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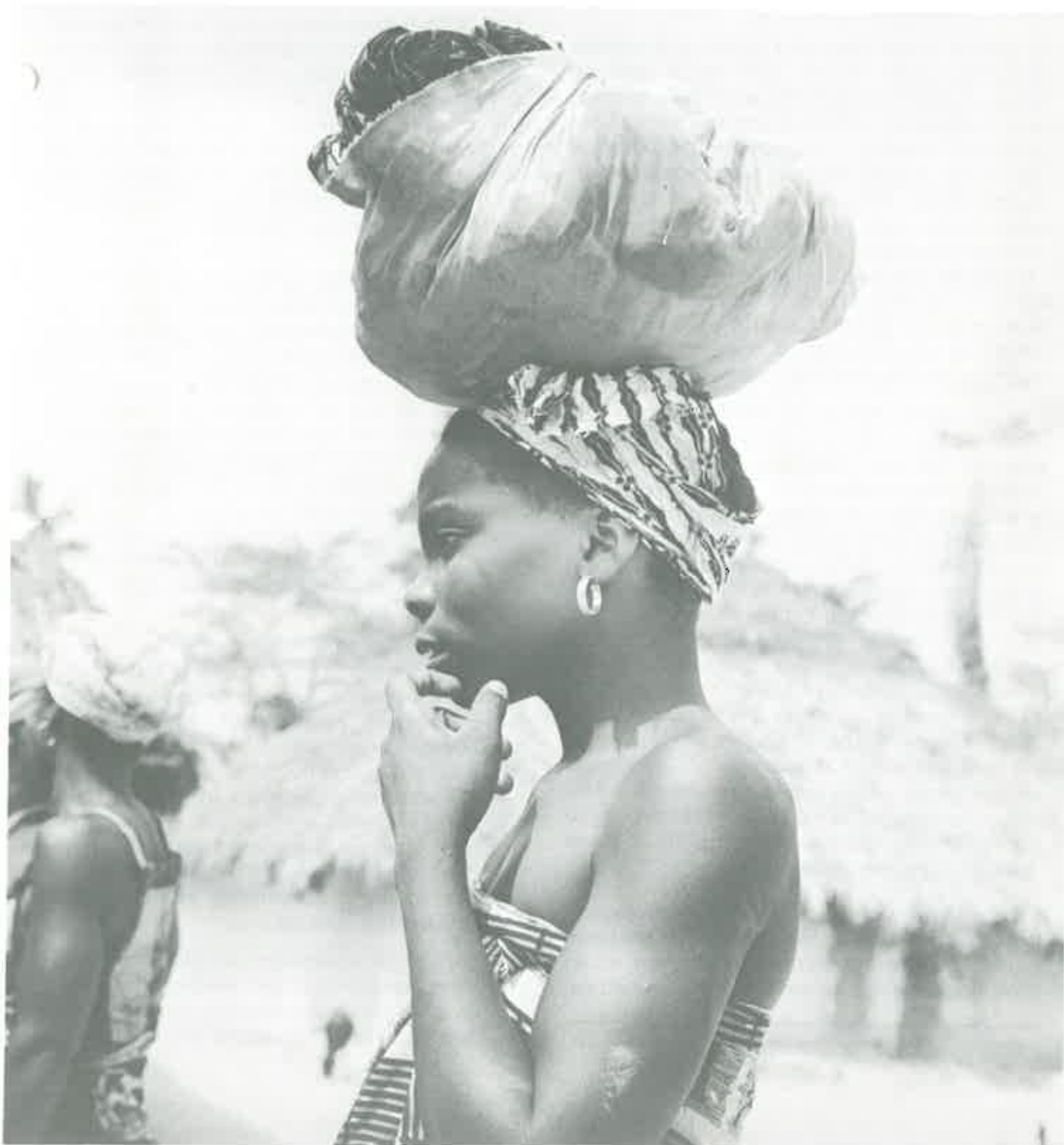
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WOMEN AND HEALTH

Women's Health is More Than a Medical Issue



WOMEN'S HEALTH—A DECADE OF PROGRESS?

As we near the end of the United Nations' *World Decade for Women*, the CMC focuses in this issue of CONTACT on the broad picture of women's health as we have come to understand it in recent years. We also try to underline progress that has been made in responding to women's health needs by taking note of some programmes promoting women's health and by suggesting ideas for action so that progress in the field of women's health can continue.

In talking about women's health one quickly becomes aware of the difficulty in defining those problems which are specific to women and those which affect women as part of the whole community—particularly in the developing world where women are impoverished, malnourished and of low status in communities where many men share these very same problems. What our authors this month emphasize is that even where men and women have the same problems, women stand at the bottom of the ladder, below men in the same communities in terms of poverty, overwork, malnourishment and low status.

Cathie Lyons' article, "A Woman's Health is More Than a Medical Issue", is helpful in pointing out the underlying health needs of women—needs which often pass unperceived when one looks at health in a more strictly medical way. This article is adapted from Ms. Lyons' address at the November, 1983, conference on "Women and Health" sponsored by the General Board of Global Ministries of the United Methodist Church in the U.S.A. The seminar called attention to the larger contexts within which women's health concerns need to be addressed: not only the UN Decade for Women, but also the WHO goal of "Health for All by the Year 2000" and the CMC emphasis on the church as a healing community. Ms. Lyons' article is a valuable contribution to understanding that women's health is more than the absence of disease.

In addition to the social and psychological needs outlined by Cathie Lyons, there are traditional areas of concern about women when their health is considered in a more medical

way: reproduction and childbirth; the special problems that sexually transmitted diseases pose for women; cancers of the breast and reproductive organs; physical abuse of women. Our issue opens with a brief extract, "The Unmet Health Needs of Women" which describes these medical problems—problems which co-exist with or are even caused by the broader issues identified by Ms. Lyons.

It is difficult to evaluate the progress made during this decade in combatting women's health problems. Health statistics in developing countries in general are hard to come by; global data on disease prevalence have mainly been analyzed by age rather than sex; data on women's problems are difficult to measure due to their complex causes; and information on certain conditions is inadequate.

There may be other reasons why information on women's health problems is sparse, beyond the difficulty of collecting adequate statistics. It is possible that women do not give accurate information about their health problems because of social customs and traditional modesty. Or perhaps, as Cathie Lyons' article points out, chronic fatigue and morbidity may simply be accepted as being normal for a female. It might also be true that if women were participating in policy making and selection of research topics, greater priority might be given to collecting reliable data about women's health.

