IDRC
CRDI
CIID

CANADA

Gender, Health, and Sustainable Development:

A Latin American Perspective

Proceedings of a Workshop held in Montevideo, Uruguay, 26–29 April 1994

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

The International Development Research Centre
Le Centre de recherches pour le développement international
El Centro Internacional de Investigaciones para el Desarrollo

Gender, Health, and Sustainable Development:

A Latin American Perspective

Proceedings of a Workshop held in Montevideo, Uruguay, 26–29 April 1994

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

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

Published by the International Development Research Centre
PO Box 8500, Ottawa, ON, Canada K1G 3H9

September 1994

Wijeyaratne, P.
Hatcher Roberts, J.
Kitts, J.
Jones Arsenault, L.
IDRC, Ottawa, ON CA

Gender, health, and sustainable development : a Latin American perspective; proceedings of a workshop held in Montevideo, Uruguay, 26–29 April 1994. Ottawa, ON, IDRC, 1994. 276 p. : ill.

/Women/, /gender/, /health conditions/, /Latin America/ — /men/, /aids/, /sexually transmitted diseases/, /occupational diseases/, /tropical diseases/, /indigenous population/ , /health personnel/, /conference reports/, /case studies/ , bibliographies.

UDC: 396:613(8) ISBN: 0-88936-748-5

A microfiche edition is available.

Contents

AIDS, Sexually Transmitted Diseases, and Gender

Environmental Stress, Production Activities, Health, and Gender

Tropical Diseases and Gender

Indigenous Peoples' Health Issues

Health Care Providers

Working Group Discussions

Related Topics and Initiatives Informally Presented at the Workshop

Foreword

The collection of papers which appear in this manuscript emerged from a workshop on Gender, Health, and Sustainable Development, sponsored by the International Development Research Centre (IDRC). This collaborative effort by IDRC's Health Sciences Division, the Gender and Development Unit of the Corporate Affairs and Initiatives Division, the Latin American and Caribbean Regional Office, and the Special Program for Research and Training in Tropical Diseases (TDR) of the World Health Organization (WHO), was held in Montevideo, Uruguay, 26-29 April 1994. The workshop included invitees from Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, Dominican Republic, Mexico, Nicaragua, Paraguay, Peru, Uruguay, Venezuela. It focused on five topic areas which were identified as priority themes in Latin America: (1) AIDS, Sexually Transmitted Diseases, and Gender; (2) Environmental Stress, Production Activities, Health, and Gender; (3) Tropical Diseases and Gender; (4) Indigenous Peoples' Health Issues; and (5) Health Care Providers.

This workshop is the second of a series of regional workshops on Gender, Health, and Sustainable Development. The first workshop was held in Nairobi, Kenya, in September 1993. Two more complementary workshops are planned: one in the Caribbean region late in 1994, and one in the Asian region early in 1995.

These workshops are the result of two initiatives. First, in 1989-1990, an initiative was jointly undertaken by IDRC's Health Sciences Division and the Gender and Development Unit, and TDR/WHO. These agencies sponsored two essay competitions on gender and tropical diseases. Selected essays were then published in two reports entitled *Women and Tropical Diseases* and *Gender and Tropical Diseases: Facing the Challenge*. It was decided that the next step forward from these competitions would be to hold a workshop with a wider focus, integrating the exploration of gender and tropical disease issues with other priority gender and health issues.

The second, more recent, initiative relates to the establishment of the *Global Commission on Women's Health* by the WHO, in response to a World Health Assembly resolution in 1992. The Global Commission seeks to raise the profile of women's health to a global level, and to develop policy responses at the country level to address inequities. Major gaps still exist in our understanding of gender and health. In many countries, there is a serious lack of careful and rigorous research which is needed to support relevant policy decisions. The decision by IDRC to host a series of regional workshops which would discuss research issues, gaps, and roadblocks to conducting gender and health research, was seen as a positive contribution to the work of the Global Commission.

The workshop consisted of a number of interrelated components. To begin with, there were five thematic plenary sessions in which selected participants highlighted the main research findings of their projects, and then identified the gender issues involved. In-depth

discussions, involving all participants, followed each presentation. A shorter session on the elements of gender analysis in health research was conducted to further sensitize participants to the issues. Smaller work groups were established to identify gaps in research, roadblocks to conducting research, and priority areas for future action.

This collection of papers represents a significant advancement on gender, health, and sustainable development issues, from a Latin American perspective. Capacity to further develop expertise with regard to gender analysis was identified as a priority by the participants. The final outcome of the workshop was a draft research agenda for gender and health, and a commitment by the participants to begin a process of improving interdisciplinary research in this area. This publication, as well as the publications from the other regional workshops on Gender, Health, and Sustainable Development, represent an important part of IDRC's contribution to the deliberations of the Global Commission on Women's Health, as well as a strategic component for health for the Women and Development Conference to be held in Beijing in September 1995.

Janet Hatcher Roberts
Senior Program Specialist
Health Policy
Health Sciences Division

Acknowledgments

This workshop, and the publication of its proceedings, were made possible through a grant from the International Development Research Centre.

We wish to express our thanks to the Montevideo-based members of the Organizing Committee, who contributed so much of their time, effort, and enthusiasm to the smooth management and running of the workshop. We would like to take this opportunity to give special recognition to A.D. Tillett, Regional Director for IDRC's Latin American and Caribbean Regional Office, Silvio Gomez, Regional Program Officer for Health, Fay Durrant, Regional Program Officer for Information Communications Systems and Networks, and Roberto Bazzani, Program Assistant, whose enthusiasm and support for the workshop, and the ideas it represented, helped to make it a reality. The hard, tireless, and at times never-ending work of Adriana Bordabehere and Carolina Oehler ensured that the workshop was a success, and was much appreciated. Also, we wish to acknowledge Socorro Donamari, for her assiduous attention to the travel arrangements for the workshop participants.

We are grateful to Betty Alce, who once again, with competence and great patience, handled the tasks of typing and formatting the manuscripts for publication.

We are especially grateful to each of the participants, who presented the papers in this publication, and who engaged in frank and lively discussions in a constructive manner. Their thoughtfulness on and analysis of gender, health, and sustainable development in Latin America, will hopefully lead to further collaboration, and the progressive development of research in this area.

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

Janet Hatcher Roberts
Pandu Wijeyaratne
Lori Jones Arsenault
Jennifer Kitts

Introduction: Opportunities and Challenges for Improving Women's Health Status[1]

Dr A. El Bindari Hammad[2]

May I start by thanking all of you for being here today. It is an honour for me to speak to such an expert group. Each of you has contributed so much to improving women's status and women's health. Your work demonstrates your intimate conviction that more can be done to improve the health of women the world over.

