was not easily susceptible to the passage of laws, however important it was to create a legal framework for equal rights. Unicef believed that the attitudinal change that must take place in society to improve the lot of women was more likely to be promoted by providing services to help her improve her maternal and domestic performance. Better health and nutrition for her children and herself were seen as inherently attractive to women, and as a first step to the opening up of their minds to a wider range of family life improvements.

By the late 1970s, certain champions of women's right had intensified the debate concerning the lot of women in developing countries. The demand of equality in job opportunities and pay which characterized much of the clamour in the Western world spilled over into the developing

world with a demand that more respect be given to the economic functions of women in rural society. A group of protagonists began trying to put across the message that, in communities living at the edge of survival, there was no division between women's role as mothers and their role as economic providers, and that any effort to help them as mothers was bound to be handicapped by a failure to take all their responsibilities into account. The long obsession with economic production as the gauge of development and its definition as something with a monetary value had obscured the fact that all the functions required of a woman in traditional society -including child-bearing -were critical to the family's means of support.

Since the days of Unicef's first support to homecraft and mothercraft in rural Africa, the enormous domestic load carried by many Third World women was well understood. What was different now was to describe this load in economic rather than social terms. In large parts of Africa, women undertook almost every task connected with growing and processing food, including planting, weeding, hoeing, harvesting, winnowing, storing the crops, and rendering them into cookable ingredients. Elsewhere their agricultural burden might not be as heavy, but the most casual inspection of the Third World countryside would show that nowhere was it light. They tended all small livestock, milked anything that could be milked, grew all the vegetables. Since most of this was done without money changing hands, none of it figured in the development statistics. In all traditional societies women also collected the family's water and fuel supply, carrying heavy pots to and from the river, gathering sticks, burning charcoal, or patting dung into cakes and drying it in sun. They fashioned cooking pots from clay, plaited grasses into baskets, scraped out gourds, spun and wove wool and cotton. "Handicrafts" like these were no pastime for creative expression, but the necessary manufacture of utensils for household use. None of these tasks counted in any national balance sheet as economic production unless their result was sold through some identifiable channel, even though the family would perish if they were not done.

The changes that modernization, or development , had wrought in the landscape over the past twenty years had tended to increase, rather than relieve, women's drudgery. Rising population had meant a heavier pressure of people on the land, which made it harder to grow enough food, further to walk to gather fuel, longer to fill the water pot from the trickle of water in the bottom of the well. It also swelled the casual labour force, making it harder for landless families -whose womenfolk routinely sought agricultural or construction site work -to make ends meet. Meanwhile, most of the opportunities for improvement had come the way of men. Agricultural development almost invariably meant cash crops, crops that could be sold by a national marketing board to pay the national import bill. Cash was for men, for the heads of household, the supposed providers. So agricultural extension workers visited the men, not the women, with advice about hybrid seeds, tools and fertilizer. Improved technology, training courses, credit to set up a mechanized mill or other food-processing business: all went to men.

Without education, women had no earning power. Yet the provision of everything needed to maintain the home and keep the children fed and clothed remained their responsibility. In a world in which it was becoming more and more difficult to manage without resource to cash, women were being thrust deeper and deeper into the cracks and crevices of society, losing status rather than gaining it. With all the demands upon them, it was scarcely surprising that when they leapt at the few opportunities they were offered, it was usually the ones that reduced their workload or improved their family comfort: a more convenient water supply, a tin roof for their hut, a chance to sell some handcrafts for cash. The lecture on nutrition or the injunction to bring a perfectly healthy toddler several miles to receive a vaccination shot which made him feverish and fretful rarely had the same appeal.

The priority need -the one women themselves felt -that their domestic load must be lightened first came forcefully home to Unicef in connection with water projects. The 1972 conference of government ministers held in Lomé, west Africa, on "Children, Youth, Women and Development Plans" was one of the first occasions in which the importance of a sure supply of drinking, water in transforming the situation of women was given forceful expression, and it was not a conclusion that Unicef, the convenor of the conference, had anticipated. Although improving family and child health was the underlying purpose of water and sanitation schemes, it began to emerge that their popularity with the women in the villages had more to do with convenience: their understanding of the connection between disease and impure water was very uncertain. As the years went by, Unicef's co-operation in water-supply programmes concentrated less on engineering and hardware, and more on women's involvement in public health. Without their participation and understanding, the full health benefits of water programmes could not be realized.

Another activity which helped to bring the role of women to the fore was applied nutrition. The only guarantee -and it was still only a partial guarantee -that green vegetables, eggs and milk grown on a family or a communal plot would find their way into the mouths of children rather than onto the local market was to equip women, not men, to cultivate them. In 1974, when the global food crisis was at its peak, Unicef turned its attention to household food processing and preparation. The tremendous outpouring of technologically-appropriate gadgets had mostly yielded improved tools for economic production: brick-making machines and better ploughshares. Unicef began to support the research and development of village technology for domestic labour-saving: bio-gas plants, fuel-efficient cooking stoves, rat-proof storage bins, the drying and canning of fruits and vegetables.

As the full weight of women's responsibilities became better understood, so did the inter-locking elements of women's overall predicament. Many hopeful schemes were languishing because women were not fulfilling their expected roles as instruments of community development. More significantly from the point of view of the economic planners, they were compounding their

problems by the large numbers of children they persisted in bearing. At a time when concern about population growth was dominated by frightening statistical estimates of the effect of exponential growth rates on dwindling planetary resources, Unicef helped to reinject the human dimension into the debate.

