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
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

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

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

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 173

Refugees, Gender and Health
Nkosazana Zuma
Discussion 181

Feminist Methodology in Relation to the Women’s Health Project
Barbara Klugman 187

Maternal and Child Health Care in Teso, Uganda: Social Issues
Hellen Rose Atai-Okei 205

Social Policies, Gender and Health in South Africa
C. C. Jinabhai 211

Gender and Household Health Seeking Behaviours
Jane Kwawu 225

Working Group Discussions

Working Group I - Gender and Disease 233
Working Group II - Health, Environment and Gender 238
Cross-Cutting Issues 243

Related Topics and Initiatives Informally Presented at the Workshop

Global Commission on Women’s Health
Maureen Law 247

Gender Analysis and Research Methodology: Key Questions and Issues
Gender and Development Program 254

Healthy Women Counselling Guide: A Multi-Country Intervention Study
Carol Vlassoff 256
Sharing Experience: African Women Development and Communication Network (FEMNET)
Rosemary Gitachu

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

Health and the Status of Women in Canada
Janet Hatcher Roberts

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

Participants

"Gender and Tropical Diseases: Facing the Challenge"
Abstracts from an Essay Competition Sponsored by IDRC and TDR
Foreword

The collection of papers and abstracts appearing in this publication emerged from a 1993 workshop as a result of two processes that were initiated to better understand the gender differentials in tropical diseases in the overall context of health and sustainable development. First, in 1989-1990, an initiative was jointly undertaken by IDRC’s Health Sciences Division and Gender and Development Unit with the Special Program for Research and Training in Tropical Diseases (TDR) of the World Health Organization (WHO). Health researchers were invited to submit papers on the topic Women and Tropical Diseases in an essay competition sponsored by the two agencies. Based on the submitted papers and the selection process, a publication resulted entitled, Women and Tropical Diseases and on Gender and Tropical Diseases: Facing the Challenge, respectively.

Although the general quality of the papers in the essay was good, the competitions also highlighted gaps in knowledge. A growing feeling both at IDRC and at TDR of the need to increase the sensitivity of health and health-related researchers on gender issues and gender analysis methodology led to designing strategies for drawing increased attention on these areas. A collaborative initiative by IDRC’s Health Sciences Division with the Gender and Development group and the East Africa Regional Office (EARO) jointly with TDR, led to a workshop for researchers on Gender, Health and Sustainable Development. This was held in Nairobi October 5-8, 1993. The workshop included invitees from Kenya, Uganda, Ethiopia, Tanzania, Zimbabwe, Zambia, South Africa, Ghana, Nigeria, Cameroon, and the United States, and focused on four topic areas: (1) AIDS, Sexually Transmitted Diseases and Gender; (2) Tropical Diseases, and Gender, (3) Social Issues, Gender and Health, and (4) Environmental Stress, Production Activities, Health and Gender.

The overall framework of the workshop consisted of thematic plenary presentations, in-depth discussions of emerging issues, and smaller working groups sessions that further analyzed the issues on a gender analysis rationale. It is believed that this collection of papers represent significant advancement on gender, health and development issues, and will stimulate further work in this important area. The papers have scientific validity and interest in their own right, but they also are important indicators of the current state of the literature on this subject. As such, it is anticipated that they will serve to inspire further interdisciplinary research on gender, health and development. It is hoped that this publication will inspire more collaborative work and networking among researchers working in the biomedical and social sciences fields. A complementary workshop on this subject area is also being planned for 1994 in the Latin American-Caribbean region.

Panduka Wijeyaratne
Principal Program Scientist
Acknowledgements

This workshop and the publication of its proceedings was made possible through a grant from the International Development Research Centre (IDRC).

We wish to thank the Nairobi-based members of the Organizing Committee who contributed their time, effort, and enthusiasm to the workshop and to the production of this manuscript. We would like to take this opportunity to acknowledge them, and to give them our special thanks: Eva Rathgeber, Regional Director for IDRC’s East Africa Regional Office, and regional staff. In particular, Rosa Ongeso and Mary-Anne Muthoni assisted in the Secretariat during the workshop, and David Mwendwa who provided timely and efficient transportation of all participants between Karen and Nairobi.

We are grateful to those who helped type the papers for this book: Diane Dupuis and Suzanne Soroka and especially Betty Alce of IDRC who has competently and with great patience handled the tasks of formatting the manuscript for publication. Also, Angie Anton and the travel staff who provided the usual efficient flawless travel arrangements for the workshop participants.

We are grateful to all of the participants who presented papers and engaged in frank and lively discussions in a constructive manner.

We remain responsible for the summaries in this manuscript and hope that they reflect accurately both the discussions that took place and the intention of the papers.

Janet Hatcher Roberts
Pandu Wiyeyaratne
Rosina Wiltshire
Introduction

Maureen Law

The International Development Research Centre (IDRC) was very pleased to sponsor this workshop on Gender, Health and Sustainable Development, in collaboration with the World Health Organization (WHO). The Centre has had a longstanding interest in research relating to gender issues in development. IDRC has a special unit to address these matters, known first as Women in Development, and more recently as the Gender Unit. Furthermore, the Health Sciences Division has been active in supporting research and research-related activities on gender and health.

This has resulted in many published articles, as well as several workshops which produced publications. It also led to collaboration with TDR/WHO in sponsoring an essay competition focusing on gender issues in tropical disease. The third of these competitions has recently been completed and will result in a publication entitled, "Gender and Tropical Diseases: Facing the Challenge". The abstracts from this competition can be found at the end of this publication.

IDRC is happy to be working with WHO on this workshop which is related not only to our alliance with TDR on gender issues, but also to the work of the Global Commission on Women's Health, which WHO established in response to a World Health Assembly resolution in 1992.

This workshop is the first of at least two. The second will be held in the Caribbean/Latin American region in April 1994. We will again be working with the Global Commission, as well as PAHO, on the development of the workshop.

These joint workshops are just one of many current collaborative efforts on gender issues in development. For example, IDRC staff members, especially Rosina Wiltshire, are working to assist in the preparation for the Beijing Conference in 1995. Also, I personally have been chairing a study of Female Morbidity and Mortality in sub-Saharan Africa for the IOM/NAS in the United States.

IDRC has worked with many organizations and institutions on gender issues, and we expect to continue to do so in the future. Despite all of this activity in the field, much remains to be done. There are still major gaps in our understanding of gender and health, especially in developing countries. Let me mention just a few:

1Director General, Health Sciences Division, International Development Research Centre.
• Health, disease, illness and death everywhere exist within, and are influenced by, socio-cultural, economic and political contexts, but how much do we really know about their differential impacts on males and females? Moreover, health is also affected by how these factors interact. For example, female education, gender power relations, and AIDS, must be considered not only separately, but also as dynamically inter-connected.

• There is a need for more interdisciplinary and intersectoral research to assist in the development of policies and programs to reduce gender inequities in health - whether they relate to the greater burden of chronic ill health in African women, or to the shorter life expectancy of men in North America.

• There is a great need for more research producing data desegregated by sex. For example, in the course of the IOM study, we have confirmed what you would no doubt expect - that there is very little African literature on injuries, occupational health or mental health - and almost nothing on gender differences in these areas.

• We need more research in developing countries, especially on health of school age girls and women after menopause. For many years, there has been a close scientific scrutiny of the health of both boys and girls during infancy and early childhood and of women’s health related to reproduction, but the rest of the lifespan - especially for women - has been largely ignored.

• How much has been documented about the sensitivity of our health care system to the special needs of women? Health systems research, which includes consideration of gender issues, would be helpful.

• What do we know about gender-related accessibility to, or acceptance of, innovative health technologies? How much do we know about gender differences in the health impact of various development strategies, including structural adjustment?

Obviously this is not an exhaustive review of the research needs with regard to Gender, Health and Sustainable Development, but perhaps it is enough to remind us that there is plenty of work to keep us all very busy if we are to achieve our joint goals of health for all and sustainable development. This workshop publication represents a significant contribution to the achievement of this research agenda.
Opening Address

Margaret Kenyatta

It is indeed a great honour and privilege for me to be here today to share some thoughts with you at this Gender, Health and Sustainable Development Workshop. I wish at this juncture to congratulate the International Development Research Centre (IDRC) and the World Health Organization (WHO) for holding this very important workshop which I am certain will contribute towards sensitizing and promoting awareness and concern about the health situation of women in Africa.

This Workshop is indeed laudable as it is within the framework of the WHO Global Commission on Women's Health, which seeks to raise the profile of gender, health and development to the international scene, and as a result, the integration of women’s interest in decision-making roles and perspectives into the mainstream of national health development plans. Without doubt, the objective which we set ourselves, to provide health for all, will be unattainable if the gender-inspired inequalities in health are not addressed by incorporating gender values into health and health-related sectors.

Ladies and Gentlemen, over the years, there has been a tendency to identify a person’s sex as a key variable in determining risks and responses to infection. Yet this sex categorization alone cannot provide sufficient understanding of the full impact of disease, and hence it is necessary to take into account the broader spectrum of gender relations. I wish to state that gender refers not only to sex, but also to the wide variety of behaviours, expectations and roles attributed by social structures to women and to men.

A gender approach to disease therefore examines both the differential impact to women and men and also the social, cultural and economic contexts within which they live and work. Gender analysis of health begins from a global perspective, with attention to the well-being of the individual - not as a mother, father or child - but as a human being with personal needs, priorities and preferences. It sees women and men as the principal agents of their own health.

However, there has been a lack of attention to women’s health, particularly in developing countries, beyond the context of their reproductive roles. Yet women’s health should be considered as a human right. Health should be seen as a fundamental non-negotiable human right.

\[1\text{Former Kenyan Ambassador.}\]
Moreover, it is even more imperative and appropriate that relevant research is carried out to identify ways and means of enhancing women’s health status in the developing countries. This information would then be widely disseminated and effectively shared. I note with appreciation that this is what this workshop has set out to do. Namely, to provide opportunities for researchers funded by IDRC, WHO and other organizations to share experiences and results from ongoing and recently completed research, to identify gaps with respect to the role gender differentials play in health status, and third, to introduce researchers to gender analysis methodologies.

Ladies and Gentlemen, the question then arises, what needs to be done to improve the health status of women? Women in developing countries, for the most part, are affected by poor health and do not have access to better health facilities and services. This is despite the fact that in most households women have the main responsibilities for a broad range of activities that affect health. They manage household chores, keep the house clean, process foods and prepare meals, feed and care for young children, and look after the sick. Women’s own health and their efficiency in using available resources have an important bearing on the health of others in the family, particularly children.

A starting point, I believe, would be ensuring access to education for women. Education greatly strengthens women’s ability to perform their vital role in creating healthy households. It increases their ability to benefit from health information and to make good use of health services, it increases their access to income, and enables them to live healthier lives.

In this regard, and because people’s ability to improve their own health depends so much on income and education, I would wish to call for policies that boost economic growth, reduce poverty, expand schooling, especially for girls, and help strengthen women’s ability to care for their families.

In addition to education, other policies can enhance women’s capacity to improve their health and that of their families. Removing discrimination - in the labour market, in access to credit, in property law, and so on - can boost women’s earnings and financial security, which can promote family health. And women need to be healthy themselves to fulfil their roles as mothers and household managers. Furthermore, a strategy needs to be evolved to integrate women in health care from adolescence onward.

Another area of concern in women’s health status, is domestic violence and rape. Although this has only recently been viewed as a public health issue, it is a significant cause of female morbidity and mortality, leading to psychological trauma and depression, injuries, sexually transmitted diseases, suicide and murder. Rape and domestic violence cause a substantial and almost comparable level of disease burden per capita to women in developing and industrial countries. These problems account for about 5 per cent of the total disease burden among women aged 15-44 in developing countries, where the burden from maternal
and communicable causes still overwhelms that from other conditions. By damaging a woman’s physical, mental and emotional capacity to care for her family, domestic violence and rape also hurt the health of other family members, especially young children.

Another factor impeding better health for women is the reduction of the provision of state-supported health care services due to economic restructuring, which has meant a decline in the quality of and access to services. In these situations, women are less inclined to use formal health care services.

Ladies and Gentlemen, the solutions and remedies for creating a better health status for women are varied and sometimes complex and involving. However, I believe strongly that what is required is a concerted effort by both governments and the international community. Donors and developing country governments can also do much to improve the effectiveness of aid for health. This is especially important in African countries with low incomes, where aid already accounts for an average of 20 per cent of health spending. In addition, the benefits to the developing world from adopting sound policies for health are too enormous to be overlooked.

In conclusion, Ladies and Gentlemen, I would wish to note that it is only healthy women, men and children who can participate in the sustainable development of their countries. Let me once again thank you for the privilege of being able to offer these remarks on such an important occasion. I now declare this workshop officially open. Thank you.
AIDS, Sexually Transmitted Diseases and Gender
Socio-Cultural Determinants of HIV Infection in Zimbabwe

Gilford D. Mhloyi and Marvellous M. Mhloyi

Introduction

Zimbabwe, like many other African countries, is facing an AIDS problem of great magnitude. Concerted efforts must be made to reduce the number of future infections. The objective of this paper is to highlight some of the underlying factors of HIV infection. Specifically, it will present data from a recent study of the social-cultural determinants of AIDS in a rural community in Zimbabwe. It is hoped that an understanding of these factors will facilitate the formulation of educational packages which might be used for intervention.

Demographic, Socio-Economic and Cultural Factors

The demographic and socio-economic context of Zimbabwe provides a background for the spread of HIV and AIDS. Zimbabwe’s population has a high proportion of young people; infants and children below 15 years of age comprise approximately 47 percent of the population. Compared to other regions of the world, Zimbabwe, like many other African countries, has a relatively high proportion of future sexually active persons, child-bearers and infants who may be exposed to the risk of HIV infection. Furthermore, the main mode of transmission has been, and continues to be, heterosexual sex, rendering "main stream" society at risk.

Zimbabwe has a dual economy which is characterized by urbanized industrial centres and expansive agricultural communities which are connected by a well developed communication infrastructure. Families are often separated: males work in urban areas, while females remain in the rural areas. Couples, therefore, spend a large proportion of their sexually active and reproductive years away from each other. This often results in multiple sexual partnerships.

The practice of polygyny serves to legitimize male extra-marital relations. Males can justify extra-marital relations, explaining that they might evolve into additional marriages. While polygyny is generally low (only 10-15%), and possibly declining in both Zimbabwe and other African countries, there is a strong possibility that extra-marital liaisons are

---

1Department of Sociology, University of Zimbabwe, Mount Pleasant, Harare, Zimbabwe.

2This project is being funded by IDRC.
increasing and replacing formal marriages. These informal marriages may be associated with an increased risk of HIV exposure because there is limited control of sexual activity of informal "wives".

Finally, the cultural practice of postpartum sexual abstinence may also lead to multiple sexual partnerships on the part of the male. While sexual abstinence after the birth of a child is often proscribed for females, males are often allowed to "graze around".

**Zimbabwe and the AIDS Pandemic**

Zimbabwe has been greatly affected by the AIDS pandemic. Twelve percent of Africa's AIDS cases reported to the World Health Organization in 1993 were from Zimbabwe. The trend and pattern of the pandemic is similar to that of other African countries. While it is likely that there is a gross under-reporting of AIDS deaths, there is still an alarming rate of increase. For example, the number of reported AIDS deaths increased almost five-fold between 1987 and 1993 (see Table 1). Seroprevalence among pregnant women was found to range from 7.7% to 42%, with an average of 20.5%. Seroprevalence among STD patients, ranged from 24.5% to 59.6%, with an average of approximately 25%.

**Table 1: Reported number of AIDS cases in Zimbabwe (1987-1992)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of AIDS deaths</th>
<th>Cumulative number of AIDS deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>249</td>
<td>249</td>
</tr>
<tr>
<td>1988</td>
<td>420</td>
<td>669</td>
</tr>
<tr>
<td>1989</td>
<td>369</td>
<td>1038</td>
</tr>
<tr>
<td>1990</td>
<td>644</td>
<td>1682</td>
</tr>
<tr>
<td>1991</td>
<td>704</td>
<td>2386</td>
</tr>
<tr>
<td>1992</td>
<td>1208</td>
<td>3594</td>
</tr>
</tbody>
</table>

*source: Adapted from 1989 - 1992 NACP annual reports*

The data reveal that the ratio of male to female AIDS cases is 1.3:1 (see Table 2). Zimbabwe is in the advanced endemic stage and it is expected that women will soon overpass men in the number of AIDS cases. Furthermore, women tend to be infected at earlier ages than males. For instance, in the 5-29 age group, the ratio of males to females is less than
There is a decline in the number of AIDS cases in the older age groups. Despite this decline, a significant number of the elderly, often grandparents who are left to care for AIDS orphans, are also affected.

Table 2. Age and sex composition of reported AIDS cases in Zimbabwe between 1989-1992.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>Ratio of male to female cases</th>
<th>% of total cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 4</td>
<td>1683</td>
<td>1480</td>
<td>3163</td>
<td>1.14: 1</td>
<td>17.2</td>
</tr>
<tr>
<td>5 - 14</td>
<td>60</td>
<td>67</td>
<td>127</td>
<td>0.89: 1</td>
<td>0.69</td>
</tr>
<tr>
<td>15 - 19</td>
<td>71</td>
<td>382</td>
<td>453</td>
<td>0.19: 1</td>
<td>2.46</td>
</tr>
<tr>
<td>20 - 29</td>
<td>2574</td>
<td>3092</td>
<td>5666</td>
<td>0.83: 1</td>
<td>30.8</td>
</tr>
<tr>
<td>30 - 39</td>
<td>3602</td>
<td>2028</td>
<td>5630</td>
<td>1.78: 1</td>
<td>30.6</td>
</tr>
<tr>
<td>40 - 49</td>
<td>1554</td>
<td>660</td>
<td>214</td>
<td>2.35: 1</td>
<td>12.0</td>
</tr>
<tr>
<td>50 - 59</td>
<td>669</td>
<td>215</td>
<td>884</td>
<td>3.11: 1</td>
<td>4.81</td>
</tr>
<tr>
<td>60+</td>
<td>232</td>
<td>41</td>
<td>273</td>
<td>5.66: 1</td>
<td>1.48</td>
</tr>
<tr>
<td>Total</td>
<td>10445</td>
<td>7965</td>
<td>18410 (**</td>
<td>1.31: 1</td>
<td>100</td>
</tr>
</tbody>
</table>

Adapted from: 1989-1992 NACP annual reports.

(*) Data has been pro-rated.

(**) The table does not include the 321 AIDS cases reported before 1989 because this data was not broken into age and sex groups.

Sources of Data and Methodology

The study took place in a rural area in Manicaland province, situated in East Zimbabwe, approximately five hundred kilometres from the capital city, Harare. This site surrounds a large (by rural standards) business centre, located at an important intersection, with main roads leading to Harare via Mutare in the east, and to Masvingo, the largest town in Masvingo province, in the west. The centre is along the Birchenough bridge-Masvingo road, and on both sides of the bridge.

Four villages surround this business centre. Each village has its own a primary school, while they share a high school. They also share a clinic, located in the main business centre. The fifth village (the control) is twenty kilometres from this main business centre, along the Birchenough bridge-Mutare road. This village has its own amenities (a business centre, primary school, high school, and a clinic) almost similar to those shared by the four villages.
The study involved a Knowledge, Attitudes, Beliefs and Practices (KABP) baseline survey, which assessed AIDS awareness and sexual practices, including condom use. Then the intervention took place, followed by a post-intervention KABP survey. An open-ended structured questionnaire was used, as well as participant observations, group discussions and secondary clinical data. The sample comprised 1582 cases equally distributed between men and women. Clinical data have yet to be processed. This paper will present data from the baseline study, as well as qualitative data.

Knowledge and practices surrounding sexually transmitted diseases (STDs), the dependent variable, were also assessed. STDs are a very important co-factor, as evidenced by seroprevalence levels among STD patients. Bivariate cross-tabulations are used to describe the general relationships between the variables. Logistic regression is used to show the relationship between STDs and the explanatory variables. Interpretation of the quantitative results is enhanced by the qualitative data.

Results

a. AIDS Awareness by Demographic and Socio-Economic Variables

It is often assumed that high levels of knowledge regarding HIV and AIDS will facilitate the adoption of safer sexual practices. It is important to recognize that a measure of knowledge, based on simple awareness of AIDS, might be misleading. As shown in Table 3, AIDS awareness is almost universal; approximately 99% of respondents reported that they had heard of AIDS. This high basic awareness level can be found across all age, sex and marital groups. There are no marked socio-cultural differentials in AIDS awareness. 95.5% of followers of traditional religion were aware of AIDS. There was 100% awareness among those with a high level of media exposure (newspapers and radio).

Despite this widespread general awareness, there seems to be a lack of more detailed knowledge which might help to reduce the chance of acquiring HIV/AIDS. Approximately 36 percent (see Table 4) of the respondents reported that they did not know the difference between HIV sero positivity and AIDS, while 32% reported no difference between the two. Only 13 percent reported that a HIV positive person is healthier than one who is suffering from AIDS.
Table 3. Knowledge of the differences between HIV+ and AIDS victims

<table>
<thead>
<tr>
<th>Differences</th>
<th>Percent Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t know the difference</td>
<td>35.9</td>
</tr>
<tr>
<td>There is no difference</td>
<td>32.1</td>
</tr>
<tr>
<td>HIV+ victim is healthier</td>
<td>13.1</td>
</tr>
<tr>
<td>Not sure</td>
<td>3.4</td>
</tr>
<tr>
<td>HIV+ victim can be cured</td>
<td>0.9</td>
</tr>
<tr>
<td>Other</td>
<td>2.1</td>
</tr>
</tbody>
</table>

The data also reveals that there are misconceptions regarding the causes of AIDS (see Table 5). Only 19 percent of the respondents are aware of the fact that AIDS is caused by the HIV virus. The majority of the respondents believed that AIDS is caused by women, prostitutes, and soldiers, respectively. Only 12% reported multiple sex partners as a determinant of HIV infection. The results are consistent with the cultural belief that sexually transmitted diseases are a "woman’s disease", and that women are vectors, while men are victims. The association of AIDS with "high risk" sexual groups is a belief which serves to distance HIV infection from the main stream population.

Table 4. Causes of AIDS

<table>
<thead>
<tr>
<th>Causes of AIDS</th>
<th>Percent Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV virus</td>
<td>18.9</td>
</tr>
<tr>
<td>Women</td>
<td>21.4</td>
</tr>
<tr>
<td>Men</td>
<td>5.9</td>
</tr>
<tr>
<td>Prostitutes</td>
<td>16.8</td>
</tr>
<tr>
<td>Soldiers</td>
<td>11.6</td>
</tr>
<tr>
<td>Truck drivers</td>
<td>3.8</td>
</tr>
<tr>
<td>Many sexual partners</td>
<td>11.0</td>
</tr>
<tr>
<td>Other</td>
<td>10.5</td>
</tr>
</tbody>
</table>

There appears to be a greater understanding of AIDS symptoms, as shown in Table 6. 53% of respondents identified weight loss as a symptom of AIDS, while 38% identified continuous illness. 27% of respondents had no idea of the AIDS symptoms. While there is a relatively high level of understanding of AIDS symptoms, there is a general lack of comprehension concerning the latency period of HIV infection. Some young men believe that you can be careful "by picking a woman you can see is AIDS-free". Only 22% of those surveyed reported current use of condoms.
Table 5. Symptoms of AIDS

<table>
<thead>
<tr>
<th>Symptoms of AIDS</th>
<th>Percent Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>No idea of AIDS symptoms</td>
<td>27.3</td>
</tr>
<tr>
<td>Weight loss</td>
<td>52.8</td>
</tr>
<tr>
<td>Continuous illness</td>
<td>38.3</td>
</tr>
<tr>
<td>Wounds/pimples</td>
<td>6.1</td>
</tr>
<tr>
<td>Swelling</td>
<td>1.5</td>
</tr>
<tr>
<td>Other</td>
<td>10.7</td>
</tr>
</tbody>
</table>

b. Sexually Transmitted Diseases by Demographic and Socio-Economic Variables

i. Bivariate Results

STD prevalence is almost identical for males and females, with a slightly higher rate among females. Female rates may be even higher since there tends to be an under-reporting of STDs among women. Approximately 15% (see Table 7) of the respondents reported having had a STD in the past year. STD experience is highest for the middle age group (20-40 years).

Marital status is a significant factor with regard to STD prevalence. STD prevalence ranges from 6% among the widowed to 34.4% among the divorced. However, bivariate results showed no marked socio-economic differentials in STD experience.

It is worth noting that AIDS awareness does not seem to have a negative impact on STD experience. Those who report an awareness of AIDS are more likely to have contracted a STD in the past year than those who report no knowledge of AIDS. Even those people who know the difference between HIV positivity and AIDS are more likely to have experienced a STD than those who do not know the difference.

Condom use does not seem to have the expected negative impact on STDs. While 11% of those people who were not currently using condoms reported a STD experience in the past year, approximately 22% of current condom users reported a STD experience. A possible explanation may be that condom use is precipitated by a STD experience.

Although these bivariate results give some idea regarding the possible relationships between demographic and socio-economic variables and STD experience, it is possible that significant differences are masked by such a simplistic analysis which does not consider the complexity of interrelationships between variables. Thus, a multivariate analytic technique based on logistic regression, using maximum likelihood estimation, was employed to re-examine some of the relationships.
ii. Multivariate Analysis Based on Logistic Regression

Most of the background variables which are considered in the bivariate analyses were selected for inclusion in the regression equation with experience of STDs as a dichotomous dependent variable. All the independent variables are also entered as dummies with one category omitted from the model for reference.

Unlike the bivariate analyses, results from the logistic regression show that there are some demographic and socio-economic differentials in STD experience. Consistent with the bivariate analysis, males are slightly less likely to have contracted a STD than females (Table 7 below). However, there is no distinct relationship between STD experience and age. The youth (10-19-years old) are less likely to have contracted a STD that those aged at least 40 years, a group which tends to show the highest chances of having had a STD.

Significant differences, depending on marital status, were found. Being married reduces the likelihood of STD experience, while having a dissolved marriage increases the likelihood. Separated people are about 4 times more likely than single people to have experienced a STD. The widowed and divorced are approximately 1.7 and 2.5 times, respectively, more likely to have contracted a STD than single persons. Those who have at least five regular partners are 1.3 times more likely to have experienced a STD than those with no regular partner. Finally, migration has a positive impact on STD experience.

There is a positive relationship between a STD experience and duration of time that a person has been out of the village. Those who have spent their time in towns and cities during their absence from the village are 1.2 times more likely to have a STD experience than those who spent most of their time in another village.

With regard to education, having very little formal education is positively related to having a STD experience. However, those with ten years of education are at least 1.5 times more likely to have contracted a STD than those who have never attended school. Finally, those with at least 11 years of education are less likely to have contracted a STD than those who have no education.
Table 6. Logistic regression of STD experience by selected background variables.

<table>
<thead>
<tr>
<th>Variables/Categories</th>
<th>Coeff</th>
<th>S.E.</th>
<th>Wald</th>
<th>O.R.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>-0.1162</td>
<td>0.1949</td>
<td>0.3554</td>
<td>0.8903</td>
</tr>
<tr>
<td>Female (R.C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-19</td>
<td>-2.0350</td>
<td>0.3869</td>
<td>27.660</td>
<td>0.1307</td>
</tr>
<tr>
<td>20-29</td>
<td>-0.0619</td>
<td>0.2078</td>
<td>0.0888</td>
<td>0.9400</td>
</tr>
<tr>
<td>30-39</td>
<td>-0.4494</td>
<td>0.2504</td>
<td>3.2217</td>
<td>0.6380</td>
</tr>
<tr>
<td>40+ (R.C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Away last 12 months:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0.3799</td>
<td>0.2835</td>
<td>1.7963</td>
<td>1.4622</td>
</tr>
<tr>
<td>No (R.C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weeks away last 12 months:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>less than 1 week (R.C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4</td>
<td>0.1531</td>
<td>0.6702</td>
<td>0.0522</td>
<td>1.1654</td>
</tr>
<tr>
<td>5-8</td>
<td>0.2822</td>
<td>0.5226</td>
<td>0.2916</td>
<td>1.3261</td>
</tr>
<tr>
<td>9-24</td>
<td>0.3185</td>
<td>0.6078</td>
<td>0.2746</td>
<td>1.3750</td>
</tr>
<tr>
<td>25+</td>
<td>0.5451</td>
<td>0.5535</td>
<td>0.9698</td>
<td>1.7248</td>
</tr>
<tr>
<td>Migrations:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Village (R.C)</td>
<td>0.1764</td>
<td>0.2357</td>
<td>0.5601</td>
<td>1.1929</td>
</tr>
<tr>
<td>City</td>
<td>0.1186</td>
<td>0.3284</td>
<td>0.1305</td>
<td>1.1260</td>
</tr>
<tr>
<td>Town</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single (R.C)</td>
<td>0.5415</td>
<td>0.2302</td>
<td>5.5255</td>
<td>0.5447</td>
</tr>
<tr>
<td>Married</td>
<td>0.9202</td>
<td>0.4742</td>
<td>3.7664</td>
<td>1.7187</td>
</tr>
<tr>
<td>Widowed</td>
<td>-0.6076</td>
<td>0.5692</td>
<td>1.1395</td>
<td>2.5099</td>
</tr>
<tr>
<td>Divorced</td>
<td>1.3262</td>
<td>0.4458</td>
<td>8.8499</td>
<td>3.7669</td>
</tr>
<tr>
<td>Separated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of Marriages/RP:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None (R.C)</td>
<td>-0.6233</td>
<td>0.8878</td>
<td>0.4930</td>
<td>0.5361</td>
</tr>
<tr>
<td>1-4</td>
<td>0.2913</td>
<td>0.8916</td>
<td>0.1067</td>
<td>1.3382</td>
</tr>
<tr>
<td>5+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Att (R.C)</td>
<td>0.5551</td>
<td>0.2341</td>
<td>5.6247</td>
<td>1.7421</td>
</tr>
<tr>
<td>Grade 1-5</td>
<td>0.4586</td>
<td>0.2408</td>
<td>3.6271</td>
<td>1.5818</td>
</tr>
<tr>
<td>Grade 6-7</td>
<td>0.4682</td>
<td>0.2441</td>
<td>3.6789</td>
<td>1.5970</td>
</tr>
<tr>
<td>Form 1-3</td>
<td>-3.8931</td>
<td>15.729</td>
<td>0.0613</td>
<td>0.0204</td>
</tr>
<tr>
<td>Form 4+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>-0.3738</td>
<td>0.1901</td>
<td>3.8666</td>
<td>0.0121</td>
</tr>
<tr>
<td>Spiritual</td>
<td>-0.2476</td>
<td>0.2538</td>
<td>0.9513</td>
<td>0.6550</td>
</tr>
<tr>
<td>Traditional</td>
<td>-4.4167</td>
<td>15.6331</td>
<td>0.0798</td>
<td>0.7807</td>
</tr>
<tr>
<td>Other (R.C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farmer</td>
<td>-0.4231</td>
<td>0.3087</td>
<td>1.8779</td>
<td>0.0053</td>
</tr>
<tr>
<td>Soldier</td>
<td>-0.6691</td>
<td>0.5108</td>
<td>1.7758</td>
<td>0.6550</td>
</tr>
<tr>
<td>Driver</td>
<td>-5.2313</td>
<td>7.6103</td>
<td>0.4725</td>
<td>0.5122</td>
</tr>
<tr>
<td>Manual Worker</td>
<td>-0.5625</td>
<td>0.4713</td>
<td>1.4246</td>
<td>0.5698</td>
</tr>
<tr>
<td>Proff</td>
<td>-1.3118</td>
<td>0.7483</td>
<td>3.0732</td>
<td>0.2693</td>
</tr>
<tr>
<td>Others</td>
<td>-0.4789</td>
<td>0.4383</td>
<td>1.1937</td>
<td>0.6195</td>
</tr>
<tr>
<td>Not Emp (R.C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Read Newspaper:</td>
<td>Daily</td>
<td>Most days</td>
<td>Once a week</td>
<td>Less Often</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------</td>
<td>-----------</td>
<td>------------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>0.2592</td>
<td>0.2050</td>
<td>1.5989</td>
<td>1.2959</td>
</tr>
<tr>
<td></td>
<td>0.2790</td>
<td>0.4620</td>
<td>0.3646</td>
<td>1.3218</td>
</tr>
<tr>
<td></td>
<td>0.6384</td>
<td>0.3781</td>
<td>2.8499</td>
<td>1.8934</td>
</tr>
<tr>
<td></td>
<td>0.2875</td>
<td>0.3963</td>
<td>0.5264</td>
<td>1.331</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Listen to Radio:</th>
<th>Daily</th>
<th>Most days</th>
<th>Once a week</th>
<th>Less often</th>
<th>Never (R.C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-0.4086</td>
<td>0.6668</td>
<td>0.3754</td>
<td>0.6646</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.0097</td>
<td>0.2985</td>
<td>0.0011</td>
<td>0.9219</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-0.0813</td>
<td>0.2247</td>
<td>0.1310</td>
<td>1.0098</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.2062</td>
<td>0.2879</td>
<td>0.5139</td>
<td>1.2292</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Condom Use:</th>
<th>Yes</th>
<th>No (R.C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-0.0766</td>
<td>0.2734</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AIDS Awareness:</th>
<th>Yes</th>
<th>No (R.C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-0.4432</td>
<td>0.6092</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Difference between HIV+ AIDS:</th>
<th>Don't know (R.C)</th>
<th>No difference</th>
<th>HIV+ is healthier</th>
<th>Not sure</th>
<th>HIV+ can be cured</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.3318</td>
<td>0.1865</td>
<td>3.1659</td>
<td>1.3935</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.4004</td>
<td>0.2402</td>
<td>2.7784</td>
<td>1.4924</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.1151</td>
<td>0.4252</td>
<td>0.0733</td>
<td>1.1220</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-0.0687</td>
<td>0.8172</td>
<td>0.0071</td>
<td>0.9336</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.2503</td>
<td>0.5034</td>
<td>0.2473</td>
<td>1.2845</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Coeff—coefficient  S.E.—Standard Error  Wald—Wald Test  O.R.—Odds Ratio

With regard to religion, this study only distinguished between Christians, spiritualists, traditionalists and atheists. While most people in Zimbabwe, particularly the educated, report that they are Christians, they may also believe in traditional religion to some extent. Distancing from traditional religion is usually associated with modernity rather than religious conviction. There is little significant behavioral differences between Christians of different denominations. Spiritualists, however, do not believe in the Western medical system. Study results show that believing in some form of religion reduces the risk of a STD infection. Christians are less likely to have experienced a STD than traditionalists. Poverty appears to predispose people to STD infections. Being employed, regardless of occupation, reduces the likelihood of STD infection.

Results on media exposure variables are mixed. People who report exposure to newspapers are more likely to have contracted a STD than those who do not. However, listening to radio has a negative impact on STD experience.

AIDS awareness tends to reduce the likelihood of STD infection. However, individuals with greater levels of knowledge about AIDS are more likely to have contracted a STD than those who cannot even distinguish the difference between those who are HIV positive and those with AIDS.

17
As expected, those who reported current use of condoms are less likely to have contracted a STD within the past year than non-users.

**Discussion**

Results reveal that a knowledge of AIDS reduces the chances of having contracted a STD within the past year. However, people with more knowledge with regard to AIDS and HIV infection are more likely to have contracted a STD than those with limited knowledge. The focus discussions brought out the fact that many people appear to doubt the knowledge that they have.

The depth of knowledge with regard to the diseases is extremely limited and not necessarily part of the culture. Knowledge gained through informal channels, such as the mass media, is of limited effectiveness since people do not have the opportunity to ask questions. One-way communication is often incomplete, and may be interpreted to be mere propaganda. First-hand experience, on the other hand, often has better success in promoting behavioral change.

Some people may act on insufficient and incomplete information, often to their detriment. In the words of one 30 year old man who purported to know a great deal about AIDS, *Since I got to understand more about AIDS, I only go out with younger girls, or even married women if I can; no more prostitutes.* As noted earlier, some men believe that they can determine whether or not a woman is HIV positive, and report that *these days you have to be careful with the choice of partners.* Some choose to ignore the information on HIV/AIDS and refuse to alter their sexual behaviour. As one 40 year old man remarked, *Death is with us, we can’t run away from it.* In the words of one woman, *Well, we are all HIV positive, no one will remain; it is just a question of time.*

As people observe more and more people dying of AIDS, some may assume that they are also infected and decide that there is no benefit in changing behaviour. People learn to live with AIDS and sometimes unnecessarily tolerate death; a silent conspiracy of complacency develops.

Many women feel incapable of protecting themselves from infection. As women generally noted, *what can we do, men will always graze around.* Unfortunately most women report that they cannot initiate safe sex because it is not culturally acceptable. As one women remarked, *if you want to get divorced, try asking your husband to use a condom.* However, other women reported that they often use a condom for many weeks when their husbands return from town until they are sure he is no longer infected. Disturbingly, some women appear to be unaware that they can be infected by their husbands. One 35 year old woman believes that *the AIDS problem is for the men who spend time with prostitutes, this is not our problem.*
The fact that exposure to radio is more likely to reduce the likelihood of STD infection than exposure to newspapers, tends to suggest that people need to identify more with the mode of communication. Most of the radio shows include question and answer sessions, and the fact that they are live presentations tends to make such discussions more realistic.

Our study experimented with different educational approaches, including drama, songs and discussions. We brought both men and women together from all age groups, and exposed them to important messages about AIDS through drama, the use of role models and discussions. These types of innovative approaches served to reduce communication barriers, as well as inform people about key issues.

It is crucial to break down barriers to communication. The play and the songs were filled with conversation-provoking lines. For example, one line from the play read, Theresa, don't you know that when you are in the middle of that business, you can barely think of a condom? The business alluded to was sex. This line caused children below the age of puberty to laugh, while older children looked down. Parents initially were surprised, but then often started to laugh. In the discussions, participants of all ages and both sexes raised important questions. For example, one ten year old boy asked, But where do we get these condoms? Parents accepted this question, and highlighted the unavailability of condoms.

One highly disturbing fact is that condoms, the most commonly suggested behavioral change, appear to be widely unavailable. Many people reported a desire to use condoms, understanding their efficacy in reducing the chances of contracting a STD. The unfortunate reality that the majority of people often do not have access to condoms has been grossly overlooked and must be properly addressed.

There are many factors that contribute to the non-adoption of safe sexual practices, including lack of knowledge, complacency, denial, and poverty. Effective educational campaigns, which create a dialogue, are necessary. Information through the mass media is a good start but is clearly not sufficient. Educational packages, based on dialogue, must be sensitive to socio-cultural beliefs and practices. They must be implemented by well-trained personnel, capable of answering questions in an effective and complete manner, not just providing rehearsed answers.

One church leader argued that the promotion of condoms is tantamount to promotion of promiscuity, which is unholy. We asked him, Reverend, isn't it better for you to have a church full of sinners whom you should no doubt endeavour to convert, than to have an empty church whose worshippers have succumbed to a disease which could possibly be prevented? He responded, I think you are right, by God's grace, we will conquer this AIDS. During this intervention, we managed to convince most people that AIDS is a problem for everyone and must be discussed in families and all cultural groups. Chiefs, church leaders and elders publicly made demands for the wider distribution of condoms. One village health worker reported that there is a three-fold increase in the sale of condoms, and no complaints
against condom sale. When individuals complained about condom distribution, our response was, 

*Isn't it true that most people exchange gifts and money for sex. Do you think that one's life, which one needs to enjoy all these exchanges, is worth the 10 cents you need for each condom? Besides, what is ten cents vis-a-vis the cost of entertaining a sexual partner for the night?*

This type of blunt factual presentation of otherwise taboo issues convinced listeners of the gravity of the problem. We began our presentation with an apology for our ignorance of the cultural taboos which we all shared; we explained that grave circumstances demanded that we transcend our cultural beliefs. Individuals appeared to appreciate the opportunity to engage in a dialogue.

**Conclusion**

Given the magnitude of the AIDS problem in Zimbabwe, and in Africa generally, concerted efforts must be made to reduce the number of future infections. Educational campaigns are crucial. Innovative strategies, as described above, could be easily replicated throughout the country at a reasonable cost, especially when one considers the cost of AIDS. If this problem is not satisfactorily addressed, the AIDS pandemic will leave an indelible mark on the population, economy and social life of Zimbabwe.
Discussion

• There were a number of requests for more information and clarification regarding sample size, methods of intervention and evaluation of interventions. Also, participants would have liked gender-differentiated reporting of data.

• There was discussion surrounding the accuracy of reports with regard to number of sexual partners. There is a great tendency on the part of men to claim that they have many sexual partners. The presenter acknowledged that while men can exaggerate, it is not unreal that many men do have numerous sexual encounters.

• A multidisciplinary approach, involving professionals from many different areas, is needed to come up with a solution to the AIDS crisis.

• The role of religious beliefs in safe sex behaviour was discussed. Muslims may have a lower risk of infection because of circumcision practices (circumcision may lead to better hygiene). In Zimbabwe, spiritualists, who do not believe in Western medicine and who use water and prayers, may be at a higher risk of infection.

• There is a need to look at the extent to which African women internalize and perpetuate their position of subordination. Women need to be empowered to take more control over their bodies and their sexuality. Gender socialization practices may prevent African women from being assertive about their rights.

• The role of drama as a means of communication was discussed as a viable mode of sharing important information, particularly for sensitive issues.
Gender Differentials and Household Issues in AIDS

Lawrence A. Adeokun

Introduction

There is a close association between household gender differentials and inequalities in the health status, care-seeking behaviour and welfare of household members. The outbreak of the HIV/AIDS epidemic has exacerbated the most serious aspects of these links. This paper will explore major gender inequalities that exist within the household. It will also examine the extent to which the HIV/AIDS epidemic has led to a restructuring of relationships between the sexes within the household.

The Household Defined

The way the household operates is the product of the socio-cultural context in which it is located. As society and culture respond to the needs of new situations prompted by health, economic, and other considerations, household operations are in turn affected. Therefore, household features vary from place to place and from one time period to another in a given place.

The strength of the household as a social, economic and cultural organism rests upon the completeness of its structure. The composition of its members - their ages, sexes, and generations - is important. Also, the extent to which there is a complementary division of labour, in terms of occupation, income generation, and income disposition is also relevant. The functioning and continuation of the household is dependent upon the presence of adults, the presence of an income earner, and the ability of members to provide intra-family support for those in need of such support. Some gender differentials form an intrinsic part of the functional household.

Gender Differentials Defined

Status and Conditions

To understand gender inequalities, one must look at the status and conditions of each sex vis-a-vis those of the other. Status, and its associated privileges, can be gained from participation in both informal and formal social and economic institutions. Education, occupation and income-earning capacity are the main determinants of socio-economic status.

\[1\] Institute of Statistics and Applied Economics, Makerere University, Kampala, Uganda.
(SES). In predominantly illiterate societies, the informal basis of status, rooted in the ascribed positions of individuals within the household, can be as powerful as formally acquired status. The status of women is not equal to the status of men, and this results in different conditions for each sex.

**Biological and Cultural Bases of Gender Differentials**

The biological sex of an individual contributes to some gender-based differential treatment. However, there is no logical reason why status and its associated privileges should be tied to the sex of an individual. There are some household issues and AIDS outcomes which are a direct result of basic biological differences, and there are others which are indirect outcomes of social, cultural and economic factors.

It has been suggested that the anatomy of the female reproductive system may be intrinsically more conducive to HIV transmission than the male anatomy (Carael 1993). This is a purely biological explanation for a gender differential in the pattern of infection. Cultural practices may serve to aggravate this biological propensity, thus increasing the chance of the female contracting HIV/AIDS (Schoepf 1993). For example, "dry sex" is practised in various African communities. This culturally-determined practice may have contributed to significantly higher risks of infection among the women involved (Brunborg et al. 1993).

A similar type of interaction between biology and culture is illustrated by the relationship between HIV infection and male circumcision. It has been suggested that circumcision results in higher levels of personal hygiene, which is a factor in the prevention of both sexually transmitted diseases and HIV/AIDS.

The age-sex distribution of adult AIDS cases in Uganda, as shown in Figure 1 (AIDS Control Program 1992), does not necessarily demonstrate that young females have an intrinsically weaker immune system than those of their male counterparts. Instead, it may be a result of early female sexual activity, resulting from the local social and political economy. Encouragement of early marriage among women may contribute to the high rate of transmission of the HIV/AIDS virus in young females (Ntozi and Lubega 1992).

There are a number of gender differentials which are based solely on social and cultural factors. These include the domestic division of labour, the division of financial and decision-making powers, and the degree of access to educational, economic and other opportunities. These factors are direct determinants of the political and economic dimensions of gender inequalities.
Economic Dimensions of Gender Inequalities

Some women, depending on their socio-economic group, are more likely to be exposed to STD and HIV infection than others. This may be related to their degree of economic independence and their level of education. The relative "power" or "autonomy" that women gain from economic independence affects their ability to control the events of their sexual and reproductive health. This has a favourable impact on their own health (Defo 1993), and the health of their children (Castle 1993), as well as benefitting society in general (United Nations 1992).

Economic Crises and the Aggravation of Gender Inequalities

There has been an unremitting sequence of crises in Africa. These crises can lead to significant changes and restructuring of relationships between the sexes; they can lead to the stabilization or disruption of existing gender inequalities (Mwabiere 1993). The operation of
the market economy and the commercialization of services, such as education and health, constitute major burdens on women within the household and affect their adaptive behaviour within and outside the household. One well-documented adaptive sexual behaviour is the increasing prevalence of sex-working or prostitution (Adomako-Ampofo 1993; Anarfi 1992).

**Dimensions of AIDS Relevant to Gender/Household Issues**

A number of features of the HIV/AIDS epidemic may detrimentally affect the normal functioning of the household. These include: (a) the predominance of heterosexual transmission and the resulting consequences on age and sex distributions; (b) the age-sex correlates of exposure, infection and progression from HIV infection to AIDS; (c) the sex-specific correlates of knowledge and practice of preventive methods; and (d) the sex-specific consequences of the decline in the coping capacity within the household as it is progressively decimated by AIDS.

**Features and Consequences of Heterosexual Transmission**

The HIV/AIDS epidemic in Africa is mainly the result of heterosexual activities. Therefore, attention can focus on this form of transmission and its associated features. Available scientific evidence suggests that it is much more difficult to acquire HIV through heterosexual sex than through other modes of transmission, such as blood exchange processes (Carael 1993).

As referred to earlier, there is an observed difference in infection levels depending on age and sex. The ratio of male to female reported AIDS cases in Uganda varies from 1 to 5 among those aged 15-19, to 1 to 2 in the 20-25 age group, and to an even 1 to 1 in the next age group. In the higher age brackets, there is a less dramatic sex imbalance. There is compelling evidence that this pattern of transmission is culturally determined: namely, there is no evidence of such sex bias in the pattern of paediatric HIV/AIDS cases which are the result of vertical transmission from infected mothers to their infants.

Early entry into marriage and sexuality among females likely accounts for high levels of female HIV/AIDS cases in the earlier years. The high incidence in males occurs after age 20, which is likely tied to the delay of entry into marriage, and a relatively high level of exposure to commercial sex workers among males in this age group. Reported age-sex profiles of sexual activity within and outside marriage in rural and urban Rwanda, as well as in other African situations, reinforce this interpretation (Carael et al. 1992; Orubuloye 1993). This is especially the case when there is a particularly high proportion of men, such as in mining regions and some urban areas (Carael 1993).
The Determinants of Exposure, Infection and Progression

i. Exposure Factors

Age is an important determinant of exposure to the risk of HIV/AIDS infection. Available evidence from fertility and sexuality surveys suggests that the mean age of first sexual intercourse is between 15 and 18 years. The mean age of marriage is between 17 and 21, with legal union usually occurring one to two years after the onset of sexual activity (Carael et al. 1992).

The relationship between onset of sexuality and pattern of infection has not been well documented. There is a lack of scientific data drawn from African countries providing estimates of the mean time between infection and symptoms. Estimates of the time between infection and disease range from less than a year to four years. A significant proportion of female cases occur between the ages of 15 to 24, and are definitely related to very early sexual contacts (Konde-Lule 1992). Early sexual activity therefore plays an important role in the transmission of STDs/AIDS. Strategies aimed at delaying the entry of females into sexual activity and marriage are clearly important. The practice of polygyny as well as the economic basis of male delay of entry into marriage are relevant socio-economic factors affecting the pace of the epidemic.

ii. Infection

The presence of a sexually transmitted disease greatly affects the probability of HIV transmission. The risk of HIV infection through ulcerating sites is high (Basset and Mhloyi 1993; International Women's Health Coalition 1991). Most STDs cause painful symptoms in men, but not in women. There is therefore a higher degree of STD treatment in men, and, consequently, a lower degree of HIV/AIDS transmission (Ramasubran 1992; Carael 1993).

iii. Pregnancy and Progression

Progression of the disease is related to the basic health and immune status of the individual prior to infection. One of the most devastating features of HIV/AIDS in Africa relates to the rapid progression of the disease in pregnant women. Women who are pregnant are affected more seriously than non-pregnant women. The biological and reproductive nature of women, combined with low socio-economic status, resulting in poor general health and nutrition, has calamitous effects on African women.