We appreciate, as human beings coming from all parts of the world, the dialectic between "same" and "different", "belongingness" and "otherness." As I have highlighted in other fora, this same opposition can be applied to men and women. We are the same, yet we are different. We are similar as human beings, yet profoundly different as a result of our biological and physiological makeup.

Throughout the history of mankind, we have used natural, political, economic, and cultural differences to create separations between peoples, between men and women. When these separations become synonymous with inequalities and discrimination, they can only be perceived as unjust. And yet differences can, and should, be treated with respect, as long as we can ensure the dignity and fundamental human rights of all human beings while respecting the value of diversity.

The Global Commission on Women's Health has been established because, in the 1990s, many women continue to suffer from unnecessary morbidity and mortality. But it is important to our deliberations that we agree on one point: women are strong. Women have ensured the survival of the human race and continue to do so despite war, famine, drought, and oppression. One cannot help but wonder how much further ahead the world would be if women were assured health and quality of life in a climate of peace and justice. It is in the light of women's strengths that we will be looking at ways to improve women's health.

Women's health must be seen in a holistic way: as a continuum that starts in utero and progresses cumulatively throughout a woman's entire life. Such a perspective goes much further than reproductive health, and encompasses the socioeconomic determinants of both ill-health and well-being.

---

[1] This paper was originally presented at the Interagency/Interregional Meeting on the Global Commission on Women's Health at WHO/HQ, 13 April 1994.

[2] Special Advisor to the Director General on Health and Development Policies, WHO, Geneva, Switzerland.

We must be careful that, in our struggle to improve women's health, we do not isolate women. There is a tendency to consider "women" as a problem in itself, rather than recognizing problems as they *affect* women, just as there are specific problems affecting men, children, migrant workers, and other groups. Certainly the most important and unique aspect that sets women's health apart from the health of men, is the impact that the health status of a girl or woman can have on subsequent generations.

The health of women must also be seen in the context of global changes and emerging trends in the world today. These changes are occurring rapidly, and their effects are being felt in the most isolated parts of the globe. Human health is, and will continue to be, profoundly affected during this continual and accelerating process of change. The degree to which women have benefited from the fruits of development will be reflected in their health status and quality of life. Indeed, available data show that, although there has been an overall improvement in women's health, when one considers physical quality of life indicators, qualitative indicators reveal a widening gap between women who are enjoying better health, and those who continue to suffer unacceptably high levels of morbidity and mortality. Some indicators even suggest that there has been a deterioration in the health status of the most disadvantaged women.

There are also certain common denominators in the lives of all women which may be seen as major factors determining their health status. Where women have poor health status, it is a result of the different types of poverty from which they suffer. This refers not only to poverty in an economic sense, but the multidimensional poverty that could start even before birth, when an infant girl is seen as a liability rather than an asset. It is the poverty that results when she is valued less, fed less, put to work at a very early age, denied schooling and denied access to resources, technology and essential services which respond to her health needs. This insidious poverty follows her throughout her entire life. These multifaceted and interlinking aspects of poverty ultimately determine health outcomes.

We know more about women's health than we have ever known before. Because of their biological attributes, women live longer than men. As they increasingly form a larger proportion of the elderly population, they will become more susceptible to disease. Certain health problems are more prevalent in women; others are unique to women; still others affect women in a different way than they do men.

When women suffer from conditions such as reproductive tract infections or tuberculosis, they often deny their symptoms until they are too serious or too severe to ignore because of heavy competing workloads. Often, the social ostracism women suffer as a result of these diseases is different from that of men. In the case of onchocerciasis and other mutilating diseases, such as burns, men expect and receive care, while women are often shunned by their families, or even banished from their communities and left to die.

Adequate nutritional intake is important for all human beings, and is closely linked to patterns of morbidity and mortality. However, adequate nutritional intake is particularly important for girls and women because of the cumulative effects in different phases of a woman's life, and the inter-generational effects of her nutritional status on the children she bears. Discriminatory feeding practices in childhood can lead to protein-energy deficiency. The stunting which results in the girl may cause problems in her subsequent reproductive life, such as obstructed labour, birth asphyxia, and many other conditions. The adolescent girl requires, but rarely gets, 18% more iron per kilogram of body weight than does the male adolescent. Virtually all adolescent girls in developing countries suffer from iron-deficiency, contributing to chronic fatigue, increased vulnerability to infection, and many other conditions.

The reproductive health of a woman shapes the quality of each day of her life, and yet we can see how the effects of women's socially disadvantaged position are often reflected in reproductive tract infections, maternal morbidity and mortality, and sexually transmitted diseases, including HIV/AIDS.

It is unacceptable to find that maternal mortality has decreased dramatically in all industrialized countries, and yet persists as a priority problem in the developing countries. In parts of the developing world, there are more maternal deaths in one day than in all the developed countries in one month. The negative indicators of women's health, including maternal mortality, anemia, unsafe abortion, low birth weight and perinatal mortality, remain high. The data available provide a poignant illustration of the gap between women who are benefiting from progress, and those where we see only slow improvement or even a deterioration in these indicators.

The increasing number of teenage pregnancies throughout the world is cause for concern. These children are often uneducated, poor, and physically and emotionally immature for childbearing and rearing. Teenagers constitute a high percentage of the twenty million women who terminate unwanted pregnancies through unsafe abortions every year. Some of the reasons for this include lack of access to relevant care and services, such as family planning, costly contraceptive methods, lack of information, and restrictive legislative practices. How can we change this?

How many girls and women in the world still suffer from poverty of education, information and knowledge? This type of poverty denies women the understanding of how their bodies function, and how they can protect themselves and prevent diseases. It creates a vicious circle of myth and misinformation which perpetuates health-damaging behaviours and harmful practices, including food taboos, throughout the life of girls and women, unsanitary practices during childbirth and subsequent care of the newborn, the introduction of harmful substances into the vagina, and female genital mutilation.

Although grossly under-reported, violence against women is now reaching alarming proportions in developed and developing countries alike. Domestic violence and rape have only recently been viewed as a public health problem; yet they have always been, and will continue to be, a significant cause of female morbidity and mortality.

Violence is not only physical or psychological. Women face moral violence when they are denied access to health care, when legislation requires them to seek the consent of a man in a decision about their own bodies such as fertility regulation, or when culture or tradition dictate the obedience and submission of women. All of these are a denial of fundamental human rights and freedom of choice.

