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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Gender, Counselling and STDs/AIDS

Don H. Balmer

Introduction

This paper explores the relationship between gender-defined roles and counselling in the context of STDs/AIDS, with specific reference to issues in sub-Saharan Africa. It begins with a brief discussion of current thinking around gender issues. Sexual relationships, in particular, are explored in terms of gender identity and roles. The development of counselling as it relates to STDs/AIDS is examined. It is argued that a theoretical counselling foundation is necessary if sustainable behavioural change is to be achieved, and that behavioural change should aim at an increased convergence of gender roles.

Gender

Gender is a multi-dimensional concept of social knowledge that helps to regulate socially-defined, sexually-differentiated roles and relationships, particularly power relationships between women and men (Cook 1990; Crawford and Maracek 1989). Further, it determines the behaviours, expectations, and roles associated with masculinity and femininity (Mintz and O’Neil 1990).

A distinction between biological sex and gender is important to any understanding of sexually-differentiated roles and behaviours. Biological sex depends upon the physical sciences for legitimacy, whereas gender depends upon the social sciences. Biological scientists divide people objectively into either male or female, although the validity of the distinction is sometimes questioned (Davies 1989). Social scientists divide people subjectively on the basis of gender roles that influence their behaviours. Psychologists make a distinction between male and female, but it is not with the same objectivity as biological scientists. Freud examined sexuality, particularly its unconscious motivations, and maintained that the unconscious part of the mind was bisexual, and that as the child developed, she or he moved from bisexuality to heterosexuality (Rose 1993).

In developing an integrated approach, the views of both physical and social scientists need to be incorporated into a consolidated model. In the following configuration (Figure 1), the bipolar continuum of the biologists, between female and male, provides a baseline upon which the social science distinction between gender roles, can be illustrated.

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1Department of Psychology, University of Nairobi, Nairobi, Kenya.
These roles tend to be mutually exclusive: by choosing one, the individual rejects the other; thus we talk of the 'opposite sex'. This exclusivity increases the degree of separation between the sexes and leads to strange paradoxes - for example, men who spend more time with other men, extolling masculine virtues, are perceived as being more strongly heterosexual, whereas men who spend more time with women, engaging in shared activities, are regarded as effeminate. Each gender seeks out its own group to reinforce the differentiated behaviour and this process helps to sustain the separate roles.

However, there is an area of convergence between sexually-defined roles, because sometimes both sexes are concerned with the same activity, such as child-rearing. The degree of convergence fluctuates throughout history. While gender roles were sharply divided in the last century, recent social, educational and economic developments have led to increased gender convergence. A number of factors, including greater female employment in traditionally male occupations, have led to more equality in the workplace, and resulted in greater role convergence, as shown in Figure 2.

However, other social phenomena, such as sexually-defined behaviour, remain unchanged. Sexual activity is culturally taboo and not publicly debated. This may be due to the lack of shared experiences and the resulting absence of a satisfactory convergent vocabulary. There are two distinct vocabularies: the medical, which is cold, precise and
avoids any emotional expression; and the slang, which tends to be emotional, and is sometimes abusive and aggressive. The rift between these two sets of vocabularies contributes to a corresponding rift between gender roles, as shown in Figure 3.

Gender role analysis helps to increase understanding of the subtle ways in which gender expectations influence the lives of men and women (Kaschak 1981). An analysis of gender roles reveals that males are often expected to be self-contained, emotionally controlled, self-sufficient, assertive and homophobic. Such expectations may result in the blocking of emotions, denial of vulnerability, avoidance of openness, and a decreased capacity to receive interpersonal feedback (Werrbach and Gilbert 1987). Pressures to be self-sufficient and contained have prevented men from acknowledging weaknesses and hindered attempts to understand the male gender role (Pleck 1985).