Labouisse's statement for the 1974 Population Conference in Bucharest argued persuasively that the population issue needed to be examined from the point of view of parents' decisions about family size. Apart from pride and joy in their children, parents in poor communities needed large numbers of children to swell the family workforce and ensure that enough survived to care for them in their old age. On the other hand, they were also beginning to worry about dividing shrinking landholdings into ever smaller portions among their male offspring and the expenses of schooling. But those who weighed up the pros and cons of family planning were usually men: the low status of women meant that they did not have much say in decisions about conception and pregnancy. No affect could be made on parental decisions about family size and spacing without taking these considerations into account and doing something about them.

The disappointing results of many family-planning campaigns opened the way to a new appreciation of women's status. Most modern contraceptive technology inhibited female, not male, fertility. Yet the women in poor societies, those who bore most of the world's children, were not stepping forward with alacrity to swallow pills and have loops inserted. Unless the male head of household began to feel children as an economic burden, rather than a value, he would not encourage his wife to go in for family planning. As women did all the work connected with rearing children, including carrying the economic burden for their food and dress, the men had little motivation to listen to the family planners. And a woman was most unlikely to oppose her husband; such an idea would not occur to her, however exhausted she was by child-bearing and however painful the prospect of another mouth to feed and little to put in it.

In certain places, in Kerala State in India, for example, the success of family-planning campaigns began to illustrate a connection between a woman's education and her susceptibility to family-planning advice. Some learning made a great difference to a woman's capacity to resist pressure from a husband or a mother-in-law. It also influenced how her children regarded her, and their attitude later in life towards the role of women. A sense of herself, of her own ability to do something and be something of her own encouraged her to consider spacing her children, of having a certain number rather than whatever number God and her husband conspired to send her. Once again, the attitudinal break-out from under heavy layers of fatalism was the trigger for behavioural change. Demographic researchers were beginning to establish that, apart from a leap in economic fortune, the factor correlating most closely with a drop in the birth rate was a rise in female literacy. Here was another means of advancing social goals without having to wait for the distant millennium of universal prosperity.

During the late 1970s, Unicef's practical emphasis for women continued to be on maternal and child-health care and nonformal education, within which responsible parenthood was an important strand. Women's lack of economic and decision-making power was still a problem Unicef felt reluctant to tackle specifically. There was support for vocational training and women's groups: sewing machines and cookery equipment were standard items in many country programmes. But the rationale behind their supply was not that they might permit women to enter the tailoring or catering business; rather that they could run up small garments for their children or ring nutritious changes in the family diet.

Attitudes were, however, rapidly changing. The Western ethnocentric view that women, no matter what their cultural environment or how perilous their hold on the means of survival, were primarily housewives who looked after children while their husbands went to work was finally being eroded. Concern about another social problem -the misery of life for increasing numbers of mothers and children in the slums and shanty towns of Third World cities -finally laid any residual prejudice to rest.

From: UNICEF: The Children and the Nations - Maggie Black (Sydney, Australia). 1986, pp419-425.

Special health needs of women (WHO)

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

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

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

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

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

In many countries women have been excluded from public life and its institutions for so long and so extensively that they are unlikely to be invited, or to attempt, to participate in spheres heretofore barred to them and, indeed, are often unfitted to do so. What are required, and most often lacking, are the mechanisms for increasing the participation of women in health endeavors at all levels. The lack of such mechanisms will contribute to the failure of many actions, whether these are at the grass-roots level (e.g. to improve mothers knowledge about oral rehydration treatment) or at the highest level, where the goal may be to recruit highly qualified women health professionals.

As a result governments and institutions, perhaps with the best of intentions, continue to define women's needs for them, without women having a say, thereby often leaving the real needs of women unanswered. A telling example is a report describing problems with women's programmes: "Women lack motivation. They are little interested in our housekeeping courses and our educational talks. They prefer to carry out their small trade in the street, which brings them some money, rather than attend classes." It is highly likely that the bit of money from street trading would be spent on food, schooling, clothing or other basic needs of their children. Perhaps a programme to help women increase their income-earning power would be more appropriate than housekeeping courses.

Simple measures designed to bring women into the needs assessment and decision-making processes at all levels might have prevented this type of situation and resulted in the identification of more relevant priorities and use of resources. Another example of failure to meet women's real needs is the maternal and child health clinic that is open only in the mornings- the busiest time of day for women.

Still more fundamental than the absence of mechanisms for drawing women into decision-making is the apparent lack of desire on the part of many to bring women into the mainstream at all. Social attitudes are the key obstacle to progress. Women themselves are often unaware of their basic rights, potential and needs, or are unwilling to pay the enormous social costs of asserting themselves.

There is also the male's reluctance to share familial responsibilities. For example, in a developed country with some of the most advanced laws on shared family responsibilities a law allows men extensive paternity leave that can be taken over a prolonged period; research, however, showed that in practice 78% of fathers did not take a single day of such leave.

Women could learn much from men in terms of defining needs, planning, and obtaining resources to better fulfil their responsibilities, particularly in the context of public and formal institutions. Men, on the other hand, have a great deal to learn from women about the practical

dimensions of implementing theoretical schemes. Until there is a full exchange and men and women can bring their respective experiences to the solution of the problems facing all people, health-for-all cannot be achieved.

The close of the United Nations Decade for Women must therefore be viewed as only a beginning. The following outline of forward-looking strategies indicates the measures necessary to overcome obstacles and constraints and build upon the important activities already under way .

National Strategies

Each Member State must analyse the situation of women at the local and national levels to determine the relevant major issues. No country can succeed in tackling all the problems at once. Each community, country and region must select its own priorities, and try to achieve what is feasible in a socioculturally relevant manner within the context of its particular possibilities, resources and constraints. The forward-looking strategies are thus meant to be guiding principles rather than detailed plans of action. They highlight approaches which would make a substantial contribution to progress not only for women, but for all people. They not only give examples of measures that can be taken, but indicate a way of thinking concerning the integration of women's issues within health programmes.