It is true that women live longer than men as a result of their biological makeup. In the years to come, the number of women over 65 in both industrialized and developing countries will increase from 330 million in 1990, to 600 million in the year 2015. What kind of life can these women look forward to in their later years with so many of them suffering from chronic diseases associated with aging, such as osteoporosis and dementia, conditions of neglect such as malnutrition, alienation and loneliness, reproductive ill-health, and lifestyle-related morbidity and mortality? A most disturbing trend is the rising incidence of violent attacks against elderly women, in their homes, at the hands of family members, and in the streets. Sick, dependent and vulnerable, they cannot defend themselves.

The worldwide phenomena of market liberalization, privatization, breakdown of family structure, economic recession, and relinquishment of responsibility on the part of both parents and the state, have led in some instances to changes in lifestyles. With the erosion of value systems and increasing emphasis on accumulation, health is wrongly seen as just another commodity with a price tag. Health is sacrificed in the search for new markets as can be seen in the current targeting of women by tobacco companies. In an environment of sedentary occupations, excessive consumption, stressful lifestyles, and new opportunities, women are increasingly subject to health risks. The choices they make will affect their own health, as well as that of their children. How can women be equipped to make healthy decisions and adopt healthy behaviour patterns?

Economic poverty is a major force behind the poor health of women. Women are increasingly playing an important role in the productive sphere, and yet they are still concentrated in the lowest skilled, lowest paid positions.

Despite legislation to the contrary in most countries, child labour is on the rise in many places as a result of global economic recession. Children as young as six years old are forfeiting their childhoods, and working in factories, mines, brothels, and on the streets of the world. Both boys and girls suffer from the consequences of child labour, which range from chronic physical and mental problems, to loss of body parts, or even death from accidents at the work site.

Girls and young women are a particular target in a highly competitive climate where they are seen as a source of cheap, docile labour: easy to hire and easy to fire when they are no longer needed. Tens of thousands of young girls are working in factories, using tools designed for adults, carrying heavy loads, and working long hours with no breaks and few, if any, safety standards to protect them. Young girls carry with them throughout their lives the health consequences of their work in both the domestic and public spheres, leading to chronic back pain, distorted pelvis, spontaneous abortions, detrimental effects on unborn children, and disability in old age.

What do these examples illustrate?

They show us that inequity lies at the root of the persisting ill-health of women. This inequity is multi-dimensional and is comprised of exclusion from participation and decision-making, structural inequities that result from rapid processes of change, and the underlying and deeply-rooted inequities which exist in all societies stemming from their traditional and cultural foundations.

The result of these inequities is discrimination, denial, and lack of choices, which keep women in a state of poor health. If we are to improve women's health, we need to reduce inequities, remove discrimination, combat denial, and increase choices.

How can we guarantee that girls be given an equal chance to survive and thrive, and that girls and women will enjoy personal security throughout their lives? What must we do to provide the specific information and knowledge women require at all periods of their lives to expand their options, and to allow them to choose wisely between these options, with full knowledge of the outcomes for their own health, and that of their children?

Now that we know more about women than ever before, and have identified the major health problems they face, what can we do to accelerate actions which we know will alleviate unnecessary suffering and death? Among the large number of areas that need to be addressed, how can we choose the critical few which will make the greatest difference in the lives and health of many? How can we effectively involve women themselves in this process? Is it not perhaps women, with their unfailing strength, who could help show the way forward and add the touch of realism and practicality which is needed?

Health is not a commodity. It is not a negotiable good that can be bought and sold for a price or traded off against economic gain. It is a fundamental human right. We all hope and look to the Global Commission on Women's Health to help restore this right to the many women to whom it is being denied.

Health Policy Research in Latin America and the Caribbean: The Role of the Household[1]

A.D. Tillett[2]

The issues of health and gender, the title of this workshop, are intimately related. A gender analysis can provide a perspective on the structure of health services, their performance and delivery. The ability of health systems to provide for and differentiate between gender needs is a test of their relevance and purpose. Both perspectives are required in order to analyze the changes which face - some would say threaten - health institutions and practices in developing countries.

Investing in Health

An impressive analysis of the challenges facing health research, organizations, and professionals, is to be found in the World Development Report for 1993, entitled *Investing in Health*. The authors argue that current resources in developing countries suffer from misallocation, inequity, inefficiency, and exploding costs. They also assert that, in order to achieve "Health for All by the Year 2000" - the optimistic goal adopted by the World Health Organization at Alma-Ata in 1978 - developing countries will have to target resources to those with the greatest needs, redefine and restrict the role of government institutions, and consequently use private firms and organizations to provide for the remaining services and needs. Privatized services may well be a combination of new, expansive activities, and older services, once provided for free or for a nominal fee. These changes will make for sounder policies, and bring, according to the World Development Report (1993, p. 16), great benefits:

> There is a great potential for change during the closing years of this decade as more countries encourage broad political participation and public accountability, as levels of education and knowledge improve, and as an understanding of human biology, public health and health care systems increases. If the right policy choices are made, the payoff will be high.

In order to evaluate the payoff for gender and health activities in Latin America more fully, it is important to examine the components of the proposed policy reform - in particular, that of the household.

---

[1] Workshop statement given in place of Maureen Law, Director General, Health Sciences Division, IDRC, who unfortunately could not be present. The words of welcome are excluded on grounds of space.

[2] Regional Director, IDRC Regional Office for Latin America and the Caribbean, Montevideo, Uruguay.

Policy Reform

The process of policy reform is based on three institutional pillars: the household, the government, and the private sector. These categories are well known to economists as collectively they comprise the components of a national economy.

The first set, the household, is seen as the generator of personal or family wealth. Given the skewed income distribution in most countries, the Report advocates supporting measures that can assist poor households because of the close relationship between income and health choices. According to the World Development Report (1993, p. 7), a major contribution to health will come from societies that pursue economic growth, and governments that target the poor: "The reason is that the poor are most likely to spend additional income in ways that enhance their health; improving their diet, obtaining safe water, and upgrading sanitation and housing."

If income influences the *range* of health choices, greater education influences the *quality* of those choices. The Report cites data showing that increasing female literacy reduces child mortality, and that educated mothers find and use health facilities more often when compared to less educated mothers. The World Development Report (1993, p. 42) provides the following reasons:

> Education greatly strengthens women's ability to perform their vital role in creating healthy households. It increases their ability to benefit from healthy information and to make good use of health services; it increases their access to income and enables them to lead healthier lives.

Additionally, for these health values to be sustained, there must be a consistent social view of the role of women and their rights; that is, the "enabling environment" must contribute to and become part of their empowerment. However, such processes will not come easily - as many know here today, rights have to be fought for and defended.

Before turning to a discussion of the situation, as I understand it, in Latin America and the Caribbean, it would be something of an injustice to the 1993 World Development Report to leave unmentioned the second and third pillars of policy reform: government investment, and the role of the private sector. The Bank calls for governments to support the delivery of a basic public health package, and to reduce the range of specialized activities and services provided by hospitals by substituting essential clinical services to all citizens. The Bank also recommends greater recognition of the role of private sector services when designing health sector reform. I hope these complicated and controversial proposals will be discussed during the course of the workshop.

