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FAMILY WELFARE PROGRAMMES
(COUNTRY STUDIES OF THE CARIBBEAN)

Unemployment of Women in Jamaica

In analysing the labour force absorption of women in Jamaica, an ILO study draws on three small surveys as well as historical and secondary material. It examines various factors influencing the sexual division of labour, the behavioural characteristics of the working population and the unemployed. Chronic poverty, inequality and rates of unemployment as high as 25 per cent have forced most lower income women into the labour market, many as rural migrants to Kingston, the capital. Women have also been forced by the loose, informal family structure into the position of being primarily responsible for the upbringing of their children. No less than three-quarters of children are now born to unmarried women, who can rarely count on the financial assistance of the father.

Women in the countryside have long migrated to Kingston to take jobs as domestics; they have also dominated petty trading, known as "higgling". Yet in other countries industrialisation and high levels of unemployment have forced large proportions of women out of the recognised labour force. That this has not occurred to anything like the same extent in Jamaica is due in part to the behavioural characteristics of male workers and, in turn, to the nature of available jobs over a long period, for a century and a half.

The nature of the jobs has scarcely encouraged the development of commitment to regular, career-oriented employment. Few men and even fewer women have had real access to industrial training, and it is a striking feature of Jamaica that, on average, women have acquired as much if not more schooling as men; among the working class it is women who have been more literate and supposedly qualified to gain access to semi-skilled industrial jobs. Women too have been employed in increasing numbers in the civil service, and it is only in certain professions that they have fared badly.

From: ILO: Women at Work, 1/83 (Geneva) p 24.

Father as Parents

According to a report published by the Equal Opportunities Commission, the existing legal provisions do not adequately take into account the involvement of fathers and paternity leave. It cites examples from Denmark and France where fathers are entitled to a short period of paid leave when their children are born. The report includes recommendations for image improvement and identifies key areas for medium and long-term reform. It also recommends the introduction of five days'paternity leave, stating that "The inclusion of fathers in the statutory scheme would also greatly increase the choices available to parents... A well-thought-out scheme of parental support would enable people to fulfil their commitments as parents and as employees. "One of its chapters, entitled "What is missing", discusses the needs of certain groups of the population such as non-employed mothers and fathers who are not usually included in the statutory provisions.

From: ILO Women at Work, 1/83, (Geneva) p 21.

Latin America and the Caribbean: Strategies to the year 2000.

Strategies proposed by the Organisation of American States (OAS) to overcome the problems faced by women in Latin America and the Caribbean include: job training for women; creation of instruments that improve their access to the job market; revision and expansion of regulations governing labour; and participation at the decision-making and managerial level of employment and labour. Of particular importance is the need to provide future employment opportunities for women in order to induce them to obtain the required educational levels, especially in regard to the nontraditional fields, such as scientific and technical studies at the professional level, or applied technologies in agriculture and industry. Occupational training for women should also include programmes towards self-employment such as appropriate technology for rural women, handicrafts, community organisation, co-operatives and management. As well, projects on the teaching of labour legislation to women should be initiated.

While much has been done in the field of legislation and administrative measures, means to monitor and enforce the implementation of relevant legislation needs to be developed. As well, further labour legislation is required to introduce standards regulating paid domestic and part-time work.

Child care is presently very limited in the region and in several countries laws require that child-care facilities be financed by employers, which can be counter-productive in that it causes additional cost for labour by women which could lead to discrimination. Day-care centres should be regarded as a social service and as such be financed by the whole of society.

Other strategies proposed include the creation of employment agencies for women; strengthening of organisations of women workers and professional women as a transitional measure to achieve mixed trade union and professional associations; and the promotion of a broader participation of women in the planning, managing and application of labour policy. It is also essential to strengthen the still weak and incomplete statistical information on women's employment and its features.

From: ILO: Women at Work, 1/86 (Geneva) p 32.

Dismissal on Pregnancy.

(Westinghouse v. Electrical, Radio and Machine Workers' Union, August 1980).

A lawsuit brought by the Electrical, Radio and Machine Workers' Union six years ago against the Westinghouse Corporation finally resulted in a settlement that will provide more than US$ 300,000 in back pay, plus appropriate seniority and retirement benefits, to present and former female workers who had been discriminated against due to pregnancy. Several employees terminated because of pregnancy will also be entitled to reinstatement in their job.

The Westinghouse Company was charged with a series of policies which discriminated against pregnant employees. These included denial of seniority during maternity leave, health benefits and forced unpaid maternity leave after a certain time-limit regardless of the employee's desire and physical capacity to work. Another discriminatory policy cited in the suit included rules which forced women to give the company written notice of pregnancy within the first five months. Failure to do so was considered to be grounds for dismissal.

Under the settlement the company also agreed to treat pregnancy-related disabilities in the same manner as all other disabilities; eliminate limitations on insurance coverage of certain medical procedures for pregnant workers (X-rays and laboratory tests); and to compensate workers if they not return to the same or a better job after maternity leave.

From: ILO: Women at Work, 2/1982 (Geneva) p 32.

Barbados

In April 1981, the rate of maternity benefit in Barbados was increased from 60 per cent to 100 per cent of average insurable weekly earnings. The Employment of Women (Maternity Leave) Act of 1976 stipulates the grant of a minimum of 12 weeks' maternity leave to female employees and for the protection of their jobs during such leave. It applies to all employees, including those in the public service, although in the latter case the maximum period of leave granted is normally four months. Maternity benefits are payable by the National Insurance and Social Security Scheme to which compulsory contributions are made both by the employer and the employee.

From: ILO: Women at Work, 2/1984 (Geneva) p 49.

Women and Ocupational Risks.

(Budapest, 16 to 18 February 1982)

A working group on "Women and occupational risks" organised by the WHO and the National Institute of Occupational Health in Budapest considered specific aspects of working women's health, including illnesses arising from exposure to toxic chemicals, biological, psychosocial and ergonomic factors. The working group could not agree on a definition of what is signified by "women of reproductive age", but examined medical implications of pregnant women's health at work. While there is some evidence of abortions, malformations of offspring for laboratory workers exposed to anaesthetic gases and "suggestive" evidence for workers exposed to lead, copper smelting, solder fumes, sterilising agents and plastic materials, there is a need for more research in some of these areas. On shift work, according to this group, women appear to be more susceptible to health problems-which may be connected to their domestic responsibilities.

From: ILO: Women at Work, 2/1982 (Geneva) p 35.

1- Embarazo y Parto

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El embarazo y parto en la adolescencia son fenómenos frecuentes en los países en desarrollo y aún en los no desarrollados. Si bien es cierto que históricamente el inicio de vida sexual activa ha sido común a temprana edad en la mayoría de las culturas, no es menos cierto que el cambio en los estilos de vida y la tendencia hacia una menarquia más temprana, así como los factores que favorecen una madurez sexual precoz y los elementos sociales asociados al desarrollo urbano, favorecen que un número mayor de adolescentes desarrolle vida sexual activa en unión estable o no, con un mayor índice de embarazo y parto en dicha población.

En la República Dominicana, donde la población adolescente en mujeres de 15 a 19 años representa el 26.9% del total de la población femenina y con un índice de unión consensual establecido en 24.6% es evidente un alto índice de embarazo y parto en esta población.

Es un grupo de alto riesgo obstétrico y prenatal, considerando que la población situada en el rango de los 10 a los 20 años difiere fisiológica y sicológicamente de niños y adultos, por consiguiente forma parte de un grupo distinto de individuos, en el que la incidencia de complicaciones asociadas es directamente proporcional a su desarrollo orgánico social y sicológico.

De ahí que se reporta una alta frecuencia de morbilidad y mortalidad, especialmente en áreas en desarrollo y considerando que no se han identificado en la mayoría de los servicios, acciones especiales dirigidas a este grupo en particular. Esto último es asociado a las dificultades sicosociales agregadas, especialmente en lo que se refiere a la incapacidad de la adolescente para identificar el grado de responsabilidad necesario y su capacidad para una respuesta adecuada al embarazo.

Veamos una revisión retrospectiva realizada de 5 años de servicios (1975-1980) a la adolescente embarazada en el Hospital de Maternidad Nuestra Señora de la Altagracia en Santo Domingo.

El análisis comprendió todas las variables que pudieran incidir sobre el curso clínico del embarazo y parto de las pacientes; datos sociales, antecedentes obstétricos, control médico, solución obstétrica, morbi-mortalidad materna y fetal.

Resultados y Comentarios

Se identificaron tres grupos de edad: un primer grupo con pacientes entre 12 y 14 años que representó el 4.5% de todos los casos (27 casos), un segundo grupo de 15 a 17 años que representó el 50.8% (305 casos) y un tercer grupo con pacientes de 18 a 19 años constituido por el 44.7% (268 casos). Llama la atención el número significativamente alto de pacientes entre 15 y 17 años y no es menos importante considerar que en el primer grupo se identificaron 27 pacientes (Cuadro No. 1).

Cuadro No. 1

DISTRIBUCION POR GRUPOS DE EDAD

GRUPO	EDAD	N	%
I	12-14	27	4.5
II	15-17	305	50.8
III	18-19	268	44.7
TOTALES		600	100.

Los antecedentes obstétricos se asociaron por grupos de edad, en el análisis relativo a gestas, observamos en el Cuadro No. 2 que el grupo I arrojó un 3.8% sin antecedentes de embarazo (23 casos); el grupo II (218 casos) era para un 36.3% y el grupo III, un número de (108 casos) 18%. Es importante señalar, en este renglón, que 4 casos del grupo I (0.7%) tenían el antecedente obstétrico de un embarazo y el grupo II, 19 casos (3.1%) tenían el antecedente de 2 embarazos, aumentando a 7% (42 casos) en el grupo III.

Cuadro No. 2

GESTAS
ANTECEDENTES OBSTETRICOS POR GRUPOS DE EDAD E HISTORIA OBSTETRICA

GRUPO	*1*		*2*		*3*		*>3*		*TOTAL*	*%*
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*		
I	23	3.8	4	0.7	-	-	-	-	27	4.5
II	218	36.3	66	11.	19	3.1	-	-	303	50.5
III	108	18.	106	17.6	42	7.	-	-	270	45.0
									600	100.0

En lo relativo a paridez, el análisis del Cuadro No. 3 nos revela sin antecedentes en el grupo I, 4% de los casos, en el grupo II, 226 casos (37.6%), en el grupo III, un 20% de los casos (120 pacientes). Es importantes comentar que en el grupo II un 1.6% de todos los casos tenía un antecedente de 2 partos y que en el grupo III se había incrementado a 38 casos que representa el 6.3% observándose con 3 o más partos en este mismo grupo hubo una frecuencia de 1.2% (7 casos).

Cuadro No. 3

PARIDEZ
ANTECEDENTES OBSTETRICOS POR GRUPOS DE EDAD E HISTORIA OBSTETRICA

GRUPO	*0*		*1*		*2*		*3*		*>3*		*TOTAL*	*%*
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*		
I	24	4.0	3	0.5	-	-	-	-	-	-	27	4.5
II	226	37.6	64	10.6	10	1.6	-	-	-	-	300	50.0
III	120	20.0	108	18.0	38	6.3	6	1	1	0.2	273	45.5
											600	100.0

Cuadro No.4

ABORTOS
ANTECEDENTES OBSTETRICOS POR GRUPOS DE EDAD E HISTORIA OBSTETRICA

GRUPO	*0*		*1*		*2*		*3*		*>3*		*TOTAL*	*%*
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*		
I	27	4.5	-	-	-	-	-	-	-	-	27	4.5
II	299	49.8	5	0.8	1	0.2	-	-	-	-	305	50.8
III	238	39.6	27	4.5	2	0.3	1	0.2	-	-	268	44.7
											600	100.0

Cuadro No. 5

CESAREAS
ANTECEDENTES OBSTETRICOS POR GRUPOS DE EDAD E HISTORIA OBSTETRICA

GRUPO	*0*		*1*		*2*		*3*		*>3*		*TOTAL*	*%*
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*		
I	26	4.3	1	0.2	-	-	-	-	-	-	27	4.5
II	298	49.6	7	1.2	-	-	-	-	-	-	305	50.8
III	256	42.6	11	1.8	1	0.2	-	-	-	-	268	44.7
											600	100.0

Los antecedentes de abortos y cesáreas no fueron muy significativos en la serie analizada, observándose como dato importante que en el grupo III hubo una incidencia de antecedentes de un (1) aborto sólo en el 4.5% (27 casos) y en lo relativo a cesáreas, en este mismo grupo, 1.8% (11 pacientes) de los casos tenían el antecedente de una (1) cesárea (Cuadros Nos. 4 y 5).

El 55.2% de todas las pacientes (331 casos) no tuvieron ningún tipo de atención prenatal. Con 1 a 4 consultas 33.6% (202 casos), con 5 ó más consultas únicamente pacientes para un 11.2%. Es evidente una falta importante de atención prenatal a estos pacientes por los factores comentados anteriormente, dado que el 88.8% de todos los casos tuvieron menos de 5 consultas que es el límite mínimo considerado para una atención prenatal adecuada. (Cuadro No. 6)

Cuadro No. 6

CONTROL PRENATAL
NUMERO DE CONSULTAS RECIBIDAS

Número	*Total*	*%*
0	331	55.2
1 - 4	202	33.6
5 - 8	60	10.0
5 - 9	7	1.2
TOTAL	600	100.

El análisis de la morbilidad prenatal (Cuadro No. 7) para las pacientes sin control, resalta la amenaza de parto prematuro con 92 casos para un 27.8% y la hipertensión arterial aguda inducida por el embarazo (Toxemia) representada por 68 casos que suman un 26%. Es evidente que estas dos patologías suman más del 50% de la totalidad y las mismas corresponden a series previamente publicadas, especialmente para países subdesarrollados. La morbilidad total en este grupo fue de 56.5%.

Cuadro No. 7

MORBILIDAD AL INGRESO, PACIENTES SIN CONTROL PRENATAL. T=331

TIPO DE MORBILIDAD	*N*	*%*
Amenaza parto prematuro	**92**	**27.8**
Toxemia leve	**30**	**9.1**
Toxemia moderada/severa	**31**	**9.4**
Eclampsia	**7**	**2.1**
RPM*	**11**	**3.3**
Abortos	**8**	**1.3**
Sífilis	**2**	**0.3**
Sufrimiento fetal agudo	**2**	**0.3**
Otros	**4**	**0.7**
TOTAL	187	56.5

El cuadro de morbilidad para las pacientes que tuvieron control prenatal, refleja una importante disminución en los elementos de complicación comentados previamente y como se observa en el Cuadro No. 8, sólo la hipertensión inducida por el embarazo es significativa, reportada en total en 21 casos (7.8%); sin embargo, el grado leve es el más importante (19 casos). La morbilidad total de este grupo fue reportada en 8.2% (22 pacientes).

Cuadro No. 8

MORBILIDAD DURANTE EL EMBARAZO, PACIENTES CON CONTROL PRENATAL. T=269

TIPO DE MORBILIDAD	*N*	*%*
Toxemia leve	19	7.1
Toxemia moderada	2	0.7
Sífilis	1	0.4
TOTAL	22	8.2

La morbilidad para este grupo de pacientes con control prenatal al momento de su ingreso al hospital (Cuadro No. 9) fue reportada en 42.1% (111 casos), observándose una alta incidencia de amenaza de parto prematuro, en el que en 58 casos (21.5%) fue el diagnóstico de ingreso, no hubo cambios significativos en los totales relativos a Toxemia leve; sin embargo, fue importante el aumento en los grados de hipertensión inducida por el embarazo en sus niveles de moderados/severa con 14 casos, para un 5.2%.

Cuadro No. 9

MORBILIDAD AL INGRESO, PACIENTES CON CONTROL PRENATAL. T=269

TIPO DE MORBILIDAD	*N*	*%*
Amenaza de parto prematuro	58	21.5
Toxemia leve	23	8.5
Toxemia moderada/severa	14	5.2
Rotura prematura membrana	14	5.2
Otros	2	0.7
TOTAL	111	41.1

Se hizo un cotejo total de la morbilidad prenatal observándose en 49.4% representada básicamente por amenaza de parto prematuro e hipertensión aguda inducida por el embarazo. Es evidente una alta morbilidad en estas pacientes, independientemente de acciones que favorezcan la adecuada atención prenatal, considerando sin embargo que en este último caso hay una significativa disminución de las complicaciones, especialmente en lo que se refiere a su gravedad (Cuadro No. 10).

Cuadro No. 10

TOTAL MORBILIDAD PERIODO PRENATAL T=600

TIPO DE MORBILIDAD	*N*	*%*
Amenaza parto prematuro	150	25.0
Toxemia leve	53	8.8
Toxemia moderada severa	45	7.5
Eclampsia	7	1.1
Rotura prematura membranas	25	4.2
Abortos	8	1.3
Sífilis	3	0.5
Otros	6	1.0
TOTAL	297	49.4

La edad gestacional al momento de producirse el parto fue la siguiente: de 38-40 semanas, 428 pacientes que corresponden al 71.3% de, 32 a 37 semanas, 25% (150 pacientes). Con menos de 32 semanas, 22 casos para 3.7%. Se puede observar la alta incidencia de parto prematuro, con una suma total de 172 casos (28.7%), eventualidad frecuente que produce consecuencias graves en las condiciones de salud del recién nacido y su desarrollo.

Se obtuvo parto vaginal en el 89.2% de los casos (535 pacientes), operación cesárea en 57 casos (19.5%), reportándose una cifra de 8 abortos (1.3%) que no necesariamente representan la incidencia de abortos para adolescentes en los años estudiados, sino revisados. De estos partos el 93.9% fue eutócico* y el 6.1% distócico,* representando los 57 casos de cesáreas el 100% de distocia* para el procedimiento (Cuadro No. 11).

Cuadro No. 11

TERMINACION DEL EMBARAZO

SOLUCION OBSTETRICA			*EUTOCICO*		*DISTOCICO*	
TIPO	*N*	*%*	*N*	*%*	*N*	*%*
Partos	535	89.2	501	93.9	34	6.1
Cesáreas	57	9.5			57	100.0
Abortos	8	1.3				
TOTAL	600	100.0				

La morbilidad intra-parto y post-parto se analiza en los Cuadros Nos. 12 y 13, observándose que para la primera lo más importante es lo relativo al APGAR* en el que encontramos que 35.7% de los casos (214 recién nacidos) tenía menos que 7 puntos, lo que equivale a un importante grado de morbilidad neonatal.

Cuadro No. 12

MORBILIDAD TOTAL INTRA-PARTO. T=600

TIPO DE MORBILIDAD	*N*	*%*
Apgar <7	214	35.7
Desgarre Perineal	50	8.3
Hemorragia	28	4.7
Obito Fetal	15	2.5
Retención Placentaria	3	0.5
TOTAL	310	51.7

Cuadro No. 13

MORBILIDAD TOTAL POST-PARTO T=600

TIPO DE MORBILIDAD	*N*	*%*
Hipertemia >38º	45	7.5
Abceso de Pared	24	4.0
Dehis Episiorrafía	18	3.0
Dehis de Pared	4	0.7
Shock Séptico	3	0.5
Amnioitis	18	3.0
TOTAL	112	18.7

Cuadro No. 14

MORTALIDAD MATERNA Y CAUSA PRINCIPAL ASOCIADA

CAUSA ASOCIADA	*N*	*%*
Sepsis	1	33.3
Sepsis + Eclampsia	1	33.3
Sepsis + C.I.D.	1	33.3
TOTAL CASOS	3	0.50

Las demás complicaciones corresponden a desgarro perineal, 8.3% (50 casos), hemorragia, óbito fetal,* retención placentaria para una morbilidad total de 51.7% que pudiera representar algún tipo de iatrogenia;* sin embargo, es evidente que el manejo del parto en la adolescente está asociado a una alta morbilidad infra-parto.

La morbilidad post-parto fue reportada en un 17.7% de los casos dada básicamente por hipertemia de más de 38%, 45 casos (7.5%) y por acceso de pared, 24 casos (4.0%).