Mothers with HIV/AIDS face incredible cultural pressure when necessity demands that they leave an offspring behind. Infected males also face great anxiety concerning leaving offspring. This reluctance to leave results in an increased probability that infected men will expose their wives to both infection and pregnancy because they want to leave behind children (Ssekiboobo 1992), and thereby hasten the progression of such wives.
developing a full-blown case of AIDS. A higher degree of female autonomy may result in wives being able to refuse sex and procreation from husbands who are HIV/AIDS infected (Orubuloye 1993).

**Knowledge of Modes of Infection, Prevention and Status**

The next cluster of features of the epidemic with significant gender differentiation concerns the level of knowledge of modes of infection and prevention, and knowledge of infection status.

**i. Knowledge of Modes of Infection**

As a result of the global HIV/AIDS pandemic, national control, monitoring and preventive programs were developed. Effectiveness of most African programs has been compromised by limited available resources. At the initial stages of the epidemic, the level of knowledge of modes of infection varied depending on the success of the respective national AIDS control programs (ACPs). With the progression of the epidemic, and the continuation of activities, a saturation of knowledge has been reached.

While there is a high level of basic AIDS awareness as a result of mass media messages, there may be a lack of depth in the knowledge. In Uganda, for example, nearly all adults know the basic messages about the modes of transmission. However, people may have inaccurate information and may not understand concepts such as the "infectivity of a person" or "repeated exposure to virus".

**ii. Knowledge of Modes of Prevention**

At the initial stages of the activities of ACPs, the knowledge of prevention strategies may differ among individuals depending on whether or not they have been exposed to information on the radio, at clinics, or through print media. At later stages of the epidemic, knowledge of the central role of the use of the condom as a means of preventing the transmission of the virus has no significant male/female differential.

**iii. Knowledge of Infection Status**

The likelihood of being tested for HIV/AIDS and being informed of one's status are linked to the reproductive role and status of the individual within the household. Women tend to have more interaction with modern health services than men and therefore are more likely to be tested routinely or in connection with some reproductive health crisis.

Emerging evidence suggests that the reaction to knowledge of status varies from individual to individual. In 1989, a pilot project in Uganda reported that close to 80 percent of respondents had a desire to be tested. Approximately three-quarters of those who wanted to be tested, also wanted to be told the result. Less than a fifth would, however, share the
knowledge with relatives (Ankrah and Ouma 1989). An individual’s knowledge of his or her HIV/AIDS status could result in a departure from the home or community, or he or she may decide to stay and hide the information.

**Power to Act on Knowledge or Cope with Disease**

*i. Decision-making Authority*

The ability to take health preserving knowledge, and translate it into preventive action, is influenced by a number of factors. African women often have a limited ability to influence the sexual activity of their spouses or partners. Also, no matter how much knowledge a woman has, it is nearly impossible to overcome cultural hurdles, such as the traditional 'rights' of husbands to the persons of their spouses. Finally, many men are opposed to the use of condoms.

There are limited family planning services, and a limited availability of condoms, in many African regions that are greatly affected by AIDS. Lack of resources may make it impossible for those wishing to take preventive measures to do so.

*ii. Coping Capacity of Individuals and Households*

As HIV/AIDS progresses in an infected individual, there may be socio-economic repercussions which strain both human and material resources of the household. The affected individual progressively loses the vitality needed to cope with routine household or income generating activities. They then experience a period of debilitation and dependence, and finally die. The sequence of incapacitation produces serious consequences for the household. At each stage there are important differences between the position of males and females (Berer 1993).

The sexually active individuals of a household also happen to be the economically active members. There is a higher level of formal sector participation by males than by females. Consequently, the lost opportunity costs of male ill-health are believed to be higher than those of females. Women are the traditional care-givers, and household illness usually means that greater demands are placed on the woman in this role (Wilson 1993).

In the case of household illness, extended family members may interfere to the detriment of the woman. She may be accused of being the source of the male infection. As a result, she may be deprived access to the person and property of the husband. If the female is the patient, she may be treated in a particularly harsh manner by meddling relatives; she may be relocated to her parental home as a way of reducing her burden on the marital household. There is a widespread perception that AIDS is a retribution for some earlier wrong doing. When the disease is traceable to previous sex-work, the community and household may react in a particularly cruel fashion (Agyeman 1992; Anarfi 1992).
Upon the death of a male head, the cultural institution of male ownership of property may result in severe resource deprivation for surviving female household members. This can have horrendous consequences for other family members. The death of the prime income earner (usually male) can result in serious coping difficulties for surviving members.

At advanced stages of the epidemic, the rapid sequence of deaths of adult household members can result in the total collapse of households. The tragic consequence is the emergence of high levels of orphanhood and child destitution. This phenomenon is quickly emerging in the worst affected areas of Africa.

**Policy and Research Imperatives**

There are a number of policy and research imperatives emerging from this discussion of the interaction between household gender differentials and the AIDS epidemic.

The risk of HIV/AIDS transmission is related to the sex of the individual. This gender differential should be considered when formulating testing, screening, educational and preventive programs.

A number of cultural institutions exacerbate the terrible effects of the AIDS epidemic. Appropriate policy initiatives are needed to change deleterious social and legal traditions. The unfairness of inheritance systems has occasionally been raised in some spectacular court cases. Governments need to move beyond the rhetoric of gender equality and make the necessary legal modifications to traditional practices which so patently deny equality to women.

With regard to research, there is a dearth of Africa-specific HIV/AIDS data. This lack of information has significant implications for the control of HIV/AIDS transmission. Data from the Western world, estimating infectivity, progression and outcome of HIV, are inapplicable to the African situation. There is therefore a need for high quality biomedical research into the course of the disease, especially in pregnant women. The social, economic and health status context in which most African women are located needs to be addressed.

**Conclusion**

The relationship between gender inequalities within the household and features of the AIDS epidemic raise the spectrum that the worst is yet to come. The economic consequences of the epidemic are only gradually being understood. There will be a heavy social price to be paid, in terms of orphanhood, child destitution, and in terms of collapse of community and household coping mechanisms. The magnitude of this social price is likely to be significantly more serious if the household level reactions to the epidemic are not piloted toward greater tolerance to HIV/AIDS patients, especially female patients.
References


Ampofo, Akosua Adomako 1993. Women and AIDS in Ghana: I control my body (or do I?). Paper presented at the Seminar on Women and Demographic Change in sub-Saharan Africa, Dakar, Senegal, 3-6 March.


Castle, Sarah E. 1993. Intra-household female status differentials in rural Mali; variations in maternal resources for children’s illness management and day-to-day care. Paper presented at the Seminar on Women and Demographic Change in sub-Saharan Africa, Dakar, Senegal, 3-6 March.


Discussion

- Programmatic concerns were discussed. For example, is there too much emphasis on AIDS? The focus on AIDS should not let us marginalize or ignore other STDs, which are often a marker for AIDS.

- Discriminatory aspects of society must be fully addressed. For example, the fact that women have no access to property when a husband dies often creates great hardship on surviving family members. Other cultural issues besides wife inheritance, such as rape, incest, circumcision, and saying no to sex, need to be confronted. It was noted, however, that it is difficult to legislate in areas of culture.

- Social and cultural bases of behavioral practices were noted. For example, in some countries, if a person dies without a child, then his or her body is treated differently. He or she may not be entitled to last funeral rights. This may help to explain why some HIV-infected individuals may try to have a child - they may be willing to suffer in order to have a proper funeral. Furthermore, HIV-infected individuals may strive to get pregnant as a way of proving that they are healthy. Finally, it is interesting to look at how people view death. Death is sometimes not the worst possible thing. This type of information may change the way people look at AIDS.

- Women may not have much access to media (radio and papers) which are methods of receiving information on STDs/AIDS. For example, the man of the household may decide when the radio can be turned on and lock it up after use.

- Both presentations looked at levels of knowledge about AIDS, and demonstrated that "a little knowledge is a dangerous thing". Men and women need more education to dispel myths such as the erroneous belief that women are the cause of AIDS.

- Links between dry sex, AIDS, STDs and cervical cancer must be looked at.

- There was much discussion surrounding condom use. While countries may have national policies advising use, the policy may have little impact on the population. It was noted that there is a widespread shortage of condoms. If professional sex workers want to use a condom each time they have intercourse, they may need a large number of condoms, which may not be available. It was also noted that women may get further abrasions from condoms.
• In Africa, AIDS is primarily transmitted through heterosexual sex. It was submitted that a dialogue between men and women must be created so that they can renegotiate sexual relationships. The process of negotiation between men and women is often not about sex, but about power.

• Finally, it was mentioned that there is a burgeoning women and AIDS international network with which researchers can link up.
"It's Difficult to Leave your Man over a Condom": Social Understanding of AIDS and Gender

Anna Strebel

Introduction

Over ten years ago, the Human Immunodeficiency Virus (HIV), which causes AIDS, was first identified. Since that time, the number of people affected by the disease has grown substantially, and the patterns of transmission have shifted considerably. Originally, AIDS was thought to affect mainly homosexual males. However, throughout the world, there has been a dramatic increase in the extent of HIV infection among women. The World Health Organization (WHO) estimated that by 1990, approximately three million of the eight to ten million HIV-infected people worldwide would be women. Furthermore, it is expected that by the year 2000, the number of infected women will equal that of men (Panos 1990).

In the United States, women have remained a relatively small percentage of the total number of HIV-infected people. However, the growth rate is currently two and a half times faster among women than men (Rodin and Ickovics 1990). Minority women are consistently worst affected, with over 70% of new cases among women of colour (Campbell 1990; Carpenter et al. 1991).

In sub-Saharan Africa, women constitute a far greater percentage of those infected than in the United States. Indeed, one in forty women are believed to be currently infected with the HIV virus (Panos 1990). While distribution across the continent has been highly variable, recent studies have found that the rate of infection is greater in women than in men (Ankrah 1991; Decosas and Pedneault 1992). For example, at a voluntary and confidential public HIV testing service in Uganda, seroprevalence among 872 clients was 35% among women and 24% in men (Muller et al. 1992). In South Africa, at the end of 1992, it was estimated that women accounted for about 180,000 of the total 320,000 HIV-infected people (Department of National Health Population Development 1993). In rural Natal/Kwazulu, results from an anonymous HIV seroprevalence survey showed that 1.2% of cases were HIV-infected, and that the prevalence among women was 3.2 times greater than among men. After six months, the rate had increased to 2.5%, and within the 15-30 year age group, most of the cases were women (Abdool Karim et al. 1992).

1Department of Sociology, University of the Cape, Belleville, South Africa.
There is a growing recognition of the extent to which AIDS is an issue for women, and this is reflected in the striking increase in research and writing on the topic. This research is beginning to produce a clearer understanding of the ways in which women and men are differentially affected by the disease. This has important implications for prevention and care initiatives.

**Biomedical Factors**

For women, the chief mode of transmission of HIV is heterosexual contact. Furthermore, there are indications that women are more likely to become HIV-infected through heterosexual transmission than are heterosexual men (Mantell et al. 1988; Rodin and Ickovics 1990). In this regard, there is increasing evidence of the possibility of a greater physiological vulnerability in women than in men (United Nations Development Program 1992). In addition, women frequently appear to have a poorer prognosis once infected and die sooner than men (Jones and Catalan 1989; Berer and Ray 1993). Another major feature of HIV infection in women is the fact that perinatal transmission from mother to infant forms the chief mode of transmission to infants. Approximately 30% of babies born to HIV-positive mothers are infected with the virus (Global Program on AIDS 1992).

The presence of sexually transmitted diseases (STDs) has been shown to increase the risk of HIV infection. In women, symptoms of a STD are often less apparent than in men. STDs in women often go undetected, and therefore untreated, which results in an increased vulnerability to HIV infection (Standing and Kisekka 1989).

Therefore, there is compelling evidence that the epidemiology and natural history of HIV is different in women than in men. However, the biomedical features are only one factor that needs to be addressed. Recent writing has explored the extent to which the social construction of the problem influences vulnerability and responses to AIDS. Gender has emerged as a crucial variable in understanding the social dynamics of the epidemic. There are a variety of ways in which this happens, which will be discussed below.

**Sexuality and Gender**

An understanding of sexuality and gender is central to considerations of AIDS as a social problem. The traditional view of psycho-sexual development was that biologically-determined differences between males and females were the basis for the emergence of separate sex roles for men and women. These biological differences, combined with intrapsychic processes and social learning, were believed to result in typical masculine and feminine characteristics. Typical masculine traits include strength, assertiveness, rationality, as well as biologically-driven sex needs, while feminine characteristics include softness, dependence, passivity, emotionality and physical attractiveness (Miles 1992).
However, feminist writers have challenged this version of fundamental and unchanging differences between men and women. Many have outlined how sexuality is in fact socially constructed and historically located within a matrix of intersecting social, economic and cultural factors (Capian 1987). It is argued that gender relations are not natural and biologically determined. Instead, they are based on differential relations of power in which patriarchy exerts substantial control over women in a variety of spheres. One of the most powerful forms of such social control over women’s sexuality is the fear of violence from men (Smart and Smart 1978; Posel and Posel 1991).

These gendered power relations have significant implications for understanding the problem of AIDS. In order to avoid infection, women are advised to abstain from sex, practise monogamy or negotiate the use of condoms with their male partners. These options reflect a focus on a male, heterosexual construction of sexuality as depicted in the media and serve as a means of reinforcing social control over women’s sexuality (Juhasz 1990). Women are consistently portrayed as being responsible for ensuring that safe sex is implemented (Worth 1989). However, this view upholds the prevailing notion of a male sex drive for which men are not responsible, but which women are expected to curb, and entrenches dominant gendered power relations (Hollway 1984; Holland et al. 1990). Thus, women paradoxically are required to exert control and make choices in a domain over which they have notoriously little control and few options (dos Santos and Arthur 1991; Hollis 1992). Moreover, these constructions of prevention see safe sex as a matter of individual concern and responsibility (Patton 1989). Finally, for many women sex has frequently been associated with danger (of violence, pregnancy, health risks) so that to talk of safe sex poses somewhat of a contradiction (Holland et al. 1990).

In light of these factors, feminists have suggested alternative responses to the threat of AIDS. In fact, for some the AIDS epidemic has provided an opportunity to refocus attention on the feminist project and to resume talking about sex (Ardill and O’Sullivan 1988). Fundamental to this approach would be the need to substantially change the power dynamics between men and women toward greater equality and more women-centred notions of sexuality (Kippax et al. 1990; dos Santos and Arthur 1991). This would involve the legitimization of alternative sexual practices, such as non-penetration and mutual masturbation (Miles 1992).

In addition, attempts to curtail women’s sexuality and the advances of the women’s movement by calling for monogamy need to be resisted (Kippax et al. 1990). In Africa, high rates of HIV and STD infection have often been attributed to the “unbridled promiscuity” of black women, so that prevention activities become a means of controlling women’s sexuality (Vaughan 1990). In order to counter these possibilities there should instead be a focus on expanding women’s sexual options, enhancing pleasure and desire (Thomson and Scott 1991).
However, some writers have cautioned that there needs to be recognition of the fact that women are not uniformly without power in gender relations, that women are actively engaged in constructing their sexuality, that there are contradictions and spaces which can be exploited in negotiating safe sex (Hollway 1984; Holland et al. 1990). Also, implicit in such a gender analysis is the understanding that responses to the problem are not seen in terms of individual responsibility and blame, but as opportunities for collective development of appropriate responses. While empowerment in sexual relations must involve individual behaviour, it also includes collective action at community and social levels (Patton 1989; Holland et al. 1991).

The Political Economy of AIDS

Much of the above debate has been located specifically within a feminist perspective. However, for others, these issues have been part of a broader view of the problem. Especially for minority women in the USA and women in Africa, there has been a recognition that race and class variables intersect with gender to compound the complexity of power relations (Ramazanoglu 1989; Stamp 1989).

In this work, it has been argued that because of their differential positioning in society, economic factors impact on men and women differently, so that women often lack power and social status, and thus access to economic resources. Therefore, they are usually poorer than men, and more likely to work in the informal sector or to be unemployed (Schoepf 1991; Ulin 1992). Frequently, therefore, they are economically dependent on men (Campbell 1990; Ankrah 1991).

In Africa, this situation is regarded as the result of a long-term process, whereby the intersection of colonialism and traditional culture gave rise to large-scale migration and urbanisation, initially of men but later also of women (Bassett and Mhloyi 1991; Larson 1990). This led to the presence in cities of large numbers of economically destitute women and female-headed households, which usually have less income than male-headed ones (Schoepf 1988; Ulin 1992). For many women, sexual relationships with men became a valuable source of income, as sexual exchange frequently involved the transfer of material resources (Standing and Kisekka 1989). The implication of this was that women might come to rely on a number of sexual partners and that for financial reasons they would be less likely to be able to insist on the use of condoms, thus increasing their risks of HIV infection (Schoepf 1988; Larson 1990).

There are other implications of gender inequality and poverty for the spread of HIV. Poverty frequently results in limited access to health care, as well as reduced access to education and employment. All of these factors are likely to result in reduced exposure to AIDS education, as well as care for those already infected (Strebel 1992). As discussed above, it is women who are more likely to suffer the consequences of poverty and, thus, be at increased risk of infection.
However, some writers have warned against a too simplistic analysis of economic factors. They are concerned that this could result in a false dichotomy which encourages some women not to recognize their own risk of infection. They suggest that the issues are more complex. To begin with, many studies have found that it is in fact women of higher economic status who become HIV-infected (Gwede and McDermott 1992). It has been suggested that it is the wives of men who are more affluent, more mobile and thus more likely to be able to pay for sexual favours, who are first infected (Larson 1990).

Also, women in single-headed households are not necessarily less able to negotiate safe sex because of greater financial need. While for some women single status is unavoidable, others are increasingly choosing not to marry because they argue that this strengthens their economic situation (Ramphele and Boonzaier 1988; Stamp 1989). These women may in fact be in a better position to insist on condom use.

It is important to acknowledge that women do not only have multiple sexual partners for material benefits (Pickering et al. 1992). It must be remembered that it is not numbers of partners, but specific sexual practices, which increase risk of infection, so that many monogamous women are also being infected (Carpenter et al. 1991; Berer and Ray 1993).

It has also been argued that a too narrow focus on economic factors may lead to limited attention being paid to the often contentious issue of traditional culture. A number of writers have elaborated on ways in which notions of culture are always linked to power and how men invoke these to legitimate and perpetuate oppressive practices toward women (Ramphele and Boonzaier 1988; Stamp 1989). In tackling AIDS prevention then, it has been suggested that these issues need to receive urgent but sensitive attention. Ankrah (1991, p. 972) has argued that:

The unassailable facet of African culture, the customary and legal right of males to unlimited numbers of partners, according to his wishes, should now be questioned as a value, because the heterosexual pattern of transmission puts all African men who have multiple partner sexual encounters at risk of HIV. Where culture and tradition, including polygamy, no longer advance a people, they should be jettisoned.

**Prostitution**

Another manifestation of the impact of gender relations on AIDS is in the practice of prostitution. Commercial sex needs to be understood in terms of women’s subordinate position in society. On one hand, their limited access to economic resources makes material exchange for sex an important source of income; while on the other, their oppression in patriarchal society positions them as the objects of men’s "natural" sex drive (Posel and Posel 1991; Pauw 1993). While prostitutes are usually depicted as vectors of HIV, who are inevitably contaminated and infective, actual rates of infection vary enormously and a number of studies have in fact found that prostitutes do not necessarily have higher rates of infection than other women (Mantell et al. 1988). However, poor women, who are understandably under pressure not to refuse client demands for unprotected sex, are more
likely to be at risk, as are women intravenous drug users, especially users of crack (Mantell et al. 1988; Tan et al. 1989; Campbell 1990). There has been considerably less attention paid to the needs and problems (like violence and discrimination) of sex workers, and very seldom has the focus been on their clients (Pauw 1993). Moreover, early constructions of AIDS as a problem of "others", oversimplified the boundaries of commercial sex and failed to recognize the variety of forms and circumstances of sexual exchange for many women struggling to survive with limited resources (Standing and Kisekka 1989). However, it is not only women who are involved in such sexual exchange. The expanding epidemic in southeast Asia has highlighted the role of sex tourism in the spread of HIV, and the involvement of youth of both sexes, often street children, in sex for money (Ford and Koetswanang 1991).

**Sexual Violence**

Another consideration in examining the impact of gender inequalities on AIDS is the risk of HIV infection as a result of sexual violence. Social constructions of traditional sex roles, together with women’s limited control over their lives, make sexual violence a potential threat for many women. Women who are sexually harassed or raped face the possibility of HIV transmission from an infected assailant (Berer and Ray 1993). Another facet of violence toward women is that, given their lack of power in gender relations, there is the danger that women who refuse sex or insist on condom use or fewer partners may face domestic violence (Strebel 1992).

**Further Issues of Gender**

Gender inequalities are also evident in the field of research into AIDS. Despite the fact that women make up an increasing number of those infected with HIV, they remain at a disadvantage regarding diagnosis, treatment and care. Rosser (1991) has attributed this to the pervasive male bias in science and medical research. Generally funds have been limited for research into women-related aspects of AIDS, except when it concerns their role as vectors of vertical transmission. This has frequently led to the late diagnosis of HIV infection and the under-reporting of AIDS cases among women. Moreover, women are often not included in drug trials, so they are less likely to have access to future vaccine and treatment options (Kurth and Hutchinson 1990; Levine 1990). Hankins & Handley (1992, p. 967) have argued that:

> A concerted effort on the part of clinicians, researchers, funding agencies, and decision-makers is required for redressing the inequities in both the gender-specific knowledge of the natural history, progression, and outcome of HIV disease and the adequacy of medical and psychosocial care for women with HIV infection. The unique features of HIV infection in women have been subject to both scientific neglect and policy void.
It is significant, therefore, that the "soft option" of awareness-raising and education, which is often largely in the hands of volunteer, non-professional women, is focused primarily on women; while the "hard science" clinical research into vaccines and treatments is in the hands of "expert" professional male scientists and conducted largely on men.

It is widely recognised that women are the majority of those in care giving roles, both in the formal health sector, where they make up about 75% of the health services labour force, and informally in the community and at home (Jones and Catalan 1989; Strebel 1993). It is often assumed that this is women's "natural" role as nurturers. Women then have to add the load of caring for infected family members to their already substantial duties in the domestic and formal employment spheres (Schoepf 1991). With little power and status to demand the necessary financial and emotional support, women may easily become isolated and over-extended.

Finally, the fact that women are able to transmit the virus to their infants raises complicated and often contradictory issues regarding reproduction. Calls for women of childbearing age to avoid pregnancy or undergo abortions occur within the context of their already limited control over social and personal facets of their lives (Bayer 1990; Hollis 1992). Debate around reproductive choices also focuses only on the behaviour of women and excludes men's responsibility in decision-making (Kurth and Hutchinson 1990).

A Case Study: Accounts by South African Women About AIDS and Gender

From the above we see that gender intersects with the issue of AIDS in a range of complex and pervasive ways, which clearly have profound implications for prevention and care interventions. Some of the detail and inter-wovenness of this relationship is captured in a study conducted into women's discourses of AIDS in Cape Town, South Africa. Focus group discussions were held with almost one hundred black women (and a few men) from antenatal and sexually transmitted disease clinics, community political organisations, and with domestic workers, teachers and students. One of the dominant themes in their talk centered around gender issues, and particularly focused on notions of power and responsibility.

A given for many women was that men had the power to determine the nature of sexual relationships. This meant that men had multiple sexual partners and women were not entitled to protest or expect men to admit to this behaviour. They saw this as either natural, or the result of outside forces like socialisation and political oppression. However, they recognised that gendered power relations were also more complex than this: firstly they believed that women did have some power, and might themselves have multiple partners; and moreover they saw that women were able to be assertive in some contexts and so ought to be more challenging regarding safe sex. Yet these exhortations to confront gender relations seemed to reflect a potential space for action rather than one which many women actually inhabited, and they saw many obstacles to challenging the status quo.
Another key dimension of the gender focus was the contradictory issue of responsibility. While they were aware that safe sex required shared responsibility to change behaviour, they recognized that this was not an easy task. First, they felt that men did not, and would not, take responsibility for prevention, in the same way as they did not do so in reproductive matters. However, women generally did take responsibility for health issues and so a prevention method which women could control was essential. Another position was that women should take responsibility for "getting" men to practise safe sex; all of which depended on women having such power in the first place. Yet the acceptance that safe sex was "women's work" generated difficult dilemmas for women. They recognised that there were many barriers in relationships to such action: partnerships were invested with different meanings at different stages which made the introduction of condoms tricky for either long-term or transient couples; attempts to introduce safe sex practices posed a challenge to conceptions of romantic love, fidelity, promiscuity; and the stakes in doing this were high, as women could be physically punished or deserted as a result. On another level, they were concerned that by assuming responsibility for AIDS prevention, women were in fact making AIDS a women's problem, and so taking such responsibility away from men. The irony then was that it was men who engaged in unsafe sex and had the power to implement changes. However, many women recognised that the positions were not that unambiguous: women were not only victims of male irresponsibility, they too were reluctant to take the necessary action; while not all men were unconcerned and unwilling to change their behaviour.

This range of varying and sometimes contradictory understandings of gender and AIDS gave rise to a variety of reactions among participants: they expressed sentiments of blame toward men, guilt at their own impotence, and especially strong feelings of fatalism. A few voiced the possibility of united power, to work together to identify problems and solutions.

Conclusions

Clearly an analysis of gendered power relations is central to understanding issues involved in the spread of AIDS, as well as to generating realistic and effective interventions at the levels of both prevention and care. Such an analysis does much to shift perceptions of the disease as a matter of individual blame and responsibility by providing a broad, structural framework of societal influences. By the same token, the solutions that it suggests are likely to be at the macro-level, involving long-term, structural change. Such proposals might, however, not be easy to centred, as seems evident from the fact that most interventions have in fact been at the individual and small group level. Moreover, these understandings might be less helpful in generating specific concrete and strategic options.

One of the most striking features of the social focus on gender and AIDS is that by far the bulk of the extensive and varied research and intervention work has centered on women. At the same time it has been accompanied by a virtual absence of similar attention to heterosexual men. This almost exclusive focus on women undermines any serious attempts to address issues of gender and AIDS and in fact serves to perpetuate dominant
gender stereotypes. Male sexuality and power need to come under the spotlight if the analysis is to reflect the complexity of issues involved and generate realistic and effective solutions.

References


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 behaviour change is to be achieved, and that behaviour 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.

---

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 Taquu 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.

**References**


Center for Disease Control 1989. HIV/AIDS surveillance report. Atlanta, GA.: CDC.


Gender and Acceptance of Medical Innovations and Technologies Related to STDs and AIDS in Africa

George K. Lwihula

Introduction

In order to effectively manage STDs and AIDS, there must be widespread adoption of safer sexual practices, as well as early and complete treatment (for treatable STDs). The presence of a STD greatly increases the probability of HIV transmission. In fact, individuals with a sexually transmitted disease are 3 to 10 times more likely to become HIV-infected through intercourse with an infected partner, than those who do not have a STD (Ndyetabura 1983; NACP report 1988; Grosskrith 1989). The probability of HIV transmission is most pronounced with the presence of a genital ulcerative condition, although there is mounting evidence that non-ulcerative cases can also enhance the probability of HIV transmission. The importance of STD control as a major strategy for reducing HIV transmission has been emphasized by many experts and international organizations such as the World Health Organization and the World Bank. This strategy is particularly important in Africa where heterosexual sex accounts for more than 80% of all HIV transmission cases (Hrdy 1987; NACP report 1988).

There have been small-scale attempts to put the above theory into practice by launching STD Control Programs both in the urban and rural settings (NACP report 1988; Grosskrith 1989). The thrust of the messages advocated by these programs are the following:

- Promotion of changes in sexual practices through intensive and effective information, education and communication strategies (IEC). These strategies are aimed at reducing the number of sexual partners of sexually active people, thereby reducing the probability of contact between infected and non-infected people.

- Promotion of the use of condoms as a barrier method during sexual intercourse. The use of barrier methods can help to reduce the transmission of both STDs and HIV.

- Promotion of early and complete treatment.

1Department of Social Sciences, Faculty of Medicine, Dar es Salaam, Tanzania.
Successful implementation of the above messages requires that at-risk individuals take personal responsibility and adopt safer sexual practices, such as the use of condoms. Success also demands that individuals monitor themselves and promptly report signs and symptoms to health care units so that appropriate action may be taken.

Although this approach may sound well-intentioned, scientifically sound and appropriate to STD/AIDS experts and health educators, evidence indicates that targeted communities do not readily accept medical innovations and technologies, such as condoms. There are a number of socio-cultural issues which might influence acceptance of the use of condoms.

To better understand these issues, we need from the outset to understand local cultural practices and values in light of policy measures that are being designed and implemented to mitigate the problem of STDs/AIDS. This paper shall therefore look briefly at cultural traditions that may in one way or another affect the adoption of such innovations in specific socio-cultural settings.

**Marriage and Fertility**

Marriage and fertility are central issues of family life in the African context. Courtship between a young man and a young woman commonly precedes a marriage. The courtship process often involves "testing out relations" (sexual intercourse) between the two potential marital partners. This sometimes occurs with the implicit approval of parents. Such "testing out relations" may involve more than one prospective marital partner before a more permanent relationship is established. Today we are witnessing marriages between men and women at later ages, often after a prolonged period of "testings out of relations".

After the successful consummation of marriage, the next major issue for newly married couples is fertility. Successful marriage bonds in African settings are cemented by the bearing and rearing of children. A childless couple is often shunned and ridiculed. More often than not, the woman is blamed for the failure to have children, and is assumed to be infertile. The man is usually not blamed. It may be suggested that the woman misbehaved in the past and engaged in risky practices that have caused her infertility. This is often acceptable grounds for abandonment and/or divorce.

Within marriage, extra-marital affairs are not uncommon. Indeed, there are a number of traditions, contexts and situations which involve the inter-change of sexual partners, and which may increase the risk of STD/HIV infection. The dilemma facing many Africans today, is finding a balance between the demands of traditions on one hand, and acceptance of medical advice and technologies suggested by STD/AIDS programs on the other. The latter, at first glance, may appear to interfere with cultural expectations related to reproduction. This dilemma is well exemplified in the following remark:
If couples begin to use condoms they will not produce children....Children are the goal of marriage....A woman without children is an insignificant woman. (Bledsoe 1990).

The cultural importance placed on having children also helps to explain why some HIV positive women risk pregnancy, despite expert advice to the contrary.

**Economic Survival**

Despite the risks, women continue to engage in multiple sexual relations, often for economic reasons. There are numerous single parent mothers (some of whom have been victims of male abandonment) in both urban and rural settings in Africa. In these situations, economic survival may depend on engaging in commercial sex. In the wake of the AIDS pandemic, one might have expected a decrease in the amount of promiscuous behaviour, which significantly increases the risk of acquiring both STDs and HIV. However, in the words of one commercial sex worker: *The reason why I do this is because I have two children, no husband, and what else is there for me to do? I don’t enjoy it, but I have got no alternative...* (Bledsoe 1990).

Despite the clarion call to adopt safer sex methods which, among other things, involves the reduction of sexual partners and the use of condoms, behavioural patterns have not changed for many of these women. The choice before these women is between STDs/HIV, diseases they remotely understand, and their day-to-day survival.

Women involved in high risk behaviour may be blamed by men for spreading STDs/HIV. The media and the police have contributed much to the publicization of this issue. Such divisive perceptions between genders and groups may detrimentally affect STD/AIDS control efforts in gaining cooperation and compliance of the blamed woman. Also, research into the underlying factors of such activities is often belittled.

**Local Traditions and the Status of Women**

There are a number of traditional practices in Africa which lead to a multiplicity of sexual partners, thereby increasing the risk of exposure to STDs/HIV. For example, following the death of a man, one of the deceased man's brothers may "inherit" his widow. Intrafamilial sex may be sanctioned if the husband fails to impregnate his wife. Furthermore, the traditional practice concerning the sexual cleansing of widows requires the widow to sleep with a stranger. Traditionally this is done immediately after the death of the husband in order to fend off haunting spirits of the dead husband.

In these situations, the woman may be forced into sexual relations for which she is not prepared. Most likely, no protection against STDs/AIDS is used. In areas where STDs/AIDS are endemic, these traditional practices involving extended sexual networks carry the risk of STD/HIV transmission.
Power Relations in Couples

Power relations in African couples clearly favour men. Men dominate decision-making in the household and their dominance extends to conjugal relations. Men may demand sexual intercourse even if it is against the will of their partners. Traditionally, a wife’s refusal of the husband’s "conjugal right" is a legitimate ground for divorce.

Even if a wife suspects that her husband has been unfaithful or that he has engaged in promiscuous sexual behaviour (Bledsoe 1990; Lwihula 1993), she may dare not say no to him. She has to compromise with cultural expectations at the risk of contracting a STD or HIV from her husband. This inequality of power between men and women also makes it difficult for women to suggest the use of condoms. There are several reasons why the use of condoms may be viewed as unacceptable:

• condom use denies a man children;
• women who ask for condom use are perceived to be promiscuous/prostitutes;
• condom use may signal a desire to end a relationship;
• a woman who uses condoms may have an outside lover;
• a woman who requests condom use is suspected of HIV infection;
• a woman who requests condom use suspects that her partner has a STD or HIV.

Problems of Communication in Couples

Most prevention and control measures require understanding and cooperation from both parties. However, there is often minimal, or even a complete absence, of communication between couples on matters related to STD/AIDS control and prevention. If an individual raises the issue, she or he will be accused of being suspicious that the partner is infected. This suspicion continues to be a significant barrier in the effectiveness of IEC (information education and communication) efforts which, inter alia, encourage partners to continuously share their knowledge on sexual diseases and how best to protect themselves.

Condom Promotion: Unresolved Issues

The use of the condom is one of the main medical technologies promoted to fight the spread of HIV. It also offers protection against STDs, as well as pregnancy. The condom is worn on the penis to prevent the partner from being infected by seminal fluids. It also protects the male against infection from vaginal fluids.

The use of condoms requires cooperation and consent on the part of the male. Often women have little power in influencing men to use condoms. There are also situations, particularly among women involved in commercial sex, when the immediate economic
benefits of sexual activity without a condom outweigh, at least in the short-term, the risks. Another difficulty is that some men abuse condoms by tearing the tip. The recent creation of a female condom might provide women who want to protect themselves with more control.

Furthermore, the use of condoms in regular or permanent sexual relationships is reportedly almost non-existent (Beldsoe 1990; O'Connor et al. 1992; Lwihula 1993; Lwihula, et al. 1993), even though suspicion might exist between the two partners. Casual partners, after several sexual encounters with the same partner, often cease using a condom, because the relationship is assumed to be permanent.

Condom Availability and Misconceptions

Condoms are often unavailable to potential users in Africa. This may be due to poor management of distribution or due to logistical problems. They can be obtained more easily in urban centres and family planning units than in rural areas.

Family planning units tend to be women-oriented and accessible only to women. Often women obtain condoms without the knowledge of their husbands or partners. This often leads to a quarrel when the husband or partner discovers the condoms. If the couple is already using another method for contraception, the man may become suspicious and wonder why their partner has obtained condoms, despite the fact that they have other important uses (Kapiga et al. 1993).

There are a number of misconceptions that continue to affect compliance with condom use. Among men, there are still doubts that condoms provide protection against STDs/AIDS. Some men complain that condoms prevent sensation and enjoyment during intercourse. Some of the false beliefs surrounding condoms include the notion that the condom may remain in the vagina and cause infertility, that they may burst and cause cancer, and that they are implanted with the HIV virus by manufacturers.

Compliance to STD Treatment

Many STD control programs have had little success in obtaining compliance to treatment from targeted populations (O'Connor et al. 1992; Lwihula 1993; Lwihula, et al. 1993). There are a number of obstacles to their success. For example, explanatory models on STD causes and treatments may not be well suited for the targeted populations, especially women. There is also a stigma associated with the programs; to have a STD is disgraceful in many African contexts and associated with sexual immorality.

For those who are willing to have treatment, they may be discouraged by a number of factors, such as the irregular supply or complete lack of STD drugs, major distances to treatment centres, poor service and abusive language from health workers, and lack of privacy and confidentiality. Furthermore, the requirement that infected individuals bring their partner as a condition for treatment, may greatly affect compliance. While those in a
permanent relationship may be willing to meet this requirement, those who are married and also have casual sexual partners will not likely be willing (O'Connor et al. 1992; Kapiga, et al. 1993; Lwihula 1993; Lwihula et al. 1993). The final obstacle is related to alternative and traditional treatments strategies, such as voliae injectionists and traditional healers. Some may believe that STDs can only be treated by these measures and may doubt the efficacy of health-centre based treatment programs.

Conclusion

Before medical innovations, such as the condom, can be initiated in a given socio-cultural situation, factors which will encourage and/or hinder their adoption must be closely examined. The introduction of medical innovations and technologies such as the condom should be preceded by a careful analysis and investigation of the cultural setting in order to understand how best to come up with culturally-tuned programs. If this is not done, many medical technologies might well go to waste as they are not culturally sensitive or appropriate.

References

Bledsoe, Caroline. 1990. The politics of AIDS, condoms and heterosexual relations in Africa: Recent evidence from the local print media. In Births and power social change and the politics of reproduction (eds.) W. Penn Handwerker.


Hrdy, Daniel B. 1987. Cultural practices contributing to transmission of human immunodeficiency virus in Africa. Review of Infectious Disease 9(6)

Kapiga, Saidi H., Lwihula, George, Shao, John, and Hunter David J. 1993. Predictors of AIDS knowledge condom use and high-risk sexual behaviour among women in Dar-es-Salaam, Tanzania. (Submitted for publication).

Lwihula, G.K. 1993. Ethnographic study on STD in Mwanza Region Tanzania (report on progress).


Implementing Issues in Gender and Health: Emphasizing STDs in Rural South Africa

Shirley Ngwenya¹

Introduction

Sexually transmitted diseases (STDs) continue to be a major health problem in South Africa. Despite current publicity, a sizable proportion of the population still lacks adequate information about STDs, including HIV. Moreover, there is a shortage of quality service in the prevention and management of STDs.

Strategies aimed at reducing STDs and HIV should give priority to rural South Africa. Specifically, there should be a focus on young girls and women, who are particularly vulnerable to STD infection, including HIV/AIDS.

In my work as a Primary Health Care Nurse in rural northeastern Transvaal (South Africa), I have been involved in the provision of Comprehensive Health Services in rural clinics, and in the coordination of training programs for Primary Health Care Nurses (PHCNs). I have also been involved in informal education and community development initiatives, focusing on women and youth. These experiences have helped to increase my understanding of gender-specific health issues. Increased gender sensitivity led to the incorporation of gender issues in the Sexual Health Program, developed by the Health Service Development Unit in the northeastern Transvaal area, South Africa.

Sexually Transmitted Diseases Including HIV/AIDS: A Literature Review

There has been substantial international coverage of STDS, including HIV/AIDS. Prevalence rates continue to escalate, particularly in developing countries (Brunham 1992). In South Africa, it has been estimated that rates of infection for "conventional" STDS are forty times higher than rates in western Europe and other industrialised societies (Ballard 1993).

There are a number of factors that contribute to the spread of STDs, including HIV/AIDS. These include poverty, political instability, rapid urbanisation, widespread alcohol abuse, migrant systems of work, and inadequate treatment protocols (Evian et al. 1988).

¹Health Services Development Unit, Acornhoek, North Eastern Transvaal, South Africa.
The Importance of a Gender Specific Approach

Women make up half the world's population and contribute substantially to the world's economy. Their health care needs deserve attention (Maddox and Culin 1992). STDs, including HIV/AIDS, primarily affect sexually active individuals, as well as newborns. The devastating effects of STDs tend to be more pronounced in women, compared to men. For example, STDs in women can lead to infertility, stillbirths, post partum inflammatory diseases, perinatal AIDS, ectopic pregnancy and genital cancer (Hirshmann 1993). The anatomical and physiological structure of the female reproductive system makes recognition and treatment of STDs difficult. Internal organs, asymptomatic states of STDs, and the natural state of women, in which the vagina is usually moist, make detection of STDs difficult. As a result, treatment of women for STDs may not occur until the disease has significantly progressed.

Women need to be educated about the functioning of their reproductive organs, and about diseases that affect them. Measures to prevent and control STDs, such as accessible health and counselling services, are also needed (Berer and Ray 1993). Women also need to receive education with regard to socio-political issues that may affect their lives, such as sexual violence, migration, discrimination and polygamous marriages. Many of the contributing factors related to the transmission of STDs, including HIV/AIDS, in women, are related to gender discrimination. For example, polygamous marriages, and men's primary decision-making role in the adoption of preventive measures, such as condoms, are important factors. In order to combat these discriminatory factors, women must assert themselves, and focus their minds on positive strategies.

Control, Prevention and Management of STDs Including HIV/AIDS

Sai and Nassin (1989) outline the following key components in a reproductive health approach:

- education for girls;
- elimination of social and cultural practices that discriminate against women and hold them in bondage to men;
- improvements in general economic conditions;
- massive health education campaigns; and
- family planning.

The benefits of a community-based approach in reproductive health care programs has also been highlighted. Such an approach would include participatory research on women's reproductive health, as well as participatory mass education on sexual, reproductive and social issues. The development of village-based women's health care services is also advocated (Bang and Bang 1989).
AIDS and STD control programs should focus on the following objectives:

- partner notification and treatment services;
- improving access to services by expanding services sites and working with other health and family planning programs;
- developing attractive, accessible and comprehensive services for priority groups such as adolescents and commercial sex workers;
- developing and evaluating treatment regimens;
- promoting public education, targeting women’s organisations, men’s groups, children and youth. Education on human sexuality, gender issues and prevention of reproductive health infections should be provided (International Women's Health Coalition 1992); and
- providing preventive and treatment services freely or at very low costs (Moses et al. 1992).

Improving the lives of girls and women, through educational training and services, in an effort to achieve gender equality, is another important objective. Nongovernmental organizations can play an important role at community and national levels in building sustainable institutions to accelerate development (Maddox and Curlin 1992).

One major hurdle, highlighted by Townsend, concerns the difficulty women often face in getting their sexual partner to wear a condom. Strategies need to be developed to increase male compliance. It is hoped that the female condom, while yet to be tested sufficiently, may perhaps offer women more control in this matter (Townsend 1993).

From Concept to Action - The Tintswalo Sexual Health Program

It is essential to move from concept to action in developing reproductive health services (Faundes et al. 1989). The Tintswalo Sexual Health Program has done just that.

In the late 1980s, news of the HIV epidemic created pressure to develop this program. At the time, there were also other serious reproductive health problems, including teenage pregnancy, sexually transmitted diseases, especially gonococcal infection, syphilis and chancroid.

The program is located at Tintswalo Hospital (Acornhoek). Many different groups contribute to the program, including hospital staff, staff of the Health Services Development Unit (a community health project at the University of the Witswatersrand), community-based educators of the Progressive Primary Health Care Network - AIDS Group, as well as community organisations within the Bushbuckridge area (women, youth and clergy groups).

Bushbuckridge (Mhala-Mapulaneng) is a rural area with a population of approximately 500,000, located within the two homelands, Gazankulu and Lebowa. There are three hospitals; Matikwane, Tintswalo and Mapulaneng. As a result of migrant work, women
comprise 60% of the population. There are very low levels of education, especially among women. Tables 1 and 2 (below) provide a recent census done in one of the villages in the area (Faundes et al. 1989).

### Table 1. Educational Status of the Agincourt Community

<table>
<thead>
<tr>
<th>Age Group</th>
<th>% Male</th>
<th>% Female</th>
<th>% Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-12 yr olds in primary school</td>
<td>72.5</td>
<td>74.1</td>
<td>73.3</td>
<td>5892</td>
<td>5912</td>
</tr>
<tr>
<td>13-17 yr olds in secondary school</td>
<td>16.4</td>
<td>25.8</td>
<td>21.2</td>
<td>3382</td>
<td>3581</td>
</tr>
<tr>
<td>12 yr old with primary education</td>
<td>27.5</td>
<td>25.9</td>
<td>26.6</td>
<td>16207</td>
<td>18951</td>
</tr>
<tr>
<td>20 yr old with secondary education</td>
<td>10.4</td>
<td>8.0</td>
<td>9.1</td>
<td>11105</td>
<td>13532</td>
</tr>
<tr>
<td>21-35 yr old with tertiary education</td>
<td>4.2</td>
<td>3.9</td>
<td>4.1</td>
<td>5833</td>
<td>6856</td>
</tr>
</tbody>
</table>

### Table 2. Migrancy by Age and Sex: Agincourt

<table>
<thead>
<tr>
<th>Age Group</th>
<th>% Male</th>
<th>% Female</th>
<th>% Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 - 19 years</td>
<td>3.8</td>
<td>1.0</td>
<td>2.4</td>
<td>3006</td>
<td>3216</td>
</tr>
<tr>
<td>20 - 24 years</td>
<td>23.4</td>
<td>4.7</td>
<td>13.4</td>
<td>2507</td>
<td>2856</td>
</tr>
<tr>
<td>24 years</td>
<td>52.2</td>
<td>10.2</td>
<td>28.9</td>
<td>9202</td>
<td>11388</td>
</tr>
</tbody>
</table>

While it is difficult to get accurate figures, estimates of STD prevalence rates are very high. Figure 1 illustrates the extent of gonococcal infections managed with intramuscular penicillin in the outpatient department at the Tintswalo Hospital over a month.

HIV seroprevalence rates are under-diagnosed. Among antenatal women, the rate of infection is 2%, and among TB patients the rate is 5.8%. More and more young girls are becoming sexually active (Tintswalo Hospital Statistics 1993). For example, births by teenagers (13-19 years) form 35% of total deliveries.

**Goals of the Sexual Health Program**

Given the extent of the sexuality problems in the area (increasing rates of STDs/HIV, teenage births, infertility), an intervention was developed with the objective of raising awareness, and intensifying STD treatment protocols.
Management of STDs with intramuscular Penicillin, Tintswalo Hospital Aug. 1993

While all members of the community were viewed as target groups for the program, youth were the main focus group in the prevention and management of STDs/HIV and teenage pregnancy.

Approach Adopted

A community-based approach, with the community playing an active role in the development of the program, was adopted. Issues around sexuality are traditionally not discussed openly and are therefore very sensitive issues to tackle. A needs assessment was done to determine community knowledge and attitude toward sexuality education, focusing on STDs and HIV/AIDS, as well as teenage pregnancy. Community members expressed an overwhelming need for urgent youth intervention (Ngwenya et al. 1992).
Fig. 2 highlights total STD consultation at a health clinic over 3 years.

Working with the community led to a common approach to deal with sexuality issues. The community identified potential educators who were given training for three months in sexual health education and counselling. On completion of the training program, the educators then went to work with youth, primarily in villages. They worked with youth attending school, as well as those who did not attend. They also worked with women through women's groups.

The main topics covered in the education and counselling program included information on the reproductive system, physiological and psychological changes, conception and pregnancy, effects of sexual activity (abortion and sexually transmitted diseases including HIV), contraception, sexual violence, and peer pressure. They also provided training on assertiveness.
In order to evaluate knowledge and attitudes gained from the educational sessions, participants are encouraged to stage a drama, design songs and poems on STDs and AIDS, which could be presented at rallies, Open Days and World AIDS Day celebrations.

**Other Issues Concerning the Prevention and Management of STDs/HIV**

Health education is provided at the community level. Health services at Tintswalo Hospital, as well as satellite clinics, provide screening and treatment of sexually transmitted diseases through its antenatal and family planning clinics, as well as through daily consultations. These services are provided by trained nurses, using updated protocols.

There is no "free" treatment for STDs. However, through the partner notification system, partners are actually treated without cost. Unfortunately, there are constant reports of partners, especially males, who are reluctant to be treated. Health education and counselling is provided, but not as thoroughly as desired due to lack of staff. Condoms are distributed when they are available; unfortunately, the condom supply is often out of stock.

Condom use within these rural communities is highly varied. Some parents do not support the use of condoms, particularly among youth - some tend to believe that youth should abstain from sex altogether. This demonstrates that some parents are still very naive about the sexual habits of their children. Women, including young girls, have problems accepting condoms. They fear rejection from their male partners. This highlights the need for assertiveness-training for women and young girls.

