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PREPARATIONS FOR THE FOURTH WORLD CONFERENCE ON WOMEN: ACTION FOR EQUALITY, DEVELOPMENT AND PEACE: REVIEW AND APPRAISAL OF THE IMPLEMENTATION OF THE NAIROBI FORWARD-LOOKING STRATEGIES FOR THE ADVANCEMENT OF WOMEN

Second review and appraisal of the implementation of the Nairobi Forward-looking Strategies for the Advancement of Women

Report of the Secretary-General

Addendum

II. CRITICAL AREAS OF CONCERN

C. Inequality in access to health and related services

1. In the Nairobi Forward-looking Strategies for the Advancement of Women, health is one of the three sub-themes, along with employment and education, of the three goals - equality, development and peace - of the United Nations Decade for Women. In designing measures for the implementation of the basic Strategies at the national level, a number of areas for specific action were identified.

2. With the recognition of the vital role of women as providers of health care and the need for strengthening basic services for the delivery of health care came the need both to promote the positive health of women at all stages of life and to recognize the importance of women's participation in the achievement of Health for All by the Year 2000. The Strategies stressed the need to increase

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* E/CN.6/1995/1.

the participation of women in managerial and higher professional positions, through appropriate legislation, training and supportive action and to change the attitudes and composition of health personnel.

3. They also emphasized the necessity for providing health education to the entire family and the need to combine promotional, preventive and curative health, and access to water and sanitary facilities that involved women in all stages of planning and implementation. They stressed as well the need to comply with the International Code of Marketing of Breast Milk Substitutes, forbidding any commercial pressures that interfered with the priority of breast-feeding, the application of vaccination programmes for children and pregnant women and the elimination of any differences in coverage between boys and girls, as well as the eradication of the marketing of unsafe drugs and of practices detrimental to health and the provision of access to essential drugs.

4. The Strategies called for the provision of adequate nutrition for women and children and the promotion of interventions to reduce the prevalence of nutritional diseases such as anaemia in women of all ages, particularly young women.

5. They also stressed recognition of the fact that the ability of women to control their own fertility was an important basis for the enjoyment of other rights. The Strategies called for the provision of appropriate health facilities, adapted to women's specific needs, and the reduction of the unacceptably high levels of maternal mortality. The need was also expressed to strengthen maternal and child health and the family-planning components of primary health care, and to produce family-planning information and create services, pursuant to the basic human right of all couples and individuals to decide freely and informedly the number and spacing of their children. The urgency of developing policies to encourage delay in the commencement of child-bearing was indicated, since pregnancy in adolescent girls had adverse effects on morbidity and mortality, as well as the need to change discriminatory attitudes towards women and girls through health education. There was a need for providing adequate fertility-control methods, consistent with internationally recognized human rights, as well as with changing individual and cultural values.

6. The need to encourage participation of local women's organizations in primary-health-care activities was part of the focus of the Strategies, as were the application of gender-specific indicators for monitoring women's health and the necessity of enhancing the concerns with occupational health and the harmonization of work and family responsibilities.

7. The Economic and Social Council, in its resolution 1990/15 (adopted by the Council upon the recommendation of the Commission on the Status of Women, at its thirty-fourth session), adopted the recommendations and conclusions arising from the first review and appraisal of the implementation of the Nairobi Forward-looking Strategies, contained in the annex to that resolution. The following constitute the most detailed recommendations arising out of the review process.

"Recommendation XII.

"15. Since the beginning of the 1980s, there has been a decline in the standard of health and nutrition of women in parts of every developing region due, inter alia, to a decline in per capita expenditure on health. This is a particularly alarming situation since maternal and neonatal health are crucial to infant survival. Infant and child mortality rates have been rising in a number of countries after having declined for decades.

"Recommendation XIII. Governments, international organizations, non-governmental organizations and the public in general should be aware of the decline in women's health in developing countries. Improvement of women's health by the provision of appropriate and accessible health services should be a priority within the goal of health for all by the year 2000.

"Women constitute the majority of health-care workers in most countries. They should be enabled to play a much larger role in decision-making for health. Governments, international non-governmental organizations and women's organizations should undertake programmes aimed at improving women's health by ensuring access to adequate maternal and child health care, family planning, safe motherhood programmes, nutrition, programmes for female-specific diseases and other primary health care services in relation to the goal of health for all by the year 2000.