Latin America and the Caribbean

At this point, I thought that it might be useful to look at data which could help us to make some initial judgements about the household in Latin America, and which might serve to

provide a basic framework for further discussions. However primitive the quality of the data in the four subsequent tables, there is one general point which emerges from their examination - Latin America and the Caribbean cannot be described consistently, and is becoming a "geographical expression." Many policy analysts and promoters cannot deny the urge to sketch broad generalizations from quite limited data sets. Nowhere is this tendency more damaging than in Latin America (and the Caribbean) where there are now major differences between countries, and where generalizations can be falsified and made quite carelessly. The following four tables are intended to explore this proposition.[3]

Per Capita Growth

Table 1 attempts to describe, by using conventional data, the current economic circumstances of the larger Latin American and Caribbean countries (LAC). To generalize about these 22 countries, by using the arithmetic average, as seen in the last line but one, is highly misleading. First, Latin America and the Caribbean have a highly diverse range of per capita income - from Haiti, which is 15 percent of the average ($2,390), to Trinidad, which is about 50 percent above the norm. Second, between 1981 and 1991, per capita income remained static or declined in all but five countries, in contrast to the average for the developing world. Per capita income figures are, of course, indices, and should be weighted to take account of real purchasing power and income distribution. Without discussing this data, I think that it is a fair generalization for most LAC countries to admit that their income distribution worsened, and consequently, the distance between the rich and poor widened. However, population growth rates, one part of the simple index, are expected to decline for most countries in the ten year period 1991-2000 (four exceptions), and the last column shows the difference between the two decennial periods. Although the outlook for per capita income growth is improving, the present decade is unlikely to produce growth which will lead to major income changes for many countries. Per capita growth may turn positive, but its impact on poorer families is unknown. Positive discrimination for the poor remains an urgent policy objective.

The Role of Government

Table 2 looks at changes in Latin American and Caribbean government expenditures. It is not surprising that it found that, for most countries where there was data (the information was often poor and incomplete), governments spent less of their national product in 1991 than they did in 1980. However, there were exceptions - Colombia, Ecuador, Mexico, Uruguay, and Venezuela - although it is not clear if these are trends or the result (as one

[3] The data is taken from the World Development Indicators which form part of the World Development Report (1993). The data refers to 1991, and the numbers printed on the left refer to the per capita income ranking for that year - the higher the richer.

Table 1. Per Capita Growth and Population

WB Country		Income USD	Per Capita 1980-91	Population 1980-91	Growth 1991-2000	Population Change
23	Haiti	370	-2.4	1.9	1.7	-0.2
30	Nicaragua	460	-4.6	2.7	3.1	0.4
34	Honduras	580	-0.5	3.3	2.9	-0.4
LI	**Countries**	**350**	**1.0**	**2.6**	**2.4**	**-0.2**
41	Bolivia	650	-2.0	2.5	2.4	-0.1
47	Guatemala	930	-1.8	2.9	2.9	0
48	Dominican R.	940	-0.2	2.2	1.6	-0.6
49	Ecuador	1,000	-0.6	2.6	2.1	-0.5
53	Peru	1,070	2.4	2.2	1.9	-0.3
54	El Salvador	1,080	-0.8	1.4	2.0	0.6
57	Colombia	1,260	1.2	2.0	1.5	-0.5
58	Paraguay	1,270	-0.8	3.1	2.6	-0.5
60	Jamaica	1,380	0.0	1.0	0.5	-0.5
72	Costa Rica	1,850	0.7	2.7	2.0	-0.7
74	Panama	2,130	-1.8	2.1	1.7	-0.4
76	Chile	2,160	1.6	1.7	1.3	-0.4
LM	**Countries**	**1,590**	**-1.6**	**2.0**	**1.8**	**-0.2**
88	Venezuela	2,730	-1.3	2.6	1.9	-0.7
89	Argentina	2,790	-1.5	1.3	1.0	-0.3
90	Uruguay	2,840	-0.4	0.6	0.6	0
91	Brazil	2,940	0.5	2.0	1.4	-0.6
92	Mexico	3,030	-1.5	2.0	1.9	-0.1
96	Trinidad	3,670	-5.7	1.3	0.9	-0.4
UPM	**Countries**	**3,530**	**0.6**	**1.5**	**1.1**	**-0.4**
L&M Income		1,010	1.0	2.0	1.7	-0.3
LAC		2,390	-0.3	2.0	1.6	-0.4
World		4,010	1.2	1.7	1.6	-0.1

Source: World Bank Indicators, 1993.

Table 2. Central Government Expenditures, 1980 and 1991

WB Country		Percent		GDP Change	Health		Change	Education		Change
		1980	1991		1980	1991		1980	1991	
23	Haiti	17.5			4.5			6.6		
30	Nicaragua	32.6	32.6	0.0	14.6			11.6		
34	Honduras									
LI	**Countries**									
41	Bolivia	29.0	18.8	-10.2		3.3			18.7	
47	Guatemala	14.4	12.0	-2.4		9.9			19.5	
48	Dominican R.	17.5	12.3	-5.2	9.3	14.0	4.7			
49	Ecuador	15.0	16.0	1.0	7.8	11.0	3.2	34.7	18.2	-16.5
53	Peru	21.0	16.4	-4.6	5.6	5.6	0.0	15.6	21.1	5.5
54	El Salvador	17.6	10.4	-7.2	9.0	7.7	-1.3	19.8	14.4	-5.4
57	Colombia	13.5	15.1	1.6	3.9			19.1		
58	Paraguay	9.8	9.4	-0.4	3.6	4.3	0.7	12.6	13.3	0.7
60	Jamaica									
72	Costa Rica	26.3	25.9	-0.4	28.7	32.0	3.3	24.6	19.1	-5.5
74	Panama	34.2	30.3	-3.9	12.7	20.5	7.8	13.4	17.1	3.7
76	Chile	29.1			7.4			14.5		-14.5
LM	**Countries**									
88	Venezuela	18.7	23.9	5.2	8.8			19.9		
89	Argentina	19.2	13.1	-6.1		3.0			9.9	
90	Uruguay	22.7	27.2	4.5	4.9	4.5	-0.4	8.8	7.4	-1.4
91	Brazil	20.9	35.1	14.2	8.0	6.7	-1.3	0.0	3.1	3.1
92	Mexico	17.4	18.1	0.7	2.4	1.9	-0.5	18.0	13.9	-4.1
96	Trinidad	32.5			5.8			11.6		
UPM	**Countries**									
L&M Income										
LAC										
World										

Source: World Development Indicators, 1993.

might suspect in a number of cases) of taking two points in time. The columns for health and education are percentages of government expenditure and here, with an even more reduced data set, the point is to see if government expenditures in the social sector compensated for declining per capita income and mirrored this decline. In four cases (out of ten), health expenditures declined; in three cases, government expenditures increased; in six countries, education expenditures declined, usually in greater proportions than those found for health.

