# *Risks, Rights and Reforms*
# Key Findings



## Introduction

The United Nations General Assembly convenes on June 30-July 2, 1999 against a sobering backdrop for the five-year review of implementation of the Programme of Action adopted by 179 nations at the International Conference on Population and Development (ICPD) in Cairo in 1994. Uppermost on the agenda is the shortfall in economic resources that imperils realization of the Cairo agreement. The ICPD estimated that US$17 billion would be needed by the year 2000 to cover the costs of core family planning and reproductive health programs identified by the Programme of Action. The share of the international donor community was US$5.7 billion (adjusted for inflation, this figure is now about US$6.5 billion), of which only US$2 billion has been delivered so far. Four countries - the United States, the United Kingdom, Germany and Japan - account for more than 70 percent of bilateral assistance. Donor countries are also far from achieving the ICPD goal of devoting four percent of overseas development assistance to family planning and reproductive health.

While developing countries have met more than two-thirds of their commitments to fund reproductive health programs, most of these resources have been generated in a few large countries. In the world's poorest countries, health and education spending is a minuscule proportion of gross domestic product compared to debt repayments. The crushing debt burden of countries in Africa, Latin America and parts of South Asia makes their family planning and reproductive health programs heavily dependent on donor aid in the short term, the outlook for which is less than promising.

Overshadowing the issue of lack of funds is the global economic crisis, precipitated by the unregulated flow of transnational capital that began in Thailand in July 1997, rocked south-east Asia and Russia and by January 1999 was shaking Brazil and Latin

America. The Asian financial crisis has led to drastic cuts in social sector spending in countries in the region that have long invested strongly in health and education. Coupled with precipitous devaluation of national currencies, this has placed food, medicines and other essentials beyond the reach of large sections of populations. Malnutrition among women and children is sharply on the rise. Massive job losses and rise in poverty across the region, especially in Indonesia, and the lack of social safety nets and unemployment benefits have thrown millions of families into acute distress. In Russia, the number of people living below the poverty line is now an estimated 30 per cent, up from 18 per cent in 1996. In Japan, the economic crisis has spawned a growing category of new poor who are not covered by any form of health insurance.

The unprecedented economic crisis in Asia has forced important proponents of the free-market ideology, including the World Bank, to acknowledge that globalization and liberalization prescriptions can wreak havoc in the absence of strong legal and banking systems and controls on international financial flows. But this is small consolation given what accelerating globalization has already wrought: staggering increases in income disparities, widening North-South development gaps, massive social exclusion of populations and a rise in crime, violence and sexual trafficking. Women make up 70 per cent of the world's 1.3 billion absolute poor. In every country and community, they are first in the line of fire, bearing the brunt of human and social costs of crisis and transition. Women's heightened risks as a result of current economic policies are in poignant contrast to the universal recognition of women's empowerment as a key to development that has been enshrined in all the UN conferences of the nineties.

The social, political and institutional instability created in beleaguered economies struggling for survival is not conducive to advancing goals of human development and addressing environmental concerns. Unregulated movement of toxic materials and increased use of pesticides in agriculture to meet the demands of a global economy have resulted in devastating health effects, reproductive health in particular.

In the five years since governments adopted the Programme of Action, the enabling environment of sustainable development, respect for human rights and equality essential to fulfil its promises has thus come under severe attack from a range of forces. Globalization, privatization and fiscal austerity policies have cut public spending and services without denting the debt burden of poor countries. Economic reform policies in general have led states in rich and poor countries alike to withdraw from their role as primary provider of social services.

Through the nineties, governments have started to implement reforms designed by the World Bank and other donors aimed at improving the cost-effectiveness of public health systems. Health sector reforms have introduced market principles of efficiency

and viability in the vital social sector and, in effect, led to a competing reality with that of human rights and social justice envisioned at Cairo. Market reforms imposed on top of economic crisis have dealt public health services a body blow in countries experiencing acute pangs of economic transition, such as Russia and the Ukraine.

The reports in this survey add to accumulating global evidence of the erosion of equity and rights-based approaches in health as a result of the economic environment. At the same time, they attest to the efforts of individual countries to advance the goals of the Programme of Action under difficult political and social conditions. The 1994 ICPD and the 1995 Beijing women's conference have fostered the growth of new and creative partnerships between policy-makers and civil society, including non-governmental organizations, legislators, community and religious leaders and the private sector. These strategic alliances have enabled a significant number of countries to act on their Cairo commitments, reinforced by those made in Beijing.

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## A. Moving Forward

The Programme of Action represented a seismic shift in the thinking on health and population policies. It challenged traditional family planning approaches that focused on averting births rather than human well being. It affirmed women's unencumbered right to reproductive choice and freedom. The ICPD Programme not only made reproductive rights the centerpiece of family planning programs. It articulated a holistic concept of reproductive health in the context of primary health care that encompasses family planning counseling and services, pre-natal and post-natal care and safe delivery, prevention and treatment of infertility, treatment of reproductive tract infections and sexually transmitted diseases, prevention of abortion and management of the consequences of abortion. Gender equality and equity are at the heart of the Cairo agenda. They are addressed in the preamble and principles that provide the framework for the Programme of Action, and also form the subject of an entire chapter.

In the five years since ICPD, governments, NGOs and UN and other donor and international agencies have worked in a number of ways to advance the goals of reproductive and sexual health and rights articulated in Cairo. The Programme of Action, reaffirmed by the Beijing Platform, has in many instances provided momentum and direction to pre-Cairo government policies and women's health advocacy. New initiatives range from adolescent sexual health education programs to the creation of ministries for women's affairs, integration of HIV/AIDS prevention in reproductive health services, redesigned programs for reproductive health and family

planning, stiffer penalties for sexual offenses, improved maternity laws, and research and programs addressing environmental links to health.

Twenty-eight countries report that reproductive health is an explicit part of national health policy. In Mali, the 1998 national action plan for women contains the first official reference to reproductive health. In the U.S. and New Zealand, which do not have a national health policy, reproductive health is part of programs and services. Reproductive health terminology is not part of Italy's national health plan, but the country's network of family health counseling centers provides a wide range of required services.

Some of the most visible advances have been in the scope of reproductive health services. The Programme of Action has influenced redesign and delivery of services in countries such as China, Colombia and Korea. The U.K. and Nigeria have established reproductive health programs with male involvement. Public health systems provide screening services for female cancers in a number of countries, including Australia, Brazil, Chile, Costa Rica, Mexico, New Zealand and the U.S. HIV/AIDS prevention and treatment are part of reproductive health services in Germany, Korea and Senegal; Germany also has a pilot project specifically for women with AIDS. Adolescent sex and health education programs are a priority in Cuba, Germany and Jamaica. Free primary health care for women and children under six years is a cornerstone of South Africa's reproductive health policy and marks an important shift from curative to preventive care.

Despite the crippling effects of the U.S. economic embargo, Cuba's public spending on health has increased steadily. India made a major policy shift in 1996 when it released family planning from centrally mandated targets. Indonesia's family planning program has also tried to overcome its strongly target-driven practices and adopt client-centered methods - a shift now jeopardized by the economic crisis. Iran's reproductive health spending has more than doubled to six per cent of the total health budget since 1994. Zimbabwe has introduced reproductive health in population and health policy guidelines.

Norway has allocated half of its reproductive health assistance to Africa.

The Netherlands has maintained a high level of international population assistance relative to its economy and has more than doubled funding for population and reproductive health between 1994 and 1996. U.S. population assistance is moving from its traditionally strong family planning focus to a more integrated reproductive health approach. U.K. donor aid provides funds for projects in critical areas such as post-abortion care and sexual violence.

The U.K. and Canada have programs addressing the links between breast cancer and the environment, especially pollution. New federally funded initiatives in the U.S. include a Long Island Breast Cancer Study and studies funded by the Department of Defense Breast Cancer Research Program to analyze women's environmental exposures.

