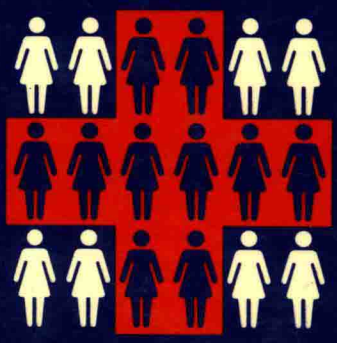
WOMEN AS PROVIDERS OF HEALTH CARE



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WORLD HEALTH ORGANIZATION
GENEVA
1987

ISBN 92 4 156104 1

PRINTED IN SWITZERLAND

86/6990—Populaires—8000

The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this organization, which was created in 1948, the health professions of some 165 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

By means of direct technical cooperation with its Member States, and by stimulating such cooperation among them, WHO promotes the development of comprehensive health services, the prevention and control of diseases, the improvement of environmental conditions, the development of health manpower, the coordination and development of biomedical and health services research, and the planning and implementation of health programmes.

These broad fields of endeavour encompass a wide variety of activities, such as developing systems of primary health care that reach the whole population of Member countries; promoting the health of mothers and children; combating malnutrition; controlling malaria and other communicable diseases, including tuberculosis and leprosy; having achieved the eradication of smallpox, promoting mass immunization against a number of other preventable diseases; improving mental health; providing safe water supplies; and training health personnel of all categories.

Progress towards better health throughout the world also demands international cooperation in such matters as establishing international standards for biological substances, pesticides, and pharmaceuticals; formulating environmental health criteria; recommending international nonproprietary names for drugs; administering the International Health Regulations; revising the International Classification of Diseases, Injuries, and Causes of Death; and collecting and disseminating health statistical information.

Further information on many aspects of WHO's work is presented in the Organization's publications.

CONTENTS

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ACKNOWLEDGEMENTS

This book is the result of an international cooperative effort in which a large number of countries, agencies, and individuals have been involved. The authors express their sincere thanks to all those — too numerous to mention — who have contributed to its preparation.

The text relies heavily on ideas and opinions put forward in the working papers, discussions, and reports of two multinational consultations on Women as Providers of Health Care, which took place in December 1980 and August 1982. The names of the participants in these two consultations are listed on pages 160-163. We are particularly indebted to Dr B. Grab and Dr Bui Dang Ha Doan who provided statistical input to Chapter 2, to Mrs Helga Morrow and Miss Ellen Cahill for their contributions to Chapter 3, and to Dr Beverley DuGas who revised Chapter 5.

Mrs Helena Pizurki devoted much effort and interest to this publication but sadly she passed away before the work was completed. Her intellectual input was considerable and her devotion encouraged the authors to maintain the momentum needed to complete the work.

INTRODUCTION

In conformity with the objectives of the United Nations Decade for Women (1975–85), which stressed the equitable participation of women in national development, WHO, with financial support from the United Nations Fund for Population Activities (UNFPA), has initiated a number of projects, including the Multinational Study on Women as Providers of Health Care.[1] Although its title might give the impression that the project is limited to research, this is only one of its components. Essentially a country-based effort with an active, problem-solving approach, it began early in 1980. It was envisaged at the outset that national efforts would be promoted and supported by certain international activities, including consultations and workshops at which countries and agencies would be represented, and the production and dissemination of material designed to stimulate awareness and encourage appropriate action. The present publication is the first on the situation of women as providers of health care to be prepared by WHO, and the first in the world to provide a general survey and analysis of this situation and guidance for those entrusted with the development of programmes to deal with it. It represents both a result and an expansion of the earlier stages of the study.

The project that has led to the publication of this book consists of a set of interrelated activities organized and managed by WHO. These have included:

(*a*) the first WHO Consultation on Women as Providers of Health Care, at which priority issues were identified;

(*b*) the second WHO Consultation on Women as Providers of Health Care, at which participants identified and discussed the main constituents of a national strategy for achieving the long-term aims of the project, as specified below;

(*c*) the preparation of an annotated bibliography on women as health care providers in both formal and non-formal health systems; and

(*d*) the preparation of papers by participants from 17 different countries, each dealing analytically with a specific issue and containing broad proposals for action (see Annex 2).