Finalmente se reportaron 3 muertes que representan 0.5% del total de los casos en el que diagnóstico principal fue siempre Sepsis.*

Conclusiones

Es evidente que la adolescente embarazada representa un grupo de muy alto riesgo en su manejo médico, con una alta incidencia de morbi-mortalidad asociada, que refleja la necesidad de crear y desarrollar acciones que identifiquen plenamente los elementos para manejar este grupo de población, con criterios diferentes a los adultos, de forma tal que se disminuyan y contro en oportuna y adecuadamente, los factores determinantes de su problemática, especialmente la posposición de la primera relación, posposición del primer embarazo, ampliación del período intergenésico y supervivencia infantil.

GLOSARIO

- Parto eutócico	- Parto natural, normal
- Parto distócico	- Parto complicado, quirúrgico
- Distocia	- Relativo al parto natural
- Apgar	- Siglas del método utilizado para valorar el estado del recién nacido
-Obito fetal	- Muerte del feto intrauterino antes del parto
- Iatrogenia	- Daño producido por la intervención médica o de los medicamentos
- Hipertermia	- Aumento de la temperatura por encima de lo normal (37 º)
- Acceso de pared	- Infección localizada en el área quirúrgica (aplicada generalmente al área abdominal)
- Sepsis	- Infección

BIBLIOGRAFIA

1. BATTAGLIA, F.C.
Obstretic and Pediatric Complications of Teenage Pregnancy.
Pediatrics, 32:902, 1971

2. GISPENT, M. FALK R.
Sexual Experimentation and Pregnancy in Young Black Adolescents.
AM. J. Obstet Gynecol - Vol. 126:4; 1976

3. MONTGOMERY T.L.
Adolescent Sexuality and Panamariage
AM. J. Obstet Gynecol - Vol. 124:8, 1976

4. OBSTETRICS ASPECTS OF ADOLESCENT PREGNANCY AND DELIVERY
Int. Journal Vol. 15 - 1978

5. REGISTRER GENERAL'S ANNUAL REPORTS
England and Wales. 1971

6. SILUER T.S.
Adolescentes y Anticonceptivos (Versión Adaptada)
Bol. of Sanit Panam - Vol. 93:3 - 1984

7. FERRANOTTI, N.G.
Educación para la Salud en la Adolescencia. Relato de una Experiencia
Bol. of Sanit Panam - Vol. 97:3 - 1984

8. DAVIDSON, JR. E.C.
An Analysis of Adolescent Health Care and the Role of the Obstetrician - Gynecologist
An. J. Obstet Gynecol
Vol. 139:7 - 1981

9. PROGRAMAS DE PLANIFICACION FAMILIAR
Informes Médicos: Fecundidad Adolescentes. Riesgos y Consecuencias
Serie J No. 10 - Agosto 1976

10. CENTER FORDISEASE CONTROL
Family Planning Evaluation. Teenage Fertility in United States
Summary 1960 - 1970 - 1974
February 1978

11. RELACIONES PRE-MATRIMONIALES Y EMBARAZO EN LA ADOLESCENCIA
REPUBLICA DOMINICANA
Documentos 12-14 PROFAMILIA - 1982

12. SENDENOWITZ J., PAXMAN S.M.
Population Bulletin
Adolescent Fertility; Wordwide Concerns
Vol. 40:2 - 1985.

From: "Fertilidad en la Adolescente" En Familia Año III No.3, (Santo Domingo), pp 13-18.

Giving birth is safer now (Cuba)

The reasons behind the large drop in Cuba's maternal mortality are discussed in this contribution. Of particular value has been the establishment of maternity homes in which women from outlying districts can be accommodated near hospitals during the last two weeks of pregnancy. A substantial decrease in deaths from toxaemia is attributable to improved antenatal care and better socioeconomic and nutritional conditions.

Cuba's national health system was established in 1961, since when all health activities have been the responsibility of the Ministry of Public Health. In order to carry out their tasks, the health services were soon organized on a regional basis. The country was divided into health provinces, regions and areas, and a referral hierarchy was established, going from the most basic levels with limited resources (including health areas, polyclinics, rural health posts and rural hospitals) to an intermediate level consisting of regional hospitals, and finally to the top level comprising provincial or teaching hospitals.

'Maternal and child health care has been a priority from the outset, and special programmes have been carried out in this area. Not surprisingly, a striking aspect of the improvement in the general level of health over the past quarter century has been the fall in maternal mortality from 118 to 31 per 100 000 live births between 1962 and 1984 (Fig. 1).

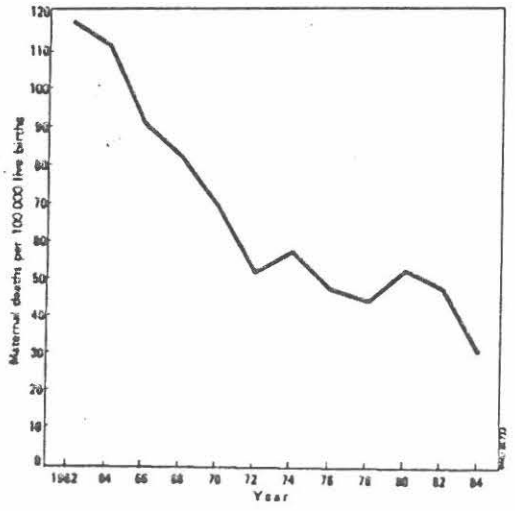

Fig. 1. Maternal mortality in Cuba, 1962–84.

One of the first steps towards reducing maternal mortality consisted of providing more health care at delivery by adequately trained staff in hygienic conditions. In order that delivery could occur in health institutions, a network of hospital services for the entire population was established. Special attention was given to rural areas, where access was difficult because of poor routes of communication. Most of the existing hospitals were enlarged and new ones were built in the rural areas. Maternity homes were set up in the vicinity of hospitals so, that women from areas that were remote and/or difficult of access could be accommodated during the last two weeks of pregnancy. Delivery does not take place in these homes, most of which are ordinary houses that have undergone some alterations and have 15 to 20 beds. The first was opened in 1962; by 1984 there were 85 with 1461 beds. Thanks to these homes, the proportion of deliveries in health institutions increased from 63% in 1963 to 99% in 1984 (Table 1).

Table 1. Live births in Cuban health institutions, 1963-84

Year	Live births in health institutions (%)
1963	63
1966	77
1969	89
1972	98
1975	99
1978	98
1981	99
1984	99

Antenatal care

Another very important step was to ensure that all pregnant women received antenatal care. In order to achieve this, the number of antenatal clinics was increased so that all localities were served. In urban areas, sufficient time was made available for consultations at polyclinics, and in rural areas antenatal consultations were provided at rural hospitals and health posts. A substantial proportion of antenatal care is provided by obstetric nurses, the first of whom graduated in 1963, and by general practitioners with obstetric training. A perinatal survey covering the whole country in the first week of March 1973 showed that only 0.9% of pregnant women went without antenatal care.

The number of antenatal consultations per delivery has increased, thanks to the opportunities for attending consultations and the educational work that has been carried out with the active involvement of the people. In 1965 there was an average of 4.1 consultations per delivery, and by 1984 the corresponding number was 12.5 (Fig. 2).

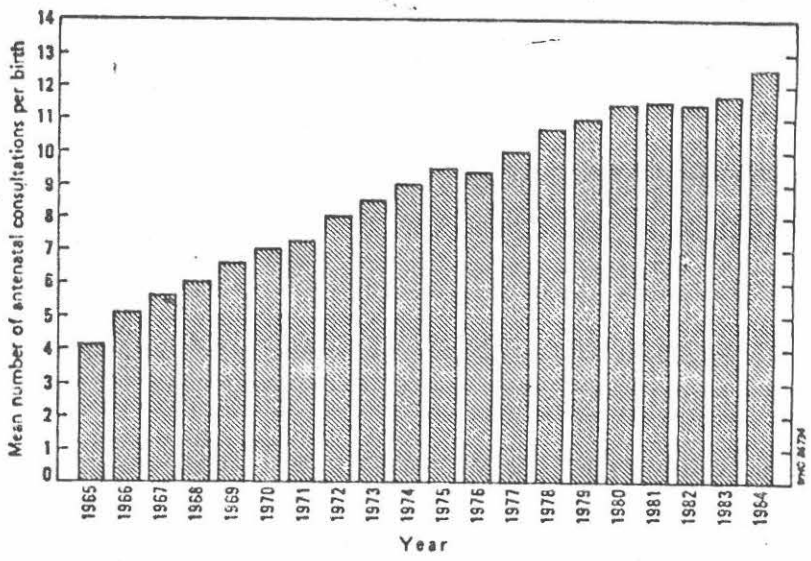

Fig. 2. Antenatal consultations in Cuba, 1965–84.

Antenatal care is entirely free of charge and includes analyses, tetanus immunizations, treatment for oral diseases, and the provision of some drugs, including iron and multivitamin preparations. Working women's wages are not reduced on days when they attend for antenatal care.

In 1981, according to data from an obstetric risk survey, 73% of pregnant women attended for antenatal consultations in the first 14 weeks of pregnancy, thus making possible the early detection of abnormal conditions (e.g., ectopic pregnancy, vesicular mole, and congenital malformations) as well as diseases that may endanger life, such as diabetes, heart disease, hypertension and sickle cell anaemia.

One of the first steps towards reducing maternal mortality consisted of providing more health care at delivery by adequately trained staff in hygienic conditions.

Risk approach

At the end of the 1960s the risk concept began to be applied: an attempt was made to single out certain groups for priority care. A classification of high obstetric risk, devised by Professor Sergio García Marruz, was introduced throughout the country. Four levels of risk were recognized in pregnant women:

- absence of risk factors;
- no past or current disease or complication, but presence of some unfavourable biological or social characteristic;
- no current disease or complication, but a history of problems in previous pregnancies;
- current disease or complication of pregnancy.

At the same time, corresponding levels and standards of care and a referral system were established within the framework of the regional structure of the health services so that the needs of each case could be met.

The high-obstetric-risk classification was replaced in 1975 by a scoring system. Scores in the range 1-8 are given in accordance with the maternal condition or disease presented. The total score falls into one of four risk categories:

- normal, 0-3;
- low risk, 4-7;
- medium risk, 8-10;
- high risk, 11 or more.

The scoring system like its forerunner, is used as a guide to care and referral.

The risk approach has made it possible to use nurses and general practitioners for obstetric care with an acceptable safety margin, and has led to a more rational use of resources.

In the last few years, the demand for obstetric care has been concentrated on the large provincial and regional hospitals. Thus in 1984, 82% of births took place in 38 maternity units,

each of which was responsible for more than 1000 deliveries a year. This is conducive to maintaining permanent medical duty rosters, operating theatres, blood supplies for emergency transfusions, anaesthetists, and so on.

Analysis of maternal deaths

The Ministry of Public Health decided as from 1962 to investigate every death related to pregnancy, delivery and the puerperium, including deaths outside hospitals. In the early years, a national commission met in the hospitals where maternal deaths occurred. Subsequently, it became possible to set up provincial commissions.

The detailed study of all maternal deaths has shown why and how they occurred. The investigation of a case by a specialist not previously involved with it, perhaps even by one from outside the hospital where the death occurred, offers the greatest likelihood of determining the cause of death and any unfavourable attendant circumstances.

From the outset, all the doctors in any hospital where there were deaths, or disorders leading to death, have participated in discussion of the circumstances. This has considerable educational value, since everything to do with pregnancy, antenatal care, delivery and the puerperium is covered. Furthermore, shortcomings in medical care are highlighted. The mistakes encountered have generally been attributable to failure to act in accordance with established standards, rather than to ignorance or lack of skill. The national application of obstetric standards arose out of the study and discussion of maternal deaths in this way.

Table 2. indicates the main causes of maternal death. The most striking changes have been in deaths from toxaemia of pregnancy and the puerperium, which fell from 35 to under 4 per 100 000 live births between 1960 and 1984, and in deaths from haemorrhage, which fell from 32 to under 2 per 100 000 over the same period. The decrease in deaths from toxaemia is attributable to improved antenatal care and improved socioeconomic and nutritional conditions. The increase in the proportion of births in large hospitals, where there is continuous medical surveillance and where blood banks are available for use in emergencies, has contributed to the decline in deaths from haemorrhage.

Table 2. Causes of maternal death in Cuba, 1960-84

Causes	Maternal deaths per 100 000 live births				
	1960	1970	1975	1980	1984
Toxaemias of pregnancy and the puerperium	35	6	11	4	4
Haemorrhage of pregnancy and childbirth	32	8	6	6	2
Abortion	14	22	12	15	5
Sepsis of childbirth and the puerperium	9	8	12	9	6
Other complications of pregnancy, childbirth and the puerperium	29	28	27	19	15

The decline in deaths from abortion in recent years is a result of the policy of providing facilities in hospitals for the interruption of unwanted pregnancies. Although contraception is widely practised, the rate of interruption of pregnancy is still high.

There has been no appreciable reduction in deaths from sepsis in the last 25 years. The likelihood of delayed and difficult deliveries among mothers aged over 30 accounts for a higher number of deaths from sepsis and amniotic fluid embolism among this age group. Caesarean section

The increase in the proportion of births in large hospitals has contributed to the decline in deaths from haemorrhage

is another risk factor: of the 54 deaths from sepsis between 1980 and 1984, 41 occurred after this type of delivery. There were 13 deaths due to anaesthetic problems associated with caesarean section during the same period.

Maternal mortality has shown variations in relation to age. For 1980-83 the lowest rate was among mothers aged 15-19 years; the rate increased with age to reach 191 per 100 000 live births among mothers aged 40 or over. Very young mothers under the age of 15 had an above-average mortality of 55 per 100 000; death from convulsive eclampsia was notable in this group, and also among mothers over 40. The incidence of deaths from haemorrhage and rupture of the uterus was relatively high among older mothers, possibly a reflection of multiparity.

The initiatives taken by the Cuban Ministry of Public Health in 1961 have been handsomely rewarded: maternal mortality is now about 75% lower than it was then. It should not be forgotten, however, that in addition to the technology made available for the direct care of women during and after pregnancy, improved socioeconomic conditions have contributed vitally to the successes achieved.

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From: World Health Forum, Vol.7 1986. WHO (Geneva), pp 348-352.

Community Health Workers (Haiti)

Effective primary health care is a grass-roots activity. Governments try to reach rural populations but often lack the personnel and mobilizing capacity necessary for a nationwide system. People seeking to meet their own needs can play a vital role in primary health care. The initiative described in this article was made possible by co-operation between a local Haitian priest and a private foreign organization. They succeeded in combining local and external resources, and inspired enthusiastic community participation.

In 1981 the government of Haiti initiated a training programme for community health workers throughout the country, with a view to bringing primary health care to more people. Trainees were selected from persons nominated by the communities to work under the supervision of nurses in nearby dispensaries. Training was given in the main district towns and lasted three months. It was intended that those successfully completing the course should become government employees. The original aim was to provide one trained community health worker for every 2000 people in Haiti, but the cost of the programme made this impossible. Some missionary health services took up the challenge of training community health workers as volunteers for rural communities not covered by the government scheme.

The 40 communities of the Leogane district, comprising 100 000 people, were in this situation. The area includes a chain of mountains ranging in height from about 1000 to 1600 m, and is accessible only on foot or horseback. The chief source of income is the land, which is cultivated by family labour. Women travel from the farms during the night to sell their produce at dawn in markets near Leogane. Most people go to local churches on Sundays to participate in both religious and social events.

Treatable ailments, including diarrhoea, worm infestation, childhood diseases, tuberculosis, pneumonia and traumas, are common. The treacherous terrain prevents quick, easy and safe transport of very ill people to the nearest hospital. Follow-up hospital visits by patients are almost impossible.

Birth of a training scheme

Community and church leaders from the 40 communities met with the president of the association of churches in the district of Leogane to discuss how affordable health care could be made more accessible and how health education could be obtained at community level so that serious ailments could be prevented. The International Nursing Services Association (INSA) was asked to help with the design and implementation of training for community health workers.

Mission groups in Haiti run a number of private, government-approved dispensaries and hospitals. One of the dispensaries is located at Darbonne in the Leogane district. Run by a priest, it is part of a missionary complex including primary and secondary schools for about 1000 children, technical training facilities for young men and women, and a church.

The first training sessions were held in the presbytery; 15 months later a specially constructed building was being used. Seven weeks of training were given to each of two groups of health workers, in three periods of 2 weeks and one of 1 week, at intervals of 3 months; during the intervals the newly acquired skill were practised.

Although the training format differed from that of the government, the actual content was based on the teacher's manual and 11 booklets on the main Haitian health problems used in the national programme. A set of booklets became the personal property of each community health worker.

The trainees

Forty-nine participants from various religious denominations were selected by the communities and churches to become the first health workers in their communities. Four were identified as having leadership qualities and a deep sense off commitment; they were given twice as much training as the others, by assigning them to both groups. They took part in co-training and teaching, and helped with practical exercises, role-playing, and supervision.

Several trainees had more than one occupation, and were encouraged to maintain this state of affairs because there was no assurance that they would become salaried. Neither the government nor the churches had the funds to pay them salaries once they had graduated.

Several trainees had more than one occupation, and were encouraged to maintain this state of affairs.

The programme

The government's job description for community health workers was the foundation for the competency-based curriculum. The philosophy of the primary health care programme at Darbonne was to encourage learning, to start at the level of the trainees, and to build upon what they knew. The first workshop started by considering community needs as seen by the participants. Better roads and more schools were the needs listed most often. When the health problems in the various

communities were drawn together, the participants were surprised at the similarities. Health-related customs and traditions were identified early and were discussed under the headings "harmless", "beneficial", and "harmful". Most customs were related to nutrition in small children and pregnant women.

Topics covered during the first week of training included first aid and techniques for interviewing and examining a sick person. These subjects were taught by means of exercises, role-playing, and demonstrations. Thanks to the collaboration and assistance of the four community health workers trained as supervisors, each participant received individual support and attention.

Changed behaviour was apparent during the third and fourth workshops. Participants became assertive and were more precise in their questions and answers. They spoke more readily about aspects of primary health care practice that could work in their communities.

During the fourth session, the participants were taught how to keep materials clean and sterile, and how to give an intramuscular injection. The techniques were reviewed in subsequent workshops and in follow-up sessions.

Although there was no political content in the course, the trainees developed a social and political awareness. They learned the power of group collaboration and came to understand more fully their place in the government health care system, and their self-confidence increased correspondingly.

Each community health worker receives additional money from treatment and medication charges.

Five of the original 49 trainees did not graduate: four dropped out of their own accord and one did not qualify. After graduation, the community health workers received a health kit including first-aid materials, condoms and essential drugs, and were expected to follow the Ministry of Health's standard requirements, e.g., filling in census forms and providing health coverage for 750 to 1500 people in the mountains, or 2000 people on the plain.

By the end of training, plans for continued support, supervision and follow-up of community health workers had been made in conjunction with another missionary group. At the same time the district medical officer and district nurse became the overall supervisors of the community health workers, at government expense. However, the four most direct supervisors, who had participated in the first training programme, were appointed from the community itself. Their current duties are

twofold: to follow up the graduate community health workers in the community, and to help the main INSA instructor with the training of new community health workers. The continued support of the community health workers has enhanced the success of these rural community initiatives. The supervisors meet every month with the health workers to discuss new approaches to primary care problems and to co-ordinate activities.

In any given month, each community health worker provides basic care for acute problems, e.g., fevers, diarrhoea, and worms, to an average of 15 people, in addition to carrying out preventive, educational and promotive activities. Referrals to the physician include patients with tuberculosis, bleeding ulcers, and pneumonia. Once diagnosed as having tuberculosis, a patient receives the prescribed streptomycin injections from a community health worker.

Income

No formal system for paying community health workers was devised during the planning sessions before training. Several alternatives came up during the programme . At first, it was proposed that the workers should be considered part-time primary health care volunteers, keeping their regular nonmedical employment. Once they obtained the health kit, a revolving fund was initiated. The community health workers sold medicines at a small profit, using a standard price list prepared by the Sainte-Croix Hospital, which sold the medications to the workers at subsidized prices. Price lists were posted in the communities.

Beginning in February 1984, each community health worker in the Leogane district received a stipend of 30 dollars a month from the Sainte-Croix Hospital. Each community health worker receives additional money from treatment and medication charges. A full 40-hour week is completed by only two of the community health workers, the others doing 20 hours on average. The workers also give health education out of a sense of community responsibility.