The successes documented in this survey are especially a tribute to the efforts of women's health advocates in advancing the feminist vision of the Programme of Action. In the majority of countries, it is women activists who have been catalysts of change. Through tireless campaigns and coalition-building, they have wrested victories in some of the most contested areas in the Programme of Action, such as reproductive and sexual rights, adolescent sexual health and education, and harmful traditional practices. In many countries, it is women's energy, resilience and resourcefulness in face of daunting political and socio-cultural obstacles that have kept the Programme of Action alive. In the process, women's NGOs have often taken on responsibilities that governments have been unwilling or unable to handle. Specific NGO partnerships with governments have been in service delivery, policy-making and health and sex education.

## Building Coalitions

A key strategy adopted by women's NGOs to advance Cairo goals has been to build broad alliances with a range of civil society actors to overcome conservative challenges to reproductive choice and freedom. Egypt's FGM Task Force, composed of activists, researchers, doctors and feminists, played a pivotal role in broadening debate on the sensitive and charged issue of female genital mutilation and creating a climate for a political ban on the practice. Government-NGO coalitions are emerging in Mali and Nigeria to fight FGM and violence against women.

The Argentinean experience shows how alliances between health professionals, community members and church can work in a repressively conservative environment. Reproductive health services were introduced in 1998 without opposition of any kind in the province of Buenos Aires, which has a third of the country's population. A law endorsing creation of a family planning program for women was also the result of such alliances. In Korea's male-dominant culture, women's groups have been vocal and active in promoting sex education stressing gender equality and raising funds to fight domestic and other forms of violence against women.

In Australia, women activists launched a massive community campaign with support from a woman member of Parliament to remove abortion from the criminal code in 1998. In Bangladesh, women health providers, NGOs and community leaders have

mobilized to take up women's health concerns and have worked with the government to develop the new health and population program. In Brazil, the National Council on Women's Rights was revitalized with greater political clout in 1995. The Council worked with the National Commission on Population and Development to defeat an anti-abortion provision in Congress in 1996. Similar alliances between activists and policymakers in South Africa led to the historic Choice of Termination of Pregnancy Act in 1997, the first of its kind in Africa. In Sri Lanka, an emerging partnership between NGOs and women legislators calls for legalization of abortion services.

Drawing on the Beijing Platform commitments, NGOs have also collaborated with governments to establish institutional mechanisms for women's rights. There are new ministries for women in Colombia, Costa Rica and Mali. China, Fiji, Iran, Mali, and Nigeria have launched women's action plans stemming from both the Cairo and Beijing conferences. Government and NGOs in Zimbabwe have begun national consultations on a new gender policy.

In some instances, women have slowly expanded the space offered them by the state to become creative and vocal agents of change. In Iran, an association of volunteer women health workers set up by the government to attend to women's family planning and general health needs in congested and under-served urban areas, has acquired a life and will all its own. Now more than 20,000 strong, these community health workers have become empowered in the family and community and enlarged their sphere of activities, organizing around community and environment issues and, in some cases, publishing their own newsletter. To the chagrin of the government, which saw them as effective but docile agents of family planning, the volunteer women are now an organized force seeking a greater role and political voice.

In many countries with discouraging political and social environments, NGOs have worked with governments to make decentralized policymaking a reality. In Bangladesh, a pilot project to promote participatory planning with communities forged ahead thanks to the persistence of activists, overcoming the resistance of government officials. In strife-torn Algeria, a cooperative committee of citizens and youth is collaborating with government and NGOs to address the spread of HIV and sexually transmitted diseases and devise policy responses to the slaughter of civilians by armed insurgents. A newspaper campaign in Uganda targets adolescents on sexuality and reproduction issues. Botswana's youth clinics have taken on reproductive and sexual health education and service delivery to stem the rampant spread of HIV.

In Canada, women's advocacy efforts have impelled successive governments in Ontario to help community health centers provide counseling and services for refugee women and undocumented migrants. In the U.S., where HIV/AIDS is a top killer in

the African-American community, the Congressional Black Caucus made the issue a top priority of its 1998 agenda. Working with health care professionals, activists and community leaders, it has got the federal government to designate this as a public health emergency and develop a package of initiatives to address it.

Women's advocates have spearheaded legislation against discrimination and violence in many countries. Korea's new law banning the pernicious practice of sex selection of fetuses to abort girls is one example. In Botswana and Tanzania, women's activists have worked with government bodies to bring about stiffer penalties for rape, especially for rapists who are found to be HIV-positive.

These achievements are all the more remarkable in light of the fact that the concept of comprehensive reproductive health that takes a life-cycle approach to women's health as defined in the ICPD Programme is still struggling to emerge in a number of countries. In Senegal and Morocco, women activists report that their governments have adopted ICPD principles in spirit but not absorbed them in practice. In South Africa, despite progressive and far-sighted changes in health policy and the presence of a strong and sophisticated women's health movement, reproductive health is used interchangeably with women's health in the White Paper that sets out policy.

In others, the policy shift to reproductive health is merely semantic; the approach remains rooted in family planning and fertility control. These old-style practices have proven especially hard to dislodge in countries with long-standing family planning programs aimed at population control. They are still the norm in the three populous countries of South Asia - India, Pakistan and Bangladesh - and China, despite encouraging new initiatives there aimed at doing away with demographic targets and expanding women's health services at the village level. By and large, new orientations after ICPD have not significantly deflected from the official view of women primarily as mothers, with little regard for their health needs before and after their reproductive years.

The focus on female methods of contraception and sterilization also remains unchanged in these countries and Iran and the Philippines, to name a few. Despite new efforts by the Chinese government to involve men in family planning, only nine per cent of men undergo sterilization compared to 40 percent of women. Nicaragua's National Health Plan makes no mention of male responsibility in family planning and has no provision for reproductive health programs for men. In Peru, activists uncovered gross violations of women's rights in sterilization procedures under the state's family planning program in 1996. Bangladesh activists report that incentive payments to providers of sterilization were resumed after ICPD.

Given the lack of conceptual clarity and the persistence of demographically-driven approaches, it is not surprising that an overwhelming number of respondents say that reproductive health services offered do not meet women's needs. The greatest shortcomings are reported in pre- and post-natal care - an area in which vast rural-urban disparities persist - availability of contraceptives, emergency obstetric care, post-abortion care, services for post-menopausal women, detection and screening services for female cancers and male responsibility for family planning.

Donor funds play a key role in defining the scope and direction of reproductive health in national health policies and programs. With declining levels of aid - since 1996, all major bilateral donors have had their budgets cut, USAID by as much as 35 percent - donor agencies are under greater pressure from their governments to show measurable achievements for funds allocated. This fosters a reliance on numerical indicators of "success" such as contraceptive prevalence rates and fertility rates. The result is that client governments are under increasing pressure from donors to emphasize family planning above all other components of reproductive health, or promote long-acting methods, regardless of health concerns voiced by women activists. NGOs in Egypt and Bangladesh, for example, point to both these disturbing trends, which raise critical issues of the nature of partnerships among government, bilateral and multilateral donors and civil society.

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## B. Reforms and Risks: Economic Constraints

Declining trends in donor assistance, structural adjustment policies that curb social sector spending, health sector reforms that aim to make public health systems cost-effective, the serious debt burden of many countries in the South and recent economic crises all pose challenges to the achievement of Cairo goals. The world's poorest countries owe an estimated US$371 billion in external debt, and are also faced with acute levels of human and environmental distress. Nigeria's external debt exceeds a full year's GNP. Tanzania spends nine times as much on debt repayments as on basic health care and four times as much on debt as primary education. In Peru, debt servicing consumes 22 percent of total government spending, compared to seven percent on health. Policy reforms that curtail public expenditure have deepened poverty and inequity in developing countries. All respondents to this survey cite economic reforms as paramount constraints in implementing the ICPD Programme. Health sector reform in particular is emerging in most countries as a challenge to expansion to reproductive health services.

