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
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INTERNATIONAL DEVELOPMENT RESEARCH CENTRE
Ottawa • Cairo • Dakar • Johannesburg • Montevideo • Nairobi • New Delhi • Singapore
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Social Policies, Gender and Health in South Africa

C.C. Jinabhai

Introduction

When exploring gender and health issues from the perspective of social policies in South Africa, it would be appropriate to locate them in the context of the demographic, socio-economic, epidemiological and legal/constitutional status of women. This framework provides a conceptual and programmatic basis for analysis, and a foundation for the multiple interventions needed to address these issues. A particular strength of a broad approach to these questions is that South Africa is currently undergoing a unique constitutional, political and social transformation. If managed correctly, this transformation could lay the basis for a profound evolution in the status of women. This provides an unprecedented opportunity to develop strategies that address immediate short-term health and socio-economic issues, and medium- to longer-term social, developmental and political/constitutional issues. Policies and services in the health and welfare sectors are used to illustrate the extent to which South African society is gender sensitive.

The 1991 population census has estimated the total population in South Africa at 37 million, of which 75.3% are African, 13.4% are whites, 8.7% are coloured and 2.6% are Indian. The race, gender and regional profiles are reflected in Tables 1 and 2.

A Review of Key Social Policies Influencing the Status of Women

The current situation of women in South Africa is a direct product of the apartheid policies of the Nationalist Party. The social and historical legacy of these policies on women is likely to persist for at least a generation or more, even as the constitutional and legal basis for the triple oppression of women is dismantled. Likewise, a new constitutional and legal dispensation for women, which actively compensates for past discrimination, is a necessary but not sufficient condition for emancipation. The social, cultural and material conditions for such positive policy measures to flower must also be created. The legal status of women still condemns them to the status of minors in terms of customary laws that prevail in homeland and rural areas.

The following are the major features of health, social welfare and education policies that have evolved under the apartheid system (Jinabhai 1992):

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1Director, Centre for Health and Social Studies, University of Natal, South Africa.
fragmentation of policies along ethnic, class, gender and geographic lines;
inequity as reflected in the inadequate financing, allocation and distribution of resources along racial lines, with whites enjoying preferential access, and urban-rural disparities that mirror the black-white discrimination;
the lack of appropriate social indicators, needs assessment and information systems for policy formulation and planning;
the attempt to use the private sector and the market place to deliver services, i.e., the rapid privatisation of service as the black majority begin to demand access and equity;
insensitivity to the differing development needs and social profiles of blacks and of women;
Euro-centric and high tech models of service delivery, teaching and curriculum content and inappropriate criteria for selection of students in tertiary institutions; and
inadequate monitoring, evaluation and accountability of policies and services.

From this critical analysis, the following guiding principles have been developed by the democratic movement to provide an ideological and moral foundation. Certain operational issues have also been identified to provide the organisational framework for alternative social policies.

- **The Need for National Unity**: building a national consensus to redress the social divisions and the political and economic disparities created and institutionalised by colonialism and apartheid.
- **Participation in Development**: full participation on equal terms by all individuals and groups in social, political and economic activities as central to the building of a democratic culture.
- **Promotion of Equity**: social policy changes to alter the distribution of resources, status and power between groups or classes.
- **Shift from Rehabilitation to Prevention**: increasing poverty, urbanisation and the growth of informal settlements requires a balance between developmental and therapeutic services.

**Operational Issues**

The operational issues arising out of these principles include:

- determining eligibility - for services and acceptable measures to establish eligibility;
- accessibility - to social services;
- benefits and services - for individuals and families;
- reorganization and administration - of service delivery; and,
- financing - defining the roles and responsibilities of the public and private sectors.
The Social Welfare Sector

In the social welfare area, a number of critiques have identified the major limitations and weaknesses of current polices and services, examined alternative guiding principles and service options and located the role and contribution of this sector within a broader developmental social welfare model (Jinabhai 1992; Lund 1992; Patel 1992).