[1] Consultants to the project: Dr Irene Butter, Professor of Health Planning, School of Public Health, University of Michigan, Ann Arbor, MI, USA; and Dr Bui Dang Ha Doan, Director, Centre of Medical Sociology and Demography, Paris, France.

Long-term aims

The general long-term aims of the WHO project are:

(*a*) to enhance the political, economic, and social status of women as health care providers in both formal and non-formal health systems;

(*b*) to ensure that all women receive education, training, and/or orientation that will enable them to provide health care for themselves, their families, and other members of the community;

(*c*) to ensure that, within the formal health care system, there is no discrimination against women employees as regards position, pay, responsibility, and authority; and

(*d*) to facilitate in other respects the participation of women in both national and international efforts to achieve "Health for all by the year 2000".

Within this framework, the present publication aims more directly at:

(*a*) creating a broader awareness among people in general, and decision-makers in particular, of the extent of women's contribution to national health development and the obstacles they face both inside and outside the formal health system;

(*b*) creating a broader awareness of the sources of the imbalance between men and women in the extent and nature of their participation in health care;

(*c*) providing information, particularly to women themselves and to decision-makers, concerning the basic factors to be considered in the development of a long-term strategy to improve the socioeconomic status of women health care providers; and

(*d*) guiding both women and men on the planning of relevant action and on the preparation of proposals for funding and other forms of support.

Why this publication is needed

It is paradoxical that, while societies depend so heavily on women to provide health care, their contribution to health development is frequently undervalued. As regards working conditions, women in most countries are discriminated against in terms of position, pay, responsibility, and authority. WHO's growing emphasis on universal accessi-

bility to primary health care, and people's right and duty to participate individually and collectively in the management of their own health care, makes the role and status of women as health care providers an issue of critical importance in the context of the goal of "Health for all by the year 2000". In addition, in many countries, women's special needs for care in connection with their reproductive functions make it imperative that there should be more professional women health workers to care for those women who do not wish to be treated by men.

Evidence suggests that, *in every country*, there is a need to improve the status of women, relative to that of men, within the health care system. Even more important is the universal need for a general improvement in the physical, mental, and social well-being of men, women, and children alike. It is to this end that efforts to enhance, facilitate, and recompense the work of women in health development should be aimed. It is hoped that it will thus be possible to develop health care systems in which neither sex will have a monopoly in terms of control or financial profit, and in which the people in the community will exercise control and reap the reward of better health care.

The importance of women's contribution to the health and welfare of individuals, families, and societies as a whole, has gone largely unrecognized. More often than not women have been viewed as *sources* of health problems requiring and sometimes receiving special attention, mainly through programmes focusing on maternal and child care, family planning, and nutrition. In this book, however, they are viewed as *resources* for the solution of health problems—their own and those of others.

An underlying premise is that, if WHO and its Member States are to design and implement successfully a strategy whose cornerstone is primary health care and which aims at "Health for all by the year 2000", it is essential to concentrate on women as resources. At the same time, a kind of "chicken-or-egg" question arises, namely whether the relatively low status and prestige of primary health care is largely due to the fact that it is mainly provided by women, or whether it is mainly provided by women because it is still regarded by too many people, particularly men, as inferior work.

Whatever the answer to this question, it is essential to find ways of increasing the status and prestige of primary health care. One way might be to involve men and women to an equal extent in the provision of primary health care, with no discrimination between the sexes as regards tasks and rewards. Another might be to shift the greater proportion of the health budget and other resources to primary health care. Yet another might be to ensure that, if women are to continue to be the foundation on which primary health care rests, their work in this area is appropriately acknowledged and rewarded.

It should be noted that an increasing number of women are concerned about the fact that, when countries were busy establishing modern medical schools and new posts for physicians, in most of them there was little talk of the need for women applicants and instructors. With the advent of primary health care, on the other hand, it is women on whom countries appear to be depending. While the belated recognition of the need for women in health care is to be applauded, it can no longer be taken for granted that women will be content with a pat on the back as acknowledgement of their worth. It is hoped that this publication will contribute to reducing the discrimination against women in both the formal and non-formal systems of health care as regards education, training and orientation, employment, career development, and rewards.