**Conclusion**

In the words of Maggwa and Ngugi (International Women’s Health Coalition 1991), ...women in most African countries have little or no say in sexual relationships and yet they suffer more severe consequences from reproductive health infections than men do. Women therefore deserve more attention. Nonetheless, the control of reproductive tract infections should be the responsibility of both men and women and not only women...

The work of health providers with youth highlights the need for a multifaceted approach to sexuality problems:

- community-based programs are necessary to foster support and maintain education; educating community members to work as educators helps to demystify sexual health issues;
- schools needs to provide sexual health education;
- counselling services on sexual matters, including relationships, should be available;
- youth assertiveness-training is needed, especially for young girls; working on building the self-esteem of young girls should begin as early as possible.
A focus on women in sexual health education with regard to STDs/AIDS has brought two important issues to light:

- the plight of women in the prevention of STDs and HIV due to the cultural acceptance of men having multiple sexual partners; and
- the great difficulty that many women have in insisting that their sexual partner use a condom. This lack of power is exacerbated by the fact that most rural women are economically dependent on the male.

The policy proposed by Sai and Nassim could provide a blueprint for the implementation of gender and health programs. Strategies aimed at reducing STDs and HIV should give priority to rural South Africa. Specifically, there should be a focus on young girls and women, who are particularly vulnerable to STDs, including HIV/AIDS.

References


International Women’s Health Coalition. 1991. Reproductive tract infections in women in
the third world. National and international policy implications. Report of a meeting
at the Bellagio Study & Conference Centre. IWHC. New York.


Thornsons Limited. Northhamptonshire.

Washington, D.C.

Moses, S., Marji, F., and Bradley, J. 1992. Impact of user fees on attendance at a referral

Bushbuckridge community on sexuality education. HSDU.


Bushbuckridge area of the Eastern Transvaal. Methods and results. Poster presented
at an ESSA Conference. Durban. August.

International. 13(4). May.
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 Awai and Emmanuel Wansi

Introduction

Malaria and schistosomiasis are respectively the first and second most important diseases in tropical and sub-tropical countries, with respect to the number of people they affect and to their socio-economic and medical consequences (WHO 1991). Both diseases can be considered diseases of poverty, since they affect people who live and work in unsanitary surroundings that favour disease transmission, or else who cannot afford preventive and curative measures (Reubin 1992).

Women are not considered genetically more predisposed to malaria and schistosomiasis than men. However, the gender roles of women, determined by the social and cultural beliefs and values of different tribes and ethnic groups, put them in greater contact with disease transmission sites (Agyepong 1992; Michelson 1992; Reubin 1992).

The need for gender-specific research in tropical diseases, especially the use of qualitative and quantitative methods by multi-disciplinary teams of biomedical and sociological researchers, to find out about the socio-cultural determinants of diseases, has been emphasized in recent years (WHO 1991; Aaby 1992; Khan and Manderson 1992; Manderson 1992). In Cameroon, where malaria and schistosomiasis are endemic in several regions, many studies on these diseases have stratified their prevalence by sex (Moyou 1984; Anyangwe 1990; Ratard 1990), but very few have studied gender-related roles as a determinant in disease prevalence (Sama 1990).

This paper describes the results of two studies carried out by multi-disciplinary research teams, both studies using rapid assessment methods to determine the gender-related factors associated with urinary schistosomiasis (in 1992) and malaria (in 1993). The purpose of both studies was to determine whether social, cultural and economic factors in the study areas put women at greater risk than men of acquiring the diseases. The generic term "women" includes female children.

Study Areas

Kotto Barombi, where the 1992 schistosomiasis study was carried out, is a volcanic island in a crater lake in the equatorial rain forest region of south-west Cameroon. It is

1Faculty of Medicine and Biomedical Sciences, University of Yaounde I, Yaounde, Cameroon;
*Ministry of Health, Yaounde, Cameroon.
about 40 kilometres from the nearest town. There is a rainy season and a dry season, each lasting about six months. It has been a known holo-endemic focus for urinary schistosomiasis since the early part of this century (Wright 1978). The prevalence of schistosomiasis there has been known to reach 75% of the population, and females were said to have higher prevalence than males (Moyou 1984). The population of the island is about 500, while about 1200 people inhabit a mainland village on one shore of the lake. Females outnumber males on the island (53% and 47% respectively). On the island, there is neither pipe-borne water nor wells. All drinking water is fetched from the mainland, and water for all other domestic chores is obtained from the lake. Fishing and farming are the predominant occupations, and all farming is done on the mainland. The only means of transportation to and from the island is by canoe, although children take delight in swimming across the 400 metre distance in the hot, dry season. The village school, market and health centre are on the mainland. Our study took place between April and July 1992, just before the rainy season.

Simbok, where the 1993 malaria study was done, is a rural village located about 8 kilometres from the capital, Yaounde, in the equatorial rain forest zone of the Centre province of Cameroon. It is in the meso-endemic belt for malaria, and has a population of about 900, 57% of whom are female. Many of the village males work in the capital city. Farming is the predominant occupation. The village has no pipe-borne water, no health care facility, no school and no market. The village children attend school in the nearest district, about 4 kilometres away. Simbok is partially surrounded by expanses of marshland and lush forest. There are four seasons: a long and a short rainy season, and a long and a short dry season. No studies on malaria, or anything else, have been done in the locality. On investigation, the villagers say malaria is their biggest problem, and state that many children have died of the illness before getting to hospital. Our study took place between April and May, 1993, just before the short rainy season.

Research Methods

The methods used were a variety of socio-anthropologically proven rapid assessment procedures (RAP) that generate a lot of information for the formulation of hypotheses within a relatively short time frame. These methods are increasingly being used in epidemiologic research on tropical diseases (Scrimshaw and Hurtado 1987; Manderson and Aaby 1992).

For the schistosomiasis study, the methods used were participant and non-participant observation; focus group discussions (FGD); informal interviews with key informants in the community; a semi-structured questionnaire survey of a sample of the population. Two research assistants stayed in the village for two months. The other members of the research team were a physician/epidemiologist, an anthropologist and a parasitologist. Sixteen FGD were carried out with males and females of the following age groups: 6-9, 10-14, 15-19, 20-44, 45 and more years, on both island and mainland.
For the malaria study, the methods used were informal interviews with key informants; 1 FGD with each of the following groups: pregnant women, mothers of children aged 0-4 years, mothers of children aged 10-14 years, male heads of households, and children aged 10-14 years; 30 in-depth interviews; 10 case histories in homes where someone had suffered from malaria in the past month. In this study, the qualitative methods were validated by a cross-sectional knowledge, attitudes and practices (KAP) survey of a systematic sample of inhabitants aged 10 years and above in 30% of the households in the village. The survey instrument was a structured, pre-coded and pre-tested questionnaire. The research team was comprised of two physicians/epidemiologists, a sociologist and four research assistants.

For both studies, a household census was done and baseline disease prevalence ascertained at the onset. The results of the census and prevalence studies were analyzed using EPIINFO, while the RAP results were analyzed manually, using content analysis.

**Results**

**Baseline Prevalence**

The prevalence of schistosomiasis in Kotto island was 51%, and 40% on the mainland. On both the island and the mainland, males had a slightly higher prevalence than females. However, on both island and mainland, but especially on the island, females excreted a significantly greater number of eggs than males (12,660 and 8,328, respectively). The egg burden on the mainland was negligible, and so our study focused mainly on the island.

The overall prevalence of malaria in Simbok was 30%, and there was little difference between males and females, but plasmodium counts were much higher in females than in males.

**Women's Gender-Specific Roles and Risk of Schistosomiasis**

In Kotto Barombi, adult women and girls are traditionally responsible for washing utensils, laundry, fetching water for household use, and lake-side fishing, all activities that require constant and prolonged contact with the infested lake. Utensils and clothes are washed on the shores of the lake, where water is also fetched for household cleaning, cooking and sometimes bathing. Basket-fishing is a female occupation, and consists of women wading a few metres into the lake and positioning their fishing baskets under rocks from where they catch small fish and shrimps. They can spend from six to ten hours on any one fishing expedition, waist-deep in the lake, and during which time they urinate and defecate in the lake as the need arises. Females, young and old, usually carry out their activities in groups, transforming their mundane tasks into times for social entertainment and information sharing. They are therefore usually in no hurry to leave the lakeshores.
Mothers of infants and young children take them to the lake and while working, either keep them strapped to the back, or let them play alone or with older siblings on the shores. These children are also bathed in the lake or with lake water at home.

Males fish from canoes in the middle of the lake. Both sexes farm food and cash crops on the mainland. Female children start their gender-defined roles as early as the age of three years when they can walk unaided to the lake to fetch water or to wash. While females are duty-bound to be in contact with the lake during much of the day, male children are in it most of the time for recreational swimming, especially in the dry season.

Females in Kotto are therefore, by virtue of the traditional and culturally-prescribed gender roles and water contact patterns, more often exposed to urinary schistosomiasis, which they also help propagate by promiscuous urinating and defecating in the lake.

**Women’s Gender-Specific Roles and Risk of Malaria**

In Simbok, gender-specific roles for women are just as clearly defined as they are in Kotto. Women and men farm the land, but men specialize in cash crop farming (coffee, palmwine, firewood) while women are mostly food crop farmers, predominantly groundnuts and maize which are planted several times during the year. The food farms need more constant weeding and harvesting, exposing the women to mosquitoes more often. There is no market in the village and it is an unwritten law that foodstuffs are not sold within the village to fellow villagers. Each family therefore has a food farm that is the responsibility of the women in the family. Although most women wear trousers to farm, their arms, feet and faces are rarely protected. Harvesting of maize is usually done before dawn so that the crops are taken to markets in the capital by women at dawn.

Laundry and fetching water are predominantly female chores, both of which are done either at the springs or river that flow through parts of the village. We found mosquito larvae even in the drinking water portion said to be the "cleanest" part of one such spring.

**Women’s Perception of Causes and Transmission of Disease**

In both study sites, women had adequate knowledge about how schistosomiasis and malaria are contracted, and in each site, the disease under study was cited as either the most important or the second most important disease affecting the community. In Kotto, "bilharzia", as the disease is called by all for lack of a name in the local language, is believed to be contracted when people spend long periods of time in the lake, where they also urinate and defecate. However, there were serious misconceptions, among young and old, educated and non-educated females alike, about how schistosomiasis entered the human body. They thought that the "worms" that cause schistosomiasis enter the human body through the urethra or anus, during urination or defecation in the lake. All age groups also
affirmed that throwing household garbage in the lake produced those "worms", and although they all had seen small snails on vegetation on the banks of the lake, no one knew what part these snails played in the transmission of schistosomiasis.

On the other hand, in Simbok, malaria is called tir miki in the local dialect, translated as "the meat of blood", and explained to mean "the animal that feeds on blood". Most women, young and old, educated or not, believed malaria to be caused by mosquito bites, although some did not know from where the infective agent in the mosquito came. Some also added other causes like heavy rains, walking for a long time under the sun and catching a cold.

**Women’s Perception of Severity and Complications of the Diseases**

For schistosomiasis, female children and adults believed that the disease can cause anemia, emaciation and even stunting when chronic, but did not think the disease could kill. Adult women, including primary school teachers and traditional birth attendants, believed that chronic schistosomiasis led to infertility, but stated that the disease had no negative influence on either sexual desire or on intercourse. All age groups affirmed that the disease had no negative effect on manual work or on academic performance in school.

For malaria, most children and adult women believed that malaria can kill a child under 5 years of age, and cited malaria as the most severe disease in children. Adult women, especially mothers of children, were categorical that malaria does cause abortions.

**Women’s Treatment-Seeking Behaviour**

Women believed both diseases to be treatable. In Kotto, there is no traditional medication for schistosomiasis, and prior to our study, praziquantel was the drug other researchers had treated infected villagers with, free of charge. The drug was also available in the village health centre, at a price of US$3 per tablet ($12 per adult dose), which any villager could hardly afford. This meant that almost no one got treated for their infection. Most children stated that their mothers were the parents they first told about their infection, if they told anyone at all. Otherwise, mothers would only discover the infection if they noticed blood on the children’s clothing or bed. Nonetheless, mothers still had to ask fathers for money and permission to take themselves or their children to the health centre if they deemed the infection serious enough to require treatment. Money is so seldom available that some mothers have tried native concoctions which they claimed alleviated the symptoms of the disease. In our study, we freely treated all infected persons with a single dose of metrifonate, which on our advice has been put on the list of essential drugs in the health centre, at a cost of about US $1.50 per adult dose.

In Simbok, as in Kotto, fathers make the decision about when to go to a health care facility for treatment. Malaria was most often diagnosed by mothers who, initially, tried traditional remedies like herbal infusions or a vapour bath over a boiling pot. They then
usually proceeded to administer often inadequate doses of various anti-malaria medications, especially chloroquine and aspirin, which they purchased without prescriptions. If the fever subsided, even after a single dose of medication, most mothers stopped giving the treatment. They informed the fathers about the malaria when their initial treatment had not seemed to work, or when complications like convulsions set in. Parents, especially, mothers, usually bought their medications from street hawkers, or in grocery stores, because they complained about the lengthy periods spent in hospitals and health centres, just waiting to consult for diseases as common and as recurrent as malaria.

**Women’s Proposals for Control and Prevention of Disease**

At present, the women in Kotto do not do much to protect themselves or the community from urinary schistosomiasis. Due to the fact that their gender roles put them in constant and prolonged contact with the infested lake, they get recurrent or chronic infections which they can hardly afford to treat, thereby increasing the risk of perennial contamination from the lake. Adult women propose that periodic chemical mollusciciding of the lake, even it means killing some fish, and provision of low-cost oral medication for treatment of the infection, would be the most effective and appreciated method of controlling the disease in their community. They also propose that pipe-borne water be installed on the island, and that there should be official prohibition by law, backed by fines for defaulters, of bathing, urinating and defecating in the lake. Children advocate that the state (health centres and hospitals) treat all infected children free of charge at all times.

Protection against malaria in Simbok is presently done in the most archaic way imaginable. Adult women and children alike say that the most usual method of keeping mosquitoes away is by waving them off! Some say that they burn sugar cane chaff at night, while a few sporadically buy mosquito coils or insecticides. Most of the children know that bushes around the houses should be cleared and water-retaining containers drained. However, few of them do this since they are not asked to do so by their parents. Adults complain about the cost of insecticides, mosquito nets and malaria treatment. Their proposal is for government teams to continue spraying their houses and farms with insecticide, a practice that was abandoned several years ago.

**Conclusion**

These two studies have clearly demonstrated that there are close links between women’s gender roles and their susceptibility to chronic or recurrent ill health from urinary schistosomiasis and malaria. The studies have also highlighted the fact that a woman’s health depends as much on her as on external factors, an important one being a man’s decisions on financial matters. The limited educational level of women does not seem to greatly affect their knowledge about these diseases. Their treatment-seeking behaviour has more to do with lack of financial resources than with lack of will or knowledge to seek treatment. Constant and repetitive health educational sessions on preventive and curative measures should be emphasized in primary schools and in the community for the benefit of mothers. Control
programs should target women in particular, and should include culturally-appropriate measures to ensure that women are empowered educationally and financially. Without these, schistosomiasis and malaria might still be highly prevalent diseases of poor women well into the 21st century.

References


Sama, M.T. 1990. Human behaviour as an index to the prevalence and intensity of schistosoma haematobium transmission in the urban population of Kumba, SW Province, Cameroon. Dr PH dissertation (unpublished), Tulane University, New Orleans, USA.


Please note that the discussion notes from Dr. Stella Anyangwe’s presentation can be found at the end of Dr. Uche Amazigo’s presentation.
Gender and Tropical Diseases in Nigeria: A Neglected Dimension

Uche Amazigo

Introduction

In Nigeria, as elsewhere, inequities exist in health care and policy, and in tropical health programs. These inequities exist between rural and urban residents, between groups with different religions, and between genders. This is largely due to the failure of policymakers to appreciate the many linkages between women, health care provision, and sustainable development. Within Nigeria’s policy on health delivery and health care financing, gender has not been the central focus, except in fertility/population control and contraceptive programs where women have received significant attention as the vehicle through which specific goals were to be achieved rather than as the primary beneficiaries of the development process (Vlassoff and Bonilla 1992).

Tropical diseases received the attention of health providers in the early 1960s in Nigeria. Since the 1980s, with the economic recession, debt and adjustment policies, tropical diseases, with the exception of malaria and perhaps guinea worm, have lost their position to other health problems. At any given time, however, over one third of Nigerians are suffering from one or multiple parasitic infections, including malaria, intestinal helminths (hookworms, ascaris, trichuris), schistosomiasis (bilharzia), onchocerciasis, or guinea worm.

Gender has been a neglected dimension in tropical health programs in Nigeria, as there is little appreciation that in addition to the general health needs which women share with the rest of the population, women have their own specific health needs. Also, there is scant knowledge about the central role of women in Nigeria in the transmission and control of tropical diseases. Tropical diseases are diseases of neglect and are exacerbated by poverty. Both rural men and women in Nigeria share the consequences of decades of neglect that have left rural communities with limited income-earning opportunities. Rural females are disproportionately more disadvantaged. As a result of poverty, a high proportion of the Nigerian population live under conditions in which parasitic infections thrive. Rural women in particular tend to consider their health problems as "secondary" needs, not as "primary health care" needs.

According to the 1993 World Development Report (WDR 1993), females globally loose fewer disability-adjusted years (DALYs) from premature mortality than men, but the DALY loss from disability is similar for males and females in spite of under-reporting of illness by women. Sex-specific data on tropical parasitic and infectious diseases are higher

1Department of Zoology, University of Nigeria, Nsukka, Nigeria.
for males than females. Disability-adjusted years lost to parasitic and infectious diseases are also higher for males (763.7) than for females (716.7) in sub-Saharan Africa (see WDR pages 216, 218). These figures are deceptive to a health program planner as they obscure other consequences of tropical diseases. Health cannot be divorced from the everyday lives of men and women and cannot be quantified purely in biomedical terms. The simple fact that women live longer than men masks unquantifiable disability and psycho-social consequences for women of tropical diseases such as leprosy, lymphatic filariasis, onchocerciasis, guinea worm and schistosomiasis. It also masks important qualitative differences in the way parasitic diseases affect the lives of men and women. Since determining gender-based mortality and morbidity has methodological difficulties (Freedman and Maine 1993), this paper shall examine the impact of tropical diseases in Nigeria on women’s social life and self-esteem, on their sexual health, on marriage and family life, and on anemia in women.

**Primary Health Care Program and Tropical Diseases**

With an estimated population of 49 million in 1988 in Nigeria, women and children make up over 50% of the population, and are the most vulnerable to economic hardship and disease. Health For All by the Year 2000 and beyond is the primary goal of Nigeria’s health services and the primary health care (PHC) system, and has been the focus of Nigeria’s Health Policy. While there has been inspiring progress in Nigeria’s Primary Health Care Program, a selective primary health care emphasis on infant mortality and women’s reproductive health has been pursued as the most promising approach to medical intervention. As a result, personnel and facilities for the detection of infections, documentation and treatment of parasitic diseases (with the exception of malaria) among women who attend clinics at the health centres are not provided for within the PHC program in Nigeria.

Women utilize the services provided for under the PHC program, particularly for child health and obstetrics services. In an onchocerciasis hyper-endemic community in Enugu State, women who had come to the only health centre in the community (24,000 inhabitants) were asked on three occasions their reasons for attending the clinic. Of the 53 (16-39 years old) women asked, 47 came because their children were sick, 5 women were pregnant, and 1 had fever and diarrhoea. Nevertheless, 20 (38%) of these women had at least one clinical manifestation of onchocerciasis. When asked why they were not presenting their own health needs along with those of their children, a respondent observed, *the services here (health centre) are for our children and diseases that affect them (naming poliomyelitis, tetanus, tuberculosis, measles). I am not aware that they (nurses) can treat filariasis. They do not remove nodules and doctors hardly come to our centre* (Amazigo 1989, unpublished document).
Diseases that Affect Women's Social Life and Self-Esteem

Because the dermis and the psyche share the same embryological origin, and are functionally intertwined (Van Moffaert 1992), skin disfigurement generates serious emotional distress in patients, affects their socio-economic activity (Jowett and Ryan 1985), and has an impact on bodily interaction and on sexual contact. The tropical diseases that cause visible disfigurement are guinea worm, leprosy, onchocerciasis, lymphatic filariasis and urinary schistosomiasis. They have strong psycho-social implications. Serious consideration should be given to gender issues in the planning of Nigeria’s training, services and preventive health programs. While these diseases affect the health and social lives of both men and women in Nigeria, the following questions must be addressed: (1) Does the impact of skin disfigurement on the social lives of men and women differ? (2) Do the cultural meanings and the emotional implications of these tropical diseases outweigh the burden of the clinical symptoms for women? and, (3) By paying attention to gender issues, can women’s health and tropical health programs be improved within the existing health services in Nigeria?

Stigma attached to skin disfigurement and disabilities often affect not only the individual, but also her family and friends (Amazigo and Obikeze 1991). In a recent study in Nigeria, Hellandendu (1992) examined how 143 individuals, (83 males and 60 females) coped with disability. Diseases and disabilities affecting the 60 disabled women were recorded as leprosy (UNFPA 1990), blindness (Bradley 1976), epilepsy (Edungbola et al. 1978), and 25 other women had different disabilities including chronic ulcer, paralysis of limbs and vesica-vaginal fistula. Disability affected the women’s chances of staying married depending on the extent to which "disability interferes with execution of household and farming activities". As many as 43% of the women and only 20% of the men were either divorced or widowed. Disabled men were less prone to exploitation or deception while the disabled women were found to often fall prey to elderly men as husbands because they could not find a husband easily. The following case history illustrates the consequences of skin disfigurement on the marriage prospect and future life of adolescent females in rural Nigeria.

Case: Miss A. is a 23 year-old unmarried girl who has been treated for onchocerciasis by medical and traditional doctors for 13 of her 23 years. She is physically good looking except for the gross elephantiasis legs. In an in-depth interview, Miss A. disclosed that she has never been asked for marriage. This, according to her and others in Akpugoeze, is attributable to her disfigurement. Miss A. now has a three month old baby girl. According to her story, because of the social stigma attached to elephantiasis, and the fear of not being able to have children after a certain age, she fell prey to an old married man and became pregnant from the relationship. It was her decision to carry the pregnancy to term, for according to her, in my condition I thought I may not be able to get pregnant...when I found out that I was pregnant, I still was not sure I will survive the pregnancy (Amazigo and Onwurah, forthcoming).
Onchocerciasis is the most economically devastating disease known to man and the second leading cause of blindness (Edungbola 1982). Unfortunately, there are no Nigerian studies examining the social and economic consequences of blindness on women’s domestic and economic roles, particularly among female-headed households. Blindness of a mother may have a disastrous effect on the family. As the demands on the blind mother increase, a daughter is kept from schooling and her domestic responsibilities increase. As a result of onchocerciasis, the mother’s burden becomes the daughter’s sacrifice—a sacrifice much less frequently demanded of boys (UNFPA 1990). In a study which examined factors influencing village abandonment, several interconnected factors were implicated but the continual presence of onchocerciasis and its vector was the most important factor (Bradley 1976). The disease was responsible for out-movement but significantly deterred in-movement into affected villages. Studies to examine the impact of village abandonment and of blindness on females, and of village abandonment on schooling and learning outcomes of school-age girls in northern Nigeria, are highly recommended.

In the rainforest endemic communities, blindness is not a common occurrence. However, unsightly lesions from acute and chronic papular dermatitis, lichenified onchodermatitis characterised by pruritic hyperpigmented hyperkeratotic plaques seen in teenagers and young adults of marriage age is shown to have emotional and socio-cultural dimensions of stigmatising illness. In a study to examine the socio-cultural consequences of onchodermatitis among adolescent girls in Nigeria, it was found that unmarried adolescent girls with skin lesions try to conceal their disease condition and shy away from school and social age grade activities (Amazigo and Obikeze 1991). Stigma attached to unsightly skin lesions from onchocerciasis affects the age at which a girl is married, and the types of friends she has, as well as disqualifies her from full social acceptance. In an on-going study in Etteh, Nigeria, exacerbation of skin lesions form papular onchodermatitis in pregnancy has been observed with an increase in gestational age (photographic documentation by Amazigo, 1990 is presented in Brabin and Brabin 1992). Because the interplay between socio-cultural and biological forces is often difficult to identify and quantify in epidemiological studies, in several of such studies done in Nigeria (Edungbola et al. 1978; Edungbola et al. 1983; Dipeolu and Gemede 1983), information on the socio-cultural dimensions of onchocerciasis is lacking; prevalence and intensity of infection have been observed to be higher in males than in females.

Sex differences have been attributed to difference in exposure to the bites of the blackfly vector (Edungbola et al. 1983) and in farming activities which supposedly took men into high transmission areas and for longer periods than women. Contrary to the findings of Remme et al. (1986), 52% of the agricultural labour force in Nigeria are women. In Southern Nigeria, women contribute the most labour to agricultural production (Okonjo 1988), spend more time in the high transmission zone and are certainly as exposed or even more exposed to the bites of tropical diseases vectors than men. Also, Okonjo observed in 1988 that the responsibility for food production is increasingly being shifted to women as men...
move into lucrative fields (e.g. oil press) and to white collar jobs. Unfortunately, the definition of agricultural production as only cultivation excludes planting, weeding, harvesting, threshing, and winnowing which are predominantly carried out by women but are ignored in assessing exposure to the bites of vectors. Given the high rate of low-birth weight infants reported in studies done in northern Nigeria (Harrison 1985), studies on the effects of mixed infection of malaria and onchocerciasis on low-birth weight are desirable.

**Lymphatic Filariasis and Leishmaniasis**

In Nigeria, reports of lymphatic filariasis and leishmaniasis (Ukoli 1984) are scant, and differences by gender are not documented. Cases of genital involvement in females have rarely been reported. *Wuchereria bancrofti* is one of the species of filariae that infect men in Nigeria causing some of the most dreaded clinical complications - hydrocele and elephantiasis in which the scrotum and legs assume unsightly deformities of elephantine shape and size. As succinctly observed by Ukoli (Kisekka et al. 1992), *while elephantiasis provokes pity from members of the community, hydrocele provokes laughter instead, to the embarrassment of the afflicted*. The detrimental effects of lymphatic filariasis to the sexual health of Nigerian women would be difficult to document because of the unwillingness of adolescent females and women to undress for the predominantly male health workers or field researchers in Nigeria - women would likely be unwilling to have, as women in northern Nigeria put it, *strange men gazing at their nakedness* (Kisekka et al. 1992).

**Leprosy**

Globally, Nigeria ranks second after India in the number of leprosy cases per year. The disease is hyperendemic and centres are established in six states -- namely Edo, Cross-River, Akwa Ibom, Abia, Niger and Plateau States (Brightmer 1990; Asuquo 1993). The highest prevalence rates are found in communities in Northern Nigeria, where females are more susceptible than males (ratio = 1.5:1), contrary to observations in Southern Nigeria and probably due to cultural disposition of females. According to the results of an on-going study in Nigeria (Asuquo 1993), males contract the disease during interstate and inter-country travels and trading. Occupations most at risk are fishing, farming, and traders who are engaged in the transportation of tobacco to Cameroon.

Women become infected as a result of cohabitation with infected husbands, while adolescent females are exposed due to close association with mothers and grandmothers (Asuquo, personal communication). Multi-drug therapy (MDT) is the recommended treatment approach for patients. According to studies, children and adolescents (5-20 years old) have higher infection rates than adults in Akwa Ibom State. Higher susceptibility in the younger age groups seen in Akwa Ibom State may be due to early exposure to infection or the effectiveness of the State control program in identifying early cases (Brightmer 1990; Asuquo 1993). In any case, the epidemiological situation of leprosy in Akwa Ibom State deserves attention.
Leprosy has a devastating impact on schooling and on the marriage prospects of girls in some communities in Nigeria (Asuquo 1993). In a study in Nigeria, 200 leprosy patients from 6 communities in 3 states (Bendel, Abia and Cross River) were interviewed. The study revealed that leprosy was responsible for higher divorce rates in Ekun and Sapele than in other Nigerian communities. In these same communities, parents threats to withdraw their healthy children from school force teachers to expel affected girls and boys. The affected children who are forced to leave school usually take up menial jobs and/or marry early before deformities and disabilities ensue. As a result, affected adolescent girls face a high rate of divorce as soon as their conditions become visible**. There is a dire need for Nigerian studies that examine depression or anxiety among leprosy patients, similar to studies done in India (Weiss et al. 1992). Studies examining adolescents, and the consequences of leprosy on schooling, cognitive function and academic performance of children are particularly important.

Using onchocerciasis as an example, the problems in controlling tropical diseases that disfigure are summarized in Figure 1.

**Tropical Diseases, Gender and Anemia**

Of the tropical parasitic diseases, malaria has received the most attention with well-known published results of longitudinal studies and cross-sectional surveys done in Nigeria (Bruce-Chwatt 1952; Harrison 1985; Weiss et al. 1992). \textit{Plasmodium falciparum} is the dominant parasite. In the Garki study (Weiss et al. 1992) similar parasite rates were reported for male and female children under 4 years old but lower parasite rates and densities were reported for female children above 4 years of age.

Malaria is highly endemic, therefore indigenous women acquire significant protective immunity during adolescence. Unlike most parasitic infections, however, any advantage in parasite clearance gained from continuous exposure to malaria are lost during pregnancy due to immune depression. Perhaps because of its danger and consequences for foetal life, impressive and well documented studies have been conducted in Nigeria on placental malaria, anaemia and low birth weight due to malaria in pregnancy (Spitz 1959; Fleming et al. 1984; Obasi 1991). In studies on maternal malaria, reported figures on placental parasitaemia vary between 15-33\% (Brabin 1991). Haemolysis in pregnancy stimulates erythroid hyperplasia especially in primigravidae, increasing folate requirement and causing anaemia in women (Fleming et al. 1968). In a study of 228 young primigravidae seen at Zaria clinic, Fleming et al. (1984) reported that 43 percent of the women were anaemic (Hb < 11.0 g/dl). Falciparum malaria was present in 28\% of the 228 women, but in 40\% of the anaemic women. These are risks that men do not face: the risks inherent in pregnancy and childbirth. Further, studies by Harrison (1976) and Harrison and Ibeziako (1973) associated poor foetal

** For more information on leprosy, the reader may wish to contact Dr. M.A. Asuquo, National Institute for Medical Research, P.M.B. 2013, Yaba, Lagos.
nutrition to maternal anemia due to malaria. In spite of these impressive findings, studies on the efficacy and pharmaco-kinetics of antimalarial drugs, such as chloroquine and pyrimethamine, deserve more attention.

Anemia among adolescent females deserves special attention because of early marriage practices, poor nutritional habits of women and the cultural practice of feeding adolescent girls last within the family. Early marriage takes precedence over education among several ethnic groups where marriageability of girls at an early age is desired. School attendance requirements conflict with responsibilities that married girls have, with regard to domestic, outdoor and seasonal agricultural activities (Kisekka et al. 1992). According to the National Fertility Survey (Harrison and Ibeziako 1973), 24.3% of all marriages in Nigeria take place before 13 years of age, 37% by age 14, and 51.8% by the age of 15. More than 80 percent of women in Nigeria marry before the age of 20 years. Early marriage practices result in widespread adolescent pregnancy, high prevalence of anemia, low birth weight and
prenatal death, as demonstrated in the well known and impressive study by Harrison (1985). Therefore, gender issues in health are affected by variables such as education, sex and cultural health practices.

One of the most troubling problems in Nigeria’s policy on malaria control relates to sustainability and effectiveness of the country’s prenatal prophylaxis program. The nagging question is, how do we get pregnant women to accept and comply with prenatal chemoprophylaxis or other forms of preventive measures? How do we get women to our health centres for health education and treatment of malaria given the transportation costs, location of health clinics, as well as cultural restrictions? These persistent problems may be best addressed by adopting a women-centred strategy which would require additional measures such as:

- training more females in health services and in community-based research, and encouraging female community nurses to conduct home visits especially in communities where women are in seclusion for case detection and management, as part of the PHC malaria control program activities;
- encouraging researchers to understand socio-cultural barriers that may affect the delivery of health care, such as religion which may restrict women’s mobility, and intensifying appropriate information campaigns through existing national literacy programs;
- motivating women and women’s groups to participate actively in malaria control and listening to women; and,
- encouraging gender-oriented pharmaco-kinetic studies on antimalarial drugs.

Finally, very little is known about the role of women in the transmission of urban malaria, their perceptions about cerebral malaria, and early referrals in malaria management. The use of permethrin-impregnated curtains, bednets or mats is currently being studied in Nigeria (Salako 1993). Where treated bednets are accepted as a malaria vector control activity, its success will largely depend on compliance and cooperation of Nigerian women, since it is the women who have to bring the nets or curtains for redipping in insecticide.

**Tropical Diseases and Sexual Health of Women**

Of the tropical diseases that affect women’s sexual life, gender issues on schistosomiasis and guinea-worm deserve special mention in this paper.

**Schistosomiasis**

Schistosomiasis (bilharziasis) ranks second to malaria as a major cause of considerable morbidity, mortality and debility in humans. *S. haematobium* is more widely distributed in Nigeria than *S. mansoni* (Cowper 1973; Kisekka et al. 1992), and clinical infections of urinary schistosomiasis in children with visible haematuria has been reported in all parts of the country (Cowper 1973; Anya and Okafor 1986). Several of these studies have shown
that urinary schistosomiasis is widespread, focal and serious. The studies emphasized the rural nature of infection as well as its relationship with occupation. Although studies done in Nigeria show higher prevalence rates in males than females of all ages (Cowper 1973; Anya and Okafor 1986; Tanner 1989), it is difficult to arrive at a reasonable conclusion since there is considerable disagreement about the relationship between the presence of infection, extent of disability and/or development of disease (Tayo et al. 1980).

Studies done in Nigeria lack information on water contact and social risk factors that affect the epidemiology of urinary schistosomiasis, as well as the influence of gender and nutritional factors on morbidity. The only exception is the Malumfashi (Kaduna State) water contact study which found significantly lower infection rates among females than males because exposure rate was lower for females. The authors observed that females in Malumfashi remained secluded in their households and waited for the men to bring them water for cooking, washing... males were responsible for over 98 percent of the activity involving contamination from and exposure to water (Cowper 1963). What is required is a similar water contact study in non-Muslim communities where women are not in purdah, but rather, are as involved in agricultural and water contact activities as men. In Western and Eastern Nigeria, domestic activities keep adolescent girls and women exposed to water and infective cercaria for long hours, while personal water activities, such as bathing, expose boys to infection. For females, it is likely that activities with water would have a linear increase with age.

Clinical complications of schistosomiasis include anemia, cirrhosis, bilateral hydronephrosis (Cowper 1973), genital involvement, obstructive uropathy and hepatosplenomegaly. In chronic cases, schistosomiasis affects work capacity. It causes gross haematasia leading to severe iron loss (Gilles et al. 1965a), as well as anemia, a condition of serious implication for pregnant women. A number of studies in Nigeria have reported the presence of ova of *S. haematobium* in the genital tracts of females and have associated the disease with infertility and cancer (Olufemi 1967; Kisekka et al. 1992). In a study by Olufemi (1967), schistosomiasis was found responsible for postcoital bleeding, infertility, intermenstrual and postmenopausal bleeding and weight loss among women in Southern Nigeria. It was also reported that 60% of all carcinomas of the bladder seen in the Department of Pathology, University of Ibadan College Hospital, were associated with vesicular schistosomiasis.

Studies on the socio-cultural dimensions of schistosomiasis on adolescent females and women point to significant gender differences in morbidity and disability due to urinary schistosomiasis. In a study in Amagunze, Nigeria (Anago-Amanze, et al. forthcoming), it was found that the community regarded urinary schistosomiasis as a venereal disease. As a result, haematuria adversely affected the marriage prospects of adolescent girls, led to divorce in some cases, affected women's work capacity and their family responsibilities. Similarly, a 56 year-old female respondent in Aguleri, a hyperendemic community in Anambra State, Nigeria, had this to say about her experiences with urinary schistosomiasis during an in-depth interview:
...during your adolescent age when other girls are hurrying out of primary school waiting for suitors, you (the infected girl with haematuria) are busy convincing your parents and eligible male friends (bachelors) that the blood in your urine is not gonorrhea contracted from a promiscuous a lifestyle. When you finally get married, you complain of (postcoital) bleeding and irritation in the vagina. Therefore, you are unable to satisfy the sexual desires of your husband. Imagine your fate. Even when you are innocent, with these symptoms, who will believe you... (Nigerian Fertility Survey).

Because of the cultural meaning of schistosomiasis in this community, childless women and those without male offspring hide disease symptoms to avoid being sent away or being accused by their husbands of sexual misconduct. Social and clinical consequences of urinary schistosomiasis may encourage polygamy and contribute to the high proportion of female headed households. Estimates in Nigeria show that 42.6% of all married women are in polygamous unions, contrary to 56.7% who are in monogamous homes (Kisekka et al. 1991). While gender is given prominence and made the central issue in contraceptive and family planning programs, targeting women as objects of fertility control in the Federal Republic of Nigeria Policy (Nigeria Policy 1992), gender issues are not receiving any attention for diseases like schistosomiasis that leads to infertility. Gender has received no attention in the National Schistosomiasis Control Program.

**Guinea Worm**

The gender issues associated with guinea worm, another loathsome tropical disease, also deserve attention. Studies with impressive data exist in Nigeria on the impact of guinea worm on maternal and child health, primarily on pregnancy, lactation and child care (WASH field report 1988; The News 1993). The report of the Water and Sanitation for Health (WASH) Project in Nigeria provides information on guinea worm and gender. According to the report, guinea worm disease in women worsens in pregnancy, leads to loss of appetite, affects breastfeeding practices due to pain and fever, and adversely affects the quality of child care. Incapacitation due to guinea worm disease also prevent women from doing their work. Furthermore, incapacitation prevents women from taking advantage of antenatal services and taking infants to clinics for immunization (Brieger et al. 1989). In sum, guinea worm disease in a female member of the household affects general family health. Further, guinea worm among female-headed households in Nigeria has an additional impact on child health (The News 1993), and may affect the schooling and academic performance of girls who may have to abandon schooling to assume the role of child care with increased domestic responsibilities (WASH field report 1988). Unfortunately, we know very little about the consequences of guinea worm for females outside the reproductive age, particularly its effects on absenteeism, drop-out rates and learning outcomes of school-age females in Nigeria.

**Conclusion**

Significant gaps exist in our understanding of how schistosomiasis, onchocerciasis, guinea worm, lymphatic filariasis and leprosy affect the overall health status of women.
during childhood, adolescence, and after reproductive age. Even the effects of the most prevalent of all tropical diseases, malaria, on the lives of women in Nigeria remain largely unknown. The most fundamental problem facing Nigeria is how to make choices for health care that address those health needs considered significant by the most vulnerable - rural women and women in the informal sector. The sensitivity of the government shown by decentralization of the PHC beyond state and local government to community and village levels, and placing emphasis on maternal and child health, is encouraging. However, this sensitivity should be extended to tropical health programs. This has recently been emphasized by the former Minister of Health, Olikoye Ransome-Kuti: We are not identifying the real problems of the nation and tackling them. You see, we should define our objectives. What do we want to do?...If we want to tackle our problems, then we should write down our problems; measles, whooping cough, polio, diarrhoea, guinea-worm, tuberculosis, leprosy, river-blindness then we say, each of them, how do we set up a system to tackle them...." (The News 1993). Interestingly, of the eight diseases mentioned by the Minister, three are disfiguring tropical diseases which have been targeted by the World Health Organization, and for which gender issues have been a neglected dimension.

There must be a political commitment in Nigeria to the notion that certain tropical diseases (schistosomiasis, guinea worm, malaria, onchocerciasis and leprosy) are still very much around, and cause significant morbidity and disability in females of all age groups; and that alleviating illness among women shall yield high returns for the nation in sustainable development.

**Recommendations**

The Nigerian effort to eradicate guinea worm is a successful example of a cost-effective health intervention program on prevention. With the advent of praziquantel, abendazol and ivermectin, efforts to eradicate schistosomiasis, the common helminths, onchocerciasis and lymphatic filariasis, should be made cost-effective in the following ways:

- Integrating tropical disease drug distribution activities into the PHC program as this would save imposing additional cost related to infrastructure and personnel.

- The design of the PHC services should be made sensitive to the stigmas surrounding diseases that damage the skin.

- Nigeria should, as a matter of urgency, set up a viable school-based health intervention for mass treatment of children with anti-helminth and micronutrient supplementation. In addition, in communities endemic for onchocerciasis and schistosomiasis, ivermectin and praziquantel should be added to the program.

- Praziquantel and other new drugs should be made affordable to women and accessible through other local channels.
The government should make efforts to assume the role of empowering women to help create solutions to women's health problems. A way to achieve this is to encourage dialogue with women's groups. Further, it is important to include instructions on women's health in the national curriculum designed for the female literacy programs. Because we have not been able to design tropical health education programs acceptable to women and women's groups (e.g. Better Life for Rural Women, National Council of Women Societies), to help them appreciate the importance of parasites for healthy growth, interventions aimed at village level grind to a halt when initiators leave.

References


• The importance of acknowledging local understanding of disease was stressed. Quite often, a proper medical explanation of the particular disease may not be known, but the community may still know what to do. Women often know the symptoms of dangerous diseases. They may nag their husbands to bring the ill household member to the hospital. Mothers also teach their children prevention strategies - for example, they may tell them not to play in lakes. When doing research, it is important to find out the perceptions that the women in the community have about the disease in question, and their suggested solutions.

• There are many similarities in perceptions and beliefs, as well as disease patterns, from country to country. One participant pointed out that many of the results from Dr. Anyangwe’s study in Cameroon are very similar to reported results from the coast of Kenya.

• It is crucial to identify those who are most likely to be exposed to mosquitoes during peak mosquito-biting periods. Women’s work may predispose them to being bitten more than men during peak biting periods. For example, women may wake up at 2 or 3 a.m. to head off for the market, or they may stay up late at night preparing meals. These activities may put them at a higher risk for disease.

• Women are much more affected by malaria than men. If a woman’s child is ill, she is going to lose days at work. If she is ill, it is going to take longer to get her to the hospital, and she will likely go back to work before she is fully recovered.

• The male of the household may make crucial decisions with regard to malaria prevention and treatment. For example, he may ultimately decide whether or not there will be a mosquito net. He may also determine when and where to get treatment.

• Despite the abundance of clinical and technical information, diseases continue to proliferate. There was considerable discussion on the necessity of fully addressing the socio-economic dimensions of disease. Health recommendations need to be meshed with larger recommendations concerning poverty. Higher rates of certain diseases in women may be related to poverty and weakened immunological status, and not simply because they are women. Also, socio-economic status may be a determinant of the likelihood of exposure.

---

This discussion report incorporates comments raised during the discussion period for both Dr. Uche Amazigo and Dr. Stella Anyangwe.
Another fundamental economic issue pertains to the distribution of scarce resources. Often times, there may be a complete lack or severe shortage of drugs. There is a need to develop more cost effective interventions.

• There was a call for a change in the epistemology of research, with an increased recognition of crucial gender dimensions. For example, researchers need to identify whether their team of researchers is made up of men, women, or a combination of both sexes. Young girls and women may resist male researchers. It was also noted that teams with females researchers reinforce the notion that women, as well as men, can be researchers.

• There continues to be a problem of disease identification by community members, as well as difficulties in determining what diseases are treatable and how. There is a great deal of biomedical research on malaria and plenty of valuable information concerning prevention and treatment strategies. This information often doesn't get transmitted to the people/community who most need it. More work is needed with regard to linkages to the community.

• Finally, more attention should be placed on the way in which environmental degradation can impact on women’s lives. For example, tropical diseases are often a sign of ecological damage.
Gender and Acceptance of Technologies for Tropical Disease: Impregnated Mosquito Bednets for Malaria Control

Martin Sarikiaeli Alilio

Introduction

The prospects for malaria control implemented by international and national efforts remain more elusive now than ever before. In many countries these programs have lost momentum due to a number of reasons, including: (i) cuts in national and international organisations' expenditures; (ii) refusal of householders to allow spraying because nuisance insects are not killed, objections to strangers entering their houses, and because of unsightliness or odour of the older types of insecticide; and (iii) resistance of some vector populations to some insecticides and the tendency of some species not to rest long enough inside houses to pick up a lethal dose (Curtis 1993). The question now, therefore, is, are there alternative techniques of proven effectiveness which well-motivated communities would be willing and able to apply for themselves, with minimum training and assistance from central authorities?

One possibility may be the use of the mosquito bednets, particularly when treated with insecticide, as a means to reduce man/mosquito contact. It has been repeatedly shown that permethrin-impregnated mosquito nets are effective not only against mosquitoes but also against one of the most irritating of biting insects — bedbugs, Cimex (Charlwood and Gagaro 1989; Lindsay et al. 1989; Njunwa et al. 1991).

A number of factors have been identified as necessary for active and sustained community participation in disease prevention and control. These include knowledge, competent technical assistance, an appreciation of long-term benefits, and a strong sense of community. While these factors may be necessary, they may not be sufficient for cooperation to prevail. More recently, a number of other factors have been identified, including the need to incorporate gender-related issues within and outside the household. Since malaria affects men and women differently, socially, economically and physically, gender is an important aspect to be considered when planning any intervention measures for malaria. This paper highlights gender issues related to malaria control.

1National Institute for Medical Research, Amani Medical Research Centre, Muheza Tanga, Tanzania.
Malaria and Traditional Sex Roles

While the exact number of people infected with malaria each year remains unknown, this number is hardly less than 100 million, 2/3 of whom are women and children. Indeed, some estimates based on alternative methods of statistical evaluation suggest that there may be over 400 million cases per year (TDR 1989). Malaria is the major cause of mortality in tropical areas, especially in Africa. Not only is malaria the most serious of the diseases faced by the tropical world community, it is also the most tricky. Both parasite and vector are opportunists with a high rate of reproduction, with a resultant high rate of genetic rearrangement. Thus a wide repertoire of possible genotypes exist that can confer adaptation or resistance to any weapons which are developed.

As many institutions, especially non-governmental, now focus on projects aimed at placing malaria prevention and control in the hands of individual families and communities, it is becoming clear that there is a need to examine the social relations of members of the individual household/family. Indeed, data from recent studies show that there are marked gender differences in the risks of exposure, vulnerability and access to protective measures against malaria (Alilio 1990).

The depressed health of women for example, which in Africa is related to general malnutrition and infection, as well as complications of pregnancy and child birth, are some of the reasons for the high levels of mortality and morbidity in women from malaria. These conditions also occur in the context of poor socio-economic situations where education, health and other social services are very limited for women. Some of these underlying causes have their roots in socio-cultural beliefs and practices that adversely affect the status of women in society (Mpanju 1992).

The average African woman has 6 or 7 children, and therefore goes through many cycles of pregnancy and lactation. Between the ages of 20 and 45 years, women are bearing children at a very short intervals, breastfeeding them, and at the same time continuing to perform energy-consuming work loads. Studies in Tanzania show that most women continue to carry out energy-consuming work even to their last days of pregnancy, without adequate caloric intake. Accordingly, they continue to fetch water and firewood for fuel, to farm, to cook and wash, to take care of children and sick members of their families, among other tasks (Mpanju 1992). A malnourished woman does not necessarily reduce her workload, rather, she takes longer to accomplish it. In this context, resting during pregnancy which is not associated with overt disease is seen as sign of laziness. Such attitudes contribute to maternal depletion syndrome, which results from a chronic imbalance in the energy demands on the bodies of women. Other factors which contribute to the negative energy imbalance in pregnancy include: (i) inadequate food intake; (ii) frequent infections; and (iii) cultural practices and food taboos. However, poorly nourished women may feel less inclined to participate in activities such as attending prenatal care, taking their children for growth-monitoring and immunization, or paying attention to health education messages essential for their own health.
Anemia, particularly nutritional anemia, is known to contribute considerably to recurrence of malaria episodes. Studies in Tanzania indicate that anemia results from a combination of factors which include (i) low intake and low bio-availability of dietary iron; (ii) protein-energy malnutrition; and (iii) effects of parasitic infections, especially malaria, schistosomiasis and intestinal worms. Malaria appears to be the single most important factor related to the geographical variability in the prevalence of anemia (Mpanju 1992). In one study conducted in Nzega, in central Tanzania, anemia, clinical malaria and fevers during pregnancy where identified in 87% of 1072 women surveyed. Malaria and anemia were also found to be the most important determinants of pregnancy outcome in a study in Ilula, in southern Tanzania, further emphasising the importance of anemia in pregnancy.