Men perceive their masculine role as aggressive, and expressing anger may serve as a defense against the expression of other feelings such as sadness and hurt (Sharkin 1993). They may reinforce this defense by talking about their aggressive behaviour in male groups. Many men choose to express their anger in circumstances where they are least likely to feel threatened, such as at home with their wife and children. Male anger is also reflected in sexual behaviour. The male vocabulary of sexual conduct tends to be aggressive and abusive. Popular media tends to condone and emphasis this aspect, and men who aggressively pursue sexual activities are portrayed as being particularly masculine.

Meanwhile, the feminine gender role is characterised as being emotional, sensitive, nurturant, interdependent and non-violent. Women place great emphasis on their friendships with others, particularly men (Kaplan 1979; Cook 1985). Women tend to doubt their capacities to maintain relationships with men. In the case of a relationship failure, women often do not express anger, needs or wishes, and may believe that the breakdown is an individual failure (Kaplan 1986). Women’s vulnerability therefore increases their potential to devalue themselves and further inhibits self-esteem. Poor self-esteem may be reflected in sexuality; many women view sex as something that 'happens' to them (Lees 1993). This can result in women submitting to male sexual aggressiveness. In one study, girls reported
that under certain circumstances it was alright for men to use force to obtain sex (Miller 1988), and some women believe that men cannot be stopped, or stop themselves, when they are sexually aroused (Miller and Marshall 1987).

Violence, confrontation and distrust between the sexes may be exacerbated by some aspects of sexual activity, such as birth control. Condoms are associated with a range of negative connotations and can lead to distrust and suspicion. The dual purpose of condoms, that is, to prevent pregnancy as well as disease, is another source of ambiguity and raises a potential conflict of values (Ulin 1992).

In summary, biological sex is defined by physical scientists and gender by social scientists. The biological approach is rigid by definition, but social science acknowledges active social pressures. The more the gender roles converge, the more possibility there will be for genuine equality between the sexes. This convergence will provide the opportunity for improved behavioural strategies to prevent the spread of STD/AIDS infections.

**High Risk Sexual Behaviour in Men and Women**

Studies have shown that HIV infection is associated with being separated or widowed, having multiple sex partners, having syphilis or a history of genital discharge, receiving injections and travelling to urban centres (Barongo et al. 1992).

Both women and men engage in high risk behaviour. Although it is generally acceptable, even expected, for men to have sexual partners outside of marriage, this is not the case for women. However, in sub-Saharan Africa, there are examples of rituals where women are permitted to have extra-marital sexual contacts. Examples include the following: the birth of twins; funerals, especially the funeral of the husband; and weddings, where the bride’s paternal aunt might have sex with the groom before the bride does. Outside of these situations, it is generally not acceptable for women to have sexual partners outside of marriage.

Despite this prohibition, there may be situations where women themselves feel justified to take another sexual partner (for example, if the husband does not materially provide for her, to gain greater sexual satisfaction, or for revenge on an unfaithful husband) (McGrath et al. 1993).

**Adolescents and STDs/AIDS**

The reduction of the incidence of STDs/AIDS through sustained behavioral changes poses particular problems in the case of adolescents. Recent studies suggest a trend towards increased sexual experimentation, by more adolescents, at a younger age, with more sexual partners (Cochran and Peplau 1991), and without the benefit of effective or regular contraception (Lema and Kabeberi-Macharia 1992). Several surveys confirm that substantial numbers of adolescents engage in sexual behaviours associated with HIV risk (Center for
Disease Control 1989; DiClemente et al. 1992). Adolescents tend to see themselves as immortal and invulnerable (Gray and House 1989), and these factors make them a high risk group (Jurich, Adams and Schulenberg 1992). Experts predict that adolescents are at great risk from the spread of HIV (Hein 1990), and the magnitude of the problem is already evident in some sub-Saharan countries, where adolescents represent a large section of the population. The results from a genital ulcer disease study in Nairobi found that, of 347 female patients with the disease, 108 (31%) were adolescents (12-20 years). 69.5% of the adolescents had a regular sex partner and 90% of them reported that they had acquired their STD from their regular sex partners (Nasio et al. 1993).