"The World Health Organization and other organizations of the United Nations system should further develop emergency programmes to cope with the deteriorating conditions of women's health mainly in developing countries, with particular attention to nutrition, maternal health care and sanitation.

"16. Women's access to information and services relating to population and family planning are improving only slowly in most countries. A woman's ability to control her own fertility continues to be a major factor enabling her to protect her health, achieve her personal objectives and ensure the strength of her family. All women should be in a position to plan and organize their lives.

"Recommendation XIV. Governments, non-governmental organizations and women's movements should develop programmes to enable women to implement their decisions on the timing and spacing of their children. These programmes should include population education programmes linked to women's rights and the role of women in development, as well as the sharing of family responsibilities by men and boys. Social services should be provided to help women reconcile family and employment requirements.

"Family planning programmes should be developed or extended to enable women to implement their decisions on the timing and spacing of their children and for safe motherhood.

"The United Nations Secretariat, the United Nations Population Fund, the World Health Organization and other organizations of the United Nations system should develop collaborative programmes to link the role of women in development to questions related to population.

"17. During the past five years, women's health, both physical and psychological, has been increasingly affected in many countries by the consumption and abuse of alcohol, narcotic drugs and psychotropic substances.

"Recommendation XV. Governments and other competent national authorities should establish national policies and programmes on women's health with respect to the consumption and abuse of alcohol, narcotic drugs and psychotropic substances. Strong preventive as well as rehabilitative measures should be taken.

"In addition, efforts should be intensified to reduce occupational health hazards faced by women and to discourage illicit drug use.

"18. The emergence, since the Nairobi Conference, of new threats to the health and status of women, such as the alarming increase in sexually transmitted diseases and the acquired immunodeficiency syndrome (AIDS) pandemic, requires urgent action from both medical and social institutions.

"Recommendation XVI. Greater attention is also needed with respect to the issue of women and AIDS. Efforts in this regard should be an integral part of the World Health Organization Global Programme on AIDS. Urgent action and action-oriented research are also required by social institutions at all levels, in particular the United Nations system, national AIDS committees and non-governmental organizations, to inform women of the threat of AIDS to their health and status."

1. Women's health: an overall view

8. In the 1991 progress report on women, health and development of the Director-General of the World Health Organization (WHO), 1/ presented to the Forty-fourth World Health Assembly, it was recognized that women's health was influenced by biological, environmental, social, economic and cultural factors. 2/ It was further recognized that women's health, their status and their multiple contributions were pivotal links between the health of a population and its prospects of sustainable development - prospects which, despite the remarkable progress of the 1960s and 1970s, had been dimming in the 1980s. 3/

9. Setting an agenda for women's health must begin with a recognition of the fact not only that the health situation of women is different from that of men, but also that the systems identifying and determining that health situation are fashioned according to gender-biased models. Gender discrimination has tended to be hidden within the general issue of poverty and underdevelopment. In practice, women and girls suffer disproportionately because of their low status in society.

10. While most of the world's poor suffer from poor health and nutrition, in many countries, particularly those of South Asia, rates of malnutrition are generally higher among females than among males of the same age group. In many countries, food is distributed within the household according to a member's status rather than according to nutritional needs.

11. Low health status is the outcome of biological as well as social, political and economic factors acting together. Many women suffering from poor health status are found to lack knowledge, information, skills, purchasing power, income-earning capacity and access to essential health services. Health must be considered in a holistic manner.

12. Reliable and high-quality health services promote sustainable development. The greatest reduction in fertility rates have resulted from a combination of women's improved economic and social status, education and access to reproductive-health-care services.

13. Despite the fact that in households and sometimes in the community, women are the primary providers of health care, they often lack access to outside health care for themselves. For example, data show that in many countries there are fewer women than men who are treated in hospitals, receive prescriptions for medication, receive timely treatment from qualified practitioners and survive common diseases. Restricted access to health services leaves women less capable of taking care not only of their own health, but also of that of their children, thereby perpetuating a trend of high child mortality.

14. Ensuring women equal access to the benefits of public health care is critically dependent upon gender-specific health strategies. This is true because men and women tend to suffer from different illnesses. Women are far more likely to suffer from reproductive role-related illnesses such as sexually transmitted diseases, anaemia, and the complications resulting from child-bearing. Targeting these health problems clearly involves different strategies for men and women.