**Women and Malaria Control Technologies**

In Thailand, South China, and parts of Latin America and Africa where the nuisance of mosquitoes is particularly severe, the use of mosquito bednets is already common, even among poor people. The cost of sufficient pyrethroid for impregnation is small compared with that of a net, and the cost of treating the nets in a house is less than the cost to spray the same house with DDT. (Li Zuzi in Curtis et al. 1990). Net treatment is also much more acceptable to people than DDT house spraying. However, the problem with bednets compared to other malaria control measures like DDT spraying, is that most poor households cannot afford to buy sufficient bednets for everyone in a family. In this case, the sharing of few nets tends to reflect the inequality which often exists between men and women within the family, in which men tend to be the decision-makers and therefore the benefactors.

The situation is worse in the parts of Africa where perennial malaria exists, and where bednets are thought of as a luxury item for rich men. Findings from a study conducted in Muheza, Tanzania suggest that the "issue" is not whether people will accept or reject protective measures against mosquitoes, but rather whether they can afford them for all family members (Allilio 1990). The study also revealed that mosquito bednets are expensive when one takes into account the total turnover of the household economy. Hence bednets may not be high in the order of priorities of the household. The outlay required to buy a net is perceived as beyond the means of the poor. Malaria incidence, therefore, has as much to do with poverty as with other ecological factors. Poor families simply do not have the resources to protect every member of the family from malaria.

**Is Appropriate Policy Missing?**

There are a number of policy issues which need to be examined in the context of bednet use. There is a strong argument in favour of subsidizing the cost of bednets if only to the wholesale price in order that they be more widely accessible, although this might be resisted by those who favour commercial, as opposed to socialised, medicine. If the nets were sold at a lower price by village health workers, this would add one more to their many responsibilities and a small incentive payment would probably be required. Such sales would
undercut the commercial market in mosquito nets and could be an additional cause of friction between village health workers and economically powerful members of the community (MacCormack 1990).

Bednets might also be considered by governments as a medical appliance and not a luxury item and could, therefore, be free of sales tax and customs import duty. It is in everyone's interest for there to be a high level of usage of impregnated nets in a community, as this ensures that many mosquitoes are killed by contacting insecticidal nets (Curtis 1991a).

To encourage widespread use, communities might be encouraged to form small groups to manufacture mosquito bednets for local community use. Instead of importing industrially made nets, local tailors could be encouraged to make mosquito bednets so that people can have the size and types of nets they prefer. This approach could stimulate further economic benefits to trickle down through the local economy.

Formal surveys (e.g. Desfontaine et al. 1990) and casual conversations show that it is the nuisance of insects (including disturbance of sleep by noise of mosquitoes) which is of more immediate concern to most people than their vectorial role. Charlwood and Dagaro (1989), and Lindsay et al. (1989) report that headlouse infestation rates were reduced by use of impregnated nets, presumably because dust containing pyrethroid enters the sleeper's hair. To induce acceptance, all such authenticated beneficial side effects of impregnated nets should be incorporated in information packages to be provided to the communities.

If people are unwilling to sleep under conventional bednets because they obstruct ventilation, they may find it more acceptable to use impregnated curtains over doors, windows or eaves gaps (Majori et al. 1988; Sexton et al. 1990), or impregnated broad mesh nets (Kurihara et al. 1985; Hossain and Curtis 1989). Broad mesh nets may also be more portable by people who spend nights away from home to guard crops or for other reasons. However, if broad mesh nets are adopted by a community, their timely reimpregnation is particularly important as they provide only a chemical barrier and not a physical one.

If nets are to be marketed and impregnated at prices affordable by the very poor through the primary health care system, one should also consider doing the same with other forms of personal protection such as deet repellent, good quality mosquito coils or substitutes for them such as insecticide impregnated rope (Sharma et al. 1989). With all these methods it is most important that primary health care workers are provided with understandable, accurate and commercially unbiased information on the need for personal protection and how the various methods are used.

Primary health care workers are generally expected by the public to provide curative medical services and are often under severe pressure in their communities (MacCormack, 1990). They cannot therefore be expected to impose preventive vector control activities on
an unwilling or apathetic community. Therefore, if vector control is to be carried out via the primary health care system, it is essential that it has the active support of public opinion, as well as the necessary skills and materials.

Good educational material is of great importance if primary health care workers are to play any role in encouraging communities to use impregnated mosquito nets. Some people do not know that mosquitoes come from aquatic larvae and many do not know about the different kinds of breeding sites occupied by the vectors of malaria, filariasis, dengue and Japanese encephalitis. In informing people about these matters, it is important that educational material does not give an over-optimistic impression about the feasibility of effective disease control via larval control. There have been innumerable disappointments because people did not realise how intensive the searching for breeding sites must be, that some mosquitoes can fly considerable distance, and that where transmission is intense, a very large reduction in adult vector density is necessary to have any impact on the prevalence of malaria.

It is important that studies now compare the cost of mosquito bednets per capita vis-à-vis per capita treatment cost of antimalarial drugs. There is some evidence which shows that mosquito bednets are more cost-effective. If the same could be found to be true in other malarious regions, the evidence might be used to convince policy-makers to promote mosquito bednet usage.

Research Gaps

A number of research gaps still exist, particularly related to gender differentials in the prevention and control of malaria. There is urgent need for information about the burden which will be added to women if malaria control responsibility is placed on the shoulders of families, especially in the rural areas. More information on the gender implications of such a strategy is needed. If governments and public authorities are no longer willing or able to invest in malaria control activities, placing the malaria control burden on the shoulders of household and families will inevitably have detrimental effects on women, although the nature and degree of these effects is not yet known.

In addition, very little is actually known about the decision-making process within the household. This process has a direct effect on who in the family benefits from any particular malaria control strategy. More research needs to be done in order to better understand and incorporate these processes into any intervention strategy, so that it may be both culturally appropriate and gender-sensitive.
References


Chan Kai Lok, et al., 1990. Control of *Aedes* mosquitoes by the community. Ch. 6 in *Appropriate Technology in Vector Control* e.d.e.f. Curtis.


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

J. Munguti Kaendi

Introduction

Malaria

Malaria is a vector-borne disease caused by protozoal parasites of the genus Plasmodium. The symptoms for most types of malaria include, among others, headache, malaise, nausea, vomiting and generalized body pains. Sequential chills, fever and sweating may also be present. Plasmodium falciparum malaria is the most dangerous form of the disease. Attacks could lead to complications which are usually fatal if untreated. Chronic and repeated malaria infections cause impaired growth in children and loss of productive activity in adults. Pregnant women show increased susceptibility and increased prevalence of anemia. As such, prevention and control of malaria, especially in light of the complications to pregnant women, is imperative. It has been noted that P. falciparum is a significant cause of spontaneous abortions in non-immune pregnant women, and that infants, especially the first-born of malarious mothers, generally have lower birth weights than those of healthy women, and therefore a poorer chance of survival in early childhood (WHO 1987).

Leishmaniasis

There are three different forms of human leishmaniasis: (1) mucocutaneous leishmaniasis which affects the mucous membranes; (2) a cutaneous form which affects the skin; and (3) visceral leishmaniasis (kala-azar) which affects the liver and spleen. This paper focuses on the visceral form of leishmaniasis. Leishmaniasis infections are caused by intracellular protozoan parasites transmitted by more than 50 species of female sandflies of the genus Phlebotomus (for old forms of the disease and Lutzomyia for new world forms). It is estimated that there may be as many as 1.5 to 2 million cases of the disease worldwide (Walton 1988).

After contact with an infected sandfly, the onset of kala-azar is gradual. Its incubation period varies from 10 days to more than one year. The breeding and resting sites for sandflies (the disease vector) are diverse and widespread. They include termite hills, tree trucks and rodent burrows. This diversity of vector habitats leads to complications in designing effective prevention and control measures. The symptoms of kala-azar are

---

1 Institute for Development Studies, University of Nairobi, Nairobi, Kenya.
recurrent fever, malaise, weight lose, wasting, enlargement of the liver and spleen, anemia and, in some cases, diarrhea. Despite the large numbers of people suffering from the disease and those at risk, the research has shown little interest in this fatal disease.

Unlike many diseases, for which there are no distinct gender differences, it has been observed that kala-azar tends to affect males more often than females (Wijers 1974). This has been attributed, at least in part, to occupation (especially herding) and type of clothing (Fuller 1979; Thakur 1981). In an epidemic study in India, Thakur observed that 85 percent of those afflicted with leishmaniasis were male. He argues that clothing patterns may expose the male more than the female, as women tend to be better clothed than their male counterparts. Additionally, the disease seems to primarily affect the productive age groups of the population (Bodero 1988). However, recent studies showing that sandfly vectors inhabit the walls of houses raise new issues in relation to disease and gender (Mutinga 1980).

Both malaria and kala-azar exist in similar geographical areas. They also present similar symptoms; in fact, kala-azar may be confused with malaria at a certain stage of illness. Southgate (1981) has observed that kala-azar infection gives rise to a progressive disease which resembles a long drawn-out episode of malaria. There have been suggestions that the two diseases may actually interact and complicate each other. According to Cox (1979), leishmaniasis-induced anemia may have the effect of depriving malaria parasites of preferred host cells. On the other hand, leishmaniasis-induced immuno-depression could benefit the malaria parasites. There is also the possibility that the treatment of one infection may, while achieving its intended aim, complicate a super-imposed infection or cause the recrudescence of a latent one (Cox 1979). Thus, prevention measures may be better informed in addressing both disease problems simultaneously.

*Socio-Economic Determinants of Malaria and Kala-azar*

In order to effect sustainable control measures for infectious diseases, it is necessary to understand the social, economic and political context within which these diseases abound. Tropical diseases are found in underdeveloped regions of the world, namely Africa, Asia and Latin America. At the national level, countries in these regions are characterized by political instability, poor nutrition, low levels of education and inadequate health services. Contrary to the popular notion that the existence of these diseases is related to climactic conditions (tropical climates), socio-economic factors appear to be more important in their existence and perpetuation. The spread, persistence and selectivity of these diseases has been attributed to the existing socio-political structures of underdeveloped countries which are diametrically opposed to the interests of the poor (Doyal 1977).

It has been shown that kala-azar and malaria, like other ‘tropical diseases’, are closely associated with poverty (Rosenfield 1990; Gramiccia 1981). Most people living in endemic areas for kala-azar have low levels of education, income and poor quality housing (Kaendi 1986). Wijers (1973) argues that starvation may be a factor of importance in relation to kala-azar, and that people who are well fed have higher resistance to the disease. This view
is also shared by Mutinga (1984), who notes that children with signs of malnutrition are more likely to get the disease (Mutinga 1984), thus identifying a synergism between nutrition and kala-azar infections.

Similarly, malaria has persisted as a disease partly because of etiological and behavioural factors and resistance of parasites to drugs, but largely because of the socio-economic conditions of the populations at risk. The populations suffering from endemic malaria live in economically marginal rural areas. They are also excluded from the benefits of the larger social political system. Medical facilities serving them are scarce (Gramiccia 1981). Since infectious diseases are intricately related to people’s social conditions, control efforts should aim to solve these socio-economic problems. The eradication of malaria in Europe shows that the disease can only be eliminated when social cohesion, basic health services and economic conditions of the community have reached high levels (Bruce-Chwatt 1985). Similar sentiments have been expressed by Stevenson (1987:2), who aptly points out that:

Although inexpensive techniques are available for the control and treatment of common tropical infections, there has been a tendency to use them without simultaneous social and economic progress. While medical techniques may reduce the burden of disease, they are in most cases palliatives, and must be continued indefinitely since they do not strike the root of the evil. Poverty and the diseases which are associated with it can only be abolished by long term policies of improved education and economic advancement.

Gender Dynamics in Prevention and Control

Prevention and control (P and C) of malaria and kala-azar must be seen in terms of socialized gender. The concept of socialized gender enables us to examine those non-medical constraints whose removal would contribute to disease prevention. This approach involves looking at health and development simultaneously. For example, the improvement of road networks in many rural areas may increase the utilization of health services for the entire population. Also, the provision of clean piped water to households would reduce women’s workload burden, thus giving them time to concentrate on health issues.

Distance to health facilities and the quality of care is also important in the prevention and control of disease. In a study on malaria and kala-azar that took place in Baringo (Kenya) during 1992-1993, I found that distance was the major determining factor in health care utilization. There were, however, inter-gender differences with more women (62 percent of the female respondents as opposed to 48 percent of the male) indicating distance as a factor in their health-seeking behaviour (Kaendi unpublished). The distance travelled to health facilities has implications for women, particularly in rural areas, where walking is the common mode of transportation. Thus, women themselves have to walk to these facilities when ill, and as health care givers, they have to walk long distances with sick children strapped on their backs. Hence, there is a need to make health facilities accessible if we are
to encourage their use in the prevention and control of disease. Mobile clinics or the provision of transport, such as ambulances to take sick persons to distant clinics, would greatly improve accessibility.

There exists a need to involve women and other members of the community in health care planning and delivery. As the major users of these services, they are more likely to be aware of the existing health needs and priorities. While keeping gender-specific aspects of prevention and control in perspective, we believe that vector control measures for malaria and kala-azar must involve the whole community. Vector control involves the use of insecticides against the mosquito and sandfly, larvicides, removal or modification of breeding sites and, at the household level, reduction of contact between people and vectors by appropriate screening of houses, use of bednets, protective clothing and repellents. Various logistical issues must be considered in implementing these measures such as cost, cultural appropriateness and acceptability to the community. Rajagopalan et al. (1986) have demonstrated the effectiveness of integrating vector control with income generating activities for poor rural populations, as this improves their economy while strengthening control measures. The involvement of the community (especially women) points to the need for participatory democracy in order to enable communities to participate effectively in the implementation of control programs.

Certain factors, with significant gender inequalities, such as levels of education, and the distribution of domestic power, need to be taken into account in the control of infectious diseases. In Kenya for example, the level of literacy is reported to be lower among females than males. Even in areas of the country where general literacy is low, the corresponding rate of female literacy is even lower, and the enrolment of girls tend to be low in the whole school spectrum (UNICEF 1989).

In a study conducted in Baringo (Kaendi 1992-1993), of 608 households, 63% of the female respondents had no schooling, compared to 48% of the males. 10% of the males had over eight years of schooling, while only 4% of the females had comparable educational levels. As a consequence of the low levels of education among women, only a small proportion of them (12%) knew the correct etiology of kala-azar as opposed to 26% of the men (P<0.05). Knowledge and awareness of disease etiology is important in prevention; those who know the correct causative vector are more likely to take action in protecting themselves and their families. There is therefore a need to improve literacy and educate women on these two diseases.

The importance of female literacy in disease control cannot be overemphasized. Education strengthens women’s ability to perform vital roles in creating healthy households. It also increases their ability to benefit from health information and to make good use of health services. With literacy, health messages can be correctly interpreted and assimilated into disease prevention and control programs. Education further increases women’s access to income and enables them to live healthier lives (World Development Report 1993). In Nigeria for example, Gesler reports that maternal education was associated with the use of
Western-based health care and more effort by mothers to reach practitioners (Gesler 1979). Thus, advances in female education are likely to positively impact the prevention and control of disease.

Socially, infectious diseases such as malaria and kala-azar affect men and women differently. Gender stratification influences women’s health status and shapes their experiences as health care consumers and health care providers in the home (Browner 1989). In many societies, women tend, in addition to their regular roles, to take up the activities of sick household members, thus the "shadow effect" of disease on women. There is a need to identify the "shadow" and "multiplier" effects of infectious diseases on women with a view to finding ways to reduce the illness/disease burden on them. Women are major agents in the socialization of family members on health beliefs, illness behaviour and utilization of health services, and can therefore play an important role in prevention and control of these two diseases. Additionally, as the crucial providers of health care to their families, women have to be healthy in order to play a key role in maintaining healthy families.

Although women play an important role in the health of their families in many societies, the distribution of domestic power is such that the decision on where and when to seek care lies with their husbands or male members of the households. Since observations show that women tend to use out-patient services more than men (Cleary 1982; my observations in Baringo 1992-1993), women can play an important role in the prevention of disease. Thus, there is a need to empower women so that they can participate fully in household and community decisions on health care and prevention. It is encouraging to note that in a study I just completed in Baringo, women seem to have a "free" hand in making decisions on where to seek care for malaria and kala-azar.

Conclusions

Malaria and kala-azar are infectious diseases which tend to affect men and women differently, both in terms of physical manifestations and societal implications. Gender stratification influences the health status of women and shapes their experiences as both health care consumers and health care providers in the home. As such, any prevention and control measures designed to manage these diseases must involve not only the community in general, but women specifically. As the major agents in the socialization of family members on health beliefs, illness behaviour and utilization of health services, women can and should play an important role in the prevention and control of these two diseases.

References


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

Halima Abdullah Mwenesi

Introduction

Health care delivery systems and health intervention programs have been subject to numerous investigations. These investigations have provided insights into factors that influence health-seeking behaviour, utilization services, and successes or failures of health intervention programs. Factors that have been cited as influencing health-seeking behaviour in particular, include access to health facilities, quality of services, social distance between providers and clients, and personal factors such as educational levels and economic status (Igun 1979, 1987; Fosu 1989; Subedi 1989; Mwenesi 1993). This type of information has guided policy on the equitable distribution of health facilities, and contributed to the emergence of the primary health care (PHC) concept.

In many developing countries, however, additional factors related to the interrelationship between gender roles and health care systems and health intervention programs have not been given due attention. It is common knowledge that health care, especially for children, begins at the household level. It has been assumed that mothers as care-givers have the prerogative of making health care decisions for their children. This assumption has directed past health interventions programs for a number of diseases, including malaria. It presupposes the existence of a situation of choices, with mothers and significant others bidding for their preferences, within the context of equal say in households (Rogler 1989). The purpose of this paper is to assess decision-making dynamics and the significance of family and other social networks in the health seeking process - with specific emphasis on childhood malaria. The implications of the study findings for gender relations and malaria control efforts are discussed.

Setting of the Survey

The study was carried out Kilifi district, Coast Province (Kenya). The population consists of Mijikenda people, of whom 90% are Wagiriama. Migration from up-country has resulted in a large settlement of other peoples, such as the Luo from Western Kenya. Agriculture in Kilifi is mainly subsistence. The district is served by three hospitals, six health centres and thirty-four dispensaries.

1Kenya Medical Research Institute, Medical Research Centre, Nairobi, Kenya.
Three study sites, namely, Kilifi town, Motondia, and Sokoke were chosen. Kilifi town is a peri-urban area within easy reach of Kilifi District Hospital (KDH). Motondia is a slum settlement community about 15 kilometres away from Kilifi town, with fairly adequate accessibility to KDH. Sokoke is a rural area 40 kilometres away, with poor accessibility to Kilifi District Hospital (KDH).

Method

The objective of the study was to assess decision-making dynamics and the significance of family and other social networks in the health seeking process. Specifically, the goal was to determine who in the household makes decisions for health care, who is consulted, at what point in the illness episode the consultations take place, and how choice of treatment is made. Malaria was the illness focus.

Complementary data collection methods (quantitative, qualitative and non-participatory observation) were used. The study was carried out in four stages. First, a sampling of households with mothers caring for children aged 0-9 years was established after mapping and censuses in the three sites. Second, a structured questionnaire was administered to all eligible mothers, and a total 883 mothers were successfully interviewed. The response rate was 99%. Third, mothers were re-interviewed at either health facilities or at retail outlets during a current self-diagnosed illness episode of their children. Last, 60 key informants, male and female adults, provided the nosology of Luo and Mijikenda peoples. Four questionnaires and an in-depth interview schedule were used, after extensive pre-tests. The data were processed using the Dbase IV program and analyzed using the EPI-INFO software package. The ethno-medical data were transcribed and used as background for analysis of the quantitative data.

Results

Table 1 shows the socio-demographic profiles of 883 mothers who were successfully interviewed. Qualitative data showed that the Mijikenda people have a well-defined social structure in which everyone "knows their place". The community is patriarchal. It is characterized by male dominance. Women are perceived to be the property of men, because men pay dowry to marry. Women are not expected to make any decisions concerning themselves or their (husband’s) children without consulting their husbands or other males in the household. In the absence of a senior adult male, elderly women, usually the mother-in-law, or a senior sister-in-law, can be consulted. Nevertheless, mutual respect and reciprocity is expected of each member of the community for the smooth running of day-to-day life.

The Luo community is also patriarchal. Luo women in Motondia, however, had fewer relations to be answerable to and to consult; in the absence of a husband, they could make decisions on their own behalf and on behalf of their children.
With regard to the respondents’ perception of malaria, they perceived it as a mild, inevitable but transient illness, caused by natural processes. It was viewed as not being preventable, but as treatable with modern treatments. Only 10% of the respondents understood the mechanisms of transmission, but the majority described its symptoms correctly (Mwenesi 1993).

Table 1: Socio-demographic characteristics of mothers (N=883)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Attribute</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residency</td>
<td>Kilifi Town</td>
<td>352 (40%)</td>
</tr>
<tr>
<td></td>
<td>Motondia</td>
<td>224 (25%)</td>
</tr>
<tr>
<td></td>
<td>Sokoke</td>
<td>307 (35%)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Mijikenda</td>
<td>608 (69%)</td>
</tr>
<tr>
<td></td>
<td>Luo</td>
<td>152 (17%)</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>123 (14%)</td>
</tr>
<tr>
<td>Age group</td>
<td>10-34 = Young</td>
<td>663 (76%)</td>
</tr>
<tr>
<td></td>
<td>35-59 = Middle age</td>
<td>245 (28%)</td>
</tr>
<tr>
<td></td>
<td>60+ = Old</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Religion</td>
<td>Christian</td>
<td>353 (40%)</td>
</tr>
<tr>
<td></td>
<td>Traditional</td>
<td>280 (32%)</td>
</tr>
<tr>
<td></td>
<td>Muslim</td>
<td>250 (28%)</td>
</tr>
<tr>
<td>Marital status</td>
<td>Married</td>
<td>716 (81%)</td>
</tr>
<tr>
<td></td>
<td>Partnered</td>
<td>13 (4%)</td>
</tr>
<tr>
<td></td>
<td>Un-partnered</td>
<td>154 (15%)</td>
</tr>
<tr>
<td>Education</td>
<td>None</td>
<td>445 (50%)</td>
</tr>
<tr>
<td></td>
<td>Primary</td>
<td>304 (34%)</td>
</tr>
<tr>
<td></td>
<td>Secondary/Tertiary</td>
<td>97 (12%)</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>37 (4%)</td>
</tr>
<tr>
<td>Occupation</td>
<td>None/Housewife</td>
<td>776 (88%)</td>
</tr>
<tr>
<td></td>
<td>Service/Pros</td>
<td>89 (10%)</td>
</tr>
<tr>
<td></td>
<td>Labourers/Farmers</td>
<td>18 (2%)</td>
</tr>
</tbody>
</table>

How significant, in the context of the social organizations described above, are family and other social networks in the health seeking process? Table 2 gives a summary of the findings.
Table 2: Decision-making dynamics on Health Seeking Behaviour among the Mijikenda and the Luo
peoples

Decisions to seek care

Both Luo and Mijikenda mothers routinely consulta "significant
other" (SO). These are the dictateS of their patriarchal societies.
On noticing symptoms in a child, a mother observes to see if the
symptoms will clear. If they do not, she consults a SO, who
may advise the mother to observe further, to give a home
remedy or over-the-counter drugs.

Persans who are consulted

The SO is usually the husband. In bis absence, bis father and
brothers may be consulted. Only if the father is away and if the
husband's brothers are younger siblings, would senior females in
the household be consulted. The men have the final say in
therapy choice. Among the Luo, obseiving this protocol is very
important, as the "chira" infliction can befall a household where
relationsbips of seniority are ignored. Most consultations are
kept within the household until necessary.

Reasons for consultations

SOs are consulted because "it is the way it is" in these societies.
lt is men who make ail decisions, so this is a continuation. They
are the ones who have the finances, who stand to lose if their
wives are not chaste. Children's illnesses are one way of
monitoring female behaviour.

Social networks were found to be important in health-related consultations. The
consultations involved family members, and were carried out within households. Husbands
(63%) (amongst married women) were consulted most frequently. Fifty percent of a11
mothers interviewed (N=883) reported to do so because it was expected of them, and 50%
reported to only consult when they perceived an illness to be serious or when they did not
understand the nature of the illness. It was surprising that almost all the mothers, 880 out of
883, regardless of marital status, would reportedly seek advice before taking an il1 child to a
hospital, while 386 (42%) would seek advice for retail outlet use. Figure 1 illustrates
responses to a retrospective hypothetical situation.
These findings were unexpected, except for findings on use of traditional healers.
The expected finding would be that because mothers were responsible for day-to-day care of
the children, they would use a hospital, prepare a home remedy or buy drugs from retail
outlets as a matter of course, and only consult for other alternative care. During a current
illness episode in their child, they were re-interviewed at both health facilities and retail
outlets during a health seeking action. The consulting pattern was maintained (e.g. Figures 1
and 2).
When asked whether they had consulted anyone before bringing the child to the health
facility, 29 (42%) of 69 mothers re-interviewed answered in the affirmative, while 58% said
they had not sought advice. Of the 29 mothers who reported to have sought advice, 22
120


Figure 1: Percentage of mothers who consult before seeking treatment

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>100%</td>
</tr>
<tr>
<td>Retail Outlet</td>
<td></td>
</tr>
<tr>
<td>Home Remedies</td>
<td></td>
</tr>
<tr>
<td>Traditional Healers</td>
<td></td>
</tr>
</tbody>
</table>

Figure 2: Comparison of reported consulting behaviour

Mothers Interviewed

- Advice for HF Use
- Advice for RO Use
(75%) had consulted the husband, 6 had consulted their own mothers, and one had consulted another female relative. Husbands, and other female relations reported to have been consulted, usually lived within the respondent’s household (79%). Like mothers in the community, 15 (51%) of the 29 mothers who consulted, reported to do so as a matter of course, while 14 (49%) consulted for illnesses they perceived to be serious.

The 40 (58%) of 69 mothers who reported to have made their own decision to bring the child to the health facility during the current episode were asked how often they made decisions on health matters for their children. Twenty-two (55%) said they always made decisions on health matters relating to their children, and 18 (45%) said they rarely made such decisions. Nine of the 18 mothers who rarely made health decision also reported to consult their husbands more often. The remaining nine consulted other female relatives, including their own mother. Further examination of the results reveals that at any given time, only 22 (31%) out of 69 mothers always made their own decision for seeking health care for their children.

Out of the 53 mothers with ill children re-interviewed in detail at health facilities, nineteen were among (29 out of 69 described above) those who reported to have consulted before visiting health facilities. The 19 mothers were asked whether the significant other person volunteered the advice or whether they themselves sought the advice before seeking health care for the child. Twelve (63%) mothers said that the significant other had noticed that the child was ill, while the remaining 7 (37%) had asked for advice. This implies that other members of the family take an interest in the health status of children.

At retail outlets, only four (22%) of 18 mothers re-interviewed reported to have consulted someone before purchasing drugs. Three of the mothers had consulted their husbands and one had consulted a neighbour. Eleven of the fourteen (78%) mothers who said they had not consulted, reported to always make health care decisions for their children on their own. Three said they only rarely made such decisions.

Overall, 493 (56%) out of 883 mothers reported to consult for health seeking advice and 38% of those who reported to consult sought advice from their husbands and other relations living within the household. Combining the data from both health facilities and retail outlets shows that a total of 87 (10%) out of 883 mothers were re-interviewed. Of these, 54 (62%) usually sought advice and 33 (38%) did not.

Qualitative information on decision-making dynamics did not show the mothers as having as much say as the quantitative data suggested on making health-related decisions for children. Both the female and male key informants reported that mothers, whether married or not, must consult someone else before making decisions on what to do about a child’s illness. The main reason advanced was that illnesses, whatever their nature, were a matter of life and death, and thus someone else other than the mother must be involved in the health seeking process.
Plurality of choice was also mentioned as another reason why mothers must consult before seeking care. The mother is expected to seek a second opinion on the likely cause of a child's illness. Does the illness look "natural and straightforward enough" to warrant a visit to a health facility, or should a mother visit a traditional healer? The informants reported that mothers could be excused if on their own they decide on a home remedy or decide to purchase over-the-counter drugs. Aspirin (acetylsalicylic acid) was most frequently mentioned. However, a mother would have to consult the husband, another male relative, or another in-law before seeking treatment at a health facility or from a traditional healer.

The informants based their argument on the fact that mothers often required financial assistance for paying for either the treatment or transport, yet very few had their own finances. They also argued that a husband, a father or a mother (their own or an in-law) is more likely to make a better decision, and, out of experience, is more likely to know different options. Furthermore, matters of life and death cannot be left in the hands of women. Men deal with death. It is men who must decide that a death has occurred without foul play; and it is they who must decide that a death is suspect and therefore seek the cause. Further, some illnesses are believed to be consequences of sexual transgressions. Having to seek advice for a child's illness not only acts as a check for 'bad behaviour', especially on the part of women among the Mijikenda, and men among the Luo, but, according to the informants, hastens the child's chances of being treated quickly and effectively without wasting time and sometimes money at health facilities. It also prepares other members of the household in the event that cleansing treatments involve the entire family.

Different healers specializing in different aspects of traditional medicine will also not treat a child if male relations are not in the therapy seeking group. The cultural expectations which sanction a mother's ability to decide on treatment for her child makes it imperative for her to be accompanied by a male relative, husband or other (from the husband's family), when visiting a healer because family history may be required and the mother may not be able to provide the information (she is a wife, a mother; but still an outsider in her husband's family).

The informants were asked why mothers must consult before taking their ill children to health facilities. It emerged that most husbands are suspicious of health facility visits because some women use their children's illnesses or 'Well Baby Clinic' visits as an excuse to go to health facilities for family planning services. Most of the male informants did not see the need for these services.

Discussion and Conclusion

The findings of this study suggest that there is no democracy on matters of health in certain communities. Decision-making processes for health care in different types of households and settings take their form from the social structure of the society, especially the aspect of who "owns" the child. Clear social roles delineate who makes what decisions. Among the Mijikenda and Luo, women may make decisions regarding what their family meal
will comprise of, but which "cut" of meat or poultry to serve to the head of the household or other male members of the household is already sanctioned by their traditions. Likewise, Kilifi mothers had no mandate to make decision for their husband's children or even themselves. This applied to partnered or un-partnered mothers. The decisions for health care lay exclusively with the male head of the household, particularly the husband, who not only decided the final diagnosis of an illness, but also the therapy to be used. Parkin (personal communication, 1992) also noted this trait while working among the Mijikenda and the Luo in the late sixties through to the seventies. Male in-laws, in the case of married and widowed women, fathers and brothers in the case of unmarried women, hold the mandate to make health decisions. These are patriarchal societies in which children belong to a man and his kin.

Similar findings were reported by Janzen (1978). Zairian mothers and even female heads of households did not make decisions on health matters for either themselves or their children. However, unlike in Kilifi, where patriarchal kinsmen made the decisions, in Zaire matriarchal kinsmen including mothers, maternal uncles or siblings, made health decisions. In Tanzania, McCauley et al. (1992) reported that although mothers were responsible for the care of their ill children and treated them with herbal teas for minor ailments, they had to seek the expressed permission of their husbands before utilizing a health facility or traditional healer. The women did not usually decide to use any kind of health care source on their own. In contrast, Glik et al. (1987), while working in Rwanda, reported that mothers were generally expected to make decisions on child health matters, without necessarily involving other members of the households.

The concept of "therapy management group" with regard to health care decision as described by Janzen (1978, 1987), was not encountered among the Mijikenda and Luo. Janzen (1978, 1987) describes "therapy management" (diagnosis, selection and evaluation of treatment, as well as support of the sufferer) and "therapy management group" (the set of individuals who take charge of therapy management with or on behalf of the sufferer), as observed in Zaire. In fact, consultations for health care matters rarely went out of the immediate household, unless it was absolutely necessary. This was especially so for illnesses that had any moral ethno-etiology implicated or were suspected to result from sorcery. The element of social control implied by ‘folk’ illnesses such chirwa, which presents as PEM, and which these communities believe can only be treated traditionally, is a case in point. Keeping matters within the household protects the position of male heads of households. Further, the suspicion was that mothers may by choice, or by persuasion (by health workers), use family planning services, which would further erode the control of women by males. Finally, sorcery may be practised by kin against kin. Thus, matters of illness remained within immediate households until other kin even in next door households had been cleared by a muganga (traditional healer).

The implications of these findings of malaria control are serious. The time taken to consult various people for a child suffering from severe malaria could mean death or serious neurological impairment (Bahemuka 1981; Matuja 1989; Brewster et al. 1990). Further, any
interventions for malaria that are targeted at women as child carers are bound to have little impact. This is best summed up by McCauley et al. (1992) based upon their experiences in Tanzania. They report:

Although the mothers were responsible for both water use and the health and cleanliness of their children, ... the decision to change behaviour [to control trachoma in children] had to be sanctioned by the husband in the household and the community as a whole.

Interventions designed for the control/prevention of malaria, or for any other disease, must therefore take into account these social constructs. If they are bypassed, it is unlikely that they would be effective. The role of women in society must be changed before women-centred interventions could become viable solutions.

References


Environmental Stress, Production Activities, Health and Gender
Introduction

The level of participation of women in different fields of industrial and non-industrial occupations varies from society to society and region to region. The participation of women in formal occupations is strongly related to industrial development. It is important to look at the occupation-health interaction amongst women workers. The working conditions of several industrial and nonindustrial occupations have a direct influence on the health and well-being of women. Many women are subject to inhumane exploitation through their participation in low-skilled and low-paid jobs in the formal sector. They may also be vulnerable to debilitating manual work in traditional economies (UNECA/ATRCW 1986; ILO 1985).

Because of the reproductive role of women in society, the issue of women's occupational participation and health has been the subject of several pieces of protective legislation, as well as international conventions (ILO 1990). Nevertheless, there is a lack of quantifiable occupational and medical information on the occupation-health interface among women participating in different occupations.

This paper examines the occupational participation of women, and associated health hazards in various spheres of economic activity. It also looks at some legislative measures aimed at the reduction of hazardous working conditions.

Occupational Participation of Women

Women are playing an increasingly important role in modern society. Over the last few decades, there has been a significant rise in the number of women participating in both industrial and non-industrial occupations (Bodrova and Anker 1985; UNECA/ATRCW 1986). As a result, women represent an important component of the productive force of their respective countries.

Industry

The significant growth in women's participation in the industrial labour force is evident in many parts of the world. For example, in 1980, in the former socialist states of

---

1International Labour Organization, Addis Ababa, Ethiopia.
Bulgaria, Czechoslovakia, Hungary, Poland and the USSR, women accounted for approximately one half of the industrial labour force. In 1970, women comprised one third of the labour force in Western Europe and North America. By 1980, this figure had grown to 46% in the United States (Bodrova and Anker 1985). There have also been significant increases in Canada and Nordic countries (ILO 1989). In Turkey, the proportion of women in industries increased from 45% in 1960 to more than 52% in 1980 (ILO 1989).

In developing countries, particularly in Africa, there is little available data concerning the occupational participation of women. However, the proportion of women in the industrial work force is significantly lower than in more developed countries. For instance, in Tanzania, the industrial employment of women (accounting for 12% of the labour force) increased from 8.8% in the early 1970s to 15.6% in 1980 (UNECA/ATRCW 1986). In Côte d'Ivoire, during about the same time period, about 8% of the labour force in textile factories was women. Furthermore, in Nigeria, women constituted 11% of the private sector manufacturing employees.

In contrast, the participation of women in the textile industry in Ethiopia is high. Fifty percent of the textile workers in 13 establishments in 1979 were women (UNECA/ILO 1979). This number increased continuously until the late 1980s (Ministry of Industry 1992).

Industrial type homework predominates even today in most industrialized and developing countries. The majority of the homeworkers are women (ILO 1990). There is a wide range of activities and products that fall in the homework category: the production of clothing, textiles, carpets and rugs, leather works; ancillary tasks such as sorting, cleaning, packaging and labelling; sub-assembly of electrical and electronic products; and traditional industries associated with the preparation of food, handicraft, pottery and so on.

Non-Industrial Occupations

Women also participate in non-industrial occupations in developing countries. Women make a significant contribution to the labour force in farming activities, animal husbandry, local handicrafts and informal occupations. In subsistence agriculture-based societies, a significant proportion of the major farming operations are carried out by women. For instance, in Africa, 80% of transporting and storing the harvest, 70% of the weeding and hoeing, and 50% of the sowing and planting are carried out by women (FAO 1989). In Ethiopia, handicrafts such as pottery, basketry and spinning for weaving are women-specific occupations.

In developing countries such as Ethiopia, the "informal" gender-specific occupations are an important category of activities that have health implications. Most of these traditional tasks are load-associated. For instance, young girls and women in Ethiopia frequently carry up to 77 kilograms of fuelwood and other produce (95-300% of their body weight) and travel an average of 11-12 kilometres daily (Haile 1985; Abegaz and Junge 1990).
Working Environment and Occupational Hazards

The working environment is an interactive process between man and technology and has two main components: the physical and the psychosocial. The physical component includes variables such as acceleration, vibration, noise, heat, cold, humidity, toxic chemical agents and radiation (ILO 1976). The psychosocial component of the working environment involves occupational elements such as working hours, shift, resting period, work demand and work procedure, skill demand, risk and safety status, supervisory, managerial and workmate relations and cultural elements like ethnic background, urban-rural habitat life style, peer and domestic relations. These inter-relationships in the working environment can cause, under certain circumstances, illnesses and dissatisfactions affecting productivity levels. Environmental variables in the workplace may have a negative influence on productivity through constraining the power, strength, endurance, learning ability, skill, performance, motivation and the general state of health of the worker (Fraser 1983).

Inappropriate working conditions tend to affect women more than men. The absence of proper sitting, sanitary, restroom and nursing facilities has detrimental effects on women in general, and pregnant women in particular. In factories, women often work for hours at a time, either standing or using seats which are not ergonomically designed. Women who frequently work under such conditions often suffer from back problems and other ailments which are aggravated during pregnancy (ILO 1990). Women textile factory workers in Ethiopia often operate under adverse conditions such as high temperature, poor working facilities and lack of protective devices. As a result, there are many illnesses, especially those related to the respiratory system.

Finally, women in Africa, and Ethiopia in particular, suffer from indoor pollution. Since women are closely associated with domestic duties, they are more affected by pollutants in the household caused by the use of fuels such as kerosene and industrial byproducts such as rubber, canvas, leather, oil seed cakes and fuelwood. These factors may contribute to the high incidence of asthmatic and other respiratory diseases, as well as eye problems. Furthermore, the WHO estimates that about half the world population today uses biomass as cooking and heating household fuel, often without proper ventilation. Exposure to biomass smoke can cause chronic lung disease; biomass reportedly contains a chemical that may contribute to lung cancer. It may also lead to acute respiratory infection in infants, right side heart failure, as well as low birth weight (Indoor Air Pollution from Biomass Fuel, WHO 1992/WHO/PEP/92.3A WHO Geneva).

Night Work

Women often have a dual responsibility in the household. They are expected to engage in income-producing work and also to care for children and other family members. Sometimes these demands conflict. For example, work hours can affect the health and well-being of the family. In particular, shift work involving night work is detrimental to both the physical health of women and the welfare of the family. In Ethiopia, for example, women
night workers are often forced to sleep in the factory after work due to the lack of adequate
transportation services to their homes. If a woman takes a service bus which lets her off at a
central point, she will be exposed to the risk of both rape and robbery. Therefore, many
women decide to spend the night at the work area and often fail to get sufficient sleep
(Ministry of Labour and Social Affairs; personal contact; ECA/ILO 1979).

Several legal provisions have been introduced in an attempt to address the problem of
women and night work. In 1948, the ILO introduced the night work convention which
prohibits women from engaging in night work. This convention was revised in 1989 and
1990. At present, the differential treatment in the convention concerns only pregnant women
and mothers of children below a prescribed age.

Countries vary with regard to their provisions concerning the number of normal
working hours, stipulated rest periods, special breaks for nursing mothers, and annual and
maternity leaves. Some countries do not make any distinction between women and men in
relation to normal working hours. However, in other countries, provisions dictate that
women should work fewer hours per week than men (40 hours versus 48 hours per week in
some instances) (ILO 1990).

In addition to physical and postural inconveniences in the working place, the exposure
of women to physical agents such as toxic chemicals, radiation, heat, humidity, noise and
dust may affect their physical health and decrease their productivity. These agents may also
detrimentally affect the reproductive ability of female workers.

The effects of these hazardous agents on the health of women workers are aggravated by
poor nutrition and lack of sufficient rest. Furthermore, exposure to such agents may also
affect the offspring of the women who work in such hazardous environments. It is important
to note that the adverse health effects of toxic substances can be more pronounced in women
than in men. The fat soluble nature of organic compounds, combined with the tendency of
women to have a relatively high proportion of body fat, sometimes results in menstrual
disturbances and may also affect breast feeding babies.

In non-industrial occupations in developing countries, load is an important health
factor among female workers. Women in developing countries often carry, lift and transport
heavy loads in their daily activities. In Table 1 (see below), load data by fuelwood carriers
in Ethiopia are compared with ILO weight limits. Even in industrial countries, manual
handling of loads by women is reported to result in an increased incidence of back strains,
lower back pain and other physical damages (ILO 1989).
Table 1. Limits for lifting and carry loads for women by loads carried

<table>
<thead>
<tr>
<th>Age</th>
<th>Permissible load (in kg) frequency of lifting and carrying</th>
<th>Average loads (in kg.) currently lifted and carried by women in Ethiopia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Occasionally</td>
<td>More frequently</td>
</tr>
<tr>
<td>15-18</td>
<td>15¹</td>
<td>10²</td>
</tr>
<tr>
<td>19-45</td>
<td>15¹</td>
<td>10²</td>
</tr>
<tr>
<td>over 45</td>
<td>15¹</td>
<td>10²</td>
</tr>
</tbody>
</table>

1. Limits which cannot be exceeded without health risk.
2. Values recommended from an ergonomic point of view. Source: ILO 1989; Haile 1990

**Protective Legislations for Women**

Various protective measures have been taken by the ILO in order to minimize the number of accidents and amount of injury to women’s health. However, while a number of ILO conventions exist which specifically address the protection of the health of women workers, their implementation by member countries has been less than desired.

One example of the various ILO conventions is the ILO maximum weight convention, 1967 (No. 127), and its accompanying recommendation (No. 128). This convention asserts differential maximum weight of loads for men and women. According to this convention, women should carry or lift substantially lighter loads than men in order to avoid injury (ILO 1990). Protective measures also recommend that women should be excluded from work environments with extremely high or low temperatures.

The Radiation Protective Convention, 1960 (No. 115) does not make a distinction between men and women. It only stresses that pregnant women should inform their employer of the pregnancy.

The Night Work (Women) Convention, 1948 (No. 89) prohibited the employment of women at night work in industrial undertakings. This, however, was revised in 1990, and retitled the Night Work Convention. Article 7 of the convention states that measures shall be taken to ensure that alternatives to night work are available to women workers during pregnancy and child birth. Pregnant and nursing mothers should be transferred from night work for at least sixteen weeks. If this is not possible, the provision of social security benefits and an extension of maternity leave should be extended. It also prohibits the dismissal or notice of dismissal because of pregnancy and child birth. During such periods, the income of the woman worker, her benefits regarding status, seniority and access to promotion, which may attach to her regular night work position, should be maintained.
The White Lead Convention of ILO, 1921 (No. 13) forbids the employment of women in industrial painting involving white lead or lead sulphate or any product containing these pigments. The same convention was ratified in 1988.

Conclusion

Over the last few decades, there has been a significant rise in the number of women participating in both industrial and non-industrial occupations. Adverse working conditions, which have a direct influence on the health and well-being of women, must be addressed. While there are a number of ILO conventions which specifically address the protection of the health of women workers, their implementation by member countries has been less than desired. In order to tackle this problem, it is hoped that the efforts of women in development groups, and others concerned with occupational safety and the protection of women, will help to significantly increase the level of awareness among governmental and nongovernmental agencies, industrialists, entrepreneurs and the community at large.

References

Abegaz, Z. and Junge, B. 1990. Women’s workload and time use in four peasant associations in Ethiopia. UNICEF.


1989. Special protective measures for women and equality of opportunity and treatment. Documents considered at the meeting of experts on special protective measures for women and equality of opportunity and treatment. MEPMW/1989/7 ILO, Geneva.


Discussion

• An extended definition of occupation is essential. Some women engage in various forms of work which may total up to 18 hours a day. The cumulative impact on women of these different types of work must be addressed.

• The presenter’s research on rural women was greatly appreciated. Her focus addresses the fact that most women do not work in factories, but in the informal sector. Their work, which may involve, for example, heavy lifting or long hours in the sun, has important health implications.

• There are lots of pieces of protective legislation, but very little that addresses the concerns of women. Most protective legislation has been designed by men. Furthermore, while the ILO has passed several regulations concerning these issues, there are serious problems concerning the implementation of these regulations. How do we ensure that ILO recommendations are enforced? Both employers and employees are unaware of the regulations, and therefore don’t adhere to them. Therefore, education of employers and employees, to create greater awareness of health issues and rights among workers, is strongly encouraged.

• The provisions in place, even if implemented, may not necessarily help women. Night work was prohibited for years - then this was subsequently revised. Today, according to conventions, women involved in night work can ask their employer to be switched to another shift. If this is not possible, they have the option of getting social security. This is not necessarily going to help the woman.

• Women must be aware that unions, which are usually male-dominated, may not fight for the interests of women. Unions have a poor record of addressing women’s reproductive health issues. Women must also be on guard for the possibility that protective legislation will be used against women’s best interests. This is currently a major issue in the United States. In an American case, Johnson Controls, protective legislation, excluding "women who are pregnant or who are capable of bearing children", was used to prevent women from obtaining high paying jobs.
Gender and Health Effects of Environmental Stress Among Kampala Textile Workers

Joseph Carasco

Introduction

This paper will outline some of the health effects of environmental stress on a group of workers in a small Ugandan textile factory. The data is drawn from a larger project of conditions of workers in several sectors of production in Uganda. Environment will be defined broadly to include socio-cultural, working and living conditions. Data will be presented separately for female and male workers.

This particular factory, United Garment Industry Ltd. (UGIL), is located in Kampala, Uganda, and employs less than five hundred workers. It was selected for our case study because it employs a relatively high percentage of female workers. It was hoped that an examination of this production unit would provide some information on particular problems faced by female workers. The principal source of data was obtained from a questionnaire administered by UGIL workers from April to June 1993. Other information was obtained from direct interviews with workers, as well as from the literature.

UGIL was incorporated in 1966 as a joint venture company between Uganda Development Corporation and two private Japanese companies. The Uganda Government has the majority shares (75%), while the Japanese companies own the balance (25%). Over the years, the factory has developed the following types of production capacities: spinning, using locally grown cotton; knitting of both local and imported yarn; and garment manufacturing, which includes T-shirts, shirts, school uniforms, trousers, etc.

This paper will explore the effects of environmental stress on both men and women, noting areas of particular concern to women. There is a wide-range of environmental conditions that affect all factory workers. While they often overlap, for the purposes of this study they will be sub-divided as follows: socio-cultural factors, wages (income), living conditions, health conditions and workplace conditions. In all tables presented, the sample for female workers is 40, and for male workers it is 67.

\(^1\)Centre for Basic Research, Kampala, Uganda.
Socio-Cultural Factors

Table 1: Personal Data of Female and Male Workers in UGIL

<table>
<thead>
<tr>
<th></th>
<th>Female (n=40)</th>
<th>Male (n=67)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age (years)</td>
<td>29.5</td>
<td>30.9</td>
</tr>
<tr>
<td>Marital Status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>47.5%</td>
<td>92.5%</td>
</tr>
<tr>
<td>Single</td>
<td>30.0%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Divorce</td>
<td>2.5%</td>
<td>0</td>
</tr>
<tr>
<td>Widow/er</td>
<td>5.0%</td>
<td>0</td>
</tr>
<tr>
<td>Separated</td>
<td>15.0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Children:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number</td>
<td>1.9</td>
<td>2.1</td>
</tr>
<tr>
<td>Average age (years)</td>
<td>7.1</td>
<td>7.1</td>
</tr>
<tr>
<td>Workers with no children</td>
<td>20.0%</td>
<td>22.4%</td>
</tr>
<tr>
<td>Child mortality rate/1000</td>
<td>81</td>
<td>126</td>
</tr>
<tr>
<td>Dependents:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number</td>
<td>3.6</td>
<td>4.4</td>
</tr>
<tr>
<td>Number without dependents</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

The average age at the factory of both female and male workers is about thirty years (Table 1). This is a relatively low average for a factory that began production in 1964. It suggests that there is a high turnover of workers either through resignations, lay-offs, or as a result of both factors. A 1991 study reported that some workers intend to become self-employed after they have gained some tailoring experience (Ahikirie 1991). However, the majority of workers are let go, either on disciplinary grounds (often because of petty theft), or as a result of lay-offs by management, which has happened several times during the past three decades.