### Health Sector Reform

Health sector reform has become an integral aspect of adjustment policies stressing market principles in the social sector. It has been introduced in a host of developing countries, with similar processes underway in industrialized countries with established social welfare systems. The overall goal is to minimize the bureaucracy and inefficiency of overly centralized systems and make health spending cost-effective by re-organizing services and resources.

Some of the means employed are decentralization of management and budget to make the health sector more accountable to users by ensuring district and community participation; introducing cost-recovery mechanisms such as user fees and insurance; encouraging greater private and other non-governmental sector participation in health delivery; and modernizing administration through financial and management information systems. In the 'reformed' health sector, the state stays responsible for no more than a basic health package, whose components can vary depending on a country's level of development.

There are clear benefits, in principle, in several health sector reform measures, such as shifting decision-making and responsibility from central to local authorities and the community, and integrating vertical management structures for greater efficiency. But problems arise from the technocratic and sectoral approach of reform to health as a discrete commodity, unrelated to environmental, social and economic factors. Further, health sector reform is based on some untested assumptions: that swathes of poor populations have the ability to pay for health care, and that governments in developing countries have the capacity to back reform measures with managerial, technical and financial resources. While holding the promise of greater accountability and responsiveness of health systems, in reality, health sector reform has in many instances eroded equity of access to health services.

Decentralization has most often taken the form of governments shedding responsibilities to the provinces or districts without allocating resources. Cash-strapped local authorities cannot make local services viable because of the poor purchasing power of most of their users. The imposition of user fees has placed basic services beyond the reach of the poor, women in particular, with disastrous health effects. Prescription medicines, basic medical supplies and consultations that were previously free must now be paid for, forcing many of the poor to delay health care and risk disease and death. The income exemption limit for user fees suggested by the World Bank has often failed to take into account inflation and currency devaluation and is too low in many countries to protect vulnerable populations. Contrary to Bank guidelines that fees collected stay in the local health facility to improve services, governments often use this revenue to stabilize national budgets to meet stringent targets for fiscal stabilization. As a result, health services have not only deteriorated in quality but become more expensive.

Lay-offs of public health personnel and wage freezes in the public sector have also contributed to a decline in quality of services by collapsing morale, prompting an exodus of health professionals to the private sector or abroad. Employment-linked health insurance in the formal sector means that the primary bread-earner, usually male, has access to employer-sponsored health services, while women and children in the family have to use fee-for-service facilities. Public sector lay-offs as part of overall structural adjustment not only strike at this slender provision of health, but also increase the work and disease burden of women. They have to take on the role of primary caregiver in the family as well as put their own health needs last. Like all other adjustment policies in the social sector, health sector reforms have defined efficiency without taking into account the enormous human cost of coping strategies adopted by the poor, women in particular.

## Charging Fees

The majority of countries in this survey report some or all of these effects of health sector reforms. Cost recovery tops the list, cited by 70 per cent of countries as resulting in several adverse health consequences for women. Zimbabwe provides an object lesson of the ways in which World Bank and government calculations of the role of user fees have gone tragically awry. An OXFAM study cited in this report found that fee structures introduced in 1994 raised primary care costs six-fold. Antenatal care previously free cost Z$10. Strict enforcement of fee collections led to a fall in out-patient attendance by 18 percent and a 12 percent rise among in-patients, suggesting that people were delaying health care until absolutely necessary. Antenatal clinic attendance fell, while admissions of unregistered mothers and babies born before arrival rose more than 20 percent. The maternal mortality rate among these women was five times higher than for women who had pre-natal care.

In Nigeria, women must now pay for blood and blood products and use of equipment and even bring their own candles to hospitals in case of a power outage during delivery. In Uganda and parts of Tanzania, poor women can no longer afford the cost of pre- and post-natal care and have to resort to traditional midwives. In Sri Lanka, patients are increasingly required to pay for basic services in public health systems, such as medicines and injections.

## Privatization

Fifty-four percent of countries report that privatization trends have weighted the odds against access to health services by the poor, women in particular, the elderly and immigrant and minority populations. Privatization of public services and competitive market mechanisms increasingly characterize the health systems of rich and poor nations alike known for extensive and long-standing state-supported social programs,

such as The Netherlands, New Zealand, Russia, India, Indonesia, Tanzania and Zimbabwe. In the Philippines, privatization has led to the sale of government land and closure or scaling down of vital public hospital services in mental health, leprosy and TB. In Sri Lanka, Tanzania and Egypt, medical staff in public facilities invest more time in private practice to the detriment of quality of public health services. Tanzania and Kenya have the dubious reputation of being the biggest "exporters" of qualified medical personnel from the region to southern Africa.

In New Zealand, health sector analysts note that public hospitals have been transformed into commercial enterprises, required to operate not as caring institutions but successful businesses. Government officials say that health rationing is now a fact of life. In 1997, there were 86,000 people on public hospital waiting lists, 20,000 more than when reforms began. In the U.S., when privatization has led to health institutions being taken over by Catholic administrations, women face a double burden: reduced access and denial of reproductive health services on religious grounds.

Simultaneously, the removal of price controls on pharmaceuticals and the opening of domestic markets to multinational corporations under globalization have added to health care burdens. Medicine costs have soared 300 percent in Egypt. NGOs in Algeria, China, India, Morocco, the Philippines and Russia report that spiraling costs of medicines are a growing barrier to health care. In China, treatment for common ailments is prohibitively expensive: a typical prescription for Western drugs can cost US$60, or half a month's salary for an urban worker. In India, the increased cost of medical care is the second most common cause of rural indebtedness. Women place their health needs last when cost is an issue, seeking medical care too late or not at all.

## Decentralization

Fifty-two percent of countries, Bulgaria, Canada, India, Mali, Pakistan, the Philippines, Russia, Senegal and South Africa among them, point to decentralization of responsibilities without adequate resources, a phenomenon endemic among countries in Latin America. Canadian activists say that the shift in responsibilities from provincial to regional authorities has occurred without allocation of new resources, creating a funding crisis in community health centers.

India's formal rural health infrastructure is beset with problems and offers limited services of poor quality. In the Philippines, many local governments are too poor to assume health care responsibilities, and pass patients back to nationally funded tertiary centers or NGOs. In Pakistan, decentralization to improve service delivery under the Social Action Program has fallen short of goals, especially in rural areas.

Only a third of communities surveyed in an independent study had health facilities, with less than half of male doctors reporting for work.

## Cuts in Budgets and Public Services

Forty-four per cent of countries report cuts in public health services. In Costa Rica, reforms have reduced per-capita health spending, and led to stagnation of public services and cutbacks in health services covered by the social security system. Poor women have less access to services of specialists such as gynecologists; in Argentina, they have to wait from dawn to midday to see a doctor. Long waiting periods and inconvenient clinic hours are further deterrents to women seeking health care.

Budget squeezes that lead to closure or emasculation of public hospitals particularly affect women because these are the only institutions that provide reliable care with equipment and staff for quality obstetric-gynecological services. This is the experience of Peru, where reforms have increased the number of health centers but more than halved the number of public hospitals in the last six years. In Russia, the transition from state-supported health services to a market economy has thrown the health system out of gear. Budget cuts have forced closure of hospitals in rural areas and cutbacks in emergency obstetric services.

The Bulgarian and Ukrainian experiences with abortion shows how market forces have placed women between a rock and a hard place. Abortion is legal and traditionally the main method of birth control. Women resort to abortion in large numbers even though it must now be paid for and despite the fact that abortion is a major cause of secondary infertility. Activists say this is because government budgets provide no funds for public education on the damage caused by repeated abortions and most women cannot afford contraceptives at market rates - 15-40 percent of average monthly income in Bulgaria.

*Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion*

*Programme of Action, 8.25*

More than a fourth of respondents, Australia, Argentina, Canada, Morocco, Russia, Tanzania, Turkey, the Philippines and Sri Lanka among them, report cuts in the health budget as a result of economic reforms including structural adjustment. Inflation, currency devaluation and monetary crises have offset the impact of budget increases in most other countries. Moreover, public investment as a proportion of total health spending is declining in many developing countries, where the poor are seen as consumers of private health care. In India, household spending on private health care

accounts for five percent of total consumption expenditures in rural areas, and two percent in urban areas.

### HIV/AIDS Burden

Health sector reforms have been put in place at a time when the imperatives for public investment in health are the greatest - whether because of increasing poverty and social exclusion as a result of structural adjustment and economic crisis, as in parts of eastern Europe and Asia, or the HIV/AIDS pandemic ravaging entire countries and generations in parts of Africa. The stupendous demands on systems and resources created by galloping rates of HIV infection have brought health systems in worst hit countries to the verge of collapse and reversed significant gains in reducing maternal and infant mortality. Forty-two percent of countries report the increased costs of HIV/AIDS treatment as a burden on over-stretched health systems.

In Botswana, where one in four people are infected with HIV, pregnant women who are HIV-positive can receive AZT free of charge only in the first trimester. Women are especially vulnerable to infection because of physiological factors that predispose them to infection, their lack of bargaining powers in negotiating safe sex and their economic dependence on men. HIV infection rates are rising among women in Argentina, India, Japan, Kenya, the Philippines, South Africa and Zimbabwe. HIV/AIDS is also spreading rapidly among the young, with 2.5 million people aged 15-24 and 600,000 children under 15 catching the virus in 1998. The UN estimates that six young people are infected with the AIDS virus every minute.

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### C. Rights and Risks: Socio-Cultural Constraints

The women's health and human rights movement has acquired unprecedented visibility and pre-eminence through the Cairo and Beijing platforms. In asserting their rights, however, women have had to contend with an array of opposing forces, old and new, that have grown in strength and number. NGOs in every region of the world report that conservative forces in various guises, predominantly religious, represent key obstacles to the advancement of Cairo goals. Religious and cultural resistance to reproductive rights is the greatest - although by no means restricted to - countries that entered reservations to the Programme of Action's commitments on abortion, adolescent sex education and services, and sexual and reproductive rights. The power wielded by these forces is most evident in restrictions on abortion rights and adolescent sex education and services - two highly contested aspects of the Programme of Action.

## Conservative Forces

Religious forces, especially the Roman Catholic Church and its Rome-based affiliate, Opus Dei, oppose reproductive rights in various ways. Common tactics are public campaigns against abortion and contraception in schools and the media, especially targeting health providers and thereby affecting the delivery of reproductive health services, and influencing policy-making. Some of the hardest battles for reproductive rights are being waged by women in Latin America, where key government officials are openly and staunchly allied to the Catholic hierarchy. Activists report that anti-choice groups in this region are also buoyed by substantial support from ultra-right wing forces in the U.S.

In Nicaragua, women's groups say that a new Ministry of Family is the single biggest constraint to advances on reproductive rights. Its minister, an Opus Dei affiliate, has vowed to outlaw anything that "disintegrates the family," such as extra-marital sex and divorce, and to campaign for natural methods of contraception such as rhythm and withdrawal. In Argentina, reproductive health is not part of national health policy and women activists' efforts to introduce it in legislation, with support from women policy-makers, has been stymied by the Catholic Church in all but two provinces. Costa Rica has kept reproductive health out of official national policy to avoid interference from the Church, while Guatemala has chosen not to have one out of deference to the Church and other conservative quarters. In Mexico, right-wing groups such as Pro-Vida, Human Life International, the Opus Dei and Christ's Legionnaires, oppose all forms of contraceptives, abortion even in cases permitted by law and adolescent sex education.

Activists in the Philippines also report the pervasive and repressive influence of the Catholic Church. To counter ICPD goals, Catholic alliances have sought key positions in local government, pushed for legislation against family planning and abortion, campaigned to replace population education with "pro-life sexuality modules" and proclaimed that tetanus vaccines are abortifacients.

In Poland, the anti-abortion law of 1993 made abortion illegal, overnight abolishing the provision for abortion on social grounds that had been legal since 1956. The provision was restored briefly in 1996, and withdrawn again by the conservative government in 1997. Alongside, the Catholic Church has kept up a relentless campaign against modern contraceptives, characterizing their use as ineffectual, harmful and sinful. The influence of Catholic and other conservative forces has stopped approval of Mifepristone in Australia and ensures that abortion is a crime in most states. In the U.S., women activists point to the "pervasive moral zealotry" of conservative forces that has led to unrelenting violent attacks on reproductive rights, especially abortion, and opposition to family planning programs at home and abroad.

In parts of West Africa, women report that Islamic conservatism is flexing its muscle to counter women's voices for sexual rights and reproductive choice. Muslim women's associations have sprung up in Mali with funding from Arab countries to discourage contraception and protect FGM. Militant Islamists in Algeria have committed horrific acts of violence against women deemed "enemies of Islam." Activists report that while the state opposes the Islamists militarily, it accommodates fundamentalist pressure on key women's concerns, such as marriage and polygamy.

In Argentina, on the other hand, with women legislators as allies, activists have defeated attempts by the state to introduce constitutional provisions seeking to protect life from the moment of conception. In Brazil, women's health advocates have staunchly countered many conservative attacks on abortion rights and launched signature campaigns to convince lawmakers to support a 1997 abortion law.

### Restrictions on Adolescent Sex Education

Adolescent sex education is under attack from the Catholic hierarchy and other conservative forces in Australia, Chile, Costa Rica and Mexico, to name a few. These are also among the countries where sexual activity begins early and teen pregnancy rates are unusually high. Young people aged 15-19 in Mexico have the lowest rate of contraceptive use. Childbirths among women in this age group account for more than 15 per cent of total births. Costa Rica reports a 20 per cent rise in teen pregnancies over 1996-97. Thirty per cent of young people polled in a survey said they get little information about pregnancy.

Failure of the health system, even in industrialized countries, to meet critical sexual and reproductive health needs of young people is reflected in high rates of abortion and sexually transmitted diseases in this population. With almost one million pregnancies among adolescents each year, the U.S. has among the highest teen pregnancy rates in the industrialized world. So does the U.K., with 30 per 1,000 live births in 1997. Pregnancy and abortion rates are sharply on the rise among young women in Japan, where sex education at schools, homes and in the media is almost non-existent. The government remains oblivious, with the Ministry of Education taking the stance that it "is best not to wake a sleeping child." Abortions among young women account for 33 per cent of the total in Korea, where activists report that education on family planning, sexuality and gender relations is inadequate and outdated.

### Restrictions on Abortion Services

Abortion remains illegal and/or restricted to varying degrees by law in most countries of the world. Although Paragraph 8.25 of the Programme of Action does not call for

universal legal and safe abortion, it does call for greater actions to deal with the health impact of unsafe abortion. Most importantly, in emphasizes that "in all cases, women should have access to quality services for the management of complications arising from abortion." The vast majority of countries in this survey are far from fulfilling this requirement. Lack of resources to provide post-abortion care is only part of the reason. The larger influence is from conservative forces that reserve their most virulent tactics for abortion. Even in countries where abortion is permitted by law to save a woman's life, women can be denied the procedure by doctors and other health providers on religious grounds. They also have to endure humiliating and time-consuming formalities at the hands of the police, courts and other bureaucratic bodies, with often fatal consequences. Activists in Argentina, Nicaragua and Peru report these trends.