15. Under increasing economic pressure in the past four years, 37 of the poorest countries have cut health-related spending by 50 per cent. Some countries report on the implementation of social compensation programmes to offset the impact of structural adjustment policies.

16. A major factor mentioned by many countries is the focus on primary health care, promoted by most developing countries. To provide equal care to both rural and urban women, many countries have adopted the system of primary health care including family planning, maternal and child care, vaccination and reinforcement for the curing of diseases, including prevention of sexually transmitted diseases and human immunodeficiency virus (HIV)/AIDS.

17. In Asia and the Pacific, the focus of policy in the area of women's health has generally been within the context of reproductive health. Fertility control and family planning have been the major set of issues around which health policies and programmes have generally evolved in the past.

18. Some countries report that the fact that women have come to dominate the teaching and health professions has resulted in the feminization of those professions, and a consequent lowering within them of prestige and pay. Several national reports acknowledge the skills of women in the areas of birth attendance and traditional medicine practices, and various areas of self-healing, although these practices have not yet been duly incorporated in the medical system.

19. In many countries, there is not yet a policy for women's health, except for reproductive health. The reports often link improvements in the overall situation of women's health to demographic trends and improvement in infrastructure. Health is considered an outcome of combined factors promoting quality of life.

20. Many countries note the contribution of specific health programmes, like the expanded programme of immunization, to women's health, and the contribution of local non-governmental organizations in health campaigns.

21. Rural health centres are in general on the decline, and in much poorer condition than urban ones. For instance, one country reports that a person in the rural areas consults the health centre about twice a year, versus four times a year in the urban areas.

2. Environmental health

22. Sustaining the global cycles and systems upon which all life depends is a first requisite of health. The combination of population and production growth and unsustainable consumption patterns has, however, heavily depleted natural resources, threatening the environmental base upon which health and survival depend.

23. In developing countries, where populations are still expanding, pressure on scarce resources has made it very difficult to improve living conditions. In 1990, an estimated 1.5 billion people did not have access to safe water, and almost 2 billion people lacked sanitary means for disposing of excreta.

24. Many countries have subscribed to the goal of universal access to safe water for the year 2000. Some reports indicate that improvements have been made in sanitary education and in the application of low-cost technologies. One country refers to an initiative to save on wood energy, for example, through cheaper production of charcoal and improved charcoal stoves.

3. The life-cycle perspective

25. In the case of women's health, the using of a lifelong perspective that takes into account the whole life-span is of paramount importance, since health conditions in one phase of a woman's life affect not only its subsequent phases but also future generations. It is also useful to look at common issues or themes so as to identify a useful framework from which a feasible agenda for action can be elaborated.

26. For every 100 females delivered into the world, there are 105 males born. The female human being is biologically more resistant, and the surplus of male infants is nature's way of balancing the sex ratio in the population. Ordinarily, the number of surviving girls soon surpasses that of boys. However, there are parts of the world where this male-to-female imbalance is never overcome.

27. Human intervention, in the form of neglect of girls, favours the survival of males. In several countries in the Asian and Pacific region, the preference for sons over daughters has resulted in a differential treatment of infants by sex. The data show that there is a higher risk that girls, as compared with boys, will die before age 5, in spite of the natural biological advantage of girls. In Bangladesh, the under-five mortality rate for girls was recorded as 175 per 1,000 live births, as against 160 for boys, and in Nepal, 187 for girls as against 173 for boys. The pattern is much more alarming in regions within large countries like India and China, known for their strong preference for sons. In India, there are 957 females aged four years or under for every 1,000 males in the population.

28. Preference for sons is most marked in South Asia and the Middle East, but is not confined to those regions alone. In Colombia, the number of deaths of boys between the ages of one and two is 75 as against a figure of 100 for girls in the same age group. Recent empirical evidence suggests that excess female mortality during childhood also occurs in Latin America and the Caribbean, particularly in the less developed countries with low life expectancy.

29. Globally, at least 2 million girls per year are at risk of having to submit to genital mutilation. WHO estimates that 90 million women in the world today have - at some time between the ages of 2 and 15, depending on local custom, and most commonly between the ages of 4 and 8 - undergone one of the procedures that fall under this category. Most live in Africa, a few in Asia, and, increasingly, due to migration processes, some in Europe and North America.

30. Many Governments have publicly denounced the practice. Some have translated their concerns into laws prohibiting female genital mutilation or into programmes to persuade people to abandon the practice. Several countries report on the existence of harmful traditional practices and their impact on women's health. One report, on the other hand, highlights coexisting cultural practices that are beneficial, including respect for and assistance to elders, mutual assistance networks and breast-feeding.