The national strategies encompass steps that can be taken within the context of primary health care, including measures to strengthen the health system infrastructures. The regional strategies are based on priorities identified within the regions that would support country needs and actions. The global strategies, in turn, are designed to provide maximun and appropriate support to the regions and Member States in their efforts to improve the situation.

(1) Health science and technology:

The following strategies are proposed with regard to the essential elements of primary health care:

Education concerning prevailing health problems and methods of preventing and controlling them

- ensure that messages meant to be received by women are relevant to their health priorities and are suitably presented;

- ensure that education is geared towards changing social attitudes and values that are discriminatory against women and detrimental to their health (e.g. attitudes against child spacing);

- ensure that women have access to appropriate health education that will enable them to better play their role as health providers, particularly at the family level.

Promotion of an adequate food supply and proper nutrition:

- facilitate women's access to and control over income to provide adequate nutrition for themselves and their children;

- foster activities that will increase awareness of the special nutritional needs of women, especially during pregnancy and while breast-feeding;

- promote the provision of social support to ensure sufficient rest in the last trimester of pregnancy and while breast-feeding;

- promote interventions to reduce the prevalence of nutritional anaemia in women, especially during pregnancy;

- encourage the changing of any discriminatory attitudes in the family with regard to food distribution for girls or women;

- provide appropriate information for women regarding family diet.

Adequate supply of safe water and basic sanitation:

- ensure that women are consulted in the planning and implementation of water and sanitation activities;

- ensure that women are trained in the maintenance of water supply systems;

- ensure that women are consulted with regard to technologies used in water and sanitation projects (e.g. in selecting pumps that are not too heavy for them to operate and durable enough to withstand continual use);

- conduct surveys of women's issues regarding community involvement and utilization of water supply systems or latrines;

- provide support to local women's groups to include water and sanitation activities in integrated programmes by furnishing supplies and equipment and co-operating in training and evaluation;

- ensure that women's local customs, preferences and traditions are taken into account through needs assessments (e.g. with regard to the design of new facilities such as latrines).

Maternal and child health care, including family planning:

- provide technical and methodological support to strengthen the maternal and child health and family planning component of primary health care; increase emphasis on the assessment, adaptation, development and field-testing of acceptable family planning methods and appropriate technologies addressing problems specific to pregnancy and delivery;

- support traditional practices that enhance the health of women and children (e.g. breast-feeding) and discourage harmful practices;

- promote fertility patterns that are not detrimental to women's health and that of their children, and the provision of appropriate information and services for family planning, including infertility;

- provide family planning advice and services, appropriate to the cultural setting, to adolescent girls to avoid precocious childbearing, which is harmful to women's health;

- promote behavioural and nutritional patterns that foster healthy pregnancies and appropriate infant and young child feeding;

- prevent and treat complications of pregnancy and childbirth;

- promote social support measures that will facilitate women's economic and family roles, such as day care for children, maternity leave and breast-feeding breaks, as well as care of the elderly;

- follow up recent recommendations of the World Population Plan, which reaffirmed the need to take measures to control mortality and morbidity, and to this end enhance the status of women in health and development through maternal and child health and family planning;

- give special attention to technologies for priority areas of women's health, in particular with a view to overcoming abuses and over-use of technologies in pregnancy and childbirth and ill effects of contraceptives;

- promote intersectoral activities that especially affect the health of women and children.

Immunization against the major communicable diseases

- collect and analyse information on immunization, according to sex, and promote health education to increase coverage in general and to reduce any differences in coverage between boys and girls;

- ensure that pregnant women are, or have been, immunized against tetanus.

Prevention and control of locally endemic diseases.

- ensure women's full participation in prevention and control programmes for communicable and noncommunicable diseases (e.g. in the family and through women's groups and organizations);

- develop and/or adapt socially relevant technologies, where necessary, for prevention and control.

Appropriate treatment of common diseases and injuries.

- ensure that services are conveniently located;

- ensure that services are available at times and on days of the week that are suitable for women, bearing in mind their work patterns;

- ensure that services can be afforded by women, especially the many women who are heads of households;

- ensure that the training of health workers includes education on the true nature and value of women's contribution to health care, and that this is reflected in the health workers' attitudes and behaviour, particularly in providing health information to women.

Provision of essential drugs

- ensure that, at the community level women are consulted in the implementation phase of drug action programmes;
- ensure that essential drugs are relevant to women's health needs and priorities;
- ensure that essential drugs specific to the health needs of women are available in the health facilities;
- ensure that essential drugs are accessible to women at appropriate times and distances;
- ensure that, in the case of local revolving fund schemes, women are members of the group which manages the fund;
- ensure that women are provided with appropriate information on drugs;
- prevent misuse of drugs that could be harmful to women's health or to the health of their offspring.

Prevention of mental disorders and promotion of mental health in women

- give special attention to the psychological factors that are important for women in relation to the utilization of health services (e.g. attitude of health workers, health care settings);
- give special attention to the social and psychological effects on women, as individuals and mothers, of development and technology which lead to changes in lifestyles and increased stress;
- devise ways of assessing the needs of special groups of vulnerable women (e.g. migrants, women whose husbands have migrated, and the urban poor), and promote measures for dealing with those needs (e.g. self-help and other community groups);
- ensure that primary health care workers are properly trained to recognize and treat mental health problems in women, and that women are treated in the same way as men with regard to mental health problems;
- promote research on the relationship between the mental health and psychosocial problems of women and developmental, behavioural and mental disorders in their children, including

studies on the incidence and nature of such problems, with a view to devising early intervention strategies;

- promote research on the prevalence and patterns of use by women of psychotropic drugs, with particular emphasis on reasons for abuse.