In the U.S., since 1993, there have been seven murders of doctors and workers in abortion clinics and 14 attempted murders. In 1997 alone, nearly a fourth of abortion clinics nationwide were targets of violence and threats. In Canada, where abortion is legal and available without restriction on reason, the right-wing swing in many provinces and the election of anti-choice advocates in local governments, coupled with deficit-cutting cutting measures as part of decentralization, have led to cutbacks in family planning and abortion services. In Norway, the Christian Democrats in the governing coalition are seeking to restrict the 1978 law on abortion on demand, creating new fears of a rightward shift.

*Seventy-seven per cent of anti-abortion leaders are men. 100 per cent of them will never be pregnant - Advertisement of the Pro-Choice Public Education Program in New York City subways*

Several countries cite the criminalization of abortion as the biggest contributing factor to the persistent tragedy of maternal mortality, an area in which governments have made the least progress since ICPD. Illegal abortion is cited among the highest causes of maternal death by a number of countries surveyed, including Argentina, Chile, Colombia and Guatemala. By contrast, Italy's experience with abortion confounds conservative critics. Legalization and safe and affordable access, along with expanded family planning choices, has reduced the number of abortions, especially by preventing clandestine operations.

## Negative Male Attitudes and Discrimination

Male attitudes of control and subjugation, especially in sexist and patriarchal cultures, are another category of persistent socio-cultural constraints. These are often institutionalized in law or practice. In India, for example, contrary to government guidelines, health providers often seek male authorization for women seeking

abortion. In Iran, women must get spousal authorization for all forms of contraception, especially tubal ligation. Korea's dominant male culture causes women to care for the health of men while ignoring their own, even when they are sick. In Botswana, although 90 percent of the population is aware of how HIV is transmitted, extra-marital affairs are the norm among many men, who also refuse to use condoms with their wives. In Algeria and Senegal, women say that opposition from husbands is a main reason for failure to use contraception and spread of sexually transmitted diseases. Tanzanian men oppose contraception because they believe it causes women to be promiscuous.

The attitudes of health providers, often influenced by class, community, race and gender, deter women from seeking professional care. Activists in Mexico report that authoritarian attitudes of health providers and their belittling of symptoms undermine the principles of equity in reproductive health services. In India, the attitude and the quality of care provided by staff in public clinics changes with a woman's socio-economic status. Poor and unmarried women often have to seek care in the private sector as a result. Discrimination, denial and destitution still characterize the world of women HIV/AIDS patients in many countries, even in countries with exponential increases in infection and disease.

Such discriminatory attitudes become pronounced deterrents to health care for women of ethnic and racial minorities. When accompanied by a lack of government attention to the health status and needs of these groups, this leads to a failure to recognize the differential health status of minorities. Activists in Canada and Costa Rica, for example, point to the failure of the health system to address the high rates of breast and cervical cancer among women of African descent in these countries. In the U.S., ectopic pregnancy, a consequence of untreated STDs, is the leading cause of death in early pregnancy among African-American women.

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### D. Women's Health and the Environment

The Programme of Action highlights the links between increasing population, environmental changes and sustainable development. Principle 2 recognizes the fundamental right of all people for a life "in harmony with nature." Principle 3 emphasizes the need for a dynamic balance between population, resources, the environment and development to ensure the well being of all people. Key to these goals is the basic human right to adequate food, housing, water and sanitation. Agenda 21 adopted at the 1992 UN Conference on Environment and Development emphasizes the goals of sustainable development that relate to gender equity. Assessment of progress on connections between gender, environment and development include

examination of a gender focused approaches towards education, training, data gathering and assessment and enhancing women's role in decision-making with respect to the environment.

Environmental threats stem from traditional problems related to poverty and development including lack of access to safe water, poor sanitation, food contamination, indoor air pollution from cooking, inadequate solid waste disposal, occupational hazards in agriculture and cottage industries, natural disasters and disease vectors. In many countries, the World Health Organization has found that a "risk transition" is occurring, placing people in double jeopardy, as traditional environmental health hazards are exacerbated by new threats. While surface-water sources were already contaminated by sewage, groundwater sources are now polluted by industrial wastes seeping into water tables. Air pollution from vehicular transportation, power plants and industrial sources is on the rise, especially in rapidly growing urban areas. Exports of wastes and obsolete technologies from 'developed' countries brings with it modern dangers of chemical and radiation hazards. Rapid urbanization has combined with rapid industrialization to double total industrial waste in parts of the world. The drive for economic growth is pushing countries to over-exploit natural resources including timber, fossil fuels and minerals, resulting in unprecedented deforestation and land degradation.

While environmental threats affect hundreds of millions of people, causing increased illness and disability, women are often those who are most sensitive to changes in the environment because they are in closest contact with the home and the land and they are the first line of defense when threats face the family system as a whole. Survival of women and their families is closely linked to the health of the land, forests, fisheries and other natural resources on which their survival depends. Women's health is essential to ensuring the safety of future generations. It is women who must guide the growing child through the most fragile stages of development. There is strong evidence in this report of the irrevocable damage caused by environmental assaults during various stages of the life cycle, but particularly to the fetus and growing child.

The report is also a testimony to the struggles women wage in the face of growing environmental degradation. In developing countries, one in five children will not live to see their fifth birthday, most because of avoidable environmental threats to health. This translates into roughly 11 million avoidable childhood deaths per year. As caretakers and mothers, women bear the brunt of this pain on a daily basis.

Women throughout the world have been innovative in their response to these problems. In the U.K., where breast cancer mortality is the highest in the world, women are working to map environmental exposures that may be linked to the disease. In the U.S., women have emerged as some of the most active leaders in

community-based grassroots environmental organizations. In China, women all over the country are being trained in environmental protection and sustainable development, and are in turn training other women. In Kenya, women activists plant trees. In Nigeria, they have come together in the Ogoni region to fight the impact of oil pollution in the Niger Delta.

## Water Pollution and Supply

At every UN conference from Rio to Rome, governments agreed to ensure universal access to safe drinking water in sufficient quantities by the year 2000. Yet one billion people lack access to safe water supply. The UN estimates that 40 percent of the world's population, living in 80 countries, suffer from severe water shortages. No region of the world is likely to reach full coverage with safe drinking water in rural areas in the next 20 years.

In general, information on water quality is variable and dependent on monitoring systems, with many countries in the process of installing or upgrading them. Rapid economic growth and industrialization affect water quality in countries worldwide. Ninety percent of countries in this survey report water pollution as a serious threat to women and health. Inadequate sewage systems continue to lead to untreated runoff in many developing countries. In Peru, mine wastes run into drinking water, dumping heavy metals along the coast. In Russia, 30 percent of groundwater is contaminated by industrial wastes. In Nigeria, 90 percent of industries have no pollution equipment and discharges flow into rivers and streams. In Cuba and Russia, poor technology, maintenance and equipment have led to worsening conditions of supply. Women search for clean water with babies on their backs or with the added burden of pregnancy. In India, pregnancy complications are reported to result from this task. With pollution of fresh water sources increasing, women now must go even longer distances to find water clean enough to meet their needs.

The health effects of water pollution are especially severe on women and children. In the Ukraine, 13 percent of the illnesses in women and children are due to water pollution. In Russia, pollution has led to doubling of bladder and kidney disorders in pregnant women. In Uzbekistan, prolonged use of water polluted by pesticides and industry has led to increases in pregnancy complications and birth defects, and a higher incidence of anemia, and kidney and liver diseases in women.