4. Adolescents

31. More than 50 per cent of the world population is under age 25, and 80 per cent of the 1.5 billion young people between the ages of 10 and 24 live in developing countries. Although fertility levels have been decreasing in many regions, the fertility rates of adolescents are very high and in some cases increasing. At present, it is estimated that close to 15 million infants per year (10 per cent of total births) are born to adolescent mothers.

32. Adolescents girls are more vulnerable to reproductive health problems than young men. The age of the first sexual encounter is declining everywhere. For example, a survey in Nigeria found that 43 per cent of schoolgirls in the age group 14-19 were sexually active. During the 1980s, 30.2 per cent of female adolescents in Jamaica and 12.7 per cent in Mexico were sexually active before they were 15 years of age. The proportion of females under 20 years of age who used contraceptives at first coitus was 40 per cent in Jamaica, 21 per cent in Mexico and 8.5 per cent in Guatemala.

33. The rate of pregnancy among girls in the age group 15-19 is 18 per cent in Africa, 8 per cent in Latin America, 5 per cent in North American and 3 per cent in Europe. In Venezuela, the number of births to girls under age 15 rose by 32 per cent between 1980 and 1988. In the Caribbean, 60 per cent of first births are to teenagers, most of whom are unmarried.

34. One quarter of the 500,000 women who die every year from pregnancy-and-childbirth-related causes are teenagers. A survey in Bangladesh found that maternal mortality in age group 10-14 was five times higher than in age group 20-24.

35. The sense of urgency in addressing the situation is justified by the sheer numbers of girls involved. In 1990, girls aged 15 or under constituted 40 per cent of the female population in Egypt and Morocco, 44 per cent in Algeria and Mauritania, 45 per cent in Ethiopia and Mali, 46 per cent in Djibouti and Somalia, 48 per cent in Nigeria, Uganda and the United Republic of Tanzania, 50 per cent in Côte d'Ivoire, and 52 per cent in Kenya. Increasing concern for the status of women and girls prompted the South Asian Association for Regional Cooperation (SAARC) to declare 1990 the Year of the Girl Child.

36. Some countries report an increase in the life expectancy of girls over that of boys. One country reports that owing to the availability of medical facilities and health units in all villages, life expectancy at birth for girls increased from 2 to 66 per cent, or at a rate of 127 per cent, from 1981-1982 to 1992-1993.

37. Many countries indicate strong policies of readmitting teenage mothers into secondary schools. Many have included courses on family-life education at school. One country reports a peer approach counselling programme at the Young Women's Christian Association (YWCA).

5. Reproductive health

38. The health of women in the years 15-45 is influenced predominantly by their reproductive and maternal roles. Despite progress in a number of key areas, the morbidity and mortality rates of women due to reproduction remain unnecessarily high in many areas of the globe. Maternal mortality is the indicator that exhibits the widest disparity among countries. Of the 150-200 million pregnancies that occur world wide each year, about 23 million lead to serious complications such as post-partum haemorrhage, hypertensive disorders, eclampsia, puerperal sepsis and abortion. Half a million of these end with the loss of the mother.

39. Ninety-nine per cent of these deaths take place in developing countries. The incidence of maternal death ranges from almost non-existent to very high (the rates in some poor countries reach as high as 1,600 times those in industrialized countries). Scattered information suggests that in some countries, one fourth to one half of all deaths of women of child-bearing age result from pregnancy and its complications.

40. Maternal mortality rates in central and eastern Europe, apart from Romania and Albania, are about twice as high as the average for Europe as a whole. In Romania and Albania, maternal mortality has fallen dramatically since the legalization of abortion, as previous rates were largely due to unsafe abortions. Unsafe abortions are among the top causes of maternal mortality in all countries except Azerbaijan. Azerbaijan's exceptional status might be due to the way it defines such practices. In the Russian Federation, nearly 200 abortions are reported for every 100 births.

41. Comparing new information on maternal mortality with that available five years ago suggests that pregnancy and childbirth have become safer for women in most of Asia and in parts of Latin America. Nevertheless, data are still too scattered and more needs to be done to have a more complete picture. However, frequent child-bearing, which can seriously compromise the health and nutrition of a woman's children, continues to be characteristic of large numbers in many areas of the world.

