

WOMEN AND HEALTH: A SUMMARY REPORT FROM THE UN END OF DECADE FOR WOMEN CONFERENCE

Sari Tudiver

Sari Tudiver, militante pour la santé des femmes au Manitoba, assista à la conférence de Nairobi comme représentante de la délégation de Health Action International. Elle fait un reportage des réussites dans le domaine de la santé des femmes à la conférence officielle, et elle examine les questions et les stratégies les plus importantes soulevées par les femmes aux ateliers du Forum 1985.

My goals in attending Forum '85 were to learn more about the quality of health care for women in various countries; about how women are organizing new or alternative services and the problems they face; and to discuss strategies for lobbying governments to improve legislation and services. Given my involvement in Women's Health Interaction in Canada and in the recent tour of the play *Side Effects* across Canada – and especially in rural and Northern Manitoba – I was anxious to share our experiences using theatre as a tool in health education and to learn about the initiatives of others.

In addition, I was to be the Canadian arm of the delegation of Health Action International (HAI), an international network of consumer, development and women's health groups based in The Hague, which promotes the rational use of pharmaceuticals. The Manitoba Council for International Cooperation (MCIC) has had close ties with the HAI network since HAI was formed in 1981. It was in this latter capacity that I was part of a group of women trying to have some small impact on the official conference through redrafting a section of the Forward Looking Strategies Document.

THE OFFICIAL CONFERENCE

Amendments to the Forward Looking Strategies Document could be proposed by organizations with observer status at the UN; representatives from observer NGOs could also speak briefly to an

amendment. The International Organization of Consumers Unions (IOCU), a sponsoring organization of HAI, was able to put forward our proposals and those of the International Baby Food Action Network (IBFAN).

I met several times with women from WEMOS (Women and Pharmaceuticals group from The Netherlands), with IBFAN representatives from Kenya and Trinidad and Tobago, with women from the Australian Women's Health Network, Pesticides Action Network, IOCU and others to develop our strategy. Almost no one had seen a copy of the FLS document prior to coming to Nairobi. (I had received my draft shortly before leaving). We reviewed the relevant sections pertaining to women's health and the use of pharmaceuticals in particular.

Paragraph 153 fused trafficking in drugs with therapeutic uses of drugs which, we felt, left the intention ambiguous. Through collective effort we came up with an alternate version. As well, major amendments were proposed for Paragraph 159 which pertains to fertility control methods. Several women, including myself, then passed these proposed amendments on to members in their official delegation. In my case, I spoke with Muriel Smith, Manitoba Minister Responsible for the Status of Women, and explained the rationale behind our amendments. The proposals were taken to the appropriate committee for consideration, with some success for Paragraph 153 and considerably less for Paragraph 159. The process of trying to change even one paragraph was time-consuming and somewhat frantic. Our proposals would have benefitted from a review of the FLS Document prior to coming to Nairobi. At the same time, the experience was an intense course in identifying key issues, sharpening lobby skills and gaining added insights into the process of compromise and nuance so integral to UN conferences.

As a document to which all participating member states gave consensus,

the FLS paper becomes a useful tool for lobbying national governments and for heightening public awareness on specific issues addressed within it.

FORUM '85 – HEALTH ISSUES

Health was one of the sub-themes of the Decade and a variety of workshops focused on family planning methods; trends in the development of the new reproductive technologies; quality and safety of reproductive health care; primary health care and training of women; maternal and child health; nutrition; women and mental health; traditional practices affecting women and children in Africa; women and pharmaceuticals (workshops on DES, Depo-provera, and other drugs); and workshops on the organizing of international women's health networks and other coalitions such as IBFAN (International Baby Food Action Network) and Health Action International. There were only a few workshops pertaining to women and occupational health. Health concerns were raised in other workshops on topics such as peace (for example, the impacts of nuclear testing in the Pacific on women's reproductive health and of violence against women). Workshops usually consisted of 4 or 5 – 15 minute presentations followed by discussions, questions, comments.

Health-related workshops which I attended focused on the Quality of Reproductive Health Care (organized by health professionals from Asia, Latin America and Africa), Women and the Pharmaceutical Industry (led by a Norwegian pharmacist); The Uses of Estrogen-Progesterone Drugs Internationally (WEMOS – The Netherlands); Women as Consumers (IOCU and IBFAN); and Building an International Feminist Health Network (Boston Women's Health Collective, ISIS). Other workshops organized by DAWN (Development Alternatives With Women for a New Era) on development

strategies also raised issues pertaining to reproductive choice and the links between population and development. In Nairobi I spoke with organizers from DES Action groups and received reports on other workshops addressing population/family planning issues. In addition, I had the opportunity to speak with several doctors and other health workers from Bangladesh, India and Kenya. I spent several hours visiting a clinic where health workers monitor and treat sexually transmitted diseases among prostitutes. This clinic, located in a slum area of Nairobi, was part of a collaborative study between Kenyatta Hospital and the University of Manitoba.

In this report I will highlight some major areas of concern raised by women in the workshops I attended and some of the initiatives which women are taking to address their health needs.

1) *Women consistently expressed concern about inadequate information concerning drugs; an inability to make informed choices or a lack of choice at all concerning contraceptives.* Third World women wanted to have information on what current medical opinion is in countries where laws are more stringent and to know what is banned elsewhere. There was discussion about double standards in marketing practices; unethical advertising of pharmaceutical companies, and drain of precious resources to purchase non-essentials or only partial doses of antibiotics. Third World women shared stories about increasing use of tranquilizers in their countries and multiple prescriptions. A woman from Senegal spoke of the "good doctor" as one who is seen to prescribe the most medication.

