executive committee of the directing council

PAN AMERICAN HEALTH ORGANIZATION

working party of the regional committee

WORLD HEALTH ORGANIZATION

95th Meeting
Washington, D.C.
June-July 1985

Provisional Agenda Item 13

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WOMEN, HEALTH AND DEVELOPMENT

Resolution XXVII of the XXI Pan American Sanitary Conference (1982) requests the Executive Committee to convene its Special Subcommittee on Women, Health and Development at least twice a year to monitor the program and review achievements. The Subcommittee members (Canada, Cuba and Ecuador) will hold their first meeting in 1985 on 21 June, to prepare their report and present it to the 95th Meeting of the Executive Committee.

As this is the final year of the United Nations Decade for Women (1976-1985) and the Five-Year Regional Plan of Action on Women, Health and Development (WHD), the Subcommittee will be reviewing progress made in this area during the past 10 years and identifying priorities and strategies for the future.

The main goal of the Five-Year Plan is to assist PAHO and its Member Governments to successfully integrate women of the Americas into new and ongoing health and development activities. The XXVIII Meeting of the Directing Council (1981), in Resolution XV, adopted the Five-Year Regional Plan of Action, requesting that its activities become an integrated part of the Plan of Action for the Implementation of the Regional Strategies of Health for All by the Year 2000. The two plans were developed separately to ensure prompt action in relation to women, health and development in the second half of the Decade for Women. The goals of the Five-Year Plan constitute an important part of the regional strategies, in which women are considered as a priority group because of their greater vulnerability and degree of exposure to health risks.

During its XXX Meeting (1984), the Directing Council approved Resolution VI (annexed) which includes in its recommendations to the Member Governments that they increase educational opportunities for women; enforce laws protecting women's rights; and strengthen national WHD focal points, increasing their participation at the decision-making level and providing them with the resources and time they need to bring about adequate intersectoral coordination among the different government institutions and nongovernmental organizations.

The Directing Council further requested the Director of the Pan American Sanitary Bureau to continue giving priority to the WHD program; to provide special training to enable women to better compete for senior positions in the Organization; and to ensure that the goals and actions of the Five-Year Regional Plan of Action be pursued beyond 1985 and be fully integrated into the Plan of Action for the Implementation of the Regional Strategies for the Attainment of the Goal of Health for All by the Year 2000.

In preparation for the Subcommittee's report and the ensuing discussions, the Executive Committee may wish to review the attached resolution (CD30.R6) as well as the goals and activities of the Five-Year regional Plan of Action on Women, Health and Development.

Annex

DIRECTING COUNCIL

PAN AMERICAN HEALTH ORGANIZATION

REGIONAL COMMITTEE

WORLD HEALTH ORGANIZATION

XXX Meeting

XXXVI Meeting

CE95/8 (Eng.)
ANNEX

RESOLUTION VI

WOMEN, HEALTH AND DEVELOPMENT

THE XXX MEETING OF THE DIRECTING COUNCIL,

Considering the importance of the United Nations Decade for Women in securing recognition for their role in society in the countries of the Region and the agencies of the United Nations System and other regional agencies;

Considering, however, that to guarantee the improvement of the health status of women that recognition must be translated into concrete action based on the goals of the Five-Year Regional Plan of Action on Women, Health and Development; and

Cognizant that these actions must continue beyond the end of the five-year period as an integral part of the strategies for attainment of the goal of health for all by the year 2000,

RESOLVES:

1. To urge the Member Governments:

   a) to intensify their efforts to provide more educational opportunities for women such as will contribute to their occupational development and give due recognition and support to their important contribution as provider and user of health care at all levels;

   b) to strengthen country WHD focal points and give them a part to play at the decision-making level and the resources and time they need to bring about adequate intersectoral coordination among the different government institutions and women's nongovernmental organizations;

   c) to enforce their laws on the protection of women's rights and have all discriminatory legislation rescinded.

2. To request the Director:

a) to continue giving priority to support for country activities in implementation of the Five-Year Plan and to the WHD Program, and to continue efforts to facilitate exchanges of information and experience in this field among the Member Countries, and to encourage PAHO Country Representatives to meet regularly with the heads of national offices established by countries to address special issues relative to women;

b) to provide special training in key areas so as to enable women to compete on an equal basis for senior positions in the Organization, and to establish targets for staffing professional and senior positions with women;

c) to continue specific support to the Special Subcommittee on Women, Health and Development in the performance of its functions, and to facilitate for the countries represented on it the receipt of current information on the subject;

d) to ensure that the goals and actions of the Five-Year Regional Plan of Action on Women, Health and Development continue to be pursued beyond 1985 and are fully integrated into the Plan of Action for the implementation of the Regional Strategies for the attainment of the goal of health for all by the year 2000.

(Approved at the fifth plenary session,
26 September 1984)

executive committee of the directing council

PAN AMERICAN HEALTH ORGANIZATION

working party of the regional committee

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REPORT OF THE SPECIAL SUBCOMMITTEE ON WOMEN, HEALTH AND DEVELOPMENT

In compliance with operative paragraph 4 of Resolution XXVII of the XXI Pan American Sanitary Conference, the Special Subcommittee on Women, Health and Development, consisting of Representatives of Canada, Cuba and Ecuador, met on 21 June 1985 in Washington, D.C., to review the work done by PAHO and the Member Governments to implement the Five-Year Regional Plan of Action on Women, Health and Development (WHD).

The Delegate from Canada was elected by the Subcommittee to chair the meeting. The subcommittee then reviewed the agenda proposed by the Secretariat, which included the Secretariat's presentation on progress achieved, discussion by the Subcommittee of this report and of "Forward-Looking Strategies for the Region," and the formulation of recommendations to the Executive Committee. The agenda was revised by the Subcommittee to include, as an additional item, PAHO's participation in the 1985 World Conference on Women (to be held in Nairobi in July).

Along with the reports presented by the Secretariat (listed below), the Subcommittee members were presented with other relevant documents including: 1) the Health and Nutrition section of the UN report summarizing responses of Member Governments to the survey on progress made during the Decade for Women (Document A/CONF.116/5); 2) the UN report on progress achieved during the Decade and obstacles encountered by the United Nations System (Document A/CONF. 116/8); and 3) the Report by the Director-General of WHO entitled "Collaboration within the United Nations System: Women, Health and Development" (Document EB75/22).

The Subcommittee commended the Director on PAHO's recent publication on the health status of women in the Americas.

I. PAHO's ACTIVITIES ON WOMEN, HEALTH AND DEVELOPMENT (1976-1985)

The Subcommittee examined the Secretariat's report on WHD activities carried out in the Region during the UN Decade for Women, taking note of the activities underway in health education and community participation, maternal and child health and family planning, nutrition of women and children, acute and chronic disease control, environmental and occupational health, human resource development and social support services.

The Subcommittee decided to present the report to the Executive Committee (see Annex I, separate) to facilitate the Committee's review of progress made. It further requested that a chronological summary of PAHO activities during the UN Decade be appended to the report, along with a chart summarizing WHD activities underway in the Region, by country.

Based on the report, the Subcommittee concluded the following:

1. Certain emerging health needs are just barely being recognized at the end of the UN Decade, particularly topics including appropriate reproductive technologies, women's mental health, the health aspects of violence against women, and women's occupational health. Member Countries should examine and improve their research on women's health to include these and other topics of current concern.

2. Furthermore, Member Countries should examine the roles, participation and opportunities for women in the field of research, as well as the amount of research that is concentrated on women's health needs.

3. Statistical information should be collected and published, by sex, to allow for adequate comparisons of how disease patterns and health system utilization differ between men and women.

4. Indicators should be developed that permit evaluation of programs and activities to measure progress made in achieving the WHD goals and integrating women, health and development into HFA by the year 2000.

5. The Subcommittee commended the Director for the steps already taken in the area of maternal and child health and family planning but raised current concerns that are not yet reflected in most MCH reports, which are still cast in traditional modes. These include: infertility, the epidemic of sexually-transmitted diseases, and male and female roles in responsible family planning, sexuality and parenthood.

6. The capacities of Member Governments should be strengthened to follow through on national programs by using fellowships to provide internships with Focal Points so as to share their technical expertise in this field.

II. REPORT ON CERVICAL CANCER AS A HEALTH PROBLEM OF WOMEN IN LATIN AMERICA AND THE CARIBBEAN

The Subcommittee examined the report which it had requested of the Secretariat during its last meeting held in October 1984. The Subcommittee acknowledged the excellent quality of the report and the usefulness of the type of report for increasing understanding of the magnitude of certain health problems and defining the actions needed to address them.

It was requested of the Secretariat that, for the next meeting of the Subcommittee, a similar, state-of-the-art paper be written on women's mental health at all stages of the life cycle, focussing on both women's productive and reproductive roles. Given the paucity of available information on this subject, the Subcommittee considered it an appropriate topic for further study.

The Subcommittee decided to present the report on cervical cancer control to the Executive Committee (Annex II, separate).

Based on the report, the Subcommittee concluded the following:

1. Cervical cancer poses a serious threat to the health of Latin American and Caribbean women. More than 30,000 deaths occur each year, many of them at a relatively young age.

2. Currently, control programs are inadequate and screening activities do not appear to effectively reach the most vulnerable populations. In many countries cervical cancer control activities are conducted on a small scale, lacking coordination and efficiency, and often isolated from other primary and secondary care programs.

3. Furthermore, there is evidence of unnecessary re-screening of low-risk women and of commercialization of screening technology. Public awareness of the need for early detection and treatment of pre-invasive lesions is necessary to create as well as to educate and involve the community in cervical cancer control.

4. Comprehensive screening programs would cost less than the costs of treating a large number of invasive cervical tumors which are not currently being detected in their earlier stages when treatment is more effective and less expensive.

5. Therefore, Member Governments should institute cervical cancer control programs through country-wide mass screening, included as an integral component of general health services.

6. Education programs should be established by Member Governments, geared to increasing women's knowledge of the pathogenesis, risks and treatment of cervical cancer causes, risks and treatment, to improve their participation in prevention and control activities.

7. The Director's cooperation and support for Member Countries is urgently needed to improve national capabilities for developing appropriate and effective country-wide cervical cancer control programs.

III. REPORT ON THE STATUS OF WOMEN AT PASB

The Secretariat presented a summary report on the recruitment, training, and promotion of professional women at PASB during the last 10 years and, in response to a request made by the Subcommittee when it last met, the Secretariat also presented a summary of actions being taken by other UN agencies and international organizations in the recruitment, selection and promotion of professional women.

The Subcommittee decided to annex the summary report presented by the Secretariat to its report to the Executive Committee as well as additional information requested by the Subcommittee on the contracting of women as short-term consultants and temporary advisors (Annex III, separate).

Based on the report, the Subcommittee concluded the following:

1. The Director has made notable efforts to systematically recruit, select and promote professional women at PASB, but given that women are still underrepresented at the senior levels (P.4 and above), further efforts are needed.

2. WHO's newly established target of increasing to 30% the proportion of women filling professional posts should be considered as an appropriate target for PAHO as well.

3. There were few initiatives in other agencies from which PAHO can learn new ideas for increasing women's status, with the exception of two agencies, FAO and UNESCO, which, in their selection processes, provide for the selection of a woman whenever the choice is between a woman and a man who are equally qualified for a post.

IV. PAHO's PARTICIPATION IN THE WORLD CONFERENCE ON WOMEN

The Subcommittee discussed the importance of the upcoming World Conference on Women in articulating forward-looking strategies for the years beyand the Decade to the year 2000. Based on PAHO's important leadership role in the Member Countries in the area of women, health and development, and given the numerous WHD activities already underway in the Region, the Subcommittee recommended that the Director ensure that PAHO be represented at the Conference in Nairobi.

The Subcommittee further noted that PAHO is the appropriate regional organization for representing the health needs and contributions of women in the Americas. It should play an active role in shaping the

forward-looking strategies at the Conference and be present to accept its cues for further integrating women, health and development into the health and development programs in the Region.

V. PROPOSED RESOLUTION

The Subcommittee proposes that the following resolution be presented by the Executive Committee adopt the following resolution:

PROPOSED RESOLUTION

THE 95th MEETING OF THE EXECUTIVE COMMITTEE,

Aware that the Special Subcommittee on Women, Health and Development, in compliance with Resolution XXVII of the XXI Pan American Sanitary Conference, has met to evaluate the program and review its achievements; and

Having reviewed the report of the Special Subcommittee on Women in Health and Development,

RESOLVES:

To recommend to the XXXI Meeting of the Directing Council that it approve a resolution along the following lines:

THE XXXI MEETING OF THE DIRECTING COUNCIL,

Acknowledging that the International Decade for Women has revealed that women's health is an important determinant of national development and that a nation's health is also dependent upon women's development, particularly in the sectors of health, education and employment;

Recognizing that women represent approximately 80% of all health care providers in the majority of countries of the Region, but are still underrepresented at policy, planning and decision-making levels;

Taking into consideration that the Region's poorest segments of urban and rural society are overrepresented by women, particularly those who have sole responsibility for children or who are aged and infirm;

Reaffirming the continuing importance of all PAHO resolutions dealing with women, health and development (CSP19.R27, CD23.R10, CD24.R25, CD27.R17, CD28.R15, CSP21.R27, CD29.R22, CD30.R6), as well as the most recent WHA resolution on the subject (WHA28.27);

Commending the Director on the achievements thus far in collaboration with the Member Governments, the interagency cooperation, as well as beginning collaboration with the non-governmental sector, particularly in health education;

Further commending the Director for the notable progress in the establishment and development of WHD Focal Points in Member Countries and in PAHO, for the help and encouragement of the Regional Focal Point through field visits, workshops and seminars, for the important paper on cervical cancer, and on the recent publication on the health of women in the Americas;

Realizing that at the end of the Decade significant efforts are required to improve the health status of women and to enhance their effective participation in health care in the Region;

Furthermore, recognizing that the WHD goals and activities remain an integral part of the regional strategies to attain health for all by the year 2000 and, indeed, that its attainment is impossible without women's active participation as agents and beneficiaries; and

Acknowledging that the Forward-Looking Strategies recently articulated by WHO and more generally stated at the 1985 World Conference on Women require regional interpretation and implementation,

RESOLVES:

1. To urge the Member Governments:

   a) To review, reaffirm and renew their commitment to the goals of women, health and development which address the physical and mental health needs of women in their productive and reproductive roles in the context of socioeconomic development and adopt effective action plans based on the Forward-Looking Strategies as well as the Regional Strategies to achieve health for all by the year 2000;

   b) To recognize the actual and potential contributions of women to the health sector and to overall socioeconomic development by working systematically to integrate women into all levels of health planning, organization and delivery of health care;

   c) To strengthen the capacities of WHD Focal Points to stimulate appropriate action and to monitor and report on progress attained.

2) To request that the Director:

a) Reaffirm PAHO's commitment to carrying out the continuing mandates of the Organization related to women, health and development and the Forward-Looking Strategies by:

i) Providing full support for the Regional Program on Women, Health and Development as an integral part of PAHO's overall responsibilites, and ensuring that PAHO's technical programs focus clearly on women's health needs and contributions;

ii) Developing regional forward-looking strategies and guidelines for action to be integrated into short-term plans, medium-term plans, and long-term plans for women, health and development as part of the regional strategies to achieve health for all by the year 2000;

b) Convene the Special Subcommittee on Women, Health and Development twice yearly to monitor progress, to propose solutions to problems identified, and to promote concerted action on women, health and development.

