Fourth Canadian Conference on International Health

Conference Theme: Women, Health and Development

Notes for a presentation:

Women, Health and Development: A Holistic Approach

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I want to start with something unusual and so I will share a poem with you that will help to initiate my discussion. It is called *Old[er] Women's Choices*[1]:

We keep our thermostats at fifty-nine
so we can give our children gifts
we really can't afford.

We buy bruised, overripe fruit
from the distressed produce
and donate to our churches.

We buy our own clothes at thriftshops
but select grandchildren's presents
from the nicest shop in town.

We eat the same boring dinner every day
because we won't cook for ourselves
but produce a feast for guests.

We never say we need help when we do
but do without, not wanting to burden
those whose burdens we carried.

Some of us break out of these patterns
realize we have rights and choices
to care for ourselves too
but it is hard to forget early teaching.

Even after all these years
we put ourselves last.

Written by Ruth Harriot Jacobs, the poem gently asks us to reflect on our mental constructions of women. Our mental pictures of the world's women must consider a vast range of diversity including the vision of this older women as well as the young girl who has just been through her first cycle of menstruation or who has crossed the threshold and rights of passage. The poem reminds us of the socially constructed and deeply rooted roles and choices in which women partake. And women are socially reinforced in these behaviours: historically, society has put women last. And to the extent that public systems mirror social norms, both public and private, we find similar attitudes and choices reflected in publicly funded health systems. A few

[1] Jacobs, Ruth Harriet. ***Old Women's Choices,* If I had my life to live over I would pick more daisies**, edited by Sandra Haldeman Martz, Papier-Mache Press, USA, 1992, p186.

examples will serve to reinforce how this marginalization occurs. Health and well-being are not only determined by socio-cultural, economic, environmental, behavioral and biological factors, which differ for men and women, but gender is also an important factor in whether a person fully enjoys the resources and opportunities related to these factors. Women historically have more limited access to economic resources, enjoy less personal autonomy, and are under-represented in institutions and decisionmaking processes of governance. As providers women are most often health care workers rather than policy makers and so have almost no control over how research is interpreted and resources allocated. As beneficiaries of services, the full range of their health care needs are not addressed as priorities. Health care research often reinforces these disparities, because most formalized knowledge production neglects the differences between men and women and their social contexts as these factors apply to a range of health care issues. To many of you here, this understanding is not news, but it bears repeating because it is only through understanding the whys and the hows of this marginalization in health that can we begin to reverse this process.

Aujourd'hui, je réponds à votre invitation pour parler de la recherche innovative qu'impulse le Centre de recherches pour le développement international. L'approche du CRDI devant les questions entrelacées du rôle des femmes, de la santé et du développement s'inspire d'une intime conviction, à savoir la nécessité de comprendre par quelles voies les institutions et les chercheurs pourront être amenés à ne plus reléguer les femmes au dernier rang (ou pire, à les ignorer tout à fait)[2]. Nous pouvons entreprendre de la recherche qui dans la perspective de la restructuration des soins de santé et d'autres systèmes sociaux redonnera aux femmes la primauté sur des résultats obtenus parfois à leur corps défendant.

I start my exploration with an observation about a situation that seems to exist everywhere in the area of women and health: this is the dilemma of high attention but scarce resources. For example, despite high attention being given to women's health issues, such as breast cancer, we in Canada are also facing domestic health care cuts, of which the closing of the Women's Hospital in Toronto is but one example. On the international level, Canada has not lost its interest in the state of worldwide health related issues. Indeed, within the last year and apart from this conference, Canada has demonstrated its leadership and interest in this area by hosting at least three international conferences related to women's health issues.[3] Yet even while awareness surrounding these concerns is high, the available resources lag behind the demand. Determination and foresight will be required on the parts of researchers and practitioners to share their research results and to coordinate their activities. Scarce resources can be wasted in duplication of efforts and on competition rather than collaboration.