(2) Health systems infrastructures

Information gathered for evaluating health situations and trends and health systems should be suitable for assessing women's health needs. Data on morbidity and mortality should therefore be collected and analysed according to sex, and sex-specific socioeconomic indicators should be included in monitoring progress towards health for all. National and local capacities for the gathering and utilization of information should be strengthened, and women's organizations involved in these efforts.

Managerial processes for national health development should take women's issues into account, and women should be involved in all stages. Strategies are to:

- establish mechanisms for collaborations between various health services, heath institutions, and nongovernmental and voluntary organizations, with special emphasis on women's organizations;

- take measures to eliminate discrimination against women in filling middle and upper level managerial positions;

- ensure that women are equitably represented at decision-making levels.

Health systems research should be integrated within the managerial process, to generate appropriate knowledge to improve the planning, organization and operation of the health system, taking women's issues into account. Strategies are to promote research on:

- problems faced by women regarding the utilization of health services;

- women's roles as health care providers in the home and community;

- the relationships between health and women's work and time patterns;

- the integration of health activities within women's development programmes;

- the influence on health of social, economic and behavioural factors specific to women, to ensure that assumptions basic to health strategy development are realistic in relation to women's lives;

- the development of appropriate technology (involving women in developing criteria for the selection of technology, and in research to adapt technologies, develop new ones, and evaluate their effectiveness, safety and acceptability).

Health legislation facilitating the attainment of health objectives specific to women should be promoted. Strategies are to promote legislation to:

- protect maternity (e.g. paid maternity leave);

- prevent the abuse of women's bodies (violence, sexual exploitation, sexual mutilation);

- ensure working conditions for women which promote good infant and young child health and nutrition (e.g. regarding breast-feeding and care of children);

- prevent occupational hazards specific to women, especially in industries that employ mainly women;

- prevent abuses of technologies regarding women's health;

- control the marketing of substances harmful to women's health;

- prevent misuse of pharmaceuticals;

- provide back-up community support measures for women;

- fix a minimum age for marriage that is safe for childbearing.

Appropriate health care facilities should be planned, constructed and equipped so as to be readily accessible and acceptable to women - in harmony with their work and time patterns as well as their needs and perspectives.

Women are key human resources in the formal health care system. Strategies to redress existing imbalances and to raise the status of women as health professionals are to:

- ensure that women and men have equal training for all levels of health care and are equally remunerated;

- redress imbalances in the proportions of women in certain health professions where discrimination exists, and in the higher categories of the health professions;

- promote the training of women for managerial positions;

- ensure the utilization of all potential human resources (both men and women) for improved health.

Among the principles and approaches of primary health care and health-for-all that are particularly relevant to women, two stand out as being especially important: community involvement and intersectoral approaches.

(3) Community involvement

Communities in general, and women in particular, are already very actively involved in making decisions about their own health care and disease prevention. Activities at the community level should be based on what is already being done at that level in terms of health promotion, disease prevention and traditional forms of treatment. Health personnel should identify human and material resources in the community which could be used more effectively in the planning and delivery of formal health services, as well as to provide health information in such a way as to promote appropriate attitudes, beliefs and practices on the part of the community.

Education should be provided to women and women's organizations to make them aware of their rights and responsibilities for their own personal health care and that of their families, and to encourage them to demand health services that will meet their particular needs and concerns. Strategies to support women's organizations in health care activities are to:

- devise ways of involving women and women's organizations in decisions concerning the health system, at all levels;

- ensure that women's organizations are represented in national and local health councils or committees;

- encourage women's organizations to promote and participate in activities for (a) improving health care and social support measures for women; (b) improving employment and work conditions of women health care workers; (c) monitoring the health systems to ensure equity;

- encourage local women's organizations to participate in primary health care in their communities , in collaboration with the health system;

- devise ways of supporting women in taking responsibility for self-care as well as community care;

- take steps to change men's attitudes and increase their health knowledge, so that health care responsibilities, especially in the family, are shared by women and men;

- encourage young girls to be involved in health activities (e.g. through schools, clubs, and informal networks).

(4) Intersectoral approaches

The attainment of health targets is dependent on progress on the economic front, social policy measures aimed at greater equity, education as a promoter of self-care, improvement in the environment, the availability of adequate food supply, the implementation of appropriate population policies, and political and institutional changes enlisting the active co-operation of the public. Primary health care, with its emphasis on preventive and promotive action, requires the co-operation of sectors other than health. The intersectoral strategies regarding women, health and development are to:

- enact social policies that ensure equity in all aspects of development, particularly with regard to education and agricultural development;

- enact policies that will give women the social and economic freedom to space their children and limit the size of their families;

- establish mechanisms for intersectoral action, such as the representation of government departments responsible for women's affairs in multisectoral health councils and interministerial committees;

- provide resources, including small amounts of "seed money", to women and women's organizations at the grass-roots level to enable them to organize intersectoral activities and to continue carrying out and improving the effectiveness of the many such activities in which they are already engaged (e.g. organization and running of day care centres; preparing food for children whose mothers are away working running shared vegetable gardens; organizing and carrying out village clean-up campaigns; monitoring community water sources; receiving and being responsible for commercial credit or loan schemes that contribute to health);

- support intermediary-level community groups in carrying out activities such as: fund-raising for local projects; training and education programmes; providing facilities for local groups' actions; organizing programmes for day care, care of the elderly, legal and career counselling, consumer education; managing voluntary health and nutrition centres.