There is a significant difference in the marital status between female and male workers. Approximately half the female workers are married, which is in sharp contrast with the percentage of men that are married - over ninety percent. Thirty percent of the female workers are single, compared to only six percent of male workers. There would likely be considerable social stress on the single female workers because in Ugandan society (like in many other developing countries), marriage is considered the norm for adults. A relatively high percentage (about 20%) of both female and male workers do not have children.
For those women who are single, or have no children, they have probably not chosen this situation. Rather, extremely low factory wages (to be discussed below), may make marriage and children nearly impossible. For workers who do have children, the average number is two. It should be noted that both female and male workers often maintain more than just their own children. Study results reveal that each worker has an average of four dependents. Some dependents are children of deceased relatives. Less than ten percent of the workers reported that they had no dependents at all.

The divorce rate is low (2.5%) for female workers and zero for male workers. A higher percentage of female workers are separated; fifteen percent compared to only one- and one-half percent of male workers. This is probably related to the fact that it is very difficult for women to obtain a divorce. It often involves a long and difficult struggle as men are reluctant to accept that women have a right to divorce. It is easier for a female worker (with an independent income) to separate from her husband than to obtain a legal divorce. Also, the cost of legal proceedings may be prohibitive.

Five percent of the female workers were widows and would likely find it difficult to re-marry. On the other hand, because there were no reported male widowers, it appears to be relatively easy for male workers who lose their partner, to re-marry.

Child mortality rate (under 5 years of age) among female workers (81/1000) and for male workers (126/1000) is high for both groups of workers. Poor living conditions, as well as poor medical services (see below), likely contributes to this high mortality rate. The main reported causes of child death were malaria and measles. Tetanus, meningitis and pneumonia were also reported. Most of these diseases are largely preventable. They are also not necessarily fatal.

The significant difference in child mortality rates of female and male workers can be partially explained by the fact that female workers are enjoying better living conditions than male workers (see section on residence). This is likely because the female worker is married and her partner earns a wage as well. However, in the case of the male worker, his partner may not be employed in the formal sector and could be less educated. While this may provide a partial explanation for the difference in child mortality rates for female and male workers, further work on this topic is necessary. Female and male workers earn the same salary for performing the same functions. The average wage of the male worker is a little higher (Table 2) than the average female wage because most of the top positions in this company are held by male workers.

The salaries for both men and women are not sufficient to meet their basic needs. The most expensive expenditure item of the workers monthly salary is food. It appears that the entire month's salary is necessary simply to purchase and prepare food. Figures provided by female workers for the cost of food are believed to be more reliable than figures provided by male workers because it is almost always the woman who purchases and cooks the food.
Wages (Income)

Table 2: Average wage and expenditure (in Uganda Shillings) of male and female workers in UGIL.

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly wages</td>
<td>62,260</td>
<td>68,190</td>
</tr>
<tr>
<td>Monthly expenses*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td>62,400</td>
<td>55,000</td>
</tr>
<tr>
<td>School fees</td>
<td>13,700</td>
<td>10,730</td>
</tr>
<tr>
<td>Clothing</td>
<td>7,000</td>
<td>8,330</td>
</tr>
<tr>
<td>Taxation</td>
<td>6,000</td>
<td>6,560</td>
</tr>
<tr>
<td>Rent</td>
<td>21,600</td>
<td>17,570</td>
</tr>
<tr>
<td>Total expenses</td>
<td>110,700</td>
<td>98,190</td>
</tr>
</tbody>
</table>

*Transportation and energy costs are not included in expenses. Medical expenses are excluded because the company is supposed to treat both the workers and their families.

In order to meet all basic expenses (food, school fees, clothing, taxation and rent, as well as transportation and energy costs), it would be necessary for workers to receive double their current wages. Even if UGIL workers earned double their salary, this is an absolute minimum, with no provisions made for household goods including furniture, emergencies and entertainment.

It is clear that no UGIL worker depends completely on her/his salary to live in Kampala. Because this fact was recognized before the questionnaire was prepared, an item was included to find out whether the workers received income from other sources. Only ten percent reported that they did. Most of those who mentioned that they had some side income did not explain how it was obtained. Of those that did, it included small farms, and for the female workers, that their husbands provided for them.

Most workers live in permanent houses made of bricks, with a cement floor, and roofed with iron sheets. Each house has an average of one and a half rooms, with about four people living in each room.

For most workers, the source of water is from a tap but a significant number obtain their water from a stream (22 - 25%) and some from a borehole (9.5%). A small percentage have taps at home (6 - 10%), although most have to walk a distance of less than 0.5 kilometres (67 - 72.5%); some between 0.5 - 1.0 kilometres (12.5 - 19%). The rest walk more than 1.5 kilometres to fetch water. In the majority of the families, it would be the woman or another female in the family who would be fetching the water.
### Living Conditions

Table 3: Living conditions of female and male workers in UGIL

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCOMMODATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walls:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baked bricks</td>
<td>70%</td>
<td>58%</td>
</tr>
<tr>
<td>Unbaked bricks</td>
<td>20%</td>
<td>27%</td>
</tr>
<tr>
<td>Mud</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Wattle</td>
<td>--</td>
<td>3%</td>
</tr>
<tr>
<td>Roof:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron sheets</td>
<td>87.5%</td>
<td>98.5%</td>
</tr>
<tr>
<td>Tiles</td>
<td>5%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Asbestos</td>
<td>7.5%</td>
<td>0</td>
</tr>
<tr>
<td>Floor:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cement</td>
<td>95%</td>
<td>85%</td>
</tr>
<tr>
<td>Uncovered</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td>Rooms:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number</td>
<td>1.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Average number living per room</td>
<td>3.6</td>
<td>4.4</td>
</tr>
<tr>
<td><strong>WATER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Source:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tap</td>
<td>75%</td>
<td>68.5%</td>
</tr>
<tr>
<td>Stream</td>
<td>25%</td>
<td>22%</td>
</tr>
<tr>
<td>Borehole</td>
<td>--</td>
<td>9.5%</td>
</tr>
<tr>
<td>Distance:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within home</td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>0 to 0.5 km</td>
<td>72.5%</td>
<td>67%</td>
</tr>
<tr>
<td>0.5 to 1.5 km</td>
<td>12.5</td>
<td>19%</td>
</tr>
<tr>
<td>more than 1.5 km</td>
<td>5%</td>
<td>8%</td>
</tr>
<tr>
<td><strong>ENERGY SOURCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charcoal</td>
<td>68%</td>
<td>56%</td>
</tr>
<tr>
<td>Electricity</td>
<td>16%</td>
<td>21%</td>
</tr>
<tr>
<td>Kerosene</td>
<td>12%</td>
<td>21%</td>
</tr>
<tr>
<td>Firewood</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>SANITATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communal</td>
<td>84%</td>
<td>95%</td>
</tr>
<tr>
<td>Non-communal</td>
<td>16%</td>
<td>5%</td>
</tr>
<tr>
<td>Flush toilet</td>
<td>10%</td>
<td>3%</td>
</tr>
<tr>
<td>Pit latrine</td>
<td>90%</td>
<td>97%</td>
</tr>
<tr>
<td>Average number of users</td>
<td>9.5</td>
<td>12.2</td>
</tr>
</tbody>
</table>
Energy is mainly required for preparing meals, rather than lighting, and is usually non-renewable: charcoal (56 - 68%); kerosene (12 - 21%) and firewood (2 - 4%). A smaller percentage use electricity (16 - 21%). Charcoal is used by a large percentage of Kampala workers for two probable reasons: (1) it is more affordable because it does not have to be purchased in large quantities (compared to electricity, which must be paid in monthly bills); and (2) traditional cooking of items like bananas reportedly tastes better if cooked on charcoal, compared to kerosene stoves or electric coils or plates. Obviously, using large amounts of non-renewable sources of energy has serious consequences for the sustenance of the natural environment (forests, game parks, etc.) in the country.

With regard to sanitation, the vast majority of people use communal facilities (84 - 95%) with a high average number of users (9.5 - 12.2). A pit latrine is almost always used (90 - 97%). Rats, mosquitoes and cockroaches were reported to be present in almost every home. Occasionally, snakes were also a menace in these workers’ homes. Generally, it can be observed from the figures in Table 3 that female workers have slightly better living conditions (type of residence, water source, sanitation) than their male counterparts. As previously mentioned, this may be explained by the possibility that the female worker can combine her wages with her husband, therefore significantly increasing their total family income.

The workers reported the number of times they were sick in the past year - the average number of times that a female was sick over the past year was 3.2 times, while for male workers it was 3.8 times. A higher figure of morbidity is obtained for male workers probably because the nature of their work is different in the factory and female workers have slightly better living conditions. Generally, the male workers are machine operators, mechanics, and electricians, whereas most female workers work in the garment section.

There is supporting evidence for this hypothesis if one examines the type of medical problems each group of workers faces. However, before we look at the differences, there is one glaring similarity that needs to be noted. Namely, for both male and female workers, more than half of their medical problems were of a respiratory nature. The cause of this respiratory problem is related to high dust concentration in the environment of the textile factory.

With regard to differences, there is a higher incidence of malaria among female workers than male workers. And while 9% of the male workers reported backaches, no female worker reported this particular problem. The backaches are also most probably work-related. Another health effect that should be highlighted is the high number of stomach problems which may be connected to working and living conditions. Further work needs to be done to determine the exact nature of the stomach problems to diagnose the causes.

Only the female workers reported cases of anemia. Poor nutritional standards, due to low income, combined with the reproductive role, would be the most likely explanation of this particular problem.
Health Conditions

The health conditions are summarized in the table below.

Table 4: Medical problems and mode of treatment among male and female workers at UGIL.

<table>
<thead>
<tr>
<th>Nature of Sickness (%)</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>Cough</td>
<td>19</td>
<td>20</td>
</tr>
<tr>
<td>Chest pain</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Malaria</td>
<td>--</td>
<td>9</td>
</tr>
<tr>
<td>Backache</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Flu</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Headache</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Stomach problems</td>
<td>2</td>
<td>--</td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>2.5%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Herbal</td>
<td>2.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Hospital/Clinic</td>
<td>95%</td>
<td>96%</td>
</tr>
</tbody>
</table>

Almost all workers seem to have more confidence in hospital-based treatment rather than self-treatment, or consulting the traditional healers.

Workplace Conditions

Below is a table indicating the workers' views about the sections they work in and the major occupational health hazards found therein.

Health hazards such as poor ventilation, excess heat and too much dust and noise appear to be a problem in almost all sections of the factory. In some sections, poor lighting and drainage are also hazards. These unsafe and unhealthy workplace conditions affect both female and male workers.
Table 5: Work sections and the major occupational health hazards (hazards present indicated by ‘+’).

<table>
<thead>
<tr>
<th>Section</th>
<th>Ventilation</th>
<th>Heat</th>
<th>Dust</th>
<th>Lighting</th>
<th>Drainage</th>
<th>Noise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinning</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Knitting</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Bleaching</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>CMT/Sewing</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>CMT/Finishing</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Shirt Plant</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Quality</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engineering</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main Store</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Accounts</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

Accident-caused injuries (some more serious than others) are common in this factory. The most common accidents are piercing fingers with needles and cutting off fingers with knives. It is difficult to say whether there is a gender bias in the number of needle-piercing accidents. Although it could be assumed that females are more commonly injured in this fashion. Other accidents that occur fairly commonly include burns, bruises, electric shocks and fingers being crushed by machinery. These types of accidents occur more often with male workers than female workers because some of the sections employ exclusively male workers (mechanical, electrical and bleaching sections).

Some of the effects of these accidents could be alleviated if there were first aid kits present. It appears that such kits are not available in any productive section of the factory. Workers also reported that there was no compensation available in most cases of accidents.

In case of fire, there are only two sections of the factory that have fire extinguishers. However, even in sections where fire extinguishers are available, they would probably not be used efficiently as no worker has been trained in their use.

**Conclusion**

While there has been considerable debate concerning what constitutes "development" in lesser developed technological societies, most would agree that some degree of industrialisation is necessary. Environmental working conditions, the focus of this paper, are a component to any form of development.
The study results reveal that, in many respects, workers' conditions are far from satisfactory. However, there has been an improvement since the early days of industrialization in the colonial period. For example, colonial records (Report of the Labour Department 1955; Uganda Legislative Council 1956) from the late 1950s report that the majority of workers lived in non-permanent housing (grass huts or mud and wattle), with between 6 and 12 people sleeping in a single room. The situation today is significantly better (see Table 3).

Despite the improvement since the 1950s, a review of the environmental conditions (for example, socio-cultural, wages, living, health and workplace), clearly demonstrates that workers in this Kampala garment factory are subject to tremendous levels of physical, mental and economic stress. High levels of individual stress often has a detrimental effect on productivity, which makes sustainable development difficult.

Wages, of course, are an important factor. Sufficient wages are necessary in order to afford nutritious and adequate food, proper accommodations with healthier sources of water and environmentally safer power, as well as education. Adequate wages are particularly relevant in a state which does not provide even the minimal services in education and health. It is essential that the workers' wages meet the minimum needs of the nuclear family (average of four people, two children and two adults), as well as their other obligations (for example, other dependents - average number of two). However, wages at this factory are sufficient to cover only half of the basic needs of employees. This fact is true, in various degrees, for not only textile workers, but also workers in almost all sectors of the economy (NOTU Seminar 1987; Public Service Review 1991). This clearly is a major source of stress on employees.

The results concerning child mortality rates (under 5 years of age) at this factory are consistent with Ministry of Health statistics (Demographic and Health Survey 1989). Compared to the rest of the world, Uganda's child mortality figure is strikingly high, and is placed in the category Very High Under 5 Mortality Rate (VHUSMR) (The State of the World’s Children 1991). This relatively high figure could be a result of poor maternal diet, poor ante-natal and post-natal care, poor education of the mother, and generally poor living and working conditions.

This study, like other research of Ugandan textile factories (Mugisha 1977; Twa-Twa 1981), found a high incidence of respiratory problems among workers, which is directly related to the adverse environmental conditions in the factory. In order to reduce the incidence of this occupational health hazard, measures are needed to provide protective clothing (masks, gloves, etc.) and a generally safer working environment.
Female workers face many additional problems. Many women are the sole or primary source of family income (more than 50% do not live with permanent male partners). This is a particularly difficult responsibility in a male-dominated society. This burden is increased when one considers that there are no day-care facilities for a working-class mother. Single women workers are less well off than their married counterparts.

Jobs are segregated by sex. Male workers are exclusively employed as mechanics, electricians and accountants, as well as in the much better paid supervisory roles. Another constant problem for female workers is sexual harassment (Ahikirie 1991). Refusal to give in to the male superiors could mean loss of the job. There is a lack of job security, which makes all workers nervous about getting on the wrong side of management.

It is rare for the husband of a female worker to do much housework. Therefore, in addition to workplace health hazards, female workers face health hazards relating to household work (Chavkin 1984).

The trade union leadership is dominated by male workers, who are usually not gender-sensitive. As a result, female workers have less recourse to an organized group that is supposed to be there for the assistance of all employees. Strategies need to be developed to make trade unions more responsive to the needs of their membership, including female employees. Experience has shown that an organized voice can certainly demand and obtain more than individual voices.

In response to these stressful working conditions, workers have organized strikes in an effort to improve terms and conditions of service. However, with the current high unemployment and retrenchment taking place on a large scale in the public sector, the unskilled textile workers are in a weak position to take industrial action. Some workers have resisted in other ways, often in the form of petty theft, and more rarely by simply walking out of the job.

Female workers could organize themselves at various levels. They could actively participate in their places of residence in the Resistance Committees (RCs) and in their places of work (trade unions). In addition to joining men in these organized groups at home (RC) and at work (trade unions), they could also organize themselves separately as a lobby group. Female workers might also consider aligning themselves with the leadership of women’s organizations. However, because women’s organizations tend to be dominated by middle class women, they might not receive much support.

This study clearly reveals that there is significant scope for improving the working environment of these Kampala textile workers, in order to minimize environmental stress and the resulting adverse health effects. A positive working environment, which enables workers to meet their essential needs to live and reproduce, is a crucial component to sustainable development.
References


Proceedings of the Uganda Legislative Council. 1956. 2nd Meeting 36th session, 22nd May. p.68


Discussion

- A question was raised concerning whether or not pregnant workers have special rights or receive special treatment. The presenter responded that trade unions have managed to get minimal conditions enforced. There is a compulsory 45 days leave given after delivery. However, there is very little pre-natal and post-natal care, and no special services are provided.

- Many women have more than one job. For instance, women may engage in prostitution in order to generate additional income. The extent to which secondary employment adversely effects the health of women needs more attention. Dr. Carasco responded that, to date, he has not looked at the effects of secondary employment. One obstacle in addressing this issue is that management is often unaware of secondary employment and workers may hesitate to inform researchers of what they do after work for fear that the information will get back to management.

- The importance of bringing the results of research back to both employers and employees was highlighted. The presenter agreed and said that the results of his study are currently in the process of being disseminated.

- It was suggested that the apparent lack of backaches found among women, may be due to lack of reporting on the part of women. Sometimes women take certain health problems for granted. The response was that this was an interesting point and that he would go back and check this out.

- We were reminded of the World Health Organization's definition of health, that "health is state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Mental health and psychological health effects must be given more attention. Psychological effects, as a result of the physical working environment at the factory, were not measured. The author sought suggestions on how this could best be done scientifically.

- It was submitted that the low rates of children, by both men and women, may be due to some occupation-related factor that may have a detrimental impact on fertility. The author added that it may also be a case of poor socio-economic conditions. Many of these workers have difficulty caring for themselves, much less children.
• The problems will continue unless training programs are introduced for both employers and employees. Employees are unaware of their rights and employers are therefore able to take advantage of this lack of knowledge. At present, they are now working with trade unions to devise and implement training programs. Management is not concerned with these issues; they must be dealt with at the grassroots level.

• One participant mentioned that it would be helpful if a description of the types of jobs the women perform in the textile factory, compared to men, was provided. This would be helpful when looking at patterns of job segregation based on sex.

• Finally, the importance of identifying the sex of the people who are doing the interviewing was raised. Women tend to open up more with women. For example, they may be more likely to report on backaches to a female interviewer. The response was that women were the interviewers in this study. Indeed, they would not have got as far as they did without the female interviewers.
Environmental Degradation, Gender and Health in Ghana

Dzodzi Tsikata

Introduction

In August and September 1993, after months of preparation, I carried out the fieldwork for a study of two communities - Mepe and Tefle in the North and South Tongu Districts of Ghana, respectively. The purpose of the study was to document the effects of ecological change on health and livelihood, and the responses of community members to these effects. This report concentrates on the health issues raised by the study, although questions of livelihood are discussed whenever relevant.

There are a number of reasons why the Tongu area, situated in the Lower Volta Basin, was particularly suitable for this enquiry. The Lower Volta area in Ghana has experienced dramatic ecological changes over the last few decades. This is a result of major development projects - the construction of two Hydro Electric Power Dams over the Volta at Akosombo and Kpong in 1964 and 1982, respectively. There have been many changes related to the river, the creek and the soils which have been acknowledged to be a direct result of the Dam.

With regard to the river, two changes are of particular importance. First, the river's flow has become quite sluggish all year round. Second, the seasonal flooding of the river stopped in 1964 when the first dam was constructed. This is significant because livelihood and major economic activities, such as farming and fishing, were organised around the seasonal flooding.

River changes have also created the appropriate conditions for the growth of thick vegetation over large areas of the banks of the river. As a result, the river now harbours snails which are vectors of schistosomiasis (better known in the area as bilharzia), as well as mosquitoes which transmit malaria.

There has also been a loss of alluvial soil, which used to be deposited annually along the banks of the river and numerous creeks in the Lower Volta. This has led to a decline in soil fertility, and therefore agriculture, which relied on this source of moisture in an area of traditionally low rainfall. Furthermore, there has been a significant decline in the fish population in the river and creeks, and clams have completely disappeared from the Lower Volta.

1Institute of Statistical, Social and Economic Research, University of Ghana, Legon, Ghana.
Finally, industrial waste, deposited into the river by two textile factories located at Akosombo and Juanpong, which were made possible by the generation of electricity from the dam, has led to increasingly high levels of pollution in the river.

Many of the ecological changes and problems outlined above were predicted (Preparatory Committee 1956), and have been confirmed in more or less detail by a number of studies (Lawson 1972; Hart 1980; Chisholm 1983). However, they have not received much attention. This is due in part to financial arrangements which were made during the construction of the dams, which concentrated on compensating individuals who had to be resettled because the lake flooded their homes and farmlands. Policy-makers expected that the losses of the areas downstream would be mitigated by the seasonal upstream migration of Tongu fishermen, who were expected to benefit economically from the large increase in fish stocks in the lake created by the Akosombo dam (Preparatory Committee 1956). Large numbers of Tongu fishermen and their families did migrate to the lake, but their seasonal migration was soon transformed to permanent migration in many cases as the conditions in the Lower Volta continued to deteriorate economically.

The effects of this migration on the Lower Volta are not fully known. However, Chisholm (1983) recorded demographic indications, such as high dependency ratios and peculiarities in the structure and composition of households. He argued, however, that the communities have adjusted to the changes brought by the dam (Chisholm 1983). Few studies of the Tongu area have been done, with the exception of Lawson’s work in 1956 and 1967 (1972). Most studies about the Volta Basin have concentrated on the lake and lakeside problems and resettlements (for example, Paperna 1969, 1970; Derban 1984; Diaw et al. 1990). The purpose of this study was to begin to address this gap in knowledge about the Lower Volta - that is, how the changes have affected health and livelihood, and how members of affected communities have coped with their situation.

One shortcoming of the few studies to date, is the absence of consistent disaggregation of effects and responses to effects, by gender, age, occupation, and access to and control of resources such as land, labour, capital and education. As a result, findings do not differentiate between various social groups, their responses to changes, and the factors which have shaped their responses. This study was seen as a step in that direction.

Studies of this nature are useful for a number of reasons. To begin with, there is an increasing understanding that there is a close link between the environment and sustainable development. Increased knowledge about the effects of ecological change on health and livelihood, and the responses of different constituents of affected communities, could lead to more informed decisions about future development projects. This type of information might also lead to the development of community-centred criteria for environmental impact assessments. Such studies promote the possibility of the adoption of measures which alleviate the negative effects of ecological degradation for the community as a whole, and not just some social groups.

151
Some Conceptual Issues

This section will define key concepts being employed in this study, such as health, livelihood, sustainable development, and gender relations. These concepts are interconnected. For example, health and livelihood are central to any assessment of the state of development. Gender relations are an important component of social relations, which govern the health and livelihood chances of individuals and their access to and control of resources, and therefore the state of their development.

The concept of health adopted in this study, a state of physical, mental and social wellbeing (1978 WHO/UNICEF Alma Ata Declaration, quoted in Ostergaard 1992), allows for the consideration of cultural, economic, social, political and environmental factors, as well as biological and genetic ones. This broad definition acknowledges the role of human activities, social structures and the environment, including ecological factors, in good health. It also creates the space for discussing preventive health measures. This broad definition of health is important because this study focuses on the contribution of environmental, economic, social and cultural factors to disease and health patterns. In this study, disease is used to mean both the diagnosis by medical practitioners of an abnormal health condition, as well as the patient’s own perception of the existence of these conditions (See Ostergaard p. 111, for a distinction between the two).

The adopted definition of health also creates the space for a discussion of the role of gender and gender relations in health. Gender relations are the largely unequal and hierarchical socio-economic relations between men and women, which operate in the household and other institutions in society, and are rationalised in terms of real and assumed biological differences between the sexes. Some of the manifestations of these relations are the legitimization of a sexual division of labour beyond purely biological roles in both production and reproduction, and gender discriminatory practices in society.

Livelihood refers to income earning occupations or economic activities. In the study area, the major means of livelihood are also the key sources of food and nutrition. Sustainable development is defined as a state of satisfactory achievement of needs such as health care, food, shelter, safe water and education, which can be produced for both present and future generations. Environmental conservation and the efficient harnessing of natural resources are key factors in this definition of sustainable development, as is the equitable distribution of the benefits of development.

Environmental degradation in this context includes negative changes in both the physical environment and the ecology, such as water pollution, inadequate rainfall, receding vegetation, and poor soils. It also includes negative changes to the human environment such as poor sanitation and hygiene and poor housing. It is important to identify the connection between these two components of the environment and their relationship with health. Ecological degradation can adversely affect the human environment and lead to poverty, which in turn can adversely affect the health prospects of people.
Methodology

Research Sites

The two rural communities selected as research sites, Tefle and Mepe, are situated below the Volta Lake on the lower reaches of the Volta River, the last 60 kilometres before it enters the sea. In this quite homogeneous riverine environment, these two communities were chosen for both their similarities and differences.

Tefle, the former site of an important ferry crossing, is very close to the bridge across the Volta River, on the international road to Togo, Benin and Nigeria. This bridge, which was constructed a few years before the Akosombo dam, introduced changes in river transport and related support services, and brought an end to Tefle’s role as a river transport port. This led to a decline in service occupations, such as food, the renting of shelter, mosquito nets and mats, which had sprung up in connection with the crossing. Only the bread making industry, mainly women’s work, continues to thrive in Tefle.

Mepe, on the other hand, had been a predominantly farming and fishing economy until the Volta Dam was constructed. Economic activity surrounding the harvesting of clams, a predominantly female activity, has completely disappeared. There are other differences between the two communities. Mepe has easier access to the Battor Hospital. However, Tefle’s proximity to a major road gives it easier access to markets and other facilities in Tongu and neighbouring districts.

Research Tools

The study was conceived as an exploratory study. The interview schedule of the survey, the major source of data, covered a wide range of issues. Questions addressed bio-data, some demographic characteristics of target population, such as household size and composition, age and sex distribution, household headship, the characteristics of migration - sex distribution of migrants, ages, patterns of migrations. Other issues explored include economic activities and occupations, the organization of production and consumption, local knowledge about the ecological and socio-economic changes and their relation to livelihood and health. The survey also looked at responses of individuals, households and communities to these changes. Specific questions were asked about common diseases, the ones which have been suffered by the respondent and other members of his or her household, duration of illness, treatment and cost of treatment. There were also questions about preventive measures, whether any members of the household were particularly vulnerable to any of the diseases, and the effects of diseases on the household.

In addition to the survey, four small groups (5 people each) were brought together in each community. There were two groups of women, young (up to age 30) and older (over age 30), and two groups of men of similar composition. These groups answered questions concerning the organization of the communities and social relations, such as marriage,
kinship and the organization of production. They also answered questions pertaining to existing educational, health, recreational, water and sanitation facilities, and community organisations and institutions.

Finally, personnel of the health facilities in the two communities and in Sogakope and Battor (which were also used by the research communities), were interviewed. They were asked about their facilities, catchment area, and disease patterns and control in the research communities. Health statistics were obtained from two of these institution - the Battor Hospital and the Sogakope Health Post.

When the full report of this study is written, the survey and other sources of information will be supported by secondary data on ecological degradation, livelihood and health, HEP dams, population responses to ecological change and so on. It will be further enriched by interviews with officials of the Volta River Authority (VRA), as well as petitions, letters and other information about the Tongu area, which can be obtained from VRA files.

**Sample Size**

The sample size for the survey was computed on the basis of 1984 population census figures because reliable estimates could not be obtained from the Statistical Services for 1993. The total population for the two Tongu Districts for 1984 was 115,768. The two research areas had a total population of 3366, with the following breakdown:

- Tefle: 1553
- Mepe: 1813
- Total: 3366

Only a section of this population formed part of the sample population. The study concentrated on three age clusters of the population: 15-24, 25-44, and 45 and over. The choice of these three clusters was to ascertain the contribution of age and gender to the effects, and to the choice of responses to the crises of livelihood and health. It was also to ensure that persons over 45 years of age were part of the sample. These individuals were adults at the time of dam construction and could therefore discuss the changes directly from their own experiences. The section of the population which fell outside the sample (0-14 years) was estimated at a little over 40% of the total population. Therefore, the section of the population relevant to the survey was 60% of 3366 or 2019 individuals. The sample size was 20% of this figure, that is, 408 people - 204 men and 204 women. There was an equal division among the three age clusters. The sample for each community was computed as follows:
The sex division of the population in the two communities in 1984 indicates that there were more females than males. In Tefle, the figure was 645 males to 908 females, while Mepe had 820 males to 993 females. It is unlikely that this structure of the population would have altered significantly. However, an equal number of men and women were interviewed in each community. Therefore, the sample size for each age cluster in the two communities together was as follows:

<table>
<thead>
<tr>
<th>Community</th>
<th>No. of males</th>
<th>No. of females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tefle</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Mepe</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
<td>66</td>
</tr>
</tbody>
</table>

From the above discussion, it is clear that purposive sampling techniques were applied to a random choice of respondents in the two communities. Not more than one person was interviewed in each household to ensure that a reasonable number of households were covered from the 776 households in the two communities. Both male and female headed households, as well as a range of economic activities, were represented in the sample.

The survey provided general information about the current situation in the two communities, as well as information concerning changes that have occurred since the Akosombo Dam. One expected difficulty was whether or not respondents would be able to reliably and accurately recall information that happened many years ago. Respondents were expected to answer questions about the current community situation, as well as recall changes which took place nearly thirty years ago. In an attempt to deal with this potential difficulty, open-ended questions and probes were used to allow for the opportunity to remember, and also to allow variations in experiences to be expressed more fully. The data collected from the survey is in the process of being compiled and analyzed. The discussion below is based on notes made from a preliminary reading of approximately 50% of the questionnaires.

Results

Background Information on Research Sites

The Volta River is the main source of water for household use in both communities. Water is fetched by women and the young in households. Each town has a few wells, but
these are privately owned. Most households use firewood as fuel, and cooking is usually done in an open courtyard. A few homes use charcoal and even fewer use kerosine. Household members usually live in one room, although a few respondents had between two and three rooms. A few large houses were built in both towns as a result of the fishing boom on the Volta Lake, but they have not been maintained. Mepe has more shops selling household needs and drinking bars than Tefle. Mepe, unlike Tefle, has a local market. Neither community has hydro-electric power.

Both Mepe and Tefle have suffered ecological degradation as a result of the changes in the Volta River. In addition, many respondents in both areas mentioned that lack of proper toilet facilities, poor sanitation and hygiene were causes of stomach and diarrhoeal diseases. 1988 and 1990 Ministry of Health statistics showed that the Tongu area had the highest figures for diarrhoeal diseases, typhoid fever and intestinal worms in the Volta Region. Furthermore, it had the second highest figures for malaria. These were among the top ten diseases in the Tongu Districts' Health Profile for 1990-1991.

With regard to diseases related to polluted water, the Tongu area had the highest figures for bilharzia and acute eye infections. Most respondents complained about the deterioration in food sources. Agriculture and fishing are the main sources of livelihood. The Tongu area also had the highest figures for malnutrition and anemia in the Volta Region.

**Health Facilities**

Tefle has a small health centre which is run by 1 enrolled nurse and 2 public health nurses, and serves Tefle as well as neighbouring communities such as Vume, Sokpoe, and Kodzi. This centre is mainly concerned with public health programs such as child immunization, child care education, nutrition, sanitation and family planning. In addition, it diagnoses and treats general ailments such as malaria, diarrhoea and upper respiratory tract infections. Schistosomiasis cases are referred to Sogakope, which has laboratory facilities.

The Sogakope Health Centre, a few kilometres away from Tefle, is run by 9 general nurses, 2 midwives and 5 maternal/child health nurses. It has a maternity block and a laboratory which does basic blood, urine and stool tests.

Mepe is three kilometres away from the Battor Catholic Hospital. This district hospital has 145 beds, laboratory, x-ray and fluoroscopy equipment, and operating theatres. The hospital has a staff of over 120 people including 4 medical officers, 29 nursing officers and 38 ward assistants and attendants. The Battor hospital serves a wide area, with people coming far distances for some of its specialised facilities such as gynaecology and fertility treatment. 44% of its patients are Tongu and 39% are Adangbe (from a nearby district). In 1987, the hospital had 108,000 cases. The most common cases were as follows in descending order of prevalence: intestinal worms, malaria, upper respiratory infection, gynaecological disorders, hypertension, diseases of musculo-skeletal nature, diarrhoeal
diseases, skin diseases, anemia, bilharzia, eye diseases, pregnancy-related complications, malnutrition, ear infection and tuberculosis. A significant number of these diseases are directly or indirectly related to the large scale environmental degradation of the area.

Battor Hospital statistics are not disaggregated by gender or age. However, admission figures give some indication of gender and age. For hookworm and ascari cases, the admission figure for children (508) is more than double the figure for either male (205) or female adult patients (249). In the case of bilharzia, there were 121 children, 96 men and 71 women. All hospital malnutrition cases were children. Anemia is the only condition with a significant difference between men (215) and women (571). For anemia, children once again have the highest number of cases (1045).

**Disease Patterns**

Respondents in both Mepe and Tefle stated that malaria/fever, bilharzia, skin itching and rashes, eye troubles, diarrhoea, stomach problems, hypertension and anemia were the most prevalent diseases in the area. This response confirms Battor hospital statistics. While very few respondents referred to intestinal worms specifically, the references to stomach problems probably includes such cases. Malaria, bilharzia, skin itching and rashes, eye troubles and diarrhoea were attributed to river pollution, the slow flow of the river, and the use of the river for domestic activities. A few attributed malaria and fevers to high temperatures arising from low rainfall. A few respondents also suggested that diet was a cause of disease.

With regard to disease distribution, some patterns are emerging from the survey. Malaria and bilharzia are mentioned most frequently. Mepe may have more cases of bilharzia than Tefle. This is may be because the practice of having household water fetched by young men with barrels for a fee is more widespread there. Age seems to be the most significant variable in bilharzia infection. The population below the age of 25, especially the children (up to age 14), is the most infected for both communities. Gender differentials seem to be negligible, although women have a slightly higher figure. Educational qualifications and occupation do not appear to be significant, except that virtually all fishermen have suffered from bilharzia in the last two years. Respondents over the age of 45, of both sexes, have the lowest figures of infection.

Malaria does not present the same patterns. Infection rates are almost uniform in the population. Respondents in both Tefle and Mepe reported seasonal increases in malaria, diarrhoea, malnutrition, eye troubles and skin rashes.

When questioned about groups at risk, most could not identify particular groups at risk, or said that everyone was at risk. The few who did mention a particular group identified the children, and said they were at risk from malaria, bilharzia and diarrhoea.
People were identified as being at risk of disease because of the following: the use of the river for domestic purposes, the practice of bathing and swimming in the river, lower levels of resistance to disease, and poverty (which results in an inability to pay for treatment).

Most male respondents who were working said they paid for treatment of diseases of household members. Only a few men said that they accompanied the sick to the hospital. Not surprisingly, most female respondents over the age of 25 took the sick to the hospital, sometimes paid for treatment, and performed household chores. A few women mentioned that they prepared herbs for treatment.

The reported adverse health effects include: loss of income generation time (due to care of the sick), financial costs of treatment, loss of labour from the sick, long-term adverse health effects, poor school attendance, as well as pain and suffering.

The most common preventive measures reported were the boiling of drinking water and the cessation of the practice of bathing in the river. A few mentioned that they had constructed wells. A number of people pointed out that they could not change their situation because they had to use the river.

Discussion of Findings

The most serious health hazards in the Tongu area are environmental degradation, and poverty stemming from the resultant deterioration and loss of livelihood sources. Therefore, health education would only partially assist in helping communities to cope with the diseases which afflict much of the population. In fact, respondents of all ages and both sexes displayed a high knowledge level about the causes of malaria and bilharzia. The continued use of the Volta as a source of household water is a necessity in the absence of better water sources. Viable sources of livelihood for all sections of the population is central to any long-term solutions.

Disease and treatment findings suggest that age is the most important variable in disease distribution and adverse effects. Important exceptions are the figures for anemia, gynaecological disorders and pregnancy-related complications. Battor Hospital morbidity statistics indicate that women suffer from some diseases particular to them as women. While anemia is not a gender-specific disease, the high figure for women (571 cases compared to 215 male cases) suggests that there are gender differentials in the health prospects of the population. A full explanation would require an examination of the extent to which socio-economic factors interact with environmental factors in the determination of health.

The Tongu area has more women than men. In 1984, there were 62,632 women and 53,136 men. Survey results found that more young men were planning to migrate than young women. In discussions about migration, women were more likely than men to cite caring for children, accompanying husbands, widowhood and divorce as reasons for not migrating or returning to the area. Among those who had lived outside the area, women were more likely
to cite marriage as their reason for living outside the community. It appears to be easier for men to respond to economic problems by migrating than it is for women. As a result of high male migration levels, there is a large number of single income households headed by women in both communities.

Survey results show that most migrants could not or did not consistently support households. Meanwhile, there appears to be very little income generated by economic activities in both communities. Apart from a few bakers and shop owners in Tefle, and fishermen and artisans in Mepe, most respondents complained of dwindling incomes. More female respondents than males said that they were receiving financial support from relations outside the community to help maintain their households. As a result of low incomes, adequate nutrition is likely to be beyond the reach of many households, especially for farmers. Poverty is a well established factor of disease (Ostergaard 1992).

There are sharp differences in male and female educational levels in both Mepe and Tefle. Literacy figures are higher for men in all age categories. With regard to schooling, there are only 70 girls out of 202 students in one of the two Junior Secondary Schools at Mepe. At the only Senior Secondary School at Mepe, there are only 23 girls out of 96 students, and 16 of them are studying home economics. No girl is studying metal works. Only one is in building construction, while the others are in visual art.

With regard to occupation, male respondents reported a wide range of occupations, including driving, masonry, carpentry and alcohol distillation. Women in non-agricultural professions are mostly petty traders. In Tefle, a large proportion of female respondents are bakers and bakers’ assistants. There are far more male teachers than female. Therefore, far fewer women than men have the opportunity to engage in occupations not tied to the deteriorating environment.

Due to an uncertainty surrounding agriculture, firewood gathering and charcoal burning are becoming increasingly popular occupations for women. Although the sample had very few respondents involved in these occupations, there is plenty of evidence of these activities on the 30 kilometre stretch between Kpotame junction on the main Accra-Lome road and Mepe. Many former clam fisherwomen, who had no training for other activities, have turned to farming, petty trading, as well as firewood gathering.

The loss of the clams and the deterioration of fishing and farming have negatively affected nutrition standards. Indeed, most respondents said that the lack of food was one of the five most serious problems facing the Tongu area. This places great stress on women who are usually the food providers. They can no longer produce their own carbohydrates and protein. Most food now has to be imported from the Afram plains and other parts of the country to be sold in Tongu communities. Low incomes make it difficult to afford enough food, especially proteins, which are expensive. This situation has likely significantly contributed to the high levels of anemia and malnutrition, as well as the reduced resistance to other diseases.
Finally, women tend to do the bulk of caring for the sick. This is in addition to their already heavy household duties, such as child-care, the fetching of water and fuel, and cooking. Therefore, women cannot afford to be sick themselves. It would be useful to discover how many ailments exist among women but never receive attention from the medical profession.

Factors which adversely affect the constitution of individuals probably play a role in the statistics related to pregnancy related complications. The statistics do not provide any information on the differences among women in their vulnerability to particular ailments during pregnancy.

**Conclusion**

The study’s findings about the health prospects of the people of Mepe and Tefle supports that argument that morbidity figures are not enough to show gender differentials in health prospects, especially in a situation where the major diseases are the result of a deteriorating environment. The challenge is to find ways of ensuring that health studies are designed to take into account all the determinants of health and disease in any society so that these differentials become visible to policy makers.

**References**

Aidoo, A. 1985. Women and environmental rehabilitation. ATRCW/ECA.


Kandiyoti, D. 1985. Women in rural production systems. Problems and policies. UNESCO.


Z. Tropenmed Parasitol. 21, 411.

Sudara, S. 1984. EIA procedures in developing countries. Clark, B.D. et al. (eds). 
Dordrecht.

Taylor, B.W. 1973. People in a rapidly changing environment. The first six years of Volta 
Lake in Ackermann, W.C. (eds.). Man-made lakes. Their problems and 
environmental effects. Washington D.C.


World employment program. ILO. Geneva.

Unpublished Reports

1. Catholic Hospital, Battor Brochure for 30th Anniversary Celebrations, 1987
2. Tongu District Health Profile, 1990-1991

Endnotes

a. Tongu literally means by the river, and is used by the people and outsiders to refer to the location, the language 
and the people of the area. The Tongu are a sub-group of the Ewe people who are mostly found in the Volta 
Region, in the most south-eastern portion of Ghana.

b. Other changes such as lower rainfall figures have been recorded, but have not been conclusively traced to the 
dam.

c. In Battor, one of the Tongu communities, in 1967 it was found that 65% of crops were grown on creek land 
which was much more productive, and matured crops such as cassava much more quickly (Lawson 1972, p.32).
The target of both developed and developing countries is the attainment of an acceptable level of health for all citizens that will permit them to lead socially and economically productive lives. The health and safety of the worker is fundamental for the achievement of maximum productivity necessary for economic development, social well-being and political independence of the state. It is essential that the health and safety of the worker not be neglected at the expense of high productivity.

**ILO/WHO Definition of Occupational Health**

According to the internationally accepted definition of occupational health, defined by the ILO/WHO joint committee on occupational health in 1950, *occupational health should aim at the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations.*

Occupational health is concerned with the prevention of illness and injury, resulting from working conditions. Preventive measures include advising employers, workers and their representatives about: (1) the requirements of establishing and maintaining a safe and healthy working environment which will facilitate optimal physical and mental health in relation to work; and (2) structuring workers' responsibilities according to their physical and mental health. Measures also involve the provision of first aid and treatment services.

**Women and Occupational Health and Safety**

Maintaining a safe and healthy working environment for all workers, including women, is an important objective. There are increasing numbers of economically active women in the world. Indeed, according to ILO estimates, the total number of economically active women in the world is approximately 600,000,000. It is predicted that this figure will rise to approximately 900,000,000 by the year 2000, at an average of about 11,000,000 a year. Developing countries are expected to contribute about 83% of the increase. The health of these women is greatly affected by potential health hazards in the workplace.

---

1 Zamabian Organization of Occupational Health and Safety, Ndola, Zambia.
The Workplace and its Hazards

Zambia, like other African countries, has a high incidence of occupational disease and injury. Virtually all work includes some hazards. Heavy work, incorrect working methods, insufficient organization and inadequate or inappropriate technology may lead to accidents, physical harm, low productivity and considerable losses of production and equipment.

There have been a number of changes in the workplace as a result of technology, and economic and social development. Many of these changes are dramatically affecting the worker. While this has resulted in some progress, there are a number of new problems as a result of development.

While some hazards are obvious, others are insidious and slow to manifest themselves. Workers may be exposed to the dust-laden air of a mine, to fumes and gases in chemical extraction plants, to the freezing temperatures of cold storage, to the high level of radiant heat of a steel rolling mill, to artificial humidification in cotton mills, to the loud noise of testing aircraft engines, to vibration from pneumatic drills, to certain paints which contain solvents that can be absorbed through the skin, to rays from electric welding, to tropical heat or to attack from wild animals (snakes, etc.). They may be struck by falling bricks and masonry on demolition sites, or receive an electric shock from a wet switch; their work on conveyor belt production may be boring and tedious; they may suffer physical stress working in tree felling, or over-excitement working as a fireman, or suffer psycho-social stress due to problems at home and work.

In Africa and other developing countries, workers, especially women, are involved in agricultural activities. Due to a lack of knowledge and poverty, workers may be exposed to dangerous chemicals without protection. Sometimes these chemicals are banned in the countries of origin/manufacture and are dumped in the developing world. It has been demonstrated that some agro-chemicals are related to cancer, birth defects, damage to the brain and nervous system, and/or low intelligence in children and adults. DDT has been shown to be a contributing factor in cancer, mental illness, sterility in men, and abortions/miscarriages in women.

Employers and manufacturers of toxic chemicals usually know more about the toxic effects of their products. Unfortunately most of their workers, especially in developing countries, are unaware of the toxic effects of the chemical materials they handle.

There are a number of occupational related diseases, such as pneumoconiosis, contact dermatitis, cancers, mental illness and so on, which may be difficult to diagnose. It may take a long time for symptoms to appear. These types of diseases are not identifiable in the same way as industrial injuries. Occupational diseases may not be diagnosed until long after the worker has left his or her employment. In developing countries, it is particularly
difficult to relate the disease to the occupation since most workers are not medically assessed. This is due to a lack of occupational health and safety services and reinforcing legislation to police the services.

Workplace illnesses and diseases can be exacerbated by infections and parasitic diseases which are not necessarily related to occupation, for example, malaria, hook worm, HIV/AIDS, as well as by socio-economic problems such as hunger, poverty and lack of knowledge. All of these factors have an adverse effect on productivity.

Both developed and developing countries are sharing the results of these global calamities. It is imperative that agencies involved in correcting occupational health and safety at the grassroots, national, regional and global levels use the systems/resources available to protect and promote workers’ health.

**Accidents**

Every three minutes, somewhere in the world, one worker dies of an occupational injury or illness. For every second that passes, at least three workers are injured. It is estimated that about 180,000 workers die from occupational related injuries each year, and that 110 million are injured in occupational accidents.

In Zambia between 1970-1973, about 5,000 industrial accidents occurred annually, including 160 fatalities. These accidents were a result of inadequate provisions of occupational and human surveillance. It is essential that the government take steps to reverse this trend, including enacting occupational health and safety legislation.

**The Health Care System**

Compared to many other developing countries, Zambia has a fairly good health infrastructure and reasonably good health personnel. However, the health care system tends to emphasize curative services over preventive services. It also tends to provide more resources for the urban population than for the rural population.

The Zambian Party and Government of the First and Second Republic had, as part of their national development plans, a policy aimed at developing national occupational health and safety services. It also aimed at the establishment of a National Institute of Occupational Health and Safety. Furthermore, it intended to enact appropriate legislation on the matter. International experts were consulted to assist the country with its proposed objectives. Despite a number of initiatives involving the assistance of international experts, including feasibility studies, evaluations of local resources, numerous reports, discussions, visits to institutes and workplaces, many of the government’s laudable goals have not been implemented.
Over the years, Zambia has drawn upon legislation from both Britain and South Africa. There have been several pieces of legislation enacted in Zambia concerned with occupational health and safety, including the following:

Mines and Mineral Act 1969  
The Explosive Act 1975  
The Action for Smoke Damage  
The Pneumoconiosis Act 1980  
Medical Examination of Young Persons and Children Act 1933  
The Factories Act 1967  
The Lionizing Radiation Act 1974  
The Workmen's Compensation Act 1969

Other related occupation health legislation include:

Employment Act  
Aviation Act  
Road and Road Traffic Act  
The Professional Boxing and Wrestling Control Act  
National Food and Nutrition Commission Act  
National Council for Scientific Research Act  
Petroleum Act  
Public Health Act  
Environment Pollution Act 1990

**Zambian Organization of Occupational Health and Safety (ZOOHS)**

Zambian Organization of Occupational Health and Safety (ZOOHS) has suffered from a lack of operational funds to support its activities. Many proposals made to the government and other organizations have been unsuccessful. However, ZOOHS has had a few achievements over the years, including the following:

1. ZOOHS has successfully initiated occupational health and safety programs. In 1989, 1990, and 1992, occupational health nursing programs were conducted, in conjunction with Anricia Health Care and the Royal College of Nursing (London), successfully training 64 occupational health nurses. In 1992, 8 health care professionals were trained in the first multidisciplinary course on occupational health, safety and environment. ZOOHS has urged the government to introduce OHS programs at primary/secondary school, college and university levels.

2. In 1992, ZOOHS influenced the government to set up the National Occupational Health Centre, and urged it to enact the Occupational Health Bill.
3. ZOOHS established a collaborative system with the Zambia Federation of Employers and the Zambia Congress of Trade Unions.

4. ZOOHS hosted PACOH '92 and initiated an organization for women in development.

**Industry**

In 1985, about 375,000 people were engaged in Zambian industries and factories. The major industries in Zambia, past and present, include peasant farming, mixed farming, copper mining, factories, timber, cement and construction of electrical work, as well as industries in petro-chemical, fertilizer, textile, food processing, social manufacture, and general manufacture.

There is a complete lack of occupational health and safety regulations for the agricultural industry. The mining industry, on the other hand, has some relevant legislation in place. Also, the following institutions were solely established for the benefit of miners: Mining Safety Department, the Pneumoconiosis Medical and Research Bureau and Pneumoconiosis Compensation Board.