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[2] Fugh-Berman, Adriane, *Training doctors to care for women",* Technology Review, Feb/March 1994, pp. 34-40.

Vlassoff, 1994 C. *Gender inequalities in health in the Third World: unchartered ground.* Social Science and Medicine, Vol. 39, No. 9, pp 1249-1259.

[3] World Conference on Breast Cancer, Kingston, Ontario July 13-17; 8th International Congress on Women and Health Saskatoon, Saskatchewan June 7-10, Canadian Public Health Association, July, Halifax, Nova Scotia.

Dans un tel esprit de coopération indispensable et compte tenu de son expertise dans l'aide à la recherche pour le développement, le CRDI a concentré ses actions dans quelques domaines de programme choisis qui affrontent la problématique de la santé et du développement. Je m'arrêterai sur quatre avenues de recherche - en donnant des exemples de projets ponctuels pour chacune d'entre elles et en terminant par une brève liste de projets dignes d'intérêt que le CRDI mène à bien dans le cadre d'initiatives multiples.

Les grandes avenues de recherche que je viens de mentionner sont les suivantes :

(1)Écosystème et santé humaine
(2) Initiative Micronutriments
(3) Initiative internationale sur le tabac
(4) Évaluation de la réforme des politiques sociales (Décentralisation)

For those of you who are less familiar with IDRC, I offer the following explanation. Following the 1992 Earth Summit, the Canadian government of the day tasked IDRC with the mandate to support research in the South that would help to address problems relating to environmental challenges. Based on this backdrop, one of the Centre's programming areas has evolved into a research framework called Ecosystem Health.

Within this area, research proceeds on the understanding that the health of environmental diversity influences human health. The Centre is not alone in this belief. Women's groups have long since recognized the link between the health of the environment and women's health. This link has been recognized publicly in several world conferences such as the 1991 World Women's Congress for a Healthy Planet, which took place in Miami, Florida in preparation for the Earth Summit. And more recently, at the 1997 World Conference on Breast Cancer, in Kingston, "environmental ills" were identified as a potential contributor to the rise in breast cancer in developing countries. These conferences, and the 4th World Conference on Women[4] have displayed an interest in the interface between women's and environmental health, in part, because of women's obvious and undisputed role in food security and nutrition. Among women there is also growing interest in the health consequences associated with the dumping of hazardous and toxic wastes, as well as the uses of unsafe pharmaceutical, agricultural, and consumer products.

It is not hard to draw the connections between ecosystem stress and a disproportionate burden falling onto women's already heavy workloads. In Africa and Asia, women constitute more than 50% of the workforce on agricultural ecosystems. If the land is overworked, it is more often women who must increase their labour to maintain production levels. If water is polluted, the care of those who become ill by using it often falls to women. And considering their

[4] The Beijing Declaration and The Platform for Action, United Nations, New York, USA, 1996, Chapter K Women and the environment, pp 137-145.

disproportionate assumption of household and family health care work, in addition to the agricultural labour, women's support and involvement in the solutions is essential.

IDRC's support for Ecosystem Health addresses the state of dynamic balance among the different living and non-living components of an ecosystem.[5] A trans-disciplinary approach is used to identify the determinants of and opportunities to improve human health that exist within ecosystem management. For example, one research project has looked at the issue of mercury exposure in communities living along the Amazon.[6] From the outset, this research has addressed the differential health impacts on women and men. Gold extraction techniques cause over 130 metric tons of mercury to be spilled annually in the Brazil Amazon. Thus, mercury contamination and large-scale destruction of the aquatic ecosystems have become focal points of environmental concern. Committed to a trans-disciplinary approach the research team is composed of 14 types of experts from different disciplines and the community.[7] Until recently, the suspected cause of the mercury-related human health problems was gold mining. However, research demonstrated that most of the mercury pollutants have come from soil where forests had been cleared. The mercury enters the food chain of adjacent aquatic systems and accumulates in fish, a major component of the human diet.