Programs designed to increase adolescents’ knowledge about HIV have not eliminated high risk behaviour (Baldwin, Whitely and Baldwin 1990). Available evidence suggests that adolescents continue to engage in high risk sex, even after participating in education programs (Thurman and Franklin 1990; DiClemente et al. 1992). Programs attempting to promote the use of condoms as a preventive measure have only increased awareness and not usage (Jay et al. 1988). Effective education of adolescents on disease prevention is urgently needed (St. Lawrence et al. 1993).

Counselling

One possible strategy to increase gender role convergence is counselling. Counselling, based upon a sound theoretical foundation, may help individuals to consider the consequences of their role behaviour and make informed choices about future options.

There are many therapeutic benefits of counselling, including the following:

1. insight - the person learns something important about herself/himself;
2. self-disclosure - the person feels confident to reveal sensitive information about herself/himself;
3. acceptance - the person feels accepted as a respected individual;
4. instillation of hope - the individual comes to believe that improvement is possible;
5. catharsis - the person can release strong suppressed emotion;
6. guidance - receiving help with personal problems;
7. universality - the person appreciates that people share similar problems;
8. altruism - when the person comes to understand that s/he is important in the lives of others through helping them;
9. vicarious learning - understanding the course of other people’s therapy;
10. interpersonal action - where people relate more sensitively, intimately or assertively to each other (Bloch and Crouch 1985).

Counselling and STDs/AIDS

For many years, counselling has successfully educated people about STDs/HIV (Green, 1989), promoting behavioral change and condom usage. Furthermore, counselling
patients with HIV infection has helped them to behave in ways that both retard progression of the disease and reduce transmission of the virus (Peltzer et al. 1989). There is also evidence that counselling has succeeded in reducing the risk of STD/HIV infection in women (Allen et al. 1992).

Counselling was adopted as a means of education and medical care in sub-Saharan Africa when the AIDS virus first appeared. Some counselling has focused upon general populations in rural areas (Chavva 1990), while other approaches have identified high risk groups in urban centres (Simonsen et al. 1990). Changing sexual behaviour patterns was initially believed to be the major way of limiting the spread of STD/HIV infections. However, attempts to control sexual behaviour through education have not always proved successful. In a recent study of male truck drivers with a 25% prevalence of HIV, 90% had sufficient knowledge of STDs and HIV, including knowledge of condoms and lower risk behaviours (Bwayo et al. 1991). Despite this knowledge, two thirds of the men reported at least one prostitute contact in the past year, and 25% reported prostitute sexual contacts on a weekly basis.

Counselling, therefore, has had limited success in changing behavioral patterns, as articulated by one commentator:

Our benign and hopeful assumption that reasonable people given reasonable information in a reasonable way would be reasonably likely to make reasonable changes in their behaviour to reasonably reduce their risks of acquiring HIV turned out to be unreasonable (Keeling 1993, p.307).

It is inadequate to use counselling simply as an educational medium. While counselling has had some success in educating individuals about the risks of STDs/AIDS, there needs to be more focus on the role of counselling in helping to achieve sustained behavioral change.

Counselling is based upon a range of theoretical foundations and some are better at initiating change, while others are better at sustaining change. Although behavioural theories have shown that counselling can initiate change (Rachman and Wilson 1980; Leonard and Hayes 1983), they have not been seen to sustain change (Bandura 1977). Psychoanalytical and humanistic theories, however, have shown that counselling can sustain change (Rogers 1980). Therefore, it might be beneficial to combine different axioms drawn from behavioural, psychoanalytic and humanistic theories to provide an unified theory for STD/AIDS counselling. The following axioms are particularly relevant:

1. the 'self' concept is the central construct by which counselling interventions can be understood and monitored;
2. sexuality is a powerful motivating drive;
3. there is a need to guide, advise and inform people about STDs/AIDS;
4. people have the ability to solve their own psychosocial problems given a supportive climate;
5. much dysfunctional behaviour has been learnt and can therefore be unlearnt and substituted with preferable behaviour;
6. it is often possible to find the cause of behavioral patterns; an understanding of the cause may serve to positively influence future behaviour;
7. individuals have the ability to determine their own future;
8. the optimum characteristics of genuineness, warmth, empathy and concreteness are required by counsellors;
9. counsellors should respect the uniqueness and singularity of each client.