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In order to present as objective a picture as possible of the situation of women as health care providers throughout the world, a special effort has been made to obtain numerical data and other information relating to a variety of countries from a variety of sources. The authors are, however, aware that a significant proportion of the information and figures presented reflect a bias in the existing literature, in that they refer mainly to developed countries; in many cases, comparable data are simply not available for developing areas. Nevertheless, the data presented in this publication suggest a great diversity among the countries of the world as regards: how far and in what way women participate in health development; the position of women as health care providers; the measures taken (or not taken) to increase the knowledge and skills of women in order to enable them to participate more effectively in health development activities; and the measures taken (or not taken) to facilitate such participation in other respects.

While the authors of this book lay no claim to having *proved* anything, they have tried to stimulate thought and to remind readers, once again, that each country differs from others in a multitude of ways, including those relating to and affecting women as providers of health care. What may be a priority problem in one country may not be a priority in another. Moreover, even where several countries have a problem in common, its solution may require a different approach in each country.

Chapter I

THE CONTRIBUTION OF WOMEN TO NATIONAL HEALTH DEVELOPMENT

Women play a far greater role than men in the delivery of health care. This is true in most countries and is a relatively well established phenomenon, predating the emergence of modern health care systems. As mothers, grandmothers, wives, daughters and neighbours, they are the principal providers of informal health care in families and communities. In many developing countries, women act as traditional birth attendants for relatives and neighbours, often without financial reward, and still carry out the majority of deliveries. Outside the family, women lead the ranks of volunteers in hospitals, self-help clinics, and other community organizations. Also, in the elementary schools of many countries, the majority of teachers are women whose tasks include the teaching of health-sustaining attitudes and behaviour. Equally important is the role of women in the formal health systems of many countries, where they often constitute the majority of health care providers. Whether within or outside the family, whether in a formal or non-formal setting, women outnumber men as providers of health care.

The concept of division of labour by sex

There are many reasons why there is a tendency for women to play a relatively greater part in providing health care than men do. One explanation links it to patterns of gender-role differentiation instilled in individuals from the moment of birth through a process of learning and social conditioning. Such differentiation is not, for the most part, biologically conditioned or a social necessity, though it has been interpreted in this way by individuals and by institutional authorities in many cultures for a long time. Rather, gender-role differentiation is associated with reproductive differences between the sexes and is transmitted through habit, custom, and education, to perpetuate the notion that women are especially adept at "feminine" tasks and men at "masculine" ones.

Gender-role differentiation produces a sexual division of labour in the family as well as in the formal labour market. While every society practises a division of labour by gender there are considerable cross-cultural variations, so that what is considered to be proper work for women in one society may be typical men's work in another. Both men and women

are conditioned from early on to have different functions, capabilities, and aspirations. For women in most societies, these functions include not only looking after the home and the family, but also more general caring, counselling, and nurturing functions extending into the neighbourhood and community.

It appears to be deeply embedded in social traditions and customs that the division of work between men and women within the family is complementary rather than competitive, and that fathers and mothers serve as role-models for sons and daughters respectively, thus perpetuating a pattern of role differentiation from generation to generation. One explanation given for the complementarity of the gender division of labour in families is the protection of marital relationships through the limitation of work-related competition between spouses. Although there is no reason why the culturally assigned domestic functions of women could not be assumed just as well by men, there are apparently no societies in which men have wholly replaced women in these functions. The pattern of complementarity is replicated in labour markets in the form of gender-typing of jobs and the development of non-competing worker groups. A further differentiation between the sexes within families is the assignment of subordinate roles to women and dominant roles to men, and this pattern too is frequently found in labour markets, both formal and informal.

One additional aspect of gender-role differentiation in both developing and developed societies is the distinction between market and extra-market functions and the relegation of men primarily to the former and women primarily to the latter. This form of specialization has often made women economically dependent on husbands and also has led to a general lack of recognition and undervaluation of household-related work. However, specialization in the production of goods and services for the family's own consumption (extra-market work) has not necessarily precluded the production by women working at home of such goods as food, clothing, and handicrafts for sale on the market. Nor has it always prohibited women from working for pay outside the home. In view of the various types of work in which women around the world take part as home-based producers—paid employment, paid self-employment, work in family enterprises for which they do or do not earn individual wages, unpaid domestic work in the home, and contributions to the money-earning capacity of their husbands—the concept of extra-market work requires to be rethought and redefined.