Monitoring progress

Significantly, many of the global indicators for monitoring progress towards health-for-all are of direct relevance to women and can be used to monitor progress in women's health and their participation in health development at the global and national levels -e.g. the proportion of infants with a birth weight less than 2500 g (an indirect indicator of nutrition and health in pregnancy); access to trained personnel for attending pregnancy and childbirth; and female literacy (a potent indicator of women's status, with a strong influence on their own health and that of their families, their fertility and their participation in health development).

Several other global indicators, if collected separately for each sex, would provide useful indications concerning women's and girls' health status - e.g. infant mortality, immunization coverage, weight-for-age, and life expectancy.

There are many other powerful indicators that can be used at the country level: of these, none is more telling than maternal mortality, which has been adopted as a regional indicator in five regions. Fertility rates, birth intervals, the proportion of first births taking place to very young women (under 18 years) or to older women (over 35 years), and availability or use of contraceptives are all good indicators of women's control over their own lives. Nutritional status indicators include data on weight-for-height, the prevalence of nutritional deficiency diseases, especially anaemia, and weight gain in pregnancy. Minimum legal age at marriage and/or the proportion of teenage women married, and the proportion of girls enrolled or attending school, are all status indicators directly related to health. The involvement of women and women's organizations at the primary health care level is important, but statistics on the proportion of women at the policy and decision-making level in the health sector are more telling of women's equitable participation.

As to infant mortality, it should be noted that biological and pre-natal conditions of the mother particularly affect mortality in the first months of infancy, and continue to affect morbidity and health status of both boys and girls in later life. Post-neonatal mortality and morbidity are more a reflection of environmental factors, particularly the microenvironment of the family, the psychosocial surroundings and caring behaviour that the family, in particular the mother, is able to provide.

From: Who: Report on women, health and development. (Geneva) 1987, pp5; 23-38.

ILO Standard on Maternity Protection

I. General background

There are two maternity protection Conventions -No. 3 of 1919 and No. 103 (Revised) of 1952, the operative clauses of which determine:

- 12 weeks of maternity leave (with possibility of extension if necessary);
- cash benefits during maternity leave;
- interruption of work for child-nursing during working hours (one hour per day); and
- prohibition of dismissal during maternity.

Recommendation No. 95 of 1952 aims at higher protection, e.g. 14 weeks maternity leave, higher cash benefits, more facilities for nursing care and employment security. The Maternity Protection (Agriculture) Recommendation, 1921 (No, 12), widened the scope of the protected group to include women employed in agriculture (Convention No. 3 was applicable only to women employed in industry and commerce). Part VII of the Plantations Convention, 1958 (No. 110), extends to maternity protection in the agricultural sector, adding two clauses to the earlier standards: prohibition of employing a pregnant woman if the work is harmful, and prohibition of dismissal because of pregnancy or childbearing.

Convention No. 3 of 1919 has been ratified by 28 countries -nine in Africa, nine in the Americas and ten in Europe[1]. Greece was the first country to ratify this Convention, which came into force on 13 June 1921. It applies to women employed in extractive industries, manufacturing, construction, transport and commerce. It provides for compulsory leave, of no less than six weeks after confinement, the right for women to cease working six weeks before the presumed date of confinement, two half-hour nursing breaks, benefits paid out of public funds or through an insurance scheme and the right to free medical care. It also prohibits dismissal during maternity leave. Convention No. 103 (revised) of 1952 has been ratified by 22 countries -two in Africa, six in the Americas, one in Asia and 13 in Europe[1]. It came into force on 7 September 1955 following its ratification by Uruguay and Cuba. Its main feature consists in the fact that it extends the scope of the earlier Convention to women employed in the agricultural and services sector, including women wage earners working at home. While maintaining a period of maternity leave of at least 12 weeks, six of which must be taken after confinemen, Convention No. 103 allows national laws or regulations to determine arrangements for the remaining six weeks. Moreover, whereas Convention No. 3 did not set any fixed amount for maternity benefits but merely required that they

should be "sufficient for the full and healthy maintenance" of the working woman and her child, Convention No. 103 establishes minimum cash benefits at a rate of not less than two-thirds of previous earnings.

Since Brazil and Uruguay denounced Convention No. 3 when they ratified that of 1952 and since certain countries have ratified both Conventions, the international standards have legal force in 39 countries. However, the impact which these international instruments have had on laws and regulations is far greater than the relatively small number of ratifications might suggest, and a great number of countries that have not ratified the Conventions have borrowed from them extensively in drafting their own maternity protection legislation.

The text of selected Articles from the relevant standards are cited below.

II. Relevant Articles

1. Duration of maternity leave

Convention No. 3 (1919) lays down maternity leave as six weeks before and six weeks after confinement, while Convention No. 103 (1952) stipulates compulsory six weeks after confinement, with a total of at least 12 weeks, but does not specify the duration of leave before confinement[2].

Convention No. 3 (Article 3); a woman:

"(a) shall not be permitted to work during the six weeks following her confinement;

(b) shall have the right to leave her work if she produces a medical certificate stating that her confinement will probably take place within six weeks."

Convention No. 103 (Article 3):

"2. The period of maternity leave shall be at least twelve weeks and shall include a period of compulsory leave after confinement.

3. The period of compulsory leave after confinement shall be prescribed by national laws or regulations, but shall in no case be less than six weeks; the remainder of the total period of maternity leave may be provided before the presumed date of confinement or following expiration of the compulsory leave period as may be prescribed by national laws or regulations.

4. The leave before the presumed date of confinement shall be extended by any period elapsing between the presumed date of confinement and the actual date of confinement and the period of compulsory leave to be taken after confinement shall not be reduced on that account."