The South African social security system is made up of four elements: state welfare, civil pensions, private pensions and workplace security (Unemployment Insurance Fund, Workmens' Compensation Accident fund and pensions and provident funds). State welfare covers the aged, disabled, family and child care and relief of distress (Lund 1992). Many of these have been concretised into a set of recommendations in a major UNICEF/National Committee for the Rights of Children (NCRC) Report entitled Children and Women in South Africa: A Situation Analysis (UNICEF/NCRC 1993).

A national consultation on transforming the structures of policy-making and service delivery, suggested both radical dismantling of the apartheid state and incremental proposals to gradually transform the white civil service, welfare bureaucracy and administrative systems (Jinabhai 1993). The participants in this process of national consultation were unable to clearly spell out the different strategic and operational planning techniques that were required to accomplish these goals. Those who came from the government sector were accustomed to an autocratic style, while those who came from the progressive and community-based sectors, had little experience in financing and policy formulation.

The spiral of violence, destabilisation of community and political organisations by hit squads and security forces, and the paralysis and insecurity of the white civil service, makes it difficult for everybody, especially women, to participate in the policy formulation process. In a politically volatile climate it is difficult to separate the policy process from the political and constitution-making processes. A common attitude in the alternate social sector is that the acquisition of political democracy will resolve all policy problems, resulting in a reluctance to explore specific legislative and operational issues.

Current proposals being discussed for developing an appropriate non-racial democratic social welfare policy include the following:

- Welfare policy formulation is inextricably tied to a new political and constitutional dispensation. Democracy and participation in all decision making structures is a **sine qua non** for policy formulation.
- The financing of social welfare services, sources, amount and forms, raises issues of morality and philosophy, of making hard choices between political freedom and economic democracy, and ultimately about the nature of the new South Africa. Several options for financing exist, ranging from universal provision of comprehensive services (welfare state model) to limited, but comprehensive, services for targeted groups (aged, disabled, poor) and a national contributory pension scheme,
to the maintenance of the present residual model. The economic implications of these policy choices, in the face of resource constraints, are unclear at the moment. Welfare and social security expenditures in South Africa represent a small portion of the public budget, and a limited percentage of the population is covered by publicly funded and supported development programs.

- There is substantial agreement that the welfare system needs to move toward equity, and a comprehensive provision of generic and specialised services, with a major shift toward decentralised, cost-effective and community development models of care. Priority sectors include rural and informal squatter communities, and within these, the poor, indigent, handicapped and aged.
- While there is agreement concerning the involvement of government, voluntary, business and the non-governmental sectors, their exact roles and responsibilities remain ill-defined.
- A single national state welfare department should be created.
- Black women in South Africa have been severely disadvantaged by racial discrimination, sexual oppression and economic exploitation. Meeting women's needs and developing gender sensitive policies should be a major focus of development planners and policy makers.
- Implementing developmental social welfare programs requires a policy for the training of community social workers and social development workers; inter-sectoral collaboration (especially with education, health, labour, housing and the environmental sectors), with an appropriate system of social welfare indicators and a national welfare information system designed to monitor and evaluate the service.
- Improved accessibility for discriminated groups requires the use of active out-reach programs based on clearly defined geographic areas, comprehensive community profiles, education and awareness of clients rights, and resources to increase utilisation.

Addressing these critical dimensions will lay the basis for the next stage of strategic and operational planning for social welfare service delivery.

**Gender and Health Issues: An Epidemiological Profile**

A proper national profile of all the diseases and disabilities that women face is not available. The information system is fragmented between homeland and non-homeland (Republic of South Africa) areas, and is not sensitive to the dimensions of gender and class. Furthermore, the conventional approach to women's health focuses on reproduction. Indicators of maternal mortality, fertility rates and maternal diseases are negative measures of health and welfare status, and do not adequately reflect the socio-economic, legal and political status of women. Concern has been expressed about the way in which these social policies and services define women in reproductive terms, with very little attention to their productive roles (Klugman 1992; Berer 1993).
The data in Table 3 reflects the trends at King Edward Hospital (KEH), the second largest teaching hospital in South Africa (Department of Obstetrics and Gynaecology, KEH 1993).