In addition to considering women as receivers of health care or as those whose health is influenced by social and psychological factors, we should also be aware of women's role as providers of health care. Women provide health care to the majority of the people in the world—whether as workers in primary health care and in clinics or hospitals, or more informally in families, as they care for children, the sick and the elderly. Yet the contribution that women make to community health is often undervalued or ignored.

When we look at women's traditional chores—cleaning, preparing food, feeding the family, and washing dishes, disposing of trash, obtaining and storing water, doing laundry, bathing

children—then we realize that women are also the basic teachers of hygiene and sanitation. The way they live their daily lives has an important influence on the health of their children and their communities.

Women workers in more formal health programmes, whether nurses or primary health care workers, often have very low status. Many observers in developing countries point out that primary health care itself seems to suffer from low status, perhaps because most village health workers are women. Two suggestions are often given for improving the status of women health workers: more education and more voice in decision making at every level of health work.

The women who are quoted in this issue of CONTACT send a message of hope and a call to action to women everywhere. They ask that women work for access to education, resources and decision making; and they suggest that women help each other in reaching for these means to healthy lives. Taken together, these views on women's health seek to help women toward the kind of lives embodied in the CMC's working definition of health:

Health is a dynamic state of well-being of the individual and the society; of physical, mental, spiritual, economic, political, and social well-being; of being in harmony with each other, with the natural environment and with God.

Courtesy CIRIC, Geneva

Learning to read in Nicaragua.



SPECIAL HEALTH NEEDS OF WOMEN

The following brief paragraphs describe the special health needs which women have, simply because they are female. Most of these needs are experienced by women in every country, but cultures have different responses to women's health needs, depending upon customs and resources. We need to ask if women are being taught about their own health. Are they motivated to take care of themselves? Are they learning to recognize abnormalities? If help is available for health problems do women know how to make use of it?

HEALTH NEEDS RELATED TO REPRODUCTIVE FUNCTIONS

Maternal Health

Pregnancy is fundamentally a healthy process, but it can be dangerous to the mother if the environment is poor: if no care is available; if hygiene surrounding delivery is seriously deficient; if food is inadequate or if the mother has no time to rest. Too many pregnancies, or pregnancies too close together, also result in ill health or death for mother and child.

Every woman should be examined early in her pregnancy to detect risks, so that she then may receive the attention necessary to avoid serious problems associated with pregnancy and delivery.

While in developing countries there is a lack of adequate maternal care, many problems arise in industrialized countries because of the abuse of technology and over-medication during pregnancy and delivery. Both situations call for an appreciation of the knowledge possessed by midwives and informed self-help by women whenever possible.

Family Planning

While many couples use some preventive method, family planning is by no means within everybody's reach. Although it is women who carry the major burden of too frequent pregnancies and births, all too often they do not have access to information or a family planning service. Husbands often do not allow their wives to make use of family planning methods. Sex preference in children, the State and

religious authorities also play a major role. If there is to be self-reliance in family planning then there cannot be forced sterilization or oppressive population control.

Research into birth control methods for men has to be speeded up and attitudes favouring joint responsibility for family planning developed. At the same time, not enough is done to compare the full range of contraceptive methods, including barrier methods, as to their acceptability to women.

Abortions

Throughout the world, women are seeking abortions in large numbers; it is estimated that one in every four pregnancies ends in abortion. Where they are illegal, the operations are carried out without adequate hygiene or care, leading to short- and long-term complications and death. The availability of effective and safe contraceptive methods has to be increased to prevent such abortions.

Infertility

Infertility is a major problem, especially in societies in which childbearing is highly valued. Among the many causes are the different sexually transmitted diseases, especially gonorrhoea and syphilis, and infections due to inadequate care during childbirth, delivery and abortion. However, it is not always the woman who is responsible for the childlessness of a couple. Unfortunately in many societies men refuse to have themselves examined and the whole blame is put on the woman.

Sex Education

Sex education is not yet widespread. As a result, many couples never talk about subjects related to sexuality and fertility, and insufficient or wrong information can be harmful to them.

Anaemia

Anaemia in women, especially iron-deficiency anaemia, is very common; in developing countries it may affect at least half of the non-

pregnant and two-thirds of the pregnant women. Anaemia is particularly serious when combined with infections such as parasitic diseases, and in view of women's heavy workloads. It lowers resistance, causes fatigue, affects working capacity under conditions of stress, and increases susceptibility to other diseases. (Iron-deficiency anaemia is a condition characterized by a low haemoglobin content of the blood.)

Female circumcision

Female circumcision, a cultural practice which has less severe and very severe forms, can lead to accidental damage to surrounding organs, infertility, severe pain, infections, psychological disorders, urinary complications, difficulties in or impossibility of sexual relations, difficult labour, brain damage to the child born because of delayed labour, psychosexual complications in both partners and death of the woman either as a result of the operation or during childbirth. Local initiative and education can change the situation.

INFECTIONS, INCLUDING SEXUALLY TRANSMITTED DISEASES

Infections which women suffer (e.g. genital tract infections) are numerous and widespread, and they contribute to a continuous and physically draining fatigue. These infections are closely related to poor care and hygiene surrounding childbirth, delivery or abortion, to the effects of communicable diseases such as tuberculosis, schistosomiasis and filariasis, and to the many sexually transmitted diseases. The symptoms vary, though for the majority of women in developing countries they may be thought of as "normal", or not serious enough to lead them to seek medical attention. Many of the genital tract infections, if untreated, can lead to the more serious pelvic inflammatory diseases and, subsequently, to infertility.

Sexually Transmitted Diseases

As to the sexually transmitted diseases, there is a wide range of psychological, social and health issues involved which make the problems more complex for women than for men. Sexually transmitted diseases are more difficult to diagnose in women, and women's lack of information about the diseases, along with feelings of shame, social taboos and so on, hinder them from seeking treatment when

necessary. Certain sexually transmitted diseases—syphilis is an example—can be transmitted to the pregnant woman's child. Gonorrhoea can cause eye infections or blindness in the newborn.