2. Cash and medical benefits

ILO Convention No. 3 introduced the concept of paid maternity leave, the amount being determined by national legislation, provided the benefits are sufficient for full and healthy maintenance of mother and child.

Convention No. 3 (Article 3):

> *"(c)* shall, while she is absent from her work in pursuance of paragraphs (a) and (b), be paid benefits sufficient for the full and healthy maintenance of herself and her child, provided either out of public funds or by means of a system of insurance, the exact amount of which shall be determined by the competent authority in each country..."

ILO Convention No. 103 stipulates that "the rates of cash benefit shall be fixed by national laws or regulations", and if it is provided by compulsory social insurance, the rates must be at least "two thirds of the woman's previous earning".

Convention No. 103 (Article 4):

"1. While absent from work on maternity leave in accordance with the provisions of Article 3, the woman shall be entitled to receive cash and medical benefits.

2. The rates of cash benefit shall be fixed by national laws or regulations so as to ensure benefits sufficient for the full and healthy maintenance of herself and her child in accordance with a suitable standard of living.

...

4. The cash and medical benefits shall be provided either by means of compulsory social insurance or by means of public funds; in either case they shall be provided as a matter of right to all women who comply with the prescribed conditions.

...

6. Where cash benefits provided under compulsory social insurance are based on previous earnings, they shall be at a rate of not less than two-thirds of the woman's previous earnings taken into account for the purpose of computing benefits."

Women have the right to receive medical benefits according to Convention Nos. 3 and 103.

Convention No. 3 (Article 3):

"... as an additional benefit [a woman] shall be entitled to free attendance by a doctor or certified midwife."

Convention No. 103 (Article 4):

"3. Medical benefits shall include pre-natal, confinement and post-natal care by qualified midwife or medical practitioners as well as hospitalisation care where necessary; freedom of choice of doctor and freedom of choice between a public and private hospital shall be respected."

3. Nursing breaks

A nursing mother has the right to interrupt her working time to nurse her child for "half an hour twice a day", according to Convention No. 3; according to Convention No. 103, the length and frequency is to be prescribed "by national laws or regulations".

Convention No. 3 (Article 3): a woman:

"... shall in any case, if she is nursing her child, be allowed half an hour twice day during her working hours for this purpose."

Convention No. 103 (Article 5):

"1. If a woman is nursing her child she shall be entitled to interrupt her work for this purpose at a time or times to be prescribed by national laws or regulations."

Convention No. 103 states explicitly that the nursing break must be "counted as working hours and remunerated".

Convention No. 103 (Article 5):

"2. Interruptions of work for the purpose of nursing are to be counted as working hours and remunerated accordingly in cases in which the matter is governed by or in accordance with laws

and regulations; in cases in which the matter is governed by collective agreement, the position shall be as determined by the relevant agreement."

4. Prohibition of dismissal during maternity leave

During maternity leave (including the period of illness caused by pregnancy or confinement), women employees cannot be dismissed.

Convention No. 103 (Article 6):

"While a woman is absent from work on maternity leave in accordance with the provisions of Article 3 of this Convention, it shall not be lawful for her employer to give her notice of dismissal during such absence, or to give her notice of dismissal at such time that the notice would expire during such absence."

III. Table of ratifications of international labour Conventions concerning maternity protection and social security (minimun standards)

	Convention No. 3 of 1919[1]	Convention No. 102 of 1952[2]	Convention No. 103 (Revised) of 1952[3]
Africa			
Algeria	19.10.62		
United Republic of Cameroom	25.5.70		
Central African Republic	9.6.64		
Gabon	13.6.61		
Guinea	12.12.66		
Ivory Coast	5.5.61		
Libyan Arab Jamahiriya	27.5.71	19.6.75	19.6.75
Mauritania	8.11.63		
Niger		9.8.66	
Senegal		22.10.62	
Upper Volta	30.6.69		
Zambia			23.10.79
America			
Argentina	31.11.33		
Bolivia		31.7.77	15.11.73
Brazil	26.4.34[4]		18.6.65[5]
Chile	15.9.25		
Colombia	20.6.33		
Costa Rica		16.3.72	
Cuba	6.8.28		7.9.54
Ecuador			5.2.62
Mexico		12.10.61	
Nicaragua	12.4.34		
Panama	3.6.58		
Peru		23.8.61	
Uruguay	6.6.33[4]		18.3.54
Venezuela	20.11.44	5.11.82	10.8.82
Asia and the Pacific			
Mongolia			3.6.69
Europe			
Industrialised market economy countries			
Austria		4.11.69	4.12.69[5]
Belgium		26.11.59	
France	16.12.50	14.6.74	
Federal Republic of Germany	31.10.27	21.2.58	
Greece	19.11.20	16.6.55	18.2.83
Italy	22.10.52	6.6.56	5.5.71
Luxembourg	16.4.28	31.8.64	10.12.69
Netherlands		11.10.62	18.9.81[5]
Spain	4.7.23		17.8.65[5]
Sweden		12.8.53	

	Convention No. 3 of 19191	Convention No. 102 of 19522	Convention No. 103 (Revised) of 19523
Socialist countries			
Byelorussian SSR			6.11.56
Bulgaria	14.2.22		
German Democratic Republic			19.6.79
Hungary	19.4.28		8.6.56
Poland			10.3.76
Romania	13.6.21		
Ukrainian SSR			14.9.56
USSR			10.8.56
Yugoslavia	1.4.27	20.12.54	30.4.55
Middle East			
Turkey		29.1.75	
Total	28	19[2]	22