**Maternal Mortality Rates (MMR)**

No accurate national figures exist, although estimates range from 58 to 83 maternal deaths per 100,000 live births per annum (DNHPD, UNICEF/NCRC Report, 1993). The amalgamated rate for sub-Saharan Africa is 561, for developed countries it is 20.

**Abortion**

The Abortion Reform Action Group's (ARAG) estimate that there are between 200,000 to 300,000 illegal abortions annually in South Africa. This figure clearly indicates that the Abortion and Sterilisation Act of 1975 has failed (Rees 1991). Only 40% of applications for legal abortions are successful. Of the 800-1000 women who obtain legal abortions each year, most are white (Rees 1991).

**Cervical Cancer**

This is the most common form of cancer for women. It also has the greatest preventive potential. The risks of developing the disease between 15-64 years of age is 1 in 46 for Africans, 1 in 94 for coloureds, 1 in 204 for Indians and 1 in 169 for white women (UNICEF/NCRC 1993). No routine screening services exist in the public health sector, and in recent years the number of pap smear exams have been reduced.

**Sexually Transmitted Diseases (STDs) and AIDS**

There is a lack of national figures for these major epidemics. Both have major implications for women's health, in terms of their own well-being and the potential to infect their offspring. Pelvic inflammatory diseases, infertility, abortions, cervical cancer, and congenital infections are some of the complications arising from STD infection. A third of the reported AIDS cases are among African women, with infection rates in Northern Natal and Kwazulu as high as 8% (UNICEF/NCRC 1993).

**Population Policy**

The total fertility rate in South Africa ranges from 1.7 for whites, to 2.3 for Indians, 2.9 for coloureds, and between 3.7 and 5.7 for Africans (urban and rural). Contraception is very controversial in South Africa because it is seen to reflect a government attempt to reduce the black population. Non-traditional methods of contraception are part of the indigenous system of beliefs and practises, and have been greatly neglected by the formal health sector.
In 1991, 1992, there were 65,182 family planning clinics in the Republic of South Africa, with 8,058,667 clinic attendances. According to DNHPD estimates, of a total of 4.4 million fertile women, 52.3% were protected against pregnancy (DNHPD Annual Report 1991/92). An innovative aspect of the Family Planning Program has been the training of 1,653 retail pharmacists in providing family planning services. Many of the family planning clinics and the STD/HIV clinics are still run as vertical programs separate from general PHC services. There is an urgent need to integrate all these services into a comprehensive program.

A women-centred approach promoting contraception has been suggested. This would put women’s health and women’s control over their bodies as the primary goals of the state’s reproductive health program (Klugman and Weiner 1992; UNICEF/NCRC 1993).

**Gender Policies and the Environment**

There are a number of environmental issues which have a major impact on gender policies. The estimated coverage for homes with potable water ranges between 25% in the Transkei and 95% in Gazankulu; while the rate for sanitation ranges between 10% in most homelands and 20% in Gazankulu. The burden of repeatedly carrying water over long distances falls on the shoulders of women in both rural and urban communities. Contamination of the containers used for collecting water by pesticides, fertilisers and other toxins, such as cyanide and mercury, pose additional risks to family health.

**Household Food Security: Health Care and Food**

The malnutrition-infection complex is a useful approach to understanding the inter-relationships between health care and food (Jinabhai & Fincham 1993). South Africa does not have a national nutritional surveillance system, nor a policy for compulsory notification of malnourished children. No early warning system for droughts exists. No national data exists on the extent of malnutrition among all children. Estimates indicate that between a quarter and a third of all black children suffer from malnutrition, with higher figures in informal and rural areas.

**Women’s Control of Resources**

Concern has been raised about the impact of economic decline, malnutrition and household food insecurity on women, since they are primarily responsible for feeding and caring, and, in rural societies, for carrying out certain agricultural tasks (Gillespie and Mason 1991).