CANCER

For cancer of the breast and cervix, the prognosis (likelihood of recovery) is improved if the cancer is detected early. In some cases it is possible to identify a pre-cancerous condition through screening and begin active treatment.

Cancer of the Cervix

Cancer of the cervix (the neck of the uterus or womb) seems to be the most frequent cancer affecting women in certain developing countries, especially in South and Central America. Screening for cancer of the cervix is mainly done by the "Pap" smear test, named after Dr. Papanicolaou. In this test some cells are gently scraped from the surface of the cervix and examined under microscope.

The Pap test helps in early diagnosis, thus reducing the number of deaths from cancer of the cervix. Therefore it is recommended that all women should have a Pap test every year beginning at age 20 or at the beginning of sexual activity. Periodic pelvic examinations by a doctor are also recommended.

Screening programmes for cancer of the cervix are useful where resources are available. The major obstacles to such programmes are the lack of convenient facilities and a shortage of trained staff to perform the tests.

Breast Cancer

Breast cancers are frequently found by women themselves. Self-examination means earlier diagnosis, and earlier diagnosis means fewer deaths from breast cancer. Therefore self-examination of the breasts should be recommended as a routine practice for women throughout the world. It is very useful for women who rarely have access to a doctor (see pg. 4). It takes only a few minutes a month for a woman to lie flat and examine the various portions of each breast and the edge of the underarm area, with gentle pressure from the fingers held together.

VIOLENCE AGAINST WOMEN

As a result of their low social status, women become the subjects of much violence. Wife

beating is a phenomenon which exists in practically every part of the world and which is not restricted to certain social classes. Rape is another form of violence which women suffer in every culture. Incest, especially when it involves very young girls, can permanently harm the woman both physically and psychologically. Forced prostitution can also cause serious damage to the woman's health. These forms of violence not only result in direct physical suffering and psychological disorders, but can lead to other forms of ill-health as well. Violence against women may also end in murder, especially in connection with rape, prostitution or wife-beating.

These points are adapted from the "Women, Health and Development" kit prepared by JUNIC/NGO Sub-Group on Women and Development of the Joint United Nations Information Committee's Working Group on Development Education.

Educating Women About Examining Their Breasts

A woman herself is the best person to notice any sign of problems in her breasts. She knows the shape and texture of her breasts better than a doctor or health worker. Therefore, she increases her chances of finding a cancer lump early if she learns the procedure for examination and practices it monthly.

A woman may examine her breasts by lying down on a floor mat or bed. Show her how to put a pillow or folded towel under her right shoulder and then place her right hand behind her head. Explain that this distributes the breast tissue more evenly on the chest. Then show the woman how to use her left hand to gently feel the breast with the flat of her fingers. She should move her fingers in small circles or with a slight back and forth motion.

A woman will not easily see differences or changes in the shape of her breasts when she first begins to examine them herself. She should



examine them frequently until the practice is familiar. When the woman can begin to recognize what her breasts normally look like, then changes will be easier to see.

Check Near the Underarm

Tumours occur most often between the nipple and the underarm. A woman should pay special attention to this area. Also, show a woman how to gently squeeze the nipple of each breast between the thumb and index finger. She should look for any clear or bloody discharge.

A woman who finds a lump or swelling in her breast or a discharge from her nipple should visit a health clinic as soon as possible. Most breast lumps or swellings are not cancer. But to be sure, a woman should have any changes checked.

Teach Others

Ask a woman who has learned to examine her breasts if she would teach others. Ask her what she would need to teach others. Assure her that you will give her any help that she might need.

Follow your teaching session with a visit to the woman's home. Ask her whether she has examined her breasts. Ask her whether she has taught any other women these techniques.

From "Problems of Women", MEDEX Primary Health Care Series; John A. Burns School of Medicine, University of Hawaii.

A WOMAN'S HEALTH IS MORE THAN A MEDICAL ISSUE

By Cathie Lyons*

If we search for those things which affect health, we soon find a number of factors which are not commonly thought of as contributing to health or illness. Increasingly it is recognized that our health is affected by the circumstances of our lives: environmental and living conditions, resources and life styles, as well as the political and economic realities.

Customs, attitudes and cultural traditions all affect health, and in the case of women and girl children, the effect is often negative. As we look into the question, we realize that a woman's health is more than a medical issue. Women all over the world have underlying health needs which should be recognized and studied so that action can be taken to allow them to attain and transmit good health.

HEALTH AND STATUS

The interrelationship of a woman's health and her status is of primary importance. It is a painful reality that for millions of women the most pervasive disadvantage under which they live is the fact that they were born female. The status of women within the family, the community and society must be improved as an important step in the overall improvement of their health.

Fathia Al Assal, an Egyptian woman writing from her own perspective about her countrywomen, states succinctly, "Do you know what women lack most? The knowledge and conviction that they are human beings."¹ Many women across the world have accepted their lesser status as being as natural and unchangeable as the fact that they are female. No matter which way these women look there is reinforcement for the perception they have of themselves as being of little importance or value.

BOY OR GIRL?

Traditionally in many cultures the birth of a boy is greeted with rejoicing while the birth of a girl is almost ignored. In China, where girl babies have sometimes been abandoned or killed, strict government planning now limits families to one child. As a consequence, according to China's *Health News* there is an increase in the number of women who are asking for tests to determine the sex of the unborn child in order to have an abortion if a girl is predicted. According to Chinese newspapers mothers themselves are being mistreated if they do not bear a son: some are beaten, psychologically abused or abandoned because they produced a daughter. In the lives of girls the message gets across sooner or later that a higher value is placed on boy children, and that males not only have privileges, they have *rights* which women don't have.

In the rural Philippines it has been found that "families spend more money on food for boys than for girls, especially in the one-to six-year-old age group."² Researchers who are concerned about the rates of physical and mental disabilities among females state that "in developing countries, where 80% of the world's disabled population live, one of the major causes of disability for women is malnutrition."³

Sheila Sundaram (speaking at this same conference on "Women and Health") says, "Equal rights for women are enshrined in the Indian Constitution. UNICEF has started a campaign for equal rights to start in the cradle. The task of extending meaningful equality for Indian women is proving heartbreakingly slow—too many families want at least two sons, and a daughter is just an extra mouth to feed. A re-

* Cathie Lyons is Assistant General Secretary of the Program Department of the Health and Welfare Ministries of the General Board of Global Ministries of the United Methodist Church. This article is adapted and condensed with permission from the *Women and Health* Development Education Resource published by the General Board of Global Ministries of the United Methodist Church. Copyright reserved. Please do not quote without written permission.