These principles constitute a unified theory which amalgamates axioms from the three theoretical positions and should provide a therapeutic intervention (Balmer 1991). This theoretical approach has been evaluated with respect to HIV counselling research, and has been effective (Balmer 1993a). The approach concentrated upon feelings, and group members were always encouraged to focus upon emotions.

In implementing the unified theory, it is suggested that a range of intervention strategies be developed, aimed at increasing the degree of convergence of gender roles. The range would include mixed groups, families, couples, single sex groups and individual counselling. Each format offers different therapeutic outcomes. However, groups composed of both men and women may be most effective in initiating and sustaining behaviour change. Single sex formats tend to arrive at consensual gender norms, reinforcing existing behaviour patterns. On the other hand, mixed formats may encourage behavioral change; intra-group conflicts may lead to increased understanding of other points of view (Balmer 1992). Greater understanding facilitates shared experiences and the emergence of a common vocabulary, and both enlarge the area of convergence.

In summary, counselling has been effective as an educational medium in initiating some change, however there is little evidence to suggest that it has been sustained. STD/AIDS counselling based upon the unified theory has produced some sustained changes, but much more work needs to be done to refine this approach. Interventions should incorporate the complete range of individual and group counselling, and should be available in either single sex or mixed formats, but mixed formats may be the most practical in achieving the maximum therapeutic effectiveness.

**Women and Group Counselling**

While it is clearly important that men and women work together to develop new behaviour skills, group counselling may also play an important role for women. Research has demonstrated that group counselling provides an effective format for helping women deal with self-concept issues. In a group, women are able to share common experiences and perceptions. Group counselling has many demonstrated benefits for women; it has been shown to improve self-esteem and often leads to a sense of empowerment (Weitz 1982).
Women may be encouraged to express feelings, reduce anxieties, examine values and develop behaviour skills which facilitate self-expression (Moore 1981). Groups decrease isolation and provided a context where women could gain support and validation from each other. Women’s groups act as effective antidotes to negative gender socialisation, because women can learn to gain and share power by participating actively, and practice new skills in a safe environment (Burden and Gottlieb 1987). In sub-Saharan Africa, rural women have always found strength in informal organisations, mobilizing themselves around specific needs and activities, using kinship ties, neighbourhood groups and other informal networks to accomplish their aims (March and Taqqu 1982; Ulin 1992).

**Men and Counselling**

There is considerable evidence in the literature that men talk less about their emotions than women (Maracek and Johnson 1980), and that it is against the masculine gender role to seek therapy (Carlson 1987). Counselling can help men to express emotions other than anger (Pasick, Gordon and Meth 1990) and to become more intimate. In men, intimacy has become confused with vulnerability and loss of autonomy (Good, Gilbert and Scher 1990), and men need to be encouraged to explore their resistance to emotional expression. Problems of establishing intimacy is one of the prime reasons why men seek counselling (Silverberg 1986).

There is evidence that men no longer wish to engage in high risk sex, but they do not have the ability to discuss the change with their stable sexual partners (Balmer 1993b). Some men want to re-negotiate their relationships so that they may find more sexual excitement in their stable relationships. They would also like their partners to discuss their needs. While this type of sharing may initially create anxiety and discomfort, it will ultimately lead to increased gender convergence.

**Conclusion**

Sustainable behaviour change may be possible when gender roles converge, but concentrating upon either male or female gender roles exclusively may be counterproductive. Counselling can facilitate the process of gender convergence, through individual and group counselling in either single or mixed groups. This is done by increasing understanding within and across genders, which then facilitates shared experiences and the emergence of a common vocabulary. Gender convergence is a feasible aim which may in time reduce the incidence and prevalence of STD/AIDS, through sustained behavioural change.

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