42. One reason for the lack of progress is the tendency to look for rapid solutions to deep-seated problems. It has been found that safer motherhood requires a massive and simultaneous attack on all the elements contributing to the problem, including those under the headings of legislation, social services, rights of women. As regards the health sector alone, the system's entire infrastructure - including community mobilization, pre- and post-natal care, clean and safe delivery with trained assistance and above all timely referral for management of complications - needs strengthening in most countries where maternal mortality is high.

43. International commitments setting goals for reduction of maternal mortality by 50 per cent for the year 2000 have been endorsed by most countries. Many countries mention the Safe Motherhood Initiative, adopted by WHO, the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), and the United Nations Children's Fund (UNICEF) in 1987. Many countries report that the increased provision and improvement of existing maternity services at all levels of the health system is the most effective means of reducing maternal mortality. In addition, quality reproductive-health-care services, including family planning, together with good primary health care represent important interventions. Many countries report increments in health care to address the matter of maternal mortality. Several reports mention a national programme for maternal health, with campaigns on reproductive health and family planning. Several countries report the inclusion in their expanded programmes of immunization of antitetanus campaigns.

6. Fertility

44. Fertility levels, measured by the total fertility rate, have continued their tendency to decline in all regions. World fertility fell by 10.5 per cent, from 3.8 to 3.4 births per woman, between the periods 1975-1980 and 1985-1990. The total fertility rate varied from 8.5 (the highest) in Rwanda, to 1.27 (the lowest), in Italy.

45. Sub-Saharan Africa is the only region of the developing world that has not yet undergone a widespread decline in fertility. A decline has started in three countries of the area: Botswana, Kenya and Zimbabwe. Ethiopia reports a fertility rate of 7.5 births per woman in 1992.

46. The total fertility rate continued to decline in all subregions of Asia and the Pacific throughout the post-Nairobi Conference era. Between 1985 and 1992, it dropped from 2.42 to 2.19 in developing East Asia and from 3.69 to 3.37 in South-East Asia. In South Asia, it fell from 4.71 to 4.36 and in the Pacific Islands, from 4.92 to 4.61. The developed countries of the region, namely, Australia, Japan and New Zealand, which had already achieved a total fertility rate of 1.71 by 1985, experienced a further decline to 1.56, by 1992.

47. In the Caribbean, many countries have experienced nearly a 50 per cent drop, from about 6.0 to 3.0, in total fertility rate levels within the last 30 years, and the rate is expected to decline further in the next decade.

48. Although fertility rates have gone down world wide, many women still lack access to information and services, or cannot make use of them because of economic limitations or cultural norms. Only 27 per cent of couples use contraception; 140 million women in developing countries become pregnant although they did not want a child. Every year, over 20 million women terminate unwanted pregnancies through unsafe abortions, as a result of lack of access to relevant care and services such as family planning, costly contraceptive methods, lack of information, and restrictive legislative practices. Of these, 15 million survive, but with a wide range of long-term disabilities. Some 60,000-100,000 die.

49. One country reports that in 1992, for the first time since the introduction of family planning, the gender-differential participation ratio became 55 to 45 in favour of men, owing to a broader public awareness of the relative seriousness of the side-effects of contraceptive measures taken by women. Some countries consider that with respect to utilization of contraceptives, universal coverage has been reached: only 4 per cent of sexually active women are without any such coverage. The protection and monitoring of maternity programmes have been further reinforced in the last years. One country reports the establishment of family counselling services, with a counsellor-to-woman ratio of 1.4:2,000.

7. Cervical cancer and sexually transmitted diseases

50. Cancers of all types among women are increasing. Those affecting women more frequently in both developed and developing countries are stomach cancer, breast cancer, cervical cancer and colorectal cancer.

51. Cervical cancer is the most common form of cancer in women in most developing countries and the second most common form of cancer in women in the world as a whole. There are an estimated 450,000 new cases (a realistic figure including undiagnosed early cases would go as high as 900,000), and a death toll of 300,000, each year.

52. Breast cancer is one of the major causes of female mortality in developed countries. The number of women developing breast cancer and dying from the disease is growing steadily every year. As in cervical cancer, early detection plays a major role in reduction of mortality.

53. Prevalence rates of sexually transmitted diseases are higher among females than among males in those aged 20 years or under. In one industrialized country, 6 million women, half of whom are teenagers, acquire a sexually transmitted disease.