Cette approche a produit des résultats intattendus qui ont conduit à encourager les actions tendant à minimiser le rejet de mercure des sols forestiers et à réduire le déplacement du métal dans les écosystèmes aquatiques. Pour une grande partie, les données critiques de cette recherche ont été mises au jour grâce à la participation de la communauté concernée par l'étude et les connaissances dont elle était dépositaire en matière d'alimentation, de pêche et des pratiques de déforestation. Dans une deuxième phase de la recherche, les méthodes participatives seront mises davantage en valeur afin que l'équipe de recherche puisse collaborer avec les collectivités pour trouver les mesures correctives devant privilégier la gestion de l'écosystème, mettre un frein à la déforestation et réduire d'autres apports de mercure.[8]

Turning to the second of the four programme areas that I will address, I start by noting that the UN estimates that about 500,000 women die each year from pregnancy complications.[9] Of these

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[5] Ecosystem Health Programme Initiative, 1997, p 3.

[6] Ecosystem Health Prospectus, IDRC, 1997, p. 2. Example extracted from text with minor changes.

[7] The team consisted of a medical doctor, an engineer, a sociologist, a cytogenetecist, a botanist, an ichthyologist, a biogeochemist, a neurotoxicologist, numerous environmental scientists and advocates, a nurse, a community agent, a fisherperson, and a community leader.

[8] Ecosystem Health Prospectus, IDRC, 1997, p. 2. Example extracted directly from text with minor changes.

[9] The Worlds Women: Trends and Statistics, UN, New York, 1995. A more recent estimate of maternal mortality and morbidity suggest that approximately 600,000 women die annually. See *The Progress of Nations,* UNICEF 1996.

deaths, a rough and conservative estimate suggests that 20% are linked to anaemia.[10] Moreover, women suffer disproportionately from iodine and vitamin A deficiency.[11] The Beijing Platform for action called upon governments to: "implement programmes to improve the nutritional status of all girls and women...giving special attention to the gender gap in nutrition and a reduction in iron deficiency anaemia in girls and women ...".[12] Research on the relationship between iron deficiency anemia and maternal mortality has been undertaken by IDRC's Micronutrients Initiative. One of the three main goals of the Micronutrients initiative is to reduce iron deficiency anemia in women by one third of the 1990 levels by the year 2000. This concrete goal is an example of a group of donors[13] working collaboratively to end hidden hunger and address the concerns of NGOs and governments as expressed at the 4th World conference on Women. For example, one project will work with communities in Malawi to promote dietary diversification in order to combat iron and vitamin A deficiencies.[14]

Sur un autre front, le CRDI répond à un appel lancé par la Plate-forme d'action de Beijing afin de « sensibiliser les femmes, les professionnels de la santé, les décideurs et le grand public sur les risques pour la santé graves mais susceptibles de prévention dont le tabagisme est la cause principale ainsi que sur le besoin de mesures de réglementation et d'éducation destinées à réduire la consommation du tabac dans le cadre des activités de promotion de la santé et de prévention de la maladie»[15]. L'Initiative internationale sur le tabac financée par le CRDI et Santé Canada aborde les questions liées aux politiques publiques et aux aspects touchant aux pratiques culturales, à l'économie, à l'environnement et a la santé en rapport avec la production et la consommation du tabac. Cette initiative poursuit des recherches en Afrique du Sud où, par effet des stratégies de marketing de l'industrie qui ciblent en particulier la population des femmes et la jeunesse, le nombre de fumeurs ne cesse de croître. Les travaux de l'Initiative internationale sur le tabac aideront à introduire en Afrique du Sud des mesures de lutte contre le tabac et des lois visant à contrer les pressions de ce type de campagne de marketing agressive.

The Beijing Platform for Action also provides another useful context for IDRC research into health. The "Women and Health" chapter states that "women's health... is determined by the

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[10] Ross J.S. and E. Thomas in *Iron Deficiency Anemia and Maternal Mortality*, Profiles 3, Working Notes Series No. 3, MI, Ottawa, 1996. Mimeo.