Photo: ILO

Reading braille in India.

cent Punjab study, in India's best-fed state, showed that 10 times as many female infants as male infants die of nutritional marasmus."

A woman's status and her health are intricately intertwined. Any serious attempt to improve the health of women—if it is to succeed—must deal with those ways in which a woman's health is affected negatively by social customs and cultural traditions simply because she was born female.

WOMEN WITH SPECIAL HEALTH NEEDS

The Elderly and Disabled

As well as women's general unmet health needs often made worse by low status, earnest consideration must be given to the needs of special groups of women. We must listen to elderly women, widows and the disabled when they tell about the obstacles they are up against—socially, mentally, and physically—in their frustrated attempts to care for themselves, to have their abilities taken seriously and have their needs as persons recognized.

Sheila Sundaram notes that: "A casual study between 1976 and 1983 in four blocks of the Mathura area by NIRPHAD showed that in spite of prejudices and discrimination against blind women, if given the right treatment they can share in the achievements of the community...Here it is noted that training and education are key words."

UNICEF reports on health needs related to aging: "In situations of extreme poverty in developing countries, old women, who in the past were valued members of an extended family, often now live in a state of destitution. Misery among old women is quite frequent in industrialized countries as well."

Black Women in South Africa

The resettlement areas where Black South African women are forced to live are similar to one another in their barren conditions, their low levels of productivity, and the lack of job opportunities therein. Because husbands, sons and brothers work and live in white areas and are separated from their families for weeks and months at a time, the "homelands" are composed largely of women. In their care one finds the infirm, the elderly, and children.

In addition to their unmet physical health problems, these women suffer severe mental and emotional anguish, a sense of hopelessness which penetrates every aspect of their lives. The enforced mass removal from a familiar environment and the destruction of home and family support systems thrust them into an unnaturally lonely existence. Many are unable to cope adequately with the resulting trauma.

Refugees and Migrants

Refugee women all over the world share many of these same problems. The large majority of refugees in the world are women, often acting as heads of families; their men are at war, dead in combat, or in prison.

Not only are these women frequently victims of physical abuse and rape, they are also at a disadvantage in food distribution or health care. Girls and women, even heads of families, usually tend to take their places at the end of queues in any refugee situation. Recognition of this fact has prompted the World Council of Churches to recommend positive action in regard to women and girl refugees. (See box.)

That the special vulnerability of female refugees needs to be more constructively dealt with seems beyond dispute. The real question is how to do it. Even if discrimination against women could be eliminated, which will not happen suddenly, this would be no solution for countless females against whom discriminatory practices have already long been carried out. It therefore seems

inescapable to conclude that the most hopeful approach lies in purposely favouring refugee women and girls as a specific target group, with emphasis on self-reliance and an active role by them in helping overcome their problems with outside assistance when and as necessary.

The World Council of Churches through its member churches operates service programmes to refugees in all parts of the world where forcibly uprooted people are found. Among these many programmes are a number directed especially at assisting refugee women and girls. In Burundi, for example, the WCC's partner, the Protestant Alliance, has for several years been running women's programmes in refugee settlements which stress literacy, home management, child care and health education, and vocational training of several kinds...

Although refugee work is rightly carried out on the principle of making assistance available on an equal basis to all who are in need, it is only natural that exceptions be made for those persons who are most vulnerable. Evidence from refugees throughout the world convincingly indicates that women and girls belong to this category. It is therefore imperative that priority attention be given to understanding their problems and then devising ways to deliver more effective help in cooperation with them.

Refugee Service of the Commission on Inter-Church Aid, Refugee and World Service, World Council of Churches.

Another group of women with similar needs are those who migrate from poorer countries of the world to more developed countries, or those who migrate from rural settings to cities in the developing world in search of a better life. Many of these women do not make it beyond the squalor of burgeoning shanty-towns on the edges of big cities. They are among the poorest of the world's poor, and their risks of illness owing to overcrowding, lack of water and sanitation and unstable sexual relationships are much greater than those of other women in the world. Not only are these women confronted with unemployment, but they find they have no social group to fall back on for support. They suffer the lost protection of the extended family and may accept prostitution or turn to drugs for escape.

(Included in this issue is a short article describing how women in a Brazilian "favela" (Shanty-town) found answers to some of these problems.)

These examples of special needs of special groups of women show the kind of health plan-

ning which must take place, what kind of goals this planning must consider, the kind of community health training that is needed, and those who must be consulted in the planning process.

WOMEN'S WORK—NEVER DONE?

Women's work is a third focus for improving women's health. Women need shared work loads and new ways of working.

A time-tested verity states, "a woman's work is never done." Krishna Ahooja-Patel suggests, "some of the serious problems affecting women's health have remained hidden behind the barriers of traditional habits of thought."⁴ Most women are constantly at work contributing, in Patel's words "to the treasury of human endeavour." And yet, to the larger society a woman's work—particularly that which she does within the home—is largely invisible, undervalued, and not seen as a factor which is a determinant in her overall health.

Many women "remain physically fatigued and psychologically overburdened through their work life cycle", says Patel. This is true not only in rural areas of developing countries where women fetch water, seek firewood and fodder, cook the meals, do the laundry, and are, in addition, the mainstays of agricultural production as well as raising children. It is also true in urban areas of developing countries and in industrialized countries.

"A comparative study conducted by UNESCO was carried out in urban sites of ten industrial countries. The study indicated that both in free market and centrally-planned economies, wage-earning women with children were working longer hours than men and had less free time and fewer hours of sleep."⁵

New Ways of Working

Appropriate technologies to help women in their work would be of great benefit because a woman's health is directly affected by the work she does and the conditions under which she does it. Tools available to rural women are often of the most primitive kind. The girl walking from the distant well with a jar of water on her head may be picturesque but she is a symbol of neglect in a technological age.

Listen to the voices of women in rural development and they will speak not only of the need



Photo: Christian Aid, London

A labourer near Delhi, India.

for adequate clean water; they will ask also that it be locally accessible through a community well, and that they have light containers rather than earthenware pots to carry the water from the well to home. Likewise, these women will speak of the need for light carts to be used in transporting water, wood and agricultural produce.