2) *Many women were involved in organizing the delivery of various health services to women.* Discussion often came down to trying to address the root causes of ill health in poverty and inadequate public health measures. It seemed that in the last five years women in various countries had organized services which attempted better quality care and counselling. While these were isolated efforts, they reflect the attempt of an international women's movement to organize alternative services and develop models of what we would like to see as the norm. These alternative services include the following examples:

- Sandra Kabir, a doctor from Bangladesh Women's Health Coalition, discussed the organization of six clinics (rural and urban) for women that stress individualized



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attention; counselling; taking detailed personal histories; confidentiality; use of women paramedics; providing information on birth control methods and possible side effects. They attempt to help women secure employment. These clinics have a combination of government and NGO funds; some charge modest fees.

- Reena Marcello from the Philippines, a single mother working with young women (ages 15-24), described her work doing sexuality counselling, providing information on sexually transmitted diseases, teen pregnancy, and working with young women who have become prostitutes.
- A woman from Columbia discussed

how her group organized services for abused women living in slum areas to provide legal advice, family planning information, and help with dealing with doctors, secure access to abortion.

- A midwife from Senegal runs her own clinic where women are treated with respect and have their problems listened to. Young unmarried women can come for information about family planning. There are group meetings to talk about common problems and help women gain employment. She discussed the special problems of a largely rural country with a very high fertility rate (most women have at least 7 children).

Women talked about these initiatives,

Health

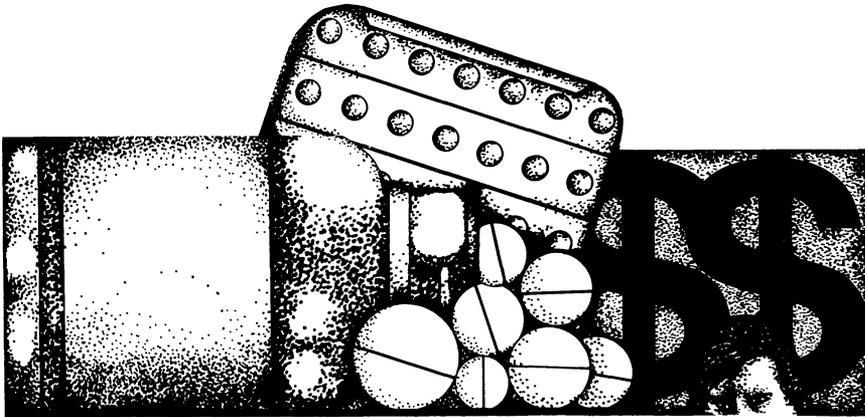


Illustration by Catherine O'Neill

Credit: Agenda for Women's Equality (Ottawa)

compared situations, funding problems, community access and raised questions about why these projects/services are so marginalized and precarious. How do women gain access to national planning and priorities regarding health care in order to ensure that their experiences and expertise are taken into account?

3) The strengths of the Nairobi conference were the possibilities opened up for sharing information internationally. Links were formed among groups such as DES Action-Canada, DES-Netherlands and information was passed on to women in other countries such as Mexico and Brazil. Information about estrogen-progesterone drugs being used as a supposed abortifacient drew many examples of its use in Europe, Japan, and Third World countries. Information on recall of the Dalkon Shield and legal suits brought against A.H. Robins were passed on. The fact that Depo Provera was banned for use as a contraceptive in the U.S. in 1984 and was used coercively in South Africa on black women highlighted the political aspects of fertility control.

By 1985 women's health networks have formed both nationally and interna-

tionally. Nairobi was an opportunity to extend these networks and plan further strategies. Among the groups formed are the Latin American Women's Health Network, supported by ISIS International which includes 250 groups, and Women's Global Network on Reproductive Health, based in Amsterdam. Health Action International, sponsored by the International Organization of Consumers Unions in The Hague, promotes the rational use of medicines and is lobbying for a Code of Marketing Practices for the Drug Industry at the WHO and in support of extending the WHO Essential Drugs Programme. HAI has a strong focus on women and pharmaceuticals. Women's health networks in Australia, India, Bangladesh, the U.K., U.S. and Canada are particularly active.

Lessons were learned from the IBFAN campaign and from the Nestlé boycott. Monitoring of the WHO Code and of national practices and policies must still continue in order to ensure that the Code is effective on breast milk substitutes. Women shared strategies of empowerment – how to lobby and exert pressure on politicians and how to mobilize women to

deal with health/consumer issues affecting themselves and their families.

Hazel Brown from Trinidad and Tobago was particularly inspiring:

Women have power they don't use. We called ourselves the Housewives Association – what could be more innocent and non-threatening than that? Housewives are not supposed to interfere – right! They are the lowest common denominator – a judge can be a housewife and a houseworker . . . In our group women come in as housewives and go out more aggressive and knowledgeable about what affects their lives.

Her advice about strategy has relevance for all women working for improved health care for women:

Know your facts: sit down in small groups and inform yourselves about milk, contamination, nutrition; try and link up with experts who can prove something is wrong.

Build solidarity among the groups and go after the key man. Make sure if you plan to hold out outside someone's office that you know who will stay with all the kids. Track down who the key person is – you always have some contacts that are useful: someone went to school with his wife or his child or works for him.

Build one issue on the other and build on your victories.

Use different kinds of strategies with different groups. Don't be afraid to ask and challenge. (They got an ad agency to produce breastfeeding campaign materials for them which became a model campaign).

Share your information with others, exchange ideas. It was in this way, through contacts with American, Kenyan and other groups that lobbying was organized for the WHO Code on Breastmilk Substitutes.

If you want to change the world, you have to start with yourself.

For further information concerning resources and networks, please contact:

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