In March 1985, 43 of the 44 trained community health workers were still working as such. One had had to find other work for medical reasons. Thirty-nine were still working in the Leogane district and the remaining four were working at a separately supervised church mission in northern Haiti. As a result of these health workers' efforts, unnecessary hospital visits have been reduced and only the more severe cases are being referred to hospital. Many communities have established health committees and are now working on sanitation and health education projects.

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From: World Health Forum. Volume 7 1986. WHO (Geneva), pp 150-153.

Encomiable estrategia de población en Jamaica

LA JUNTA NACIONAL de Planificación de la Familia de Jamaica honró al FNUAP en un banquete que tuvo lugar en Kingston, Jamaica, en el cual se entregaron los premios de la Junta. Al aceptar un premio en nombre del Fondo, el Director Ejecutivo Adjunto Tatsuro Kunugi alabó los grandes adelantos logrados por Jamaica en la esfera de la población y el desarrollo.

Jamaica ha comprendido, dijo, que "todos los esfuerzos en pro del desarrollo se hacen para el pueblo y son obra de éste, de modo que las cuestiones de población guardan relación con todas las esferas de la vida humana y de la actividad nacional".

Encomió a esa nación insular por ser la primera de esa región en formular una política nacional de población y destacó la creación de una División de Población y Mano de Obra en el Instituto de Planificación de Jamaica.

El Sr. Kunugi señaló en particular los esfuerzos realizados por la Junta Nacional de Planificación para promover "un comportamiento responsable en materia de procreación". Esas actividades, declaró, no sólo mejoran la calidad de la vida de la mujer y de su familia, sino que también facilitan la integración de la mujer en "todos los sectores del desarrollo económico y social".

Observó que el enfoque innovador adoptado por Jamaica en lo que respecta a la población incluye programas para los jóvenes, un centro para mujer y medidas para integrar los factores de población en la planificación macroeconómica. En el centro para la mujer, que cuenta con asistencia del FNUAP, las adolescentes que son madres o que están embarazadas reciben instrucción en puericultura y planificación de la familia a la vez que siguen realizando estudios. El objetivo del centro consiste en procurar que las jóvenes se reintegren a la enseñanza escolar y en reducir las probabilidades de que tengan otro embarazo prematuro.

Las estadísticas muestran que Jamaica ha realizado progresos considerables en lo que se refiere a sus problemas de población. La tasa de natalidad bruta, que ascendía aproximadamente a 40 mil en el decenio de 1960, ha bajado a 31 por mil en 1974 y a 24 por mil en la actualidad. Asimismo, se calcula que el número de hijos por mujer ha bajado de siete en 1960 a tres hoy en día.

El Sr. Kunugi afirmó que el FNUAP se siente complacido de haber estado vinculado a los espectaculares progresos de Jamaica. También expresó la satisfación del Fondo por la estrecha colaboración que se ha establecido entre los diversos organismos externos que participan en los programas de población de Jamaica, en particular el Banco Mundial, la Agencia de los Estados

Unidos para el Desarrollo Internacional (USAID) y los donantes bilaterales como los gobiernos de Noruega y la República Federal de Alemania. Para terminar, el Sr. Kunugi dijo que el Fondo espera que las noticias sobre el éxito logrado en Jamaica se difundan a otras partes del mundo, "de modo que nuestra generación pueda lograr lo que todas las generaciones anteriores se han propuesto y han logrado, a saber, dejar a nuestros hijos un mundo mejor que el que heredamos".

- Mientras estuvo en Jamaica, el Sr. Kunugi entregó un reloj de población al Primer Ministro de Jamaica, Edward Seaga.

From: Población, Boletín del FNUAP, Vol.14 No.1, Enero de 1988 (New York).

Mesa Redonda Mujer y Salud

Jenny García

COLECTIVO MUJER Y SALUD

Como representante del feminista Colectivo Mujer y Salud en esta mesa redonda, lo que me toca decir es en su mayoría crítico. Por el hecho de ser la salud de un país el reflejo de la realidad económica y social que vive, y constituir la mujer dominicana casi la mitad de la población (49.2% en 1986), urge cada vez más la necesidad de profundizar en el análisis de su realidad global y específica como es el área de la salud, ya que la mujer es la principal demandante de esos servicios, como usuaria directa o porque generalmente lleva sus hijos o acompaña al hombre al médico (tradicionalmente ha sido la responsable de la salud familiar), como brindadora de servicios (odontología, farmacéutica, bioanalista, enfermera) y ser convertida en el blanco preferido de los programas de prevención y educación para la salud, higiene, alimentación, planificación familiar y experimentos.

Esta criticidad está determinada entre otras cosas por:

1. La naturaleza y calidad de la atención y tratamiento médico en aquellas áreas que inciden más directamente sobre la vida de las mujeres: examen ginecológico, anticoncepción, aborto, sexualidad, parto, psicoterapia.

2. La estructuración del sistema de salud, que desde el surgimiento del capitalismo ha estado determinado por las necesidades de reproducción del sistema, constituyendo un arma poderosa de la ideología sexista al igual que la iglesia y la educación, en este sentido es importante señalar que nuestro sistema de salud fue estructurado modernamente en 1916 con la intervención norteamericana, producto de intereses específicos de esa época, por consiguiente, no escapa a la estructura económica y social capitalista donde el poder está concentrado arriba en instituciones monopólicas, fomentando el desarrollo y la confianza hacia la tecnología médica sofisticada la excesiva especialización y división del trabajo y el flujo de fondos para proyectos de investigación extravagantes (que con frecuencia implican la experimentación con pobres, minorías y la mujer de clase obrera). Así como desmenuzan el trabajo en pedazos, también fragmentan la distribución de la atención a la salud (servicios diversos basados en la capacidad del paciente para ganar) y del cuerpo con las especialidades. El proceso salud-enfermedad se explica en términos biológicos e individuales y no inmerso en un contexto social, con determinantes económicas, políticas y sociales; centralizan la investigación y el tratamiento en las bases orgánicas de la enfermedad evadiendo de esa manera las causas sociales de casi todas las enfermedades, además aquellas enfermedades en

que no pueden dar la explicación biomédica específica la califican de funcional o psicosomática, tratando con placebos y tranquilizantes.

3. La interacción médico-paciente es paternal o autoritaria, conscientes de que también se da en el hombre, pero en la mujer las actitudes son exageradas, sospechan que la mayoría de los problemas son sicosomáticos.

4. La mujer ocupa los escalones más bajos de la jerarquía médica, es mal pagada y tiene poco poder y voz. A pesar de que nuestra constitución establece la igualdad de derechos civiles y políticos, siguen vigentes disposiciones y leyes que dicriminan a la mujer. Las estadísticas revelan una marginación dentro de la administración pública, son escasas las directoras de hospitales, no conocemos la existencia de secretarias de Estado de Salud, ni presidentas de la Asociación Médica Dominicana (AMD).

Si revisamos un poco las actuales políticas de salud de nuestro país observamos que están dirigidos a enfatizar programas hacia grupos que corren mayor riesgo de enfermedad y morir (madre, niño, indigentes), extender la cobertura, con racionalización de recursos existentes y regionalización, iniciando sistemas locales de salud, rehabilitando centros deteriorados, suministro de medicamentos, servicios especializados en hospitales locales y otras características.

El programa materno infantil contiene una atención médica preventiva y curativa asegurando la atención prenatal y postnatal, atención del parto, lactancia materna, control del crecimiento y desarrollo del niño, control del bajo peso al nacer, alimentación básica, inmunización y planificación familiar; a pesar de esto, los problemas relevantes continúan siendo la alta tasa de mortalidad general, materna e infantil, desnutrición, incluso se observa una disminución del control prenatal, de 508,687 en 1984 1 290,947 en 1987, con múltiples factores que afectan la calidad y el acceso a la misma: horario matutino, poca concientización a la ciudadanía, gasto de pasaje, médicos no especializados, etc.

La tasa de mortalidad materna lleva una tendencia ascendente, oscilando entre 0.5 y 0.7 por 1,000 nacidos vivos. Las principales causas para el año 1985 eran: toxemia, aborto y las hemorragias del embarazo y el parto, todas en su mayoría evitables.

La respuesta a toda esta situación es multifactorial, sumándose entre otras: un número de médicos menor de 7 por 10,000 habitantes para el sector público, mientras a nivel privado es de 50 por 10,000, aún triplicándose el número de médicos en 8 años (1974: 1,311 y 1982: 3,555). La desconfianza en la calidad de atención, por la escasez de equipos y personal no especializado (hay 6 gineco-obstetras por 3,575 mujeres en edad fértil en el sector público, mientras a nivel privado es de 6 por 219 mujeres en edad fértil) sobre todo en los hospitales locales y de área, a pesar del

aumento en el gasto per cápita de salud (RD$11.38 en 1980 a RD$14.55 en 1985) no expresado en términos reales por la devaluación monetaria. Un presupuesto que no se ajusta a la situación económica actual, no correspondiendo a los lineamientos de las políticas nacionales de salud, donde la mayor parte se orienta a gastos corrientes, sueldos, salarios y a la atención de los hospitales sobre todo los especializados, lo cual conlleva al deterioro de la cantidad y calidad de atención, por consiguiente al aumento de la demanda de servicios privados. Todo lo anterior, envuelto en la crisis actual que vivimos se refleja en el sector salud, el cual al no constituir un servicio productivo deja de ser prioritario.

Con este preámbulo, particularizando en lo que a nosotras nos atañe, ¿qué podemos decir? -que los programas de atención materna e infantil se limitan a nuestra etapa reproductiva, desvinculando nuestra salud de todo lo que nos rodea ya sea el medio ambiente, el trabajo dentro o fuera del hogar. Incluso relacionando el trabajo asalariado con nuestra salud, sobre todo reproductiva, nos encontramos desprotegidas, por ejemplo: la embarazada no tiene garantizado el ausentismo laboral propio del chequeo prenatal, no está protegida de los efectos de sustancias teratogénicas, no tiene reducción de la jornada de trabajo sobre todo en aquellos que conllevan posturas incómodas o cargas mayor de 10 Kgs., no tenemos facilidades públicas para aliviar la doble carga de trabajo: guarderías, comedores, lavanderías.

Dejan en franca libertad de actuación a las industrias aún tomando actitudes abusivas como son el despido si se embaraza, o aceptación en el mismo ya con familia formada o sin hijos. No existe énfasis notable en los programas de detección del cáncer cervical, ni de la lactancia materna como lo hay en los programas de planificación familiar.

Es necesario revisar las políticas demográficas, el control de natalidad, más que planificación familiar, que no sólo deben ser dirigidos a la mujer (como sucede en la mayoría de los casos) ya que la procreación es responsabilidad del hombre y la mujer.

Por ser el aborto la principal causa de muerte en América Latina, aunque en nuestro país ocupe el segundo lugar, no podemos dejar de mencionarlo, no queremos que la mujer tenga un hijo no deseado, ni corra riesgos inútiles para su salud y vida con los abortos clandestinos. Nuestro objetivo es que no haya abortos, pero sin prohibiciones, ni condenas, sino que a través de la anticoncepción libremente escogida, la mujer sea quien controle su cuerpo, su vida, su maternidad. Es necesario despenalizarlo ante el sorprendente número de muertes o esterilidad permanente a que se ven sometidas nuestras jóvenes mujeres, consecuencia de la exposición al aborto en pésimas condiciones, sin ninguna garantía.

Los programas de formación médica, donde a la mujer se le enseña a reproducir los mismos patrones del hombre, tornándose poco solidaria, agresiva, autoritaria, deben ser objeto de análisis y reformulación.

Creemos que los problemas de nosotras con respecto a la organización y prestación de servicios de salud, no pueden resolverse dentro del sistema médico aislado, es un punto más donde se refleja la opresión social de la mujer, por consiguiente sus soluciones están enmarcadas dentro de los cambios sociales requeridos, teniendo presente las condiciones de vida: laboral, económica, familiar, afectiva, social.

Ante todo lo que nos rodea ¿qué hacemos nosotras?

- Trabajamos en los grupos de autoayuda o autoconocimiento de nuestro cuerpo, de nuestras vidas, en un ambiente de apoyo mutuo y responsabilidad colectiva. La autoayuda nos da argumentos para evaluar las instituciones, cambia nuestra imagen de nosotras mismas, nos da seguridad, autonomía, fortaleza.

- Creemos en la educación recíproca, vivencial (talleres, intercambio con otros grupos).

- Propugnamos por el rescate de ls parteras.

- Priorizamos en la medicina preventiva y no curativa.

- Incluimos en el tratamiento de las enfermedades la medicina folklórica o popular, dígito-puntura, etc.

- Denunciamos los abusos en las cirugías: cesáreas, cirugías pélvicas, etc., el uso de medicamentos nocivos a nuestra salud, por ejemplo la depoprovera.

- Compartimos y divulgamos información sobre nutrición, la salud mental, sexualidad, etc.

From: Informe General, Seminario Taller situación Socioeconómica y Jurídica de la mujer dominicana. UNICEF y la Dirección General de Promoción de la Mujer (DGPM) 1988 (Santo Domingo) pp 61-65.

What are the main trends in public health world-wide?

Maternal mortality continues to reap its horrifying harvest in developing countries at the rate of 500,000 deaths every year as compared with 6,000 deaths in the industrialized countries. But statistics for the developing countries, where more than 99% of the maternal deaths world-wide occur, are only approximate estimates based on the available national figures. "Success stories" are few and far between, and the overall situation in the developing world is far from being satisfactory. The Annual shows a clear correlation between maternal mortality rates and high fertility. In Africa, "the average number of live births per woman is 6.4. But in rural Africa it is quite common for a woman to have given birth to eight live babies and to have been pregnant several more times. Such a woman has a lifetime risk of dying from pregnancy related causes of at least 1 in 15." But in sheer numbers the worst situation is in Asia, where about one-third of a million maternal mortality cases occur every year.

From: Press Release WIIO/10 20/2/89 (Geneva).

Infant mortality rates[a/] 1970-2005

Country group	*Number of countries*	*1970-75*	*1975-80*	*1980-85*	*1985-90*	*1990-95*	*1995-2000*	*2000-05*
Developing countries								
North Africa	5	136	115	95	81	67	55	45
Sub-Saharan Africa	44	142	130	122	112	102	93	84
South and East Asia	19	124	116	103	93	84	74	65
South Asia	7	137	129	115	105	95	84	74
East Asia NICs	3	43	32	27	23	19	16	14
Others	9	92	82	73	64	55	47	39
West Asia	13	118	104	95	85	73	62	53
Mediterranean	4	117	100	79	66	56	46	38
Western hemisphere	28	80	71	63	56	50	44	40
Sub-total, developing countries	**113**	**121**	**111**	**100**	**91**	**82**	**74**	**66**
China and Asian planned economies	4	64	46	42	35	30	25	21
Least developed countries	34	146	140	133	124	114	104	95
Developed market economies	25	25	21	18	16	14	13	11
Centrally planned economies of Europe	8	27	27	24	21	19	16	14
Total, developed	**33**	**26**	**23**	**20**	**18[b/]**	**16**	**14**	**12**
World total	**150**	**93**	**85**	**78**	**71**	**64**	**57**	**51**

Source: Department of International Economic and Social Affairs of the United Nations Secretariat, based on quinquennial averages for individual countries, United Nations, World Population Prospects - Estimates and Projections as Assessed in 1984, New York, 1986, Sales No. E.86.XIII.3., annex II, and supplementary data bank. The projections for 1985-1990 and thereafter are based on the "medium variant" projection for each country.

a/ Number of deaths of children less than one year old, per 1000 live births. Country group averages are calculated from individual country life expectancies weighted by number of births.

b/ 14 excluding South Africa.

Government health expenditures per capita, in 1980 U.S. dollars (number of countries)[a/]

Country group	Total outlays 1980 All countries		Total outlays 1980 Countries with data for 1985		Total outlays 1985		Final consumption expenditure number of countries	Final consumption expenditure 1970	Final consumption expenditure 1980	Final consumption expenditure 1985
Developing countries										
North Africa	18.57	(4)	10.55	(2)	13.03	(2)	(2)	9.49	29.86	30.07
Sub-Saharan Africa	5.63	(16)	8.09	(8)	7.76	(8)	(18)	6.53	6.70	7.18
South and East Asia	3.03	(10)	2.96	(9)	3.93	(9)	(9)	1.27	2.18	3.09
South Asia	2.16	(4)	2.16	(4)	3.13	(4)	(4)	1.01	1.52	2.41
East Asia NICs	7.75	(2)	7.75	(2)	10.39	(2)	(1)	0.62	3.11	2.98
Others	5.08	(4)	5.14	(3)	5.91	(3)	(4)	5.26	10.74	12.47
West Asia	118.10	(2)	118.10	(2)	151.39	(2)	(4)	14.79	48.41	45.41
Mediterranean	175.41	(2)	175.41	(2)	135.34	(2)	(3)	8.80	17.20	18.09
Western hemisphere	39.59	(8)	39.39	(3)	37.21	(3)	(8)	21.17	23.37	27.35
Sub-total, developing countries	8.70	(42)	7.39	(26)	7.63	(26)	(44)	3.78	6.73	7.75
Least developed countries	1.86	(13)	1.69	(7)	1.84	(7)	(12)	2.37	1.96	2.17
China	5.71	(1)			b/			b/	b/	b/
Developed market economies	594.24	(23)	594.24	(23)	609.21		(15)	268.60	452.25	501.80

Source: Department of International Economic and Social Affairs of the United Nations Secretariat, based on country data from United Nations Statistical Office, National Accounts Statistics data bank tables 2.1, 2.3, 2.5; IMF, Government Finance Statistics Yearbook 1987, p. 98, and World Bank, Financing Health Services in Developing Countries, Washington D.C., 1987, Table 3, p. 16

a/ Country group averages are weighted by population

b/ No data reported

Trends in social welfare policy

The scope, complexity and costs of publicly sponsored social security and social welfare services and programmes have increased significantly in many parts of the world, although their scope and coverage remain limited in most developing countries. Social welfare concepts and practices have also been the object of considerable debate and rethinking in recent years.

Spending on a broadly defined category of social welfare programmes, including social security, has increased steadily in real terms since the late 1960s, typically at rates faster than economic growth or total government expenditure. By the mid-1980s, social welfare spending by central and local government together was the equivalent of about 14 per cent of total output in developed countries and about 6 per cent in a small sample of the developing countries, though only 3 per cent and 1.5 per cent for Africa and South and East Asia, respectively.

In the developed countries social security and welfare services are recognized as essential elements in the social advances that have been made. However, their rapidly rising costs have been a cause of concern, and some have come under scrutiny for their alleged inefficiencies and failure, despite the resources they absorb, to provide for those most in need. Expansion and increased costs are built into most systems, while budgets are likely to continue to be restricted by slow economic growth. Administrative complexity pushes up delivery costs. Services are labour intensive, and increased professionalism and training escalate unit costs. Increasing numbers of middle class people use services, particularly in a period of slow growth in personal income. Changing age structures, especially the aging of the population, add a new element, which will be progressively more significant. While the increased costs associated with an aging population may be offset by savings in maternity, child and youth services, this will require a major redirection of resources and retraining of personnel. Partly inspired by the drive to greater economy, but reflecting also changes in professional views as to the most appropriate forms in which care is to be provided, institutionalization of people who cannot support themselves is being de-emphasized in favour of community-based and family-based support. Perhaps the most significant trend is greater prominence for prevention and rehabilitation, to enhance people's capacity to function independently, effectively and productively.

In many developing countries the need for social welfare services is increasing with the spread of urbanization, migration, changing family and kinship support systems, and greater female participation in the modern economy. But as recession and economic decline in some areas are placing greater demands on the typically limited capacity of existing public systems, governments are seeking ways to maintain existing family support systems. Social welfare programmes are increasingly taking on a developmental character, with an emphasis on creating income-earning

opportunities for the poor, vulnerable, dependent or disabled. Even limited resources can have significant economic benefits if used for prevention, maternal and infant care, immunization against childhood diseases, and supplementary feeding for pre-school and school children, as well as some rural community services. To replicate such programmes in large numbers would require a redirection of resources from urban, often middle-class oriented services, with all that this implies.