[11] Haque, Yasmin Ali. *Micronutrient Deficiency -- The Women's Perspective*, prepared for the MI, Ottawa, 1995. Mimeo.

[12] The Beijing Declaration and The Platform for Action, United Nations, New York, USA, 1996, paragraph 106, p. 62.

[13] List of donors include CIDA, IDRC, UNICEF, the World Bank, UNDP

[14] Project 02838

[15] The Beijing Declaration and The Platform for Action, United Nations, New York, USA, 1996, paragraph 107, p. 66.

social, political, and economic context of their lives, as well as by biology."[16] The UN document also states that inequality is a major barrier to improved women's health, and that "Women have different and unequal access to and use of basic health resources." [p.56]

IDRC's programming area called Assessment of Social Policy Reform deals with the comparative assessments of public policy reforms in education and health and of programs aimed at reducing poverty or providing social assistance. By incorporating a gender sensitive analysis as a basis for understanding social policy construction, research can begin to assess critically and constructively the ability of health workers in decentralized health systems to address the health needs of the women, children, and men. The Beijing Platform for Action called on governments to: "Design and implement, in cooperation with women and community-based organizations, gender-sensitive health programmes, including decentralized health services, that address the needs of women throughout their lives...[and] especially local and indigenous women, in the identification and planning of health-care ... programmes."[17] What follows are a few examples of research that address this concern:

Le CRDI aide la recherche tendant à mettre en évidence le lien entre les interventions du personnel sanitaire d'une ville argentine, d'une part, et les pratiques de santé courantes et les revendications des femmes, de l'autre. La recherche étudie les perceptions des femmes adultes non enceintes et non allaitantes (âgées de 40 à 60 ans) au sujet de la prestation des services de santé et l'appréciation du caractère équitable et efficace de ces services[18]. Une autre étude qualitative vise à explorer le rôle de la femme dans la prestation des soins de santé dans une société à prédominance musulmane[19]. Dans certaines cultures, les femmes semblent être plus encline à taire leurs préoccupations de santé, peut-être par fierté, pudeur excessive devant les examens médicaux ou manque de temps et des moyens requis en vue de l'obtention des soins.

IDRC, in partnership with the Pan American Health Organization, is also funding research in Lima, Peru, and Buenos Aires, Argentina, that will assess how responsive health care providers are to their clients' individual, social, cultural, and medical needs. A similar project is being supported in Turkey.[20] Representatives of local women's organizations and experts in the area of quality of care will work together to develop a mutually acceptable framework to counteract gender disparities in the delivery of health care. This framework can be used to sensitize both health care practitioners and users about more appropriate patterns of delivery and uses of health

[16] The Beijing Declaration and The Platform for Action, United Nations, New York, USA, 1996, paragraph 89, p. 56.

[17] Ibid., paragraph 106 c, p. 62.

[18] IDRC project number 92-0212

[19] IDRC project number 02094

[20] IDRC project 94-412 and 02094

care services and products.[21]

La Plate-forme d'action de Beijing a invité également les gouvernements à : « appuyer les systèmes de services de santé... afin d'accorder le soutien approprié aux femmes en tant que prestataires de soins de santé et d'examiner les règles utiles à la prestation de services de santé aux femmes et à leur utilisation par les femmes »[22]. La recherche montre que la prévention des infections et des décès puerpéraux est possible dès lors que les complications de l'accouchement sont reconnues et traitées. Un projet Canada-Nigéria a permis la participation d'une centaine d'accoucheuses traditionnelles au travail de dépistage des problèmes rencontrés à la naissance se traduisant par une admission précoce en milieu hospitalier. Certaines femmes enceintes ont peut-être refusé des traitements substitutifs pour des motifs d'ordre culturel et spirituel, auxquels s,ajoute parfois une méfiance manifeste à l'égard de la possibilité de conjuguer nouvelles technologies et soins prénatals traditionnels. Un projet de suivi a permis l'établissement d'un centre spécial de traitement et de convalescence pour les femmes atteintes des séquelles d'une naissance dysfonctionnelle, telles que des infections des voies urinaires, des dysfonctionnements intestinaux et des fistules vaginales. Des recherches plus poussées permettront d'apprécier la satisfaction des besoins des femmes traitées pour des lésions consécutives à l'accouchement et la manière d'améliorer ces traitements[23].