There are three conditions necessary for adequate nutrition: household food security, infectious disease control, and women’s control of resources and caring capacity. While "caring capacity" refers to all household members, in practise the main responsibility lies with the mother. Her ability to manage the many competing demands will govern her ability
to maintain a clean environment (disease prevention), to care for a sick child (disease management), and to provide and prepare food for all household members (household food security). This gender dimension of nutrition problems and the broader conception of household food security is largely neglected (Gillespie & Mason 1991). The multiple roles of many women in poor households, as mothers, home managers, workers producers, and community organisers, often set two of their primary resources, namely income and time, in conflict. How does a woman balance her time between productive (income-earning) and reproductive (domestic, caring) work?

This "maternal dilemma" between a women's productive and reproductive roles, has resulted in two schools of thought. The "women-in-development" school seeks to enhance women's income-earning capacity, while the "child-welfare" school stresses their roles in producing healthy children. Currently there are attempts to bridge these schools of thought to emphasize both the productive (improving the status of women) and reproductive (improving the welfare of children) roles. Gender differentials in child nutritional status and mortality, related to female economic and social status, has relevance in many societies, such as South Africa, where women are still regarded as minors. Likewise a call has been made to develop gender sensitive food chains which takes cognisance of the depletion of maternal energy reserves in fulfilling multiple roles.

The Health Sector in South Africa is characterised by the following features:

- It has a highly developed health service, with a predominantly curative, urban and hospital-centred focus.
- There is a substantial amount of human, financial, technical and material resources and capacity available in both the public and private sectors. Much of the private sector resources are directed to meeting the curative needs of the white urban elites.
- The private and academic sectors are well developed and sufficiently powerful to block any major restructuring of the health system that would threaten their interests.
- While both the government and the democratic movements are involved in negotiations to transform the apartheid social system, it is unlikely that the balance of forces will shift substantially for the new government to fundamentally challenge the private, academic and other sectors that have a vested interest in the present status quo.
- Promotive and preventive services and Primary Health Care services are poorly developed - with little commitment by the present government to make any fundamental shifts in this direction.
- There are considerable urban/rural, racial and gender disparities both in health services, and with respect to socio-economic and environmental conditions. Investments in the provision of health services must be balanced by interventions in the socio-economic and environmental sectors. Their impact on health status must be carefully assessed.
- The informal settlements and rural areas are areas of priority, principally for PHC services.
The principal strategy for major health sector reform in South Africa, in the short term, should be based on re-orientating and rationalising the Public Health Services, developing an extensive Primary Health Care service for township and rural communities, and substantial social mobilising of all communities to demand a basic package of health services and goods.

**Social Policy: A Tool for Social Control or Development**

In considering the next few stages in the policy-making process, it is important to recognise that certain issues and priorities can only be tackled by a democratic government with national resources at its disposal. It may be useful to separate these phases into a short-term (transitional) phase prior to the establishment of a democratic government, and a medium- to longer-term phase after the installation of a new government.

During the transitional period, the critical policy need is to understand how the government and the formal health and welfare sector works, with its legislative, administrative, management, and financing policies and frameworks. The second imperative is to consider how the alternate sectors' principles and guidelines are going to be used to transform these institutions and policies, for example, to develop realistic and feasible goals and social objectives. The third imperative is to weigh different policy options and to make critical choices between different and competing social development policies, coming from the welfare sector, as well from other sectors such as education, housing, labour and employment, and health.

Once the democratic government is installed, an entirely new policy horizon will open up, with new challenges and priorities. During this period, the legislative and institutional basis of policy formulation and decision-making in the welfare sector will need to be transformed to reflect the new dispensation. Similarly the resources of the government's social sector will be available to accelerate and deepen the policy formulation process. It would be important to realise that macro-economic policies and the nature of the growth path would profoundly influence both the resource base and the policy climate. Likewise, the interests of the different sections of the social sector, which were subsumed during the transitional period under the rhetoric of the progressive sector, would come to the fore. This may produce divergent and even conflicting policy demands. During this period the social policy process would separate from the political and constitution making process, and mature in its own right.