**Occupational Health Safety Program**

Occupational health and safety must address the following: (1) the effects of work on health, and (2) the effects of health on work. There are many benefits to a good occupational health and safety program. It can help lead to high productivity, good quality control (high standard of service), and cost effectiveness. It can help improve living standards, raise the quality of life of the people, and therefore improve the economic status of the country.

A multidisciplinary approach must be taken in the provision of occupational health and safety services. Managers, unions and governments must be involved. There must also be support from national OHS policies. An occupational health and safety team should ideally include a cross section of people including doctors, nurses, hygienists, epidemiologists, chemists, ergonomists, safety engineers, employer and employee representatives.

**Occupational Health and Safety Management**

Occupational health and safety management can be addressed on a number of levels, including the following: (1) through primary health care; (2) through education and training; and (3) through community participation through cooperatives.

Primary health care is an appropriate system through which OHS services can be managed, especially in developing countries. PHC is essential health care based on practical, scientifically sound and socially acceptable methods. It aims to meet the needs of all
individuals and families in the community, at reasonable costs that can be maintained by the community or country. It forms an integral part of a country’s health care system and is central to the overall social and economic development of the community.

Health has been defined as not merely the absence of disease but a state of complete physical, mental and social well-being. Primary health care needs includes the provision of good nutrition, good sanitation, and affordable housing.

Management of occupational health and safety through primary health care services should examine the following: the existing human resource and infrastructure, as well as the community at national, provincial, district and grassroots levels.

Occupational health and safety education and training should be designed to suite the needs of each sector. Workers should receive adequate training concerning the health implications of their work, as well as the environment in which they work.

Occupational health and safety programs should also involve community participation. There are many potential benefits of community involvement, including the following:

• More work is accomplished.
• Services can be provided at a lower cost to each community.
• Both government and community will benefit from the program.
• Participation leads to sense of responsibility for the project.
• Participation helps to ensures that things are done the right way.
• The use of indigenous knowledge and expertise will strengthen the approach.
• It gives freedom from dependence from professionals.
• It raises the consciousness of community of issues involved.

Finally, cooperatives are essential tools to bring the community together and may help in the implementation of occupational health and safety programs. In some countries, cooperatives are large, well organized, influence governments, and contribute substantially to the economic development of the country. With a view to the promotion of improved occupational health and safety, cooperative societies can:

• Improve the economic situation of the members.
• Contribute to the economy through democratic economic activity.
• Increase personal and national capital resources, encouraging thriftiness and prevention of usury and encourage the use of wise credit.
• Increase income and employment by fuller utilization of resources, such as land, marketing and processing of agriculture, natural products, the development of local industries and processing of raw materials.
• Improve social and cultural conditions were appropriate, providing supplementary services in housing, education and communication.
• Raising the level of general and technical knowledge of members of the society.
Conclusion and Recommendations

A healthy and active worker is a valuable asset in attaining national economic growth. Good health has a direct relationship on productivity levels. The working environment can affect the health of workers, just as a workers' state of health can effect his or her ability to perform the tasks for which she or he is employed. A poor work environment, leading to poor health of workers, contributes to poor performance and low productivity.

In the long-term it is more cost efficient to prevent occupation-related diseases and injuries than treating them. The following strategies are therefore recommended:

• The best way of dealing with health problems related to occupations is to attack them at the source through preventive measures.
• Workers should be protected from hazardous materials derived from the industrial process.
• Governments, agencies and businesses should adhere to legislation stipulated in both ILO and WHO recommendations regarding the safety of the worker's health and the environment.
• Information, training and research programs should be developed with collaboration at the grassroot, national, regional and international levels.
• Occupational health and safety services, aimed at comprehensive health coverage of workers, must be a priority in national development programs.
• Occupational health and safety education should be given to workers at all levels. Programs should be established which address the needs of the disabled, women, children and the aged.
• OHS services can be implemented through primary health care systems, and can be tailor-made according to primary health care needs of the country.
• Finally, cooperatives could help in the mobilization of the working population and may be helpful in the implementation of occupational health and safety programs.

References


Afr/GOH/6.

Scientific Publication.


Karar, M.S.A. 1975. OHS in Zambia across sectional and retrospective study of OHS
hazards in Zambian industrial atmosphere.

October.


UNICEF. 1982. Assignment children - journal for children, women, and youth in
development community participation and social planning with the urban poor.
57/58, 58/60.

Social Issues, Gender and Health
For this workshop, I have been given the task of discussing ethics, gender, and health. Naturally, I have done this by using some of my own work on the human rights implications of harmful cultural practices. I began by asking myself relatively simple definitional questions. What are ethics, gender, and health, respectively?

Let us agree that ethics are principles that govern standards of conduct; that gender is the construction of sexual difference to reflect a particular view; and that health is one standard by which to measure the quality of life. Let us also agree that ethics, gender and health are concepts that are socially and culturally defined and as such, their definitions differ from place to place. To help focus our thinking, let us use the virtually global preference for male children as the problematic.

The ethics of a community are its customs and the basic building blocks of its culture. From a legal perspective, ethics as custom are the foundations of the body of rules known as customary law, which can be distinguished from formal written or statutory law. To the extent that ethics are "laws," they are also arguable and refutable. Therefore, to the extent that "culture" is based on a body of ethics, it too must be arguable and refutable. Yet time and time again, as we work on issues pertinent to the lives of women around the world, we find ourselves stymied by questions of cultural relativism. Particularly as an African woman, I find myself either defending my culture to a Western barrage or trashing it to its misguided defenders. To guide myself out of this predicament, I began by asking myself, among other things, at what point is a cultural imperative no longer useful and even harmful. It is clear to me now that such an imperative is no longer useful when it begins to undermine its own reason for being.

Much of ethics or those principles that govern conduct within a given community are passed on implicitly and explicitly in a variety of ways, ranging from teachings, to sanctions, to reward and punishment. The preference for male children is one such ethic. It governs the life of a community in a myriad of ways, for example, it influences political clout, access to resources and social ascendancy. This particular ethic is greatly influenced by a specific understanding of gender, the construction of sexual and biological difference. Male child preference evolved from the need to perpetuate a family, a lineage, a nation. Ostensibly, before a boy could be preferred he had to have properties that made him more desirable. In purely biological terms, there is nothing to recommend the male over the female of our

---

1 Independent Consultant on International Human Rights Law, New York, USA.
species. What took place, then, before the advent of male child preference must have been the engendering of biological difference to reflect and project the priorities of a powerful elite. All things in the image of this elite came to be equated with moral fortitude, righteousness, intelligence and physical strength, and were seen as powerful and desirable traits. The flip side of this point of view is necessarily that all things not male are not as valuable, and are perhaps even worthless.

Some concrete examples come from an area that has come to be called harmful cultural practices, which are those practices injurious to individuals but part and parcel of a community’s articulation of itself and its values. A host of these practices have developed over the millennia, and some of them have fallen into decline. Almost all of these harmful cultural practices are perpetrated on women and girls. These include child marriage and early pregnancy, forced feeding before a wedding, nutritional taboos, particularly during pregnancy, certain birthing practices, female genital mutilation, less food, education and health care for girls, dowry/bride price, widow inheritance and female infanticide. What all of these practices have in common is that they exist at the harsh intersection of communal identity and gender ideology. The result for individual women and girls is mitigation of their health or their quality of life. What these practices also have in common is that they evolve from or are in reaction to the preference for male children, the result of which is the disregard and neglect of girls or even the consistent harming of them.

This brings us to the question of when an ethic is no longer useful. For that we have to look at the results of male child preference for women and for their communities. Girls and women from societies that value males above females live with everything from low self-esteem to chronic ill-health and even premature death. In the context of community and national development, the diminished productivity is immeasurable. In Africa as a whole, women have the highest fertility rates, highest maternal mortality rates, lowest life expectancy rates, and we have even lost the eight year advantage nature gave us. The ethic of male child preference can be said, therefore, to be undermining its own reason for being, that is, the perpetuation of the lineage and continuation of a people. The cultural imperative of the ascendancy of maleness is no longer useful. In fact, it is compromising the lives of women and girls, as well as their communities.

There are many people, including myself, who are working to eradicate the harmful cultural practices mentioned above. What we lack is a perspective that unifies at least the impetus behind all of our efforts. My feeling is that this perspective will evolve out of a critical analysis of the ancient system of male child preference, as well as of the modern state system that tolerates and perpetuates it. It seems to me we are fighting the same war on different battlefields - we have yet to present a unified front. A long neglected arena for debate of issues such as these is the legal arena.
Some Legal Responses from African Women

When we speak of harmful cultural practices, we must first drop the euphemisms that perpetuate them and call them what they are - culturally sanctioned gender discrimination. Second, while we do the more specific work of tackling each type of practice, it would be helpful to tie each one to the well-spring of its existence, specifically, the preference for male children. In doing so we not only challenge the effects, but also the root causes of such discrimination.

In the last few years, women have begun challenging the inequities of gender-based cultural practices, as well as the customary response to them. The strategies have changed perceptively. For example, in the past we laboured at defining custom and culture, and at finding places where we could squeeze our lives into the existing language of rights. When that was too daunting, we began speaking less of rights, and more of health, as if that would be any easier to secure. We have now begun to think of the basic minimum of good health and health care as rights in and of themselves. Women are also pursuing formal legal remedies for abrogation of their rights in the "private" sphere where most violations of women's rights occur. Few formal legal systems actively pursue violence in the family or community, and this refusal to scrutinize the smallest unit of society has serious repercussions for the overall protection of the rights of women in both the public and private spheres. In the last decade, more women are using the formal legal system, thereby circumventing the skewed customary law system. The cases are setting critical precedents for action regardless of the actual outcomes.

In the strategies that are being used, it has been critical to outline the strongest points in our arguments. First and foremost, in speaking of conflicts between culture and legal rights, we are necessarily speaking of what takes place in our families and communities. Accordingly, we will be alleging violation within our families and/or our communities for acts which ostensibly honour and protect the very same. In these cases, the common governmental position has been that these are not issues of violations of the rights of individuals but rather of the preservation of communal cohesion. The tactic, therefore, has not been to deny legal remedies, but instead to deny the very existence of a problem and thus preempt the question of remedy. Current practice has it that when the treatment of women in the "private" context is questioned we are suddenly not members of families and communities but family and community itself. This is the dilemma in a nutshell.

Legal challenges to this view are coming from groups like the Association of African Women on Research and Development in Senegal and Kenya, the Women, Law and Development in Africa with chapters around the continent, the Uganda Association of Women Lawyers, the many chapters of the International Federation of Women Lawyers, the Tanzanian Legal Aid Scheme for Women, Organizacao da Mulher Angolana, les Femmes Tunisiennes Democrates, the Women in Nigeria, the Women's Law in Southern Africa and
others. These groups are redefining the rights of women, reforming existing law and claiming what accrues. Several of them are tackling the issue of gender-based discrimination and violence within the framework of African and international human rights.

The most notable of these are the cases of Unity Dow of Zimbabwe, Wambui Otieno of Kenya and Aminata Diop of Mali. Since 1987 these three most well-known legal cases brought by women in Africa have had either directly to do with conflict with cultural dictates or in one case, with how the cultural imperatives had translated themselves into the formal law. The Unity Dow case raised the question of gender discrimination relative to citizenship rights showing clearly where the formal law system had carried over from tribal structures. The case of Otieno, where the Gikuyu widow of a Luo man was not permitted to bury his body but had to relinquish it to his people, involved clear conflict between the customary and formal legal system. The case hinged on cultural and traditional dictates for burial. The last case which has not be adjudicated in Africa, is the case of Aminata Diop who fled Mali for France in order to avoid having her genitals mutilated. It was decided that she has a right of asylum in France on the basis that genital mutilation is a form of persecution under the terms of the Geneva Conventions of 1949. The politically expedient court stated, however, that because Diop failed to complain to Malian authorities, she has no recourse to French law. The case is being appealed.

Examples from the continent include the Uganda Women Lawyers Association which has been working to restrict, through the formal legal system, the cultural practice of a widow marrying her husband’s brother. Much of this debate has been fuelled by the AIDS epidemic which has hit Uganda harder than any other African country. At issue is the idea of the perpetual marginalization of the women, their inability to own property and to be the primary guardians of their children. Ugandan women have also taken up a particularly thorny problem of protection from divorce and destitution for women who refuse sexual relations with their HIV-positive husbands.

FIDA-Nigeria are engaged in law reform work around domestic violence and spousal battery. One example that they give is that assault on a man is a felony punishable by three years in jail; the exact same assault on a woman in the same town and at the same corner is a misdemeanour with a small fine. The Women, Law and Development in Africa (WILDAF) network, headquartered in Zimbabwe, is concentrating on domestic violence as an issue of the human rights of women. WILDAF and the Southern Africa Women and the Law Project continue to do important work on legal literacy with grassroots women about their rights within the family and the community.

The experience of women in other parts of the world have been instructive and the sharing of experiences and strategies empowering. One very relevant example is the work of Brazilian women to abolish the traditional defense of honour plea often invoked by men who had killed their wives and lovers. Brazilian law no longer accepts this plea and all such killings are tried as murders. Also in Brazil, women have pushed for and succeeded in creating a women’s police station, where all of the officers are women and where women can
bring complaints, particularly domestic violence complaints, without fear of ridicule. Valuable also is the work of women in the Indian sub-continent combatting through the legal system the practices of sati, bride burning and abortion of female fetuses following amniocentesis to determine sex.

Beyond work on the African continent, there is a need to support and inform African women who have immigrated to the West about the laws of the countries where they reside, with regard especially to harmful practices perpetrated upon children. In this vein, the work of the Foundation for Women’s Health Research (FORWARD) in London is exemplary. FORWARD has been instrumental in getting the 1985 UK law against female genital mutilation passed as well as having that practice included in the priorities for the child welfare offices dealing with immigrant families. The French experience in this matter is also instructive as they have decided to throw people in jail regardless of their knowledge of the host country’s laws.

One of the more recent and rampant problems we are seeing is a rise in the incidence of rape. Rape with the impunity that we are seeing in many parts of the world evolves out of a traditional and cultural disrespect for women. A great deal is made of the fact that rape is rare in Africa and that men rape most often out of a desire to marry a forbidden lover. Recent information refutes this view and, in fact, in Africa the traditional systems governing the abductions and rape of young girls where the abductor or rapist would be forced to marry the girl, have fallen away leaving a glaring crime and woefully inadequate legal responses.

The mass rapes of Somali and Liberian women as an act of war has no previous place in our consciousness and thus, no appropriate response has been available to us. The fact that we would even have to debate whether or not rape in war is a crime against humanity attests to the fracturing of our collective consciousness as well as to a profound ambivalence about the worth of a woman’s life. Where domestic remedies are not available like in Somalia or Kenya and many other countries, there is often an international body of law that may be petitioned.

In international human rights law, if a domestic legal system does not address a visible problem, that is, if there is no domestic remedy, then people have access to remedy outside of their particular government provided, of course, there is a body outside of their country to which they can address complaints. Along with legal rights in the domestic context, in the last few years there has been a determined effort to reach the human rights mechanisms of the United Nations and those specific to Africa. Since 1986, the most likely target of efforts on the continent has been the African Commission on Human and People’s Rights which interprets the African Charter by the same name.
Last year, the African Commission, in the face of mounting criticism, and to the surprise of many, stated that it had yet to receive a complaint from a woman. While the possibility of bringing cases on harmful cultural practices seemed virtually impossible two years ago, cases of culturally sanctioned gender discrimination are guaranteed to appear in the next two years.

Others are also working on a more conciliatory approach by asking the Commission to render one of its other services of either requesting a study on the human rights of women in Africa, offering an opinion on the role of culture in the life of the community, asking for more extensive information from women’s groups about their work on human rights, etc. There is the hope that the Commission will take note of Resolution 19 of the Convention on the Elimination of All Forms of Discrimination Against Women which considers harmful practices against women to be gender-based violence and calls for their eradication.
Discussion

• Much discussion focused on the lack of access to the legal world. Non-lawyers are often unaware of the law. Measures are needed to inform women of their legal rights. Children should be educated about the law through the school system. Messages need to be disseminated through mass media such as television and newspapers.

• The presenter noted that the law is intentionally confusing and that mystification is in part a job creation device. Lawyers have a vested interest in denying access to the legal system and using confusing legal language - if individuals can take a case to court on their own, then a lawyer is unnecessary. Despite this, there are legally trained women who can educate other women, and who can bring a case before the international court of justice on behalf of an individual woman.

• Significant problems exist concerning the implementation of existing laws. There are laws in place that are meant to protect girls. For example, every African country has laws concerning the education of children, as well as laws setting a minimum age for marriage. The problem, however, is that these laws are often not implemented.

• Legal issues cannot be looked at in isolation. Instead, the whole patriarchal system needs to addressed. There are a number of harmful beliefs and practices concerning issues such as property rights, widow practices, mandatory children, preference for male children, and the treatment of older women, that must be confronted.

• There are also numerous structural problems within the legal system which may prevent a woman from asserting her legal rights. For example, if a woman decides to take legal steps when a rape occurs, she may be ridiculed. She may find it painfully difficult and humiliating to go before a court of law and tell her story. Also, there may be an inherent bias against women on the part of male judges and lawyers.

• It is necessary to look at the extent to which women internalize oppression and the way in which the system rewards those who internalize oppression. For example, some women look forward to becoming older because this may be the only time in their life that they have any power over someone else.
• The importance of activism was also discussed. Women's rights have not been adequately addressed by state policy. Women must fight for their rights themselves, with the assistance of the numerous women's legal organizations. Women also must recognize their power. For instance, no man can run for president unless he has the support of women. Also, older women are the custodians of law.

• The presenter emphasized that bodies of rules are not immutable. What is ethically acceptable in one culture, may not be in another. Traditional practices can be questioned and revised by members of the culture, and culture generally is in a constant state of change.

• During the presentation, the author explained that in front of Westerners, she defends the positive sides of African culture and practices, while with Africans, she knocks down the negative aspects. When asked about the positive aspects of African culture, she responded that there are many, including respect for elders. However, the positive aspects are often not as sensationalistic as the negative cultural practices.

• The presenter discussed the case in France of mothers being jailed for aiding in the circumcision of their daughters. A question was raised concerning why fathers are not being jailed. She responded that only one father has been jailed - this man personally performed the circumcision on his daughter and killed her in the process.

• The point was raised, of the necessity of publicizing the existence of legal options and institutions. Many participants were unaware of the Hague Court or the African Commissions on Human and People's Rights, or how to access them. It was suggested that donor agencies invite representatives of these institutions to international meetings on health, to give them greater exposure and visibility.
Refugees, Gender and Health

Nkosazana Zuma

Introduction

Apartheid as a policy in South Africa has caused the most severe social and political unrest any country has ever seen under "peaceful" conditions. The entire society had to be reorganized in order to make sure that 87% of the land was occupied by "pure white". 87% of the population had to fit into 13% of the land, which consisted of scattered "black spots". This meant forced removals for millions of people. The migrant labour system dislocated families, and forced women to head their households and bring up children single-handedly in the rural areas. Men lived in single sex hostels under inhumane conditions.

The inequalities in the distribution of and access to resources was a source of poverty, unemployment, and intense hatred for the government. The Apartheid government met with very strong opposition from the oppressed. The government was intensely intolerant of this opposition.

There was extreme repression. Prisons were filled with political opponents, including children. Peaceful protests were met with live ammunition, activists were assassinated, people and homes were burnt. Apartheid as a policy had to be maintained through violence. There is therefore a long-standing culture of political violence in South Africa.

After the un-banning of the liberation movements - ANC, PAC and SACP - and the release of political leaders, there was immense optimism that violence would decrease and that a new dispensation was going to follow speedily. What was supposed to be an exciting, bright time, however, became the darkest hour before dawn, with South Africa seeing unprecedented levels of violence across the country.

The escalation of violence is largely the result of opposing forces. Those forces that want the process of change to be speeded up, to usher in a constitutional assembly and a democratic government, are finding much opposition from the forces that want to maintain the old order as long as possible. The so-called IFP-ANC conflict is a manifestation of these forces. The police and right wing are part of the forces together with Inkatha that do not want change because it will erode the power and privileges that they already enjoy under Apartheid. They fear the elections because they do not have a large following.

1Centre for Health and Social Studies, University of Natal, Durban, South Africa.
Since 1990, the violence has become less focused and is increasingly taking the form of massacres, indiscriminate shootings in trains, buses, taxis, shopping centres and funeral vigils. This is meant to instill fear and destabilise communities, so that there is no atmosphere of peace and stability to hold elections.

From the figures below you can see that from 1989-1990 the number of deaths more than doubled. About 7000 of these occurred in Natal alone.

<table>
<thead>
<tr>
<th>Year</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>879</td>
</tr>
<tr>
<td>1986</td>
<td>1198</td>
</tr>
<tr>
<td>1987</td>
<td>661</td>
</tr>
<tr>
<td>1988</td>
<td>1149</td>
</tr>
<tr>
<td>1989</td>
<td>1403</td>
</tr>
<tr>
<td>1990</td>
<td>3699</td>
</tr>
<tr>
<td>1991</td>
<td>2240</td>
</tr>
</tbody>
</table>

Total 11229 (Figures from Critical Health, December 1992).

Statistics of the dead do not truly reflect the devastation and havoc brought to families by this violence. There are people who have been made homeless. Families have lost sole breadwinners. There has been irreparable schooling disruption. Families have been torn apart by war, and society has been brutalized.

Until 1989, the reported targets of violence were mostly men. In the 1990s, however, women and children are increasingly becoming targets of this violence, particularly when there are massacres. For example, in a settlement called Uganda in Umlazi, Durban, Natal on 13 March 1992, 22 of 23 victims were women and children.

Refugees

Refugees from the political violence come from various rural and urban areas. In 1992 in Natal alone, 1432 people were killed, but 11,000 people were reported to have lost their homes or have been forced to flee during some point that year. The disruption of society is far greater than the number of actual deaths, because for every person who dies, there are 9-10 people who are affected. Many of the refugees are women and children.

During 1992 at the height of violence there were some 3000 refugees in a number of refugee centres in Port Shepstone, Natal. At least 2000 of those were women and children under the age of 12 (Irish 1993).
Living Conditions of Refugees

Refugees all over Natal are housed in groups at churches, halls, schools, tents, hospitals and sometimes in the open air. They sleep packed like sardines on cement floors with only one or no blanket. There is no privacy. Sexual abuse and assaults are common. Relief workers tend to provide food and blankets and not look at specific needs of women, for example sanitary towels. Sometimes there is no milk or food for babies.

Health Problems

Very little research has been conducted amongst refugees to determine their health problems. Some research has been done on the psychological effects of such trauma on refugees, although this tends to be done much later. In 1992, a refugee camp in Isipingo (Natal), there was an outbreak of measles and a number of children died. In the same camp there was an outbreak of gastroenteritis amongst the children, and kerosene poisoning was common. This camp consisted of tents on a playground and water had to be brought in from outside. Children would mistake kerosene for water and drink it.

Other diseases that flourish in conditions of overcrowding and high levels of stress, include poor nutrition, like tuberculosis, skin diseases, and eye conditions. Little is known, however, of the extent of these problems.

Pregnancy and STDs

There has been a large-scale breakdown in family discipline. Furthermore, pregnancies and STDs amongst teenagers have increased. In a 1991 survey of attitudes to family planning in Natal/KwaZulu it was found that 42% of women sampled were first pregnant between the ages of 11 and 17 (Smit and Venter 1991).

HIV is highest in Natal, and the seroprevalence rate has increased over the past 2 years:

<table>
<thead>
<tr>
<th>Date</th>
<th>Seroprevalence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>November/December</td>
<td>1.2%</td>
</tr>
<tr>
<td>June/July 1991</td>
<td>2.5%</td>
</tr>
<tr>
<td>June/July 1992</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

(Abdool Karim et al, MRC Natal, 1992)

The 1992 rate for women is 5.7% compared to 3.8% in men. National seroprevalence rates were 0.6% in 1990, 1.4% in 1991 and 2.69% in 1992. The Cape Province is 33 months behind Natal, the Transvaal is 14 months behind and the Orange Free State is 9 months behind in terms of seroprevalence rates. (NHPD statistics 1993). The reasons for this are a combination of migrant labour system, violence and poor socio-economic conditions. The impact of AIDS will be seen in a number of years to come.
**Mental Health**

There has been an increase in substance abuse, particularly amongst the youth. A Medical Research Council study in the Cape Town Metropolitan Area revealed that 60% of non-fatal injuries due to interpersonal violence were alcohol related. Another study of 7340 students, again in the Western Cape, showed that 20% of students smoked cigarettes daily, 15% had been on an alcoholic binge in the last 2 weeks, 10% had physically injured another person or been injured at school, and 10% carried knives at school (Yach 1993).

**Emotional and Social Consequences**

Political, social and family violence has affected millions of individuals in this country, and sometimes whole communities (Simpson 1992). Victims, witnesses and sometimes perpetrators of violence may suffer from post traumatic stress (PTS) - the inability of people to concentrate and function effectively in society (Eagles 1992). PTS is associated with powerlessness and can take the form of alcohol and drug abuse, wife battery, and chronic anxiety. Social consequences of trauma can be seen in the large numbers of youth who have left school, are now unemployed, have no means of making a living, and have no stake in the future.

**Rape**

Reported cases of child rape increased from 1707 in 1988 to 2915 in 1991, an increase of 72%. In 1991, 22,765 rapes of women were reported, which is an increase of 12% over the 1990-1991 period. Although this seems startling, the majority of rapes are still not reported for fear of the consequences. NICRO believes that only 1 in 20 rapes is reported, and they estimate that 300,000 rapes take place every year.

**Domestic Violence**

The family is part of society and the ills of society are often reflected in the family. Where violence has become a social norm it is expected that domestic violence will escalate. It is estimated that 1 in 4 women in South Africa are regularly beaten by their male partners (Angless 1992).

**Access to Health Services**

Refugees often have no access to health services. Services may be far away, they may not have money, or they may be scared. For instance, ANC refugees may not feel safe because they may be victimized. Sometimes they are frightened to venture out of their refugee centres for fear of being attacked.
Conclusion

There is very little information on the impact of political violence on the health of refugees, and even less about the way it affects men and women differently. This may be one of the gaps in research. Of course, violence will persist for some time beyond the elections since some of the violence is related to socio-economic conditions. Hostels are being used as springboards for violent attacks against township residents, particularly in the Transvaal. Unemployed youth who have no stake in the future contribute to this spiral of violence. Lack of housing is another factor. Until we can transform our country by first giving people hope, restoring their dignity, and improving their material conditions, violence, and refugee problems, will continue.

References


• Very little research is being done on refugees. This major public health area receives very little attention. Given the dearth of data, the presenter was questioned about how she was able to get the statistics that she highlighted in her presentation. She responded that most of her figures on refugees, violence and deaths, were from independent researchers. Independent monitors have done the work that government won’t do. She emphasized that they may not be accurate. AIDS statistics were obtained from government sources.

• A number of difficulties in gaining information on health and refugees were discussed. To begin with, if a researcher intervenes, she or he needs to be able to help and not just ask questions. Also, a major problem when working with refugees is that they tend not to be in the same place for very long. For example, they may initially stay at a church, and then move to another shelter. They are never in the same place long enough to put in adequate infrastructure.

• There was a discussion concerning the devastating psychological effects that the culture of violence has had on young women and men. For many years, men and women have engaged in the liberation struggle. Arms are easily obtained and quite common. As a result, youths feel very little stake in the future. They have little prospect of obtaining a job and no social security. She mentioned that the National Youth Services is currently looking at developing skill training programs for youth. It is hoped that these programmes might help to reintegrate youths into their communities, and help to restore their dignity.
Section I: Issues of Gender and Difference Within the Women's Health Project

The Women's Health Project

The Women's Health Project (WHP) was set up in Johannesburg, South Africa in 1991 to create a national interest in women's health, to promote health policy research, and to develop a women's health handbook. In the two and a half years since its inception, the project team has engaged in a number of research projects, run many information workshops for women's groups, and written and tested three workshop packages and two chapters of the handbook. It has also built a database of names of people involved in women's and health organizations and the media, health workers and academics for whom the team produces a newsletter and offers information, networking and project support.

The project was set up with a feminist intent in a country in which "feminism" was a dirty word. However, large numbers of women are engaged in a struggle for women's rights and share perspectives that would be internationally recognized as "feminist". By feminist I mean, the recognition of women's oppression within the home and in social institutions, and of the need for women to have control over their bodies and to determine for themselves their futures and the social changes needed to make society a better place for them and their children.

The employees of the project are all deeply committed to this goal. They came to the project with personal histories that included activism in one form or another around women's quality of life. Their differing and shared experiences and perspectives have framed and moved the project into its present direction. This paper explores the ways in which the overall project and the projects within it both reflect and challenge notions of a "feminist methodology" which are being debated in contemporary journals.

Defining a Feminist Methodology

The core of feminist methodology lies in its recognition of the power relations inherent in the research process and its attempt to make these relations transparent; in

1Women's Health Project, Department of Community Health, Centre for Health Policy, University of Witwaterstrand, Johannesburg, South Africa.
particular, to avoid using women "as objects of knowledge" (Cook et al. 1990), to reflect on issues of difference between the researcher and the people she is researching (Humm 1990) - which Shields and Dervin refer to as "gender sensitive reflexivity" (1993). In addition, it requires an inter-subjectivity so that the people being studied determine the research agenda and process or, at least, that the research topic is of concern to them. They reflect on the importance of recognizing the "researched" as social agents and of ensuring the research process itself is "emancipatory" (Bhavnani 1993).

This paper explores these issues, encapsulating them in two key concepts: difference and participation. Using our experiences in the Women's Health Project it both describes how we have tackled these questions in a range of projects, the difficulties and nuances they pose, and the ways we have attempted to resolve them.

**Negotiating Difference**

**Negotiating Difference Within the Women's Health Project**

The WHP team comprises six full time members. It is tempting to describe us in the categories of the day, but the process of categorization itself belittles the complexities we all experience in living as "multiple subjects" (Harding 1992). That said, it is the colour of our skins, (and the specific impact of institutionalized racism), our educational backgrounds, our family roles or lives as single women, our heterosexuality, which serve as markers of difference, and of our experiences of power and powerlessness in our lives. Our team includes black and white women, two nurses, one doctor, one public health specialist, one social anthropologist and one administrator.

We relate on a day-to-day basis with warmth and humour; we are reasonably honest about the power relations between us and how each of us feels comfortable or uncomfortable at different times in the roles we play teaching and learning from each other. Our shared concern about the pain of many women's lives, and our belief that our work can and should make a difference, is a source of unity in the group, as is our willingness to interrogate issues of difference as they arise between us from time to time.

Many people outside the group relate to us in terms of our mix of "categories". Funders, for example, are impressed by the racial mix in the team, and the fact that we have an explicit affirmative action policy. Academics are interested in our academic skills; grassroots women in our ability to run workshops on issues of concern to them, in their own languages. Within the group, we are all aware that it is our mix of skills and experiences which makes the project so vibrant. But, being located in a university environment, it is educational qualifications which determine salaries, and publications which determine cudos. As a result, except for our administrator, members of the group are under pressure to gain further academic qualifications and excel in research.
The project aims explicitly to tackle the problem that most academics are white and male. We decided from the start to employ black women as far as possible, even when they did not have formal research experience. We would build a research training process into our work, so that the members of the team would develop research skills over time. We try to ensure that members of the team take turns giving speeches so that we will all develop the confidence and image that public speaking gives one, and we will avoid a situation in which only one of us becomes a spokesperson for women’s health and for the project.

A number of us have found ourselves in conferences or meetings where the question of race has been raised by participants other than ourselves. In a number of forums, black women have accused white women of using other black women as objects of their research (Serote 1992; Funani 1992; Fouche 1992). In a number of forums, questions have been raised about why white women’s skills are deployed instead of encouraging black women to develop those skills. These are key issues for the liberation of South Africa. They are also very complex issues. In the context of two or three day workshops, they tend to be raised in a way that blames white women for their skin colour and related privileges, or that forces black women to take on prominent roles, because of their skin colour and lack of privilege, rather than dealing with the complex mix of categorization and individuality that actually determines each of our behaviour. All of us have expressed enormous discomfort with these experiences.

As a result, we decided to hold a workshop for ourselves and our Coordinating Committee, a committee comprising people from organizations with an interest in women’s health, which was set up to give us broad policy guidance. We thought we should explore issues of difference: language, colour, culture, ethnicity, class, privileges, isolation, guilt and tokenism before they developed as problems within our group. We employed a facilitator who took us through these issues. The process gave us a greater confidence to be honest with each other about ourselves and the South African situation (Women’s Health Project 1992).

**Negotiating Difference Beyond the Women’s Health Project**

In response to this context, at times each of the white women in the team has expressed reluctance to participate in public events for the project - wanting to avoid any context in which she will have to justify herself because she is white, rather than because of the way she has chosen to deal with being white (or American in the case of one member). We have debated whether we should be trying to address these issues in public forums in a more nuanced way, or simply avoid them because they are so terribly painful. Our policy at this stage is that whoever has content expertise has to go to the events which require that expertise, but that decisions about who should go to general meetings or conferences should take into account these race-based readings of the value of the Women’s Health Project. The
issue is further complicated by our belief that opportunities to travel should be shared within the project, and that one of our own aims is to build the competence and confidence of black women in research and policy work.

**Participation Within the Women’s Health Project**

**Determining a Framework and Priorities**

Given that the aim of the project is to create an interface between women on the ground, health workers, academics and policy-makers, we have tried to develop processes which facilitate this. But here too, we have found that participation is not as simple as it seems. The key issue is how a national project with a network which spans women from very different class, cultural, regional and educational backgrounds can be accountable, and how it can facilitate the participation of its members.

Before the project was set up, we invited women who had an interest in women’s health to a consultative meeting, to talk about our idea. Members of trade unions, health workers organizations, NGOs and academics attended the meeting. They liked the idea but felt that more consultation would be needed. They suggested we should fundraise in order to give me the time to consult properly. Once money was raised, I travelled to different parts of the country, inviting women from all the groups I could think of, to attend the discussions. It was this initial consultation that decided on the process and priorities of the project.

**Accountability**

The question of a group to determine the Women’s Health Project policy and direction also came up in these discussions. We approached women who represented the range of NGOs which had a direct interest in women’s health - health worker organizations, rural development organizations, social workers, etc. The aim was for this "Coordinating Committee" to give the employees overall guidance about our aims and project direction so that the employees’ interests did not entirely determine the overall project’s direction. Given everyone’s hectic schedules, though, we agreed that it would be more convenient if the members of the Committee got involved only in those aspects of the project that were of direct interest to them. Subsequently, a number of them have done so, and the Coordinating Committee itself was disbanded.

At the same time, however, the direction of the project is being developed by a wide range of members of the network through the demands they make on the project. The fact, for example, that we get so many requests for information is pushing us to develop the resource side of the project more fully. The fact that so many women’s groups have approached us to run workshops for them has led us to produce workshop packages for women’s groups to use on their own.
This process has created a rather diffuse system of participation in the Women's Health Project where, for the most part, its national orientation means that women in general, rather than a specific community or category of women, participate in the project in a range of different ways. The key for us is to keep expanding our network, both geographically, and in terms of the backgrounds of the women it reaches, in addition to coming up with innovative ways of encouraging participation from women.

**Conference Consultation**

The possibility of consulting the entire database of 800 individual women and organizations remains. At the time of writing, we are attempting to consult everyone in our network about a women's health conference, and about our future direction. The dynamics of participation are encapsulated in the difference between the response of members of the network in Cape Town, who were delighted at being consulted in advance, and were keen to get involved in the process, and a member in Jane Furse, a rural village in the Eastern Transvaal, who said, "Look, I can't even write my name and you ask me what the conference should be like - you should know!"

The question of how the WHP relates to its network is really exploring the nuances of participation. The key issue is that participation is not the same as initiation. Nor does it necessarily mean ownership. The attempt to create an incorporative national network, even while giving priority to issues and processes identified as appropriate by the majority of women, means that some of the value of specific women naming their own specific experience and strategizing how to deal with that experience is lost. We do, however, remain aware of the value of that kind of process, and have created opportunities for community-based research and action to the extent that members of the network have demanded it.

**Section II: Methodology to Promote Women’s and Society’s Emancipation**

**Creating the Possibility for Women to Influence Policy Proposals**

One of the most complex areas of "difference" in which our project engages is that of the power relations between academics and non-academics. The history of the struggle in South Africa has created a healthy scepticism amongst many activists about the role of academia. There have been many critiques of academia because of its distance from the struggle. Those few academics who have worked as activists, however, have been given opportunities to use their skills and insights by both student organizations and organizations of civil society.

An additional question, is that of the small number of black women academics. Until the last decade, all universities were racially divided and those for black students were least resourced and most politically restricted. Most academic research did not aim to contribute
positively to the emancipation of people in society. When the Women's Health Project started, we were painfully aware that women were invisible in debates about health policy, as were women's health concerns (except for the inevitable focus on the "mother and child" rubric of primary health care). Since the project began during the period of negotiations, there were black men and white men talking to each other. Women were virtually absent. But finding ways to incorporate women was not easy, since there are few women academics interested in women's health issues, and only a handful of black women academics.

**Information Before Policy**

We decided that we should create a process of consulting with women to find out what issues were of concern to them, in order to get their voices heard about policy changes on these issues. We structured the Women's Health Project so that ideas expressed by women in these consulting workshops would feed into research we would undertake. However, within weeks we became aware that while women can identify problems they experience, they often lack the information they require, in order to debate policy options. At the first discussion held with women in Jane Furse, Emelda Boikanyo, our fieldwork coordinator, introduced the project and asked for women's responses to it. In response, a woman stood up and argued that Emelda should tell them all about cervical cancer. We knew that cervical cancer was an issue of concern to women. It had been raised repeatedly as we consulted women throughout South Africa about our research priorities. We wanted to look at the options for cervical screening programs. We found that most of these women did not know what pap smears were, their value, or if they had one. This experience made us aware that while our Project was primarily concerned with doing sufficient research to be able to intervene in policy formation around women's health, we had to build in an information component, before we could engage with women about their views (Ravindran 1993). In the case of cervical screening programs, the process of running information workshops with women made us aware that many women will avoid having pap smears even when they understand that these can prevent cancer. This is because the procedure itself is so invasive, and the women experience hostility from the health workers. This has led us to include the training and orientation of health workers as a central component in our policy proposals about introducing a national cervical screening program.

This process of research through offering information and listening to women's testimony and women's groups' reflections has given rise to a number of community-initiated actions. In addition, the process of hearing women's concerns has led us to initiate one research process which has been defined and planned by the women themselves from outset to finish. These two processes are described below.
Community Based Research and Action

Community Annotate Action: Struggling for Pap Smears: Parys and Jane Furse

Two of the women’s groups, one in Parys in the Orange Free State, and one in Jane Furse, asked Emelda to talk about cervical cancer, as indicated above. Emelda offered information in their language, in an incorporative, engaging educational style. She returned time and again to offer more information on this and other issues. This process built unity within each group around their health concerns. In both cases, women from the groups decided to confront their local clinics to demand pap smears. In both cases, the clinic nurses eventually agreed that the women could have pap smears. The usual problem of follow-up does not apply, because the women themselves understand the purpose and process of cervical screening. In one case, the clinic nurses themselves have now approached us to talk about gender and health in relation to their clinic work.

While this type of link between researchers’ need for information and community needs is very exciting, it does not come easily. The above description fails to detail the wide number of women’s groups which were not able to sustain regular meetings, whether because of violence and frequent funerals; or because of the antagonism of male leadership in their communities; or the difficulties of communication in the absence of telephones; or because of having too much work to do in too little time - the problems women face in organizing around issues of concern to themselves are endless. By implication, research under these circumstances has its constraints.

Community Controlled Research: The Rural Primary Health Care Fieldworkers’ Project

This project arose out of the responses of a number of women in rural development projects to my initial consultations. When I told them some of the issues other women had identified as priorities, they asked how the project would benefit rural women. Why wasn’t the project looking at their issues: women’s lack of assertiveness; lack of jobs, of water? They were very articulate about these issues and I asked each of them why they were not writing and contributing to policy debates. They replied that they had neither the skills nor time to do so. On my return to Johannesburg, I wrote to each of them, offering to facilitate a meeting of all the women concerned, where they could jointly identify the key policy issues, debate them and develop proposals. I also offered to train them in writing such material. At the first workshop the women developed aims and objectives for this project. They also decided who should participate and how the project would be structured.

Over the past two years, we have held a series of policy workshops on the identified issues including intersectoral cooperation, women’s empowerment, financing of development, the problems facing black women fieldworkers, the role of fieldworkers, the role of village health workers, and political affiliations in development work. The women have written
about their own work, and collective articles on the policy issues. I have played a questioning and editing role, as well as doing the logistical support of organizing venues, transport, photographers, etc.

A book will be finalized in October 1993. At that workshop we will also have training sessions in public speaking, to boost their confidence in preparation for launching the book. At the book launch in December, they will each speak about one of the policy issues covered in the book. In feminist terms, the key aim of this project was to create a context in which women "could name their own experiences for themselves in order to claim the subjectivity, the possibility of historical agency" (Fouche 1992; Funani 1992; Serote 1992;).

For me, this has been the ultimate experience in the role of researcher as "facilitator of community research", rather than as "researcher on a community". The opportunity of passing on my skills, and watching these most profoundly skilled women develop some of the tools to share those skills beyond the grassroots level, has been overwhelmingly gratifying. I have found the question of my own role very complex. In deciding who should write about the history and process of the project, I hoped the women would do it themselves; they insisted that I should do it, and that my role in making the project happen should be acknowledged. In retrospect, this is the most honest approach, although the temptation to paint the project as entirely controlled by the women, and to make my role invisible, remains. The discussions have helped me feel comfortable about acknowledging that the project is also my project, although in a different way. The legitimacy of my writing about the project and its methodology, as in this paper, is now clear to me, perhaps because of having the groups' "permission".

The project is illustrative that if "community control" means community members doing all aspects of the research, then this is an almost impossible goal to reach because of the resources and skills which are a requirement of research - whether access to a telephone and meeting venues or access to facilitating or editing skills, or having the confidence and knowledge about research to demystify research codes such that "non-academics" can do research. Of course, many communities have people within them who can facilitate these things, but most do not. Control over a process does not, however, have to mean the ability to do all these things. It can, as in this project, mean the ability to decide over the processes and to delegate certain aspects.

**The Limits of Participation**

These two projects sit very comfortably within feminist methodology and indeed with contemporary discourses on primary health care research and on health promotion which also argue that research and educational materials, respectively, should be developed by a particular local community for their own use. Much of the discourse on feminist methodology argues for research to be initiated by the "researched" themselves. It argues that research should be "emancipatory" or, at least, ensure that a woman who participates in
research "emerge(s) from that interaction more conscious of her world and thus, better able to act upon it" (Bhavnani 1993). Cook and Fonow (Humm 1990) argue that one principle of feminist methodology is emphasis on the empowerment of women and transformation of patriarchal social institutions through research.

The preceding section considered project work and research that developed directly out of the needs of women in our network. This type of research not only fits well within the ideals of feminist methodology, it is also an activist researcher's dream. Activist circles in South Africa have developed a strong commitment to "research from below". We argue that it is essential that research reflects women's views. Does a point not come, however, when one has canvassed the views of so many women, so often, that one is aware of the key issues? Also, is there not a place for research at a macro-level, about issues that affect more women than those in a specific community? In the absence of effective national women's organizations and national policy and programs to tackle problems which are broadly shared by the majority of women in South Africa, albeit with local specificities, we believe that it is important to carry out some research which, while arising out of the experiences and views of women, is not necessarily directed by a specific community.

**The Relationship Between Activism, Academic Work and Policy**

This section explores, through specific projects, the difficulties in balancing the value of community participation against the urgent need for policy proposals and advocacy in the present period.

**Policy Research**

In identifying priority issues for Women's Health Project research, reproductive health services came up repeatedly. While specific issues were presented as more of a priority for different women, the overall issue of inadequate and reproductive health services was a shared concern. In response, we set up a number of research projects. In this section, I am going to discuss how we have considered the question of participation in relation to four of these projects, although they are not all complete. My aim is, in relation to policy research, to explore the tensions between national policy and local level ownership, planning, analysis and implementation of research - where can these reinforce each other, and where are they different enterprises?

**Research Without Researched Community: Costing a Cervical Screening Program**

While cervical cancer was identified by many women as an area of concern, as described above, we could also have identified it simply by looking at existing statistics, although these covered limited geographical areas, on the prevalence of cervical cancer in South Africa, and the international literature on the effectiveness of cervical screening programs. In effect, I am arguing that we as feminist, anti-apartheid researchers and health
workers, also have a legitimate voice, and that arguing for the voices of women to determine research should not be used to exclude our own experience and commitments. Moreover, research to find out the cost-effectiveness of cervical screening, while not participatory, is essential if one is to engage with policy-makers for whom "rational choices" and "cost-effectiveness" are the primary discourse at the moment.

Research thus has a range of purposes, and whereas one purpose is to facilitate a specific struggle of a specific community, another, equally legitimate, is to facilitate national struggles around national policy. These two objectives are not always exclusive, but they are not necessarily inclusive either.

Research with Disparate "Communities": Women's Experience of and Response to Contraception and Contraceptive Services

In this case, again in response to our consultative process, we wanted to pursue the question of contraceptive services. We were all aware of abusive practices in the provision of contraception, but we had not seen any documentation of this. We wanted to know what women felt about contraception; to what extent they felt able to make decisions about having children; how they experienced and dealt with the services they used.

While we considered working with a particular community of women who were interested in the issue, we decided it was important to explore the range of women's experiences, as I discuss below. Nevertheless, this experience leads me to conclude that doing research "on" women, rather than work identified by a community of women to support their own specific struggle, does not necessarily mean exploiting those women.

We ran focus group discussions. At the end of each discussion we asked how the women had felt about the discussions and the women gave very positive feedback - they spoke about how marvellous it was to have the opportunity to talk about issues which are usually ignored. After each discussion we gave the women information and answers to questions which had arisen during the discussion. This gave them useful knowledge and dealt with many of their anxieties. At the end of the discussion we gave them each a gift wrapped, scented bar of soap as a token of our thanks. We promised to come back to them when we were finished the research so that they could hear what other women had to say. In all groups women, expressed delight at this opportunity since they are so removed from the experience of other women.

This example illustrates how, even in the absence of community initiated research, or research which will be immediately useful to a community, the research process can be enjoyable and beneficial to the "researched".
Research with Disparate "Communities": Developing Standards for Primary Health Care Women's Services

This project drew on the insights gained from the focus group discussions for the above research. The aim is to develop minimum standards for primary health care services for women, covering services, personnel and costs.

Again this research does not incorporate an initial process of consulting with women about the problems we should address because we, and others, have done lots of talking with women. The issues are clear. Moreover some of the issues are internationally recognized. It is using clinic sites which have local recognition as clinics of reasonable quality, as models. In addition to a literature review, and interviewing service providers at national, provincial and local levels, at each site we are conducting record reviews and observing interactions between health workers and clients. While this could be done in a way that is empowering of clinic sisters and women in the community in which each clinic is based, such processes of community participation take months of negotiation. Should we slow the pace of this project, which aims to draw national need norms, in order to ensure the process is "owned" by all role players at each site? Or do we engage with the health workers to the extent that they are happy with the aims and then get on with gathering the information? I am not suggesting that this latter avenue is ideal. The process of gaining permission from patients for us to observe the interaction between themselves and their health workers is particularly perfunctory and in no way empowering. I do not, however, believe that the approach we are using is either disempowering or exploitative. Moreover, the findings from each clinic will be given to health workers, and they will be able to use them should they so desire.

Community-Based Research to Generate a National Policy: Research Through Implementation of Women's Health Care at a Health Service Site

Coming full circle, our work on reproductive health services so far has led us to believe that our policy proposals need to be tested in real conditions. Part of the reason is that we believe that policy makers will take certain proposals more seriously if we can show that they can be implemented within existing services and cost constraints. We are now planning to implement a women's health service at one rural site. This returns us directly to questions of community control: both the community of health service users, and that of health workers employed at the health services. The project will have to be discussed with both communities (recognizing, of course, that those health workers who live in the area will also be represented in the service users community). We hope to work with these communities to identify their health service needs and to develop processes for meeting these needs. That said, we will be bringing in our information and ideas, gleaned, amongst others, from the projects described above.
This research will therefore once again be local level research, which lends itself to community participation and even community control. It will be most effective and responsible with this approach. We believe, however, that it will generate experiences that can be used at other sites because of the similarities between health services. Presuming that the process is successful, we will develop a manual detailing how the changes can be made. We will also use the findings of the costing and impact assessments to motivate for similar health service implementation elsewhere.

