Gender, Health, and Sustainable Development

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

Edited by
Pandu Wijeyaratne,
Lori Jones Arsenault,
Janet Hatcher Roberts, and
Jennifer Kitts
Gender, Health, and Sustainable Development

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

Edited by
Pandu Wijeyaratne,
Lori Jones Arsenault,
Janet Hatcher Roberts, and
Jennifer Kitts

INTERNATIONAL DEVELOPMENT RESEARCH CENTRE
Ottawa • Cairo • Dakar • Johannesburg • Montevideo • Nairobi • New Delhi • Singapore
Contents

Foreword
   Panduka Wijeyaratne

Acknowledgements

Introduction
   Maureen Law

Opening Address
   Margaret Kenyatta

AIDS, Sexually Transmitted Diseases and Gender

   Socio-Cultural Determinants of HIV Infection in Zimbabwe
   Gilford D. Mhloyi and Marvellous M. Mhloyi
   Discussion

   Gender Differentials and Household Issues in AIDS
   Lawrence A. Adeokun
   Discussion

   "It's Difficult to Leave your Man over a Condom": Social
   Understanding of AIDS and Gender
   Anna Strebel

   Gender, Counselling and STDs/AIDS
   Don H. Balmer

   Gender and Acceptance of Medical Innovations and Technologies
   Related to STDs and AIDS in Africa
   George K. Lwihula

   Implementing Issues in Gender and Health: Emphasizing STDs in
   Rural South Africa
   Shirley Ngwenya
Tropical Diseases and Gender

Gender Issues in the Control and Prevention of Malaria and Urinary Schistosomiasis in Endemic Foci in Cameroon
Stella Anyangwe, Olayinka Njikam, Lisette Kouemeni, Pascal Awa and Emmanuel Wansi

Gender and Tropical Diseases in Nigeria: A Neglected Dimension
Uche Amazigo
Discussion

Gender and Acceptance of Technologies for Tropical Disease: Impregnated Mosquito Bednets for Malaria Control
Martin Sarikiaeli Alilio

Gender Issues in the Prevention and Control of Visceral Leishmaniasis - (Kala-azar) and Malaria
J. Munguti Kaendi

Women and Decision-Making for their Children’s Health Care
Halima Abdullah Mwenesi

Environmental Stress, Production Activities, Health and Gender

Occupational Participation of Women and Health
Fekerte Haile
Discussion

Gender and Health Effects of Environmental Stress Among Kampala Textile Workers
Joseph Carasco
Discussion

Environmental Degradation, Gender and Health in Ghana
Dzodzi Tsikata

Occupational Health, Safety and Gender
Anne Kamoto Puta
Social Issues, Gender and Health

Ethics, Gender and Health: A Brief Legal Perspective
Seble Dawit
Discussion

Refugees, Gender and Health
Nkosazana Zuma
Discussion

Feminist Methodology in Relation to the Women’s Health Project
Barbara Klugman

Maternal and Child Health Care in Teso, Uganda: Social Issues
Hellen Rose Atai-Okei

Social Policies, Gender and Health in South Africa
C. C. Jinabhai

Gender and Household Health Seeking Behaviours
Jane Kwawu

Working Group Discussions

Working Group I - Gender and Disease
Working Group II - Health, Environment and Gender
Cross-Cutting Issues

Related Topics and Initiatives Informally Presented at the Workshop

Global Commission on Women’s Health
Maureen Law

Gender Analysis and Research Methodology: Key Questions and Issues
Gender and Development Program

Healthy Women Counselling Guide: A Multi-Country Intervention Study
Carol Vlassoff
Sharing Experience: African Women Development and Communication Network (FEMNET)
Rosemary Gitachu 258

In Her Lifetime: A Report on Female Morbidity and Mortality in Sub-Saharan Africa
Maureen Law and Uche Amazigo 263