In India, high levels of pesticides, including DDT, have polluted rivers in Delhi and Agra that are major sources of drinking water. Dangerous levels of arsenic in groundwater in Bangladesh have affected millions who drink from tube wells. In Egypt and Morocco, major bodies of water are heavily contaminated with organochlorine pesticides. Problems in young children due to malnutrition, in

countries like Iran, are sometimes compounded by the health effects of continued use of contaminated water. In Algeria, typhoid is endemic, mainly because polluted water mixes with drinking water supplies. Exposure to pollution in aquatic food products is also harmful for women in countries throughout the world. In Colombia, mercury from gold mining has contaminated water supply and threatened fish populations. In the Angke estuary in Indonesia, mercury in commercial fish far exceed WHO levels for human consumption. More sustained efforts are needed by groups working with women to educate and train them about water resource protection, conservation and steps women can take to protect themselves in the face of water contamination.

## Occupational and Chemical Hazards

The drive for increased productivity in many countries has led to more and more women filling jobs in labor-intensive industries. Industrial chemicals and other toxins in the environment are taking a massive toll on the health of women around the world, through both occupational and residential exposures. Eighty-two percent of countries report on occupational health hazards faced by women.

In China, some large-scale export industries promote themselves as "environmentally friendly," although they still may contribute to problems through various practices. Other firms blatantly ignore environmental and health and safety concerns. Employers view young women as "more compliant" and "less likely to challenge" violations to health and safety laws in many countries. In Poland, the upper Silesian Industrial Zone, designated an "ecological disaster area," is characterized by high cancer and infant mortality rates and lowered birthrates. Advanced industrial development means exposure to an increasingly complex number of chemical substances, with little understanding of health impact. In Japan, studies have shown that workers are exposed to more than 50,000 chemical substances at various industrial sites. In Cairo, total industrial waste has nearly doubled in recent years. In the Ogoni region of Nigeria, women have suffered dramatic losses in food productivity as a result of environmental devastation in the region from oil exploitation.

Women also face previously unknown threats to safety and health in the workplace as a result of exposures to new types of chemicals. Risks to reproductive health from workplace exposures to chemicals need far more attention and research worldwide. Chemical exposures and alterations in reproductive behavior have been recognized in laboratory animals and wildlife while evidence for humans is less certain. While some known substances such as dioxins and cigarette smoke threaten reproductive health, analysis of the association of chemical exposures and adverse reproductive outcomes in humans is reported to be controversial. Some studies indicate that chemical exposures are associated with infertility, spontaneous abortion, or reproductive cancer in women. Other studies indicate that there is no association between chemical

exposures and adverse reproductive outcomes. The mechanism by which chemicals alter reproductive function in all species is complex and may involve hormonal changes, immune system threats, and changes at the cellular level or in DNA. Far more research is needed to clarify the ways in which specific substances affect human reproduction and by which mechanisms of action.

The reports in this survey provide numerous examples of the ways in which reproductive health is threatened through chemical exposures in the workplace. Forty-four per cent of countries report reproductive health disorders. Many occupations threaten women's reproductive health - carpet weaving in Iran, horticulture in Colombia, the shoe industry in Italy, rubber production and production of chemical fiber carpets in China. Women workers in these sectors show evidence of complex symptoms including menstrual disorders, stillbirths, miscarriages or impaired birth weight due to exposures to complex chemical mixtures on a daily basis.

Many risks to women in the workforce are still unrecognized, uncharacterized and/or uncontrolled. In most countries, there is little awareness of the growing complexity of chemical exposures for women, particularly in rapidly developing industrial sectors. Women are predominant in the informal sector or work as part-time or casual workers in many countries. While this may provide them greater flexibility in terms of juggling domestic responsibilities and tasks related to childcare, it also means that their activities are not covered by government regulation and oversight of occupational health and safety. Temporary workers are also less likely to have health coverage or access to medication. Where health and safety regulations are in place, resources to enforce them are often inadequate. In the Ukraine, for example, 87 percent of companies do not meet government safety norms.

While ILO conventions and many domestic laws regulate conditions of women's employment, response to problems of reproductive risks and workplace exposures has been varied. In Europe laws stipulate that both pregnant women and soon-to-be fathers are entitled to work that does not expose them to harmful substances. Italy, Norway, the Netherlands and the U.K. report problems with implementation of regulations allowing for changes in jobs or work adjustments for pregnant women (and in some cases soon-to-be fathers). Educational brochures in the U.S. have been developed to outline occupational reproductive risks for pregnant women and targeted health monitoring and educational programs for occupations with reproductive risks have been developed in Iran as well as guidelines for hazards related to new and expectant mothers, and blood sampling in Colombia. However, far too many women are still not aware of their rights in these areas.

Many countries approach the problem of occupational safety for women by treating men and women equally and applying the same standards across the board, as stated

in the U.K. government response. NGOs have emphasized the need for more education and training, research and monitoring of the effects of environmental pollutants on women's health. They call for women's greater involvement in decision-making on issues of environment and development to fully reflect women's needs. Labor protection statutes need to be refined along with greater cooperation between health care and environmental protection institutions to reflect sensitivity to women. Labor protection facilities need to be enhanced rapidly along with increased sensitivity to these issues in trade unions and female worker associations. Finally, there is a need for more effective protection of legal rights and interests of workers and strengthening of oversight mechanisms in law enforcement.

Occupational health clearly must be put in a perspective of community health, given that that such a great proportion of women, particularly in developing countries belong to industrial sectors which are not covered by occupational medicine legislation, that is the agricultural and informal production sectors. The medical community as a whole needs more training about occupational risks for women so that they can identify these risks.

## Pesticide Contamination

The use of pesticides in agriculture has increased worldwide in response to growing demands posed by globalization and export-oriented technologies. Women in the developing world produce half the world's food but exercise little control of decision-making and land ownership. They are often lowest paid, with the highest exposure to pesticides that pose clear health risks. Seventy-eight percent of countries report pesticide contamination as a threat to health. In Latin American and Caribbean countries like Costa Rica, female agricultural workers have neurobehavioral deficits, increased lung, cervical cancers and leukemia. Two-thirds of flower workers in Colombia suffer headaches, conjunctivitis, rashes and asthma. In Jamaica, there are concerns about potential health effects on thousands of women in the coffee industry exposed to endosulfan, now considered an endocrine disrupter. In Eastern European countries like the Ukraine, women with long term pesticide exposure report high rates of reproductive health problems including fibromymas and inflammations of the uterus. In China, pollutants from a state run fertilizer factory resulted in mental retardation in one third of local villagers and an alarmingly high number of still births and miscarriages. In Sudan, 22 percent of hospital stillbirths are linked to pesticide exposures. In Egypt, pesticides were responsible for one-third of all poisonings.

Pressures on management to increase productivity lead directly to workers being pushed to perform beyond safety limits. Of most concern is the fact that most women are unaware of the adverse effects of pesticide use. Even where products are labeled, many women cannot or do not read or understand the warnings. Women agricultural

workers generally do not use protective clothing and equipment because it is unavailable, unsuitable for hot climates or too expensive. In Indonesia, a substantial number of rural households store pesticides and pesticide equipment in kitchens and living areas. In South Africa, the problems of domestic exposure to chemicals is also a source of frequent poisonings. Women in rural communities clearly need far more education about pesticide hazards and dangers of other chemicals like kerosene as well as meaningful incentives for use of protective equipment and implementation of methods of agriculture which do not rely on chemicals so heavily.

Governments at the 1992 UN Conference on Environment and Development agreed to promotion of sustainable agriculture, but set no specific targets for reduction of pesticide use. Problematic pesticides that persist in the environment, such as DDT, are receiving new international attention through negotiations to phase out these chemicals. The benefits of reduced use are clear. Innovative efforts to reduce pesticide use such as the FAO initiatives in the South East Asia Integrated Pest Management Program involving training of farmers in reduced pesticide use has saved the government millions in pesticide subsidies while increasing farmers' incomes. However, far more needs to be done to tackle the problem, particularly in many industrialized countries where intensive use of pesticide remains highest.