Annexes: Distributed separately

executive committee of the directing council

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WORLD HEALTH ORGANIZATION

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REPORT OF THE SPECIAL SUBCOMMITTEE ON WOMEN, HEALTH AND DEVELOPMENT

ANNEXES

I: PAHO's Activities in the Area of Women, Health and Development, 1976-1985

II: Cervical Cancer as a Health Problem of Women in Latin America and the Caribbean

III: Status of Women at PASB

PAHO'S ACTIVITIES IN THE AREA OF WOMEN, HEALTH AND DEVELOPMENT, 1976-1985

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PROGRESS REPORT
PAHO's activities in the Area of
Women, Health and Development
(1976 - 1985)

BACKGROUND

This report is meant to assist the Special Subcommittee on Women, Health and Development in carrying out its role of monitoring progress made in the implementation of the Five-Year Regional Plan of Action on Women, Health and Development (WHD). The Subcommittee is convened twice yearly by the PAHO Executive Committee as called for in Resolution XXVII of the XXI Pan American Sanitary Conference (1982) and in the Five-year Regional Plan of Action on Women, Health and Development (Pt. 1.4.2).

The Five-Year Plan was developed by the WHD Subcommittee and approved by the Directing Council in response to the U. N. Decade for Women (1976-1985). The World Program of Action for the Second Half of the Decade (1980) urged governments to give priority to improving women's status in the sectors of employment, education and health. The promotion of this interrelated approach to an individual's health and other socio-economic and cultural conditions reflects the primary health care strategy, to which all the goverments of the world subscribed at the Alma-Ata Conference in 1978 and the Regional Strategies to Reach the Goal of Health for All by the Year 2000 currently being implemented by the countries of the Americas.

The term 'women, health and development' thus refers to the complex interrelationship between women's health status and socio-economic development.

Because of prevailing customs and attitudes which assign low social status to women and limit their educational and economic opportunities, they are often trapped in a cycle of poverty, ignorance and ill-health, becoming the poorest of the poor. Improving women's health is key to achieving health and development goals because women's health affects not only their own contributions to family, community and societal progress, but also their ability to bear, raise and educate healthy children.

Also, in most societies, women are key teachers of health habits and providers of health care in the home and community. If they remain in poverty and ignorance, they cannot perform this role effectively, nor will the value of their health care efforts be adequately recognized. Therefore, WHD implies a dual approach: to improve women's health status and to promote economic and social progress by women.

The main goal of the Plan on Women, Health and Development is to help PAHO and Member Governments successfully integrate women into continuing and new health and development activities in the Hemisphere. The activities of the Five-Year Plan are to be integrated into the national plans of action and activities being developed to attain health for all by the year 2000. There is no intent to create programs focused solely on women; instead the aim is to ensure that all health programs and projects take women into account and promote and support their full participation in all aspects of health activities.

The focus on 'women, health and development' has developed gradually within the broader movement to incorporate women into all fields of social and economic development commonly known as 'women in development.' Most development programs are generic, intended to benefit everyone equally; however, they have sometimes had the effect of making women 'invisible' because the unconscious norm is male and the distinctive problems faced by women go unrecognized. These include problems such as lack of cash to pay for services and medicines; lesser physical mobility to seek health services; shyness about seeing health professionals; physical and mental stress brought on by a heavy (but largely unrecognized and unrewarded) workload; high exposure to waterborne diseases; nutritional deprivation due to discriminatory cultural patterns; exposure to both home and workplace hazards. Many health programs have also tended to focus on women solely in their reproductive roles, failing to consider their complex socioeconomic and productive roles as well.

Another problem peculiar to health programs is the difficulty of bringing about a change in focus in highly structured hierarchical paternalistic medical care systems with a long tradition glorifying the predominantly male physician role. Within such a system women have traditionally been either passive patients or subordinate assistants. The current emphasis on preventive health, primary care, community participation, and women, health and development is now beginning to change this orientation.

The 'women, health and development' focus is a wholistic view of women as planners, promoters and providers of health education and care, as well as beneficiaries. Women's crucial roles in health and development should be recognized and supported and women should be involved fully in decisions affecting their individual, family and community health.

INTRODUCTION

This report summarizes activities on women, health and development in the Region of the Americas during the U. N. Decade for Women. It focuses on activities carried out at both the regional and national level. Unfortunately, there is no quantitative or explicit baseline against which to measure progress because little, if

any, information focused on WHD existed prior to the Decade. Therefore, progress can best be indicated by documenting the extent to which women's status has become an evident area of concern in the Region, and by describing the actions that have been taken to improve women's health and enhance their participation in health and development activities.

The report is based on information supplied to PAHO's Focal Point on Women, Health and Development by Member Governments and the Organization's various regional and country programs. The information therefore is not exhaustive and does not cover many activities occurring outside the PAHO framework. Information has been collected from country reports and responses to questionnaires issued by PAHO, the U. N. Commission on the Status of Women and the Inter-American Commission of Women (CIM/OAS). The PAHO Secretariat has reported yearly to the Special Subcommittee on Women, Health and Development since 1982. Because this report covers a ten-year period much of the information included in those reports is summarized here.

In spite of the limitations in the available data on the subject, an effort has been made to analyze and cross-check the varying types of data available in order to identify trends, accomplishments and problem areas and thus give as accurate a picture as possible of the progress made over the Decade; and to help focus on strategies and areas of action for the future.

The report is organized according to the major areas of action of the Five-Year Plan. Within each of these areas progress at both the regional and national levels is noted, with attention to policy, plans, implementation experience and factors which have impeded or facilitated progress when they have been indicated. At the national level, the examples given are illustrative only--they are not intended to describe all national activities--nor does failure to note an activity in any given country imply that there has been none.

PROGRESS MADE (1976-1985)

1. Strengthening and Utilization of Institutional Capabilities

a. Policy and Implementing Mechanisms

The development of a WHD focus within PAHO as a Regional organization has occurred over a number of years, see Appendix I. Some manifestations of concern for women's participation predate the U. N. Decade for Women. For example, as early as 1963 the need for active participation by women in national health and socioeconomic development was expressed at a special meeting of the Region's Health Ministers in Washington, D.C.

A series of PAHO Governing Body resolutions over several years (1974-1980) endorsed Decade goals and urged action and the establishment of machinery to evaluate progress in this area.

In 1980, pursuant to a Directing Council resolution, a Subcommittee of the Executive Committee was established and asked to prepare a Regional plan of action on women, health and development and to monitor progress made in its implementation. As noted above, the Five-Year Regional Plan of Action was adopted by the Directing Council in September 1981. The Council recommended at the same time that the Director establish a mechanism to coordinate and promote WHD activities and report annually to the Directing Council and the special Subcommittee.

In 1981, the Assistant Director of PAHO was named the Focal Point for WHD, and soon after, the Regional Program on WHD was established to promote and coordinate the activities of the Plan. Throughout the Organization a network of focal points was set up to ensure the Plan's implementation.

The PAHO/WHO goal of health for all by the year 2000 through the primary health care approach, which have developed during the years of the Decade, are closely related to the improvement of women's status and participation in health and development. The basic components of primary health care such as community participation, intersectoral coordination, the risk approach, evaluation and use of appropriate technologies and emphasis on preventive health care through participatory education, are all essential to improving women's health status and require the full participation of women for their effective implementation.

In 1981, the same year the WHD Plan was adopted, PAHO's Directing Council also approved the Regional Plan of Action to Implement the Strategies to Reach the Goal of 'Health for All' by the Year 2000. Improving women's health status and enhancing their participation in development is key to the success of the Regional Plan of Health for All and the primary health care approach on which it is based.

The governments have made varying degrees of progress in incorporating the WHD Plan's goals and strategies into national health policy, plans and programs. As of 1984, 19 countries either already had integrated the goals and activities of the Plan into the national health structure or planned to do so. At the national level, the translation of theory on women, health and development into policy and action seemed to increase after regional and national Focal Points and Women's Bureaus and Offices were established, providing a structure for collaboration and action.

By June 1984, 33 of PAHO's 35 Member Countries had established WHD Focal Points to promote and coordinate activities at the national level and all but three countries had established national machineries (offices, bureaus or units) on the status of women.

b. WHD in PAHO Programs

The Five-Year Plan stresses that WHD activities should be carried out through regular regional and national programs. The role of regional and national Focal Points is to promote, coordinate and monitor these activities. PAHO's Regional Focal Point has worked in close coordination with the Organization's technical programs to develop integrated projects and a global approach to implementing the Five-year Plan. A series of activities emphasizing research, training, information dissemination and program development have been developed and incorporated into the ongoing technical programs of the Organization. A framework of issues for assessing the women's dimension in health development programs including planning, implementation and monitoring was developed by WHO, translated into Spanish by PAHO and disseminated to focal points in the Region.

During 1983-1985, PAHO organized a series of three Regional seminar-workshops to promote country-level action in relation to the goals and activities outlined in the Five-Year Plan. Participants from a total of 19 countries included national Focal Points, other government officials, several international organizations, and PAHO field and Headquarters staff. As a result of each seminar, workplans were developed for specific activities to be carried out in the countries represented.

Most countries indicate that at the national level WHD activities are carried out through their regular health and development programs (see Appendix II). Many countries have reported making efforts to coordinate activities with other government agencies, and a somewhat smaller number have indicated some coordination with nongovernmental organizations. However, in many countries these types of links are weak.

Obstacles cited by countries in incorporating activities of the WHD Plan into ongoing programs include th economic crisis suffered by the majority of countries in the Region, lack of effective intersectoral coordination mechanisms; lack of understanding by program staff of concepts related to women, health and development and the need for such a focus; and the Focal Points' lack of resources. Some Caribbean countries indicated problems in linking Women's Bureaus (where most Caribbean Focal Points are located) with Ministry of Health programs.

At the country level, PAHO is collaborating with the countries in their efforts to overcome some of these obstacles, through direct technical cooperation and by supporting research projects and national workshops and conferences to raise awareness regarding women's health issues and to strengthen coordination among agencies. For example, during 1984 and 1985, Argentina, Canada, Colombia, Haiti and Mexico held national or regional meetings to discuss issues related to women, health and development and to better define actions to be taken at the national and local levels.

c. Inter-Agency Collaboration

To avoid duplication of efforts and to ensure improved coordination and maximum use of resources, PAHO has established and maintained contacts with other international organizations that are actively involved in improving women's status in health and development. Increasingly, since the beginning of the U. N. Decade, PAHO has exchanged information, participated in Regional and global meetings and worked towards improved coordination with organizations such as UNDP, UNFPA, INSTRAW, FAO, UNICEF, ILO, the IDB, the World Bank, the Economic Commission for Latin America (ECLA) and the Inter-American Commission of Women (CIM).

PAHO is a member of the United Nations Inter-Agency Task Force on Women's Roles in the International Water Decade and is collaborating with UNDP in evaluating the impact on women of the U. N. agency programs in selected countries throughout the world (in this Region, Haiti).

The Organization has also established contacts with various non-governmental organizations working in the area of women, health and development at the international level. These include, among others, the International Center for Research on Women, the Overseas Education Fund, Pathfinder Fund, the Pop Council, the International Women's Tribune Center, and ISIS International.

Improved coordination between WHO and PAHO in their efforts to improve women's health and their participation in development has also been achieved as a result of efforts made by the coordinating mechanisms established during the Decade and expanded information exchange and communications between this Regional Office and Headquarters.

d. Women in PAHO

Improved status of women at PAHO is an important component of the Five-Year Plan and a series of resolutions on women, health and development approved by the Governing Bodies during the years of the Decade. A study in 1975 determined that women were underrepresented among PAHO professionals and were mainly represented in the lower grades. Starting in 1976, a series of letters were written to the Member Governments urging them to assume their share of responsibility in the endeavor by nominating more female professional candidates to suitable vacancies in PAHO. Contacts have also been established, through PAHO representatives at the country level, with women's professional organizations and universities and their cooperation has been sought in advertising vacancies of PAHO positions.

Arrangements have been made, to the extent possible, to include women in selection committees and other personnel advisory bodies, such as joint administration-staff working groups. In addition, resolutions on women, health and development have been given wide publicity and training activities aimed to benefit women have been carried out as part of the Organizations's Staff Development and Training Program.

In 1980, the Women's Resource and Development Group (WRDG) was formed by a number of female staff members at Headquarters to improve the status of women at PAHO. The Group has organized workshops, published informational bulletins and sponsored panel discussions, guest speakers and film presentations on issues relevant to women's status and their participation in the work of the Organization, especially at the decision-making level.

Statistically speaking, the proportion of female staff members in the professional and higher categories throughout the Organization rose from 19% in 1975 to 22% in 1985, a decade later. The number of women occupying "senior" posts at grades P.4 and above has likewise increased from 30% of all professional women in 1975 to 38% in 1985.

2. Research and Information on Women's Health Problems

Traditionally, information on women's health has been fragmented, incomplete or unreliable and difficult to compare and evaluate because of varying definitions and indicators, making it very difficult to establish clear correlations between health system activities and women's health status. Information has also been narrowly based, focusing almost exclusively on causes of death and maternal health.

Statistical information in many areas is not broken down by sex; without such information an accurate assessment of women's overall health is impossible.

A forthcoming specialized publication on the health status of women in the Americas will help to develop viable base-line data and statistical measures and indicators for assessing progress in improving women's health conditions.

PAHO and the countries are trying to overcome some of the deficiencies in information on women's health by exploring new areas of research.

PAHO recently conducted a study on health and nutrition behavior which examines the factors influencing resource distribution within the household which may be disadvantageous to women. The objective of the project is to identify new types of educational interventions to combat such problems by promoting a more equitable sharing of responsibilities and benefits, thereby improving the nutritional status of girls and women.

PAHO is currently undertaking surveys on the health and social problems of the elderly in 10 countries, and a survey on chronic disease and the elderly in one. It is also preparing and disseminating information on maternal and child health, fertility and contraceptive use, female cancers, diabetes, hypertension and mental health, with reference to women's special needs.

Almost all countries indicate that they have undertaken some type of research on women's health. Though the level of detail varies greatly, the most common areas of research are those related to women's reproductive functions in which health problems are most urgent. Nineteen countries reported doing or planning research on maternal nutrition related to pregnancy and lactation; 9 indicated research on adolescent health; 5 cited abortion/contraception-related studies; 5 reported work on maternal risk factors, morbidity or mortality; 3 mentioned research on women's work related to pregnancy or breast-feeding; and 1 each reported studies on sexually-transmitted diseases and the effects of drugs used during pregnancy on the mother and baby.

Other research areas reported include occupational health of women (including one study on domestic work and home accidents), general research on women's health or health services for women (though much of this research probably relates to reproduction), health of older women and health of migrant and refugee women.

A few countries reported institutional or operational research on the incorporation of women into the health system. Five countries noted studies on the role of women in primary health care as professionals or paid or volunteer community health workers and one is planning a study on women in health and social occupations for 1985. One country each reported research on strengthening and institutionalizing its program on women, health and development; devising health education programs for women; and including women in solid waste management.