The family

The family as a basic social unit has undergone profound change, but with no uniform pattern. From an economic perspective, the most important changes are those related to family formation and fertility, the family as a system of support and the supporting services that families increasingly need in order to function effectively in a changing environment. In developing countries the role of the family as a production unit and source of employment continues to be of major, though diminishing, importance.

The extent to which the family, nuclear or extended, has been eroded as an effective social support system is the subject of considerable debate. Lack of precise information on the actual support rendered by family members for each other tends to make the discussion conjectural. It is probably safe to say that in the developed countries the family as a support institution has not been eroded as much as is commonly supposed, whereas in developing countries the stereo-type of the self-sufficient family is no longer an entirely accurate reflection of reality. In the areas of education and health, families are probably making a greater contribution than at any previous time, although family members receive a greater proportion of their total education and health services ouside of the family.

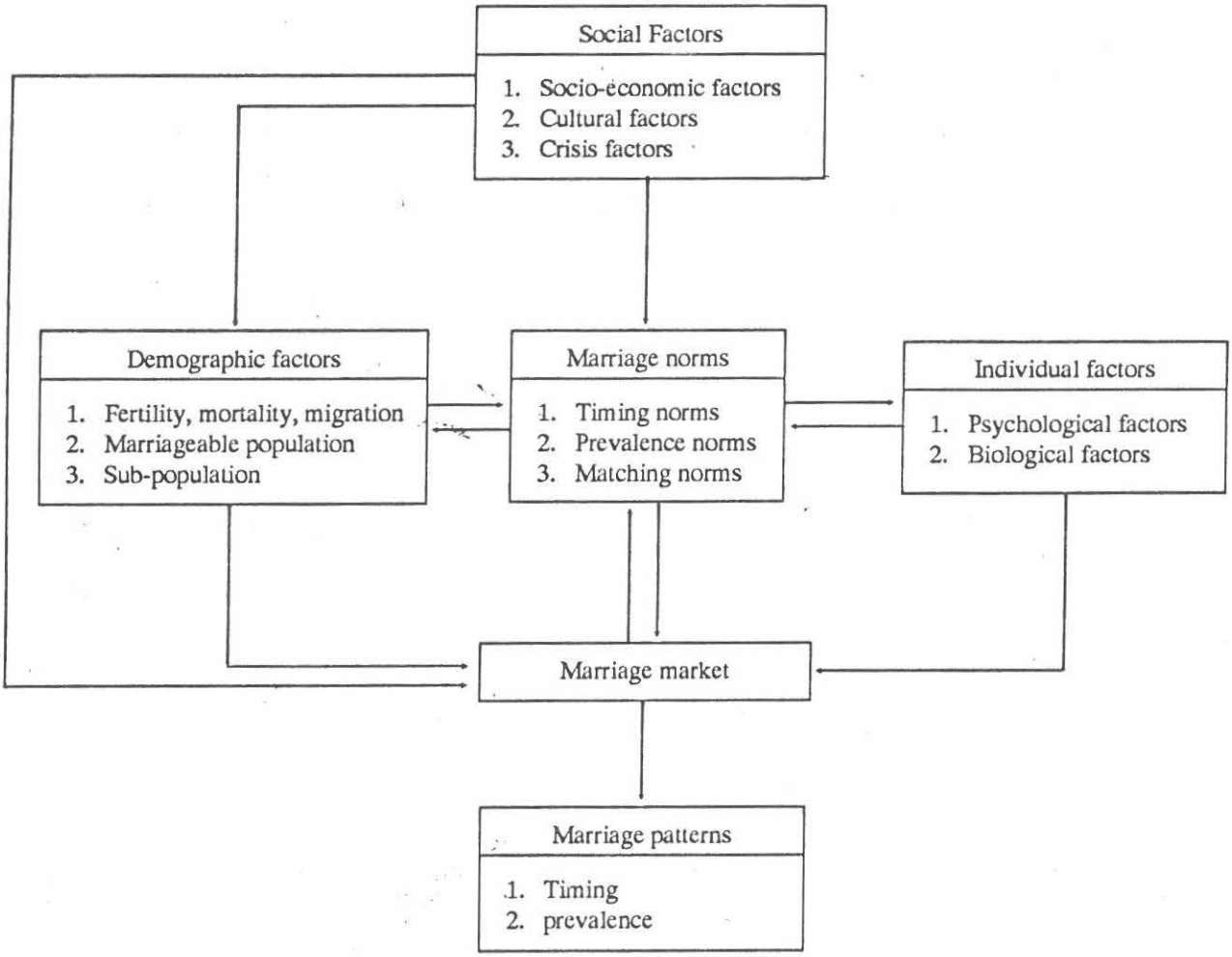
Recent trends suggest that pressure will continue for families to rely more on external support, much of it provided by public authorities in the form of specialized services and care, particularly in developed countries. In developing countries, too, as parents are less able to prepare their children for a world outside their realm of experience, families may need outside support, particularly finding suitable employment for the next generation. In many countries there are growing demands for additional services and support that would better enable parents, especially mothers, to reconcile parental, household and work responsibilities. This will be a major issue in developed countries and will become increasingly relevant in developing countries as fewer women will earn a living from home-based employment. At the same time, however, restraints on the financial and administrative resources of governments, and the availability of adequately trained child-care workers, will limit the ability of governments to provide adequate child-care for all young children. New arrangements, including participation by employers, primarly schools and other existing institutions will be needed. In some cases, it may be more efficient and socially beneficial for governments to provide direct income supplements to enable parents to spend more

time caring for their children in their own homes, or in various co-operative arrangements with neighbours or relatives.

In both developed and developing countries Governments have looked with renewed interest, in a period of budgetary constraints, at the family as a system of support which could bear a larger share of the burden of looking after the sick, the disabled and the aged. The professional view supports such arrangements as being in many cases preferable to institutionalization, and recommends public support and assistance to encourage families to provide more such support. However, the burden of care now tends to fall disproportionately on women. There is thus a potential conflict between this trend and the goal of widening opportunities for women, especially in education and employment.

From: Report of the Secretary General on the Overall Socio-economic Perspective of the World Economy to the year 2000. 1988 (New York) pp 104, 113, 118-120.

Conceptual framework for the study of marriage patterns



From: Population Newsletter United Nations Secretariat December 1987. (New York) p 13

acquire or change her nationality; the right to equal opportunity and treatment in work and to equal pay for equal work; maternity protection and protection against night work and underground work and other occupations which are dangerous to health; the right to education without discrimination in the area of education; the right to a minimum age for marriage and free consent to marriage; the abolition of ancient practices (such as ritual operations) and laws which cancelled women's basic rights; the right of married women to administer property, exercise an independent profession and have an independent residence; the right not to be subjected to discrimination in penal matters; the right of working women to free association, paid educational leave, equality in social security and travel in search of employment, etc.

The creation in 1946 of a functional subcommission of the Economic and Social Council (subsequently converted into a commission), for dealing with the situation of women marks the beginning of the process through which the examination of this issue begins to acquire specificity and relevance within the system. When the Commission on the Status of Women was established, with its mandate of reporting to the Commission on Human Rights, the Economic and Social Council was beginning to show special concern for women and devote special efforts to them, although those efforts were limited to the legal sphere.

The specific mandates of the Commission were designed to improve the social and legal condition of women with respect to nationality, race, language and religion and to place them at a level of equality with men in all fields of human endeavour, eliminating all discrimination in the legislation of the member States, in respect of political, civil, labour, education, social and economic rights. The work of the Commission, conducted through its biennial sessions, produced, if not all, the great majority of the measures designed to improve the legal situation of women. These measures, submitted as draft resolution to the Economic and Social Council by the Commission, were subsequently approved by the General Assembly, which in turn added some topics to them and requested the specialized agencies (ILO, FAO, UNESCO), to collaborate on the question of women when it felt this to be necessary.[1]

The majority of the rights proclaimed during this stage were based on conventions and agreements, that is, international instruments which impose legal obligations on the States which have ratified or acceded to them.

Many of these rights were promoted through 28 conventions and agreements arising from three fora: The General Assembly, the ILO and UNESCO. The 28 conventions and agreements may be divided into two groups, focal and non-focal, according to whether women have been the central topic of the convention or agreement or whether they were part of other topics or groups.

Those which focused on women were the following, in chronological order:

1) ILO, Convention No. 3 (1919), Maternity Protection.

2) ILO, Convention No. 4 (1919), Night Work (Women).

3) ILO, Convention No. 41 (1934), Night Work (Women). (This convention was superseded by Convention No. 89.)

4) ILO, Convention No. 45 (1935), Undergroup Work (Women).

5) General Assembly, resolution 126 (II) (1947), Transfer to the United Nations of the Functions and Power Exercised by the League of Nations under the International Convention of 30 September 1921 on Traffic in Women and Children; the Convention of 11 October 1933 on Traffic in Women of Full Age, and the Convention of 12 September 1923 on Traffic in Obscene Publications.

6) ILO, Convention No. 89 (1948), Night Work (Women).

7) General Assembly, resolution 317 (IV) (1949), Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others.

8) ILO, Convention No. 100 (1951), Equal Remuneration.

9) ILO, Convention No. 103 (1952), Maternity Protection.

10) General Assembly, resolution 640 (VII) (1952), Convention on the Political Rights of Women.

11) General Assembly, resolution 1040 (XI) (1957), Convention on the Nationality of Married Women.

12) General Assembly, resolution 1763 (XVII) (1962), Convention and Recommendation on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages.

The remaining 16 conventions and agreements were non-focal, that is, they referred to the situation of women as part of more general topics. Among them the following should be mentioned: Supplementary Convention on the Abolition of Slavery, the Slave Trade and Institutions and Practices Similar to Slavery;[2] UNESCO Convention against Discrimination in Education (1960); and a group of ILO conventions and agreements which went from general topics, such as the elimination of all discrimination in employment and occupation, social and employment policies and social security to specific topics such as pensions, work on plantations, and dangerous working conditions. (ILO Conventions Nos. 13, 81, 87, 97, 102, 110, 111,117, 122, 127, 128, 136 and 140.) The instruments in the second group had a common feature in that discrimination against women was indicated as part of a set of discriminations, on the basis of sex, religion, race, nationality and political opinion, or, in that women were merely a subgroup within the entire group affected by the convention; for example, women within a convention intended for plantation workers, women within a convention on social security intended for all workers, etc.

Besides the above-mentioned classification of focal and non-focal conventions and agreements, two other categories were established for the instruments: those which protected women (protective legislation) and those which promoted women (promotional legislation).

In accordance with the preceding categories, it may be observed that during this period, protective legislation was predominant, since there were 15 conventions of this type out of a total of 28, or 54%; while promotional legislation constituted 46% (13 conventions out of 28). Similary, non-focal legislation prevailed over that specifically directed towards women (57% and 43%, respectively). Even more important is the fact that of the 13 promotional agreements, 69% were directed towards promoting "equality" of rights between men and women, that is, they were not specifically directed towards improving the legal situation of women.

However, it should be pointed out that, even with the limitations noted above, the promotional agreements of this period caused legal instruments of vital importance for the improvement of the situation of women, both in terms of rights and with regard to social and economic life, to be elaborated and enter into force. The Convention on the Political Rights of Women (1952), the Convention on the Nationality of Married Women (1957) and the Convention and Recommendation on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages (1962), enacted by the General Assembly, the ILO Equal Remuneration Convention (1951); and the UNESCO Convention Against Discrimination in Education (1960), constituted an important part of the legal and social base which was beginning to appear within the United Nations system for the improvement and promotion of women.

In summary, the majority of the conventions and agreements of the period were protective and non-focal, emphasizing maternity protection, protection from work considered to be dangerous

and from the traffic in persons and the exploitation of the prostitution of others. The promotional conventions were oriented towards obtaining more egalitarian conditions for women in the areas of political participation, nationality of married women and marriage, equality in the workplace with respect to wages and the elimination of sex discrimination in education. The importance of labour legislation during this stage is obvious; the ILO played a predominant role in this area, maintaining the policy of protecting the rights of women in the areas of maternity and dangerous work through focal conventions, and of promoting the rights of women in the areas of employment and occupation, professional training, freedom of association, etc., through conventions on behalf for all workers.[3]

The other significant fact in the first stage was the proclamation of the Declaration on the Elimination of Discrimination against Women (General Assembly, resolution 2263 (XXII)), since it condensed the set of rights which had been proclaimed during the first twenty years.

The Declaration is a milestone in United Nations work on the promotion of women. When it approved the Declaration, the General Assembly created a single instrument containing all the rights proclaimed for women and reflecting the concerns, studies and activities carried out by the Commission on the Legal and Social Status of Women from its creation.

The preamble for the Declaration states that discrimination against women is incompatible with human dignity and with the welfare of the family and of society. The Declaration requests that all measures, including legislative ones, should be adopted in order to guarantee the principle of equal rights of men and women. It proclaims equality of rights in the area of acquiring, changing or retaining nationality and grants women the same rights as men in civil law, and in particular, equality of rights in marriage. It also states that all provisions of penal codes which constitute discrimination against women should be repealed, that measures should be taken to combat prostitution and the traffic in women, and that equal rights in education, free choice of employment and equal remuneration for work of equal value should be ensured to women. The Declaration also makes reference to the need for its principles to be implemented when it states that "Governments, non-governmental organizations and individuals are urged to do all in their power to promote the implementation of the principles contained in this Declaration" (article 11).

The Declaration did not create obligations for the member States of the United Nations. The Commission on the Status of Women compiled information on the implementation of the instrument and observed that there was a general trend among the States towards giving effect to the principles laid down in the Declaration.

The Declaration ended a stage in the process begun within the United Nations system in 1945, when the Charter of the United Nations was adopted, reaffirming "faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women...".

During the first twenty years, the question of women was examined from the exclusive perspective of making women equal to men in legal terms, discrimination being considered as an offense against human dignity and respect. Practically up to 1975, the situation of women was treated as one of the humanitarian, social and cultural questions which the system generally dealt with through its joint fora.

From the 1970s onwards, although the resolutions and mandates did not disregard concern for human rights, they situated the problems of women in a new perspective by proposing that women be integrated into development and the struggles for international peace and co-operation.

The objectives of equality, development and peace, which the United Nations established in the mid-1970s, summarized the new principles; that is, equality was possible only within the context of development and peace.

This new focus recognized the need to integrate women fully into development -conceived as a totalizing process, related to all aspects of life -and with struggles for peace, disarmament and the building of a new international economic order. In this way, the definition of the problem of women was transformed and a dynamic-structural focus adopted enabling it to be placed within the social, economic and political context which had created it.

As the process described above was taking place, the question of women was gaining specificity and relevance. Over the years, the analysis of women's rights and condition of discrimination gradually became separated from the general field of human rights and acquired its own dynamic. During the 1970s, and especially in 1975, the topic of women began to occupy a separate and significant position within the United Nations system; the work outlined in the Declaration on the Elimination of Discrimination against Women was continued; the United Nations Decade for Women: Equality, Development and Peace (1975-1985) and the International Women's Year (1975) were proclaimed; specialized bodies[4] and fora were established for examining the topic, with two world conferences held, and within the sphere of ECLAC, two regional conferences; international action plans and programmes were formulated; special programmes and projects were designed and executed; a periodic examination and evaluation was established of the progress and obstacles in the implementation of the mechanisms for the promotion of women, in world, regional and national spheres.

From the 1970s onwards, then, the question of women became the subject of concerted international action, which was clearly expressed in a change of the rights proclaimed and granted in conventions subsequent to 1975.

During the most recent five-year period (1975-1980) political rights were proclaimed in terms of actual participation and association, as a contribution to the process of development and a condition for attaining it, and the formalist scheme laid down by the right to vote of the previous stage was discarded. Similarly, the rights of the family were proclaimed, with special emphasis on the rights of single mothers, the status of persons born out of wedlock, domestic violence and family planning. There was substantial progress in public law with the proclamation of the rights of migrant women, those affected by apartheid, by armed conflicts and by all forms of foreign domination; the rights of displaced, refugee and disappeared women and of women who live in those countries where human rights are constantly being violated.

In the matter of penal law, more specific proposals, were made (conditions of detention, for example; Economic and Social Council resolution 1980/41); labour legislation was enacted in respect of social security (resolution 13 of the World Conference of 1975; Economic and Social Council resolution 1980/1) and equality of opportunity and treatment for workers and especially workers with family responsibilities (ILO Convention 156); similarly, equal access to education was reaffirmed.

The rights proclaimed during the first half of the United Nations Decade for Women were based on the achievements of the previous stage, but constituted one step further; from the vote to actual political participation; from marriage to the rights of unmarried women and their children; from labour protection to promotion; from attention to basic women's rights to the rights of groups of women in critical situations closely linked to political and social economic events; from the family as an institution to its internal problems such as domestic violence and family planning; and from equality in education to equality of access to education, including technical training, professional training, adult education and continuing education. However, the majority of the rights proclaimed were not given practical expression in conventions, being limited themselves to providing orientations for governments, in the form of resolutions, recommendations or action plans.

In this period six conventions were approved, one by the General Assembly and the five remaining ones by the ILO; only one of these conventions is intended exclusively for women, Convention No. 156, of 1981, on Equal Opportunities and Treatment.

The Convention on the Elimination of All Forms of Discrimination Against Women, approved by the General Assembly through resolution A/34/180 of 18 December 1979, is a natural

and more standardized continuation of the Declaration of the same name approved in 1967. Discrimination is defined as any "distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field" (article 1). The Convention, which contains 30 articles and entered into force on 3 September 1981, promulgates, in legally obligatory form, universally accepted principles and measures for obtaining the enjoyment of equal rights by women everywhere. The instrument urges that discrimination should be eliminated in the various spheres of social life, specially those affecting rural women; it indicates that all types of measures should be adopted, including temporary special measures, aimed at accelerating the de facto equality between men and women, and also contains provisions for modifying the socio-cultural patterns which perpetuate discrimination. The Convention also requests that protective laws should be discontinued once their objectives have been achieved (article 4). The Convention, therefore, is based upon the Declaration of the same name and gives a level of obligatoriness to the rights proclaimed in that instrument. It constitutes the highest achievement by women in terms of concerted rights and is an international instrument designed for promoting the equality of women.

The importance of the Convention is made all the more obvious by the inclusion, among its provisions, of the creation of a Committee on the Elimination of Discrimination against Women, consisting of 23 experts elected by the States parties to the Convention from among their nationals, who serve in their personal capacity (article 17). The basic function of the Committee consists of considering the progress made in the implementation of the Convention, including reports by the States parties on the legislative, judicial, and administrative measures which have been adopted to give effect to its provisions.

Six Latin American and Caribbean countries are represented on the Committee: Cuba, Ecuador, Guyana, Mexico, Panama and Uruguay.

As previously stated, six conventions were approved during the period under review, one of which was the Convention on the Elimination of All Forms of Discrimination against Women. The other five conventions were approved by the ILO; all were of the promotional type, but only one focused on women: Convention No. 156, on Equal Opportunities and Equal Treatment for Men and Women Workers: Workers with Family Responsibilities.

The Convention applies to all branches of economic activity and all categories of workers with family responsibilities (articles 1 and 2), and is intended to create effective equality between men and women workers, enabling those with family responsibilities to exercise their right to engage in employment without being subject to discrimination and without conflict between their

employment and family responsibilities (article 3). The Convention is complemented by ILO Recommendation 165 (1981) of the same name.

Besides Convention No. 156, the ILO approved four others intended for all workers, that is, non-focal with respect to women. They are: Convention No. 151 (1975) on Rural Workers' Organizations; Convention No. 142 (1975) on Human Resources Development; Convention No. 143 (1975) on Migrant Workers; and Convention No. 149 (1977) on Nursing Personnel. These instruments affirm the need for guaranteeing the participation of rural workers by promoting organizations of rural workers, without discrimination of any kind; the need for human resources policies and programmes (vocational guidance and vocational training) to be available to all persons, without any discrimination whatsoever; equality of opportunity and treatment for migrant workers without any distinction whatsoever among them or in relation to other workers; and finally, equality of conditions for nursing personnel with no distinctions among them or in relation to the workers of the country. The ILO conventions of this period are characterized by being of the promotional type and principally oriented towards treating the problems of workers in general, with no distinction by sex.