## Chemical and Industrial Exposures

Sixty-six percent of countries report chemical and industrial exposures. Women are increasingly exposed to chemicals in the home. Women and children sometimes spend the greatest amount of time in the home, which may place them at greater risk. Although there are roughly 48,000 industrial chemicals now in use, only a quarter are documented with toxicity data. New products continue to be placed on the market without adequate control over safety. Poisonings and burns, along with low-level, long-term exposures are a problem worldwide. In Nigeria, where chemical burns were once rare, they are now common among children due to storage of chemicals in homes by parents involved in soap making. The U.K. and Germany report on concerns about women's exposures to chemicals such as perchloroethylene in the home and workplace. Other chemicals of concern are hormone disrupters such as phthalates used in plastics, brominated flame retardants used in plastics, carpets and computers and Bisphenol-A used in the lining of tin cans. In China, new widespread training programs entitled "Women, Home and the Environment" educate women about day-to-day risks.

In many countries industries have sprung up in close proximity to residential areas. Even where the creation of industrial enclaves is subject to land use planning, industrial sites are often too close to where poor communities live. This raises environmental justice concerns including class and race discrimination since non-

white and poor communities are most affected by environmental degradation. Poor women and women of color have the heaviest burden of exposure and disease and are often those with the least access to formal health care services.

Women have emerged as strong community leaders in responding to these threats by becoming active at the local level. In South Africa, the poorest women have the greatest exposures to disease and toxins and suffer poor quality water and sanitation. In the U.S., black women in Cancer Alley, Louisiana, and Bayview Hunters Point, California, and indigenous and minority women in the Midwest struggle to mobilize and educate communities about connections between the environment and their health.

More efforts are needed to ensure that people can comprehend the nature of the hazards they face on a continual basis. In Germany, for example, new guidelines focus on substances with common domestic exposures. Prudent precautionary principles require that we seek to avoid suspect risks, even where scientific evidence on these risks is still evolving, in an effort to prevent harm, rather than to confirm it.

Fifty-two percent of countries link rising rates of breast and other cancers to environmental problems. The highest rates of breast cancer are found in industrialized countries, but the WHO predicts that the number of cancer deaths will double in most countries over the next 25 years. In the U.S. and Canada, high rates of breast cancer and activism by grassroots women's groups have impelled governments to fund new studies to explore environmental links to the disease. There is increasing evidence that a range of health problems, including some that specifically relate to women, may have a link to pollution generated by the industrial sector. Studies are examining ways in which women are affected through residential and household exposures as well as occupational links.

## Breast Milk Contamination

Accumulations of toxins in breast milk are reported in many parts of the world, raising critical concerns about the safety of breast milk for nursing infants. Thirty-two percent of countries report breast milk contamination from chemical exposure. In China, breast milk samples from 35 cities were found to have traces of DDT five to 10 times higher than permissible limits. While the WHO tolerable daily intake of dioxin is 1 to 4 pg/kg, nursing infants in the U.S. receive 35 to 53 pg/kg/day and in Japan 100 to 530 pg/kg/day. In Delhi, a breast-feeding infant receives 12 times the acceptable limit of DDT. In Guatemala, pesticide residues in breast milk are reported to be 250 times the amounts allowed in cow's milk. Inuit women in Canada had concentrations of PCBs and a metabolite of DDT four times higher and ten times higher for the pesticide mirex than women in control groups. Studies in Zimbabwe found that almost

all of the breast milk samples taken in some regions showed contamination with DDT. In parts of Brazil babies consume almost four times the acceptable level of DDT.

There is an ongoing debate among public health advocates on breast milk as a potential source of exposure to toxic substances for nursing infants. Evidence so far suggests that the dialogue on whether human milk and breast-feeding can always be unequivocally recommended for women worldwide needs to continue. It is clear that virtually all mothers carry environmentally derived chemicals in their bodies. Given that human breast milk is vital to the optimal development and well being of the infant, and that breast-feeding women also have decreased risk of breast cancer, the need for continued vigilance in testing and monitoring of these exposures is clear. Educational efforts are needed to help policy-makers and women make informed decisions on this issue and better understand risks.

## Air Pollution

People living in urban areas are exposed to the combined impact of pollutants from vehicular traffic, emissions from industrialization and indoor air pollution. In many cities both in developed countries and the developing world, air pollutants exceed health standards. Sixty-two percent of countries report that air pollution is a significant health hazard. Fifty percent report increases in respiratory ailments. In Russia, the most polluted air is in regions where effects of mining, metal and oil refining industries are concentrated. More than 10 percent of air samples exceeded limits on a variety of pollutants. In the Urals, the synergistic impact of chemicals is causing birth defects, tumors, malignant blood diseases and diabetes. In the Ukraine, 21 percent of all illnesses affecting women and children have been linked to air pollution.

In Tehran, where air pollution exceeds acceptable standards, a variety of public policy initiatives such as encouraging factories to move to suburbs or increasing natural gas buses have been tried. However, in some cases, such as the Netherlands, measures to cut back on air pollution by restricting traffic add to the problems of already overburdened women who may have to bicycle their children to work in addition to juggling other domestic and work responsibilities. In Germany, polls show increasing reluctance to restrict car use, even for environmental goals. In Eastern Europe, there are concerns about high levels of usual air contaminants such as sulfur dioxide, carbon monoxide and nitrogen dioxide, but also for substances such as formaldehyde, and benzo[a]pyrene classified by the International Agency for Research on Cancer as known carcinogens.

Fifty percent of countries report respiratory ailments as a result of air pollution. In the U.K., government experts found that 12,000 to 24,000 people might die prematurely

as a result of exposure to air pollution. In many developing countries, respiratory assaults are exacerbated by women's exposures to domestic pollution from particulates in indoor smoke due to cooking and living in poorly ventilated homes where coal and paraffin are burned. In Turkey, indoor pollutants, 1,000 times more likely to reach the lungs than outdoor sources, combine with industrial exposures to cause higher levels of respiratory infections in women.

In the developed world, there is a dramatic increase in asthma. Often thought to be a disease of childhood, asthma has a clear impact on millions of adults, women in particular. In the U.S. for example, death rates from asthma are 59 percent for women and only 34 percent for men.

Smoking as a serious problem for young girls emerges in many countries, including the U.K. and New Zealand. In Norway, the proportion of female smokers was previously higher for women than men, but has now begun to equalize. Additional educational efforts are needed to address smoking in pregnant girls. Although a variety of countries have strengthened smoking regulations in public places, they are often hard to enforce.

## Sewage and Solid Waste

Sixty-two percent of countries report that sewage and solid waste disposal causes serious health problems. The Programme of Action calls on developed countries to take the lead in achieving sustainable consumption patterns and effective waste management. The link between women's health and poor sanitation and waste disposal is clear. Without basic services, particularly in informal squatter communities and rural areas, human excreta and garbage accumulate, contributing to the spread of disease. Flies and hands contaminated with fecal matter help with transmission. Thirty-two percent of countries report that waterborne diseases are major environmental health problems. Diarrheal diseases, schistosomiasis and trachoma are linked to lack of hygiene.

Solid waste also attracts mosquitoes that transmit malaria. In Nicaragua, garbage disposal is largely unregulated and only 13 percent of dumps in that country are certified as sanitary. In South Africa, in informal settlements in the Western Cape, wetlands are used for human waste disposal, resulting in problematic odors and community disease. Solid waste is scattered into numerous open-air sites.