Policy Promotion

The issue of generating national policy out of a range of inputs rather than out of the victory of a national struggle, raises complex questions at the level of policy promotion. It arises most starkly in relation to abortion.

Abortion

A number of us in the Women's Health Project team have had illegal abortions. All of us are frequently approached by women who need abortions or advice about how to procure them. All of the members in our team would like South Africa to have a new policy on abortion which allows women the right to choose. The health workers in the team have known woman after woman who have died or become infertile as a result of back-street abortions and we are all aware of the international literature which shows that a safe abortion is safer than pregnancy; we are aware of the nightmare faced by both parents and children who are the product of unwanted pregnancy; we are aware that carrying our early abortions is cheaper than coping with the health effects of back-street abortions, the loss of schooling and future options for teenage mothers, and the children born as a result of unwanted pregnancies.

We know that at least 150,000 women (and estimates go up to 300,000) every year are having back-street abortions. Many women are increasingly developing the confidence to argue for the right to choose. But many women still feel constrained not to acknowledge their support of abortion because of the power of their religious background, and the overwhelming dominant social ideology which is against abortion. Antagonism towards the right for women to decide for themselves about abortion is one of the most powerful social inscriptions about women’s role in society.

So, if women do not express themselves in favour of the right to choose, do we, as a women’s health project, respect that as women’s opinion, and refrain from lobbying for a change in our abortion legislation? Do we wait until there is a stronger women’s movement and in the meantime simply make available information about the safety of legal abortions? Or do we go ahead, using international experience of the value of abortion for women, local
research which shows that women, across class and race lines have practised abortion since time immemorial (Bradford forthcoming), and our own experience and exposure, to argue for a loosening of the legislation?

We have decided to take this latter path. We believe it is the moral thing to do. But it is not based on a certainty, through research, that this position would be publicly favoured by the majority of women in South Africa. Indeed, research amongst nurses has shown them to be vociferously against abortion.

"Difference" and Participation

As discussed above, local level research lends itself to community control, whereas national research may not. In this section, I look at one interface between participation and difference. The example I use, the writing of the women's health handbook, is not a research project per se, but it requires the eliciting and analysis of information.

The Women's Health Handbook

The women's health handbook project encapsulates the contradictions around both confronting difference and facilitating participation in a very direct way.

We were fully aware that asking women to participate in the writing of a women's health handbook was not enough, since participation itself is determined by socio-economic and political factors that determine differences between women. An educated woman can write material for a handbook much more easily than a woman who cannot write, if writing is the means of participation; women in organizations, or with telephones, can link into a project much more easily than women without these mechanisms for communication. Thus participation is only a meaningful concept if it takes account of differences between women. In the case of the handbook, we conceptualized the process to facilitate a range of forms of communication, from mailing out requests for people to send us information, stories, poems and drawings, to informing rural women and all the women's groups we met about the handbook process, asking if they would like us to record the group's discussion and sometimes interviewing individual women from these groups who expressed the desire to tell their stories. In this way, both literate and illiterate women have been able to contribute. In addition, we have made it possible for academics, health workers and grassroots women to access the handbook process.

A more difficult question we have had to face is how much priority to give to the participatory process. Many women, with regional, cultural, colour and other differences, are contributing material towards the book. The process of giving priority to broad participation, in order to acknowledge difference and create a broad sense of ownership over the book, means that those participants cannot oversee and therefore have "control" in the final sense of the word.
The process of working with women on this book has involved ongoing reflection on the process of developing a sense of "ownership" over the book by large numbers of different women in different places, while managing the process centrally. While we have considered having a representative coordinating committee, in the absence of an inclusive national women's movement or women's health movement which could elect such representatives, choosing organizations which would be represented would itself end up excluding the majority of women.

The handbook project has to balance the importance of women, and especially those women who have least access to resources and whose voices are least heard, voicing their experiences through the handbook, and reflecting on their experiences by reading about women similar to themselves in the handbook, against producing a book which is useful for a wide range of women. We have chosen a middle road, where we give primacy in content and in target audience to rural African women, but we carry both content and stories about other women too. Our hope is that this process will facilitate an empathy between women across the cavernous divides of our society, without denying the real differences between us. We agree with Harding, that "members of the dominant groups, too, can learn how to see the world from the perspective of experiences and lives that are not theirs" (Lorde 1992). We hope that the way in which the handbook will acknowledge differences between women, and the power relations inherent in many of those differences, will allow the readers, in Lorde's words, "[to] develop tools for using human difference as a springboard for creative change within our lives" (Morgan 1981).

"Difference" at a Micro-Level

Thus far I have explored the problems of participation and its relationship to questions of difference. In this section I consider more micro-issues we have confronted in working with women with different "categories" of women in the same research project.

Research into Women's Experience of and Response to Contraception and Contraceptive Services

This research, as described earlier, aimed to develop a deeper understanding of how women experience family planning services. The key question we had to resolve from the start, was "which women?" Given the depth of the divisions in South African society, very few women, including feminists, will hold out gender as the primary contradiction in society. We were fully aware that services for black women were inferior to those available to white women, and likewise that middle class women could access private medical practitioners whom we assumed offer a better service. We wondered to what extent women's religious backgrounds affected their use of contraception. While most research about women in South Africa has focused on black, poor women, because they experience the worst oppression, we decided that rather than "studying down", in Harding's (1992) terms, we should explore the differences in experience between women across these divides - what is shared and what is
different?; does the power of the medical profession over women inscribe all women as ignorant about their health, or is this nuanced depending on the race or class position of the women, or the race, class or gender of the health service provider? What is the impact of the government's concern over population numbers on the "family planning" service it provides?

As a result, we decided to set up a range of groups, each reflecting a different "mix" of categories. Of the 12 groups, four were white, five African, two Indian and one "coloured"; six were working class, six middle class; seven were suburban or city-based, four from townships and one an informal settlement; some groups were young, some older, and their languages included Sotho, Tswana, English, Afrikaans and Zulu.

Having decided to explore differences in the attitudes and experiences of services amongst women of different groups, we then had to work out how to relate to all those different women. Following the literature on focus group discussions for research on reproductive health, we decided that we should choose members of our team who were most like the members of a particular group, to facilitate the discussion. This was a source of some agonizing, since we were all keen to hear what the range of women felt - to cut across rather than reinforce the boundaries. We felt that our own learning and exposure was being cut off by the decision to put "like with like". But our primary concern was that the women should feel comfortable enough to express their views, and given the tremendous cleavages in our society, this division of labour seem safest. This meant that we had to bring in one Sotho speaking woman to help with two groups, since Emelda was the only Sotho speaker. Bhavnani argues against this type of "matching", saying that differences between the researcher and people being researched sharpen the researcher's capacity to see existing power relations (Harding 1992). While this may be so, we were fully aware of the power relations and our aim was not to explore these, but to learn about women's feelings about contraception and family planning services, including some of the power relations associated with these. It was nevertheless clear to us that even with the same colour and language background, class differences make for very different lived experiences. The more similar we were to the group, the more open was the discussion. In addition, even the individual styles of different facilitators led to different responses from a group. So, we did the best we could, within these constraints.

Another dynamic we attempted to avoid in the focus groups was to set up the facilitators as people who knew more than the women themselves. Three members of our team were health workers - two nurses and one doctor. We knew that if the women in the groups knew they were health workers, the women may defer to the facilitators, and also they may be embarrassed in case they seemed ignorant. We therefore did not tell the women about the facilitators' qualifications. During the discussions, however, the facilitators would note issues that arose where the women needed information, and after each discussion they would offer the women the necessary information, and, if necessary or appropriate, indicate their qualifications to be passing on this information.
Finally, a complex issue which confronted us in relation to difference was how to conceptualize our questions. A member of the team conducted a literature review to draw our attention to key issues, and we drew on our own experience to decide what we wanted to explore. We then had to translate these issues into words that had the same meanings in different languages. We discovered that concepts like "choice" are not easily translatable. Whereas in English one could ask a group if they feel that they can choose whether or not to have a baby, in Zulu and Sotho this concept is inconceivable. We found that whereas in Zulu and Sotho one could explore the concept of "fertility", in English this term would feel awkward, and we replaced it with "how many children you have". The implications of this is that differences across culture are real; they are reflected in language itself, and cannot be simply translated away. Thus while we retained our aim of exploring different women's experiences, we had to be aware that the process of our framing the issues, translating and then translating back to English itself limited women’s responses; that to some extent, by posing the issues ourselves, we were framing the range within which women might reflect on the issues, yet trying to do so with a language that would be meaningful to them.

Conclusion

This report does not cover all of our work, nor does it address some of the most fundamental challenges around issues of difference. In particular, I have avoided that most stark of differences between men and women, even though there is increasing recognition in women's health circles that we (or should it be male researchers?) need to research and address men's experiences and concerns given their power in relation to women.

The report has reflected on two themes in feminist methodology, participation and "difference" through the experience of the Women’s Health Project as a whole, and a number of its projects. I have shown how different projects within the overall Project reflect choices to favour each of these principles in different ways. I have argued that while these principles are valuable, they are not the only values on which research or other women’s projects should be judged. I have argued that a real tension exists between control or ownership and national participation, and presented some of the avenues we are exploring to mediate this tension.

References

Bhavnani, K., Tracing the contours: feminist research and feminist objectivity. Women’s Studies International Forum 16(2), pp 95-104.


Women’s Health Project, 1992. Newsletter No. 4, November.

**Endnotes**

a. This said, however noble our intentions, developing policy which attempts to meet women’s needs does not mean that one achieves instant equity. Continuing with the example of cervical cancer, a proposal for national cervical screening within the public health system does not change the context in which the rich have access to better health services than the poor. We modelled the costs of a national pap smear program, taking into account existing levels of skills and technology, and concluded that a program should be implemented with a five yearly screening interval. We hope that this will adequately balance the costs against the advantages. Even this proposal is meeting with resistance amongst some health service providers who argue that it is too expensive, and that we do not have the infrastructure to facilitate follow-up. Should we succeed in getting it implemented, we will still have a situation in which many middle class women are having pap smears on a yearly basis, and the majority of women are only having them every five years (and even with this group, there will be a spectrum where urban women have more access than rural women).
b. We are becoming aware that some women express antagonism to abortion not because of their religious concerns, but because their knowledge of abortion is limited to unsafe backstreet abortions. Information about the ease, safety and cheapness of legal abortions can therefore shift the views of these women.

c. At the time of writing, although many political organizations are aware that abortion may be an election issue, they are mostly avoiding it. The Inkatha Freedom Party is the first party to present a policy allowing choice for abortion. The ANC argues that it does not want to take a stand on the issue at this stage, but it will probably decriminalize abortion. The first organization to take a public pro-choice position was the Black Sash, a human rights organization of women, which put out their policy in April 1993. Given their powerful record in human rights, and their policy’s assertion that people should have the right both to lobby against abortion that health workers should not be required to do abortions and that people who are against abortion should make it their business to work for social conditions in which women do not feel compelled to have abortions, this policy is proving very useful for other organizations who are trying to lobby for a loosening of the present legislation.
Maternal and Child Health Care in Teso, Uganda: Social Issues

Hellen Rose Atai-Okei

This paper is not comprehensive. It is written mainly within the Teso, Uganda experience. It was not possible to compare our situation with that of other countries, particularly to consider how other countries have addressed the issue of maternal and child health care. The writer would like to apologise for any errors.

The purpose of this paper is to inform those in leadership positions in the health field, in government, and in community activities at national, district, and local levels, of the prevailing health situation of women and children. It is hoped that this will further expand and improve health care of women, infants, children, and youth in Teso in particular, and Uganda as a whole, and also throughout the East African region.

Introduction

Teso consists of two districts located in north-eastern Uganda, and has a population of about 700,000 people. Women and children comprise almost 75% of the people living in Teso. Yet, they are the most vulnerable people living in the two districts in terms of poor nutrition, toxic substances, infection, poor sanitation, crowding, inadequate health care, and/or lack of education.

From the foregoing statement one might expect that the health care of women and children in Teso and other similar areas would be given maximum attention. This, however, is NOT the case - particularly in Teso. The need for an increased effort to expand and improve the health status and care of women and children is quite overdue.

A number of initiatives, such as UNICEF's Child Survival & Development Program, have resulted from a growing international and national concern for children's health. No such programs exist to focus on women's health. In spite of the number of "official" health conferences, seminars, and workshops organised in the name of women's health in Uganda, little has been accomplished to date in terms of measurable improvement in the status of women's health or in the accessibility of health care to women. Indeed, these conferences have been used solely for media coverage by politicians who have little genuine concern if any advancements are made for the general population.

1Chairperson, Ateki Women Development Association, Kampala, Uganda.
Some safe motherhood seminars have highlighted the appalling high maternal mortality rates in Teso, Uganda. These seminars have tried to draw the attention of policymakers to the need to plan programs for the reduction of maternal mortality, but all seems to have fallen on deaf ears.

In addition to the ineffectual high-level seminars/conferences that have been held without result, much research has been funded and carried out on women's health. Research results, however, have not been put into practice in maternity hospitals or in rural medical clinics. Many of these hospitals and clinics, in fact, have never heard of any of these health initiatives, nor such programs existing in their areas. In turn, much of the research is carried out by men in international departments, Makerere University, or medical schools where they remain removed from the grassroots health problems of women.

In summary, it is evidently clear that none of the high level initiatives are reaching the local population, especially women and children.

Social Issues

The Living Environment

For most Iteso people living in Uganda, the subsistence environment is still a rustic home on a small plot of land in a rural area. Daily life is touched little by government services or ideas. The most important institution is probably the church. The Resistance Committees serve as an effective channel for communication and community integration.

The Economy

Attempts by the government of Uganda to improve the economy will likely bring long-term benefits to the country. In the short-term, however, concentration on stimulating the income-producing sector, and consequent low budgets for social services, produce suffering for many individuals in the country and especially Teso. Low salaries tend to lead to corruption and inefficiency. On the other hand, not all of the limited funds budgeted for services that would most directly benefit women and children are actually released. It would appear that funds might be better utilised if policy-makers had more orientation toward the relationship between economic productivity and health and educational status, as well as on the economic benefits of preventive as compared to curative services.

Health Situation of Children and Women

The analysis of the present health situation is seriously inhibited by the lack of reliable data, which also limits the validity of any predictions made for the future. Available information only indicates the magnitude and relative importance of a few diseases. Nevertheless, available statistics and surveys help one to conclude that women and children in Teso, Uganda are at high risk of premature death.
Many maternal deaths could be prevented if women had better access to antenatal and postnatal care, and were able to deliver their children in hygienic conditions, whether at home with trained birth attendants or at health units. Research shows that pregnancy and childbirth claim the life of one woman in 21 in Africa. This figure may be higher in Teso. In addition to those who die, others suffer debilitating consequences such as chronic disability and poor quality of life. In Teso in particular, increases in the risks associated with pregnancy and childbirth have been aggravated by very large rises in the number of births. Women's social and economic position is made even worse if they have a child in their teens, particularly if they are unmarried, a situation that is far from uncommon in Teso. Pregnancy poses special health risks for teenage women, especially those under the age of 15. The health risks are even greater for poor teenagers since their physical condition is generally worse and they are less likely to have information about antenatal and postnatal care.

In Teso, family planning is available to far too few women. This has had terrible consequences for their health. Early teenage marriage is the rule for most of Teso and elsewhere in Uganda. It appears that many men value having many children at the expense of risking the lives of young wives.

Poor health of women during pregnancy compromises the health of fetuses. It is estimated that 115-120 children out of every 1000 born alive will die before reaching their first birthday. Preventable communicable diseases are the main cause of child death in Uganda, although poor nutritional status is also an important factor. Lack of access to appropriate, timely treatment, and the inability to take advantage of preventive services are also at the root of many child deaths. Female children sometimes suffer additional health problems due to the unequal allocation of household resources, which results in excess mortality during infancy and childhood. Combined with high maternal mortality, this illustrates the pattern of vulnerability for women and children that develops during pregnancy and continues especially during delivery and the first few months of life.

The Health Care System

Health services provided by the government are inadequate to meet the needs of the majority of Uganda's population in general, and Teso in particular. Health facilities are poorly distributed, personnel and financial resources are concentrated in urban hospitals, and transport, medical supplies and equipment meet only a small share of the demand. As a result, most people prefer to treat themselves, consult traditional healers or neighbours, or pay for treatment at non-governmental clinics rather than attend government health units. The most affected are women and children.

Health Policy Programs

Efforts by the government of Uganda to develop a national health policy are a very welcome development. The draft policy appears to emphasize primary health care.
Currently, the strongest health programs are those with this orientation and strong donor support, but a disproportionate share of government funding still goes to hospitals. Because of the lack of strong government policies, donors have therefore provided the major impetus for most health initiatives. Vertical programs tend to be established as a rapid, effective way to address priority problems.

Recently, the Ministry of Health and international donors have begun to address the problem of integration of health programs. Much work remains to be done to provide a balanced package of Maternal and Child Health care at the local level (for example, Teso), and the Ministry of Health should ensure that new initiatives are fully incorporated into existing health structures.

**Education**

Many people in Teso value the education of their children. This is demonstrated by their willingness to construct schools and contribute substantial resources to support the education system. Nevertheless, while more children attend school each year, the quality and appropriateness of the education they receive appears to be declining. Government finances are insufficient, and donor interest in filling the gap between needs and means has been less than in the health sector. Those children who complete some years in school may be frustrated because no formal employment is available to match the knowledge they have gained, while their education has left them unprepared to return to an agricultural or self-supportive life.

A very critical problem is the under-enrolment of girls, considering the direct relationship between the level of a mother’s education and the health status of her children. To aggravate the problem, most of the vital health information a future mother requires is not introduced until Primary level. What needs to be addressed and clarified, (apart from the obvious economic factors), are the social and cultural determinants behind parents’ reluctance to encourage their daughters/girls to remain in school. Otherwise, the introduction of appropriate health and child care topics at lower ages should be encouraged.

Sex education is virtually non-existent, and if it exists in any locality in Teso, then it is insufficient. Information about sex and contraception, though often incorrect, is mostly passed on by peers in school.

**Women’s Situation**

A female in Teso, Uganda leads a more difficult life than her male counterpart. This is evidenced by the longer hours she works, the more economic responsibilities she has, and the additional health risks she faces due to childbearing. She is less likely to go to school and thus be able to improve herself. Above all, she has few opportunities to participate in community activities.
Despite the government’s recognition of these problems, positive moves to improve the lives of women are being implemented very slowly. Many government programs are not targeted to women, even though women are the main participants. Much work therefore remains to be done to help society recognise the important role women already play in Teso/Ugandan life and to give them the self-confidence and economic support they need to improve their situation.

**Water and Environment Sanitation**

Among the necessary prerequisites for protecting the health of women and children are safe water supplies and sanitation. The government of Uganda tries to commit major resources and channel donor interests to this sector. However, the distribution of resources is heavily biased toward urban residents who are already better served. Planned level of investment can hardly provide 30% of the national population with access to safe water by 1995. Increasing investment in rural water supplies to reach larger areas of Teso, Uganda is still a major challenge for the government.

**Communication**

Mass media are very poorly developed in Uganda, and do not reach the majority of the population. Most communication is done through informal and traditional ways, particularly personal communication. Public education programs need to identify channels of communication that will look beyond mass media to reach the rural people. Many rural people are too poor to buy a local newspaper, let alone a radio set. Women tend to be more disadvantaged because they have little time to listen to radio or read a newspaper. Furthermore, many women are unable to read newspapers, even if they have the time.

**Strategies for Improving the Situation of Women and Children**

To change the situation of women and children in Teso, Uganda, the government, the international community, and the community must work together to find new ways to revive the economy and redevelop the social and physical infrastructure.

**A: Action in the Short-Run**

In the short-run, all parties concerned must work together to ensure that the children of Teso, Uganda, grow up as healthy and well educated as possible. There is much that can be done to make more effective use of the existing resources, and low-cost interventions can be introduced that will have an immediate impact on the direct causes of morbidity and mortality.

Strengthening sustainable control programs and increased involvement of communities in their implementation, can reduce morbidity and mortality due to malaria, diarrhoea, and acute respiratory infections. Ugandan women need special help to develop their potential.
through reducing their workload and providing opportunities for them to increase their cash income and further their education. They must also be more fully involved in local decision-making, and have access to the information they need to be able to protect their families.

**B: Action in the Long-Run**

Interventions are required in the long-run to address the indirect causes of maternal and child deaths, including inadequate social services and communications, under-utilisation of health care, low standards of female education, and the inefficient use of women’s time.

**The interventions could include**

- Sensitisation of policy-makers toward a redefinition of "productive" sectors of the economy and the development of sensible ways to finance needed social services.
- Improved informal public education and increased quality and relevance of the education system to ensure that women have the knowledge and skills to improve their home environments, and to care for themselves and children.
- Increased opportunities for women to generate income to supplement subsistence farming. Activities to improve women’s economic opportunities, education, and health should be encouraged in order to advance women’s status.
- Increased research in Maternal and Child Health care, reproductive sciences and other related health sciences. There is also a need to build local research capacity.

These measures would definitely provide mothers with improved opportunities to participate in community affairs and see that favourable local and national policies evolve for the nurturing and development of the next generation of Iteso, Ugandans.

**References**


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):
• 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 policies 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 practices, 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

219
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>Race and Gender</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Whites</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td>Coloured</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Asians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blacks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Totals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RSA Totals</td>
<td>2,218,751</td>
<td>2,307,939</td>
<td>1,381,060</td>
<td>1,466,262</td>
<td>420,836</td>
<td>434,402</td>
<td>8,908,404</td>
<td>9,366,146</td>
<td>12,929,051</td>
</tr>
<tr>
<td>Provinces:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cape</td>
<td></td>
<td>589,917</td>
<td>631,448</td>
<td>1,172,838</td>
<td>1,244,709</td>
<td>20,210</td>
<td>19,661</td>
<td>903,290</td>
<td>932,340</td>
</tr>
<tr>
<td>Natal</td>
<td></td>
<td>261,711</td>
<td>271,556</td>
<td>43,993</td>
<td>47,712</td>
<td>326,074</td>
<td>339,932</td>
<td>394,409</td>
<td>388,766</td>
</tr>
<tr>
<td>Transvaal</td>
<td></td>
<td>1,203,396</td>
<td>1,235,766</td>
<td>131,083</td>
<td>140,610</td>
<td>73,956</td>
<td>74,303</td>
<td>3,024,128</td>
<td>2,746,774</td>
</tr>
<tr>
<td>OFS</td>
<td></td>
<td>161,199</td>
<td>166,566</td>
<td>31,394</td>
<td>31,395</td>
<td>356</td>
<td>288</td>
<td>808,585</td>
<td>729,586</td>
</tr>
<tr>
<td>Self Governing States:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KwaZulu</td>
<td></td>
<td>458</td>
<td>407</td>
<td>842</td>
<td>817</td>
<td>147</td>
<td>120</td>
<td>2,072,673</td>
<td>2,431,574</td>
</tr>
<tr>
<td>KaNgwane</td>
<td></td>
<td>171</td>
<td>147</td>
<td>286</td>
<td>258</td>
<td>8</td>
<td>19</td>
<td>203,953</td>
<td>241,134</td>
</tr>
<tr>
<td>QwaQwa</td>
<td></td>
<td>30</td>
<td>29</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>9</td>
<td>138,534</td>
<td>175,264</td>
</tr>
<tr>
<td>Gazankulu</td>
<td></td>
<td>637</td>
<td>648</td>
<td>42</td>
<td>35</td>
<td>9</td>
<td>4</td>
<td>299,121</td>
<td>388,185</td>
</tr>
<tr>
<td>Lebowa</td>
<td></td>
<td>1,178</td>
<td>1,328</td>
<td>515</td>
<td>660</td>
<td>64</td>
<td>62</td>
<td>924,906</td>
<td>1,172,777</td>
</tr>
<tr>
<td>Kwandebele</td>
<td></td>
<td>54</td>
<td>44</td>
<td>67</td>
<td>66</td>
<td>4</td>
<td>4</td>
<td>138,805</td>
<td>159,746</td>
</tr>
<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>
<td>434,620</td>
<td>12,686,396</td>
<td>13,934,826</td>
<td>16,711,563</td>
</tr>
</tbody>
</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>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 - 14</td>
<td>541,274</td>
<td>517,357</td>
<td>482,155</td>
<td>478,167</td>
<td>130,318</td>
<td>125,998</td>
<td>3,066,115</td>
<td>3,109,162</td>
<td>8,450,546</td>
<td></td>
</tr>
<tr>
<td>15 - 44</td>
<td>1,076,193</td>
<td>1,082,755</td>
<td>721,296</td>
<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>
<td></td>
</tr>
<tr>
<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>
<td>2,765,909</td>
<td></td>
</tr>
<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>26,095</td>
<td>442,097</td>
<td>1,905,112</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,221,009</td>
<td>2,300,822</td>
<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>
<td></td>
</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>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal Mortality:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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>Symphsiotomy</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


223


Gender and Household Health Seeking Behaviours

Jane Kwawu¹

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 caretakers 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


Working Group Discussions
Working Group I - Gender and Disease

Part I: Identification of Gaps in STD/AIDS Research with Respect to Gender Differentials

The group decided to look at STDs/AIDS and Tropical Diseases separately. The rapporteur gave a summary of the gaps in STD/AIDS research which had been raised by the earlier presentations. To foster discussion of these and further gaps, it was decided that each working group participant would write down the research gaps in AIDS/STD research as she or he saw them. These gaps were then read aloud and classified by general categories which had been identified by the group. The following is a summary of the contributions by the participants:

1.0 Health Services

1.1 Linking awareness-raising on STDs with health care provision - building capacity to cope with demand
1.2 How to improve case reporting
1.3 Effective and acceptable ways to improve identification and treatment of STDs in women - implementation of treatment protocols on STDs by health providers
1.4 Integration of AIDS into STD control programs and services
1.5 How to improve health resource allocation and access to health care, including treatment seeking behaviours

2.0 Stigma

2.1 How should research address the issues related to stigma which is attached to STDs - including how it impacts on care and coping for women and men, and health providers attitudes towards those suffering from STDs
2.2 How to design interventions to reduce blaming women for STD transmission

3.0 Condom Usage

3.1 Further research on use, acceptability, complications of the female condom and other female methods of prevention
3.2 Spaces for women to practice safe sex
3.3 How to increase and improve condom usage and availability
4.0 **Sexuality**

4.1 Alternative approaches to the treatment of STDs, for example, traditional practices by women
4.2 How to empower women to say "no" to men - including husband-wife communication regarding sexual behaviour and preventive measures
4.3 What socio-economic and cultural factors put women at greater risk of HIV and STD infection than men - including strategies to counter socio-cultural behaviours that promote spread of AIDS
4.4 Male sexuality
4.5 Traditional forms of resistance to sexual exploitation of women
4.6 Perceptions of health
4.7 Approaches to community-based sex education
4.8 Is there a need to take a look at our value system in relation to AIDS and STDs?
4.9 What is it that makes people remain in a relationship even at the risk of death?

5.0 **Legal Issues**

5.1 Legal rights of women with HIV

6.0 **Intervention**

6.1 Improving understanding of STDs, especially non-HIV, among older children and young adolescents - including use of traditional routes in awareness-raising on sexuality
6.2 Gender-sensitive approaches to improve communication on relationships between HIV and AIDS - depth of knowledge regarding HIV and AIDS as distinct from general awareness
6.3 Socio-economic impact of STDs/AIDS
6.4 Threshold of health care seeking behaviour in terms of convenience of health care provisions
6.5 Intervention studies on detection and treatment of STDs among in- and out-of-school adolescent females
6.6 Who is best suited to influence behaviour change
6.7 Ways and channels of reaching rural women with AIDS/STD control messages
6.8 Counselling services that suit women
6.9 The impending problem of orphans

7.0 **Policy Issues**

7.1 What are the elements required to develop a national AIDS policy?
7.2 Impact of foreign/donor money on shaping the AIDS research agenda
7.3 Process of alliance-building between community and policy-makers
Research on appropriate strategies for mainstreaming women’s empowerment so that it becomes a national agenda for African governments.

Is AIDS a vertical program? Integrating the AIDS program into a comprehensive strategy based on the PHC approach.

Following the classification of the participant-identified gaps, each classification group was discussed. It was agreed that it was difficult to classify every gap, given the degree of overlap in many of the categories. The point was raised of the necessity of taking a lifecycle approach in the study of AIDS/STDs. What are the constraints for women during any particular stage of their lives? Taking a purely "reproductive" angle would prove to be inadequate, and misleading, for this type of research. As a result of the ensuing discussion during which it was agreed that the life-cycle approach would be the most appropriate, the gaps in AIDS/STD research were re-examined under the following headings:

- **Adolescents and young children: new preventive strategies**
- **Sexuality**
- **Traditional medicine**
- **Empowerment and self-esteem in sexual relationships to propagate preventive measures**
- **Orientation of health care providers to be sensitive to STD/HIV in women**
- **Development of women-centred methods of prevention and control**
- **Stigmatization of women at both the community level and the health service level**
- **Lack of gender-sensitive policy: Role of donors/funders to do gender-sensitive research**
- **Vertical AIDS programs with community effects**
- **Legal literacy on HIV/AIDS/STD rights**

During further discussion, AIDS "victim" terminology was noted as being insensitive, both to those with AIDS' and for their families. Suggestions of more sensitive terminology included "people living with AIDS", or "people affected by AIDS". This discussion led to the identification of a further gap in the research, consideration of sensitization of people with AIDS and those living with them.
Part II: Identification of Gaps in Tropical Disease Research with Respect to Gender Differentials

Discussion of the gaps in tropical disease research followed a similar process to the AIDS/STD discussion. Each participant was asked to identify some gaps in the research. Each gap was then classified. A general discussion followed the classification, and it was agreed that the headings below best categorized the gaps in tropical disease research. The following is a summary of the contributions:

1.0 Health Services

1.1 Legalisation of safe abortion
1.2 The effects of workload on the health of women
1.3 Drug resistance to TD treatments
1.4 Research on the traditional, informal and formal health care systems from the affected women’s and children’s perspective
1.5 Gender-based research on attitudes of health-care providers towards women and children affected by tropical diseases
1.6 Innovative methods of drug distribution to reach remote areas
1.7 Women’s interaction in health care facilities

2.0 Stigma

2.1 Studies on the consequences of tropical diseases that confer stigma on girls
2.2 Effects of signs of tropical disease infection on girls’ schooling

3.0 Recognition/Understanding

3.1 Identification of TDs in sub-endemic areas
3.2 Hidden manifestations of tropical diseases in women
3.3 KAP studies on causes and prevention of TDs

4.0 Coping Mechanisms

4.1 Research about support systems at local, national, and international levels available to women and children affected by TDs
4.2 Research on the attitudes/relationships among women who are closely related to other women affected by tropical diseases
4.3 How to improve partner sharing in actions to prevent and treat tropical diseases

5.0 Pregnancy and Tropical Diseases

5.1 Association between tropical diseases and infertility
6.0 Prevention/Intervention

6.1 Targeting women in marketing of new prevention/treatment options
6.2 Understand, improve and build upon use of traditional ways of managing tropical diseases
6.3 The effects of self-medication to women’s health
6.4 How to develop sustainable community-based interventions
6.5 Development and evaluation of vaccines against tropical diseases, and aspects of their effects on women
6.6 School as an entry point for tropical diseases education and prevention

7.0 Policy

7.1 Re-defining tropical diseases
7.2 How do we get women to be involved in decision-making in all levels of health services, given that they are the majority of staff and a majority in the population
7.3 Legal protection of patient’s rights
7.4 Initiation and promotion of programs to include dermatology into PHC services

8.0 Culture

8.1 Cultural norms and practices which institutionalize women’s exposure to tropical diseases

Following this classification, a general discussion ensued in the group on the nature of health care workers, and at what level has a village learned to cope with disease.
Working Group II - Health, Environment and Gender

Part I: Identification of Gaps in Health Research with Respect to Gender Differentials

Each working group participant was asked to identify five research gaps pertaining to Health, Environment and Gender. The following is a summary of the contributions by participants:

1.0 Mental and Psychological Stress Issues in Occupational and Environmental Health

1.1 How to measure mental and psychological stress
1.2 Gender differentials in the manifestation of stress
1.3 Assessment of mental health facilities in the workplace
1.4 Methods of treating psychological trauma in the living environment as a result of ethnic and racial conflict

2.0 Gender Issues in Health Interventions

2.1 Assessment of the availability, effectiveness, and the gender sensitivity of occupational health services in the workplace and in the living environment (e.g. factory health facilities, primary health care, preventive health facilities)
2.2 Assessment of availability and access to health care facilities, child care facilities and transportation
2.3 Assessment of education and knowledge/awareness of occupational health issues (knowledge of policy makers, planners, researchers, employers, community workers and families)
2.4 Assessment of awareness creating interventions
2.5 Impact of gender specific community development programs

3.0 Legal Issues

3.1 Assessment of protective legislation and the extent to which it fully addresses the needs of the female worker
3.2 Assessment of occupational health legislation and policy
3.3 Access of workers to information/knowledge of their rights (ILO Conventions, National laws)
3.4 Enforcement of laws on occupational hazards and compensation
3.5 Reproductive rights and occupational health
3.6 Trade unions and collective bargaining issues and conditions of terms of services
3.7 Occupational health impacts in developing countries of stricter environmental laws in developing countries

4.0 Policy Issues

4.1 Gender sensitive analysis of occupational and environmental health policies
4.2 Dissemination of research and policy issues
4.3 Follow-up interventions in policy research

5.0 Funding Constraints in Occupational and Environmental Health Interventions

5.1 Research grant limitations
5.2 Funding for occupational and environmental health

6.0 Workload

6.1 Impact of cumulative workloads on women’s health
6.2 Impact of gender specific community based projects

7.0 Sectorial Issues

7.1 Effects of migrant labour and resultant separation of spouses on women’s health
7.2 Effects of secondary employment
7.3 The rural environment needs to be more fully addressed
7.4 Studies of gender and occupational health issues in the informal sector of the economy

8.0 Indigenous Knowledge

8.1 Data on women’s perceptions of diseases
8.2 Data on women’s knowledge on their own health

9.0 Household Environmental Health

9.1 Gender differential impacts of environmental degradation on health

10.0 Gender Relations and Their Effects on Women’s Health

10.1 The contribution of gender relations in the household to diseases and health seeking behaviour
Part II: Application of Gender Analysis Methodologies

After research gaps were identified, the group was asked to look at the application of gender analysis methodologies. The group engaged in two main activities:

- a discussion of methodology and various research tools, their characteristics and their uses in gender sensitive research; and
- the preliminary design of a research project on gender differentials in the manifestations of stress in a hypothetical textile factory.

a) Discussion of Methodology and Research Methods

- It was pointed out that the success of research depends very much on: (1) the purpose of the research; (2) phases; (3) what you want to discover/ the final output; (4) skills of researchers; and (5) resources available.

- The purposes of research include: (1) the gathering of information; (2) evaluation function and follow-up; and (3) baseline research and implementation.

- There are two main types of research: (1) qualitative - more flexible, in-depth information and it also entails the use of rigorous procedures in the choice of samples; and (2) quantitative - identified as statistical in outlook; useful for quick collection of data (popular for policy-makers).

- Two main techniques for gathering data were discussed: (1) observation; and (2) interviews.

- In addition, the following issues were discussed: (1) the use of participatory techniques; (2) methods and tools can be combined in one study to strengthen the study; (3) the need for gender sensitivity (choice of topic, sample size and composition, choice of interviewers and researchers, desegregation of data and gender analysis of data); and (4) the importance of multidisciplinary teams.

b) Preliminary Design of a Research Project on Gender Differentials in the Manifestations of Stress in a Hypothetical Textile Factory

After the general discussion on methodology, the group was asked to identify the most important research gap. The top issue identified by participants was mental health. Specifically, the group decided to look at gender differentials and manifestations of stress in the workplace.
The general objectives of the research would include: (1) to identify the prevalence of stress in the workplace; (2) to identify gaps between factory and national policy on stress and stress situations in the factory; and (3) to influence policy on psychological and mental health.

With regard to this last point, there were numerous references made concerning the need for policy changes. This focus demonstrates the desire to make a difference and engage in research that matters. Doing good research does not mean that it will be implemented. When formulating design, it is important to look at the interaction between research and policy.

The specific objective of the research would include: (1) to identify levels of stress; (2) to identify how stress is perceived and understood by different operatives; (3) to identify manifestations of stress; (4) to look at mechanisms for dealing with stress at the level of workers and management; and (5) to look at the exploitation of females versus males.

Two assumptions were made with regard to the research: (1) there had been a request for an investigation into the prevalence of stress in the factory; (2) a literature review has confirmed the need for such a study.

With regard to the research design, it was decided that the research would look at a hypothetical textile factory with 1000 workers. There are 100 managers (1% female) and 900 workers (75% female) at this hypothetical factory.

Two phases of research were suggested. It was also recommended that the two phases might be done together for financial and "political" reasons.

With regard to the methodology, the group agreed on a qualitative approach.

Phase I would involve a preliminary study of phenomenon of stress in the factory. The following tools were suggested: (1) focus groups; (2) case histories; and (3) factory records (accidents, complaints to unions, absenteeism). This phase would also include research to record the physical conditions of the workplace (for example, noise levels, lighting, chemical pollution and other matters).

After analyzing phase I results, phase II could begin. Phase II activity would include administering a standard qualitative questionnaire to both men and women, in a sample size of 20%, with questions on gender issues.
• Sample questions could include: the character and duration of the work and responsibilities; secondary source of income, if any; sex of supervisor; sexual harassment; wages and terms of employment; work conditions.

• There would be a longitudinal study, of 6 months duration. 3 different groups of factory workers (all female, all male, and mixed) would be brought together for group discussion. The agenda of the group discussion would be determined by the interests of the group members. It was noted that it is important to be aware of gender dimensions when conducting group discussions.

• It was also suggested that some laid-off employees could be interviewed for their insights into stress.

• With regard to data analysis, it was noted that: (1) gender desegregation is essential; (2) there would be an evaluation of the research data, as well as the impact of the research process on workers.

• The importance of bringing research results back to the workers was highlighted. As a follow-up to the longitudinal study, researchers should go back to the workers, ask them what changes they want, and try to help create a group for support.

• It is important to note that this design is incomplete and is only trying to highlight issues of concern in gender research on stress.
Cross-Cutting Issues

There were a number of issues raised throughout the workshop that are relevant to all four working groups. These include the following:

• The question was raised concerning whether or not gender discrimination is any different than other forms of discrimination, or if it is just one of many inequalities. Another participant stated that, while there are inequalities relating to race and class, it is important to focus on gender. Women suffer most regardless of race or class.

• Many participants advocated more work on the health of the girl child and adolescent. Indeed, a lifespan perspective should be adopted, looking at the woman from childhood until old age. Participants also stressed that more attention needs to be placed on emotional and mental health issues.

• Much attention was given throughout the workshop to the socio-economic aspects of illness and the role of poverty. Poor people are at greater risk of disease. For example, researchers need to look at how female nutritional status may affect the way they recover from disease. Also, female poverty means less money is spent feeding children, and that these women and children are unlikely to get to a health centre for appropriate care. One participant responded that we cannot take on everything, that there are other programs looking at income generation. However, the need to contextualize health data, and place health issues within a broader socio-economic context, was reiterated. If this is not done, key issues will be overlooked.

• It was noted that the workshop had successfully moved beyond the traditional focus on women's reproductive health. Women must be seen as human beings with needs and desires that relate to them personally as women. Research with regard to women should aim to empower women as individuals, as people in their own right, without always looking at their role as nurturers.

• The importance of recognizing similarities in the gender differentials from country to country, across the African continent, was emphasized. Researchers need to be careful to avoid duplication.

• The importance of family was emphasized. Differentials tend to show up most clearly in the family. The family is where disease often originates and this is where interventions should focus.

• There were many suggestions concerning the need to improve on health services and personnel. For example, more training should be provided to sensitize health workers on women's health needs. Male health care workers sometimes lack concern for women's health
issues. Health personnel may not recognize the serious implications of some diseases for women; for example, the devastating impact of some skin diseases, and their effect on women's health and well-being, has been largely overlooked. Women's health issues should be better integrated into primary health care (prevention of STDs/AIDS, mental health, general question of stress). Women's lack of economic independence, self-esteem and education are other key issues facing health services. Finally, more thought must be given on where to target health education information. Men tend to be the recipients of information and may not tell women, or may tell them inaccurately.

- The importance of sharing health knowledge in the school system was highlighted. However, another participant warned that schooling often creates more ignorance than we dare to admit. School often takes away from common sense that is held by the people in the community. Therefore, we also need to understand and give credence to community knowledge.

- Finally, mechanisms are needed to encourage young people to get research experience. For example, small grants programs were advocated, which could help to improve the capacity of young researchers to focus on gender issues.
Related Topics and Initiatives Informally Presented at the Workshop
Global Commission on Women’s Health

Maureen Law

Background


- Approach adopted in addressing women’s health: roots of women’s vulnerability, risk factors they face, biological differences between men and women, socioeconomic factors, discrimination - these all culminate in poor health status throughout their lifespan.

Publication Women’s health: across age and frontier used as background document.

Resulted in resolution WIIA45.25 Women, health and development, calling for inter alia the establishment of a Global Commission on Women’s Health.

Global Commission on Women’s Health - Terms of Reference:

(a) produce an agenda for action on women’s health;
(b) make policy-makers aware of women’s health issues using sex-specific, desegregated data on women’s socioeconomic and health conditions;
(c) advocate promotion of women’s health issues within all developmental plans, using all mass media;
(d) provide a forum for consultation and dialogue with women’s organizations, health advocacy groups, and others who represent the mobilization of women, from the grassroots to the highest political levels;

1Director-General, Health Sciences Division, International Development Research Centre (IDRC). On behalf of Dr. A. El Bindari Hammad, World Health Organization, Geneva.
Preparation for the Global Commission on Women’s Health

July 1992: The Director General of WHO established a Working Group to implement resolution and act as Secretariat to Commission

- Agreed on grassroots strategy where activities at country and regional levels culminate in the Commission itself
- Commission to capitalize on existing networks of institutions working at country and regional levels
- Collaborate within WHO technical programs and UN agencies to quantify existing knowledge before research into gaps in priority areas is initiated.

March 1993: Inter-agency/interregional meeting held at WHO/HQ

1) Reviewed existing endeavours to improve women’s health status.
2) Proposed areas for action which will
   (a) move from advocacy to practical interventions which will lead to marked and sustainable improvement in women’s health and lives;
   (b) form a common set of areas which lend themselves to regional variations in type and severity of health issues;
   (c) seek to enhance the empowerment of women in deciding on their own lives.

Areas for Action

Information

Examples

- Sex-desegregated data
- Making information available to women to better understand the health risks they face at different times in their lives and options and services available to them.

Access to Quality Care

Examples

- Care for women when they are sick
- Facilities to provide care to sick and dying members of family
- Home-care facilities to assist care-providers
Women’s Perspectives in Development Technology

Examples

- Design of technology to be used by women
- Involvement of women in development of technology
- Involving women in clinical trials

Resources

Examples

- Quality services targeted to women
- Services responding to specific health conditions or diseases
- Educational services (formal and informal)
- Resources for activities aimed at removing specific health risks in workplaces
- Research on women’s health

3) Identified specific health issues which:

a) cut across regions yet lend themselves to regional specificities;
b) are selective pointers that reveal other health issues;
c) are feasible at low cost.

Issues and Rationale

Nutrition

- Discrimination exists in food allocation and nutritional status of girls and women.
- Malnutrition and vitamin deficiencies contribute to morbidity and mortality from a variety of infections and chronic disease.
- Anemia accompanied by chronic fatigue is the most widespread, as well as nutritional deficiency among women aged 15-49 years, particularly during pregnancy and lactation.
- Malnutrition was also found to be an increasing problem among elderly women.

Reproductive Health

- Access to relevant information and quality care services, would improve significantly women’s health
- Unsafe maternity (including unsafe abortion and delivery) kills 1 400 women each day, and causes the death of some 1.3 million newborn babies each year.
- Untreated STD has serious consequences for women, including increased vulnerability to HIV infection.
• Particular attention should be given to adolescent health, a time of growth and change (of high rates of teenage pregnancies in both developed and developing countries.)

Health Consequences of Violence

• Violence against women is widespread and affects both physical and mental wellbeing.
• The toleration of battering, rape and incest are examples of the low status accorded to women.

Aging

• Women in increasing numbers will be facing the health problems which accompany old age, e.g. osteoporosis and physical and mental frailty, which are intensified during menopause.

Lifestyle-Related Health Conditions

• Lifestyles change and health-damaging behaviours related to these changes are increasing, as reflected in a higher percentage of women smoking, drinking alcohol and taking other psychoactive drugs.
• Increased stress and lack of social support are contributing to a rise in female suicides.
• Certain diseases such as STD, HIV/AIDS and cancers affect women differently. Specific, targeted interventions must be devised to enable women to protect themselves and receive appropriate care.

Work Environment

• Women are primary victims of environmental risks.
• More attention must be given to women’s health at home, in the workplace, including the traditional roles allocated to women.

4) Identification of specific indicators to monitor changes (See annex 1 for table showing issue areas, indicators and rationale for choosing indicators)

Overall approach adopted: Human rights and women’s health

• Health as a fundamental, non-negotiable human right
• Vulnerable groups, such as women, being denied this right
• Pro-active approach. Promotion of culture of equal worth and dignity of all human beings is fostered and principle of non-discrimination is respected
• June 1993: *Human rights and women's health*: comprehensive document commissioned for World Conference of Human Rights which highlights ways in which existing international human rights laws may be better used to protect and promote women's health. Widely distributed and acclaimed (forthcoming WHO publication). Similar position papers to be prepared by notable experts in areas under discussion as Commission's input to the International Conference on Population and Development, Fourth World Conference on Women and World Summit on Social Development.

**Strategic Steps for Follow-Up**

Each WHO region to establish Working Group on Women's Health where this does not already exist.

*Each WHO region to call regional inter-agency briefing to:*

- share outcome of March meeting;
- make final decision on countries with which to set up national activities rapidly. All countries encouraged to participate in regional networking activities but a limited number selected initially for close collaboration to generate positive experiences for mobilization of others.

*Regional intercountry meetings will be held to:*

- agree on specific women's health issues of regional priority within the overall framework;
- agree on country-based studies to address these issues;
- identify suitable coordination mechanism;
- mobilize interest in women's issues at all levels;
- compile/strengthen directory of existing networks to assist in advocating women's issues at national and regional level.