In summary, during the period which began in the 1970s, six conventions and agreements on women were approved, all of the promotional type; in four of them the question of women is dealt with within agreements referring to men and women. The only two conventions referring specifically to women constitute, in their respective fields, the most important achievements in the legal sphere to have been attained in the United Nations: the Convention on the Elimination of All Forms of Discrimination against Women (1979) and ILO Convention No. 156 on Equality of Opportunities and treatment between Men and Women Workers: Workers with Family Responsibilities (1981).

Furthermore, the rights elaborated in the conventions of this period encompass all spheres of human activity, with the exception of penal matters; the conventions also reaffirm the rights proclaimed during the preceding period, make them more specific and improve them. It should be pointed out, however, that in the current period, the greatest progress in terms of types of rights and level of specificity are found in the resolutions, recommendations and mandates which do not constitute international legislation, and which are solely directed towards orienting the actions of governments and, in a few cases, of non-governmental organizations.

Among these mandates, recommendations and resolutions, those which treat the following subjects should be mentioned:

1) Conditions of detention: Economic and Social Council resolution 1980/41.

2) The family, married women without children, family planning: Economic and Social Council resolution 1942 (LVIII); resolution 17 of the 1975 World Conference; resolution 1 of the 1980 World Conference.

3) The family, abandonment and violence; resolutions 17 and 5 of the 1980 World Conference.

4) Women refugees and displaced women: General Assembly resolution 35/135 and resolution 12 of the 1980 World Conference.

5) Improvement of the status of women in education and in the economic and social fields: General Assembly resolutions 33/134; and 33/184; resolution 24 of the 1975 World Conference; resolution IV of the FAO World Conference and UNESCO resolution 13, 1978.

6) Social security: Economic and Social Council resolution 1980/1; resolution 13 of the 1975 World Conference.

7) Women in rural areas: General Assembly resolution 3523 (XXX), 1975; Economic and Social council resolution 1980/1; resolution 21 of the 1975 World Conference; resolution 44 of the 1980 World Conference.

8) Women's participation in the strengthening of international peace and security: General Assembly resolution 3519 (XXX); Economic and Social Council resolution 1980/36; resolution 29 of the 1975 World Conference; resolution 11 of the 1980 World Conference.

9) Discrimination based on race: resolution 31 of the 1980 World Conference.

10) Effects of apartheid on women: Economic and Social Council resolution 1978/33; resolution 3 of the 1975 World Conference; resolution 45 of the 1980 World Conference.

11) Situation of women in countries where human rights are violated: resolutions 32 and 34 of the 1975 World Conference; resolutions 18 and 19 of the 1980 World Conference.

12) Political and social participation, integration of women in the development *process*: resolutions 18 and 20 of the 1975 World Conference; resolution IV of the 1979 FAO World Conference.

13) Migrant women: resolution 3 of the 1980 World Conference.

14) Research on population and the integration of women in development: resolution 11 of the 1975 World Conference.

15) Disappeared women: resolution 23 of the 1980 World Conference.

16) Prostitution: resolution 7 of the 1975 World Conference; and resolution 43 of the 1980 World Conference.

The fact that there are, during this period, a great many more resolutions which do not constitute international legislation than conventions which do, indicates a possible undeveloped field of rights which could be given practical expression in new conventions in the future.

The proceedings of the United Nations system in connection with the legal situation of women during the last decade, and especially in the last five years, are characterized by having gone beyond fundamental rights and freedoms to propose effective integration and participation together with formal rights, and by focusing on promotion rather than protection of women and orientation of the action of governments rather than generation of international obligations.

The achievements of this time period are the most advanced of the century in terms of women's rights, but many of them lose force when analysed at their level of implementation. The majority of the mandates do not constitute international legislation and the most important conventions have been approved recently, which makes it difficult to determine at this point what their final level of ratification will be.[5]

In summary, it may be stated that the period from 1946 to 1981 produced a far-reaching transformation in the set of resolutions and mandates arising form the United Nations system on the legal situation of women. In the first twenty years, the question of women was approached from a liberal and legalistic perspective, in that legislation was considered to be the main factor in eliminating inequalities and discriminations. The legalistic approach was oriented towards women in general and was protective with respect to legal matters. Agreeing upon and proclaiming these rights was effected through conventions emanating from the joint fora of the system, conventions

which focused on formal rights, with very limited generation of measures and mechanisms for their implementation and evaluation, and through specific programmes and projects within the organization and the national level.

From 1970 onwards, and basically since the International Women's Year in 1975, a dynamic focus was adopted, in which the situation of women was approached in terms of integration into development. Legislative measures became subordinate to certain integrated planning strategies which contained, together with legislation -which was at that time also considered to be a planning instrument -the promotion of the association and organization of women, the adoption of continuing education programmes, the development of research programmes, and the adoption of temporary strategies and measures. Within this context, legislative measures were defined as factors facilitating the elimination of discrimination against women, but which could not in themselves provide an answer to the problem. A transition thus took place, from a legalistic position to an integrated system of planning which took into account the structural factors affecting the female population.

II. SPECIFIC ASPECTS OF THE LEGAL SITUATION OF WOMEN

The preceding diagnostic analysis of the body of laws produced by the United Nations in connection with the situation of women, and which includes both conventions and resolutions and mandates which do not constitute international legislation, needs to be complemented with the information contained in volume II of the present study, which contains the textual transcription of the resolutions and mandates since 1946, organized by forum and in chronological order.

On the basis of this diagnostic, it is of interest to point out a few aspects which go beyond the limits of this work and which may give rise to future research.

a) ***The importance granted to the legal situation of women within the action plans concerning women at the world and regional levels***

In all these spheres, there is a need indicated for ratifying international instruments in force; revising and modifying both the international instruments and the national bodies of legislation for the purpose of eliminating discrimination against women. The plans also envisage measures in the following fields of law: political rights; civil law, with special emphasis on family law; public law, in particular with respect to prostitution and drugs; penal law; the economic, social and cultural areas of law. Similarly, reference is made to the elimination of all discrimination against women and to the adoption of measures for improving their legal status, such as governments' transmitting of information on legislation and national mechanisms, studies on international instruments, legal

counselling programmes for women and programmes of education and dissemination of information for the entire population.

b) ***The fields of law which are unevolved at the international level and could give rise to future conventions, resolutions and recommendations***

Political rights. Reaffirmation of the effective participation of women in public office, national movements, unions, women's organizations, professional associations, international and other bodies.

Family Law. Legislation through conventions and resolutions on those aspects which have been disregarded or not sufficiently developed, such as violence in the home, the distribution of domestic work within the family, and administration of property. Reaffirmation of those aspects which continue to be critical areas in national legislation parental authority, guardianship of children in cases of separation, the legal situation of unmarried mothers.

Public Law. Legislation through conventions on the protection of women and children during armed conflicts and against all violence as a result of racism, apartheid, colonialism or foreign domination, political or religious differences, especially with respect to women, youths and children who have been tortured or have disappeared; measures for reuniting families and for rehabilitation and socio-cultural integration.

Penal Law. Legislation through conventions on conditions of detention and protection of pregnant detained women and of children born in prison. The right of the detained woman to an education, and to work and occupy her free time. Elimination of all sex discrimination in the area of penal law. To date there are only a few resolutions of the Economic and Social Council and the Second Regional Conference of ECLAC (1979), and one provision in the Declaration on the Elimination of Discrimination against Women (1967).

Labour law. Legislation through conventions on special groups of workers:

i) *Elderly Workers*. To date there is only one ILO recommendation (recommendation No. 162, of 1980) intended for all elderly workers,which proposes equality of opportunity and treatment, protection and preparation for and access to retirement, and recommends that the ILO prepare a convention. The World Conference of the International Women's Year (1975), in its resolution 13 on social security, states that in this connection, particular consideration and special studies should be devoted to elderly women. Furthermore, the 1980 World Conference dealt with this theme in its resolution 4, requesting that special attention should be given to the problem of elderly women, data should be collected and that a comparative study on the social security of

elderly women should be prepared, together with provisions connected with the World Assembly on Aging (1982). It also recommends that, on the basis of the studies, the General Assembly should elaborate a convention or resolutions on social security and full participation in social life by elderly women, so that these concerns will not be confined to age-group programmes, which are highly discriminatory.

ii) *Women domestic workers and salaried workers working in the home.* In neither case are there conventions regulating the work, for which reason it appears necessary to elaborate conventions on this type of women worker, especially those working in developing countries with a concentration of industries which employ women workers for work in their own homes (textile, leather and footwear), with no legal protection whatsoever.

iii) *Rural women workers.* For this group, effect should be given to the resolutions and recommendations in force designed to encourage the extension of the international conventions, especially the labour conventions, to the rural sector.

iv) *Young women workers.* It would also appear necessary to enact legislation for this group of workers, through provisions promoting equality of access opportunities and treatment.

c) ***Level at which the body of laws emanating from the United Nations in connection with the legal situation of women is reflected and implemented in national legislation***

One indicator of this level of reflection is constituted by the degree of ratification or accession to the conventions, which, nevertheless, does not provide data on the level of implementation of the norm or the extent to which the recommendations and resolutions actually orient governments' actions. This is an area which merits an up-to-date study, following research on the legal situation prevailing in the countries.

With regard to the level of ratification or accession, the following data exist concerning some of the conventions:

1) Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others (1949)
States parties: 53
Countries of the region: Argentina, Brazil, Cuba, Ecuador, Haiti, Mexico, Venezuela.

2) ILO Convention 100, Equal Remuneration Convention (1951)
State parties: 94

Countries of the region: Argentina, Brazil, Colombia, Cuba, Chile, Dominican Republic, Ecuador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru.

3) Convention on the Political Rights of Women (1952)
States parties: 90
Countries of the region: Argentina, Bahamas, Barbados, Bolivia, Brazil, Chile, Costa Rica, Cuba, Dominican Republic, Ecuador, Guatemala, Haiti, Jamaica, Mexico, Nicaragua, Paraguay, Peru, Trinidad and Tobago.

4) Supplementary Convention on the Abolition of Slavery, the Slave Trade and Institutions and Practices Similar to Slavery (1956)
State parties: 96
Countries of the region: Argentina, Bahamas, Barbados, Brazil, Cuba, Ecuador, Haiti, Jamaica, Mexico, St. Vincent and Grenadines, Suriname, Trinidad and Tobago.

5) Convention on the Nationality of Married Women (1957)
States parties: 54
Countries of the region: Argentina, Bahamas, Barbados, Brazil, Cuba, Dominican Republic, Ecuador, Guatemala, Jamaica, Mexico, and Trinidad and Tobago.

6) ILO Recommendation No. 111, Discrimination (Employment and Occupation) Recommendation (1958)
States parties: 96
Countries of the region: Argentina, Brazil, Colombia, Cuba, Chile, Dominican Republic, Ecuador, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Trinidad and Venezuela.

7) UNESCO Convention against Discrimination in Education (1960)
States parties: 62
Countries of the region: Argentina, Brazil, Cuba, Chile, Panama, Peru and Venezuela.

8) Convention and Recommendation on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages (1962)
States parties: 31
Countries of the region: Argentina, Barbados, Brazil, Cuba, Dominican Republic and Trinidad and Tobago.

9) Convention on the Elimination of All Forms of Discrimination against Women (1979)
States parties: 39
Countries of the region: Barbados, Colombia, Cuba, Dominica, Ecuador, El Salvador, Guyana, Haiti, Mexico, Nicaragua, Panama, St. Vincent and the Grenadines, Uruguay.[6]

Furthermore, out of a total of 151 ILO conventions up to 1 June 1980, addressed to all workers, seven of which refer to women directly and 18 indirectly, the Latin American and Caribbean States have ratified various conventions as indicated below:

Country	No. of conventions ratified
Argentina	60
Barbados	33
Bolivia	39
Brazil	54
Colombia	45
Costa Rica	33
Cuba	80
Chile	40
Dominican Republic	26
Ecuador	49
El Salvador	4
Guatemala	39
Guyana	28
Haiti	22
Honduras	16
Jamaica	23
Mexico	59
Nicaragua	42
Panama	69
Paraguay	33
Peru	61
Trinidad and Tobago	12
Uruguay	79
Venezuela	26

The data presented give an indication of the low ratification level of the majority of the countries of the region in respect of international conventions relating to women, and even to labour conventions of a general nature.

Countries with a ratification rate of more than 50%
Cuba (53%) and Uruguay (52%)

Countries with a ratification rate of 40% to 50%
Panama (46%), Argentina (40%) and Peru (40%)

Countries with a ratification rate of 30% to 40%
Mexico (39%), Brazil (36%), Ecuador (32%) and Colombia (30%)

Countries with a ratification rate of 20% to 30%
Nicaragua (28%), Chile (27%), Bolivia (26%), Guatemala (26%), Barbados (22%), Costa Rica (22%) and Paraguay (22%)

Countries with a ratification rate of less than 20%
Guyana (19%), Dominican Republic (17%), Venezuela (17%), Haiti (15%), Jamaica (15%), Honduras (11%), Trinidad and Tobago (8%) and El Salvador (3%).

In connection with this topic and given its crucial importance, it is necessary to: a) maintain up-to date information on the level of ratification of conventions referring to women,and also to extend this task to all the conventions of the system; b) carry out research utilizing the data indicated in item a) and evaluating the level at which United Nations resolutions and mandates concerning women are reflected in the national legislation of the countries of the region, using as possible indicators the level of ratification, the level of implementation (through collective labour agreements, social and labour situations), and the level at which legislative action by governments is oriented by the resolutions and recommendations of the United Nations system.

d) ***The degree to which the body of legislation produced by the United Nations on the legal situation of women reproduces or furthers national legislation***

This body of legislation does not reproduce national legislation of the countries of the region, but establishes antecedents in statute law for the points which are critical in national legislation and furthers them in the sense that it proposes improvements which the former do not provide. For example, while the majority of national bodies of legislation firmly establish the legal incapacity of married women, the United Nations reaffirms the equality of married women and their full legal

capacity. This feature of improving national legislation gives the theory and practice of the United Nations an enormous capacity for effecting change, both in terms of thought and planning.

e) ***The imbalance between the international instruments and the legal and social condition of women and levels of awareness of this problem***

Despite the fact that the body of United Nations legislation goes beyond national bodies of legislation, it has not been successful in becoming part of those bodies in order to produce an effective de facto and de jure change in the situation of women in Latin America and the Caribbean. This imbalance is obvious in various spheres of human activity. At the political level, women vote but barely participate in parliament or the judiciary and even less so in national executive powers; there have been only three female chiefs of State in the entire history of Latin America and the Caribbean: in Argentina, Bolivia and Dominica. Women have participated in traditional political parties as a female branch or minor partner in support activities for the most part (only in a few national and labour movements in Latin America and the Caribbean have women become more fully integrated).

In the labour field, and despite international and national legislation, women receive less remuneration than men and do not enjoy equality of opportunities and treatment; they generally perform non-directive duties and are the subject of discrimination for reasons of maternity and child care. In the educational field discrimination against women also persists, and the so-called "female careers" (nursing, social work, all branches of teaching), with a majority of female staff, are one the forms in which this discrimination is manifested.

Women in the region are continuing to reproduce stereotyped roles in which they are not considered as active subjects of the society in which they live; they study, but are prepared to postpone those studies in the name of marriage; they work, in order to complement the salary of their father or husband, without fully assuming their destiny. Similarly, they are basically dependent in the affective sphere, a situation which is favoured by inadequate legislation, legitimized by law and by a deep-seated tradition of male chauvinism.

Although international legislation may appear utopian in the current stage of development, it undoubtedly constitutes an alternative for change. It should be complemented with effective mechanisms for change, in the countries, which will help women in the region, and especially women in the popular sectors, to achieve full integration into all plans concerning what is to be done with society.

III. RECOMMENDATIONS

This work is in line with a long tradition within the UNited Nations system, consisting of systematizing its own actions. It may therefore be viewed in the context of the efforts at compiling and analysing information periodically carried out by the Commission on the Legal and Social Status of women and by the Subdivision for the Advancement of Women in connection with progress in the legal status of women in the different countries and concerning the level of ratification or accession to the conventions emanating from the United Nations. It also provides continuity with the compilation and systematization work conducted by the ECLAC Unit for the Integration of Women in Economic and Social Development. The report can be used as an instrument of dissemination and reflection and as a planning instrument. In the first case it will make it possible to compare and place in perspective the immediate legal reality and in the second will enable the transformation of that reality. The recommendations presented below envisage both of these dimensions.

1. To orient actions designed to promote the legal equality of women according to the following principles, contained in different mandates emanating from the United Nations system: (92)

a) Legislative measures cannot by themselves modify the situation of discrimination against women, but they can facilitate the conditions for eliminating it. Legislative measures should be part of integrated planning and development strategies.

b) The legal and social situation of women in Latin America and the Caribbean is closely linked with the underdevelopment and structural dependence affecting the region, and the solution of this problem can only materialize within the context of a new international economic order, based on peace, co-operation and self-determination of peoples.

c) The full integration of women in development is a process in which legal equality is a basic condition; it is a task still to be accomplished, possesses its own legality, and its success does not depend automatically on changes in society at large.

d) *De facto* and *de jure* equality of women necessarily implies equality of duties and responsibilities and women's acceptance of their contribution to the maintenance and well-being of society.

e) The idea of "integrating women into development" means including women in the creation of new and egalitarian social structures, organized without distinction based on sex, and does not assume women's integration as a minor partner into a world foreign to them.

2. To disseminate among the United Nations member States, permanent bodies, functional commissions and specialized agencies, and among women's associations and non-governmental organizations, all existing information to date on international legislation referring to women, and the United Nations resolutions and mandates which, although they do not constitute legislation, orient the legislative actions of governments.

3. To conduct research on the legal status of women in each of the national bodies of legislation of the countries of the region, for the purpose of elaborating up-to-date diagnostic analyses and a general study in comparative law. In both cases an effort should be made to delve into the rights proclaimed, the omitted or poorly developed aspects, the level of quality attained in the different fields of law (labour, penal, agrarian, etc.) and the differences between the de facto and de jure situations. On the basis of these studies and of the existing diagnosis of international legislation and related resolutions referring to women, there should be an evaluation of the level at which international legislation and the resolutions and mandates of the United Nations are reflected in the national bodies of legislation of the countries of the region, measured in terms of ratifications, accessions, degree of orientation of actions and level of actual implementation.

4. To propose that the governments of the region should review and modify the national bodies of legislation using the following elements:

a) Information on international instruments and the United Nations resolutions and mandates referring to the legal situation of women (both the diagnostic analysis and the evaluation of the level of reflection in national bodies of legislation).

b) Information on the critical points in national bodies of legislation, including the diagnostic analysis of the topic elaborated by ECLAC for the Second Conference on the Integration of Women in the Economic and Social Development of Latin America and the Caribbean (1979). (82).

c) Studies on the social, cultural, economic and political needs of women at the national and regional level. On the basis of the above-mentioned information, it is recommended that governments should: i) compare national legislation with the international instruments to de-tect differences and similarities, granting priority to the study of poorly developed fields of law or those which legitimize or sanction discrimination; ii) take legislative measures to end discri-mination; iii) elaborate strategies and integrated programmes for promoting the egalitarian participation of women, in which legislative measures are contained.

5) To recommend that the member States should ratify or accede to all the conventions approved by the United Nations and orient their actions according to the United Nations resolutions and

mandates which, although they do not constitute legislation, give legislative guidelines to governments.

6. To request United Nations bodies, specialized agencies and functional commissions to review the international legislation and resolutions and mandates of the system which, although they do not constitute legislation, refer to the legal situation of women in Latin America, for the purpose of:

a) Eliminating protective laws, above all in labour and civil law;

b) Seeking the universal ratification of the conventions formulated;

c) Elaborating conventions, resolutions and mandates relating to rights that have been omitted or poorly developed, both in international and national legislation; and

d) Formulating the conventions, resolutions and mandates taking into account the following criteria: i) the need for including certain types of women, especially those who are doubly discriminated against (such as elderly women, women in popular sectors, etc.); and ii) the advisability of accompanying legislative measures by relevant activities in the spheres of planning, research, evaluation, education and dissemination.