The reasons for these changes are to be found in the economic views and circumstances of each country, and reminds us, in the case of Chile for example, that educational expenditures are being transferred from the public to the private pocket. However, this is only partially true for Ecuador; these incomplete figures obviously need further discussion.

The first two tables attempted to look at the general economic framework and their link to households; the picture is very mixed, and easy generalizations are difficult to make. Tables 3 and 4 look at some gender variables - first for primary and secondary education, and then for infant mortality - in the hope that we can come to a more consistent picture of the LAC region.

Primary and Secondary Education

You will recall that the Bank made education the second feature of its "enabling environment" for health. The first three columns in Table 3 show the total enrolments of the primary age group (6-11), and then the number of females in primary school and as part of the age group. Percentages can therefore be above one hundred when teenagers or adults - those outside the age range - study at the primary level. With regard to gender equity, the data for primary schools is encouraging. Female enrolments are as high as male enrolments, and where a decline is indicated in column 6, it either mirrors a general trend, or demonstrates a decline in the number of teenagers or adults attending primary school. The same set of figures for secondary schools is not so encouraging. Although there have been some positive increases, the levels of female secondary school participation remain lower than the levels for males. Six countries (out of 12) had female enrolment rates of more than 50%, although only one (Uruguay, for which there is no 1990 data provided) had achieved this proportion in 1970.

The educational data says little about the most important feature of education: its quality. There is surely room for research on the relationship between education and health knowledge, as well as on the specific opportunities being provided for female education at the secondary level.

Infant Mortality

Infant mortality levels (per one thousand live births) are regarded as a key indicator for estimating changes in general welfare. In the twenty year period between 1970 and 1990, infant mortality levels fell for Latin America and the Caribbean from 82 per thousand, to 44 per thousand. In comparison, infant mortality rates for Canada fell from 19 to 7 per thousand in the same period (see Table 4). However significant the achievement in Latin America and the Caribbean, there is therefore still a long way to go. The highest rates were somewhat associated with per capita income. It comes as a shock, however, to see that Brazil's infant mortality rate remains at 58 per thousand. Of particular interest is the next

set of columns which show that, in all countries, males have a greater risk of dying before the age of five than females. Does this reflect social change or the fact that there are more male babies born than females?

Table 3. Primary and Secondary Education 1970 and 1990.

WB Country		Primary Education						Secondary					
		Total			Female			Total			Female		
		1970	1990	Ch	1970	1990	Ch	1970	1990	Ch	1970	1990	Ch
23	Haiti	53											
30	Nicaragua	80	98	18	81	101	20	18	38	20	17	44	27
34	Honduras	87	108	21	87	109	22	14			13		
LI	**Countries**	**55**	**79**	**24**	**44**	**73**	**29**	**13**	**28**	**15**	**8**	**24**	**16**
41	Bolivia	76	82	6	62	78	16	24	34	10	20	31	11
47	Guatemala	57	79	22	51			8			8		
48	Dominican R.	100	95	-5	100	96	-4	21					
49	Ecuador	97			95			22			23		
53	Peru	107	126	19	99			31	70	39	27		
54	El Salvador	85	78	-7	83	78	-5	22	26	4	21	26	5
57	Colombia	108	110	2	110	111	1	25	52	27	24	57	33
58	Paraguay	109	107	-2	103	106	3	17	30	13	17	30	13
60	Jamaica	119	105	-14	119	105	-14	46	60	14	45	63	18
72	Costa Rica	110	102	-8	109	101	-8	28	42	14	28	43	15
74	Panama	99	107	8	97	105	8	38	59	21	40	62	22
76	Chile	107	98	-9	107	97	-10	39	74	35	42	77	35
LM	**Countries**	**93**	**100**	**7**	**83**	**97**	**14**	**31**	**172**	**141**	**24**	**57**	**33**
88	Venezuela	94	92	-2	94	94	0	33	35	2	34	41	7
89	Argentina	105	111	6	106	114	8	44			47		
90	Uruguay	112	106	-6	109	106	-3	59	77	18	64		
91	Brazil	82	108	26	82			26	39	13	26		
92	Mexico	104	112	8	101	110	9	22	53	31	17	53	36
96	Trinidad	106	95	-11	107	96	-11	42	80	38	44	82	38
UPM	**Countries**	**95**	**106**	**11**	**93**	**105**	**12**	**35**	**54**	**19**	**31**		
L&M Income		79	104	25	64	98	34	24	61	37	18	39	21
LAC		95	107	12	94	106	12	28	49	21	26	57	31
World		83	104	21	71	99	28	31	65	34	28	46	18

Source: World Bank Development Indicators, 1993.

Table 4. Infant Mortality 1970 and 1990

WB Country		Infant Mortality Rate			Under 5 MR			Malnutrition (under 5)
		1970	1990	Change	Female	Male	Diff	
23	Haiti	141	94	-47	145	164	19	
30	Nicaragua	106	56	-50	59	72	13	
34	Honduras	110	49	-61	54	66	12	21
LI	**Countries**	**136**	**91**	**-45**	**125**	**148**	**23**	
41	Bolivia	153	83	-70	117	127	10	18
47	Guatemala	100	60	-40	76	84	8	34
48	Dominican R.	94	50	-44	66	72	6	13
49	Ecuador	100	47	-53	56	62	6	38
53	Peru	108	53	-55	62	76	14	13
54	El Salvador	103	42	-61	46	50	4	
57	Colombia	77	23	-54	23	29	6	12
58	Paraguay	57	35	-22	38	46	8	4
60	Jamaica	43	15	-28	16	20	4	8
72	Costa Rica	62	14	-48	13	16	3	
74	Panama	139	64	-75	24	28	4	25
76	Chile	78	17	-61	18	22	4	2
LM	**Countries**	**87**	**42**	**-45**	**50**	**60**	**10**	
88	Venezuela	53	34	-19	35	44	9	5
89	Argentina	52	25	-27	28	32	4	
90	Uruguay	46	21	-25	21	25	4	9
91	Brazil	95	58	-37	60	73	13	13
92	Mexico	72	36	-36	38	50	12	14
96	Trinidad	44	19	-25	21	25	4	9
UPM	**Countries**	**72**	**34**	**-38**	**36**	**46**	**10**	
L&M Income		102	61	-41	80	89	9	
LAC		82	44	-38	48	58	10	
World		85	33	-52	69	77	8	

Source: World Development Indicators, 1993.