While I have outlined four key research entry points in the area of development and health, there are interesting projects worth noting which exist outside these four frameworks. Broadly defined these projects address women and violence, occupational health, customary practices, and statistics.

For example, a project in Soweto, South Africa will construct integrated programmes to address the issue of sexual violence. Another in Palestine will explore the nature and consequences of violence as it affects family health and women, in particular.[24] IDRC is also contributing to a multi-donor funded initiative that is examining the role of women in post-conflict rebuilding. Wars, forced migration, and civil unrest can destroy healthy environments and prevent adequate health care. International boycotts can impede women from maintaining nutritional standards, obtaining health care or travelling to health care services. Within the context of this research women are not treated as passive recipients of assistance but are seen as leaders in the survival efforts of their families, and their efforts must include negotiating and managing their families' health needs, even and perhaps especially during stressful periods.

Occupational health issues relevant to women are gaining attention in many countries. IDRC

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[21] IDRC project number 95-0207

[22] The Beijing Declaration and The Platform for Action, United Nations, New York, USA, 1996, paragraph 109 g, p. 71.

[23] IDRC project number 01041

[24] IDRC project 96-340

funded research in Turkey seeks to analyze the occurrence of chronic obstructive lung disease prevalent in women in villages near Keskin who are chronically exposed to household burning of wood and manure. The research will assess what health improvements can be achieved by introducing feasible interventions to reduce indoor smoke exposure.[25] A project funded through ENGENDER, a Singaporean based NGO with a global mandate, will address sustainable livelihood issues, assessing, for example, if environmentally friendly dyes can replace some of the more harmful ones used in textiles.[26] ***La main-d'oeuvre féminine est prédominante dans le secteur des matériaux de construction au Viet Nam. Les recherches préliminaires tendent à prouver que l'incidence des maladies industrielles va croissant. La recherche financée par le CRDI évaluera les risques associés à la pollution sur les lieux de travail et la prévalence des maladies professionnelles chez les personnes exposées. La recherche s'avère nécessaire pour établir les critères et les normes qui aideront à protéger la santé des travailleuses et des travailleurs[27].***

A small IDRC Doctoral Research Award will address female circumcision in Mali where some estimates suggest that up to 80%[28] of the women are affected by this custom. The research will suggest alternative policies and interventions that can be used to reduce the prevalence and ultimately help to eliminate this practice.[29]

Since the Beijing conference, the Centre has funded two studies addressing the lack of empirical studies on women and women's work. Both project goals are ambitious. One project will assist in the design, implementation and institutionalization of a national gender statistics program in Arab countries that can be used as a tool for developing and monitoring healthy public policies.[30] The linkages between women, work, and health are gaining attention because of the emerging evidence of gender differences in workload distribution and the impact of disproportionate and often increased burdens on health and stress. A second project designed to assist in the process of engendering labour statistics will attempt to broaden the definition of work. It will articulate ways and means for national statistical offices to collect data and become informed about women's productive roles outside of formal markets. The statistical evidence will help to transform women's covert conditions into overt formulations, thus making it easier for decision makers to develop gender sensitive policies.[31]

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[25] Project number 95-0216

[26] Project number 02177

[27] Project 03017

[28] WIN News, USA, Summer 1997, p. 24.