There are problems affecting women's health which have received relatively little attention, such as deficient nutrition at all ages as a result of discriminatory cultural patterns, the effects of water and vector-borne diseases, particularly in rural areas; health aspects of violence against women (domestic violence and sexual assault); and women's mental health.

PAHO is using its established publication series and information channels to provide information on women's health issues and activities. Articles have appeared periodically in PAHO and WHO publications such as the Bulletin, Boletín, The Chronicle, World Health Magazine, and the CAREC Surveillance Report.

Other PAHO publications relevant to women health and development published during the Decade include the following (most are available in both Spanish and English):

- Health Conditions in the Americas, 1977-1980, 1982, which includes a section on women.

- Environmental Health: Country and Regional Activities in the Americas, Environmental Series 2, 1982. This publication includes a special section on Women and the Environment.

- The Final Report on the Symposium for Human Resources for the International Drinking Water Supply and Sanitation Decadee, Scientific Pub. 437, 1983, includes a paper entitled "Women: The Underused Human Resource".

- Women, Health and Development, Scientific Pub. 448, 1983, includes the Five-Year Regional Plan of Action on WHD.

- Mandate for Change: Women, Health and Development in the Americas, 1983, is a 16-page brochure outlining major WHD issues and suggested actions, based on the Five-year Plan.

- Salud Maternoinfantil y Atención Primaria en las Américas: Hechos y Tendencias, Scientific Pub. 461, 1984. This publication includes several papers dealing with women's nutrition and health.

- Community Participation in Health and Development in the Americas: An Analysis of Selected Case Studies, Scientific Pub. 473, 1985,includes numerous references to women's participation in health projects and programs.

- Selected Funding Sources for Women, Health and Development in the Americas, 1984.

- Health Conditions of Women in the Americas, Scientific Pub. 488, 1985.

- Health of Adolescents and Youth in the Americas, 1985

- Fertility and Health: The Latin American Experience, 1985

- Contraceptive Prevalencies in Latin America, 1985

3. Program Development

An important function of the PAHO Program on Women, Health and Development has been to promote and support program activities relevant to women's health and participation which are carried out by PAHO's various technical programs. As previously mentioned, the work of the Organization in this area represents an integrated and collaborative approach involving all relevant technical programs. The following sections summarize program activities within the priority areas indicated in the Five-Year Plan.

a. Health Education and Community Participation

Women's organizations have special characteristics that make them a key factor in community involvement and essential to the success of primary health care activities. An important regional effort to promote full incorporation of women in primary health care was a series of activities in 1983 to promote and support participation of women's organizations in primary health care.

Women's organizations with potential for participating in primary health care activities were identified and an in-depth review of health activities of women's organizations in four countries was prepared to illustrate the types of activities in which these groups were effectively working. Subsequently, a workgroup was convened with participation by representatives of women's organizations, Ministries of Health and PAHO from three of these countries. Participants discussed how women's groups could be more effectively involved in primary health care and how Ministries of Health, women's organizations and PAHO could facilitate such collaboration. These guidelines were distributed to all PAHO's Member Countries with the report on the workgroup meeting, in the hopes of promoting and reinforcing these types of collaborative activities.

During 1982, PAHO conducted a series of case studies on community participation in primary health care activities in rural and urban communities in eight countries, which identified how and the degree to which community members and groups participate in activities of mutual benefit, and where health and the health care system come into play. An analysis of the findings published by PAHO in 1985, included a focus on women's participation.

PAHO has prepared a guide for community education in perinatology which focuses on the basic information that the pregnant woman, her family and her community should know to make the pregnancy, delivery and life of the new child a healthier experience. It is hoped that this guide will serve as the basis for developing community-based perinatology education programs in many countries of the Region, with emphasis on self-care and community partipation

An analysis of national activities indicates that 18 countries reported that they train women as community health workers and 12 of these also train traditional birth attendants and incorporate them into the primary health care system. Over half the countries indicated active health education programs for women to encourage improved self and family care. But only seven countries specifically indicated that community-level women are involved in monitoring health conditions and assessing needs, and only three clearly indicated that women were involved in local health planning and decision-making. Although 19 countries indicated that women's organizations participate in primary health care activities at the national or local level, in most cases there was not enough information to determine the type and level--and thus the significance--of such participation.

Some of the problems encountered by countries in promoting either general or women's participation may be explained by the apparent lack of attention to training health personnel in the techniques of promoting and supporting community participation, only seven countries mentioned that health personnel received any such training.

Innovative approaches to reaching women with health information and education have been developed in some countries. For example, Ecuador incorporates education on maternal and child health, family planning, nutrition and cancer detection in literacy training programs. Peru and Mexico have used television soap operas for health education and Peru has also developed materials in the Quechua language. Many Caribbean countries have strong family life education programs targeted to youth, in which women's organizations participate. Cuba and Nicaragua both report close collaboration between the government health system and national women's organizations, members of which serve as community health workers.

A meeting of Central American countries is also being planned with the Inter-American Children's Institute to discuss and promote the evaluation of efforts by community organizations in primary health care. This will take place in 1986.

b. Maternal and Child Health and Family Planning

Appropriate care during pregnancy and child birth is crucial to women's health and well-being, as well as to that of future generations. Women of child-bearing age and children under 15 account for 70% of the population in most of the Region.

Reproductive problems are still a major concern in the countries of the Region. Although maternal mortality has been declining throughout the Region, complications of pregnancy and childbirth still cause a sizable percentage of deaths for women aged 15-44 in many countries, ranging from 5 to 18% in 1978. Adding to this problem is the incidence of induced abortion. Although reliable statistics are not available because abortion is illegal in most of the countries of the Region, abortion-related morbidity and mortality are seriously underreported and the incidence of abortion appears to be rising on the whole.

Enhancing women's capacities to care for their children and families through a series of support systems is the only realistic approach to improving infant and child health. It is the mother that regularly decides if and when her children will be vaccinated, if oral rehydration therapy will be used, and when to breastfeed and wean her child. Although training women is crucial to enhancing their roles as mothers, they can not act alone and will need much more support than information alone can provide. 1/

1/ Estado Mundial de la Infancia, UNICEF, 1985, p. 9.

During the past ten years, maternal and child health activities in the Region have been expanded and given increasing priority by PAHO and its Member Governments. The Maternal and Child Health Program has worked in close coordination with the Program on Women, Health and Development, as well as other relevant programs. A series of activities has been developed to support the countries in their efforts to respond to the health problems of women and children. Primary health care concepts are being introduced, including continuity of care, community and family participation, use of appropriate technologies, multisectoral approaches and promotion of preventive measures through participatory health education.

Most countries provide maternal and child health services with varying emphases on components such as immunizations, family planning, and control of respiratory and diarrheal diseases and progress has been made in extending coverage and improving service. But there are countries and groups in which high rates of maternal and child morbidity and mortality signal major health problems which must be addressed quickly if the regional health goals are to be reached. Prenatal, perinatal and postnatal care is still limited both in coverage and in the quality of services.

PAHO is collaborating with the countries to strengthen and extend coverage of their programs for health care during pregnancy, delivery, childhood and adolescence. Activities include appropriate training in maternal and child health and family planning for all health personnel and that of related sectors, particularly teachers and social workers. Efforts have focused on involving women not only as users and targets of services, but also as decision-makers in the planning, implementation and evaluation of services. The participation of family and community in decisions concerning health is now being promoted.

To improve maternal and child health programs through a better understanding of the health problems of the target population, PAHO is collaborating with the countries in a variety of research projects. For example, an interregional project is currently underway to determine the magnitude of maternal mortality and its causes. Based on its conclusions, a plan of action will be developed to reduce maternal morbidity and mortality in the context of the Regional strategies to achieve health for all by the year 2000.

Women's health is too often affected not only by inadequate care during pregnancy and childbirth, but by having children too often or at too young an age. Ending unwanted pregnancies through dangerous illegal abortions also poses grave danger to a woman's health. Because of these problems and the desire of many women and their partners to limit the number of children in their families, family planning activities have become increasingly important components of public health programs in the Region. During the past 10 years, the number of countries providing

family planning services as part of their public health programs has increased from 17 in 1975, to include all but 3 of PAHO's Member Governments in 1985. Strong nongovernmental programs also exist in a number of countries.

As described in Document CE95/16 of the Executive Committee, despite increased recognition of the need for family planning and government committment to providing services throughout the Region, surveys carried out in the countries continue to show high rates of unwanted pregnancies. In many areas services are not nearly adequate enough to meet the demands of sexually-active women between 15-44 years of age that do not want to become pregnant but do not have access to contraceptives.

As part of its comprehensive program of cooperation with the countries in the area of human growth and reproduction, PAHO and UNFPA sponsored a study by the Pontificia Universidad Javeriana in Colombia of sociodemographic characteristics and problems of single teenage mothers. Results of the study will be used to develop solutions for improving the health and social conditions of single teenage mothers in this area and the methodology used in the study will soon be disseminated throughout the Region.

Research is also being conducted in Cuba, Mexico and Panama on the beliefs and behavior of teenagers in relation to sexuality. In the English-speaking Caribbean, educational models for adolescents on contraceptive use are being developed. This educational approach is very important in the Caribbean where 11 countries are currently implementing family life education programs which will focus more and more on adolescents' needs in the future, especially in the area of reproductive health.

To promote improved maternal and child health through primary health care approaches, PAHO has recently developed a series of publications focusing on topics such as maternal mortality, fertility and health, prevalance and use of contraceptives, and adolescent health.

In the area of health technology development, PAHO has translated into Spanish and disseminated throughout the Region, reports on evaluations of medical technologies used in women's health care such as electronic fetal monitoring, ultrasound imaging, cervical cancer screening, amniocentesis and mammography.

PAHO and WHO's Regional Office for Europe (EURO) held two interregional conferences in 1984 and 1985 on appropriate technology in prenatal care and in birth. At the two meetings, experts from throughout the Americas and Europe analyzed the appropriate role of medical technology in prenatal care and the birth process. The central role of women and their right to good care were crucial themes throughout the meetings and the resulting recommendations. The proceedings of the two conferences will be published and distributed throughout the Region. Furthermore, a third PAHO/EURO meeting on appropriate technology in postnatal care is planned for 1986.

c. Nutrition of Women and Children

Although nutrition programs are receiving increasing attention in the Region and nutritional problems throughout the Region have been well established, there is still little information on the relative nutritional status of female and male children or on women's nutrition other than during pregnancy--and even pregnancy-related data is limited. PAHO has long been involved in distributing information and promotional materials on food and nutrition through its subregional centers and promoting and supporting national workshops on breastfeeding and infant nutrition. PAHO has also collaborated with the World Food Program in implementing and evaluating supplementary food programs involving pregnant and lactating women in 14 countries.

Other PAHO regional efforts include participation in a 1981 PAHO/WHO task force on breastfeeding and maternal-infant nutrition, which has led to further research supported by WHO; and an international conference on community support for breastfeeding mothers in Jamaica in 1982 which emphasized the role of women's organizations as a support structure and recommended greater participation of women at all stages of project development. The Food and Nutrition program's current study of intra-household resource distribution has already been cited in the section on research. In line with the conclusions of this study, specific research and training actions for health service personnel will be carried out in 1985.

PAHO's Food and Nutrition Program has indicated three priority areas of action: promoting multisectoral policies and plans regarding nutrition; incorporating nutrition activities into primary health care programs and facilitating women's participation in all aspects of food and nutrition activities; and reinforcing national and regional institutions and facilitating cooperation among them.

The Five-Year Plan emphasizes the need to improve women's nutrition as well as involve them in nutrition activities. At least 75% of the Region's countries direct nutrition education toward pregnant and lactating women, and most of these also have supplementary feeding programs, although coverage is often limited.

Only two countries gave indication of considering the nutritional needs of women at other stages of life: Venezuela indicated that its nutrition policy covers all ages and both sexes, not just pregnant women and children. A report from Mexico indicated that regular nutrition surveys are conducted and emphasized the need for attention to female nutrition at all ages, citing the substantial differentials in nutrition and physical development among female and male children due to cultural discrimination. Attention to the nutritional needs of elderly women was not specifically mentioned in any country report.

d. Acute and Chronic Disease Control/Adult Health

Cancer is among the five leading causes of death for women throughout the Region. Cancers of the reproductive system are among the most common cancers in women, particularly cervical and breast cancer, the incidence of which is rising. While breast cancer is associated with higher-income women and is becoming prevalent in the more developed countries of the Region, cervical cancer is a serious problem in the poorer countries and among poor women. Lung cancer among women is also increasing in the Region as a growing number of women are smoking.

Other chronic diseases with high incidence and mortality rates among the Region's women are heart and cardiovascular diseases. Although death rates for women are considerably lower than for men, high rates of hypertension among women in some areas have contributed to rising female death rates. A related complicating factor is the high rate of diabetes mellitus, particularly among post-menopausal women, noted in some parts of the Region. Diabetes death rates are higher for older women than for men, and also contribute to deaths from cardiovascular disease.

Finally, modernization is bringing about an increase in the number of elderly women, particularly in urban areas. Both higher migration and lower mortality rates contribute to a predominance of women among the elderly. During this century, life expectancy for women has increased more than that of men. In the United States of America female life expectancy increased from 48 years in 1900 to 75 in 1973 (for men the figures are 46 and 68 years respectively). In Latin America female life expectancy will increase from 65 during 1975 to 1980 to 70 years from 1995 to 2000; these figures for men will be 60 and 66 years respectively. Modernizing forces are breaking up the traditional family support system for the elderly, and governments lack the resources to fill this gap in most cases, so the countries of the Region will have to cope with a growing number of older women increasingly subject to malnutrition and chronic diseases, many of whom will lack the resources to care for themselves due to the economic and social disadvantages from which women suffer and due to the high proportion of elderly women living alone.

In relation to special health needs of women, PAHO has substantially increased its focus on early detection and control of cervical and breast cancer, stressing the need to integrate such cancer activities into primary health care programs. Although existing techniques are adequate the problems include identifying high-risk women, extending coverage and providing adequate follow-up to screening.

Despite the existence of varying types of cervical cancer control programs or activities in the countries of Latin America and the Caribbean, the impact on mortality has been much lower than expected. Many of these activities are conducted on a small scale lacking coordination and efficiency, and often isolated from other primary and secondary care programs. In Cuba and Puerto Rico it has been demonstrated that successful control programs can be carried out in Latin America. But these programs are currently the exception to the rule.

In many countries cervical cancer control activities are conducted on a small scale, lack coordination and efficiency and are often isolated from other primary and secondary care programs.

As part of its effort to promote effective cervical cancer control in the Region, in 1984 PAHO cosponsored with the American Cancer Society, a meeting in Mexico which brought together government officials, health professionals and representatives of volunteer cancer societies within the Region. This international meeting was one of the first to bring public- and private-sector organizations together to discuss collaboration in cervical cancer control in the Americas. A manual of norms and procedures for cervical cancer control, developed by PAHO, was discussed and refined at this meeting.

In addition to the cancer-related activities, PAHO has collected and disseminated information on diabetes and hypertension, both of which are significant women's health problems; and on women's mental health and other health and social problems affecting elderly women.

PAHO has also promoted analysis of disease data by sex; is planning studies and surveillance of sexually-transmitted diseases and their impact on women and children's health, and is developing strategies for their prevention and control.