While these tables do not show a consistent picture, they generally show that people are better educated and healthier than in the past. How much can policy improve the situation, and how far can the household - supported in the way proposed by the World Bank - help?

A number of long term trends may alter our views of how health systems are to be designed. First, the long term process of urbanization is increasing. In 1950, about 57% of the region's population lived in urban areas, compared to about 72% in 1990, based on a larger population, and with the growth of megacities such as Mexico (34% of its urban population) and Buenos Aires (41%). The consequent pressure on resources, such as my colleague Danilo Anton has shown for water (1993), is becoming an increasingly urgent problem, with a potentially severe impact on health. Furthermore, the last ten years have seen changes in the family structure as women increasingly enter the labour market, and wish to exercise more control over their choices, and have a more equal say in family decisions. These are as much cultural as economic changes, and will have an effect on both the way women are treated, and how the family can cope with rapid, and as times brutal, change (CEPAL 1993). These trends perhaps confirm the following generalization made by Ester Boserup (1990):

> The reduction in the number of tasks performed in the family is accompanied by a reduction in the autonomy of the family, which becomes dependent not only on the market but upon the government and other public institutions.

These trends also require further research as the role of public institutions is reduced, and the composition of the household itself is changing.

Choices

The World Bank's prescription is based on a stable household combined with economic growth. There are indications, however, that neither the macroeconomic framework, nor the evidence from other social indicators, are well enough developed to give one confidence to suppose that the policy will be a success. What is needed now, in my view, is a thorough examination of these assumptions. A discussion about the current value of gender analysis for the region, and proposed actions, can serve to strengthen the role of women, as well as the household and the choices that we provide our children. It is my hope that this workshop will look at these proposals in light of their contribution to gender and health in Latin America and the Caribbean, and propose ways in which they can be supported, modified, or examined, so that both gender and health can be promoted for the welfare of all.

References

Anton, Danilo. 1993. Thirsty Cities: Urban environments and water supply in Latin America. IDRC. Ottawa, Canada.

Boserup, Ester. 1990. Economic change and the roles of women. Economic and demographic relationships in development. Baltimore. p 129.

CEPAL. 1993. ¿Porque los hombres son tan irresponsables? Cambios en el perfil de las familias: la experiencia regional. Santiago. pp 111-121.

1993. World Development Report 1993; Investing in health, World development indicators. Oxford University Press. USA.

AIDS, Sexually Transmitted Diseases, and Gender

AIDS Research from a Gender Perspective

Leda Pesce[1]

The Paulina Luisi Movement

The Paulina Luisi Movement, founded in 1985, is a non-profit, non-governmental organization. It is based in a poor provincial area of Uruguay, in the region of Cerro Largo. The capital of this region, Melo, is four hundred kilometres northeast of Montevideo, and sixty kilometres from the Brazilian border.

Four years ago, the coordinators (of the Paulina Luisi Movement) cooperatively began to design a new model for the health care of women. For many years, there has been great concern regarding the quality of health care that women receive in both private and public health clinics. For example, with regard to vaginal discharge, women often receive little or no information regarding the genesis of vaginal discharge, how it is transmitted, how it can be treated, or how it can be prevented. Most affected women suffer from feelings of guilt if they think they might have infected their sexual partners. Many are convinced that vaginal discharge is a natural part of being a women, and that they are condemned to suffer from it for life, particularly if they maintain an active sexual life.

Health services in Uruguay generally perpetuate the notion that men, and the institutions which represent them, should be the ultimate authority. In the field of medicine, the male doctor, rather than the female doctor, holds power and knowledge. Male doctors tend to reinforce the status quo and dominate their female patients. They are usually reluctant to establish equal and cooperative relationships with their female patients.

With these problems in mind, the Paulina Luisi Movement initiated many programs aimed at improving health services for women. For example, the Health Section began to implement a protocol for "Alternative Mental, Sexual, and Reproductive Health Care." This protocol emphasized the importance of quality service, as well as quality technical care. Quality service, which must always accompany a high standard of technical care, is health service which is personalized, informed, responsible, and respectful of the rights of the consulting woman.

The Health Section also began to organize educational workshops and lectures for young and adult women, as well as for female and male adolescents. The workshops and lectures dealt with various health-related subjects, such as sexual relations, contraception, pregnancy,

---

[1] Paulina Luisi Movement, Melo - Cerro Largo, Uruguay.

sexually transmitted diseases, HIV/AIDS, and so on. Many women, especially those in the lower classes, had a complete lack of knowledge about their bodies, their sexuality, and their health rights.

The Emergence of HIV/AIDS

When HIV/AIDS emerged as a serious health concern, it was immediately incorporated into the women's health program, despite the fact that HIV/AIDS initially posed a remote risk for women. As the disease progressed, it became known that women faced a greater risk than initially believed. The Movement decided to evaluate the perceptions and beliefs of women concerning the risk of HIV/AIDS, and devise strategies to fight the spread of HIV/AIDS.

HIV/AIDS is an infectious disease which is primarily transmitted through sexual relations. HIV/AIDS must be tackled by a number of sectors including the biomedical, social, educational, political and religious sectors. It also must be dealt with within the context of a Judeo-Christian and Greco-Latin culture, which places women in a subordinate position, particularly concerning sexual aspects.

The Paulina Luisi Movement is very interested in sharing and exchanging experiences with other organizations, both in Uruguay and other Latin American countries. It is also interested in linking different groups working on health and education. In 1992, the Paulina Luisi Movement, together with another non-governmental organization (FEIM of Buenos Aires, Argentina), presented an educational action project to the World Health Organization (WHO), called "In the Face of HIV/AIDS, Can We Women Do Something?" Both NGOs had experience in the area of women and HIV/AIDS, and had worked together in the development of workshops in Uruguay. The project was approved by WHO and developed throughout 1993 in both Argentina and Uruguay. This was the first time that these two NGOs took on a joint project. The use of common methodologies allowed for the comparison of results.

Project Objectives

The objectives of the project, as outlined in the final report submitted to the Global AIDS Program of the WHO, were the following:

- to achieve the prevention of HIV/AIDS, through health education;
- to educate young and adult women about their subordinate position in sexual areas;
- to encourage self-care and the recognition of the difficulties encountered by women when they demand safer sex;
- to train women how to use condoms and how to include them in sexual foreplay;

- to promote solidarity as a way of fighting the epidemic;
- to promote the multiplication of the number of participating women; and,
- to present this joint venture between the PLM and FEIM as an example for other institutions and NGOs, governments, international organizations and cooperating agencies. This project also sought to demonstrate that by joining forces, the NGO sector could be strengthened and could better influence the development of government health policies and campaigns.