Women as providers of non-formal health care[1]

Carpenter et al. (*10*) have described the responsibilities of women as providers of non-formal health care, including: (*a*) taking decisions concerning the health care of family members; (*b*) rearing children on healthy lines; (*c*) producing, selecting, preparing, and distributing the family's food; and (*d*) providing health services at home for convalescent, chronically ill, and disabled members of the family. Other responsibilities of women include keeping family health histories, identifying illnesses (both their own and those of others); escorting the sick for necessary care; and providing nursing care, physical therapy, and first aid. Unfortunately, there is a universal dearth of information about the informal health care provided within the family, the preparation of women to provide such care effectively, how burdensome they find this aspect of their family responsibilities, and how much help they receive from their spouses. It is, however, clear that the bulk of informal health care in the home is provided by women. In fact, women hold a unique position as regards the provision of non-formal health care, both in the family and in the community.

Within the family, women are the main behavioural influence on the children of the household. While this applies in all countries, it has particular significance in countries or areas where certain behavioural factors contribute substantially to morbidity and mortality. Women in the home have the advantage of being in a position to alert the young, during their early formative years, to the adverse effects of specific forms of behaviour. By serving as positive role-models and by encouraging family members to assume greater responsibility for their own health, women can help to effect behavioural changes that may lead to a reduction in the risk of accidents, disease, mental illness, and early death.

In the community, women's unique position with respect to health care stems from the special opportunities they enjoy for communicating and interacting with other women who have similar problems as regards their own health and that of their families. These opportunities arise, for example, around the water-pump and in the laundrette, in the paddy field and the tea plantation, in the outdoor vegetable market and the indoor supermarket, in the child-care centre and the health-care centre. As can be seen, most of these opportunities occur at places where, and times when, women are engaged in other tasks pertaining to the welfare of the household. It is the performance of these tasks that allows women to reach out to other women in the community and form a network, thus helping to enhance communal action.

[1] The term "non-formal" is used in this publication to cover health care provided by, for example, family members in the home, lay health workers, traditional practitioners such as birth attendants, and self-help or mutual-help agencies, including clinics or dispensaries established and run by women (usually for women exclusively).

Primary health care outside the formal health system

Primary health care is currently provided, for the most part, outside the formal health system and mainly by women. In general, women are involved in the following basic primary health care activities.

(*a*) Health education/family life education

Education for the promotion of health and the prevention of disease is the first of the eight essential components of primary health care. In most parts of the world, in both formal and non-formal health care systems, women are the health educators and foster the type of learning that will motivate people to want to be healthy and show them how to attain health and how to seek help on health matters when necessary.

(*b*) Nutrition

Nutrition is one of the most important factors influencing the quality of life in most parts of the world, and most nutrition-related activities take place within the family. Women are the primary processors, storers, and preparers of food and are responsible for proper nutrition. They help to increase and improve food supplies by processing and preserving food to the best advantage and distributing available provisions equitably within the family. They should, in addition, be oriented towards the early detection of malnutrition and the measures needed to reverse it.

(*c*) Supply of safe water and basic sanitation

Preventable diseases associated with contaminated water supplies and a lack of basic sanitation constitute a major health problem in developing countries. Safe, adequate, and accessible supplies of water, together with proper sanitation, are therefore foremost among basic health measures. In communities where piped water supplies have not yet been provided, women are the haulers, storers, and distributors of water and the managers of basic sanitation at the family level and often also at the community level. It is primarily women who have the responsibility for introducing sound personal hygiene practices, promoting the use of latrines, and ensuring that clean water is used for drinking and other domestic purposes.

(*d*) Immunization

Immunization programmes reduce morbidity and mortality due to preventable diseases, some of which are major killers of children. Women are the main users and promoters of immunization against the principal communicable diseases, for themselves and their children, playing an indispensable role in this connection, even when the