A pervasive concern is the potential use of social policies as a tool for social control. The Nationalist government failed to use the welfare system to promote its ideology of separate development. There is a high level of awareness of the power of social policies as a tool either for disorganisation, repression and control (as used by the apartheid state), or for survival, development and transformation.
A vigorous debate between macro-economists arguing for economic growth and social developmentalists arguing for human development is currently underway. National policies would have to be sensitive to both the development and the gender dimensions, if South Africa is to avoid the mistakes made elsewhere in Africa.

Conclusion

The entrenchment of constitutional and legal rights of women in the Bill of Rights and the new South African constitution is a necessary but not sufficient condition to ensure full emancipation. Sachs (1990) has argued that all three generations of human rights must be enshrined in law - first generation civil and political rights, second generation social, economic and cultural rights, and third generation rights to development, peace, social identity and a clean environment. Other conditions include an organised and cohesive mass-based women's movement, a free press, an educational system that respects women, an independent judiciary and the commitment of financial, technical and other resources for the development of women.

As new political elites emerge during the transition to democracy and as the policy process unfolds, it will be important to ensure that the needs and aspirations of the marginalised, unorganised constituencies are not neglected in favour of those who are articulate, organised and wealthy.

Both a humanistic and technocratic orientation to planning and policy are evident in South Africa (Mayer 1985). The humanists were critical of the previous social engineering of the apartheid regime and argue that a value-based "basic needs" approach should determine priorities. They recognise that the use of technical procedures in public decision making results in the subjugation of one segment of society by another, since control over technology is not equally accessible to all ... and that rational planning is impractical because public decisions are based on power relationships (Mayer 1985). Technocrats favour rational planning. From the current debates it is clear that both the technical skills of the rational planner and the value base of the humanist, need to be fused into an indigenous development perspective to address the enormous legacy of apartheid.

Internationally, both the UN Development Program (UNDP) and the UN Centre for Social Development and Humanitarian Affairs have called for human development in the context of economic growth (UNDP Report 1991; Social Development Newsletter 1987). The UNDP Human Development Report explicitly calls for both redistribution policies to ensure distributive justice and economic growth to sustain these policies.

A Women's Charter enshrined in the new constitution would provide a similar framework. A draft Workers' Charter drawn up by COSATU includes a number of demands to promote women's health, including the need for state provision of accessible and safe health care, the problem of South Africa being used as a dumping ground for third rate contraceptives, the need for free pap smear tests, the need for an affirmative health care
program, and the legalisation of abortion (Truscott 1991). A review of all legislation dealing with children and women and the promulgation of statutes to meet new goals and objectives would have to occur. Institutional and organisational structures need to be established, both within the government and in the non-governmental sectors. Within the Ministry of Health and Welfare, separate Departments of Children and Women need to be established, with direct representation in the cabinet. The powerful women’s movement, with its extensive legacy of social mobilisation during the national liberation struggle, needs to be transformed to become the leading advocacy group.
Table 1. Race and Gender Profile by Regions (Population Census 1991)

<table>
<thead>
<tr>
<th>Region</th>
<th>Whites</th>
<th>Race and Gender</th>
<th>Asians</th>
<th>Blacks</th>
<th>Totals</th>
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<tr>
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<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
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<td>RSA Totals</td>
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<td>2,307,939</td>
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<td>Provinces:</td>
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<td>Cape</td>
<td>589,917</td>
<td>631,448</td>
<td>1,172,838</td>
<td>1,244,709</td>
<td>20,210</td>
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<td>Natal</td>
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<td>271,556</td>
<td>43,993</td>
<td>47,712</td>
<td>326,074</td>
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<td>Transvaal</td>
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<td>131,083</td>
<td>140,610</td>
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<td>GFS</td>
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<td>166,566</td>
<td>31,394</td>
<td>31,395</td>
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<td>Self Governing States:</td>
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<td>2,603</td>
<td>1,752</td>
<td>1,836</td>
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<tr>
<td>KwaZulu</td>
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<td>407</td>
<td>842</td>
<td>817</td>
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<td>KaNgwane</td>
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<td>147</td>
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<td>258</td>
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<tr>
<td>Gazankulu</td>
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<td>648</td>
<td>42</td>
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<tr>
<td>Lebowa</td>
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<td>1,328</td>
<td>515</td>
<td>660</td>
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<tr>
<td>Kwandebele</td>
<td>54</td>
<td>44</td>
<td>67</td>
<td>66</td>
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<tr>
<td>Grand Total</td>
<td>2,221,279</td>
<td>2,310,542</td>
<td>1,382,812</td>
<td>1,468,098</td>
<td>421,076</td>
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</table>