Methodology

- The groups selected were those which showed the greatest vulnerability to infection and the greatest multiplying capacity (young and adult women in the lower and middle classes).
- The variables, with their indicators, were the following: vulnerability (biological, psychological and social), submission (physical, psychological, and social) and safer sex.
- Written questionnaires were drawn up (personal and anonymous). Most of the workshops in both countries were taped.
- Workshops began by assessing the amount of information the participants already had, and by introducing a gender perspective.

Vulnerability of Women to HIV/AIDS

The set of sexual activities, practices, and circumstances of women which posed the greatest risk of HIV infection were defined. Three aspects relating to vulnerability were identified: biological, psychological and social. The biological vulnerability of women is significant. To begin with, the concentration of HIV is greater in semen than in cervical-vaginal fluids. Anatomically, with unprotected intercourse, women are the depositaries of seminal fluids. The frequent presence of inflammations, infections, and lesions in the vagina and cervix, as well as the presence of sexually transmitted diseases, increases the risk of developing HIV. STDs are more easily transmitted to women than to men. Furthermore, because women are often asymptomatic, or have very few symptoms, they may only request treatment for complications or sequelae. This has serious consequences for the sexual and reproductive health of women, as well as for the quality of their lives. According to some authors, the presence of a sexually transmitted disease doubles the possibility of infection by HIV in a single sexual encounter. The immature genitals of young women, combined with less mucous secretion, increase the biological vulnerability of these women. In post-menopausal women, the thinning of the mucous membrane, as well as the reduction of mucous secretion, are important transmission factors.

Because of their childbearing role (involving pregnancies, abortions, and births), women run a significant risk of receiving blood transfusions or derivatives. If the blood or derivative transfused is contaminated by HIV, the risk of transmission is over 90%. In underdeveloped countries, women and children receive 80% of donated blood. They often, inappropriately, receive blood for anemia.

With regard to psychological vulnerability, women are educated to be "passive" in sexual relationships. They are not accustomed to expressing their sexual wishes and needs. Concerning social vulnerability, women are in a subordinated position in society. It is very difficult for a couple in a sexual relationship to make decisions about when and how to carry out a sexual encounter. They often resort to indirect and secretive ways.

Submission

In relationships, women are often subordinated to men. They may have to submit to the judgements, opinions, decisions, and feelings of men. Three dimensions concerning submission were identified: (a) physical submission; (b) psychological submission; and, (c) social submission.

Women are often physically and psychologically subordinated to men in sexual relationships. A woman's body is often treated like an object meant to give pleasure to and satisfy men. The ability to feel sexual pleasure is often subordinated to the male. In the case of infertility, it is usually assumed to be the fault of the woman. Social subordination relates to the lack of economic independence and autonomy of women, which affects their decision-making in life, including sexual aspects of life. The inability to act on other sexual options (e.g., bisexuality, homosexuality), or to have several partners, is also affected by society.

Safer Sex

Safer sex for women is possible if women are able to choose whether or not to have sexual relations with their partners. This decision would be related to whether or not their partner agreed to use protection against HIV/AIDS.

Results

Background Information about the Women

The collected information provides a greater understanding of the women with whom the NGOs regularly work. This data could serve to help to reformulate objectives, as well as guide preventive action to achieve the desired goals. A cross-section of ages was represented, ranging from fifteen years of age to late adult years. In the lower classes of Uruguay and Argentina, younger women predominated. In the middle classes, adult women were more common.

The majority of the participants lived within a nuclear family. The man of the household usually held the economic responsibility for the family, or the woman shared the responsibility with her husband or with others. The women who were most economically dependent were from the lower classes of Melo, Uruguay, and Taoist, Argentina.

Without exception, all women were responsible for the household work, which provided no pay and minimal social acknowledgement. The women tended to be part of highly traditional situations characterized by dependency, which affected their thoughts, feelings and actions.

Information Collected on Women and HIV/AIDS

The research demonstrated that lower and middle class women in both Argentina and Uruguay are highly vulnerable, and regularly exposed to the risk of HIV/AIDS. Almost all the women submitted to the non-adoption of safer sex.

Nearly all the women believed that women are at a greater risk of contracting HIV/AIDS than men. However, most women tended to believe that it is other women, not themselves, who are exposed to this risk. Women tended to believe that the stability of their relationships protects them from HIV/AIDS. Many of the women believed that a stable relationship represented security, and that being in love would act as a vaccination shot against the spread of HIV/AIDS. Many women were unable to link their husbands or partners to "the men who fool around." This inability to view their partners as possible infectors, greatly reduced the possibility of preventive steps being taken by women.

Part of the role of the Paulina Luisi Movement has been to help break these false beliefs. We attempted to help women change their behaviours, and to adopt positive health care strategies. Besides just providing additional information, we also examined various risk situations in a woman's daily existence, with a view to preventing STDs and HIV/AIDS. For example, many women asserted that "men play around." The coordinator probed this situation with the women by asking, "which men play around?" This strategy of reflection and awareness-raising greatly enhanced the possibility of the adoption of positive preventive behavioral changes.

A very high percentage, about seventy percent, of women sampled in both Uruguay and Argentina reported that they talked to their partners about the fear of contracting HIV/AIDS. If these conversations were as open as indicated, it is likely that condoms would be used more widely, and that sexual relations according to the needs and desires of women would be more prevalent. This raises the question of what exactly takes place during these talks. The women are undoubtedly expressing "something" about their opinions, as well as sharing their fears of contracting STDs and HIV/AIDS with their partners. How is the language related to reality? What happens when a woman talks to her partner about how HIV/AIDS is transmitted? Why do the statistics continue to show the spread of the HIV/AIDS to women? What happens between the two partners? What do they hear?

The spread of HIV/AIDS can be decreased with the use of the male condom. In general, the women reported that the condom is not used. Women should be able to take concrete preventive steps and make decisions with regard to intimate situations.

Conclusions

The cooperation of the two NGOs, FEIM and the Paulina Luisi Movement, was an enriching experience. We were able to share information, experiences, techniques and skills, as well as complement each other during the workshops and seminars on sexuality and the prevention of STDs and HIV/AIDS.

Most participants had not discussed the issues of sexuality, STDs, and HIV/AIDS from a gender perspective. During their participation in the groups, women became more aware of gender issues. Gender affects the roles and functions that an individual has in relationships, in the family, and in society. As well as dealing with the gender issues, these women also had the opportunity to get to know each other and discuss the subjects which were of most concern to them as a group. We successfully created a forum for communication for the women. High participation was achieved and maintained throughout the workshops. Continuing this process of communication among women, as well as broadening the circle of women, would be a positive next step.