54. A number of countries report the launching of national awareness-raising campaigns. Several countries report the establishment of national programmes of early detection of breast cancer.

8. HIV/AIDS

55. AIDS emerged as a major health problem in the mid-1980s, in both the developed and the developing countries, threatening to undermine major gains in the reduction of morbidity and mortality. A decade ago, women seemed to be on the periphery of the AIDS epidemic, but today almost half of newly infected adults are women. Women are more susceptible to contracting the disease for biological reasons and because of their lower social status.

56. WHO estimates that well over 14 million adults and children have been infected with HIV since the start of the pandemic, and projects that this cumulative figure may reach 30-40 million by the year 2000. It is estimated that over half a million children have been infected with HIV from their infected mothers. The epidemic incapacitates people at the ages when they are needed most for the support of the young and the elderly. WHO estimates that by the year 2000, 13 million women will have been infected with AIDS.

57. The AIDS pandemic is most devastating in sub-Saharan Africa. WHO had estimated that by 1992, 1.5 million adults in the region would develop AIDS, and more than 7 million would be infected with HIV. In this region, HIV transmission is predominantly through heterosexual relations, and among the infected population, almost the same proportions of men and women are represented. In the 15 countries in Eastern, Central and Western Africa where by 1990 above 1 per cent of the adult population was infected, the already low level of life expectancy at birth (about 50 years in 1985-1990) is projected to

remain unchanged through the year 2000. Because as many women as men carry the virus, WHO estimates that child mortality may increase by as much as 50 per cent through mother-to-child transmission in much of sub-Saharan Africa during the 1990s. In Ethiopia, the trend between 1987 and 1993 (2.4:1 compared with 1.4:1) indicates that the male-to-female ratio is narrowing.

58. At the beginning, transmission of HIV in North America, Europe and Australia occurred basically through homosexual contact, but increasingly heterosexuals and drug-users are becoming the agents of transmission, especially in North America. According to WHO estimates, 1.6 million cases of HIV and close to 350,000 cases of AIDS might occur by 1992. In Latin America, the Caribbean and the urban sections of Brazil are the areas most affected. It is estimated that currently about 1 million people in the region may be affected by HIV.

59. Asia and the Pacific has exhibited the highest growth rate in HIV/AIDS among women, many of whom are married women with a single partner. India and Thailand are the countries worst affected. There are no estimates available for the region as a whole, but the estimate for India is up to about 1 million, and for Thailand about 400,000.

60. A Global Programme on AIDS was established by WHO in 1987. By 1990, more than 150 countries had established national AIDS committees to coordinate national control programmes. Part of the problem that has to be faced concerns the reluctance of national authorities to acknowledge the existence of HIV infection, and its real magnitude. Another challenge is the discrimination against people with HIV/AIDS, a response often connected with the stigma attached to sexually transmitted diseases, and the mistaken belief that HIV can be transmitted through casual social contacts.

61. The Global Programme on AIDS strategy stresses a gender-specific approach, emphasizing women's social, physical and economic vulnerability. In most countries where HIV/AIDS has become a serious threat or is expected to become one, national AIDS committees have been established to formulate prevention programmes. Several countries are devoting resources to research, guidance, educational material and technical assistance. National campaigns of education and prevention have been developed in many countries. Several have included prevention components in school curricula. A few countries report close collaboration with non-governmental organizations in training peer leaders as a way of improving service delivery.

9. Health consequences of violence

62. Although grossly underreported, violence against women has assumed alarming proportions, as can be seen in section D below. Only recently have domestic violence and rape been viewed as a public health problem, yet they are a significant cause of female mortality and morbidity. Violence against women leads to psychological trauma and depression, injuries, sexually transmitted diseases and HIV, suicide and murder.

63. Accurate figures on the prevalence of domestic violence and rape are not available, but from existing data it is known that rape and domestic violence account for about 5 per cent of the total disease burden among women aged 15-44 in developing countries. In industrialized countries, where the total disease burden is much smaller, this share rises to 19 per cent. In these countries, assaults have been reported to cause more injuries to women than vehicle accidents, rape and mugging combined.

64. In Asia, non-governmental organizations have played a pivotal role in publicizing the situation. They have collaborated with Governments in many countries in efforts involving the provision of legal aid and legal counselling to victims of violence, and the running of trauma centres and shelters for abused women.