[29] Project 96-0800-11

[30] Project 96-0216. Other donors include UNICEF, UNIFEM, Regional Bureau for Arab States of the UNDP. The Centre of Arab Women for Training and Research (CAWTAR) is working with the implementing agency, UN ESCWA.

[31] Project 03427

While perhaps not IDRC's niche, I cannot resist briefly drawing your attention to at least two areas of research that could make a difference in women's health and development. One area of concern is the occupational health of workers in export processing zones, and the second is the full exploitation of articles 2 and 12 of the Convention for the Elimination of Descrimination Against Women (CEDAW).

It does not take much imagination to predict that the promotion of free trade will probably persist into the next millennium. To date more than 60 countries have created industrial zones, in part, to attract foreign capital. Many of the export processing zones (or EPZs) display a preference for hiring young women. Although perhaps not the worst working conditions of women employed in the formal sector, from a health perspective the environment is less than ideal in these zones; the double standards become apparent when one compares these conditions with the standards set by national policies and laws guiding labour practice in the head offices of transnational companies. Research that documents and brings to light differences in standards, and presents ways and means to improve the working environments of employees in EPZs is needed. [32]

A large majority of the world's countries have ratified CEDAW, which in article 2 addresses the state's obligations to eliminate discrimination and in article 12 specifically addresses equality in access to health care. The notion of one's right to equitable health care and other social services are rights of which, in my view, full advantage has not been taken. As a step in this direction, I recommend a list of questions set out by the NGO, *international women's rights action watch*, which provides a useful guide to assist researchers and advocates in assessing states' compliance with their CEDAW obligations. Copies of these guidelines are available if you are interested (attached).

Conclusion

The poem I opened with reflects the decision making processes of many of the world's women, attitudes that are both supported and mirrored by public health systems. My closing remarks start with something I received via e-mail. If you are on e-mail, you are probably familiar with the e-mail jokes sent to you by friends and one, in particular, that lists English signs found throughout Europe. In it you find such oddities as a Swiss restaurant advertising: "Our wines leave you nothing to hope for", or a Rome laundry exhorting its patrons: "Ladies, leave your clothes here and spend the afternoon having a good time." But surprisingly, I found one related to the topic of my remarks here today. A doctor's office in Rome advertised that the doctor was a specialist in women and other diseases.[33]

This last sign reminds me poignantly of the history of women's health and women's struggle to

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[32] For more details see: Beneria, Lourdes, *A Global Vision of Women, Health and Work,* Women's Health Journal, 1/96, pp 4-13.

[33] For a feminist exploration of modern sciences' take on reproductive health See: Martin, E. 1989 The women in the body: A Cultural Analysis of Reproduction Milton Keynes: Open University Press.

reclaim control over their bodies. Given their integration into every aspect of reproductive, family, food production, and social functions, women's life spaces[34] require a definition of health that fully accounts for their diverse experiences and that returns agency and decision making to them. ***Nous avons appris cette leçon en oeuvrant dans le domaine de la recherche en développement. C'est la raison pour laquelle le CRDI appuie désormais des équipes multidisciplinaires afin d'explorer la complexité des questions dans toute son étendue, conjointement avec des approches participatives qui associent la femme bénéficiaire et ses connaissances, sans oublier pour autant de placer les besoins qu'elle exprime au coeur du processus. J'ai remarqué que les membre de WEDO (wee-doo) qui ont organisé la Conférence mondiale sur le cancer du sein à Kingston ont mis intelligemment l'accent sur les mêmes points. Ils ont encouragé les scientifiques, les artistes, les médecins et les avocats, les dirigeants politiques, les écologistes et les militants des droits et de la santé humaine à participer à l'élaboration du plan d'action mondial visant à éradiquer la maladie. Et un simple coup d'oeil au programme de la Conférence canadienne sur la santé internationale suffit pour constater qu'elle rallie avec succès et perspicacité à sa cause un large éventail d'expériences et de talents. Je vous remercie infiniment pour l'occasion que vous m'avez donnée de passer en revue le concours que le CRDI, un acteur parmi tant d'autres de l'action menée en association avec des organisations du monde entier, apporte en vue de l'aboutissement de cet effort si complexe et si important.***

[34] Term used by Bonnie Kettel, *Women, Health and the Environment*, Social Science and Medicine, 1966, Vol. 42, No. 10, pp 1367-1379.