*Many WHO Regions have made headway in implementing the above strategic steps (See table in Annex 2)*

September 1993: formulation of Global Commission on Women’s Health
## Annex 1

<table>
<thead>
<tr>
<th>Issue</th>
<th>Rationale</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nutrition</strong></td>
<td>Although women produce more than half the food in the developing world, discrimination exists in food allocation and nutritional status of girls and women. Malnutrition and vitamin deficiencies contribute to morbidity and mortality from a variety of infections and chronic disease. Anemia accompanied by chronic fatigue is the most widespread, as well as nutritional deficiency among women aged 15-49 years, particularly during pregnancy and lactation. Malnutrition was also found to be an increasing problem among elderly women and therefore in areas where the health of elderly women was subject of growing concern, malnutrition is now recognized as a significant indicator.</td>
<td>1. Proportion of women aged 15-49 years with haemoglobin levels below 12 gm/dl of blood (non-pregnant women) or 11 gm/dl (pregnant women) 2. Proportion of women under reference weight desired at 5th month of pregnancy</td>
</tr>
<tr>
<td><strong>Reproductive Health</strong></td>
<td>Access to relevant information and quality care services including family planning, safe motherhood, HIV/AIDS and STD, would improve significantly women’s health. Unsafe maternity (including unsafe abortion and delivery) kills 1 400 women in the prime of life each day, and causes the death of some 4.3 million newborn babies each year. Untreated STD has serious consequences for women, including increased vulnerability to HIV infection. Particular attention should be given to adolescent health a time of growth and change (of high rates of teenage pregnancies in both developed and developing countries).</td>
<td>1. Maternal mortality rate 2. Total fertility rate 3. Age-specific birth rate 4. Percentage of men, and women of child-bearing age using contraceptives 5. Ratio of pregnancy among girls/women under 19 years 6. Incidence of cervical cancer per 100 000 women</td>
</tr>
<tr>
<td><strong>Health Consequences of violence</strong></td>
<td>Violence against women is widespread and affects both physical and mental wellbeing. The toleration of battering, rape and incest are examples of the low status accorded to women.</td>
<td>Reduction in the health consequences related to type of violence (e.g. disability, rape, death)</td>
</tr>
<tr>
<td><strong>Aging</strong></td>
<td>Women in increasing numbers will be facing the health problems which accompany old age, e.g. osteoporosis and physical and mental frailty, which are intensified during menopause</td>
<td>1. Percentage of women not covered by a health insurance scheme or social security 2. Loss of extended family support 3. No. of women above 65 years identified as disabled, i.e. limitation in ability to perform an activity in a manner considered normal</td>
</tr>
<tr>
<td><strong>Lifestyle-related health conditions</strong></td>
<td>As industrialization and urbanization evolve, lifestyles change and health-damaging behaviours related to this change are increasing, as reflected in a higher percentage of women smoking, drinking alcohol and taking other psychoactive drugs. Increased stress and lack of social support are contributing to a rise in female suicides. In addition, certain diseases such as STD, HIV/AIDS and cancers affect women differently. Therefore specific, targeted intervention must be devised to enable women to protect themselves and receive appropriate care.</td>
<td>1. HIV/AIDS incidence (female specific) 2. STD incidence (female specific) 3. % men and women using condoms to prevent STD 4. % women consuming alcohol, tobacco or drugs 5. Suicide rate</td>
</tr>
<tr>
<td><strong>Work Environment</strong></td>
<td>Women, more and more, are primary victims of environmental risks. More attention must be given to women’s health at home, in the workplace, including the traditional roles allocated to women such as fetching water, cotton picking etc.</td>
<td>1. Proportion of population with access to adequate amount of safe drinking water in dwelling or located within convenient distance from user’s dwelling (200m from house or 1 hour to collect water) 2. % women workers disabled from work 3. Formal/informal health-related occupational hazards (to define)</td>
</tr>
</tbody>
</table>
### Annex 2

<table>
<thead>
<tr>
<th>WHO Region</th>
<th>Proposed Countries</th>
<th>Activities (where defined)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>9 countries, 3 per sub region (to be identified)</td>
<td>To be defined</td>
</tr>
<tr>
<td>Americas</td>
<td>Belize, Costa Rica, El Salvador, Honduras, Nicaragua, Panama</td>
<td>The Pan American Health Organization’s Women, Health and Development programme has been extremely active in the last decade to improve women’s health throughout the region. Specific projects have included: * Institutionalising the gender approach at all levels * SIMCA Project: technical cooperation with countries in Central America (project soon to be expanded to cover all areas of the American region) in concrete activities to improve women’s health, particularly in four major categories: (a) juridical and legal reforms; (b) policies, programmes and plans; (c) local development; (d) research Important collaboration between health personnel and NGOs • Collaboration with the media: video tape &quot;Somos la otra mitad&quot; (we the other half) • A bibliography compiled to promote self-care in women’s health • Ethnicity: project on the health of indigenous women</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>Egypt, Iran, Jordan, Lebanon, Morocco, Oman, Pakistan, Tunisia, UAE, Yemen</td>
<td>In order to maximize attendance, the meeting bringing together representatives of all United Nations agencies in the Eastern Mediterranean Region has been postponed from August until November 1993</td>
</tr>
<tr>
<td>Europe</td>
<td>Albania, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Poland, Romania, Ukraine</td>
<td>* The WHO Regional Office for Europe has chosen the New Independent States and countries of Central and Eastern Europe for initial intensified activities on women’s health. * A meeting of the country coordinators took place in May 1992. A second meeting is planned in November 1993. Coordinators will establish a networks of contacts with governmental and non-governmental institutions within their country to obtain and exchange information. * For this purpose, a questionnaire has been developed which will form the basis of women’s health profiles per country; a comparative analysis of which will be made by WHO/EURO. * A women’s health conference is planned for February 1994 in Vienna to consolidate activities and use the analysis of the women’s health profiles to plan future strategies to improve women’s health. * At the same time (February 1994) a European Women’s Health Forum will be launched: a body of eminent leaders in policies and international affairs to advise WHO on critical health issues affecting women in the European region.</td>
</tr>
<tr>
<td>South East Asia</td>
<td>Bangladesh, India, Indonesia, Nepal, Sri Lanka, Thailand</td>
<td>Informal meetings between WHO and other United Nations agencies in the region are informally held on a regular basis</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>Australia, China, Fiji, Malaysia, Philippines, Samoa, Vietnam</td>
<td>To be defined</td>
</tr>
</tbody>
</table>
Gender Analysis and Research Methodology: Key Questions and Issues

Gender and Development Program

Introduction

This brief summary will identify some key elements of gender analysis in research methodology.

Building in a gender perspective into any research process is central to improving research quality and outcomes, and fundamental to the search for sustainable policy. The focus in gender analysis is not solely on women, *per se*, but in gender relations, and takes a holistic approach to structural conditions and their impacts. The emphasis of gender analysis is therefore on relations and processes as well as roles.

The questions put forward by a gender analysis approach build in the social, cultural, political, economic and ecological constructions of gender relations. These relationships must be examined in the full consideration of the implications of women’s subordinate conditions for key development processes and outcomes.

Research Design

Gender analysis requires a new approach to research design which considers the gendered nature of knowledge. The knowledge and perspective of both men and women are crucial to accuracy and depth of research results, leading to a greater understanding of issues of access, use, participation and input into policy processes.

Gender sensitive data collection is likely to produce a more complete picture of a given situation:

- Statics disaggregate by gender tend to produce less distorted knowledge base.
- Statistically derived generalizations are more likely to misrepresent reality.

---

1 Gender and Development Program, International Development Research Centre, Ottawa, Canada.
• Productive and income generating activities in which women engage including household work, the informal sector, reproductive work, are taken into consideration as central to productive and income generating activity, and as essential to the well-being of the community.

• Contributions to the household economy and income-generation should take into account levels of control within the household.

Socio-cultural factors may tend to effect women’s ability to provide input or to provide input or to take part in research:

• women need to speak for themselves

• their perspectives or definitions of a problem must be sought to fully integrate these into the research process

• women’s most significant areas of influence and responsibility may be misunderstood, and therefore need to be explicitly probed.

Data analysis must take into consideration power differentials having implications for control over labour and resources, decision-making and management powers:

• who controls and who benefits?

• who’s knowledge base is being integrated?

• in whose terms will it be expressed?

• who will use the knowledge?

Research results and recommendations must be constructed in recognition of potential influence on policy, its destination, and the access and control actors and subjects will have over its existence. Using a gender analysis approach, the research results and presentation will be subject to the following questions:

• to whom will the material be represented? for what purpose?

• how will it influence policy?

• who will have access to the information?

• do the research or recommendations suggest positive strategies for change?

• do the findings articulate viable broad-based development programs?
Healthy Women Counselling Guide: A Multi-Country Intervention Study

Carol Vlassoff

In many countries where tropical diseases are endemic, women report less frequently than men to health services. When they do consult these services, it is often as a last resort, or to bring their children for treatment. In addition, women who bring their children frequently use the opportunity to ask about their own health problems, but as health services tend to focus only on women's reproductive period, they often are inadequate to meet women's special needs.

The project described here aims to address women's health concerns in a more comprehensive way by means of the development of a "healthy women" counselling guide that can be used at the community level. This guide would focus on women's health problems directly related to tropical diseases (malaria and anemia, lesions and secondary infections). It would also focus on other important health problems including tuberculosis, sexually transmitted diseases and urinary tract infections, and oral health. In areas with adequate treatment facilities, components on mental health, breast and cervical cancer could be included.

In order to develop this guide, several questions have to be answered. These include the number and nature of health problems that could feasibly be included in the guide, the kinds of sites in which the guide could be used (e.g. MCH clinics, women's workplaces, market areas, women's clubs), as well as ways of gaining women's confidence and cooperation in the consultation process. This information will be obtained while the counselling guide is being developed through consultation with researchers in tropical disease endemic countries. Where the questions cannot be answered otherwise, some initial focused research may be required, which would be done using rapid methods.

With regard to the steps necessary for the development and testing of the guide, the following steps have been taken by WHO/TDR and other participating WHO programs:

1. initial identification of important health problems for women by an informal WHO group of interested programs (coordinated by TDR);

2. literature reviews of interventions that have proven successful in ameliorating women's health in endemic countries, including the family planning literature;

1Social and Economic Research-TDR, World Health Organization (WHO), Geneva, Switzerland.
3. advertisement of the activity to endemic country researchers and community workers, for input, suggestions, and expression of interest for future involvement in testing of guide;

4. TDR workshop to share experiences of successful interventions and to obtain feedback regarding strategies for the further development of the guide.

Future steps were proposed at the IDRC workshop on Women, Health and Sustainable Development, and suggestions were obtained from participants regarding future strategies. These included the need for a participatory approach to the development of the materials, including the possibility of directly working with women themselves to design the messages and strategies to be adopted.

Concretely, the next steps will involve focused consultations between WHO staff, researchers and women's grassroots organizations in order to further develop a participatory research agenda. It is hoped that, by the time of the forthcoming Regional Meeting of the African Women's Association, Near East and East Africa, a workshop can be held in conjunction with this activity with participating teams to finalize plans for the development of the materials and approach to be used.
Sharing Experience: African Women Development and Communication Network (FEMNET)

Rosemary Gitachu¹

Introduction

African Women Development and Communications Network (FEMNET) was founded in 1988. The network was one of the outgrowths from NGO involvement in the Decade of Women Activities, including the African Regional preparatory meeting held in Arusha, Tanzania in October 1984, and the end of Women’s Decade meetings held in Nairobi in July 1985. FEMNET was founded by the African Women’s Task Force which met in Nairobi in April 1988. The Network was charged with the responsibility of establishing an institutional means for collective African NGO efforts to pursue the UN Forward Looking Strategies for the Advancement of Women, which was the major declaration that resulted from the 1985 World Conference.

Objectives

FEMNET has among others, the following objectives:

• sharing of information and ideas between African NGOs so as to enable a better and more effective NGO focus on women's development;

• strengthening the role of NGOs focusing on women's development and the integration of women in the development process in Africa, and to create an infrastructure and channel through which NGOs will reach one another and share crucial information, knowledge and experience, thereby sharpening and improving their inputs into African development; and

• to initiate, develop and maintain close working contacts with UN agencies and other bodies with similar objectives.

It is within this larger vision of the Network that the FEMNET Gender Sensitization Team (GST) was established.

FEMNET Gender Sensitization Team (GST)

In 1989 FEMNET identified gender responsive planning, programming and sensitization among men and women at all levels of development, including policy, planning and implementation as a priority. The aims and objectives of this program were to undertake gender responsive policy, programming and planning advocacy, sensitization and skills development among development workers, planners and policy makers. One of the key objectives is women’s empowerment.

Experiences from the Field

The GST has conducted gender training within various groups locally. These groups include

- planners and government trainers;
- program coordinators and implementors;
- community level workers;
- researchers; and
- journalists.

Topics handled have been mainly Gender and Development, Gender and Research, Media and Democratization.

Experience with Planners

Two workshops were organized by FEMNET in conjunction with Ministry of Planning and National Development.

- In both cases the planners expected the discussions to revolve around women in development and expressed their satisfaction and surprise that there was a scientific method and a framework within which to evaluate gender concerns.

- The planners evaluated gender sensitivity in the current 6th National Development Plan by looking at the chapter on agriculture.

- FEMNET GST has played a significant role in lobbying with the Government and especially the Ministry of Planning and National Development in integrating gender concerns in the National Development Plan.

- FEMNET GST has also facilitated in two workshops held by the Ministry of Planning for Government Training Institutes. Lecturers in these institutes have gone through gender sensitization. Special attention was given to gender sensitivity in their mechanisms for recruitment, courses offered and gender stereotyping in the
curriculum. This group was identified as crucial because they offer short term courses to people in the civil service, chiefs, councillors, NGOs, Government officials, and policy makers, among others.

Program Officers

- FEMNET GST has sensitized UNICEF Kenya country office, and Program Officers in the 6 UNICEF Districts. The officers were integrating gender concerns in their current projects.

- In training, the team has looked at various sectors, e.g. health, water, agriculture and education, and focused on how various gender concerns can be addressed both for greater effectiveness and for social justice.

- The team has also worked closely with African Academy of Sciences, SIDA, CARE Kenya and Freedom From Hunger Council of Kenya, and has sensitized their Program Officers.

Gender and Research

- FEMNET GST facilitated in two gender and research workshops for researchers at the Institute of African Studies, University of Nairobi. The reason for this sensitization was because of the consensus, based on research, that the available research data basically gender blind. A lot of data in Kenya, and I believe in some other countries, has been gender insensitive, and documentation on women in development has just confined itself to women.

- The results of the above exercise was a challenge to the Kenya Oral Literature Association, which responded by writing short stories and poems that are gender sensitive in order to move towards a gender sensitive culture.

The GST and the Media

A one day Gender, Media and Democratization Workshop was held in January 1992. Reporters, columnists writers, editors and feature article writers went through the gender sensitization exercise. There was greater demand from the media to have further training in August, and a three day workshop was organized. Articles, cartoons, news items and editorials were used to discuss the role played by media in perpetuating gender stereotypes and how they can respond to this.
Community Level Workers

The team has reached the grassroots through the training of community level workers. These include Chiefs (Nairobi), Councillors and District Social Workers. The training has been an exciting and a rewarding experience for both the trainers and the participants.

In one of the Chiefs’ workshops held in Nairobi recently, the Chiefs identified some of the major concerns in their daily work operations. One significant concern are the street children who are often AIDS orphans or sexually abused children.

In their plan of action, the Chiefs identified the need for information to create awareness about the ill effects of sexual abuse of children, including:

- destruction of the uterus;
- physical pain and psychological trauma;
- prospect of contracting sexually transmitted diseases; and
- stigmatization.

They would also sensitize the constituents to the fact that:

- sexual abuse is a crime; and
- children have a right to protection.

Strategies

- they would use Chief’s barazas in the locations
- mass media
- task force consisting of men and women
- use of formal structures, e.g., schools, churches, women’s groups etc. as focal points for information dissemination

Other Accomplishments

In response to its needs, the team has developed the following training materials:

- developed local case studies;
- developed FEMNET’s Model for Gender and Development Training (FGAM Model);
- produced a Manual for Trainers; and
- produced a document on Social Construction of Gender.

In addition, the team has evaluated gender sensitivity of projects and analyzed how this insensitivity affects the lives of women and men.
They have trained outside the country in Ethiopia, Uganda and conducted Regional Gender Responsive, Planning, Programming and Sensitization workshops for Eastern and Southern African Region for Emmanuel International and ACCOSCA.

FEMNET GST has been evaluated by an international agency, USAID, and was rated as one of the best gender training teams in the world.
In Her Lifetime: A Report on Female Morbidity and Mortality in Sub-Saharan Africa

Maureen Law and Uche Amazigo

The subject of female morbidity and mortality in Sub-Saharan Africa has received relatively little attention from researchers to date. Although much is known about the health status and causes of morbidity and mortality in infants in the first year of life, correspondingly little is known about these factors, particularly in females, in the subsequent periods of childhood and adolescence. In addition, while factors influencing the reproductive capacity of women ages 15 to 44 years have been studied extensively, little is known about the rates and causes of morbidity and mortality that are unrelated to reproductivity in this cohort. Finally, almost nothing is known about the causes of morbidity and mortality in women over 45 years of age.

This report analyzes critical biomedical issues in female morbidity in Sub-Saharan Africa, using the lifespan perspective. The application of the lifespan framework to public health is an innovative one. It is based on the assumption that there is a need to articulate the major causes and manifestations of female morbidity, not solely in women of reproductive age, but within other age groups as well. The perspective emphasizes the fact that diseases are not always episodic, but often have cumulative and synergistic effects that can adversely influence later health status and productivity of the individual, her offspring, or, indirectly, others within her care. It is anticipated that the final report will provide a solid documentary base that can be used in developing a systematic agenda to guide research and health policy formulation related to the overall health of females. Although the focus of the study is Sub-Saharan Africa, the study framework and outcomes are expected to be applicable to female morbidity and mortality in other regions of the developing world. The report will be published and available for distribution in the Spring of 1994.

Contents

• Summary
• Demography
• Sociocultural Influences on Health, Including Traditional Practices
• Nutrition
• Obstetric Morbidity and Mortality
• Chronic Diseases

1Information provided from the forthcoming report of the Institute of Medicine of the U.S. National Academy of Sciences.
• Nervous System Disorders and Mental Health Problems
• Injury and Violence
• Occupational Health and Environmental Health
• Vector-borne and Other Infectious Diseases
• Sexually Transmitted Diseases, Including HIV Infection

For further information, please contact

The Institute of Medicine, 2101 Constitution Avenue, N.W., Washington, DC, 20418
- Phone (202) 334-2348, FAX (202) 334-3861
Health and the Status of Women in Canada

Janet Hatcher Roberts

There has been increasing attention paid to women's health issues in Canada. Canadian women are realizing the importance of learning about their health, medical policies are slowly changing to consider the needs of women, and policy-makers at the federal, provincial, and other government jurisdictional levels are considering the importance of incorporating women's health issues into overall health policies.

Canada is made up of 10 provinces and 3 territories. Our constitution states that health is a provincial matter, and over the years the federal government has worked out a variety of funding arrangements to assist the provinces in paying for health care. Canadians are covered by a universal health care plan, which includes hospital-based care as well as ambulatory care. As resources have become increasingly tight, the amount of money contributed by the federal government to the provinces has decreased, which has increasingly lessened any influence the federal government might have had on the provinces in terms of health policies and health service delivery mandates. However, it has allowed more innovation and flexibility over time for the provinces.

In 1988, the first National Symposium on Changing Patterns of Health and Disease in Canadian Women was held in Ottawa, Canada. Following this conference, the Conference of Deputy Ministers of Health (Federal/Provincial/Territorial) established a Federal/Provincial/Territorial Working Group on Women's Health to advise them on women's health matters. To this end, a framework document was produced which identified the key issues and outlined priorities for action for women's health at the federal, provincial, and territorial levels. The response to these issues and challenges facing Canadian women was the development of a series of principles, strategies and guiding principles for improving women's health.

More recently, a special office for Women's Health was established as part of the newly reorganized Health Canada. This new office will serve as a coordinating body for women's health, and will likely take a lead role in terms of approving policy plans and program advice to the Minister of Health.

---

1 Health Sciences Division, International Development Research Centre, Ottawa, Canada
What is the status of women and their health in Canada?

- women live longer than men and practice better health habits,
- and yet, over time, they suffer more ill health and are more frequent users of the health care system
- clearly women’s health needs to be studied in the context of the social realities of women’s lives

**POTENTIAL YEARS OF LIFE LOST BEFORE AGE 75, FEMALES, BY CAUSE OF DEATH, CANADA**

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Thousands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>40</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>35</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>30</td>
</tr>
<tr>
<td>Motor Vehicle Crash</td>
<td>20</td>
</tr>
<tr>
<td>Congenital Anomalies</td>
<td>20</td>
</tr>
<tr>
<td>Suicide</td>
<td>15</td>
</tr>
<tr>
<td>Stroke</td>
<td>10</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>10</td>
</tr>
<tr>
<td>Ovarian Cancer</td>
<td>10</td>
</tr>
<tr>
<td>Lymphoid Cancer</td>
<td>10</td>
</tr>
<tr>
<td>COPD</td>
<td>5</td>
</tr>
<tr>
<td>Uterine Cancer</td>
<td>5</td>
</tr>
<tr>
<td>Homicide</td>
<td>5</td>
</tr>
<tr>
<td>Leukemia</td>
<td>5</td>
</tr>
<tr>
<td>Cirrhosis of Liver</td>
<td>5</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5</td>
</tr>
<tr>
<td>Pancreatic Cancer</td>
<td>5</td>
</tr>
<tr>
<td>Stomach Cancer</td>
<td>5</td>
</tr>
<tr>
<td>Kidney Diseases</td>
<td>5</td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td>5</td>
</tr>
</tbody>
</table>

Bureau of Chronic Disease Epidemiology
LCDC (Canada)
HEALTH AND INDEPENDENCE EXPECTANCY AT BIRTH, BY SEX, CANADA, 1986

Source: Statistics Canada/Health and Welfare Canada (Wilkins and Adams)

HEALTH AND INDEPENDENCE EXPECTANCY AT AGE 65, BY SEX, CANADA, 1986

Source: Statistics Canada/Health and Welfare Canada (Wilkins and Adams)
### Highlights

**Canadian Federal/Provincial/Territorial Initiatives**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Federal/National</th>
<th>Provincial/Territorial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly</td>
<td>• Old Age Security (OAS) basic level of income for Canadians over 65 years&lt;br&gt;• Guaranteed Income Supplement (GIS)&lt;br&gt;• Spousal Allowance (SPA)&lt;br&gt;New Horizons Program: provides opportunities for seniors to plan and operate activities for themselves.</td>
<td>British Columbia:&lt;br&gt;• &quot;Advocates for Care Reform&quot;: family members and friends of nursing home residents dedicated to improving their quality of care&lt;br&gt;• &quot;Take Time to Talk&quot; Project of the Disabled Women’s Network organized regional workshops for women with disabilities&lt;br&gt;Manitoba:&lt;br&gt;• A Drug Line for the Elderly: drug-related events contribute to 23% of admissions to hospital for the elderly</td>
</tr>
<tr>
<td>Environment</td>
<td>Health and Welfare Canada Great Lakes Health Effects Program:&lt;br&gt;• Exposure to Contaminants and Reproductive Health;&lt;br&gt;• Reproductive Endpoints.</td>
<td>Canada Ontario Agreement allows for joint plans and strategies with regard to environmental action in the Great Lakes&lt;br&gt;Action Plans in Areas of Concern: developed as needing immediate cleaning up due to environmental contamination</td>
</tr>
<tr>
<td>Occupational Health</td>
<td>Federal Government:&lt;br&gt;• Employment Equity Initiatives&lt;br&gt;• Public Service Health&lt;br&gt;• Canadian Centre for Occupational Health and Safety: - specific support for hazards to women in the workplace,&lt;br&gt;• Ontario Farm Family Study</td>
<td>Ontario Women’s Directorate — change Agent Program Goal:&lt;br&gt;• Improving economic status and representation of women in the labour force;&lt;br&gt;• Flexible working arrangements;&lt;br&gt;• &quot;Change Agent Partners&quot; share results with other organizations</td>
</tr>
<tr>
<td>General</td>
<td>Royal Commission on the Status of Women, 1970:&lt;br&gt;Now in place:&lt;br&gt;• Minister Responsible for Status of Women;&lt;br&gt;• Status of Women Canada;&lt;br&gt;• Canadian Advisory Council on the Status of Women.&lt;br&gt;Policies on Status of Women:&lt;br&gt;• Integration at domestic and international levels;&lt;br&gt;• Interdepartmental committee on the Status of Women;&lt;br&gt;• Cooperation between and regular meetings of federal, provincial and territorial status of women, Ministers and officials;&lt;br&gt;• Plans of action to advance status of women</td>
<td>Provincial Status of Women offices;&lt;br&gt;Advisory Council on the Status of Women.</td>
</tr>
</tbody>
</table>
### Highlights

**Canadian Federal/Provincial/Territorial Initiatives**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Federal/National</th>
<th>Provincial/Territorial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty</td>
<td><strong>Health and Welfare Canada, 1993:</strong></td>
<td><strong>Provincial Government of Alberta Family and Social Services — &quot;Supports for Independence Program&quot;:</strong></td>
</tr>
<tr>
<td></td>
<td>- Integrated client service delivery</td>
<td>- Reducing welfare rolls;</td>
</tr>
<tr>
<td></td>
<td>network for Old Age Security, Pensions and Family Allowance program</td>
<td>Helping women to find jobs and become more self-sufficient;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improving child care benefits available to recipients</td>
</tr>
<tr>
<td>Violence</td>
<td><strong>Health and Welfare Canada, 1986:</strong></td>
<td><strong>Provincial Government of Newfoundland and Labrador, 1993:</strong></td>
</tr>
<tr>
<td></td>
<td>- Established a Family Violence Prevention Division</td>
<td><strong>Provincial Strategy Against Violence,</strong></td>
</tr>
<tr>
<td></td>
<td>- Child Sexual Abuse</td>
<td>with funding from Health and Welfare Canada</td>
</tr>
<tr>
<td></td>
<td>- Family Violence Initiative</td>
<td><strong>Goals:</strong></td>
</tr>
<tr>
<td></td>
<td>2 major initiatives are supported by the Division’s mandate:</td>
<td>- involve community groups in recommending priorities and developing plans to address violence against women, children, elderly and dependent adults;</td>
</tr>
<tr>
<td></td>
<td>- 1991: $36M, 4-year initiative on Prevention of Family Violence</td>
<td>- consult with community groups about the proposed plans to address violence in the areas of legislation, policy and direct service delivery;</td>
</tr>
<tr>
<td></td>
<td>- HWC $55.6M: particular focus on:</td>
<td>- to develop a strategic plan to address violence.</td>
</tr>
<tr>
<td></td>
<td>1. the prevention of family violence,</td>
<td><strong>Manitoba, June 1992:</strong></td>
</tr>
<tr>
<td></td>
<td>2. improvement of community responses particularly in the health and social</td>
<td>- A National Listing of Violence Prevention Materials in the Schools</td>
</tr>
<tr>
<td></td>
<td>service field</td>
<td></td>
</tr>
<tr>
<td>Child Health</td>
<td><strong>&quot;Brighter Futures&quot; — Canada’s Action Plan for Children:</strong></td>
<td><strong>International</strong></td>
</tr>
<tr>
<td></td>
<td>- IMR down from 27/1000 to 7/1000;</td>
<td>1. $50M with provinces and territories and with NGOs to obtain better information on causes of childhood illnesses</td>
</tr>
<tr>
<td></td>
<td>last 20 years</td>
<td>2. $1M for major causes of diseases</td>
</tr>
<tr>
<td></td>
<td>- Widespread immunization plans;</td>
<td>3. $5M for nutritional programs</td>
</tr>
<tr>
<td></td>
<td>- Improved access to prenatal care.</td>
<td></td>
</tr>
<tr>
<td>Domestic Goals</td>
<td><strong>Support parents as our children’s primary caregivers;</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Reduce the number of children living in low income situations;</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Reduce conditions of risk to children;</strong></td>
<td></td>
</tr>
<tr>
<td>International</td>
<td>1. $50M for immunization programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. $1M for major causes of diseases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. $5M for nutritional programs</td>
<td></td>
</tr>
</tbody>
</table>
### Highlights
**Canadian Federal/Provincial/Territorial Initiatives**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Federal/National</th>
<th>Provincial/Territorial</th>
</tr>
</thead>
</table>
| Reproductive Health AIDS/STDs | • AIDS/HIV: 5583 adult cases of AIDS in Canada; 289 (5%) are women as of January 1992  
  • Federal Centre on AIDS  
  • National AIDS Surveillance Program  
  • Strategies for identifying biological and clinical factors causing PID (a cause of infertility)  
  • National Health Insurance pays for antenatal care  
  • $500,000/year for 3 years, 1989-1992, on reproductive health/family planning research | Ontario Ministry of Health: 1994 will begin licensing 3 "out-of-hospital" birthing centres; this is one of the initiatives that the provincial government has taken to integrate midwifery into the formal health care system |
| Research/Networking Support | • Canadian Research Institute for the Advancement of Women: National, bilingual organization which promotes, disseminates and coordinates research on women  
  • Canadian Women's Health Network (Health and Welfare Canada):  
    Goals  
    - focus on effective ways for groups to exchange resources and information.  
    - strategize for advocacy and action on women's health,  
    - build and fund a network.  
  • Medical Research Council of Canada: Advisory Committee on Women's Health  
  • National Health Research and Development Program  
  • National Health Information Council: Coordinating body with provinces and territories  
  • Centre for International Statistics: Mandate to provide statistical research services to community organizations, social agencies, policy analysts doing research on children and families | Women's Health Interaction Manitoba, Winnipeg (Manitoba) Women's Health Clinic |

---

**Notes:**

a. This presentation was originally proposed for an informal lunch-time discussion. A number of resource materials from Federal/Provincial/Territorial offices for Women's Health, Status of Women and AIDS, were utilized and circulated to the participants. The opportunity for these researchers to link with some of their Canadian counterparts was encouraged.

b. This chart was compiled from resources which were requested by the author of Federal/Provincial/Territorial offices of the Status of Women, Women's Health Bureaus and Offices on AIDS. It is not meant to represent a comprehensive compilation of activities related to women's health in Canada, but only brief highlights of activities as they pertain particularly to the main themes of the workshop.
Special Issues to Consider When Doing Research on Women

Eva M. Rathgeber

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

---

1The 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.

2Regional 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, men and children. The paper proposes a framework for gender-sensitive research on this topic and suggests some new directions for research.
Participants

Dr. Lawrence Adeokun  
I.S.A.E.         
Makerere University  
P.O. Box 7062  
Kampala, UGANDA  
FAX: 256 41 530 756  
TEL: 256 41 542 803

Dr. Martin Alilio  
National Institute for Medical Research  
Dar es Salaam, TANZANIA  
FAX: 255 53 43869  
TEL: 255 51 30770

Dr. Uche Amazigo  
Department of Zoology  
University of Nigeria  
Nsukka, Enugu State, NIGERIA  
FAX: 234 42 336 388  
TEL: 234 42 771 206

Ms. Anne L. Ambwere  
Women’s Bureau  
Ministry of Culture & Social Services  
P.O. Box 30276  
Nairobi, KENYA  
FAX: 254 2 228 288  
TEL: 254 2 228 288

Ms. Lori Jones Arsenault  
Health Sciences Division  
International Development Research Centre (IDRC)  
P.O. Box 8500  
Ottawa, Ontario, CANADA  
K1G 3H9  
FAX: 613 567 7748  
TEL: 613 236 6163

Ms. Hellen R. Atai-Okei  
Ateki Women’s Development Association  
P.O. Box 40150  
Kampala, UGANDA  
FAX: 256 41 258 571 c/o Margaret Emeljeit  
TEL: 256 41 285 193

Ms. Sandra Baldwin  
Health Sciences  
Eastern and Southern Africa Regional Office  
International Development Research Centre (IDRC)  
P.O. Box 62084  
Nairobi, KENYA  
FAX: 254 2 711 063  
TEL: 254 2 713 160

Dr. Stella Anyangwe  
Department of Epidemiology and Community Medicine  
Faculty of Medicine  
University of Yaounde I  
Yaounde, CAMEROON  
FAX: 237 31 1224  
TEL: 237 31 7619

Dr. Don Balmer  
Dept. of Psychology  
University of Nairobi  
P.O. Box 30197  
Nairobi, KENYA  
FAX: 254 2 567 825  
TEL: 254 154 32689
Dr. Jane Kengeya-Kayondo
Medical Research Council, Research
Program on AIDS in Uganda
c/o Uganda Virus Research Institute
P.O. Box 49
Entebbe, UGANDA
FAX: 256 42 20483
TEL: 256 42 21137

Ms. Jennifer Kitts
c/o Health Sciences Division
International Development Research Centre (IDRC)
P.O. Box 8500
Ottawa, Ontario, CANADA
FAX: 613 567 7748
TEL: 613 236 6163

Ms. Barbara Klugman
Centre for Health Policy
University of the Witwatersrand, Medical School
7 York Road
Park Town, 2193, SOUTH AFRICA
FAX: 27 11 6432 0733
TEL: 27 11 647 2013

Mrs. Jane Kwawu
Centre for African Family Studies (CAFS)
Pamstech House, Woodvale Grove,
Westlands
P.O. Box 60054
Nairobi, KENYA
FAX: 254 2 448 621
TEL: 254 2 747 1145

Dr. Maureen Law
Director General
Health Sciences Division
International Development Research Centre (IDRC)
P.O. Box 8500
Ottawa, Ontario, CANADA
K1G 3H9
FAX: 613 567 7748
TEL: 613 236 6163

Dr. George Lwihula
Department of Social Sciences
Faculty of Medicine
Dar es Salaam, TANZANIA
FAX: 255 51 27081
TEL: 255 51 27081

Dr. Marvellous Mhloyi
Department of Sociology
University of Zimbabwe
P.O. Box MP 167
Mt Pleasant, Harare, ZIMBABWE
FAX: 263 4 732 828
TEL: 263 4 303 211

Dr. Jane W. Muita
Public Health Nutrition
Unit of Applied Human Nutrition
University of Nairobi
P O Box 41607
Nairobi, KENYA
FAX: 254 2 632 365
TEL: 254 2 632 365

Dr. Halima Abdullah Mwenesi
Kenya Medical Research Institute
P.O. Box 20752
Nairobi, KENYA
FAX: 254 2 721 814
TEL: 254 2 725 016
Ms. Shirley Ngwenya
Health Services Development Unit
University of the Witwatersrand
P.O. Box 2
Acornhoek, SOUTH AFRICA
FAX: 27 0131982 83
TEL: 27 0131982 77

Mrs. Anne Puta
Zambian Organization of Occupational Health and Safety
P.O. Box 70126
Ndola, ZAMBIA
FAX: 260 2 614 045
TEL: 260 2 611 817

Dr. Eva Rathgeber
Regional Director
Eastern and Southern Africa Regional Office
International Development Research Centre (IDRC)
P.O. Box 62084
Nairobi, Kenya
FAX: 254 2 711 063
TEL: 254 2 713 160

Ms. Janet Hatcher Roberts
Health Sciences Division
International Development Research Centre (IDRC)
P.O. Box 8500
Ottawa, Ontario, CANADA
K1G 3H9
FAX: 613 567 7748
TEL: 613 236 6163

Dr. Anna Strebel
Dept. of Psychology
University of the Cape
Private Bag X17
Belleville, 7535, SOUTH AFRICA
FAX: 27 21 959 2755
TEL: 27 21 959 2911

Ms. Dzodzi Tsikata
Institute of Statistical, Social and Economic Research
University of Ghana
P.O. Box 74
Legon, GHANA
FAX: 233 21 668 262
TEL: 233 21 775 182

Dr. Pandu Wijeyaratne
Health Sciences Division
International Development Research Centre (IDRC)
P.O. Box 8500
Ottawa, Ontario, CANADA
K1G 3H9
FAX: 613 567 7748
TEL: 613 236 6163

Dr. Rosina Wiltshire
Gender and Development Unit
Corporate Affairs and Initiatives Division
International Development Research Centre (IDRC)
P.O. Box 8500
Ottawa, Ontario, CANADA
FAX: 613 567 7748
TEL: 613 236 6163

Ms. Nkosozana Zuma
c/o Centre for Health and Social Studies
Faculty of Medicine
University of Natal PMRC
P.O. Box 17120
Congella, 4013 SOUTH AFRICA
FAX: 27 31 258 840
TEL: 27 31 251 481
"Gender and Tropical Diseases: Facing the Challenge"
Abstracts from an Essay Competition Sponsored by IDRC and TDR
Femmes rurales et contrôle du Paludisme dans la Vallée du Fleuve, Sénégal

G.C. Carrara and P. Brigatti
Via dei Quintili V° Vial n° 12
00040-Monteporzio Catone
Rome, Italy

The use of impregnated bednets with quick-acting synthetic pyrethroid (deltamethrin), combined with immediate chemotherapy in case of malaria onset, made it possible to noticeably reduce the prevalence of malaria in 94 villages (110,000 inhabitants) situated near irrigated rice fields in Senegal. A very important element of success was the participation of rural women in both the trial and the implementation, management, and evaluation of activities. The reduction of prevalence was about 90% in the Delta villages and about 60% in the villages of the Middle Valley. This difference is linked to the fact that the prevalent Anopheles in the Delta is An. pharoensis, a less effective malaria vector than An. gambiae s.s. and An. arabiensis, prevalent in the Middle Valley villages.

Genre et maladies tropicales: Faire face au défi

Dr. E.H. Feno
Chef du Service de Santé
Service de Santé des Frontières
Ministère de la Santé
Antananarivo, Madagascar

Urinary schistosomiasis (and its clinical corollary, blood in the urine) is a continuous public health problem in Madagascar, principally in the province of Antsiranana, located in the north. Infections and parasitic diseases affect 18 percent of the population in Madagascar. This rate exceeds 30 percent in Antsiranana. Empirically, the population admits that the female gender is more disposed to have blood in the urine, essentially caused by schistosomiasis. The authors carried out a statistical investigation of a population of 675 children from both genders in the Antsiranana zone. The conclusion of the analysis is that gender presents itself as a modifying factor of the prevalence of urinary schistosomiasis.
Gender Aspects and Women's Participation in the Control and Management of Malaria in Central Sudan

Drs. Rahman, Mahamedani, Mirgani and Ibrahim
University of Gezira
Gezira, Sudan

The present study investigates the role of women in the management and control of malaria in Central Sudan - Gezira area. Particular attention was focused on gender-related aspects. Forty geographically stratified villages in the operational areas of the Blue Nile Health Project (BNHP) were randomly selected. The BNHP was launched in 1980 to control water-associated diseases in this economically important area of Sudan. Women were actively involved in the implementation of the project programs as health instructors and village health committee members.

Lymphatic Filariasis and the Women of India

Ms. Lalita Bandyopadhyay (India)
presently, 3285 S. Sepulveda Blvd. No. 3
Los Angeles, CA 90034

Lymphatic filariasis is a disease of the poor and underprivileged, and has received little attention in the past. In particular, there has been a lack of gender-sensitive research on women and lymphatic filariasis. Women suffer from lymphatic filariasis to a great extent, but embarrassment, shame, cultural constraints and social taboos are some of the reasons that refrain them from reporting problems and seeking help. Women are thus silently bearing the brunt of this disease.

This study has tried to obtain basic information on women and lymphatic filariasis through a gender-based approach. To understand the consequence of lymphatic filariasis on women in India, a holistic framework was used for this study, which encompasses all issues in women's lives, such as their perspective on the disease, their role as social and economic entities, and their relationships with others, in addition to their reproductive role. A qualitative approach using the technique of informal interviews was used for this research. Eighty-eight women and thirty-nine children were interviewed, during home visits and at clinics, primary health care centres and schools, in both urban and rural areas in India. The study has obtained much needed information on the knowledge of lymphatic filariasis among women in India, the impact of the disease on women, including social and economic aspects, clinic attendance and the barriers to health care for women with the disease, and women's awareness regarding control programs for lymphatic filariasis. The study also found how women cope with the disabilities or other manifestations of the disease. This paper discusses lymphatic filariasis using a gender-sensitive approach. It reviews the literature, describes the study, analyzes the results and suggests feasible disease control programs for women with a multi-sectoral approach.
Female Genital Schistosomiasis a Gender Perspective Brings New Challenges for Prevention and Control

Hermann Feldmeier, Gabriele Poggansee, Ingela Krantz, Ulrike Froneberg, and Stella Anyangwe
Nordic School of Public Health
P.O. Box 12133, S-402
42 Goteborg, Sweden

Female genital schistosomiasis (FGS) has been neglected as a disease entity during a period when considerable progress has been achieved for schistosomiasis as such. The pathophysiology and immunology are imperfectly understood, appropriate diagnostic tools are not at hand, therapeutic rationales do not exist, and women’s perceptions of their illness have never been studied. Based on the findings of a systematic analysis, generated by an inventory for needs of research on women and tropical diseases, it has been possible to highlight individual and public health hazards of FGS, such as the disease being a co-factor for the spread of HIV. This paper is an example of how a gender-related perspective on a well-known parasitic disease can bring new challenges to the research community and the public health sector.

Vector Control in the Domestic Domain: A Gender Perspective

Peter Winch, Linda S. Lloyd, Laura Hoemeke, and Elli Leontsini
Johns Hopkins University
School of Hygiene and Public Health
Department of International Health
615 N. Wolfe Street
Baltimore, MD 21205

The home is the setting where many vector-borne diseases are transmitted. Strategies for their control consequently must involve the active participation of household members. In this paper we propose that low rates of participation in control activities frequently are related to the negative impact they have on women’s power and authority within the domestic domain. This can arise from intrusion into domestic space by male vector control personnel, reorganization of the domestic environment as part of control activities, and promulgation of the idea that disease originates from within the home. In addition, women may need to make significant investments of both time and money in order to carry out the recommended control measures. Very little is known about the impact of vector control measures on women. This subject will assume increasing relevance as planners seek to involve householders, rather than the personnel of vertically-organized control programs, in the implementation of vector control measures.
Social Valuation of Women’s Life and Health Saving Activities by Gender Roles and Disease Control Processes in Nigeria

Mrs. Ezinna Enwereji
Department of Sociology
University of Nigeria
Nsukka, Nigeria

This paper seeks to uncover some data on how gender roles and power relations between men and women in Nigeria, with particular reference to Ibo society, have affected disease control measures and disease prevention among women. It also seeks to explain some socio-cultural, structural and biological factors that may affect women’s healthy living. The paper emphasizes the importance of communities in disease control and prevention activities, and the need for their involvement in improving their social and economic lives in order to encourage a better and healthy environment. As for the improvement of women’s health, the paper demonstrates that it is difficult to expect women alone to develop and spread activities that are sufficiently large enough to effect a major reduction in the effective control of a disease such as malaria. A collaborative action is therefore suggested. Any forceful and activist policy by women to curb the spread of diseases such as leprosy, filariasis, onchocerciasis, trypanosomiasis and others, may stigmatise them, or violate their rights and integrity. A laissez-faire attitude may be good to protect women’s freedom, but may not be effective in encouraging disease control measures. Rather, the paper suggests that informing, educating, lobbying, testifying and organizing individuals to understand the advantages of participating and encouraging disease control measures could yield effective results in the society.

Effect of Socio-Cultural Beliefs on Patients’ Perception of Leprosy - The Gender Factor

Dr. N. Awofeso
Leprosy Control Unit
National Leprosy and Tuberculosis Training Centre
P.M.B. 1089, Zaria
Kaduna State, Nigeria

A study to determine the gender factor vis-a-vis the effect of socio-cultural beliefs on patients’ perception of leprosy was conducted with the participation of 293 leprosy patients in Kaduna State, Nigeria. Results indicate that, contrary to popular belief, the male model is not the single interpretative model for leprosy as far as socio-cultural aspects are concerned. These differences are analyzed and appropriate suggestions out-lined.
Differentials exist in the degree to which leprosy incapacitates men and women prior to seeking treatment, and their treatment seeking behaviour. Males tend to seek treatment much earlier in the course of the disease (often at the first onset of symptoms), while females regularly wait until they are severely disabled before they present themselves for treatment. This differential is based in cultural beliefs about the disease and cultural attitudes toward the people suffering from it. More importantly, differential treatment seeking behaviours among male and female leprosy patients lies in broader cultural attitudes toward women. In Bangladesh, women are viewed as unproductive, non-contributing members of the community. Women are expected to be chaste, submissive and monogamous. Their virtuous behaviour is symbolic of family honour and status. Women who fail to meet the criteria for appropriate female behaviour may be unceremoniously abandoned by their husbands or families without recourse and without support. These circumstances speak directly to the issue of leprosy and the differential treatment seeking behaviours of men and women. Fear of abandonment provides women not only with the opportunity, but also with the motive, for hiding their disease. This paper utilizes Kleinman’s (1980) disease/illness distinction to discuss these issues and to suggest the need for approaches to leprosy treatment, which include the ways in which leprosy is culturally constructed and how those cultural constructions impact societal attitudes and behaviours toward leprosy patients, as well as the attitudes and behaviours of the patients themselves.

Skin Failure: The Missing Link of Health Policy

Dr. Terence J. Ryan
Department of Dermatology
Churchill Hospital
Headington, Oxford OX3 7LJ

Research on gender and tropical diseases is a worthy challenge which will only be met when the concept of "Health for All" includes "Health of the Skin for All". Skin failure is a handicap that affects women more than men. This paper describes the initial plans of the International League of Dermatological Societies to add skin to health policies worldwide, and draws attention to the importance of the nurse in carrying this out. This paper suggests that the developing world will look to the developed world for successful initiatives, and describes some of these from the Department of Dermatology, Oxford. I believe the solution to the "Advancement of Women" is humaneness rather than laws, lore or religion. Health policy that includes the skin is a mission that with zeal can overcome any opposition.
Strengthening the Quality of Care at the Health Centre: New Inspiration among Lao Women against Malaria

Dr. Bounlay Phommasack
Head of PHC Office
Department of Health
P.O. Box 1634, Vientiane
Lao People’s Democratic Republic

Despite the great efforts carried out since the last decade against malaria, the disease still remains a number one public health problem in Lao P.D.R. This situation led finally to the raising of the following questions among health authorities, national health planners, and local health researchers: (i) Has the disease been adequately prevented? (ii) Has the disease been forgotten by the health authorities due to the new emergence of the other communicable diseases such as AIDS? and, (iii) Should the health system be reviewed, in order to adequately control the disease?

The paper is composed of five chapters. The first chapter describes the natural conditions of the country, and factors influencing the health status of women and children. The second chapter remarks on the deterioration of health status due to poor planning. The third chapter reviews and redefines the role of the first line health service, focusing on the importance and role of this facility in primary health care. The fourth chapter spells out the suggested solutions to strengthen the quality of care at the first line health service. The fifth chapter presents the proposed model for further research.

Gender and African Trypanosomiasis

Dr. Ogunwale A. Wahab
57 Bale Street
Orile-Iganne
Lagos, Nigeria

The project work gave an expository relationship between African trypanosomiasis and human gender. It also explained, with reference to existing cases, the similarities between the disease and the vector tsetse fly. The project work revealed that the relationship between the disease and gender is that infection follows a particular order: more juveniles and females are affected when the source of infection is close to the homestead, while if the source of infection is far from the homestead, the disease would be predominant in males. This generalization was proven by statistical tables of recent works.

The disease affects underdeveloped rural people. The socio-economic strata of the people affected and the economic recession in Africa made it impossible for complete eradication. Thus, the regions affected need help from the world organizations either in money or humanitarian gestures. Thus I suggest some pragmatic control approaches to solve the disease. These include biological, drugs, or chemical control methods.
Control of Tropical Diseases among Street Begging Women

M.U. Adikwu
Department of Pharmaceutics
Faculty of Pharmaceutical Sciences
University of Nigeria
Nsukka, Nigeria

The paper highlights the role of street begging women in the spread of tropical diseases. The role these women can play in the control of these tropical diseases is also presented. Street beggars, especially women, are either infected with diseases such as malaria, leprosy etc., or are exposed to conditions which could easily lead to their being infected with such diseases. The families they care for, that is, their husbands and children, are also easily exposed to these diseases if the women are infected. Similarly, these females and their families do not usually have homes and sleep in the open, thereby being exposed to the bites of insects, most of which are vectors of tropical diseases. Many street beggars in developing countries do not always have the means of seeking treatment. They act, therefore, as reservoirs, and hence as vectors in the spread of many tropical diseases. Controlling the infection of street beggars with tropical diseases will form a major break in the link of the spread of tropical diseases between the insect and human vectors and the uninfected.

Le Paludisme tel qu’il est connu et vécu dans les familles de pêcheurs de Selingue au Mali

Dr. S. Coulibaly
INRSP
BP 1771
Bamako, Republic of Mali

This study, implemented in the Selingue Dam area, aimed at (i) identifying the symptoms, causes, mode of transmission, treatment and prophylactic means of malaria among fishermen; (ii) describing the types of health seeking behaviours, and the role played by the fishermen’s wives in the management of health events; and, (iii) analyzing and comparing total health expenditures with malaria-specific ones.

The results showed that the fishermen had a good knowledge of the symptoms and modern drugs used for malaria treatment. On the other hand, they had no knowledge on the mode of transmission and the prophylactic means. The mosquito was recognized as the causal agent of malaria in only 2% of the answers in both sexes. Likewise, the role of mosquito bites in malaria transmission accounted for only 3% of all the cited modes of
transmission. The usage of bednets as a prophylactic means represented 4% of the answers. Women were significantly more aware of the prophylactic use of chloroquine than the men ($X^2 = 5.54 ; p = 0.02$). In more than 80%, self treatment was done.

The role of the householder in health seeking behaviour and supporting the health expenditures was a function of the severity of the disease: the rapidity of his decision increased with the severity. The wife played an important role in the decision-making process with respect to her own problems and those of the children.

The health expenditures were very low, FCFA 700 per health event on the average. Most of the expenses covered the drug costs which accounted for 80% of all the health expenditures. The malaria-specific expenditures accounted for 22% of the total health expenditures among the men compared to 14% among women. The average cost of one malaria attack was FCFA 340.
About the Institution

The International Development Research Centre (IDRC) is a public corporation created by the Parliament of Canada in 1970 to support technical and policy research to help meet the needs of developing countries. The Centre is active in the fields of environment and natural resources, social sciences, and information sciences and systems. Regional offices are located in Africa, Asia, Latin America, and the Middle East.

About the Publisher

IDRC Books publishes research results and scholarly studies on global and regional issues related to sustainable development. As a specialist in development literature, IDRC Books contributes to the body of knowledge on these issues to further the cause of global understanding and equity. IDRC publications are sold through its head office in Ottawa, Canada, as well as by IDRC's agents and distributors around the world.