These women speak clearly about the help they need to make their work more effective and productive. On the one hand, their needs are specifically job-related. Looked at from another perspective, however, these needs are also health-related. There is a physical significance to the weight women lift in carrying firewood and water. Continual lifting of heavy burdens not only favours severe arthritis of the spine and limbs, but uses up the woman's energy.

Particularly during the last three months of pregnancy when the weight gain of the foetus is crucial, the pregnant woman should either increase her food intake or limit her physical activity to ensure proper growth of the baby.

Chronic Fatigue

More needs to be done in every country in regard to the effects that stress, fatigue, anaemia and infections have on women's lives and health. In the industrialized countries women generally outlive men, but this fact obscures the more important issue that many women suffer consistently more chronic morbidity throughout their lives. These women might live longer than their male counterparts, but their overall health status is unsatisfactory and their longer life-span is mainly due to lesser rates of accidents, cardio-vascular diseases and alcohol- and tobacco-related diseases.

Women's high morbidity—whether it is caused by malnutrition, infections, unregulated fertility, overwork or a combination of these—contributes to a continuously debilitating fatigue. This physical and mental fatigue is too often interpreted as an inherent characteristic of being female.

When one observes the work women do and the conditions under which they do it, one is made aware that the health of women could be improved in a number of ways, not least of which include: lightening the loads they carry—or better sharing them with male companions; developing the appropriate technology to make their work easier or to reduce the number of hours they work in a day; and providing possibilities for them to benefit from technical training to improve their skills and increase their knowledge.

COMMUNITY SUPPORT

The fourth underlying need for women's health has to do with communities and community services, and how aware and responsive they are to the overall health needs of women. Hospitals and clinics have invaluable roles to play in the detection and treatment of illnesses. However, community programmes are better able to focus on the community and on an individual's life situation; they can offer better preventive care and can often solve problems before they require formal medical treatment.

Take for instance, a woman who has been the victim of domestic violence. She may need medical care, but above all, she needs a change in her life situation. In Maharashtra State, India, rural women who originally banded together to form an agricultural union have used their organization to struggle against wife beating and drunkenness, seeking prevention of the problem by common action.

Community support systems vary from culture to culture: some are formally organized groups such as churches or day-care centres; others are the traditional tribal and family groups who support and nurture women during stressful times of their lives. Health workers in many cultures point out the great comfort given to women during childbirth by traditional birth attendants, families and sometimes the whole community. When women give birth in hospital situations they often lose the psychological support of families and relations; they become tense and frightened without these support systems.

Health has to do with the availability of support, whether in the form of family and friends or through community organization. No matter how informal these systems might be, they are fundamental to overall health maintenance. The example below describes the part that mutual support played in promoting mental health among Black women in South Africa whose stressful existence is described earlier.

Thousands of women in the rural reserves of South Africa are being given long-term drug therapy as psychiatric out-patients. We spoke to ten women, half of whom have been hospitalised as psychiatric patients, and who are receiving drug treatment. They have recently formed a women's club with motivation from a local social worker who sees their mental health problems as stemming almost exclusively from the stressful socio-economic conditions these women have to endure. Similarly, she sees the solution coming from a relief of these stresses and thinks that group work and community organisation are part of this solution. She rejects drug therapy, accompanied in dire cases by food rations in the form of 'poor relief' as anything but stop-gap, crisis control measures with no long-term benefits for either the mentally ill woman or the community to which she belongs.

Here is part of the discussion we had with this group, translated from Sotho.

Q: How did your group start?

Mrs P: One of our members went with the social worker to another village where the women have had a club for a long time. She was very impressed with the food in the gardens of those women, so she came home and told us we should also start a club and grow food for our children.

Q: Mrs. M, why did you go to the social worker?

Mrs M: It was that time when I came from Groothoek hospital. I slept for 2 months at Groothoek, then when I came home I found my children were living with no

food at home, just asking some food from my neighbours, so I went to the social worker to ask for help with buying food.

Mrs K: (social worker) When Mrs M. was admitted to Groothoek, she could take only this small baby with her—the one you see here which is now about 5 months old. The other children were left at home to look after themselves. There was no assistance from the government or anywhere for them. That's why these other women had to look after them. They gave them food, money for school, everything. You know, Mrs M. did not know what was happening to her children while she was in hospital. She just had to stay there for two months worrying whether her children were managing at home. Then when she came, she found that her neighbours had been helping the children.

Then she came to see me because she was desperate—there was no food from the fields, there was no money because she is the breadwinner in the family. She told me that usually she goes to work on Schoeman's farm (former Minister of Agriculture) but now since she has been sick, she had been staying at home. I wondered what I should do to help this woman. Usually I don't like poor relief—it keeps you alive for today but tomorrow you can starve—so I didn't see that as a solution. I suggested to Mrs M. that she talk to her neighbours, several of them are struggling with similar problems, and see if we could not form a women's group which could do things such as buy vegetable seeds together in bulk, then work as a group on each other's gardens. I saw that as a possible long-term solution to some of the difficulties these women were having—if they could co-operate and have a joint interest, it would help them to overcome the frustrations and despair which made them be admitted to Groothoek and treated as depressive psychotics. They just give them injections, pills and what not, then when they are a bit calm, they discharge them, send them back to the very home conditions which drove them into this condition in the first place. They know, they say people are mad, but it's mostly that they are suffering terrible burdens from living in these barren, dry places with no employment possibilities, no income, children and so on, that they just can't stand it. As a social worker in the rural areas, almost each and every day you find one or two of these cases at your office. What can you do?

Mrs R: It's good that we have made a club, because we know that if one of us goes to hospital, others will be looking after her children.

Q: How many of you have been to hospital?

Mrs R: You mean to Groothoek?

Q: Yes

Mrs S: We are five. Others also go, but from the members of our club, we are five.

Q: Do you also get treatment at the local hospital?

Mrs M: Yes, some others go every month for injections, others get only tablets. They say we must take those tablets every day otherwise we'll do funny things.

Q: What do you do together in your club?

Mrs P: We are growing vegetables and making fences for the gardens from aloe branches because we haven't got money for wire. We will work together more when our work in the fields is finished. We are still working hard in the fields.

Q: What do you grow in the fields, and how much land have you got?