NOTES

[1]The case of the ILO deserves separate mention, since this body has been legislating and issuing recommendations on the legal situation of the working woman since 1919.

[2]This convention was adopted by Conference of Plenipotentiaries convened by the Economic and Social Council through its resolution 608 (XXI) of 30 April 1956, on Supplementary Convention on the Abolition of Slavery, the Slave Trade and Institutions and Practices Similar to Slavery.

[3]During the following period, 1975-1981, the ILO policy was different, as will be seen later on, since all the conventions aimed exclusively at women were promotional.

[4]Regional commissions were designated as regional focal points for the integration of women; specialized units were established within commissions and others bodies and specialized agencies, the United Nations Voluntary Fund for Women and the International Research and Training Institute for the Advancement of Women (INSTRAW) were created.

[5]As at 30 June 1982, the Convention on the Elimination of All Forms of Discrimination against Women had been signed by 88 States. Of these States, barely 37 had ratified it and 2 had acceded to it, for a total of 39 ratifications and accessions, or 44% of the signatory States.

[6]The General Assembly conventions, as at 1 July 1982, are contained in United Nations, Human Rights: International Instruments. Signatories, ratifications, accessions, etc., 1 July 1982 (ST/HR/4/Rev. 4); the ILO conventions, as at 1 July 1980, appear in ILO, Standards and Policy Statements of Special Interest to Women Workers, Adopted under the Auspices of the International Labour Office, Geneva, 1980.

From: The Decade for Women in Latin America and the Caribbean. Background and Prospects United Nations (Santiago Chile) 1988. pp 163-179

Statistical concepts

Given the great variety of marriage formation processes, marriage types and marriage recording systems, it is clearly impossible to find a uniform statistical criterion whereby marriages could be properly recorded and used in cross-national studies. In some countries, only legal unions are recognized as marriages and thus recorded in the vital statistics system and reported in censuses. In other countries, although only legal marital unions are properly recorded in the vital statistics, other unions are acknowledged and reported in censuses. Therefore, the statistical concept of marriage depends largely on the type of definition adopted by countries during census operations, which, in the absence of good registration systems, are the primary source of information on numbers and types of marriages by age of groom and bride.

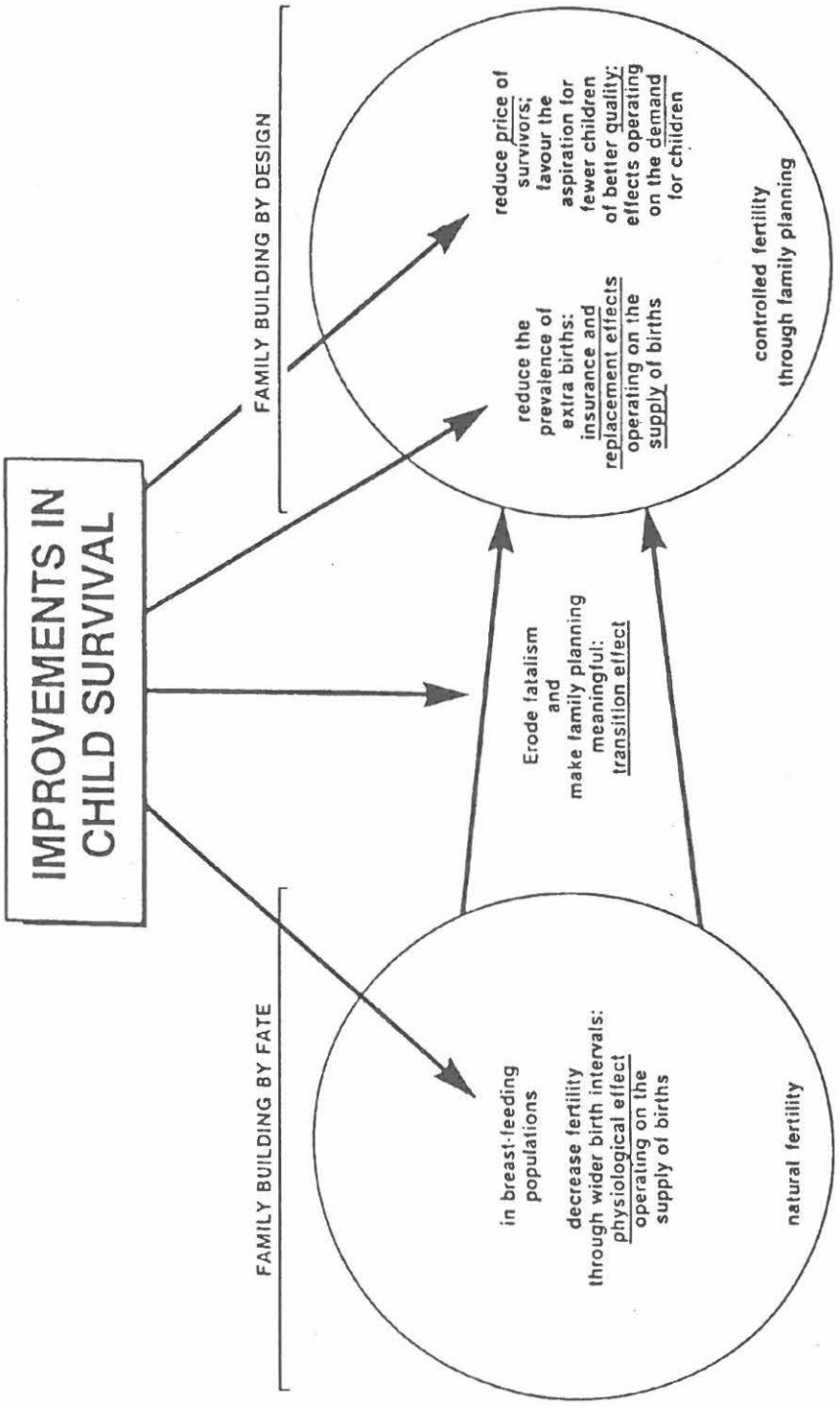
In Asia, a variety of statistical practices pertaining to a single "married" category are currently in existence (except in Sri Lanka's 1981 census) as reported in a cross-country comparison. For example, the census of 1970 in the Republic of Korea defines marital status as the "actual status of each individual marriage ... whether or not the marriage has been resgistered"; in Malaysia, the married are "all those who are legally married and all persons habitually living together as man and wife even if not legally married", while in Thailand in 1970, the married include "both persons who have registered their marriages and persons in de facto unions"; in Indonesia, the married also include consensual unions; and "married" in the Philippines includes "a person who lives with someone as man and wife, whether legally married or not" (Smith, 1980).

In Latin America, two categories, legal and consensual marital unions, are generally reported separately in censuses (Arretx, 1971; Quilodran, 1985). In the Caribbean, some censuses and recent surveys have considered visiting unions as an additional separate category, thus preventing women who are in such unions from being classified as single (United Nations, 1984a). Sometimes, women who are in a non-legal union or who were formerly in a visiting or consensual union but had no partners at the time of the interview are counted as single. Self definition of marital status can also be a source of statistical unreliability. It was reported, for example, that women in consensual unions or in visiting unions were declaring themselves single when they separated or were abandoned by their partners. Such women were classified as "not presently in union" in the recent round of fertility surveys in the Caribbean region, in order to distinguish them from single women who were never in a marital union. In certain censuses (e.g., Jamaica 1960 census), the category "never had husband or partner" was used to identify the single women in cultures where consensual and visiting unions were common. In Barbados, a woman not in a consensual or legal union was classified as being in a visiting union if she had a child in the past 12 months. The same definition was used in Guyana and Jamaica (United Nations, 1984a; Nag, 1971).

In Africa, the statistical definition of "legal" has often been determined in the past by the interpretation of Western colonial powers or even individual census takers. In certain cases, a formal marriage from the customary standpoint was not considered legal by the statistical criterion, even when customary law was recognized in legal theory. For example, in the Congo Demographic Inquiry, a legal union which lasted more than six months was recorded as consensual if the name of a man's wife did not appear on his identification booklet; if it lasted less than six months, the union was completely ignored (Van de Walle, 1968). In addition to individual erroneous answers, intentional inaccurate responses may also be given in a variety of cases. In Cote d'Ivoire, for example, where polygamy was prohibited in 1964, it is assumed that various methods were devised to hide existing polygamy (Barrere, 1984). In other cases, uncertainties arise from the type of classification. In Morocco, a category of fiancé (engaged) was added to the various marital statuses in the 1970 census (Morocco, 1972). In the 1983 Rwanda fertility survey, married women were classified as in mariages coutumiers (customary unions), mariages civils (civil unions) and unions de fait (consensual unions) (Rwanda, 1985). In Cote d'Ivoire, four categories of unions, civil, traditional, religious and consensual, were classified into one single category of married (Ahonzo and others, 1984).

In brief, this overview reveals that the concept of marriage reflects a wide spectrum of social and legal arrangements that cannot be expressed by a single term or expression. Moreover, because marriages, or more accurately marital unions are such culture-specific institutions, they often take a variety of forms. The same term may be used to describe types of unions which may not be in fact the same. This is particularly true when one tries to identify when exposure to the risk of conception begins. From among the variety of marriage formation processes, it is, however, possible to identify three major categories: legal, consensual and visiting unions. For the purpose of the following discussion, the use of the term marriage or marital unions encompasses all three types of marital arrangements unless otherwise noted.

From: First marriage: Patterns and determinants. United Nations, New York (1988), pp 55-56.



From: Population Bulletin from the United Nations No. 25 - 1988 (New York) p 29

Primary Health Care

Vanaja Ramprasad

Community health workers-an evolving force

An assessment was made in Indian villages of the performance of community health workers in primary care projects supported by funding agencies. In general these workers were neither adequately trained nor properly integrated into the programmes to which they were attached, and the results left much to be desired. Nevertheless, valuable experience was gained and it has been possible to draw up guidelines for organizing future programmes in which community health workers should be able to realize their full potential.

In India, several voluntary organizations supported by funding agencies have striven towards the extension of health services to remote areas and the introduction of village-based health workers. Oxfam gave considerable support to the training of such workers during the mid-1970s, and in the early 1980s decided to study the training of community health workers and the impact of what they did in service projects. The objectives were to:

- assess the training efforts and the supervision structure of the community health worker programme;
- assess community participation in and understanding of the programme;
- provide profiles of the community health workers (age, class, caste, marital status, understanding of their role, attitude to the community, etc.);
- assess the socioeconomic and political status of client groups;
- assess changes in infrastructure related to community health goals;
- assess the impact of ancillary programmes on community health programmes.

It was felt that it would not be possible to work out criteria for the assessment of the technical performance of village health workers, since little or no suitable data were likely to exist at project level. Furthermore, other factors besides the community health workers might have led to the improvement of the people's health status. Evaluation was approached with an awareness that every proposal and every new action was bound to contain seeds of conflict. It was thought worthwhile to try and understand the process by which voluntary groups developed or abandoned their work.

An attempt was made to combine the available quantitative data with qualitative observations in order not to be misled by projections based on purely numerical evidence. On interpreting the work of each group, more weight was given to the development process than to progress or performance.

The project organizers were contacted and it was explained to them that the ultimate purpose of our study was to assist decision-making. Neither Oxfam nor the projects had a clear idea of the exact role of the community health workers. It was assumed that their usefulness lay in the fact that they themselves were villagers, able to understand the local culture and to act as a channel for health education and as a link between project staff and the people.

It was not obvious why the projects or existing institutions accepted the whole community health package sponsored by Oxfam. The possibility existed that the community health workers were welcomed as an additional element but that there was no commitment to structural change. Were they seen as an important link in the health delivery chain to whom more and more skills should be transferred in response to the needs expressed by the community, or merely as front-line servants of the system of hospitals and health centres?

Community health workers should be broadly representative of the people they serve and acceptable to all subgroups.

In addition to the limited data that were available we relied on:

- field observations;
- discussions with management;
- interviews with field staff;
- interviews with community health workers;
- interviews with beneficiaries, including health committees;
- project reports, annual reports, and interim evaluation reports.

The projects selected for study were located in the States of Tamilnadu, Karnataka, and Andhra Pradesh. They differed from one another in various ways and their coverage ranged from 5 to 110 villages.

Health priorities for action and training: community versus planner preference

Community preference

- Community participation in various activities like construction or cleaning may be forthcoming if health priorities respond to felt needs.
- Healths workers are more respected if they respond to felt needs.

Planner preference

- Ascertaining community preference is time-consuming and must be done before training starts.
- Communities are aware of the diseases but not the causes.
- It is not always true that the people know what they need.

Role

In concept, primary health care is community-orientated, but in practice it often turns out to be project-orientated. In concept it is an outcome of the felt needs of the people but, in reality , felt needs are far from what the planners of primary care would wish them to be. In concept, primary care should grow with the support of the health care infrastructure, but in reality it may grow in a vacuum. Very often it is expected to be based on self-sufficiency but this expectation may amount to unbridled optimism. Moreover, primary care is supposedly a fruit of multisectoral collaboration, but in fact this is seldom attained. The role of a community health worker is easy to define if primary care is community-orientated and an outcome of the felt needs of the people. Where it is project-orientated, however, the community health worker is merely grafted onto a situation in which role expectations and performances do not match.

In principle, primary care implies a reduction of the widening gaps between those who have access to resources such as income, food, employment and education, and those who do not. It requires a redistribution of resources and strong self-reliance. Yet this has seldom been understood by those implementing health programmes. The role of the community health worker in all the

projects we studied was reduced to two main functions: that of acting as a link between the main programme and the people, and that of health educator.

Unfortunately, health education consisted of repeating the same messages irrespective of specific situations or problems. If the workers had been taught to spread the message of the importance of caring for children aged under five years and if this had been followed up by regular under-five clinics, it would have been clear both to the workers and the people in the communities. A transfer of knowledge and skills would have occurred from professionals to lay people, thus providing the basis for a community health programme and acceptance of the need for rational health behaviour.

If teaching materials are produced locally they are better understood because they reflect community health problems, their causes, and cultural influences.

The health workers were found to adopt an approach that was mainly individualistic and family-orientated. No impact had been felt at community level. Their training was not usually designed to produce people who could meet new challenges. The minimum expected of the community health worker was assistance while mobile clinics were being held, and the imparting of health education during home visits. Some projects went a little further, involving them in record-keeping, e.g., noting the weights of children. In only two projects was it realized that they had the potential to be responsible for selected curative services. In some projects the community health workers organized people to cope with their own problems, and in one the workers had learned how to carry out laboratory tests.

Selection

The selection of community health workers is a complex issue involving the community, local leaders, trainers and projects sponsors. Community health workers should be broadly representative of the people they serve and acceptable to all subgroups. In most of the projects examined it was considered that community health workers should be locally resident middle-aged women who were free of domestic ties, had adequate spare time and were willing to render service regardless of caste, and that it did not matter if they were illiterate. The people's health committees usually chose the community health workers. There was no clear explanation of the preference for selecting women, and indeed in one project men were trained as community health workers and provided the necessary services in maternal and child health programmes.

In India a village is usually a collection of socially stratified communities with vested interests. Very often the danger exists that health committees will consist of members of the dominant caste and that their selection of community health workers will serve narrow interests. Where a handful of leaders strongly influences decisions, community participation is a sham. Under such circumstances one can be sure that minority groups will not participate and the project team is faced with having to rectify matters. In some projects, names were proposed by the committee but the final selection was through a formal interview.

Training

The effectiveness of training depends greatly on who does the teaching and what methods are used. In typical training sessions there was an attempt at imparting knowledge on the causes of disease, preventive action, remedial measures, and simple diagnostic methods. Flash cards were used in most projects but in two the programme of lessons was periodically upgraded. In some projects, chapters from the book, "Where there is no doctor" (1) were used as lessons. Teaching took the form of lectures and only very rarely were the community health workers involved in dialogue.

Some projects demonstrated that it was possible to teach skills to illiterate community health workers, e.g., the giving of injections, monitoring the growth of children, preparing oral rehydration fluid, dressing wounds, and dispensing simple medicines. These workers also learned how to solve problems and make decisions, especially those related to diagnosis, referral and treatment.

In at least five projects the training of the community health worker was initiated by Oxfam. The training of health workers was invariably seen by the projects as a way of ensuring funding from Oxfam rather than of meeting a need. In some programmes it was found that, whatever the initial training, subsequent training was very poor.

The only knowledge transfer between trainers and health workers occurred at monthly meetings. In many programmes the health workers' field training was inadequate. Nevertheless, in some instances the workers were keenly aware of the sociopolitical background to health problems. This was directly related to the skills acquired from project team members. Unfortunately, many projects did not have suitable training personnel and made no provision for in-service training.

Guidelines

- Funding agencies should be highly selective in their support for need-based primary health care programmes.
- Funding agencies should support community health programmes that are a part of the total development of the people.
- Training that requires remote control should not be undertaken.
- The needs of programmes should be identified before expertise from outside is offered.
- Professionals can help health workers in projects to improve and learn new skills.
- Projects should be helped to evaluate their work objectively; the framework for adequate supervision and training in record-keeping is lacking and this gap should be filled by expertise from outside.
- Self-sufficiency in health care is a myth, especially if the focus is on disadvantaged and exploited sections. Funding should be ensured until local resources become adequate.

Manuals and teaching materials were scarce in many programmes and those used were sometimes considered inappropriate. It was not clear whether there were practical difficulties in obtaining health education materials suitable for local situations. If teaching materials are produced locally they are better understood because they reflect community health problems, their causes, and cultural influences. On the other hand, producing materials locally needs the investment of professional time and a good understanding of the communication of health messages, two elements that were generally unavailable in the projects we studied. Innovative methods like the use of role-playing and singing were used very rarely. Little attention was given to practical skills and appropriate technology.

It was often observed that community health workers were very willing to offer assistance to patients and fellow-workers. They had a good grasp of theory and technical detail and were fully capable of performing allotted tasks. However, most of the projects lacked any system for evaluating the community health workers and consequently there was very little scope for upgrading their skills.

In one project, young girls whose literacy was of high-school standard were recruited; they were evaluated by means of written and practical examinations. In another the continual involvement of community health workers in a variety of skilled activities enabled them to raise their status, and attendance at monthly meetings helped them to assess their problems. Some of the projects provided support systems whereby the workers referred cases in need of special attention to clinics and the coordination of immunization and other programmes was effected.

The performance of community health workers may be the best available measure of health impact, but standardized methods of assessing it are not readily available. A potentially useful method consists of determining its effect on community health, knowledge and practices, especially in connection with the prevention and early treatment of diseases. Direct measurement of changes in health status can be costly and time-consuming and it is usually difficult to know whether a particular programme is responsible for any changes detected. Measurement of the infant mortality rate or of other sensitive indicators requires a rigorous information system, which is seldom found in projects.

Conclusion

The varied approaches to and understanding of health and development showed that the concept of community health was still evolving. The overall analysis indicated that the community health workers were not properly integrated into the programmes in a way that would increase people's autonomy in health care. The role of the community health worker was limited to a large extent by professional bias, fear of quackery, and an unwillingness to take risks. In most projects the development of training methodology was approached in a very amateurish manner. There was a tendency to assume that the training of community health workers and the imparting of health education were ends in themselves.

In general, many questions concerning community health workers remain unanswered. What is their role? To whom are they accountable? How does one keep a balance between their technical training and the social and other aspects of their work? Who supervises them? Are they accepted by the community? What priority do health projects have in local development?

The role of the funding agencies, which introduced the idea of the community health worker to the projects, deserves careful consideration. Initial training was undertaken by persons from outside the community. Subsequent training and the development of the role of the health workers were neglected. When the agencies grafted the concept of the community health worker onto particular institutional set-ups they made little or no effort to create frameworks for adequate training, record-keeping and supervision. Many of the projects did not possess the required skill

and, as a result, there remains a vacuum in this sphere. To believe, therefore, that the programmes have become self-sufficient after a brief period of funding would be erroneous. In many cases the programmes have come to a standstill after the withdrawal of support in the forms of training and funds. Funding has led to programme changes but seldom to a change in perspectives.