Annex A
Accountability and Implementation: Questions to Ask[35]

l. What measures have been taken to eliminate discrimination against women in the field of health care?

2. Do women have the same access as men to health care services?

3. Is medical care for women during pregnancy and in the post-natal period free of charge?

4. Does the State seek to ensure that women receive adequate nutrition during pregnancy and lactation? If so, in what ways?

5. What health facilities and personnel are available for women? This could include hospitals, clinics, health posts, and other facilities as well as physicians, nurses, auxiliary health personnel, family planning workers, and community agents. Are there any health facilities and personnel dedicated to the health needs of women?

6. What are major causes of female mortality and morbidity?

7. What is the maternal mortality rate?

8. What are the infant and child mortality rates for boys and for girls? What are the major causes of infant and child mortality and mortality for girls? What are the major causes of infant and child mortality and morbidity for boys?

9. What is the average life expectancy for men and women?

10. What are the crude birth rates and crude death rates for men and women?

11. What percentage of women receive prenatal care?

12. What is the average number of live births per woman?

13. What is the unmet need for contraception?

14. What is the prevalence of contraception, by method?

15. What legal or cultural obstacles are there to women receiving health care services including family planning?

16. How many women work in the health sector? In what areas of the health sector do they work? At what level of seniority in these areas do they work?

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[35] International Women's Rights Action Watch (iwraw), **Assessing the Status of Women**: **A Guide to Reporting Under the Convention on the Elimination of all Forms of Discrimination Against Women,** USA, Second Edition, 1996, pp 34-35.

17. Does the country have traditional health workers? If so, what do they do? How many traditional health workers are women?

18. Is the husband's authorisation required, either by law or in practice, before a married woman can receive health services including family planning?

19. Does the State have any laws or policies that require use of family planning measures? If so, are there any consequences, such as financial penalties, where these laws or policies are not complied with?

20. Is abortion legal? If so, under what circumstances? Is the cost of abortions covered under national medical insurance or social security? Can poor women receive free or subsidised abortions? If abortions is legal, how available are services in practice?

21. Is pre-natal foetal testing available? If so, what is the incidence of abortion following pre-natal testing? If there is incidence of abortion following pre-natal testing, what are the major reason for such abortions?

22. Does the State have any laws or policies requiring abortion? If there are such laws or policies, are the wishes of the mother taken into consideration when determining whether an abortion should take place?

23. If abortion is not legal, is it performed anyway? What statistics are available for death and/or illness due to or related to abortion? What provisions are made for care of women with incomplete abortions?

24. Is elective sterilisation available? If so, what is the incidence of elective sterilisation for women? For men?

25. Does the State have any laws or policies requiring sterilisation? What sanctions exist for failure to comply with these laws or policies?

26. Is female genital mutilation or circumcision practised? If yes, under what circumstances? Is it legal?

27. Do any groups in the country perpetuate practice (for example, dietary restrictions for pregnant women) that might be harmful to women's health? If so, what measures have been introduced to eradicate such practices?

28. What measures have been introduced in the country to increase public awareness of the risk and effects sexually transmitted diseases, particularly, HIV/AIDS? Have any if these measures been aimed specifically at women and girls?

29. Have any programmes been introduced to combat sexually transmitted diseases, particularly HIV/AIDS? If so, are any of these programmes dedicated to women and girls? Do any of these programmes pay particular attention to women's reproductive role and female subordination as factors that make women and girls vulnerable to sexually transmitted diseases, particularly, HIV/AIDS?

30. What measures have been introduced to ensure the participation of women as health care workers in the context of HIV/AIDS?