Health and the Status of Women in Canada
Janet Hatcher Roberts 265

Special Issues to Consider When Doing Research on Women
Eva M. Rathgeber 271

Participants 275

"Gender and Tropical Diseases: Facing the Challenge"
Abstracts from an Essay Competition Sponsored by IDRC and TDR 279
Gender and Household Health Seeking Behaviours

Jane Kwawu

The term "gender" is a multi-faceted concept. It refers to culturally- and historically-specific concepts of femininity and masculinity. It also reflects the power relations between men and women, and refers to the social construction of sex roles between men and women. Gender shapes the sexual division of labour, as well as patterns of knowledge, responsibility and control related to natural resource management and production. Because gender roles are fundamental to understanding human interactions, we should focus on gender relations rather than on women or men. Gender roles are the result of historical, economic, ethnic, religious and external factors that have shaped the ecosystem, including households.

The household environment consists of the totality of the physical, biological, socio-economic, political, aesthetic and structural surroundings of human beings and the context of their development. The conceptualization of these environments has been of concern to many researchers interested in building theory around human ecology (Babolz et al. 1979) in family resource management and intra-household dynamics. The family ecosystem is postulated to consist of interrelated environments - the natural physical/biological, the human-built, and the sociocultural environments.

The natural physical environment includes the atmosphere and the earth. The human-built environment includes the alterations that have taken place as a result of management practices for survival and sustenance. The socio-cultural environment includes the presence of other human beings and abstract cultural constructions such as laws, practices, and values. All these form the basis for communication and coordination of human behaviour and activities, and have a powerful impact on the natural-physical-biological environment and on humans (Kirjavaihen 1993).

According to Chant (1989), households are systems of resource allocation. People are seen in a household as belonging to a certain category defined by gender, age, seniority, and class; each category has a predetermined role and responsibility. Individuals and households may also belong to corporate groupings - neighbours, kin groups, church - and these relationships have an impact on access to resources. There are also household structures - polygamous, female-headed, nuclear, extended, and class structures - poor, rich, landlords. The behaviour of individuals is largely determined by the household in which they belong.

1Centre for African Family Studies (CAFS), Nairobi, Kenya.
Traditionally, research has tended to focus on women primarily in terms of their reproductive activities. Yet women are the actual managers of families and household resources. The direct linkages between gender and health issues need to be recognized in terms of the connections between household food supply, household needs and quality of water, household energy needs, household primary health care, childbearing, reproductive health, and the total well-being of family members (World Bank 1991).

Development theories and research however, have little to say about gender as a factor which influences health care and health seeking behaviour at the household level. Very little information exists on how women and men perceive, seek and practice health. Yet experience shows that there is a vast difference.

Culturally and historically, women play a major decision-making role with regard to health care in the household, as well as being major health care providers. Health literature is increasingly recognizing this important role, and supports women as key providers of health care. Women are nurturers of children and care takers of their spouses. Women make decisions about health - from personal hygiene habits such as brushing teeth, food consumption and nutrition, to fertility-related health care and emotional health.

Women’s roles are very significant in the attainment of the goal of health for all by the year 2000. The role performance begins with women themselves and their homes. Chant (1989) examined the impact of health care, housing and urban services on household survival. She explained that in developing nations, men assume the responsibility of production and direct generation of income while women are left with the duty of reproduction - taking care of the household as a natural responsibility.

Chant documents that since 1975, experts have emphasized that health care programs should be community-based and should include women. This call has not attained full recognition and support. In her study on gender and reproduction, she emphasized that urban women in the developing world suffer from many basic health problems needs and lack of health-related needs such as subsidized housing. Households usually lack basic urban services such as piped water, sewage, sheets, electricity and garbage collection, which increase health risks at the household level.