Seventeen countries noted that control programs for sexually transmitted diseases exist, but of these, 11 did not indicate coverage by sex. The remainder specifically indicated actual or planned programs to reach women.

Only three countries mentioned mental health activities or programs specifically with regard to women; a few others indicated mental health activities without specifying sex. Family life education programs in some Caribbean countries often deal with mental health concerns. Because of the prevalence of women-headed households, self-help projects for women, including income-generation projects, often aim to help women cope with the stress of trying to support a family alone. Guatemala reported some activity with regard to the psychological aspects of childbirth, and Jamaica indicated that its midwifery program has a psychiatric component.

e. Environmental and Occupational Health

Women are central to the success of water and sanitation programs, since they most often carry water, control its use and are involved in household hygiene. Concrete actions at the regional and country levels to include women are being promoted. Specific guidelines for enhancing women's participation in national environmental health programs are now being developed by PAHO. Recommendations include integration of women into the existing institutional framework, recruiting, training and

promoting women for policy, management and technical positions in environmental health, preparing educational and media materials for women on their roles in water and sanitation activities and supporting the participation of women's organizations in this area.

PAHO is also compiling a consultant roster of female sanitary engineers and environmental scientists in the Region; and has in some cases, provided funds for female environmental health professionals to attend international meetings.

Since 1981, PAHO has participated in a number of activities related to WHD, including promoting proposals to involve women in water and sanitation projects; presenting a report at an international conference on women as innovators in water and sanitation projects; and including material on women's participation in environmental health publications. PAHO has also collaborated with the UNDP Global Project on Women's Participation in the International Drinking Water Supply and Sanitation Decade (IDWSSD) in several countries in the Region.

The link between environmental health and women's health and development needs to be strengthened by most countries efforts to promote women's participation in water and sanitation are being considered in the development of specific projects for women's involvement in planning and operation of water supplies.

With PAHO cooperation, a project is being developed in Honduras to involve women's groups in water and sanitation projects as part of the UNDP Global Project on Women's Participation in the Water Decade. Proposals have also been developed in Barbados, Guyana, Jamaica and Saint Lucia on potential project activities involving women and sanitation. In Jamaica, a project has been developed with PAHO cooperation to train community women in collecting water-related statistics.

Partly as a result of female migration and also because of general economic and social change, many more women are now working outside the home. For example, Brazil reported that the proportion of married women working outside the home tripled between 1970 and 1977, to almost 29% of all married women. Venezuela indicated that its female labor force participation increased from 18% in 1961 to 27% in 1978. In Cuba, the number of working women tripled between 1958 and 1975; women now make up almost 36% of the labor force, and their participation is growing faster than the total rate of labor force growth. In Barbados, 39% of the labor force is female.

Although official statistics indicate that women make up about one quarter of the labor force on the average, participation by women is actually much higher in most cases, particularly in agriculture, domestic and other informal-sector employment, for which statistics as well as labor law protection are seriously deficient.

Women often work in small factories, where health and safety conditions are quite precarious. They are heavily employed in textile factories, where they are exposed to toxic substances and fiber dust. And in all types of work, women suffer the physical and mental stress of a double workload.

More and more attention is being directed to women's special risks and problems related to occupational health. Eight countries indicated that they had taken some action with regard to the occupational health and safety of women and three others indicated plans to do so. Such actions usually consist of labor legislation or regulations on health and safety conditions, and often bar women from certain types of work or restrict their working hours. Most legislation of this type is directed primarily to pregnancy. A number of countries indicated that such regulations are imperfectly enforced and only partially cover women, since few regulations cover domestic service and informal sector employment, where most women workers are concentrated.

A few countries have undertaken or planned research on women's occupational risks. For example, Bolivia indicated that most women in the formal labor force are in the lowest paid factory jobs and that violations of labor laws are frequent. Information is now being collected on industries employing women and the government is considering national policies regarding occupational health and safety for women in both the formal and informal sectors.

Colombia, Cuba, Ecuador and Guyana indicated that they have health and safety laws to protect working women. Guatemala and Bolivia also have such laws, but indicated problems with enforcement. In Peru, investigations have been carried out by a nongovernmental organization on the problems of women working in mining and some other industries.

f. Human Resource Development

Women outnumber men as health care providers throughout the Region; accounting for approximately 80% of all health personnel on the average. An important aspect of PAHO's Five-Year Plan is to guarantee women equality of employment, pay and working conditions in the health sector and to increase the proportion of women in policy and decision-making positions.

PAHO's efforts to promote the participation and influence of women as professional and community health care providers have centered around workshops, support for country studies, and regional studies on the PAHO Fellowship Program with regard to women.

PAHO and three of its Member Countries participated in a WHO project on women as providers of health care from 1982 to 1984 which addressed women's participation in decision-making in health; education and training to prepare women for the health professions; and training and participation of community women in providing health services.

PAHO is also working with countries to identify and meet the needs of women working in female-dominated health professions such as professional and auxiliary nursing. PAHO is working with five countries to study the nursing profession with regard to positions, hours and salaries in comparison to other health professions.

In an effort to promote a greater use of fellowships by Member Governments for the development and training of women, PAHO conducted a study on its fellowships for women. A summary of its findings and recommendations was sent to each Member Government in 1983. The report presents and compares data on fellowship recipients for 1971-1975 and 1976-1980 to demonstrate the characteristics of the program as applied to women, to develop and promulgate policies for improvement, and to provide indicators by which to measure improvement.

The results of this study indicated that between 1971 and 1980 the percentage of women receiving fellowships rose from 31 to 41%, and reached 43% in 1981, the first year of the Five-Year Plan. In 1984, women were awarded 45% of all PAHO fellowships.

As follow-up to the study on PAHO fellowships for women, an evaluation was initiated in 1983 to measure the success of long-term (one month or more) awards to women as compared to awards to men during 1976-1980. Unfortunately, statistically significant results were difficult to identify because of low response to the questionnaire. A comparative evaluation of recipients of 1981-1985 fellowship recipients is planned for 1986 and should prove more successful.

Few countries provided concrete examples of measures taken to increases education and training of women as health care providers. In fact, on a global basis, of all the questions in the health and nutrition section of the U. N. questionnaire on progress made during the Decade for Women, the one that covered discriminatory practices towards women as health care providers had the highest non-response and negative response rate.

Some countries have undertaken concrete efforts to increase women's participation at managerial and executive levels in the health sector. For example, in Colombia a study was conducted to determine the influence of the educational system on women's participation in health occupations. A workshop on development of leadership and administrative competence for women as health care providers was held in 1984 with PAHO collaboration. Jamaica also held a similar workshop in 1984, as the first stage in a project to design leadership and management programs for women.

Progress has been made in some areas. For example, the proportion of women enrolled in medical professions has tended to increase throughout the Region during the decade, although reliable data are not readily available. In Canada women now make up from 40 to 50% of medical school students, while in the United States of America the number of women

enrolled increased 321% between 1972 and 1982, to men's 14% increase. In Uruguay, the percentage of women studying medicine increased from 45% during 1971-1980 to 59% during 1981-1983.

Seven countries noted an increased number of women in health occupations traditionally predominated by men (e.g. doctors, dentists, veterinarians, etc.), with or without any special policies to promote this. For example, Cuba and Paraguay noted that there are now an equal number of women and men in medicine; Venezuela reported that by 1982 about 21% of doctors were women; and Peru noted an increase in women doctors from 5% in 1970 to 15% in 1984, but also noted that discrimination against women is still a problem.

g. Support Services

The PAHO/WHO approach during recent years in the area of women's and family health has focused increasingly on the health implications of changing patterns of women's work and family structures; in particular, how women's roles in the formal and informal labor market affect their roles as mothers, and influence child health; and how women's roles affect family health care and what actions are required to support women in carrying out their complex roles. The activities aim to promote adequate social support measures for women and families and to learn more about women's health-related conditions and choices in order to ensure that the circumstances of women's lives are conducive to good family health and nutrition practices.

During 1981-1982, existing information about day care alternatives was analyzed in two WHO publications. In 1983 WHO collaborated with ILO to develop a publication on maternity benefits in the 80's. It summarizes existing provisions of such legislation on a regional basis, and emphasizes the need for extending the coverage of such legislation--both in terms of the target populations and the extent of each provision (e.g. increased time and facilities for breastfeeding). In addition, work has begun on an in-depth review of the health aspects of maternity legislation.

Over three-fourths of the countries reported social support services for working women (usually legislation regarding maternity benefits and child care), but a number of these indicated that coverage or compliance were limited. Some specific problems mentioned were that allowing women workers to take short time-off periods for breastfeeding is largely ineffective because there are usually few child care facilities near most workplaces; most legislation does not apply to workers in the informal sector; legislation requiring provision of day care often impedes employment of women because it raises employer costs; and legislation barring women from certain jobs or restricting their hours in the name of 'protection' also can have negative effects on their employability and income.

CONCLUSIONS AND FORWARD-LOOKING STRATEGIES

This report lists a series of actions that have been taken in the area of women, health and development to overcome obstacles and constraints to progress. These concluding comments highlight the positive impact that the activities of the Decade have had on women's status, as well as point out some of the obstacles and constraints which must still be overcome.

One of the major areas in which the Region has made initial progress is in increasing awareness of women's special health problems and needs, as well as their strengths, and contributions to the health and development process. Public awareness has increased as have levels of sensitivity to women's issues among many public health and other government officials and the international community. In addition, more women have grown aware of previously hidden or traditionally discriminatory laws and practices and have become much more assertive and organized in bringing about needed change and in realizing their own potential. The increasing number of organized groups of women throughout the Region provides concrete evidence of the growing awareness on the part of women of the need for improved representation, advocacy and collective action to bring about change.

More attention to the importance of women's health concerns throughout their life cycles, as opposed to just during their reproductive years is needed. Research activities have contributed to a better understanding of women's health and to the need to fully integrate women into the development process. Efforts to disaggregate, analyze and publish existing health information by sex have added to this growing awareness.

Despite the heightened awareness on the part of society of women's problems and of women themselves of their capabilities and rights, the concept of equality and the extent and seriousness of women's problems are clearly not yet fully understood and accepted, especially by decision-makers and educators in the countries of the Region. Furthermore, large gaps remain to be filled in the collection and dissemination of information. Even with the information developed as a result of the Decade, available data frequently are not used or disseminated.

Although increased awareness of women's issues is one of the most obvious results of the Decade's ten years' of consciousness raising, some social and cultural attitudes still present key obstacles to progress. Reluctance to change and to include women in decision-making processes continues to be a problem. Furthermore, many women are often unaware of their basic rights, health needs, availability of health services, or their significant contributions to the provision of health care. Health personnel are not always convinced of the value of passing on appropiate information to women to help them assume greater responsibility for their own health care.

In the area of policy development and strengthening institututional capabilities, important steps have been taken in almost all of the countries of the Region. Mostly during the second half of the Decade, national machineries (offices, bureaus, etc.) responsible for programs aimed at improving women's status were established throughout the Region, as were Focal Points concentrating specifically on the health aspects of women's status.

Academic programs, research centers and information networks have also been established in the countries of the Region to analyze women's status (including their health) and to bring about changes in attitudes and to improve service programs and educational practices. International and regional organizations have also established mechanisms that provide technical cooperation in this area.

Important changes in legislation and policies were made during the decade. Although some countries in the Region had established mandates prohibiting sex discrimination even before the U.N. Decade for Women, in recent years many countries have designed and modified legislation for the protection of women's rights in marriage, divorce, abortion and rape, and covering maternity benefits for domestic workers, equal pay for equal work and hiring and firing practices.

However, neither the enactment of legislation nor the establishment of policies and plans has been enough to bring about sufficient change. Lack of resources has led to slow implementation of new laws and policies. It is becoming very clear that the political commitment expressed throughout the Region during the Decade for Women has not been sufficiently backed by the resources needed to implement policies and programs. Although WHD Focal Points have been established, in most cases their actions have been restricted by insufficient human and financial resources.

More mechanisms that ensure women's participation in health activities at all levels are needed. Without such mechanisms many actions to improve women's status fail and governments and institutions, at times with the best of intentions, continue to define women's needs for them, often leaving the real needs of women unanswered. This holds true at the community level, for example in efforts to provide health education to women, and at the highest levels, where the objective may be to recruit highly qualified women health professionals.

Throughout the United Nations system, this final year of the U.N. Decade for Women has been a time for review and analysis of progress made during the last ten years and, perhaps more importantly, a time to focus on strategies for future action in the area of women and development. The Regional Strategies to Achieve Health for All by the Year 2000 provide an excellent framework for future actions related to women, health and development. As mentioned previously in this report, reaching the goals of the Regional Plan of Action of Health for All will, by definition, result in major improvements in women's health status and the enhancement of women's participation in health and development activities.

But special efforts are still needed to ensure equity for all in access to adequate preventive and curative health care. We are still far from reaching the goals of the PAHO Plan of Action on Women, Health and Development. Five years has not proved sufficient to ensure that women are involved and that their needs are taken into account in developing health programs and activities. Measures must be taken to overcome obstacles and constraints and to build upon the important activities already under way.

At the national level, each Member Government must identify its own priorities and try to improve the status of women within the context of its own social, cultural, historic and economic situation. Within each country, varying regions and communities must select actions that are feasible and appropriate in the context of their particular needs, constraints, possibilities and resources.

WHO has outlined forward-looking strategies for improving women's status at the national level focusing on steps to be taken in the areas of health science and technology, health system infrastructures, community involvment and intersectoral approaches (Document A38/12 of the 38th World Health Assembly).

The forward-looking strategies outlined by WHO are meant to be guiding principles rather than detailed plans of action, as are the Regional Strategies to Reach Health for All and the Five-year Plan of Action on WHD. They highlight useful approaches, give examples of measures that can be taken, and focus on the integration of women's issues within health programs, all in the context of primary health care.

At the Regional level, the two action plans mentioned above provide useful strategies for improving women's status and represent a commitment of PAHO's Member Governments to give priority to addressing these problems. Since 1985 marks a turning point as the last year of the Decade and the Five-year Plan, a renewed commitment on the part of Member Governments and PAHO is warranted, and should be considered along with more focused efforts to overcome the obstacles and constraints identified in this report.

At the Regional level PAHO will continue to coordinate and promote women, health and development activities as part of its proposed program and budget for 1986-1987. The program will focus on strengthening institutional capabilities, information exchange, research and program development.

To ensure the continued advancement of women during the next 15 years, to the year 2000, coordinating mechanisms at the national level should be strengthened. Focal Points for women, health and development need political support, human and financial resources, and access to existing infrastructures. It is through the Focal Points that national priorities and problems related to women, health and development can be analyzed and addressed through integrated actions as part of national health and development programs.

To ensure an increased understanding of women's health needs and contributions in health care, and to define and identify relevant problems and issues, research activities must be promoted and supported. More information is needed to better understand the prevention and control of female-specific diseases, women's nutritional status, appropriate technologies for perinatal care, women's mental health and violence against women, as well as the best ways to reach women to inform them about preventive actions they can take.

Areas in health systems research needing further investigation include: the relationship between women's health and women's work and time patterns; problems faced by women in the utilization of health services; women's roles as health care providers in the home and community; and the influence on health of social, economic and behavioural factors specific to women.