[1] The Maternity Protection Convention (No. 3), which was adopted by the International Labour Conference in 1919 and has been ratified by 28 States, came into force on 13 June 1921, following its ratifications by Romania. [2]The social Security (Minimum Standards) Convention (No. 102) which was adopted by the International Labour Conference 1952 has been ratified by 30 States, 11 of which have excluded Part VIII (maternity benefit) from their ratification (Barbados, Denmark, Ecuador, Iceland, Ireland, Japan, Mauritania, Norway, Switzerland, United Kingdom). The Convention came into force on 27 April 1955 following its ratification by the United Kingdom. [3]The Maternity Protection Convention (Revised) (No. 103), which was adopted by the International Labour Conference in 1952 and has been ratified by 22 States, came into force on 7 September 1955 following its ratifications by Cuba. [4]When ratifying Convention No. 103, Brazil and Uruguay denounced Convention No. 3. [5]Brazil and the Netherlands have ratified Convention No. 103, except in respect of occupations in agricultural undertakings, other than plantations; Austria has ratified the Convention except in respect of domestic work for wages in private households; Spain has ratified the Convention except in respect of women homeworkers.

Notes

[1] As at 31 December 1983

[2]The ILO Maternity Protection Recommendation, 1952 (No. 95), proposes a total of 14 weeks. Other measures include: 100 per cent cash benefit; nursing break of one-and-a-half hours; prohibition of dismissal from pregnancy to one month after maternity leave; and the woman's right to reinstatement in her former job, without loss of seniority rights or pay.

From: ILO Women at Work 2/84 pp 62-66 (Geneva)

RESULTADOS DE LA CAMPAÑA DE MORTALIDAD MATERNA

29 de Mayo de 1988: Inauguración del día Internacional de Acción por la Salud de la Mujer.

Es para nosotras un motivo de gran alegría dar a conocer los resultados de la Campaña de Mortalidad Materna en América Latina especialmente.

En esta publicación, nos referiremos sobre todo a nuestra región, ya que la Red Mundial de Mujeres por los Derechos Reproductivos ha hecho una publicación en que da cuenta de la respuesta de los grupos de salud en la mayoría de los países de otros continentes que participaron en la Campaña.

Más de 100 grupos y organizaciones de 45 países participaron ya sea organizando actividades, difundiendo el evento en los medios de comunicación, participando en charlas, mesas redondas, acciones callejeras, talleres y muchas otras actividades. En muchos casos la Campaña fue coordinada en un país a nivel nacional por uno o varios grupos durante un día, una semana o incluso durante el correr del año y también a futuro.

Queremos dejar constancia, en primer lugar, de la capacidad de los grupos de mujeres del Movimiento de Salud Latinoamericano e Internacional, de responder con entusiasmo, solidaridad y creatividad a nuestro llamado participando, de las más diversas formas en el Día de Acción Internacional por la Salud de la Mujer.

Creemos, en segundo lugar, que el éxito del Día Internacional de Salud de la Mujer comprobado a través de la respuesta a la Campaña en Contra de la Mortalidad Materna, demuestra el interés de las mujeres por temas que nos conciernen directamente en nuestra integridad física y psicológica a nivel personal, así como a nivel social en nuestra hermandad de sexo.

La Campaña, en tercer lugar, nos indica cómo la Redes que la coordinaron y el Movimiento de Salud Internacional son estructuras vivas que se alimentan de todas sus partes, aún aquellas que podrían parecer más pequeñas y periféricas, las que a su vez se alimentan de las Redes y del Movimiento. Tomar conciencia de esta interacción es un proceso histórico fundamental ya que va creando el impulso y la capacidad para efectuar acciones organizadas a nivel regional e internacional que tendrán más fuerza y alcance para presionar e influir en el tejido social.

En este sentido, durante la Campaña hemos encontrado respuesta de algunos organismos e instituciones de salud estatales abiertos y deseosos de participar directamente en ella. Países como Brasil son un ejemplo de esto.

Creemos que este tipo de acciones concertadas y su información posterior nos permitirá desarrollar lazos más visibles con aquellas mujeres y grupos de mujeres que trabajando en temas relativos a la salud de la mujer desean integrarse a la Red y al Movimiento; a ellas hacemos un llamado de participación en este espacio abierto que las espera. También quisiéramos invitar a las trabajadoras (es) y profesionales de la salud, a mirar nuestros problemas de salud reproductiva desde nuestra perspectiva. El personal médico y de salud tiene mucho que ganar, en lo que a humanidad y a conocimiento se refiere, si reconoce la necesidad de tomar en cuenta y respetar las vivencias de las mujeres sobre su enfermedad y su salud especialmente en lo que se refiere a la reproducción. Ayudarla a comprender su estado de salud o su enfermedad, es decir educarla, y a la vez, dejarse educar por ella en un mutuo intercambio, eriquecerá a ambas partes y servirá a la creación de una nueva visión de la mujer y de su salud.

Finalmente queremos recordarles que al impulsar la Campaña de Mortalidad Materna para el Día de Acción Internacional por la Salud de la Mujer estamos sólo comenzando a tocar un tema de vital importancia para nuestros derechos reproductivos y que el movimiento de salud internacional de mujeres con sus redes y grupos ciertamente seguirá alimentando.

Para dar a conocer la campaña hemos empleado las cartas de correspondencia con ambas redes, los artículos aparecidos en los diarios y revistas con anterioridad y posterioridad al Día de Acción y los testimonios de las mismas mujeres que se organizaron y participaron en sus países. Debido a que la Red de Salud participó en la reunión efectuada en Teresópolis, Brasil con mujeres del Movimiento de Salud Mundial, en el Simposio Tietze y en el encuentro de la Red Mundial en Río con el propósito de evaluar la Campaña de Mortalidad Materna, a principios de noviembre, nos fue posible entrevistar, a varias mujeres latinoamericanas que trabajaron en la Campaña.