10. Health issues related to ageing

65. Life expectancy for women has risen by eight years since 1970 in the low- and middle-income countries, and by five years world wide, though this gain has been less than that enjoyed by men.

66. In the years to come the number of women over age 65, in both industrialized and developing countries, will increase; and the total number of these women will rise from 330 million in 1990 to 600 million in 2015. Women over age 50 constitute more than one third of the entire female population of the United States of America. In addition, women constitute about 59 per cent of the United States population aged 65 or over, and 72 per cent of the population over age 85. In contrast, in Lithuania, female life expectancy decreased, as it did in Poland and some of the newly independent States.

67. Of these elderly women, many will suffer from the chronic diseases associated with ageing such as osteoporosis and dementia, or from the consequences of neglect such as malnutrition, alienation and loneliness. Reporting on health conditions of the elderly female population is still scanty, especially in the developing countries. Osteoporosis affects 10 per cent of women world wide above age 60. In one industrialized country, osteoporosis is responsible for 1.3 million bone fractures per year. Most of the women affected become totally dependent as a result of the illness.

68. When women do seek care for their health problems, the result is often overprescription of tranquillizers - especially to older women - instead of further investigation. A North American study found that physicians prescribed psychoactive drugs 2.5 times more often to women over age 60 than to men in the same age group.

69. Many industrialized countries are concerned with the rising demand for health-care services on the part of their growing population of elderly people. Some developing countries are restating the importance of the traditional family and community networks in caring for the elderly.

11. Malnutrition

70. Adequate nutritional intake is particularly important for girls and women. Discriminatory feeding practices in childhood sometimes lead to protein-energy malnutrition, anaemia and other micronutrient deficiencies in young girls. Higher rates of malnutrition generally exist among females than among males in the same age group. In many developing countries, food is distributed within the household according to a member's status rather than according to nutritional needs.

71. Problems caused by malnutrition in girls are responsible for subsequent problems during childbirth, like obstructed labour, fistulas and birth asphyxia. Because women need more iron than men, and because they tend to receive a lower share in the distribution of food, globally 43 per cent of women and 51 per cent of pregnant women suffer from anaemia. A third of women of reproductive age who are not pregnant have anaemia. In developing countries, 56 per cent of pregnant women are anaemic and up to 7 per cent suffer from severe anaemia. Virtually all adolescent girls in developing countries suffer from iron deficiency.

72. Because their mothers lack iodine, 30,000 babies are stillborn every year, and over 120,000 are born cretins. Iodine deficiency is the most common and preventable cause of mental retardation. At least 25 per cent of adolescent girls are affected. This deficiency leads not only to goitre but to brain damage as well, and also affects women's reproductive function. In developing countries, stunting caused by energy-protein malnutrition in girls affects 43 per cent of all women aged 15 or over.

73. Many countries mention the adoption at the World Summit for Social Development of the goal of a one-third reduction in iron-deficiency anaemia by the year 2000. Some countries have improved their nutrition surveillance system. Many report a direct impact of structural adjustment programmes on the nutritional situation.

12. Mental health

74. Community-based studies and treatment studies indicate that women are disproportionately affected by mental health problems and that their vulnerability is closely associated with their marital status, their work and their roles in society. Epidemiologic evidence is accumulating that links mental disorders with alienation, powerlessness and poverty, conditions most frequently experienced by women.

75. Several reports indicate a tendency in health services to shift their emphasis from the provision of curative services to the prevention of ill health. Although most health measures still focus on physical ill health, well-being-related measures are becoming increasingly important.

13. Substance abuse

76. Over the next 30 years, tobacco-related deaths will more than double, so that starting from the year 2020 well over 1 million adult women will die from tobacco-related illnesses annually. Women are smoking in increasing numbers in developing countries and are a special target of cigarette advertising world wide. In France, a recent survey among students showed that girls today smoke more than boys. There is also a rapidly growing trend among girls towards the use of other drugs.

77. Some 30 million women have contracted diseases due to alcohol intake. Alcoholic cirrhosis is the cause of 300,000 deaths among women each year. The ill-treatment of 50 per cent of battered wives is alcohol-related.

78. Illicit drug-abuse problems among females have been underestimated, as statistics in many countries are not gender-disaggregated. A few countries report a new bio-psycho-social approach in health services, distinct from the focus only on maternal and child health.

Notes

1/ Document WHO/FHE/WHD/92.5.

2/ Ibid., para. 16.

3/ Ibid., para. 10.