Emissions from solid waste and medical incinerators in Japan and the U.S. have led to public exposure to dioxin, which has accumulated in the food chain. Dioxin is a known human carcinogen that has been linked to birth defects, decreased fertility, immune system suppression and other hormonal dysfunction. One study in Japan

found that more than 25 percent of marine products were found to have trace levels of dioxin. The presence of dioxin in women's breast milk, as revealed by a health ministry report, was strong enough to stir a public debate in Japan last summer. The report quotes a minister as saying that breast-fed Japanese babies are on the average "taking about six times the daily tolerable amount of dioxins." However, the minister was uncertain about how dioxin affected the body.

In the U.S. and other industrialized countries, exposure to dioxin in adults is near levels at which WHO warns that subtle adverse neurological and endocrine effects may already be occurring. In the U.S. population of 260 million for example, a range of 111 to 1,114 cases of cancer may be directly linked to dioxin exposure from the food chain. A nursing infant in the U.S. and other industrialized countries may consume an average of 35-53 pg Teq/kg/day in its first year of life. The current U.S. Environmental Protection Authority virtually safe dose is 0.006 pg TCDD/kg/day. These findings make more urgent the WHO recommendation that every effort should be made to reduce exposures to the lowest possible levels.

## Lead Pollution

Lead exposure is a serious problem for women and children. While the impact of lead on children is well known, the special vulnerability of women, particularly pregnant women, has long been suspected. As a result, in some places, women have been excluded from many jobs involving lead exposure in previous years. But occupational exposures to lead remain a problem for women workers in many countries. Studies have tried to determine the degree of gender-related differences in susceptibility.

Many parts of the world - 48 percent of countries in this survey - report high levels of lead exposure. In Poland, emissions of lead in the countries most industrialized and urbanized areas are leading to severe health effects. Studies show that seven percent of children in some areas have blood lead above levels that would affect mental development. Communities can also be unknowingly exposed to lead from battery manufacture plants and formal and informal lead smelters, as documented in Jamaica.

Exposure to heavy metals such as cadmium, lead and mercury is also a concern because of accumulations in breast milk. In a number of Egyptian cities including Alexandria and Cairo, lead levels in breast milk were found to be significantly higher than permissible limits. More research is required to better understand the impact of low-level exposure to heavy metals transmitted through breast milk.

Significant efforts are underway worldwide to reduce lead in gasoline, but lead in paint and water piping is still a worrying problem. Housing conditions, smoking status and high consumption of canned foods may also be predictors for lead exposures. In

Nigeria, water bodies and springs have become contaminated with lead from mines and cooking salts collected by women are a source of contamination. A popular eye cosmetic used there also contains high lead levels. In Poland, a pre-requisite for effective prevention of occupational lead poisoning is inventory of workplaces where lead occurs and monitoring of lead concentrations in the air. Egypt has initiated efforts to relocate public and private lead smelters. Special campaigns on lead exposure need to be directed at pregnant women and mothers of small children, in addition to workplace efforts in lead industries.

## Hazardous Waste and Radiation

More than a quarter of countries report hazardous waste and radiation are growing health concerns. Hazardous waste sites, illegal dumps, landfill sites and incinerators are often located near informal settlements, in proximity to poor, minority and indigenous communities. The U.S. Environmental Protection Agency has formally recognized that health effects associated with hazardous waste sites include birth defects, cardiac disorders, changes in pulmonary function, impact on the immune system, infertility and increases in chronic lymphocytic leukemia. A Europe-wide study published by the European Commission found that women whose fetuses were malformed were more likely to have lived close to landfills than those whose babies were normal. This has raised new concerns in countries like Great Britain, where studies have been launched to examine local impact.

The devastating environmental effects of military activity and nuclear weapons and energy production result in enormous human costs, even in situations of peace. Black Mesa in the U.S., Chernobyl in the Ukraine and Chelyabinsk in Russia are places where environmental devastation from uranium mining, nuclear energy and nuclear weapons production has taken a tremendous toll on women's health. In Chelyabinsk, where radiation is twice that of Chernobyl due to a nuclear accident in 1957, cancer incidence has since gone up by 21 percent and birth defects by 25 percent. Half the population of childbearing age is sterile. Testimonies from the Tuareg in Algeria speak of the effects of French nuclear testing in the 1960s now being seen on entire tribes, including sterility among women and increased cancers. While compensation for damage from nuclear testing and mapping of health effects has occurred in some regions such as Southern Australia, most countries have no effective response.

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## Conclusions

Since ICPD, awareness has grown of the links between economic growth and environmental degradation. But development strategies are still not being revamped to

incorporate an environmental agenda. In some countries, new laws and initiatives aim at increasing environmental protection. New international agreements to regulate use of problematic chemicals include the Rotterdam Convention signed in 1998 regulating trade in some hazardous chemicals and pesticides and other 1998 protocols on heavy metals and sulfur emissions developed as part of the UN Economic Commission for Europe Convention on Long Range Transboundary Air Pollution. Negotiations are underway in the International Negotiating Committee on Persistent Organic Pollutants. International efforts have also begun to develop systems to collect and disseminate data on environmental releases and transfers of toxic chemicals from industrial facilities as part of the creation of Pollutant Release and Transfer Registers. In addition, NGOs have been innovative, despite limited resources, in developing programs and strategies to address environmental health needs.

The Programme of Action recommends measures to enhance the role of relevant groups, particularly women, in all levels of population and environmental decision-making, increased research on linkages between environment, population and human health and additional efforts to promote public understanding of these linkages. But there is still not enough recognition among governments of the effects of environmental degradation on health. Environmental groups and health organizations often do not work in tandem on environmental issues critical to health. Little has been done to disseminate information on environmental health risks to the public at large.

Yet, it is often public pressure as a result of grassroots activism that has created momentum for responsive action or legislation, as in efforts to reduce lead exposures in gasoline, for example. In general, governments' fears of alarming the public or creating new problems for the economy and the industrial sector have blocked wider progress. Prudent precautionary principles call for efforts to prevent harm by avoiding suspect risks, even where scientific evidence on these risks is still evolving. Instead, official response continues to focus on those few risks where the human evidence is overwhelming.

Five years after ICPD, there have been important initiatives to advance the Programme of Action in countries around the world considerable economic constraints. The reports in this survey show that incremental progress toward the Cairo goals is possible given political will and the presence of an informed and active civil society pushing for change. Reproductive health is now part of official lexicon, policies and programs. The emergence of new partnerships between governments, NGOs, international actors and the private sector has enabled creative collaborations and greater civil society participation and promoted rights-based approaches.

In the majority of countries, NGOs have been instrumental in bringing about key legislative changes and innovative programs through strategic alliances with

governments and non-state actors. They have also secured recognition in important policy arenas of the impact of economic policies and environmental conditions on women's health and access to services. Governments at the International Forum for the Five-Year Review of the Programme of Action, held at The Hague, February 8-12, 1999, acknowledged that globalization of the economy and privatization of social and health sectors have deepened poverty and reduced access to social and health services. Women's health advocates have also won recognition of the fact that financial viability of public health systems sought through health sector reforms can erode universal access to quality and comprehensive reproductive health services. Above all, realization of the goals of Cairo and Beijing is intrinsically linked to eradication of poverty and elimination of unsustainable patterns of production and consumption. Reducing the debt burden of the world's poorest countries and ensuring that structural adjustment and other economic reforms are responsive to gender and environmental concerns are urgent priorities.

Most importantly, the profound human crisis caused by the unraveling of the miracle economies in Asia, long upheld by the International Monetary Fund and the World Bank as stellar successes of the Washington consensus, has led to rethinking in the Bretton Woods institutions of their liberalization prescriptives. For women activists, the new climate of caution and introspection opens up critical space for renegotiating neo-liberal policies that have long ignored gender implications. Recent developments and the five-year process of the Cairo Programme of Action have borne out what women have said for the last two decades. Market-driven policies and other macro-economic issues can no longer be kept off the table when sustainable development, women's rights, the environment and health are discussed.

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