Mrs M: I've got only this field we are sitting in. It is 7 acres but because of lack of money, another rich man ploughs for me, then I give him half of what I grow. He ploughs then I've got to look for my own seed—I just ask seed from anybody who can spare some.

Q: Don't you keep seeds from the last harvest?

Mrs M: I did keep seed from last year, but it became clouded with ants, so it was useless. Then I just asked some mabele (sorghum) seed from anybody and some mealie seed, and planted them.

Q: What do you do with the grain you harvest?

Mrs M: I grind it with a stone, then make porridge for my children. Sometimes, I also get merogo (wild spinach) from the field. But since we came to this place, we do not get good harvests. We used to live on the other side, but they said we must move and come to live here. Then, after we moved, my husband died, so I've got nobody who can help me. My children are still at school.

Q: How many children have you got?

Mrs M: They are five; the first-born is a boy doing Form 2, next is a girl—she is 15, born 1967. She is staying with a school teacher in Johannesburg as a baby sitter. She is not attending school, she just looks after the children of the school mistress. That mistress from this place, then she saw that I was struggling with my children, so she said I must give my daughter to her to go to Johannesburg. She said she was going to send her to school. Now when my daughter came home at Christmas, she gave her R20, but my daughter said she was not attend-

ing school. She is looking after the small children of that mistress every day without wages. But what can I do because I've got no money?

Then, the third-born is a boy of 12 years, doing Std.I. The other two are here with me in the fields—this one is a boy of 4 years and this one is a girl—she's 5½ months. After my husband died, another man told me he wanted to marry me, but when I got this baby he ran away.

Q: How do you think that working together in the club can help you all to solve some of the problems you have?

Mrs M: When we work together we can talk and then the work goes quicker and it is less tiring. Also when you've got problems, maybe the others can help you. The trouble is we are all new to this place. We come from different places. My home is far away, then I came here with my parents five years ago. They said we must move from our home because they say they are going to make some big farms there. I think that's why I became sick because it's not good to go to a new place.

from Critical Health: "Women and Health", No. 9, May 1983. Printed by the University of Witwatersrand.

PHYSICAL PROBLEMS— PSYCHOLOGICAL DIMENSIONS

Important also is the need for understanding that some physical problems that affect both men and women take on special psychological dimensions in women. Sexually transmitted diseases (STD) and alcoholism are two examples. Not only are these diseases often more readily detected in men, but also men have cultural factors on their side in seeking treatment.

Sexually Transmitted Diseases

Many cultures accept or even encourage the fact that men will have sexual encounters with more than one woman. For example, in the Caribbean the belief exists that a man who has venereal disease will be cured if he has intercourse with a virgin. Where such beliefs exist, both men and women are victims of harmful cultural practices.

In their article on "Sexually Transmitted Diseases, A Neglected Problem for Women"⁶, Sevgi Aral and Mary Guinan write: "First, a woman may fear she will be suspected of infidelity, even if she has in fact been infected

by none other than her husband. Second, diagnosis requires the woman to remove her clothing for a pelvic examination, an excruciating experience for many Third World women. In some Muslim countries where virtually all doctors are men, women cannot even be addressed verbally by the physician, much less be touched by him."

When a sexually transmitted disease infects a woman who then becomes pregnant, she faces possible tragedy. Venereal diseases which are not treated—depending on their type and seriousness—can lead to illness or even death of the infant. As any woman knows, there is an inexhaustible amount of mental suffering for a woman whose children are infected by a disease transmitted by her.

Alcoholism

Problems similar to the above are experienced by women who overdrink or who are alcoholic. Whether a woman uses alcohol as an outlet for pent-up anger, boredom, or anxiety, her overdrinking often conceals deeper longings such as the need for love and security.

Female alcoholism has been a carefully hidden problem. A family does not like to admit it exists, and society has not wanted to hear about it. People disapprove of alcoholic women more than they do of alcoholic men.

Alcoholism and sexually transmitted diseases are only two examples of problems that affect people of both sexes but which take on special acute dimensions in women, social, cultural and economic factors make the women's situation more difficult.

MATERNAL HEALTH

Society must recognize the importance of maternal health to the infant, the family and the community as a whole. No doubt it is in the area of family responsibilities that the impact of culture and male and female roles are the most difficult to change.

The rights and privileges which women have within the family vary from country to country. Marriage laws, divorce laws and inheritance laws affect women differently in different cultures. Likewise, the role women play in regard to family and money management, or decisions about their children's lives is largely dependent on long-standing traditions.



Photo courtesy WHO

The child's health depends on the mother

However, in regard to the female responsibility to bear and raise children traditional attitudes are relatively similar. Whether in industrialized or developing countries the most ingrained beliefs are about the roles of male and female, owing to the fact that women can become pregnant and give birth. Societies have always emphasized the importance of the female reproductive role. For many women childbearing provides the best opportunity they have to be considered important and of value to their families and communities.

For too many women, however, too much emphasis continues to be put on the "value" aspect of childbearing—and hence the responsibility to bear children—while too little consideration is given to the health of the woman and her socio-economic situation.

We must consider these facts:

1. Too many women die in childbirth from complications which could have been avoided. Surveys over the past ten years have revealed that in most developing countries maternal mortality is among the top ten causes of female death. A large survey of women in rural

Bangladesh has revealed that maternal mortality has accounted for "57% of the deaths of women ages 15-19 years and 43% in the age group 20-29 years."⁷

2. Too many women have more children than they want and can provide for because the contraceptive help they need is not available, or they do not know how to use it, or are afraid of the risks involved, or—because of cultural or religious reasons—she or others in the family decide that use of contraceptives is not acceptable. Half of all Third World women recently surveyed want no more children, yet, for one reason or another, only half these women are using contraceptives.⁸

3. Too many women suffer from maternal depletion syndrome. "Undernourished, often anaemic, and generally weakened by the burdens of excessive reproduction, the victims of this syndrome become increasingly vulnerable to death during childbirth or to simple infectious diseases at any time, and their babies also swell the infant mortality statistics."⁹

4. Too many "high risk" women become pregnant with dire consequences for their own health and the health of their babies. It is a well-established fact that pregnancies too early (under 20 years) or too late (over 35 years) increase the risks of maternal mortality.