Already existing information on women, health and development issues and activities should be collected and disseminated. In many cases important data can be found in existing information systems and used for analysis at relatively low cost. Coordination with women's organizations can contribute greatly to this process.

More concentrated efforts are necessary to ensure that women's needs and contributions are taken into account in the planning, implementing and evaluating of health programs. This includes making sure that services are conveniently located; available at times that are suitable to women, especially women who are heads of households; ensuring that health workers are trained to recognize and treat women's health problems as well as to understand the nature and value of their contribution to health care; developing and adapting socially relevant technologies, where necessary; and promoting the provision of social support for women with family and career responsibilities.

Health education is crucial to the success of primary health care activities. This involves a two-way educational process between health personnel and the population at large. Educational programs concerning prevailing health problems and methods of preventing and controlling them should include a sensitivity to women's and men's changing roles and responsibilities; and messages that are meant to be received by women should be relevant to their health priorities. Personnel in the health sector also can learn a great deal from women at the community level and their traditional ways of addressing and preventing health problems.

In conclusion, the U.N. Decade for Women and PAHO's Five-year Plan have only begun to solve some of the many problems that confront women in the Americas. Although actions have led to increased awareness of the problems women face, more efficient and adequate measures are still needed. To reach the goal of health for all by the year 2000, the close of the Decade must be viewed as a beginning, the first stage of a continuing effort in each country and throughout the Region.

Appendices

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APPENDIX I

CHRONOLOGICAL SUMMARY OF PAHO'S ACTIVITIES ON WOMEN, HEALTH AND DEVELOPMENT DURING THE UNITED NATIONS DECADE FOR WOMEN

1975

- International Women's Year
- World Conference on Women, Mexico City
- U.N. Decade for Women Established (1976-1985), Themes - Equality, Development and Peace
- PAHO Resolution CD23.10

1980

- World Conference Mid-Way through Decade
- World Plan of Action for Second Half of Decade, Subthemes - Health, Education and Employment
- Women, Health and Development Subcommittee established by the Executive Committee
- PAHO Resolution CD27.17

1981

- Five-Year Regional Plan of Action on Women, Health and Development, adopted by the Directing Council (Resolution CD28.15)
- Regional Plan of Action to Achieve HFA-2000
- Assistant Director Designated Women, Health and Development Focal Point for PAHO

1982

Women, Health and Development Subcommittee met to review progress

- Coordination with other agencies strengthened
- Resolution CSP21.27, establishing Focal Points at national level

1983

- Regional Program on Women, Health and Development established in PAHO
- Five-Year Plan published (Scientific Publication No. 448)
- Study: Women as fellowship recipients, recommendations sent to Member Governments
- Project: Women's groups in PHC activities, report published
- Focal Points established in 33 countries
- PAHO holds First Regional Seminar-Workshop on Women, Health and Development (5 countries participate)
- Brochure, "Mandate for Change," published and distributed
- Subcommittee met to review progress
- PAHO Resolution CD29.27

1984

- Second Regional Seminar-Workshop on Women, Health and Development (9 countries participated)
- PAHO participated in WHO project on Women as Health Care Providers (Workshops in Colombia and Jamaica)
- PAHO participated in Regional Preparatory Conferences for 1985 World Conference on Women held in Argentina and Cuba
- Published Annotated Bibliography on Women, Health and Development (Scientific Publication No. 464)
- PAHO developed "Funding Sources for Women, Health and Development in the Americas" as guide for national Focal Points
- Subcommittee met to review progress
- PAHO Resolution CD30.6

1985

- Third Regional Seminar-Workshop on Women, Health and Development (6 countries participated)
- Subcommittee met to review ten-year progress report and special report on cervical cancer control in the Region

- National Workshop in Argentina (participation of 5 other national Focal Points)
- Health Status of Women in the Americas (Scientific Publication No. 488)
- 1985 World Conference on Women (Nairobi, Kenya)

APPENDIX II

A

Draft

INDICATORS OF COMPLIANCE WITH
5-YEAR WHD PLAN OF ACTION

	ARGENTINA	BAHAMAS	BARBADOS	BELIZE	BOLIVIA	BRAZIL	CANADA	CHILE	COLOMBIA	COSTA RICA	CUBA	DOM. REP.	ECUADOR	EL SALVADOR
1. Strengthening Institutional Capabilities														
a. WHD Focus Incorporated into National Health Plan/Policy/Program	x				x[7]	x[8]	x		x[7]	x[8]	x		x	x
b. Coordinating Mechanism for WHD	x	x	x	x	x	x	x	x	x	x	x	x	x	x
c. Efforts to monitor WHD progress			x				x		x		x			
d. Efforts to increase no. of women in decision making positions in health sector			x				x	x	x		x		x	
2. Research/Analysis of Women's Health Problems														
a. Health data collection/analysis by sex	x				x[8]	x[8]	x		x	x	x	x[8]		
b. Research on women's health	x[6]		x[6]	x	x	x	x	x	x[7]	x	x	x	x	x
3. Dissemination of information and interagency collaboration														
a. Links with government agencies on WHD information/activities	x	x	x		x	x	x		x	x	x	x	x	
b. Links with NGOs on WHD in information/activities		x	x			x	x		x	x	x	x		x
c. Publication of WHD Information							x		x[6]	x[7]				

	GUATEMALA	GUYANA	HAITI	HONDURAS	JAMAICA	MEXICO	NICARAGUA	PANAMA	PARAGUAY	PERU	SURINAME	TRINIDAD/TOBAGO	U.S.A.	URUGUAY	VENEZUELA	EASTERN CARIBBEAN*
1. Strengthening Institutional Capabilities																
a. WHD Focus Incorporated into National Health Plan/Policy/Program	x[9]	x[7]		x	x	x		x[8]		x		x[7]			x[7]	x[7]
b. Coordinating Mechanism for WHD	x	x	x	x	x	x	x	x	x	x	11,12	x	x	x[12]	x	x
c. Efforts to monitor WHD progress		x		x	x	x				x 8		x[7]			x	
d. Efforts to increase no. of women in decision making positions in health sector		x		x	x	x						x				
2. Research/Analysis of Women's Health Problems																
a. Health data collection/analysis by sex	x[8]	x[7]	x[8]	x[8]	x[8]	x[8]		x[8]		x[8]		x[8]	x		x	
b. Research on women's health	x	x	x	x	x	x	x	x	x	x		x	x	x[6]	x	x[10]
3. Dissemination of information and interagency collaboration																
a. Links with government agencies on WHD information/activities	x	x		x	x	x	x	x	x	x[9]		x	x		x	x[7]
b. Links with NGOs on WHD in information/activities	x	x		x	x	x	x	x	x	x		x	x		x	x
c. Publication of WHD Information	x		x[7]			x[7]				x			x			

B

	ARGENTINA	BAHAMAS	BARBADOS	BELIZE	BOLIVIA	BRAZIL	CANADA	CHILE	COLOMBIA	COSTA RICA	CUBA	DOM REP	ECUADOR	EL SALVADOR	GUATEMALA
c Nutrition															
1 Nutrition education emphasizes pregnancy/lactating women				x	x		x		x	x	x	x	x	x	x
2 Nutrition supplements for pregnant/lactating women	x				x	x	x	x		x		x	x	x	x
3 Child/adolescent nutrition education/supplements	x				x	x	x	x	x	x	x	x	x	x	x
4 Community women participate actively in planning/implementing local nutrition					x					x	x				x
5 Nutrition policies/programs recognize nutrition needs of women at all ages							x								
d Acute/chronic disease control															
1 Program for detection/control of female-specific cancers			x		x[8]	x[7]	x	x	x	x	x	x	x[8]	x	x
2 Program for detection/control of STD[3] in women	x[4]	x[4]		x[4]		x[7]	x	x[4]	x			x		x[4]	x[4]
3 Community women involved in disease surveillance programs						x[4]			x[4]	x[4]					x[4]
4 Program for mental health [illegible] of women							x						x[4]		x[8]

	GUYANA	HAITI	HONDURAS	JAMAICA	MEXICO	NICARAGUA	PANAMA	PARAGUAY	PERU	SURINAME	TRINIDAD TOBAGO	USA	URUGUAY	VENEZUELA	EASTERN CARIBBEAN
c Nutrition															
1 Nutrition education emphasizes pregnancy/lactating women	x	x	x		x	x	x	x	x		x	x		x	x
2 Nutrition supplements for pregnant/lactating women	x	x	x		x		x	x	x		x	x		x	
3 Child/adolescent nutrition education/supplements	x	x	x		x		x	x	x		x	x		x	x[10]
4 Community women participate actively in planning/implementing local nutrition					x		x	x	x						
5 Nutrition policies/programs recognize nutrition needs of women at all ages					x							x		x[4]	
d Acute/chronic disease control															
1 Program for detection/control of female-specific cancers			x	x	x		x	x	x		x[7]		x[4]	x	x[10]
2 Program for detection/control of STD[3] in women				x[7]	x[4]	x		x[4]	x[4]				x[4]		x[4]
3 Community women involved in disease surveillance programs		x[4]							x						
4 Program for mental health [illegible] of women				x[8]							x[4]				x[4] 10

	ARGENTINA	BAHAMAS	BARBADOS	BELIZE	BOLIVIA	BRAZIL	CANADA	CHILE	COLOMBIA	COSTA RICA	CUBA	DOM REP	ECUADOR	EL SALVADOR	[illegible]	[illegible]	HAITI	[illegible]	JAMAICA	MEXICO	NICARAG	PANAMA	PARAGUAY	PERU	SURINAME	TRINIDAD TOBAGO	U S A	URUGUAY	VENEZUELA	[illegible]
e Environmental and occupational health																														
1 Women participate in planning/implementing local water/sanitation projects	x[4]											x[7]				x[7]		x[7]	x[7]					x[4,7]						
2 Occupational health problems of women specifically taken into account	x[7]		x		x[7]		x		x	x[8]	x		x			x				x				x[6]		x[7]				
3 Research done/planned on women & occupational health risks	x[6]								x	x[7]	x													x[6]				x[6,7]		
f Human Resources																														
1 Policy promotes recruitment training of women in health occupations			x				x	x			x		x	x		x			x	x							x			
2 Evidence of new health roles for women							x				x					x		x[7]	x								x		x	
g Support Services																														
1 Legislation provides for social support for women, partic. working mothers and the elderly	x		x		x[9]	x[9]	x		x[8]	x	x	x[8, 9]	x[9]		x	x	x	x[7]		x		x	x[9]	x[9]		x[8,7]	x[8]		x	x[8]
2 Health services designed to respond to needs of working women							x			x[4]	x[4]					x[8]														x[10]

4 Program Development	ARGENTINA	BAHAMAS	BARBADOS	BELIZE	BOLIVIA	BRAZIL	CANADA	CHILE	COLOMBIA	COSTA RICA	CUBA	DOM REP	ECUADOR	EL SALVADOR	GUATEMALA	GUYANA	HAITI	HONDURAS	JAMAICA	MEXICO	NICARAGUA	PANAMA	PARAGUAY	PERU	[illegible]	TRINIDAD TOBAGO	U S A	URUGUAY	VENEZUELA	EASTERN CARIBBEAN
a Community participation (CP) and health education																														
1 Health system recognizes role of women as health promotors, providers, beneficiaries				x			x	x	x	x	x	x	x			x		x	x	x				x						
2 Self and family care by women actively promoted via health education	x[7]			x		x[7]	x		x	x	x	x	x		x	x			x	x				x		x	x		x	x
3 Women serve as community health workers	x	x		x	x				x	x	x	x	x	x	x	x	x	x	x	x	x[4]		x	x						
4 Trained TBAs incorporated into Primary Health Care (PHC) system					x	x				x			x		x	x		x		x	x		x	x						
5 Female traditional healers trained collaborate with PHC system																	x[4,7]													
6 Community women involved in monitoring health status & assessing needs							x		x	x	x		x						x[4]	x				x						
7 Community women involved in local health planning decisions							x[8]			x	x				x[4]			x[7]			x[4]									
8 Women & organizations participate in PHC projects & programs					x		x	x	x	x	x	x	x			x	x	x		x[7, 8]	x	x	x	x		x	x		x	x[10]
9 Health personnel trained in CP					x					x			x		x	x		x											x	
b Maternal/Child Health (MCH)																														
1 MCH coverage adequate or efforts are being made to improve MCH coverage	x[5]		x	x	x[5]	x	x	x	x	x	x	x	x	x[9]	x	x	x	x	x	x	x	x	x[5]	x		x	x		x	x
2 Effort to reduce maternal mortality/morbidity						x	x		x		x	x	x		x	x		x		x	x		x	x					x	
3 At least Health Program counseling & family life education mental/physical health	x[5]		x	x		x	x				x	x	x[8]		x[8]	x			x	x[7]		x	x[8, 5]	x[7]		x	x		x	x

NOTES:

1. CHWs - Community Health Workers (from community itself).
2. TBAs - Traditional Birth Attendants.
3. STD - Sexually Transmitted Disease.
4. No specific mention of gender.
5. No official family planning policy.
6. Done by NGOs, not government.
7. Planned; no evidence re implementation.
8. Partial/incomplete.
9. Problems with enforcement, implementation.
10. Not in all countries.
11. Has no Focal Point.
12. Has not yet undertaken/reported WHD activities.

CERVICAL CANCER AS A HEALTH PROBLEM OF WOMEN IN LATIN AMERICA AND THE CARIBBEAN

CERVICAL CANCER AS A HEALTH PROBLEM OF WOMEN IN LATIN AMERICA AND THE CARIBBEAN

INTRODUCTION

The magnitude and severity of the problem of cervical cancer in the Region has been a constant concern of the public health authorities. PAHO drew attention to its importance several years ago. In 1964 it documented the extent of mortality due to this cancer through the Inter-American Survey on Mortality (1), which showed that cancer in general was responsible for 25% of all deaths in several Latin American cities and that, of those deaths in women, 18% were due to cancer of the cervix. At that time the data showed in the cities of Cali, Colombia, and Lima, Peru, mortality caused by cervical cancer was up to eight times higher than in the developed countries.

Both clinical and epidemiological studies have consistently shown the importance of risk factors associated with cervical cancer. Some of these are: the age at which sexual relations begin, multiple sexual partners, multiple pregnancies, and genital viral infections, especially herpes simplex 2 and papiloma. These factors are associated with socioeconomic poverty and are frequently present in most of the countries of the Region. Furthermore, the Latin American and Caribbean countries may be classified as belonging to the type B societies described by Skegg et al. (2), which are characterized by women tending to have only one partner and men, more promiscuous, to have several, which would be conducive to situations favoring development of cervical cancer. At present research is being carried out on the role of the sexual behavior of men and on other possible risk factors, such as vitamin A deficiency and cigarette smoking in the etiology of this tumor.

This document presents a review of the present status of mortality and morbidity caused by the problem in the Region as well as a summary of the principal activities undertaken by PAHO and by the countries for controlling it. It is hoped that it will serve as a baseline for recommending actions required to reduce the morbidity and mortality rates of cervical cancer.

I. MAGNITUDE OF THE PROBLEM

A comparison of certain prominent aspects of mortality and morbidity in the different countries is necessary to determine the magnitude of the problem in the Region of the Americas.