Women are playing an increasingly important role in participatory health strategies - specifically with regard to primary health care, child survival and cost recovery. Women’s traditional domestic and agricultural responsibilities have included food and nutrition, health education, treatment of common diseases and injuries, and water and sanitation. Women also play a crucial role in implementing new technologies associated with PHC, child survival - ORT, immunization, growth monitoring and family planning. With the imposition of fees for health and nutrition services in Structural Adjustment Programs, women’s capacity for earning income takes on added importance in delivery of health care. Women’s education services have become a catalyst for health promotion.
In spite of this, knowledge in society is still assumed to be the male prerogative. Men dominate in all spheres of society where major decisions are made and implemented, including health decisions. The knowledge of women tends to be ignored. As both practitioners and consumers of traditional health, women tend to suffer from a status of inferiority and subordination, a condition that they have internalized.

Women have considerable health-related knowledge and skills, especially concerning reproduction, nutrition, and treatment of common diseases and injuries in the form of first aid. Women have dominated traditional practices concerning women’s health, especially sterility, sexual and marital difficulties and depression. Women’s practice of health is therefore limited to women and their children. Men do not acknowledge women’s traditional health knowledge.

Because of male dominance in society, women tend to seek care through their reproductive role (which is familiar to them). Women seek medical care through their birthing and mothering roles, thus perpetuating the status quo. All other health needs, physical, mental, or emotional, are marginalized, or coped with by self-treatment or simply living with the condition and its resulting pain discomfort. Generally women tend to associate the utilization of a dispensary, clinic or hospital services with health of the children. Usually the ill health of a mother is not visible to anybody, especially the husband (even to health professionals).

Child bearing is a major cause of illness among African women. It is one of the leading causes of death, especially among young women. Yet the majority of African women either do not seek contraception, or do not have access to it. Abortion, a well established cause of death for African women, is illegal even at the household level, because it is believed that a woman must be a mother. Women’s health seeking behaviours are therefore reflected in the patriarchal construction of women by men.

Men do not generally seek health care at the household level. Health is provided by women within the prescribed role of a provider. Men will seek and be able to afford curative health because they are empowered to do so as a result of their privileged position in society.

The issue of health-seeking behaviour requires further systematic research. Ethnographic studies are required to give insights in the divergent ways in which health seeking behaviours are determined at household levels by women and men. A number of important research gaps include the following:

- Where does the woman get her training to detect and decide whether she should treat illness at home herself?
- How does she decide when to take the sick child or adult out of the house for treatment?
• How do her beliefs and diagnostic skills help her in her role performance?
• Do women and men use medical facilities? Which alternative health care approaches are used?
• What quality assurance exists at household and external health services?
• What health indicators are used by women and men to measure health?
• Do women feel empowered enough to be custodians of health care in the home?
• How do women use the strengths of other women in dealing with health in the home?
• Does a woman-to-woman health network exist?
• What could be done programmatically to enable women to find solutions to problems associated with their role as health providers?
• What could be done to increase men’s support for better health delivery in the home? How could they be made partners and not dominant in the process?

Research on these questions will help to determine how numerous variables interrelate and could help to improve the health of household members. Studies should illustrate gender relations focusing on gender concepts such as power relations, decision-making patterns regarding health care and practice, patterns of allocating household resources and division of labour. It would also be helpful to generate data on epidemiological factors which cause disease and the treatment patterns at household levels. Research with hopefully provide insight on control and treatment of conditions relating to emotional health, self-esteem, stress, depression, and the effects of harmful practices such as tobacco smoking, irresponsible sex and violence.

Conclusion

Health begins at home. The roles that men and women play in seeking health can be reflected in the health status of a given household. The central role of women in household health behaviour needs recognition, more visibility and support financially and socially.

Both men and women have to create a home environment that is conducive to health. Men and women must work together to achieve good personal hygiene, clean water, provision of nutritious food and suitable housing. It is also necessary to limit family size by using a contraceptive method and ensuring that the children are immunized and cared for during crucial years. The elderly must be cared for, as well as women and men in the family in relation to their special needs.
In order to do this effectively there is a need to re-examine the environments in which women and men exist within their families. Research in the area of health seeking behaviours by women and men (gender) becomes important given the traditional restraints and constraints that have gradually weakened the ability of women and men to make sound decisions concerning the health of their families.

References