Teenage pregnancies occur in rural areas of the Third World when women marry very young. Although the legal age of marriage for girls in India is 18 and child marriage has been banned for many decades, the average age of girls marrying in Uttar Pradesh is still only 15. The girls involved often recognize that they are ill-prepared for marriage and motherhood, but they have no say in their fate. Village authorities have not been able or willing to enforce the legal marriage age.¹⁰

Teenage pregnancies are also a problem in the developed countries as youth make it clear they are going to be sexually active whether or not contraceptives are available. Problems of teenage pregnancy can only be solved by changing the community attitudes and by greater understanding by young people themselves of the risks and responsibilities of becoming teenage parents.

The health of the mother, of course, is not the only matter at stake. Other facts which need to be kept in mind include:

1. Too many infants do not survive the first week of life because they were born with too

low birth weights owing to the fact that their mothers' nutrition was so poor and their workloads so great during pregnancy.

"Of the 21 million low birth weight babies estimated to be born annually, 20 million are born in developing countries."¹¹ These small-for-date babies are mostly born at full term but with growth retardation and other problems which greatly increase their chances of not surviving infancy. A baby's weakness causes a constant physical and emotional strain on the mother.

2. When a woman's pregnancies come too close together, not only might the newborn suffer, but the next oldest child becomes a victim, too. "A study in Punjab, India...revealed the dangers that a short interval between births holds not only for the newborn baby, but also for the next oldest child. When another baby appears quickly, the nursing child may be preemptively weaned."¹² The problem is a serious one if there is not enough high protein food to replace the mother's milk. The older child eventually suffers from a protein deficiency disease (kwashiorkor), the name of which literally means in the language of Ghana "the disease of the deposed baby when the next one is born."¹³

The ability of women to have only the number of children they want, and to become pregnant only at the times they choose, is of crucial concern to their overall health and self-development and also for their freedom to participate in other activities—activities which can promote not only their health and well-being but that of their families.

Women who work 16 to 18 hours a day—whether it is in child-rearing, home management, work outside the home, or any combination of these—rarely have time to benefit from the basic educational and training opportunities which, when available, could improve the quality of their lives and the lives of those closest to them. Development studies show that when a woman is able to take advantage of education, her education becomes a positive health factor. "Studies in Bangladesh, Kenya and Colombia show that children are less likely to die, the more educated their mothers, even allowing for differences in family income."¹⁴

WOMEN MUST BE HEARD

Our final point involves the far-reaching social issues which must be addressed in an attempt

to protect and promote women's health. The health of women is a global development issue. Women make up over one half of the world's population and their health or ill health affects the well-being of their infants and other family members. Considering how important a woman's health is, it is unfortunate, but true, that many of the factors which influence her health (including cultural, educational and economic realities) are not under her control. Because of this, a number of practical steps should be taken.

First, local, community and national development processes should assure that the voices of women will be heard and that women themselves will be involved equally with men in decisions about programmes and policies which can affect women's advancement and self-development. Whether the decisions to be made are about agricultural training programmes, cash credit opportunities, the development of appropriate technologies, breast-milk substitutes, methods to regulate fertility, or the equal protection of women and men under the law, women ought to be able to participate actively through speaking and voting on their own behalf.

Second, in a good number of instances this will require the ability to think in specific ways about women's needs. For example, the developing countries are taking the lead in a new era of health care. They have realized that health services must go out to meet people where they live and work; that the promotion and maintenance of good health is dependent on improving people's living conditions; that the bulk of available health funds and expertise must be allocated to educate individuals about health and for the development of methods to keep people from becoming ill in the first place.

The theory is sound. In moving from theory to practice the appropriate questions need to be asked. For example, who are the women whom these health services are to go out and meet? Where do they live? What are the non-medical factors (cultural conditions, work conditions, etc.) which might have a particularly negative effect on their health because they are women? Are there specific needs these women have in regard to their reproductive health or because of their work styles? Are these women literate, and if they are not, what health education techniques are needed to improve their health? This necessity to think about women's needs also supposes the ability to understand the close connection between health and well-being.



Photo: John C. Goodwin, United Methodist Board of Global Ministries

Nutrition class, Bambur, Nigeria.

Women are aware of the need for modification in family law (laws which govern marriage rights, inheritance, polygamy, and divorce) so that we can all develop positive self-perception and participate in the life of the larger community. For women in Third World countries, health can depend on land reform and the development of food cooperatives where they can sell their farm goods. For women everywhere just access to resources and some financial independence are essential to improving overall health.

A woman's health has to do with her life and the world in which she lives. It has to do with her socio-economic situation, with her level of learning, and whether she is able to make healthy decisions on her own behalf. A woman's health has to do with the community in which she lives, with cultural conditions and what her worth to society is seen to be. A woman's health has to do with women being articulate about the services they need. It has to do with all of us—women and men, professional and lay persons—thinking about the many factors which affect the lives of women, their development and their health.

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BRAZIL: LEARNING TO LIVE BETTER

by Susan Brems

BRAZIL: LEARNING TO LIVE BETTER

From so much struggling to live, people forget how to live.

This statement was made by a woman *resident of a favela* (slum) on the outskirts of the south-central Brazilian city of Paraty. She and 96 of her neighbours in 2 favelas encompassing 650,000 inhabitants participated in a series of interviews conducted by the Institute of Cultural Action (IDAC) as part of the planning process for a health education project.

In 1982, IDAC undertook a study to find out why local health and medical services were so little used by women in the community. With the help of a local woman who acted as facilitator, community women were interviewed about their knowledge and attitudes towards the health services. What came out of these interviews was a tide of complaints, doubts and confusion that showed clearly where the problem lay: The type of counselling and information the women wanted was not being given.

Their chief concerns were:

- The deficiencies in the medical attention available to them; many perceived doctors as insensitive to women's needs.
- Lack of knowledge about their own body and how it functions.
- Depression and related mental health issues.
- The unsanitary conditions in which they lived.

From the problems that emerged in the interviews, the team developed an audiovisual kit that addresses these women's concerns. The material is intended for use with women by health educators as a springboard to discussion and collective mobilization.

The kit, entitled "Women and Health: Learning to Live Better," is made up of 94 slides of drawings and a discussion leader's book. For each of 22 interrelated topics, the book presents a narrative that lays out the issues. This is strengthened by quotes from community women that give concrete examples from their experience. Additional material from other sources helps put the specific issue into a broader context.