1. Mortality

The quality of the information available for analyzing the mortality is very uneven, and largely depends on the level of development of the country. However, the information reveals important characteristics, the most outstanding of which is the great differences in rates among countries of the Region. In Table 1, mortality from cervical cancer is expressed in age-adjusted crude and truncated rates (3) based on the information reported to PAHO by the Member Governments (4).

An analysis of the mortality data warrants the following considerations:

a) Deaths preventable through appropriate control programs

Since the use of technology for the detection, diagnosis and treatment of the pre-invasive forms of cervical cancer prevents the invasive forms of the disease, a large proportion of the difference in mortality among the countries is attributable to significant differences in the execution of control programs. Accordingly, an approximation of the percentage attributable excess of deaths* from cervical cancer in different countries is presented compared with the Canadian rate of 3.2 per 100,000 women (Table 2). This percentage of actual mortality is that which is hoped can be reduced through the execution of appropriate control programs, in the countries that have deficient programs, a large percentage of deaths--60% or more--are expected to be prevented through the implementation of appropriate programs. In the countries with adequate programs it is expected that when sufficient time for the impact to be produced expires, their rates will be the same as those in the developed countries. As may be seen from Table 2, almost all the countries of Latin America and the Caribbean could reduce deaths from this cancer by more than 40%.

For the five countries--Mexico, Brazil, Colombia, Chile and Argentina--which account proportionately for the largest number of deaths due to cervical cancer in the Region, it would mean preventing at least 3,800 deaths annually. Worthy of mention is the high proportion of avoidable deaths in countries such as Uruguay and Argentina. It is frequently believed that in those countries the magnitude of the problem of cervical cancer is not large, probably because of the relatively greater importance of breast cancer.

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*For an explanation of the concept of percentage attributable excess, see the Technical Note at the end of the text.

b) <u>Proportional distribution of deaths in women due to cervical cancer</u>

According to the information available to PAHO, the leading cause of death in the Region in the population aged 25-64 years is malignant tumors, which account for 25% of total deaths. The specific contribution of cervical cancer warrants analysis. It is emphasized that, among deaths produced by malignant tumors in women aged 35-64 years, cervical cancer is the leading cause in almost all countries. This becomes much more significant if we add to the number of deaths from cervical cancer those reported as "tumors of other parts of the uterus" which largely represent, in actual fact, cases of cervical cancer. On the whole, the countries may be classified in accordance with three patterns or categories, namely:

i. That in which the leading cause of death from cancer in women is cervical cancer, the magnitude of which clearly surpasses mortality from breast cancer.

ii. That which contains the countries that have a higher proportional mortality from breast cancer than from cervical cancer.

iii. That in which the proportional mortality is approximately equal for breast cancer and cervical cancer.

Table 3 presents the countries classified according to the above-mentioned criteria, including the percentage represented by mortality from cervical cancer, that of "uterus other parts" and that of the breast relative to total deaths in women from malignant tumors, for all ages and for the age group 35-64 years. The relative rank of the rates for cervical cancer and breast cancer among malignant tumors in the female population is to be noted.

If reliable information were available in all countries, it would probably show that the first group, in which the proportion of deaths from cervical cancer predominates, contains all the countries of Central America and Tropical South America. This category of countries includes large population groups that are underprivileged from the social and economic standpoint and are not covered by appropriate cervical cancer control programs.

If the second group, the pattern of breast cancer predominance characterizes countries that have achieved a higher socioeconomic level and is similar to the pattern in white women of Canada and the United States of America.

The third group comprises the English-speaking Caribbean countries in which it would appear that the determinants of cervical cancer prevail side by side with those that favor breast cancer. There do not seem to be appropriate programs for the detection, diagnosis and treatment of cervical cancer.

c) Age distribution of deaths from cervical cancer

A distinguishing feature of the age distribution of mortality from cervical cancer in the Latin American and Caribbean countries, compared with that of the United States and Canada, is the higher death rate in the population aged 35-64 years. This contrasts with the minor differences between the two groups as regards the proportion of deaths that occur under age 35.

It is noteworthy that in the United States of America and in Canada 41% of deaths from cervical cancer occur in women over 65 years of age (Figure 1), while for most of the Latin American countries this proportion is less than 30%. Cuba, with 37%, is more similar to Canada and the United States than to the Latin countries. This last-mentioned pattern appears to have characterized countries that have organized better control programs and activities. A high proportion of mortality from cervical cancer in women under 65 years of age, for example 71% in Colombia and Costa Rica, 72% in Chile and 74% in Argentina, appears to indicate a pattern of mortality in countries with control activities of low coverage. The final result of the pattern of mortality like that of Latin America and the Caribbean is a larger number of productive years lost, which seriously reduces the life expectancy of women.

The social consequences are foreseeable since we know that the women affected usually come from low socioeconomic strata, which have a high percentage of dependent children, a high rate of unemployment, and unstable unions.

2. Incidence of the invasive forms

One of the most appropriate methods of examining the magnitude of the incidence of cervical cancer in Latin America and the Caribbean is to analyze the records from cancer registries in Latin American countries and cities, some of which have been in existence for more than 30 years. The seriousness of the problem may be illustrated, in the first place, by the fact that, in accordance with the data published by the International Agency for Research on Cancer (IARC) in "Cancer Incidence in Five Continents," from more than 80 cancer registries in the world, the highest incidence of invasive cervical cancer is found in three cities of Latin America: Recife (Brazil), Cali (Colombia) and Sao Paulo (Brazil). Also among the very high rates are those of Jamaica and the Netherlands Antilles. Very high rates have also been reported in other population-based registries such as that of La Paz (Bolivia) (6), Fortaleza (Brazil) (7) and provinces of Panama (8).

a) Classification of countries by excess risk ratio

On the basis of data from incidence studies and from cancer registries and taking as a standard the U.S. and Canada rates, several of the countries in Latin America can be classified with respect to the excess risk of presenting cervical cancer (see Technical Note). Table 4 presents these risk categories. An excess risk greater than three, that is, a rate three times that of the standard, is a very high value. This category includes countries in the Region of the Americas whose rates continue to be among the highest in the world. The intermediate-risk category includes only Cuba and Puerto Rico and there is no country in the low-risk category.

The highest excess risk ratios exist in La Paz (Bolivia), Cali (Colombia) and Recife (Brazil), while the lowest is that of Cuba, 1.7 times higher than the standard of comparison. The explanation of these facts undoubtedly lies in the existence of epidemiological conditions that favor the development of cervical cancer in the high-risk category countries, in which the coverage of programs for the detection and treatment of preinvasive forms of the disease is low.

b) Risk of developing invasive cervical cancer

The approximation to the cumulative risk (see Technical Note), expressed as a cumulative rate per 100 women, that a woman will develop cervical cancer from birth to age 74 years, in various cities and countries is shown in Figure 2. It is very significant that of the first 10 countries with the highest risks, 50% are in Latin America and the Caribbean and only two (Cuba and Puerto Rico), have cumulative risks comparable to socioeconomically developed areas.

It is a very high risk for a woman to have during her lifetime a 5-7% chance of developing invasive cervical cancer, as happens with women in Latin American cities. A woman living in Cali (Colombia) has a cumulative rate of 5.5% up to age 75. In that city, according to Aristizabal et al. (11), 70% of the female population do not undergo a cervical cytology examination. Since in many areas of Latin America conditions are similar to those in Cali, in terms of high rates of incidence and low coverages of control programs, women that have not received at least one cytological examination during their sexual life have very high cumulative risks.

c) Incidence by age

As stated in the discussion on mortality, invasive cervical cancer, both in the countries of high and low risk, presents progressively higher rates of incidence as age increases. These specific rates show certain characteristics that are worthy of mention:

i. Under 35 years of age, the differences between the rates are small among countries or populations with different levels of development.

ii. From age 35 onwards, the populations of Tropical South America show a very sharp increase in the rates. In contrast, from age 35 onwards the increase is much less pronounced in Cuba, Jamaica and the Netherland Antilles.

iii. The marked increase in cases after age 35 in cities in Tropical South America determines very high rates in women age 35-64 years.

iv. The tendency of rates to increase with age is slight in Canada and the United States of America, and it may even be stated that there is a decrease in the older age groups.

v. In the higher risk areas, the rate in women aged 35-64 years reaches values as high as 151 and 149 cases per 100,000 women aged 35-64 years in La Paz (Bolivia) and the Province of Herrera (Panama), respectively.

Figure 3 illustrates the three patterns of incidence by age based on cancer registries in the Region of the Americas.

II. SITUATION WITHIN THE COUNTRIES

Considerable differences in the magnitude of cervical cancer within the geographical limits of the countries have been documented in some detail.

The national registries as well as the local registries, through an analysis of information on internal migrations, have pinpointed administrative and ecological regions where the levels of risk vary greatly.

In Colombia it has been determined that migrant women coming from 3 specific areas have double the risk of developing cervical cancer compared with migrants from other areas or women born in Cali (12).

In Panama (8) very substantial differences exist between provinces both because of the place of residence and because of the place of birth. According to the data of the national cancer registry of that country the province of Herrera shows notably higher rates than other provinces and Panama City.

Furthermore, in Mexico, the tumor most frequently reported as a cause of death is cervical cancer, which is three times more frequent than breast cancer (13). Its rates vary greatly among the different states of Mexico. Part of these differences may be explained by different population risks and part may be due to biases in the registries. Table 5 compares cervical cancer mortality within Mexico by ratios to the national rate. There is a wide range in the frequency of the disease in the country.

In Brazil, cervical cancer is also the cancer most frequently diagnosed by histopathological examination, 23.7% of cancers in women. Between 1976 and 1980 an annual average of 9,428 cases (14) was diagnosed, of which 75% were invasive cases. However, the regional proportion in Brazil varies greatly.

In the north, northeastern and central-western regions it is the tumor most frequently diagnosed; in the southern regions its frequency is less and its proportion is similar to that of breast cancer. Federal units in the same regions show very significant proportional differences, as may be seen in Table 6.

As is well known, the regions that are the poorest in Brazil and have the fewest medical resources are those that have the highest proportion of cases of invasive forms of cervical cancer. The extremely low coverages of the detection and treatment programs, which reach only 2% of the female population at risk (15), explain that situation. Faerstein et al. (15) points out that in the state of Amara in the northern region, all the diagnoses of cervical cancer are of invasive forms.

Finally, the differences in the magnitude of the problem in the countries are of great importance not only in countries with large populations such as Brazil, Mexico and Colombia but also in relatively small countries such as Panama. In addition to the prevalence of risk factors, one explanation of the differences is that detection activities also vary greatly within the geographical limits of a country. Substantial differences in the coverage of the programs by urban and rural areas, by administrative units, by social groups and by age groups have been documented in all the countries of the Americas and the Caribbean. In Chile (16) it is estimated, for example, that the approximate coverage is 15% with great differences between regions, such as 35% reported for Arica and 5.1% for Chuquicamata. In the Oncological Unit of the Hospital Sotero del Río, Chile, it was found that 71% of patients treated for invasive forms had never undergone a cytological examination (17). In Cali (Colombia) only 4.3% of the cases had undergone a cytological examination in the five years preceding the diagnosis (11).

III. PAHO ACTIVITIES

As mentioned in the introduction, the magnitude and severity of the problem of cervical cancer in the Region was revealed in 1964 by the results of the Inter-American Investigation of Mortality (1). From that time onwards, the Organization has repeatedly drawn attention to the problem and has provided the countries with support in developing control activities. Furthermore, this cancer has been designated a priority in the Strategies to Achieve the Goal of Health for All by the Year 2000. In the 1970s, special emphasis was given to programs of early detection of cervical cancer, through the Maternal and Child Health program, specifically as part of its family planning component. In 1972 PAHO published and distributed the first Manual of Standards and Procedures for Cervical Cancer Control (Scientific Publication 248). In the same period, the training of cytotechnological personnel was promoted, especially in Central America and some countries of South America.

In 1975 PAHO/WHO undertook a survey whose purpose was to estimate the extent of the cancer problem in general and the resources available for dealing with it (18). Special attention was given to information for "evaluating the mass community programs for cervical cancer control." The results of the survey again showed the importance of this specific type of cancer in the female population of most of the countries, despite the fact that information gaps in many of them were pointed out; an important finding of this survey was that cytotechnological resources were underused and that it was necessary "to expand the detection campaigns while guaranteeing activities for diagnosis and treatment of suspected and positive cases."

Another aspect that PAHO/WHO has emphasized in the past and continues to emphasize through its technical cooperation activities is improvement of information on cancer in general and on cervical cancer in particular. To that end, a large number of seminars, training courses and advisory visits to cancer registries have been carried out. Nevertheless, although it is recognized that several countries have made serious attempts to improve cancer information, for example Barbados, Bahamas, Bolivia, Brazil, Colombia, Costa Rica, Cuba, Jamaica, Puerto Rico and Panama, there continues to be a great need in many countries for information for use in identifying problems and evaluating programs and activities for the control of cervical cancer.

In 1982, after the Conference and Workshop on Cancer Epidemiology in Latin America (PAHO/WHO and the United States National Cancer Institute) had pointed out that cervical cancer continued to predominate in the Region, PAHO reaffirmed its intention to actively promote in the Member Countries the reorganization of control programs and activities so as to have an impact on mortality from that cancer, since effective technology was within the reach of all the countries.

In conformity with that purpose, several activities were undertaken of which the following warrant mention: preparation of a new, updated version of the manual of standards and procedures for cervical cancer control programs; the convocation of an expert committee for the planning of a regional meeting (June 1983); a meeting of the working group to discuss aspects of epidemiological research on cervical cancer in Latin America and the Caribbean (PAHO/WHO and the United States National Institutes of Health), Panama, July 1983; and a Regional Meeting on Cervical Cancer Control (Mexico, January 16-20, 1984).

The Regional Meeting held in Mexico was attended by representatives of 18 Member Countries and held in cooperation with the American Cancer Society. The components of an efficient control program for this type of cancer and the responsibilities of the various sectors involved were reviewed. The following conclusions of that meeting warrant special mention:

"The organization of an effective cervical cancer control program requires a political decision by the Ministries of Health, the articulation of a series of components of the program, the coordination of various official and voluntary institutions connected with these components and their integration into the different levels of health care for women."

"Those countries that do not have such a program and decide to launch one, either on a limited or a national scale, must necessarily analyze the existing situation in order to prepare a plan of action for the program. This plan would make it possible to identify needed resources as well as the articulation of existing resources. PAHO will cooperate with the countries that so request, through specialized consultants, in preparing a plan of action."

Activities underway

PAHO, as a follow-up to the meeting in Mexico and in coordination with the various technical programs, is undertaking the following activities:

1. Epidemiological analysis of the status of cervical cancer in Latin America and the Caribbean (in press).

2. Preparation of an annotated bibliography on the use and effectiveness of the early detection test, to be widely distributed in the countries.

3. Distribution and diffusion of the manual of standards.

4. Study on the educational and occupational profile of cytotechnologists.

5. Technical advisory cooperation to countries in evaluating and reformulating their programs.

6. Gathering of information in the countries on women's health programs and activities that emphasize female cancer control.

Future activities

Based on experience gained, the evaluative model developed with the advisory assistance of Canadian experts, will be adjusted and standardized in three countries (Barbados, Brazil and Colombia) for subsequent use in other countries.

The following activities are planned for the period 1985 to 1987 and extrabudgetary financing is being sought.