Los artículos y noticias nos han parecido útiles no sólo porque impulsaron la Campaña misma, sino poque dan a conocer en algún grado, la situación y los problemas específicos referidos a la mortalidad materna y a la reproducción en países determinados de nuestra región.

Historia de la Campaña

Previo al Quinto Encuentro Internacional de Mujer y Salud, efectuado en San José, Costa Rica en mayo de 1987,la Red de Salud de las Mujeres Latinoamericanas y de Caribe, asistió al Pre Taller sobre Problemas y Estrategias para el Manejo del Embarazo Indeseado en América Latina financiado por la International Women's Health Coalition y coordinado por la Fundación SI Mujer de Cali. En el Pre Taller que transcurrió durante el 22 y 23 de mayo en las cercanías de San José, la Red de Salud propuso la creación de un Día de Acción Internacional por la Salud de la Mujer cuyo tema podra ser el de la Mortalidad Materna. Las representantes de los diversos grupos aprobaron con entusiasmo la idea.

Durante algunos talleres en el V Encuentro (el taller de la Red de Salud de las Mujeres Latinoamericanas y del Caribe, la reunión de las Católicas por la Libertad de Escoger y la reunión de la Red Mundial de Derechos Reproductivos) se propuso la creación del Día Internacional por la Salud de la Mujer cuyo primer año estaría dedicado a la Mortalidad Materna. La reunión de la Red Mundial por los Derechos Reproductivos fue crucial para fijar la fecha del día. Esta fue propuesta por el grupo feminista de mujeres japonesas "Soshiren" como el 29 de mayo, día en que justamente estábamos reunidas. Además se acordó que la coordinación de la Campaña de Día Internacional de Acción de Salud de la Mujer la haría la Red Mundial de Mujeres por los Derechos Reproductivos. A comienzos de septiembre la Red de Salud de las Mujeres Latinoamericanas y del Caribe/Isis Internacional le escribió a la Red Mundial para ver en qué forma concreta podría promoverse la Campaña de Mortalidad Materna.


EVITEMOS
LA
MORTALIDAD
MATERNA
28 de mayo
DIA de ACCION
INTERNACIONAL
POR LA SALUD
DE LA MUJER


EN MAYO DE 1987 SE REUNIERON EN COSTA RICA MUJERES DE TODO EL MUNDO PARA REVISAR LA SITUACION DE SALUD DE LAS MUJERES. EN ESA REUNION SE ACORDÓ DECLARAR EL 28 DE MAYO DE 1988 COMO EL DIA INTERNACIONAL DE ACCION POR LA SALUD DE LA MUJER. EL TEMA CENTRAL DE ESTE DIA ES EL DE LA MORTALIDAD MATERNA.
La mortalidad materna es la muerte de una mujer causada por complicaciones en el embarazo, el parto y el aborto inducido.
Se calcula que cada año mueren en el mundo UN MILLON de mujeres por estas causas. Casi todas estas muertes ocurren en los países más pobres y menos desarrollados (el "Tercer Mundo").
PROGRAMA DE SALUD

1


En el Perú mueren cada año aproximadamente 1,500 mujeres por causas relacionadas con el embarazo, el parto y el aborto.
Por lo general, los fallecimientos son causados por:
- infección después de un parto o aborto provocado.
- hemorragias.
- enfermedades causadas por presión alta (toxemia, eclampsia).
Así...
Tienen más probabilidades para sufrir estas complicaciones las mujeres mal alimentadas, las muy jóvenes o muy mayores, las que tienen muchos hijos o muy seguidos, las que tienen su primer hijo.

2


La mayor parte de estas muertes y enfermedades pueden evitarse, con un adecuado control del embarazo y una buena atención en los servicios de maternidad. También, previniendo los abortos en condiciones peligrosas para la salud de las mujeres.
Entonces, ¿Por qué ocurren tantos casos de muertes y enfermedades graves entre las madres?
Las razones son muchas y diversas:
Por un lado el embarazo, el parto, el post-parto y la lactancia demandan al cuerpo de la mujer una gran exigencia que la hace más vulnerable a una serie de afecciones.

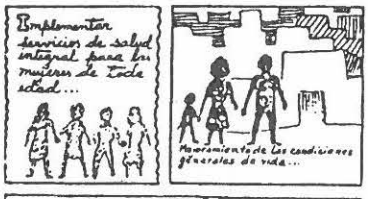
3


Cuando los embarazos, partos y períodos de lactancia son muchos y muy seguidos, el organismo de la mujer no tiene oportunidad de recuperarse y se va debilitando.
Muchas madres no comen lo suficiente por la pobreza y porque prefieren darle el alimento a los otros miembros de la familia.
De cada tres embarazadas, dos tienen anemia nutricional. Esto significa que están débiles.
POSTA
CERRADO
Las mujeres por costumbre y por vergüenza no buscan de su propia salud y no se mantienen regularmente durante su embarazo.
Muchas veces los servicios de salud no son adecuados. Los horarios son limitados. El personal no está bien capacitado para reconocer enfermedades o riesgos del embarazo a tiempo, no se da información sobre temas que importan a las madres.
No preocupes al doctor, ¡son mañas!
Por último, muchas madres se embarazan sin desearlo y recurren al aborto en forma ilegal. Si el aborto no es hecho por personal capacitado y en condiciones mínimas de higiene y seguridad para la mujer, éste puede provocar hemorragias e infecciones.

4

5

6



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From: Red de Salud de las Mujeres Latinoamericanas y del Caribe, Boletin 18-19 (Santiago de Chile) pp 2-3; 20-21