The topics are wide-ranging and probe the core of the women's concerns. Some 45 of the residents of the favelas of Ilha das Cobras and Parque de Mangureira agreed to discuss these issues at meetings held every 3 weeks for a year. Participants found that problems they considered particular to them were common to the majority of the group.

Among the topics they focused on were:

- Interpersonal relationships and sexuality.
- Economic dependence and day care.
- The need for a support network and for women to talk together.
- Appropriate pre-natal care and why it is important.
- The attitudes of health workers and the need for counselling on normal functions, not just illness.
- Consumers' rights in health services.
- The alienating policies of hospitals, particularly in childbirth and post-partum. One woman complained that "women are taught to be mothers, but not to give birth."
- Maternity leave and post-natal care.
- The breakdown in the family and community support network brought about by increased in-hospital births. Hospitals vs. traditional birth attendants.
- Preventive health and knowing your own body.

After the first year, the women decided to focus on illnesses caused by environmental conditions. With the aid of a public health physician and an urban development specialist, the group learned how to prevent hepatitis, worms, dehydration, and malnutrition.

When the women learned that a certain worm was transmitted by pigs that new urban dwellers brought with them to the city, they used the local newspaper to bring this to the attention of the community. As a result, local authorities declared that the animals would have to be penned up or removed within 30 days.

Current work centres on obtaining a contract with the local government that guarantees the right to live in the favelas.

This health education project again confirms that a person's health is the result of a diverse set of conditions that contribute to well-being: knowledge of one's body and how it functions; capacity to guard against physical and mental illness; utilization of available medical resources; understanding of affective and sexual relationships in all their dimensions; a feeling of self-worth through information about citizens' rights; and a balanced socio-economic situation with a minimum guarantee of a place of residence and a supply of food.

Most of all, the project demonstrates that people need to be able to find a time and space to reflect on themselves and their lives. The

women of the favelas of Paraty have taught this and, in the process, are learning how to live better.

This report was drawn from the book described above in the audiovisual kit "As Mulheres e A Saúde: Aprender para viver melhor." It is available free of charge, in Portuguese only, from: IDAC – Instituto de Ação Cultural a/c Mariska Ribeiro, Rua Visconde de Pirajá no. 550, sala 1404, 22.410 Ipanema, Rio de Janeiro, RJ, Brazil. The accompanying slides can be reproduced at cost on request.

From "Salubritas" May 1984. Published by The American Public Health Association and the World Federation of Public Health Associations.

SUGGESTIONS FOR ACTION

Health is a universally desired human condition. It helps people to lead a socially and economically productive life. The achievement of conditions in which people's health can be improved should be everybody's concern. **You, your organization or group can contribute to the amelioration of individual and community health in ways which do not need to be complex or costly.**

The following suggestions for action may not be relevant to every situation. Some will be useful for rural, some for urban areas, some for developing and some for industrialized countries. Choose those which you consider most appropriate to your circumstances and design other relevant action programmes.

- *If your organization or group plans to act at the local level, why not start by inviting someone who has public health experience in your community to talk informally to your group? Ask her/him about:*

The major aspects of primary health care. Are those aspects (such as community involvement, easily available care, cost-effectiveness, emphasis on prevention, indigenous medication, etc.) easily recognizable in your community? Can your organization contribute to a more effective primary health care?

The number of women working in local health services. Would the employment of more women at the planning and decision-making levels make health services more responsive to women's health needs? Could your organization raise the awareness of the local community and of health authorities in this respect?

- *Health needs of women can be best identified by women. The participation of women in the identification of and response to their health needs is therefore highly desirable.*

How could your organization encourage women to take an active part in assessing and responding to their health needs? Could you, together with women of your community, identify those areas of health care which women could take into their hands if provided with adequate information? Could you encourage self-help or the utilization of community resources whenever possible?

- *In order for women to become more effective agents of health care their work-load needs to be lessened, their education encouraged and their socio-economic status improved.*

Could your group or organization form discussion groups involving the local community, making people aware of the need to raise the status of women? Could you encourage people to give equal educational chances to their daughters and sons? Could you approach your government urging legislation which does not discriminate between the sexes? Could you encourage women to participate actively in the amelioration of their own situation?

- *Poverty is bad for people's health. Unjust international structures can be as dangerous for health as inequitable local structures. Women, especially the elderly, the handicapped, migrants, refugees and those who are heads of families, form the poorest segments of society.*

Can your group encourage women to form cooperatives in order to increase their agricultural and industrial production, thereby raising their income? Can you take steps to ensure that women would have access to land and credit?

Can your organization engage in local, national and/or international efforts to provide women with equal chances for education and employment?

Can you identify the most disadvantaged segments in your society, and together with

them work for the amelioration of their situation?

Can your group initiate and support programmes aiming at the *provision of clean water*? Could you help design and prepare *appropriate technology* for alleviating the heavy burden of carrying water?

Can you identify health problems related to *nutrition* in your area? If you consider that nutrition education is not adequate, could your organization make it available to your local community?

- *Development programmes can further or hinder the health of women*

Could your group *examine* existing and planned *development programmes* in your area, with regard to their effect on women's health? Could you *develop criteria* on the basis of which the health effectiveness of development programmes can be evaluated?

- *Maternal and child health are key indicators of the community's health. Adequate health care related to women's reproductive function is a good investment for the health of the whole community and of future generations.*

Does your organization possess adequate information about *sex education* in your com-

munity? Could you organize information sessions and discussion groups if necessary?

Could you take steps to ensure that *family planning services are available to everybody*?

Can your organization work on one of the many types of programmes to *encourage breast-feeding*: education of young people and parents-to-be, legislation to ensure adequate maternity leave, changes in hospital or clinical practices that discourage breastfeeding, sensitization of health and social workers, provision of crèches near working places for children of working mothers, implementation and monitoring of the International Code of Marketing of Breastmilk Substitutes, and any other activities which raise the status of women? In those cases where women must use breastmilk substitutes, can you teach them to prepare them properly and hygienically?

Can you contribute to education and information about appropriate and timely *weaning practices*, in particular encouraging the use of locally available weaning foods?

Can you challenge *abuse of technology* and *over-medicalization* during pregnancy and childbirth in industrialized countries, and advocate informed self-help wherever possible?

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