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# Gender, Health, and Sustainable Development

**Proceedings of a Workshop held in Nairobi, Kenya, 5–8 October 1993**

Edited by
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The International Development Research Centre
Le Centre de recherches pour le développement international
El Centro Internacional de Investigaciones para el Desarrollo

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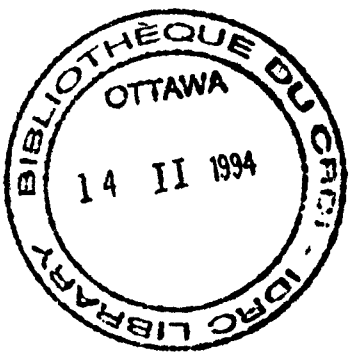


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# Special Issues to Consider When Doing Research on Women[1]

Eva M. Rathgeber[2]

***Why should we look at women separate from men?***

At the most general level, we have been involved in international development efforts since the 1950s. Despite the thousands of programs that have been established in education health, agriculture, and economic development, however, many countries are less affluent today than ever before. It is obvious that something has gone wrong and that mistakes have been made. Reasons are varied and some go far beyond the focus here but argue that one mistake that we have made is to assume that the norm of male experience is equally applicable to women - that women have the same attitudes and perceptions, the same opportunities and lack of opportunities, and the same needs as their male counterparts. For this reason most of the programs and projects we have designed in the past have to some degree bypassed women. They certainly have not recognised and made use of women's knowledge and capabilities.

This is true with respect to virtually all aspects of international development, but at a more specific level related to health, one might point to a few pertinent facts:

- women have special health problems that men do not experience;
- women are more vulnerable to certain conditions than are men;
- some health conditions are less easily detected in women;
- women's health directly affects child survival chances; and
- women's needs are often neglected if not specifically identified.

As noted, some health conditions particularly affect women. These include:

- malnutrition (especially protein and iron deficiencies);
- maternity;
- family violence;
- sexually transmitted diseases, which are often particularly difficult to diagnose in women;
- cervical and breast cancer; and

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[1]The ideas in this overview have been greatly influenced by World Federation of Public Health Associations, Women and Health. Information for Action Issues Paper. Geneva, Switzerland, WFPHA, 1986.

[2]Regional Director for Eastern and Southern Africa, IDRC, Nairobi, Kenya. Formerly Coordinator, Gender and Development, IDRC, Ottawa, Canada.

- occupational hazards (women often do jobs with the lowest levels of pay and little protection with respect to working conditions).

My main focus is on the socio-cultural and socio-economic factors connected with women's health. I would like to consider a few issues related to women's roles as health care users and providers, and point out research methods which could be used to capture women's roles and contributions.

***What do we know about women? From where do we get our information? National and international statistics about women's economic roles can be misleading for a number of reasons:***

- they often are not disaggregated by gender;
- they under count women's work and tend to ignore entirely the work done by women within the household;
- they focus only on formal labour force participation and therefore do not capture the work done by women in the informal sector;
- they do no count or under count the numbers of female-headed households (which number up to 40 percent worldwide);
- they do not give information about the underlying socio-economic and cultural structures which cause or relate to high female malnutrition, low literacy rates, or high morbidity.

***It is important to realize that social conditions are different for men and women. For example,***

- in areas of food scarcity, women often eat last and less;
- lack of education makes it difficult for women to obtain well-paying jobs (nonetheless, nutrition levels in female-headed households still tend to be higher than in male-headed households, on average, since women are more likely to spend higher proportions of their incomes on food);
- women often are paid less money for doing the same work as men;
- they often are pressured by husbands and relatives to have large families;
- there is often a preference for male children, coupled with a tendency to give less care to female children, including food, medication attention, immunization, vaccination;
- women tend to work longer hours - there are differences from region to region, but estimates vary from 16-20 hours per day in some areas;
- women often have little or no leisure time, especially during certain agricultural seasons.

*Women often are not permitted to speak for themselves, because:*

- male household heads speak for them, even on subjects about which women may have more intimate information;
- in some cultures, women spend large proportions of their lives in seclusion, completely cut off from contact with the outside world.

As researchers, we have tended to accept this too easily. We must develop ways of getting around it, and of ensuring that women are permitted to speak for themselves, to describe their own problems and constraints, and to participate actively in finding ways to improve their situation.

***Despite these constraints, and disadvantages, women are the main health providers of most households. They are responsible for:***

- the provision of safe and abundant water;
- food production, preparation, serving and storage;
- breast feeding and weaning;
- routine child care, including home treatment of common problems such as diarrhoea;
- taking children for immunization; and
- often for taking children to clinics.

***How can we collect better information on women?***

There are some useful methods such as rapid appraisal, using a combination of interviews and observations to obtain an overview of any given situation. Focus group interviews are also useful as a method of gaining specific information about a topic which might be too sensitive for one-on-one interviews.

***What kind of information do we want to have?***

This, of course, will vary, depending on specific cases, but a general checklist might include information about:

- health conditions that mainly or solely affect women;
- chronic or asymptomatic conditions for which women rarely seek treatment;
- women's own sense of community priorities;
- women's reaction to quality, content and convenience of available primary health care services;
- women's daily activity patterns and its relationship to personal and family health;
- women's education levels and access to community media;
- women's economic and productive activity inside and outside the household;

- resource allocation patterns within the family;
- decision-making patterns within the family;
- family and non-family child care arrangements;
- who cares for children when they're sick;
- capacity and function of local women's organizations;
- the level of women's participation in other community organizations;
- religious and cultural factors affecting women; and
- factors affecting women's participation in health sector training and employment.

For further information on this topic, particularly as it relates to tropical diseases, please see Eva M. Rathgeber and Carol Vlassoff, Gender and Tropical Diseases: A New Research Focus, *Soc.Sci.Med.* Vol. 37, No. 4, pp 513-520, 1993.

***ABSTRACT*** This paper examines the underlying assumptions that have led to a lack of attention to women's health, particularly in developing countries, beyond the context of their reproductive roles. It is argued that the peculiar nature of women's responsibilities both in economic production and within the family, may have a profound impact on the extent to which they are affected by tropical diseases and their responses to disease. It is suggested that the gender relations of health are of considerable significance in explaining the differential consequences of tropical disease on women, mean and children. The paper proposes a framework for gender-sensitive research on this topic and suggests some new directions for research.