Acknowledgement

I am grateful to Oxfam (India) Trust for permission to publish this paper.

Reference

1. Werner, D. Where there is no doctor: a Village Health Care Handbook. Palo Alto, CA, The Hesperian Foundation, 1977

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UNITED NATIONS
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WOMEN, POPULATION AND DEVELOPMENT
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Low-cost Water and Sanitation: Tasks for all the People

Schemes for the provision of water and sanitation in urban fringe or rural communities of the Third World are unlikely to realize their full potential if they are put into effect by centrally directed engineers with little or no reference to local aspirations and preferences. Extensive consultation with the people who are going to use the services should take place from the outset, and women should figure prominently in the process. The practicalities of achieving this are considered below in relation to a field study conducted in Indonesia.

Deepa Narayan-Parker

Most governments cannot assume complete financial responsibility for the provision of satisfactory water and sanitation systems. This has led to a search for low-cost technologies and alternative strategies of implementation, primarily for rural areas and urban fringes.

User involvement

Community participation in decision-making about low-cost systems leads to solutions that are socially relevant, as local knowledge and preferences interact with technical expertise from the outside. When communities have helped to make decisions they are more likely to pay for, use, maintain and repair a system than would otherwise be the case. Although community participation is viewed by many as a means of cost reduction, eliciting it is costly and time-consuming, a factor usually overlooked when budgets are being prepared.

The use of the term "community participation" has created some problems, because a community is an abstraction and therefore cannot be mobilized. It is the units making up communities that have to be relied on. Communities are rarely smoothly functioning, homogeneous entities in which everybody is equally interested in water supply and sanitation. They are made up of people, some richer and more influential than others. Ethnic divisions may be present. Important as it is to work with community officials and leaders when devising low-cost programmes for water supply and sanitation, it is equally necessary to mobilize the energies of ordinary people, including women.

In most cultures, women's needs, interests, friendships and ways of networking tend to differ from those of men. Unless special attempts are made to understand the environment of women,

they will continue to be bypassed. Women's involvement should not be limited to women's projects or components of projects. The important thing is for women to take part in decision-making.

Most water utilities were developed at a time when engineers worked in accordance with blueprints produced in centralized, vertical, hierarchical structures. Later, a new approach was introduced: engineers were asked to establish a dialogue with communities and to respond to their traditions, aspirations and preferences. It is now clear that engineers and planners should use social data to develop feasible schemes.

A baseline study in Indonesia

Baseline studies can be invaluable in discovering cultural, social psychological, physical and organizational factors of relevance to water supply an sanitation. Unfortunately, academic baseline studies have often been of limited value to planners. Additionally, the time-lag between the start of a study and the presentation of results is often too long.

A baseline study is a learning process and, ideally, in a participatory water supply and sanitation programme, the first step in user involvement. Regrettably, baseline studies in this field have become surveys with structured questionnaires, the main problem with which is the assumption that the investigator knows what questions and answers are meaningful for a particular group of people. Consequently, unless much previous work has been done to understand the psychology of a group, the data collected can be meaningless. Data gathered from questionnaires describe situations but do not explain them and if used in isolation are of limited value to planners. Furthermore, direct questioning is not the best way to obtain information on socially sensitive issues and to untangle underlying processes. Baseline studies tend to amass huge amounts of data, only some of which have a bearing on water supply and sanitation.

Sampling procedures are faulty in many studies. For example, no study that considers men only can claim to have taken a representative sample. It should also be noted that, in most cultural contexts, it is extremely unlikely that women will add to, correct or contradict what their husbands tell an outsider in joint interviews. Male interviews, especially those from outside, are not given the kind of information by women which a female interviewer might elicit. Where reliance is placed on key informants, who are usually men and include village officials and other leaders, the data assembled are likely to be biased and incomplete. Any attempt to form judgements about women's knowledge and interest in water and sanitation which involves talking to village officials will probably be even less satisfactory than interviewing women's husbands.

A baseline study undertaken in Nusa Tenggara Timor, Indonesia, by the women's organization *Pembinaan Kesejabteraan Keluarga*, under the direction of Dr Nafsiah Mboi, involved a mix of 13 techniques, including ones that were observational, qualitative, participatory and quantitative in nature [1/].

Unless women and children become convinced of the need to change the way they handle drinking-water in the home it will continue to be polluted, despite improvements at source.

All the methodologies were viewed as tentative and were modified in the field. The techniques included 252 open-ended household interviews, half of them with women, conducted in privacy by interviewers of the same sex as the interviewees; also used were key informant interviews, structured and participant observation, interviews with groups, and participatory mapping.

Engineers and planners should use social data to develop feasible schemes.

Women's and men's concepts of good health and illness were investigated by organizing a simple health game. Additionally, schoolchildren aged 10-15 years completed a brief questionnaire related to water, sanitation, and the management of diarrhoea. It should be stressed that not all of the techniques mentioned are necessary in narrowly defined baseline studies.

The same issues were often explored by different investigators using different techniques and talking to different people. This allowed the cross-checking of information and made it possible to avoid misinterpretation.

Perceived problems

If a community has been selected for water supply improvements it is important to know whether its members consider that problems exit in this sphere. When there are multiple water sources of different types and the population is very scattered, households are not equally affected by water problems.

Both men and women were asked to recount their activities from morning to night for the previous day. They were then asked to indicate the easiest, most difficult, most liked and most disliked daily activities. The questions were open-ended and asked prior to any reference to water or sanitation issues. No men and only two women indicated that water collection was the activity they liked best. After weaving, the carrying of water was the activity considered most difficult by women. The three activities considered more difficult than water collection by men were land preparation, carpentry and weeding. Overall, 71% of interviewees said they experienced family problems; for men and women respectively the values were 80% and 63%. The single most important problem mentioned by women was that of water collection. For men the most important problem was lack of money, although water was mentioned by 13% of them. More women than men expressed concern over the quality of water. The main complaint of men in respect of water related to the distances to sources and the time and labour involved in water collection. This is particularly interesting in the light of the fact that 87% of the water journeys observed were made by women or by children below 17 years of age. Men were more likely to be involved in water collection if the distances were long and the terrain steep.

Bringing women into the picture

Certain difficulties will have to be overcome if women are to be mobilized to solve water problems. Not surprisingly, it was found that women had less formal education than men. Fewer women than men could read well. It is also important to note that gatherings of women, unless clearly associated with the performance of some task, were seen by both men and women as leading to gossip, an activity disapproved of.

Both men and women usually rated women significantly lower than men in all abilities. However, men sometimes rated themselves lower than women rated them. A few women considered themselves equal to or better than men. Both men and women pointed out that men usually participated in village administration, spoke Bahasa Indonesia, and went out more often than women. Thus men were exposed to richer variety of experiences than women .

Members of both sexes pointed out that women led relatively isolated and monotonous lives, being involved in the same type of activity day after day.

In informal conversations, village leaders laughed when asked if they thought that women could be mobilized to help solve water problems.

Local institutions

In a society where women led relatively isolated lives, where their friendships are limited to their immediate families and neighbours, and where both men and women consider women's potential to be low, it is a formidable task to elicit their participation in a development project. One solution is to work through women's organizations and village-level institutions. However, without an understanding of how decisions are made within local institutions it may be difficult to achieve broad-based participation in programmes.

Each village in Indonesia is headed by an elected village chief and his assistants. Decisions are made in the village development council and considered in a musyawarah or community discussion meeting. In effect, however, decisions are usually made by the chief. Women are rarely present at council meetings. If they do attend, they almost never participate in decision-making. The study revealed stresses between the wards of a village and in many cases people lacked trust in their leaders, especially in connection with financial management.

Pembinaan Kesejahteraan Keluarga is the main vehicle for stimulation, support, organization and management of development efforts by Indonesian women. In the area of the study it is a relatively young body, intensive organizational efforts having started in 1979.

At village level it is headed by the wife of the chief; she is assisted by trained volunteers. In the four villages studied, *Pembinaan Kesejahteraan Keluarga* was functioning poorly : there were major leadership problems and no clear plans. Decisions were made by the chiefs. Despite this, it is important to note that ordinary village women expressed strong interest in learning through the organization and in making it into a force for self-help. Despite the relative youth of the organization, the women it trained were emerging as leaders in the villages. This is extremely important in a cultural context where, traditionally, the wife of the village chief has assumed the leadership of women's activities.

Women should take part in decision-making

Clearly, where both the formal village council and the women's organization are not dynamic or representative of the population at large, a satisfactory outcome cannot be excepted if they are asked to be responsible for a water project without substantial support in the form of training and management. In such instances, it is important not only to build the capacity of local institutions but also to organize lower-lever decision-making groups of users which can function under the umbrella of the larger bodies.

Quality tests

As well as providing safe sources that are likely to be used, it is important to protect the quality of water on its way to the user.

Tests for faecal coliforms were conducted on water samples from sources and form drinking vessels and containers for carrying and storage. The findings indicated the importance of involving women and children in water projects. Faecal coliform counts in springs, wells, rivers, pipe systems, and holes near rivers ranged from 0 to 5344/100 ml; the geometric mean for all sources was 17.7. For water in carrying containers the corresponding values were 0-12008 and 140.6, while for that in storage containers they were 0/12008 and 128.1. The geometric mean for boiled drinking-water was 24 while that for unboiled drinking-water was 85.

These findings clearly indicated that the way women and children were handling water contaminated it. Information on water-handling was also obtained through observation and during household interviews. There was a strong negative correlation between the presence of children aged 0-4 years in households and the quality of water. Its was also observed that 78% of drinking-water containers were kept within reach of young children. Unless women and children become convinced of the need to change the way they handle drinking-water in the home it will continue to be polluted, despite improvements at source.

The baseline study was a starting point for drawing up plans, training staff, and winning co-operation from technical departments.

Moving from research to implementation has meant changes for all involved. Technical departments eager to support the programme had to be convinced that the solution did not consist of immediate intensive drilling operations in all four study villages. Male community organizers had to overcome their embarrassment in dealing with women and had to learn to be facilitators rather than leaders.

Scepticism about women's abilities has begun to diminish. A small, home-made wooden model is being used to get women involved in the design of spring captures. The temptation to bypass nonfunctioning village organizations for the sake of quick results has been resisted. Twenty-four user groups have evolved under the umbrella of *Pembinaan Kesejahteraan Keluarga*, while women have taken the lead in improving 33 water sources. Women are now playing their part alongside men, and technical staff no longer work in isolation.

Acknowledgement

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Reference

1/ Narayan-Parker, D. Women, water and sanitation. Kupang, Indonesia, Pembinaan Kesejahteraan Keluarga, 1986 (unpublished document).

From: World Helath Forum, Vol 9 N0. 3 1988, WHO (Geneva) pp 350-360.

A shelter that saves mothers' lives

In recent years, maternal mortality in the rural area covered by Ekwendeni Hospital, Malawi, has been reduced to zero, partly because women have been persuaded to use an antenatal shelter situated about 50 metres from the delivery ward. The shelter is a house with three shared bedrooms, a kitchen, a toilet, a shower, and clothes-washing facilities. Each woman brings her own food and cooking utensils, and may be accompanied by a helper.

The main problem has been to encourage mothers at risk to attend hospital prior to going into labour so that during all stages of childbirth they are under supervision. This allows intervention to take place in good time if necessary.

Although Ekwendeni Hospital is private, no charge is made for the use of the shelter. Between 5 and 25 women reside there every night. The duration of their stay depends on the kind of referral, their knowledge of their expected date of delivery, and the distance they have to travel. Most referrals are from medical units where there are trained birth attendants but no surgical facilities; a few women refer themselves to the shelter. The length of stay tends to be relatively short for women who know their expected date of delivery, live nearby and are referred from another medical unit. The women who stay longest are self-referred and come from places at least 250 kilometres away.

Maternal emergencies should be a thing of the past because today there is much wider coverage than formerly through static and mobile antenatal clinics. Only rarely do we see a woman who has been in labour in the bush for two or more days, with all the associated complications. Perhaps once a year we have to deal with a ruptured uterus. Maternal mortality has declined because it is now possible to identify at-risk mothers and persuade them to attend hospital at an early stage and stay at the antenatal shelter if this seems desirable.

Other factors contributing to the fall in maternal mortality have been:

- a large increase in elective caesarian sections;
- routine prescribing of iron tablets for pregnant women;
- the existence of a blood transfusion service;
- increased supervision of deliveries and consequent reduction in harmful self-medication;

- aggressive use of antibiotics in puerperal sepsis and suspected criminal and infected abortion;

- control of high blood pressure and of toxaemia, made possible because most women attend antenatal clinic five times during pregnancy;

- culdocentesis is performed in cases where ectopic pregnancy is suspected, before treatment by operation.

Clearly, it is important to persuade all pregnant women, including those who are well but possibly at risk, that they should use the antenatal shelter, rather than to concentrate exclusively on those who are unwell.

From: World Health Forum, Vol 19 No. 3 1988. WHO, (Geneva) pp 387-388.

The problems

Among the major problems of adolescent reproductive health are those resulting from the traditionally early marriage of girls that still prevails in many, especially rural, parts of the developing world. Despite legislation designed to eliminate the practice, many girls marry shortly after puberty and are expected to start having children almost immediately. The World Fertility Survey found that 25% of 14-year-old girls in Bangladesh, for instance, and 34% of 15-year-old girls in Nepal were married, although the legal minimum age for marriage is 16 in both countries.

Although an adolescent girl is likely to give birth and rear her children within the context of an extended family, the risks she and her children run of illness, injury and death are far greater than those for a mature woman in her twenties. The chances of anaemia developing during pregnancy and of retarded fetal growth, premature birth and complications during labour are all significantly higher for the adolescent mother, as are the risks of her own death during pregnancy or childbirth. According to a survey carried out in Matlab, Bangladesh, for example, maternal mortality rates were five times higher in 10-14-year-olds than in 15-19 year-olds, and twice as high among the 15-19-year-olds as among women aged 20-24. Similar observations have been made in some African countries. Moreover, children born to adolescent mothers are about 40% more likely to die during their first year of life than those born to women in their twenties, and are at even greater risk during their second year.

Further problems may arise during pregnancy in adolescent girls who have not yet finished growing. Failure to meet the increased nutritional requirements imposed by pregnancy may result in damage to the girls' future health, including their ability to achieve full growth.

Formal education of girls generally ends with marriage, and from then on their social status may well depend on fecundity. An adolescent girl who proves to be infertile (or whose husband is infertile) runs the risk of being rejected by both husband and family and thus of losing what little status she has.

Similar problems of early childbearing are encountered in certain societies, such as some Caribbean and African countries, in which adolescent pregnancy and childbirth are common outside marriage and regarded as a means of improving status, demonstrating fecundity, and attracting a new partner to provide support for each successive child.

The second major set of problems of reproductive health in adolescence results from the profound socioeconomic changes taking place in most developing countries. The average age of menarche has fallen, there is a trend towards later marriages, and young people are often less directly supervised than was the case in the past - all of which have the effect of increasing the

opportunities for sexual encounter. In some parts of Africa, for example, 50-80% of those aged 15-19 have experienced sexual intercourse, while in the United States of America, estimates for 1982 from the National Survey of Family Growth showed that about three-quarters of unmarried 19-year-old women had had sexual intercourse.

Since the subject of adolescent sexuality remains taboo in most societies, there is widespread ignorance among young people of the risks associated with unprotected sexual activity. Sources of information and contraceptive advice are rarely available or accessible to them. In addition, impulsive sexual behaviour and non-use of contraceptives are sometimes exacerbated by alcohol and drug abuse. Unwanted pregnancies are common and frequently terminated by illegal and clandestine abortion. When a pregnancy is allowed to continue it may be concealed for as long as possible, placing the mother's health in jeopardy. After the birth, health risks to the mother -and her child- are even greater than for the married adolescent mother, and the child is less likely to receive adequate parental care. Although it is difficult to confirm, it is widely believed that these circumstances may be responsible for increases in infanticide, baby abandonment and child abuse. For these same reasons, pregnancies among adolescents are a continuing concern for many industrialized countries even though overall fertility rates are at low levels.

A further problem of uninformed and unprotected adolescent sexual activity is the increased exposure to sexually transmitted diseases, including infection with human immunodeficiency virus (HIV), the causative agent of acquired immunodeficiency syndrome (AIDS). While incidence data are not available on a global level, there are indications that age-specific rates of sexually transmitted disease are highest among 15-29-year-olds, with concomitant increases, at least in the industrialized countries, in age-specific hospitalization rates for pelvic inflammatory disease and cervical cancer. Epidemiological data on patients with AIDS suggest that, in many cases, infection with HIV was acquired during adolescence.

When young people lack guidance and information, and measures to prevent exposure are inadequate, they will be less likely to seek timely professional medical help and more likely to undertake dangerous self-treatment. The consequences of this may be permanent impairment of health, infertility, psychological damage and even death, with long-term effects not only on their immediate families but also on society as a whole.

From: The Reproductive Health of Adolescents. A Strategy for Action. A joint WHO/UNFPA/UNICEF Statement. WHO (Geneva) 1989. pp 9-11.

How maternal care reduces infant mortality

The causes of perinatal death (essentially death occurring between the 28th week of gestation and one week of life) can be very difficult to classify, but precise diagnosis is probably not important. The main causes of death are intrauterine and birth asphyxia, low birth weight (due to either prematurity or intrauterine malnutrition), birth trauma, and intrauterine or neonatal infections.

Infants with low birth weight are particularly vulnerable to loss of body heat, and hypothermia is a major contributing cause of neonatal death among these infants. Low birth weight is closely linked to maternal malnutrition but other factors of major importance are prematurity (often caused by mothers continuing to undertake heavy work during pregnancy), maternal disease, high blood pressure (toxaemia of pregnancy), and infection (especially malaria and sexually transmitted diseases).

Perhaps the most important factor leading to maternal malnutrition is the effect on the mother of too many and too frequent pregnancies. The continued depletion of the mother's body resources increases the risks of her giving birth to an infant with a low birth weight and of maternal disease, factors that in turn increase the risk of perinatal and maternal mortality.

The causes of neonatal death are much the same as those of perinatal death; they include low birth weight, infections, and the sequelae of birth trauma.

Neonatal infections are often related to unhygienic delivery practices, or they may result from infections of the amniotic fluid or the cord following prolonged labour. Such infections can cause pneumonia or general sepsis in the infant.

Neonatal tetanus is perhaps the single most important cause of neonatal death in many countries, because of its high case-fatality rate (without treatment, close to 100%) and its high incidence. In many African and South-East Asian countries, mortality rates from neonatal tetanus of between 10 and 30 per 1000 live births have been recorded, and occasionally even higher. The global number of deaths due to neonatal tetanus is estimated to be between 750 000 and 1 million cases annually. Since the incidence is directly linked to unhygienic childbirth practices these deaths can be prevented by appropriate training. Traditional practices, such as treating the cord with cow dung, ash, or clay to stop bleeding or cutting the cord with unclean instruments, are largely responsible for this problem. Strict hygiene during delivery has been demonstrated to be very effective in controlling the disease. The disease itself is also special in so far as it lends itself to passive immunization of the fetus by giving tetanus toxoid to the mother (two doses) well before delivery...

The most urgent and immediate action to be taken in countries where infant mortality is high and there is a high incidence of neonatal tetanus, is the reduction of neonatal infections. The strategy should be two-pronged:

- training of traditional birth attendants (and education of the pregnant women themselves) in hygienic delivery techniques and cord care; and
- immunization of pregnant women and, preferably, all women before their first pregnancy.

From: Maternal care for the reduction of perinatal and neonatal mortality. A joint WHO/UNICEF statement. Geneva, World Health Organization, 1986, pp. 11-14.

From: WHO Chronicle, Vol.46 No.5 (Geneva) 1986, pp. 199.

Female literacy lowers infant mortality

Even where mothers are poor, if they have received some schooling their babies have a better chance of surviving past childhood.

An analysis by WHO of studies involving 160 000 women in some 30 developing countries confirms that the higher the female literacy rate, the lower the infant mortality rate. The studies themselves were carried out by the countries concerned as part of the World Fertility Survey, and published in 1984 by the International Statistical Institute, Voorburg, Netherlands.