1. Pilot project of model program in three countries with different characteristics as regards health systems and socio-cultural aspects.

2. Application of the evaluative model in the countries. In 1985 evaluations will be continued in Nicaragua, Dominican Republic, Honduras and Costa Rica.

   In 1986 and 1987 three or four countries a year will continue to be evaluated, for which purpose the technical resources of the countries that have already made evaluations will be used. In this way, exchange of experiences and technical cooperation among developing countries (TCDC) will be fostered.

3. Meeting of a working group to discuss the results of the study on educational and occupational profiles of cytotechnologists in Latin America and the Caribbean and to make recommendations in that regard.

4. Support to national and local workshops for the implementation of control activities.

5. Advisory technical cooperation assistance for the organization of registries and of cytotechnology laboratories.

6. Monitoring of activities and programs in the countries.

7. Five years after the Mexico meeting it is planned to evaluate the epidemiological status of cervical cancer in the Region and possibly to hold a regional meeting to present the results and evaluate the impact of the programs, based on an analysis of mortality.

SUMMARY AND CONCLUSIONS

An analysis of recent information on mortality in Latin America and the Caribbean leads to the conclusion that cervical cancer accounts for approximately 15% of cancer deaths in women and that the mortality rates in several countries of the Region continue to be among the highest in the world; that mortality from cervical cancer in several countries in Latin America is four times higher than that in developed countries such as Canada and that in almost all the countries, in the age group 35-64 years, cervical cancer is the leading cause of death from malignant tumors. In the countries where this is not so, cervical cancer is of great importance because of the large proportion of avoidable deaths and the relatively young ages of the women affected.

Effective control of this pathology is based on early detection, diagnosis and treatment of preinvasive forms of cancer, which require technologies within the reach of all the countries. It is important to recognize that other comprehensive activities that lead to an improvement in the level of living of the population are of great importance and would help reduce cervical cancer incidence and mortality. The organization of appropriate cancer control programs and activities in all the countries of Latin America and the Caribbean can reduce deaths from that disease by more than 20% and in most of them by more than 60%.

TECHNICAL NOTE

1. Mortality

PERCENTAGE ATTRIBUTABLE EXCESS

In any community, a risk factor for developing invasive cancer of the cervix is the absence of truly comprehensive programs for the detection and treatment of the preinvasive forms of the disease. The invasive forms are the causes of mortality. At present mortality can only be reduced substantially by preventing the dysplastic and *in situ* forms from progressing to the invasive form. On the basis of this premise, the excess attributable to the lack of appropriate programs is calculated in the form of the percentage attributable risk. Thus:

$$\text{Percentage attributable excess} = \frac{\text{Mortality rate in the country without program} - \text{Mortality rate in the country with a program}}{\text{Mortality rate in the country without program}} \times 100$$

2. Incidence

EXCESS RISK

The numerator is the rate of the population being analyzed and considered exposed. The denominator is the rate of 10 per 100,000 women which is midway between that of British Columbia (Canada) and Connecticut (USA). This was selected as an average value that approximately reflects the adjusted incidence of invasive forms in populations in which the programs have made a substantial contribution to its reduction.

CUMULATIVE RISK. 0-75 years of age

This is calculated by adding the age-specific rates for each age group up to 74 years and multiplying the result by the number of years in each age group, in this case 5, because the age-specific rates are for 5-year age groups. The result can be interpreted two ways. The first is a direct standardized rate with the same population size in each age group. The second interpretation is an approximation to the cumulative risk if the rate is multiplied by 100. It is more convenient to express this per 100 than per 100,000 women. In this context, the result shows the probability that a woman, from birth to age 75, will develop invasive cancer of the cervix uteri in the absence of other causes of death.

STANDARDIZED TRUNCATED RATE

It is calculated for the purpose of facilitating comparisons between the rates of different populations. The rates in very advanced ages are discarded since presumably they contain errors due to defective conditions of events that occurred a long time ago. It is concentrated in the age group that is most relevant for cancer, namely the age group 35-64 years. It is obtained using age adjustment based on the standard world population for the five year age groups from 35 years to 64 years. Usually when we speak of truncated rates in cancer we refer to the adjusted rate for 35-64 years. The range of 35-64 years is not appropriate for cancers whose maximum incidence occurs in childhood or in very advanced ages.

Table 1. Mortality from cervical cancer in the Region of the Americas. Crude, age-adjusted and truncated rates, per 100,000 women

Country	Most recent year	Rate		
		Age adjusted*	Crude	Truncated * (35-64 years)
English-speaking Caribbean. Average rates of 11 countries (Antigua and Barbuda, Barbados Bahamas, Dominica, Jamaica, Martinique, Montserrat St. Kitts-Nevis, Saint Lucia, St. Vincent, Trinidad and Tobago)	1980	14.7	11.4	29.5
Chile	1982	13.6	11.9	27.7
México	1978	12.5	6.8	25.8
Paraguay (reporting area)	1982	12.5	7.8	30.3
Panama	1982	12.1	7.6	24.5
Guyana	1978	11.7	6.8	25.2
Costa Rica	1980	11.1	6.8	20.0
Colombia	1977	10.8	6.0	21.3
Venezuela	1978	10.5	6.1	21.6
Belize	1982	10.4	7.1	18.2
Peru	1978	6.3	3.8	12.3
Ecuador	1978	6.1	3.5	12.6
Brazil	1980	5.6	4.2	...
Uruguay	1978	5.5	6.5	13.2
Cuba	1978	5.0	4.3	9.7
El Salvador	1981	5.0	3.0	10.7
Guatemala	1981	4.7	2.8	10.0
Argentina	1979	4.5	5.0	9.7
Dominican Republic	1982	4.0	2.2	8.1
Guadalupe	1978	...	3.7	...
United States of America	1979	3.3	4.3	6.8
Canada	1981	3.2	3.8	6.5
Puerto Rico	1980	3.2	2.8	7.4
Honduras	1981	0.5	0.3	0.6

...Data not available

* Adjusted to the world population. See Technical Note at the end of the text for truncated rate.

Note: No information is available for Bermuda, Cayman Islands, Falkland Islands, French Guyana, Nicaragua, St. Pierre, Miquelon, Virgin Islands, Bolivia, Haiti. The data for Central America with the exception of Costa Rica and Panama are considered to possibly reflect a high level of under-registration.

Source: Reference 3.

Table 2. Percentage of annual deaths from cervical cancer that can be prevented through appropriate control programs, relative to Canada, 1981

Less than 20%	20 to 39%	40 to 59%	60% and more
Puerto Rico	Cuba	Brazil	Colombia
Bahamas		Ecuador	Chile
		Peru	Costa Rica
		Uruguay	Mexico
		Argentina	Panama
			Venezuela
			English-speaking Caribbean) (11 countries)

The calculations are based on the age-adjusted rates (adjusted to the World Population) of the countries circa 1980. For the countries not included in the table, no information was available or the information available was considered to reflect a high level of underregistration.

Source: Reference 3. The data for the English-speaking Caribbean available in PAHO agreed with those of the author of reference 5.

Table 3. Classification of countries into categories according to the percentage distribution of deaths from cervical and breast cancer in relation to total deaths from malignant tumors, circa 1980.

Category	Cervix uteri %	Other parts of uterus %	Cervix and other parts of uterus %	Breast %	Rank	
					Cervix uteri	Breast
1. Countries with high percentage of deaths from cervical cancer*						
Colombia						
35-64 years	14.1	8.7	22.8	9.2	1	3
All ages	10.8	7.4	18.2	6.2	2	4
Costa Rica						
35-64 years	17.5	4.0	21.5	9.3	1	3
All ages	11.0	3.2	14.2	6.6	2	4
Chile						
35-64 years	19.2	2.8	22.0	12.6	1	2
All ages	12.1	2.7	14.8	9.4	2	3
Venezuela						
35-64 years	14.7	14.6	29.3	12.5	1	2
All ages	10.8	2.2	13.0	9.6	2	3
2. Predominance of deaths from breast cancer**						
Argentina						
35-64 years	6.1	8.7	14.8	25.3	3	1
All ages	3.9	7.1	11.0	18.3	6	1
Cuba						
35-64 years	7.3	11.1	18.4	21.3	5	1
All ages	5.3	9.8	15.1	15.4	5	1
Uruguay						
35-64 years	7.0	8.0	15.0	27.0	2	1
All ages	3.9	5.8	9.7	18.5	5	1
3. Similar percentage of breast cancer and cervical cancer						
English-speaking Caribbean (11 countries)						
35-64 years	15.5	7.7	23.2	19.0	2	1
All ages	15.3	6.7	22.0	15.5	2	1

* Countries such as Brazil, Mexico, Panama and Peru are also classified in this category

** Canada, United States and Puerto Rico are also classified in this category

Source: PAHO Statistics

Table 4. Excess risk ratio* from invasive cervical cancer in selected cities and countries relative to the incidence in the white female population of the United States and Canada**

Risk Ratios: Less than 1.5	1.5 to Less than 2	2 to less than 3		3 or more
Low	Intermediate	High	Very high	
No Latin American or Caribbean country	Cuba and Puerto Rico	Jamaica Antilles	Brazil (Sao Paulo)	Bolivia (6) (La Paz)
		Netherland Antilles	Brazil (Recife)	Provincia (8) Herrera (Panama)
		Argentina (9) (La Plata)	(Cali)	Colombia Brazil (7) (Fortaleza)
		Panama (8) (Panama City)		Peru (10) (Lima)

Sources: Cancer Incidence in Five Continents. IARC, Vol IV, 1982 and data from the references noted in brackets which are from the list of bibliographical references.

* For explanation of calculation of excess risk ratio, please see Technical Note.

** Age-adjusted rate of 10 per 100,000 was used for comparison, which is midway between that of British Columbia (Canada) and Connecticut (USA).

Table 5. Comparison of cervical cancer mortality within Mexico by ratios to the national rate (1973)

State	Ratio
Republic of Mexico	1.00
Colima	2.34
Morelos	1.76
Coahuila	1.66
Tamaulipas	1.61
Yucatán	1.50
Campeche	1.27
Jovora	1.20
Veracruz	1.17
Distrito Federal	1.08
Puebla	.94
Sinaloa	.90
Durango	.77
Zacatecas	.75
San Luis de Potosí	.64
Hidalgo	.57
Guerrero	.52
Oaxaca	.44
Quintana Roo	.35

The data for the calculations were taken from the article of La Loza and Lima, reference 13.

Table 6. Percentage distribution* of diagnosis of cervical cancer relative to all malignant tumors. Regions and federal units Brazil, 1976-1980

		Regions				
		North	Northeastern	Center	Southeastern	South
% cervical cancer		45.2	36.1	36.3	19.6	17.8
Order of the three most frequent tumors	1	Cervix	Cervix	Cervix	Cervix	Skin
	2	Skin	Skin	Skin	Cervix	Cervix
	3	Breast	Breast	Breast	Breast	Breast
Range of percentage	High	Acre 64.3	Maranhao 66.5	Mato Grosso do Sul 44.7	Distrito Federal 35.3	Santa Catarina 23.4
	Low	Amazonas 43.3	Ceara 23.8	Mato Grosso 33.5	Sao Paulo 17.8	Rio Grande do Sul 15.3
% Invasive forms		88.9	79.6	70.0	66.9	77.3
% in situ forms		11.1	20.4	30.0	33.1	22.7

Source: Cancer No Brasil, reference 14

*The frequencies are for histopathological diagnoses of malignant tumors.

FIGURE 1:

PERCENTAGE DISTRIBUTION BY AGE FOR DEATHS FROM MALIGNANT NEOPLASM OF THE CERVIX UTERI SELECTED COUNTRIES AROUND 1980

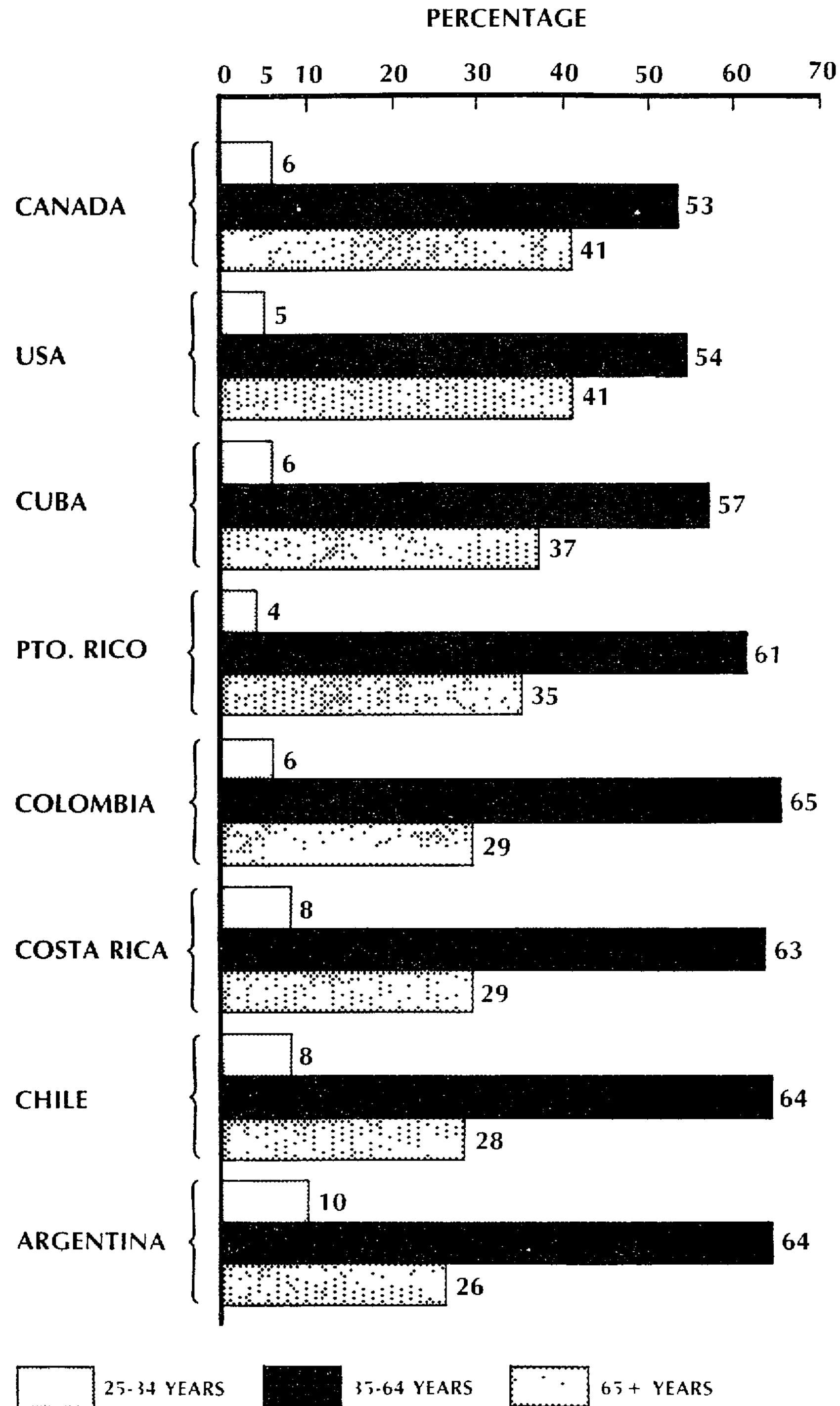
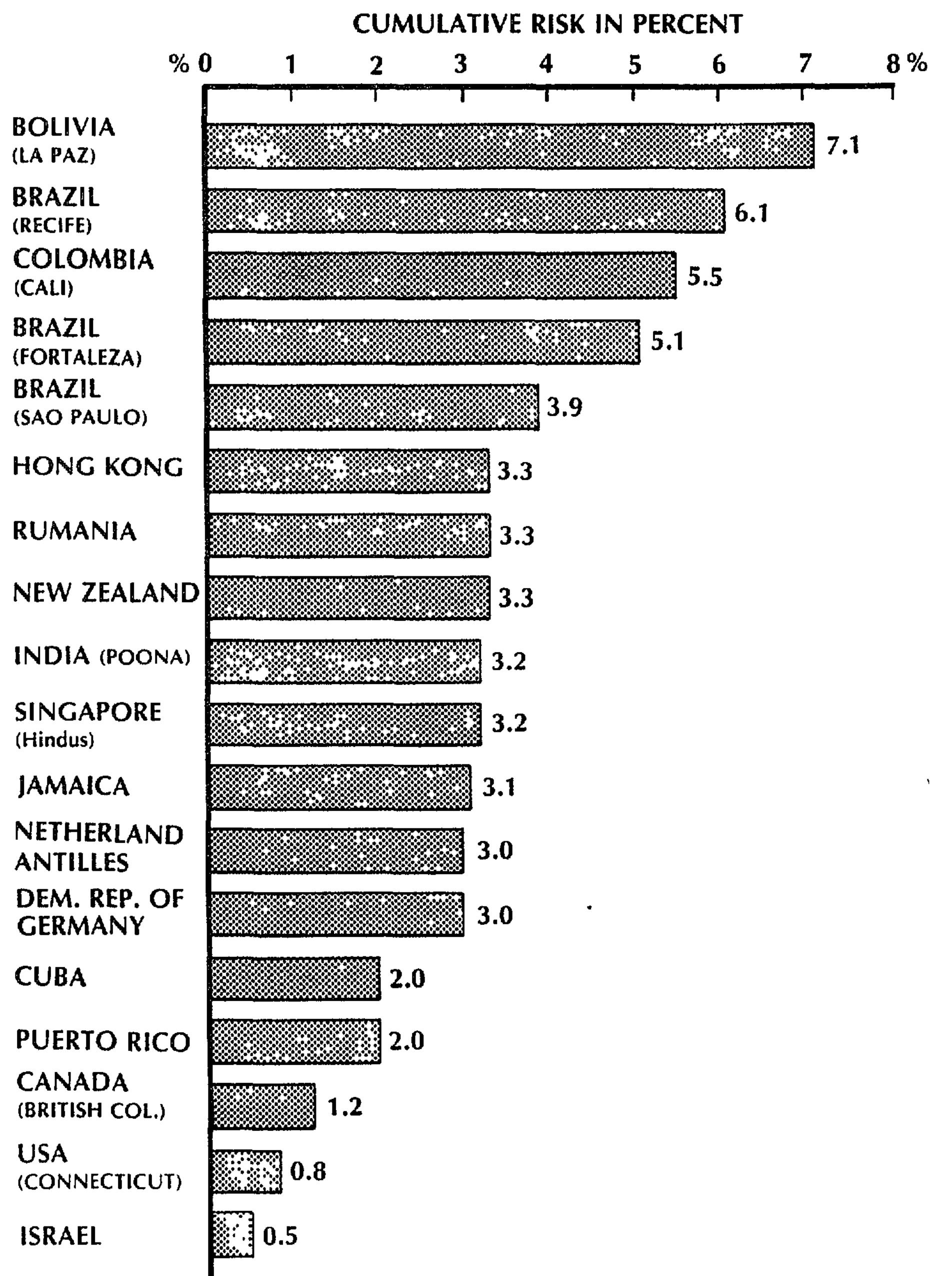


FIGURE 2:

APPROXIMATION TO CUMULATIVE RISK FOR INVASIVE CANCER OF THE CERVIX UTERI, 0-74 YEARS OF AGE*

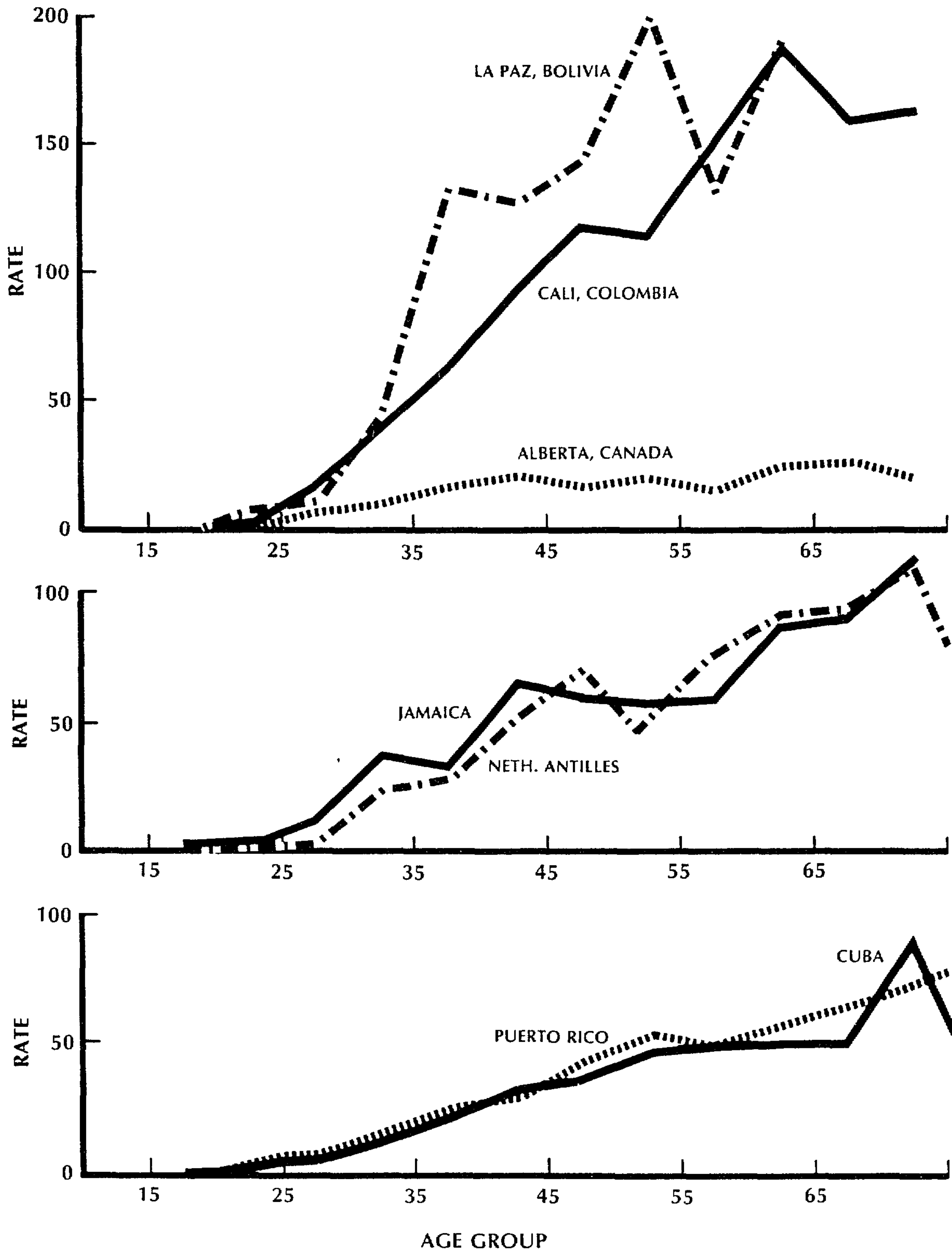


*For explanation of concept and calculation of cumulative risk, please see Technical Note

FIGURE 3:

MALIGNANT NEOPLASMS OF THE CERVIX UTERI

INCIDENCE AGE-ADJUSTED RATES PER 100,000 WOMEN



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STATUS OF WOMEN AT PASB

STATUS OF WOMEN AT PASB

A. SUMMARY OF APPOINTMENT AND PROMOTION PATTERNS OF WOMEN

Data summarizing appointment and promotion patterns are shown in Appendix I. The data provided should be looked at in terms of the overall staffing profile of the Secretariat during the period concerned, which reflect a net decrease of 157 staff members (23.8%). The proportion of women in the professional and higher categories has risen from 18.6% in 1975 to 22.2% a decade later, organization-wide. On an average, 55% of female professional staff members have received promotions during the period 1976-1985, as compared to 29.3% of male professional staff members who received promotions during the same period. There has been an increase in the absolute numbers of women occupying "senior" posts at grade P.4 and above, from 30.1% of the female work force in 1975 to 38.3% in 1985.

It might also be relevant to mention that PAHO has been active in the Task Force on Women in the United Nations system, which was established by the Subcommittee on Training of the Consultative Committee on Administrative Questions for the purpose of improving the current situation of women in the United Nations system. A PAHO Personnel Officer recently participated in a workshop of the Task Force to consider viable training proposals for female staff members. The training models that were presented to the participants at the workshop are being considered for possible adoption, dissemination and implementation in this Hemisphere.

Among the agencies of the United Nations system, only PAHO and the World Bank have had educational assistance programs to support career development, a factor of significance in career efforts for women. Of equal interest are the statistics that, during 1984, 396 females, as compared to 197 males, participated in the entire Staff Training and Development Program of the Organization. Our university-supported program covers 82 women, as compared to 25 men, who will be acquiring their professional degrees in the coming years.

B. STATUS OF WOMEN IN UNITED NATIONS AGENCIES AND OTHER INTERNATIONAL ORGANIZATIONS

The United Nations has been concerned about the status of women for many years. Since 1975 the Secretary General has included in his report several resolutions, statistics, and data related to the relative status of women and men. The most recent important document of the General Assembly is dated late 1984 and demostrates other efforts in relation to recruitment, career development, staff management relations,

and even the strengthening of the role of the Office of Personnel Services. In this connection, the UN has also established a post which is devoted to the concerns related to women and UN policies on a full-time basis.

The International Monetary Fund has no specific program on women. This might be due to their field of work, i.e. economics and finance, whereby sppointments and details of personnel originate from the top hierarchies of the Ministries of Finance and of Treasury Boards of the Bank's member states.

It is understood from the Inter-American Development Bank that they have been involved in efforts similar to ours during the past three years. In this connection, a group of professional women has been formed to study their participation within the Bank. Recommendations have been made on the issue of personnel procedures and practices related to the hiring of women professionals and promotion policies. Efforts will be made to increase the proportion of women in upper grades of the Bank.

The Organization of American States has provided statistics showing their personnel profile and the distribution of posts between males and females. However, they have no specific program designed for the promotion of women or for the improvement of their status. The Organization of American States has instead been relying on the principle of equal pay for equal work, regardless of race, creed or sex.

The World Bank and the International Finance Corporation have been active in the promotion of women; their recruitment as well as their advancement. The Bank wishes to achieve a more adequate representation at every level of its staff. The Bank encourages women to accept development assignments, such as positions in resident missions, to help women prepare themselves for managerial positions.

The World Health Organization for many years has been concerned with increasing the proportion of women within the Organization. Several related resolutions have emanated from the World Health Assembly as well as from the Executive Board. The most recent ones indicate a proposed target of 30% women at the professional levels.

The Food and Agriculture Organization's (FAO) target is to achieve a steady and measurable increase in the number of women staff members at all levels, in all occupations and at all duty stations. As one of the initiatives taken, and inter-divisional working group of women in development was established in 1976, to perform a catalytic and coordinating role within FAO and other agencies. Directives have also been given to the Professional Staff Selection Committee to select a woman candidate where two equally-qualified male and female candidates

are short-listed. The Director-General has written to all FAO member states, requesting their cooperation in nominating suitable female candidates. Although a steady increase in the recuitment of women has been noted over the years, one difficulty continues to be the insufficient number of applications from qualified and experienced female candidates in the highly-specialized fields of the Organization.

UNESCO has introduced the following measures: 1) reminder in letters notifying member states of vacancies, 2) broadening of contacts for recruitment to include associations and institutions likely to promote female candidatures, 3) systematic retrieval by the Office of Personnel of females candidates from central roster, 4) careful checking of job descriptions to eliminate discriminatory exigencies and, 5) giving priority to women when equally qualified in the framework of the trainee programme. The principal obstacle identified by UNESCO is the lack of qualified female candidates from under represented countries. It is felt that progress in this area is closely related to the access of women to higher education in Member States and, the need to develop positive attitudes concerning women professionals.

APPENDIX I

a) STATUS OF WOMEN IN PAHO

1975-1985

HEADQUARTERS AND FIELD

		Sin Clas.	D2	P6 D1	P5	P4	P3	P2	P1	TOTAL	(%)
MALE	1975	2	2	17	154	243	50	42	28	538	(81)
	1985	4	3	12	124	168	34	39	8	392	(78)
FEMALE	1975	0	0	1	3	33	47	25	14	123	(19)
	1985	0	0	2	7	35	29	22	18	113	(22)
TOTALS	1975	2	2	18	157	276	97	67	42	661	
	1985	4	3	14	131	203	63	61	26	505	

b) Comparison of Women Professionals in PAHO with Other International Organizations

December 1979 and December 1984

Organization	Headquarters				Field Offices				Total				PERCENTAGE
	Dec. 1979		Dec. 1984		Dec. 1979		Dec. 1984		Dec. 1979		Dec. 1984		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	CHANGE
ADB	n.a.	n.a.	17	2.9	n.a.	n.a.	0	--	n.a.	n.a.	17	2.9	--
IDB	66	11.8	99	16.1	0	--	6	3.3	66	9.3	105	13.2	3.9
IMF	187	23.1	220	22.5	1	10.0	3	10.7	188	22.9	223	22.2	-0.7
OAS	155	23.4	146	18.2	7	5.8	12	4.3	162	20.7	158	14.6	-6.1
PAHO	55	28.9	68	31.8	69	16.7	44	15.2	124	20.6	112	22.2	1.6
United Nations	516	27.8	631	32.7	273	15.4	388	18.1	789	21.7	1,019	25.0	3.3
UNDP	95	24.7	93	24.0	38	11.6	67	19.0	133	18.6	160	22.0	3.4
World Bank/IPC	322	12.2	436	13.9	8	6.0	5	3.8	330	11.8	441	14.0	2.2
WHO	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	279	17.0	241	16.6*	-0.4

Source: IDB, as provided by Personnel Officers of the organizations listed.

*As of October 1984

c) ADDITIONAL DATA ON CONTRACTING WOMEN AT PASB

(1) Senior level personnel (P.4 and above)

	1975	1985	
Female	30.1%	38.3%	(percent of all female professionals)
Male	69.1%	61.7%	(percent of all male professionals)

(2) Short-term contracts (Short-term consultants and temporary advisors)

	1982	1984	
Female	15.8%	22.4%	(percent of all female professionals)
Male	84.2%	77.6%	(percent of all male professionals)

Total number of women on short-term contracts in 1984 = 373