Table 2. Population Distribution by Age, Sex and Race (CSS, 1991)

<table>
<thead>
<tr>
<th>Age</th>
<th>Total (Years)</th>
<th>Males</th>
<th>Females</th>
<th>Male</th>
<th>Females</th>
<th>Male</th>
<th>Females</th>
<th>Males</th>
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<td>0 - 14</td>
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<td>478,167</td>
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<td>3,109,162</td>
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<td>15 - 44</td>
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<td>1,082,755</td>
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<td>775,471</td>
<td>219,963</td>
<td>229,186</td>
<td>4,452,582</td>
<td>4,614,336</td>
<td>13,171,782</td>
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<td>45 - 59</td>
<td>350,531</td>
<td>354,758</td>
<td>143,545</td>
<td>161,081</td>
<td>53,785</td>
<td>45,992</td>
<td>809,205</td>
<td>836,010</td>
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<tr>
<td>60 +</td>
<td>253,011</td>
<td>354,952</td>
<td>70,399</td>
<td>97,207</td>
<td>21,542</td>
<td>26,095</td>
<td>442,097</td>
<td>648,809</td>
<td>1,905,112</td>
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<tr>
<td>Total</td>
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<td>1,417,395</td>
<td>1,511,926</td>
<td>425,628</td>
<td>438,271</td>
<td>8,769,999</td>
<td>9,208,317</td>
<td>26,293,347</td>
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</tr>
</tbody>
</table>

(b) Geographic Distribution by Gender (%)

<table>
<thead>
<tr>
<th>Area</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Homeland Areas</td>
<td>52.2</td>
<td>47.8</td>
<td>100</td>
</tr>
<tr>
<td>Non-Independent Homelands</td>
<td>45.8</td>
<td>54.2</td>
<td>100</td>
</tr>
<tr>
<td>Independent Homelands</td>
<td>43.8</td>
<td>56.2</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 3. Obstetric Profile of all Women Attending KEH

<table>
<thead>
<tr>
<th></th>
<th>1989</th>
<th>1990</th>
<th>1992</th>
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</thead>
<tbody>
<tr>
<td>Perinatal Mortality: M S B</td>
<td>380</td>
<td>352</td>
<td>333</td>
</tr>
<tr>
<td>F S B</td>
<td>331</td>
<td>330</td>
<td>132</td>
</tr>
<tr>
<td>N N D</td>
<td>252</td>
<td>198</td>
<td>132</td>
</tr>
<tr>
<td>Maternal Deaths</td>
<td>41</td>
<td>40</td>
<td>25</td>
</tr>
<tr>
<td>Total Deliveries</td>
<td>14,010</td>
<td>14,268</td>
<td>12,739</td>
</tr>
<tr>
<td>N V D</td>
<td>8,319</td>
<td>9,056</td>
<td>7,630</td>
</tr>
<tr>
<td>C/Sections</td>
<td>5,490</td>
<td>5,102</td>
<td>5,003</td>
</tr>
<tr>
<td>Vacuum</td>
<td>89</td>
<td>51</td>
<td>47</td>
</tr>
<tr>
<td>Forceps</td>
<td>36</td>
<td>27</td>
<td>22</td>
</tr>
<tr>
<td>Symphysiotomy</td>
<td>76</td>
<td>32</td>
<td>37</td>
</tr>
<tr>
<td>Primigravidas</td>
<td>4,693</td>
<td>4,791</td>
<td>4,112</td>
</tr>
<tr>
<td>Attendance</td>
<td>11,951</td>
<td>11,998</td>
<td>10,792</td>
</tr>
</tbody>
</table>

References