In countries where the female literacy rate is low -less than 35%- children run from two to three times greater a risk of dying during the first years of life than in countries where female literacy is above 90%. And the effect is independent of income. In every economic setting, the children of literate women have a better chance of survival than those of illiterate women.

In addition, 30% of women of childbearing age with at least seven years of schooling use a modern contraceptive, such as the pill and the intrauterine device. The figure for women with no formal education is 10%. Women with schooling tend to marry later, delay childbearing, and are more likely to practise family planning. They generally have fewer children with a wider spacing between births. Women with no schooling, on average, have almost twice as many children as those with seven or more years' schooling.

These patterns are illustrated in graphic form in the recently published World Health Statistics Annual, 1985, [1/] which is compiled from information made available to WHO by countries. The Annual gives mortality rates for over 50 causes of death, such as heart disease, cerebrovascular disease, lung cancer, cirrhosis of the liver (alcoholism), and car accidents, as well as estimated infant mortality rates and life expectancy for developed and developing countries.

Infant mortality

According to the data just published, the rate of death among infants under 1 year old ranged from 6 to 8 per 1000 live births for Japan, the Netherlands, the Nordic countries and Switzerland, to over 100 for most African and many Asian nations.

Among the lowest infant mortality rates for developing countries or territories, based on estimates, are:

- Africa: Mauritius with 27 deaths per 1000 live births; Madagascar, 59; Zimbabwe, 61; Cape Verde, 68; Botswana, 71.

- Latin America and the Caribbean: Puerto Rico, 15; Costa Rica and Martinique, 18; Cuba, 19; Barbados and Guadeloupe, 20.

-Eastern Mediterranean: Cyprus, 15; Kuwait, 25; Bahrain, 30; Qatar and the United Arab Emirates, 38.

- South-East Asia: Democratic People's Republic of Korea, 28; Sri Lanka, 30; Thailand, 42; Mongolia, 43; Indonesia, 76.

- Western Pacific: Singapore, 10; Hong Kong, 11; Fiji, 24; Republic of Korea, 25; Malaysia, 26.

According to data for 1983-84 made available to WHO, the industrial countries with the lowest infant mortality rates are: Japan, 5.9; Finland and Iceland, 6.2; Switzerland, 7.1; Denmark and Sweden, 7.7; and Norway, 7.9. The rates for the most populous developed countries, apart from Japan, are: Canada, 8.5; France, 8.2; Federal Republic of Germany, 10.3; German Democratic Republic, 10.7; Italy, 12.4; Poland, 19.2; Romania, 23.9; Spain, 14.3 (1979); United Kingdom: England and Wales, 10.2; Northern Ireland, 12.1; Scotland, 10.5; USA, 10.9; USSR, 22.

Maternity care

More than half of the births in developing countries - a total of 53 million annually, according to WHO estimates - are unattended. This means that mothers deliver without the assistance of any trained person, not even a trained traditional birth attendant. Largely as a result, there are an estimated half million maternal deaths in the world every year - virtually all of them in the developing countries. The following figure show the extent to which maternity care is lacking in the developing countries:

- Africa: 12.5 million unattended births annually (estimated around 1980), or 63% of all births;

- the Americas: 4.5 million unattended births (36%);

- Eastern Mediterranean: 9.5 million unattended births (77%);

- South-East Asia: 28 million unattended births (73%);

- Western Pacific: 2.5 million unattended births (9%).

WHO's hope in publishing the Annual is that "the dissemination of such information will encourage countries to use these data to identify health needs and to improve the management of their health systems".

Poisoned? Help is at the end of a telephone

A little girl thinks it is lemonade ... and swallows household bleach by mistake. A deadly snake rears in fright and strikes its poison fangs into a human foot. A scorpion attacks. Someone is found comatose from an overdose of drugs. A worker is in danger from an industrial accident involving a chemical substance. These are the times when poison centres are called into action.

The countless individual cases of poisoning and the industrial accidents endangering whole communities formed the backdrop to the Fourth General Meeting of the World Federation of Associations of Clinical Toxicology Centres and Poison Control Centres held at WHO headquarters, Geneva, on 7-9 October 1985. The meeting was attended by 75 representatives from centres in 33 countries.

1/ See "Recent WHO publications" in this issue.

From: WHO Chronicle, Vol.40 No.2 1986. (Geneva), pp. 77-78.

The following questions should be answered before the start of a training programme for community health workers

- Is the programme need-based?
- Does it include both curative and preventive services?
- Is it part of an overall development plan?
- Are the health services integrated with the overall development input?
- Is the programme compatible with existing health services?
- Is a referral system envisaged?
- What training facilities are there?
- Are sound baseline data available?
- Who are the beneficiaries and does the programme identify them?
- Is there a system for keeping records and reporting?

From: World Health Forum, Vol.9 No.2 1988. WHO (Geneva), pp. 233.

The Commonwealth Caribbean Community

The Commonwealth Caribbean Community has long recognised the need to improve the health status of mothers and children. It has also recognised that optimal maternal and child health is predicated on both the quantity and quality of services.

Consequently, a Strategy and Plan of Action to strengthen Maternal and Child Health (MCH) services was formulated in 1975 by technical specialists from the Caribbean territories in collaboration with technical experts representing various regional and international agencies. The recommendations contained therein relate to MCH problems prevalent in the territories at the time in the areas of services to mothers and children as well as in the health service infrastructure. Specific target dates were suggested for implementation of the recommendations. It was also proposed therein that each country review its own situation in light of the general Strategy and Plan of Action, prepare its own plan of action and implement the recommendations.

In 1978, the World Health Organisation set the Global Goal of Health For All By The Year 2000. The Governments of the Caribbean region have confirmed that primary health care is the principal strategy for attaining this goal. They have also agreed that a major thrust of the activities of the primary health care (PHC), strategy should be toward the achievement of adequate health protection and promotion services for women and young children. Further, that specific areas which require strengthening should be emphasized such as the identification of risk groups and improving the levels and quality of their care.

In 1981, an evaluation of the performance of the MCH programmes and the degree of attainment of the targets of the MCH Strategy was carried out in the area. This seemed appropriate in light of the fact that the respective countries were in the process of devising or implementing their strategies for attaining the global goal.

Findings from the evaluation indicated that there was much variation in MCH performance, in terms of morbidity and mortality outcomes, coverage, quality of care and adequacy of support services, among the services in individual territories as well as inter-territorially. Specific areas have shown much improvement, while there is need for much improvement in others.

Major evaluation recommendations were that the MCH Strategy should be revised, made more definitive and that the various elements should be prioritized. A Technical Meeting to update the Strategy was proposed.

Resolution No. 25 of the Eight Meeting of the Conference of Ministers Responsible for Health, convened in July, 1982, endorsed the recommendations made in the Evaluation Report. It

also requested PAHO/WHO to convene a meeting of selected technical and administrative personnel from the region to review and update the Strategy in the context of primary health care.

Such a Technical Group Meeting on Maternal and Child Health was convened in response to this Resolution, October 24-27, 1983. The objectives, targets and recommendations made by that Body, comprise this Revised Strategy.

Summary of Status for Maternal and Child Health (1981)

Evaluation of the performance of MCH programmes conducted in 1981, indicated the following:-

Antenatal services have generally failed to attract pregnant women early in their pregnancy, less than one-third registering by the 16th week, in the majority of territories.

There has been a general tendency to reduction of neonatal mortality, and a tendency to increasing hospital delivery and delivery by qualified personnel.

Postnatal care services need to be more developed, only two countries seeing 70% or more postnatal mothers.

Supervision of infants at health clinics is generally good, but the immunisation coverage target of 80% of children under two years of age has not been achieved.

Both infant deaths and deaths in children one to four years of age have been falling in most territories.

Services to school children are the least well developed, and only one country has established a Health/Education Coordinating Committee.

Little has been done in many of the countries to develop the infrastructural framework necessary for the support of the MCH programme.

There are only five countries with written MCH plans.

In relation to the development of an Information System, those data relating to vital statistical events are generally readily available. However, data required for evaluating coverage, especially of children, is less readily available, and data on abortion is almost impossible to get. Even where data is available, they are not used routinely for evaluation of the services.

The criteria for high risk pregnancy and a system for appropriate care have been established in all countries except one.

Most of the services recommended for children are provided by the majority of countries, with the exception of one. The areas of greatest deficiency are provision of supplementary food and iron and vitamins, and promotion of dental health.

Oral rehydration at district level has been established in nine territories.

Generally the weak areas in services to school children are in the provision of child and parent guidance and screening for vision, hearing and heart defects. Only one country has specially trained public health nurses to perform screening procedures in schools.

All countries except two have a system of day care. In some countries these are government-run - either through the Ministry of Health or Education and, in others, they are run by voluntary organizations. A code of standards for the operation of these centres has been adopted in three territories.

The Revised Strategy

INTRODUCTION

The Revised MCH Strategy for the Caribbean embraces the fundamentals of the Primary Health Care approach which are in essence:

(a) ***The extension of coverage of health services to the maternal and child population*** to ensure the promotion and maintenance of their health and that of their families;

(b) ***Inter-sectoral co-ordination*** to enable the relevant sectors, agencies and the community itself, which impact on maternal and child health, to be involved comprehensively in achieving stated goals;

(c) ***Community participation*** to ensure:

- that individuals, families and groups comprising the MCH population are fully involved in measures designed to improve their care; and
- that MCH programmes and services and related and responsive to the needs of the community;

(d) ***The progressive movement and reorientation of resources in the direction of primary health care*** to ensure an optimal operational framework for promotion and maintenance of the health of mothers, children and families.

Embodied in the various components of the revised Strategy are three important processes or methodologies, expressed in the objectives and targets:

(i) ***The Risk Approach*** which will enable the selection of priority problems; the identification of population sub-groups in which these problems are concentrated; an assessment of the capacity of the health sector to effect changes; and the definition of intervention strategies according to health needs;

(ii) Co-ordination of activities targeted through a sound and suitable ***Health Information System***, which will enable national decision-making, planning and evaluation;

(iii) Continuous ***Monitoring and Evaluation*** of health conditions and levels and the effectiveness and efficiency of services which will enable judgements of the extent of progress toward goals.

1. The Extension of Coverage of MCH Services

A. THE MOTHER

Women of reproductive age comprise about 25% of the total population of the Caribbean countries. Thus the need for a comprehensive maternal service is readily recognized.

Fertility patterns have indicated a tendency for first pregnancies to occur earlier in the child-bearing period and an increase in the number of women who have conceived. Efforts are needed to reverse this trend.

Maternal mortality, though very low in most countries, is still an on-going concern. Maternal morbidity is of major concern and is in need of much attention. Some of the related problems within the countries of the area that contribute significantly are anaemia, pre-eclampsia, the consequences of unregulated fertility such as multiparity and closely spaced pregnancies, lack of trained personnel in the delivery of care and lack of community education about the importance of maternal services.

Late and often poor attendance at antenatal clinics is a continuing problem in the area. Teenage pregnancy is a tremendous health and social concern.

Overcrowding in urban hospitals has necessitated reduction in the average post-partum hospital stay.

The health and social benefits of family planning are widely recognized. However, innovative strategies are required to increase the number of family planning acceptors and to convince acceptors to remain on the methods.

Males are greatly in need of motivation toward responsible parenthood. The health of a woman during the childbearing period depends to a large extent on multiple factors. Important among these are her general standard of health during the pre-childbearing stage, particularly her nutritional status; certain health-related risk factors such as age, social conditions, education and employment status; specific health factors such as the presence or absence of disease conditions; her accessibility to services; the availability of programmes to promote her well-being and reduce health problems which might occur; and the quantity and quality of antenatal, intranatal, postnatal and interconceptional care.

Maternal health services, integrated into the primary health care (PHC) system, should ensure the care of the pregnant woman, the safe delivery of her child, her postnatal care, the initiation and maintenance of lactation, the care of her newborn infant, guidance in parenthood and family planning; early detection and control of breast, cervical and uterine cancer and care of other gynaecological problems.

Objectives and Targets:

I. Antenatal Care

1. Each country should ensure that every pregnant woman receives adequate health care by a trained health professional.

1.1 Each country should assess its situation regarding antenatal services and aim at improving coverage.

1.2 Methods should be introduced such as flexibility of clinic hours, increasing the number of sessions, introduction of appointment systems and reduction of waiting periods at clinics.

2. Antenatal care should be initiated by the twelfth week of pregnancy and at the latest, the sixteenth week.

3. There should be a minimum of four antenatal visits up to the thirty-second week of pregnancy in uncomplicated pregnancies, and a minimum of four additional visits up to term.

4. Every pregnant woman should have a complete physical examination before the end of her second trimester of pregnancy.

5. All pregnant women should have a haemoglobin level taken at the first antenatal visit, and at the thirty-second week of pregnancy.

5.1 If the haemoglobin is less than 10 grams, the patient should be fully investigated and treated accordingly.

5.2 All pregnant women should be given iron and folic acid supplements routinely.

5.3 Women should be advised about adequate diet during pregnancy.

5.4 The prevalence of mild to moderate anaemia (Hb between 8 and 10 grams) should be reduced to under 15% and of severe anaemia (Hb below 8 grams) to 1% in women at the thirty-second week of pregnancy. This is in consonance with the Strategy for control of anaemia in the English-speaking Caribbean.

6. Every pregnant woman should possess an updated health record which could be used for the transfer of information between hospital and clinic.

7. High risk pregnancies should be identified as early as possible in order to ensure the institution of appropriate management measures. The following are considered high risk conditions:

- Patients with significant medical conditions, such as hypertension, heart disease, anaemia (including sickle cell anaemia), diabetes, respiratory disease and obesity;
- Patients with a significant past obstetrical problem such as previous uterine surgery, previous stillbirth, antenatal haemorrhage, post-partum haemorrhage, recurrent abortions or premature labour;
- Patients with severe psychological, emotional or social problems.

7.1 All high risk patients should be referred to appropriately trained personnel as determined by national protocols.

7.2 An adequate system for referral of pregnant women to appropriate health care levels should be instituted in each territoy.

8. All countries should improve the quality of antenatal care by the training of health workers and provision of adequate support services.

II. Intranatal Care

9. Each country should ensure that every pregnant woman has a safe delivery and that intranatal services can adequately meet the needs of the mother and family as well as any obstetrical emergency that might arise.

9.1 All deliveries should be attended by trained personnel.

9.2 All high risk patients should be delivered in hospitals equipped with resources consistent with the required level of care. (See 18 and 19.)

10. Specific criteria should be strictly adhered to in the selection of cases for home deliveries in countries where hospital delivery is not possible for all pregnant patients.

10.1 The patient's home should be visited before the twenty-eighth week of pregnancy and an assessment made of social and environmental conditions as well as communication and transportation support services.

10.2 Trained personnel should be provided for domiciliary services in adequate numbers.

10.3 Traditional birth attendants may be utilized for home deliveries if they are adequately trained and supervised, in those territories where they still provide services. (See 74.1 and 102.6)

10.4 A referral mechanism should be established for any obstetric emergency which might arise.

11. *Each territory should improve its coverage for deliveries in institutions according to local needs and resources.*

11.1 The resources required for adequate coverage should be reassessed.

11.2 The provision and proper integration of centres with facilities for normal deliveries should be encouraged.

11.3 Maximum use should be made of maternity beds in district hospitals through the provision of adequate equipment, trained midwifery personnel, public education and a referral system for emergencies.

III. Post Natal Care

12. The post natal period, particularly the first ten days, should be considered a crucial stage in the maternity cycle.

12.1 All women and newborn infants should receive post natal care, and services should be increased by 10% per annum.

12.2 A minimum hospital stay is necessary post delivery but early discharge is acceptable provided that a peripheral service, i.e. a service in which follow-up home visits are made, is available.

12.3 Women who cannot be accommodated by the peripheral service should be kept in hospital a minimum of three days.

12.4 Women who are accommodated by the peripheral service and those who have had home deliveries should be visited a minimum of three times within the first ten days post delivery by a District Nurse Midwife. Evaluation of the progress of mother and infant should be provided as well as breast feeding support.

12.5 Post natal services should be provided at the primary care level in addition to the central institution.

12.6 Post natal, family planning, cancer screening and child health services should be integrated within PHC services.

12.7 Each country should ensure that mother and infants are serviced jointly at post natal clinic sessions. Family planning services should be provided as well.

12.8 Appropriately trained nurse-midwives should be allowed to conduct post natal examinations on women who have had normal deliveries.

12.9 The transfer records of patients' obstetrical information and referrals between hospitals and clinics should be strengthened.

IV. Cancer Detection

13. Each country should introduce a cancer register and provide education regarding prevention and early detection of the disease.

13.1 Cancer screening services should be made available to women at greatest risk from breast, uterine and cervical cancer.

13.2 Community education on cancer in women should be provided.

14. The agreed regional co-operation effort for improvement of facilities for early diagnosis and treatment of cancer should be strengthened.

14.1 An Eastern Caribbean Center for Diagnosis and Treatment of Cancer should be established.

V. Abortion

15. Appropriate measures for the reduction of induced abortions should be taken for the protection of women's health.

15.1 Family planning information and services should be provided to all hospitalized post-abortion patients.

15.2 Laws related to abortion should be reviewed with a view toward their liberalization, if deemed appropriate.

VI. Family Planning

16. All families and individuals should be informed about and have access to family planning services.

16.1 Family Planning should be integrated into the PHC service and should be available at all levels of the health care delivery system.

16.2 Every effort should be made to promote contraceptive use by women at any point of contact with the health delivery system.

16.3 Efforts should be made to strengthen family planning educational and counselling services for all persons, with emphasis on programmes to increase coverage to males and youth, e.g. through youth centres.

16.4 Family planning services to high-risk groups, i.e. those with health problems, high fertility age groups and prospective young mothers and fathers - should be emphasized.

16.5 Factors that contribute to discontinuation of contraceptive practices should be investigated and appropriate steps taken to reduce them.

16.6 Client follow-up programmes should be developed through use of field workers, community health aides and others. Greater emphasis should be placed on tracing defaulters.

16.7 All health workers should be provided with family planning information through continuing education and basic training programmes.

16.8 Screening of personnel to work in family planning services should be carried out to decrease the extent of poor staff attitudes and low coverage of services.

16.9 Deterrents to continued use of contraceptive methods should be removed by giving special attention to flexible clinic schedules, improving clinic efficiency, making supplies more readily available and providing adequate medical supervision of side effects or complications.

16.10 Young teenagers should be encouraged to postpone having children. Prevention of the first pregnancy or delaying of the second should be strongly emphasized. Special counselling services should be available.

16.11 Screening and treatment facilities for sexually transmitted diseases should be developed within the family planning programme.

16.12 Family planning should be an important component of any Population Policy and countries should be encouraged to develop same.

16.13 The draft Caribbean Medical Policy on Contraception should be supported and made an integral part of MCH service delivery.

B. The Infant and the Pre-school Child

Present population trends indicate a rapid increase in the relative size of the zero to five year age group in the Caribbean. Therefore there is an urgent need to plan for and meet the needs of this group, particularly infants below one year.

The major cause of death in children under five years of age in most of the Caribbean territories is conditions originating in the perinatal period. The facilities, services and training opportunities in the region are grossly inadequate to deal with this situation.

The health of the infant during the neonatal period, particularly during the first week of life, depends largely on obstetrical conditions; its weight and Apgar score at birth; the type and quality of care provided for the infant at risk or for the sick infant and the adequacy of facilities for the levels of care required, among other factors. There is need for improvement of facilities, services and quality of care, through strenghtening of the risk concept in perinatal health care programmes and in later stages of early childhood.

In the Caribbean as a whole the incidence of certain diseases, preventable through immunization, such as diphtheria, whooping cough, tetanus and measles, is still significant. Epidemics of poliomyelitis and measles have occurred in recent years as well. This all serves to underscore the fact that the immunization status of the population generally, and that of the young child particularly, is unsatisfactory. There is a dearth of special experience and equipment in the region for the management of the disease conditions leading to chronic disability and mortality in children.

The mental health of children has been largely neglected and there is the need for training and utilization of specialized personnel in this area.

From: PAHO 1985 Maternal and Child Health Strategy for the Caribbean Community. (Barbados), pp. 1-9.