The mass media, through educational campaigns, has presented a great deal of information about HIV/AIDS. However, it was only through participation in these groups that these women began to learn more about their sexuality, and to recognize the personal risk they may be exposed to, as well as ways of preventing HIV/AIDS. The language used in the media and in public educational campaigns may be suitable for some people with certain verbal skills or from certain cultural backgrounds. However, many women do not benefit from this information.

It is important to analyze how women from the lower classes think about, discuss, and deal with issues of sexuality, and how they negotiate sexual relationships. It is also important to learn more about their beliefs concerning their risk of acquiring STDs and HIV/AIDS. More information on their cultural and sexual universe would greatly assist in the creation of appropriate educational messages.

Most women in stable relationships did not believe that they were at risk of HIV/AIDS. This misbelief was reinforced by unclear media messages. Stability in a relationship was often confused with monogamy. This must be clarified with women.

A network needs to be developed whereby the women themselves bring these messages into their communities and discuss these issues with their neighbours. Women should be selected, trained, and sent out to the communities to continue spreading messages of "safer sex." Face-to-face work with women is highly effective. What happens in intimate

relationships needs to be reviewed and re-imagined. Strategies to care for health, and the adoption of safer sex routines to prevent STDs and HIV/AIDS, need to be introduced in effective ways.

A total of eighty women in the two countries were involved in the project. These women reflected, reviewed, learned, and achieved new perspectives in order to avoid infection. Given the magnitude of the problem, the number of women reached was very small. In order to achieve a greater impact, it is necessary for private and public institutions to develop similar types of workshops for women, aimed at the promotion of "safer sex." In the development of these workshops, non-governmental organizations of women who are knowledgeable about gender issues related to STDs/HIV/AIDS should be contacted, to ensure that messages are effectively communicated.

References

Dixon-Mueller, R. 1991. The culture of silence. New York: IWHC.

Paulina Luisi Movement. 1993. Final project report "In the face of HIV/AIDS, can we women do something?" (Melo, Uruguay), FEIM (Buenos Aires, Argentina).

Criteria to guide technical cooperation on woman, health and development 1991-1994. 1990. PAHO/WHO. Washington, DC.

PAHO/WHO. 1990. Health conditions in the Americas.

Uruguayan women's health network. 1993. Policies for population and development from a gender perspective. Montevideo.

Germain, A.; Holenes, K.; Piot, Peter J. 1993. Reproductive tract infections. New York: IWHC.

Hankins, Catherine A.; Handley, Margaret A. 1992. HIV disease and AIDS in women: Current knowledge and research agenda. *Journal of acquired immune deficiency syndrome*, (5) 957-971. New York.

Merson, M. 1993. 2nd International conference on HIV in children and mothers, Edinburgh, 7-10 September. GPA.

Male Bisexuality, Gender Relations, and AIDS in Brazil

Carmen Dora Guimarães[1]

Introduction

Brazil is struggling to understand and deal with the reality of HIV/AIDS transmission. Despite significant efforts over the past fourteen years, many dimensions of the epidemic are still poorly understood. Since the early 1980s, the AIDS epidemic has predominantly affected the male homosexual and bisexual communities. However, over the past few years, an important epidemiological shift has occurred. There has been an increase in the number of AIDS cases among both women and children. This paper will look generally at gender relations and AIDS in Brazil. It will also explore the link between male bisexuality and the increase in the number of women infected with AIDS. Bisexual relationships, which are prevalent in many parts of the world, including Latin America, present a particular difficulty for the prevention and control of HIV transmission.

The findings presented in this paper are based on the literature concerning Brazilian sexuality, as well as on selected AIDS-related sociological and anthropological studies (Guimarães et al. 1988; Parker 1989, 1991, 1993). The findings also stem from recent fieldwork on gender relations and AIDS, carried out in two settings located in Rio de Janeiro: (1) the AIDS clinic at the Gaffrée Guinle University Hospital and, (2) a clinic run by BEMFAM-Sociedade Civil de Bem Estar Familiar, one of Brazil's largest non-governmental organizations devoted to family planning and reproductive health (Guimarães 1990, 1992, 1993, 1994; Guimarães and Brasil 1991).

Women and AIDS in Brazil

Since 1982, when the first cases of AIDS were diagnosed, Brazil has rapidly become one of the countries with the highest number of reported cases. Between 1980 and 1994, a total of 40,849 male cases, and 7,317 female cases, were registered. The majority of these cases were the result of sexual transmission. Of the male cases, homosexual transmission (13,084 or 32.7%) and bisexual transmission (6,773 or 16.9%) contributed to approximately 42.89% of all reported AIDS cases in Brazil. To date, 3,361 cases (or 6.98% of all cases) have been reported among heterosexual women (Ministry of Health, AIDS Epidemiological Bulletin January 1994). It should be noted that it only became mandatory to report AIDS cases after 1985, the year that seropositive testing became technically available. It is estimated that over half of all cases are not reported.

---

[1] Federal University of Rio de Janeiro, Rio de Janeiro, Brazil.

In 1988, the Epidemiological Bulletin for AIDS recorded a significant increase in the number of AIDS cases among women other than prostitutes. While the ratio of male to female cases in 1986 was 17:1, in 1987 it suddenly changed to 10:1. In 1988, it again changed to 7:1. Currently, in the large urban centres of Rio de Janeiro and São Paulo, the ratio is 4:1. Male homosexual and bisexual men continue to be the groups most profoundly affected by AIDS.

Research carried out at the Gaffrée Guinle University Hospital indicated that, between February 1988 and March 1992, of the 1,095 accumulated cases of adults, with AIDS, 21% were related to heterosexual transmission. Of these, 83% were cases of women, and 17% were cases of men (Sion 1992).

Until the late 1980s, married women between 20 and 40 years of age, or those with steady partners, were believed to be at a relatively low risk of HIV infection through sexual transmission. Over the past few years, the rise in the prevalence of sexual transmission of HIV in these previously low risk women led to epidemiological investigations. As a result of the investigations, it was discovered that many of these women unknowingly had bisexual partners who were HIV-infected, and who frequently practised anal intercourse.

This "discovery" raises the following questions: Why was this possibility not considered from the onset of the epidemic in Brazil, particularly since official statistics since 1982 have indicated that male bisexuality accounts for 30% of all reported AIDS cases? Why was the female dimension of male bisexual relations so grossly ignored by AIDS medical specialists?

Despite the fact that women and children are at an increasingly high risk of developing HIV/AIDS, prevention and control programs continue to target female prostitutes and/or male homosexuals. The majority of the population merely receives recommendations to reduce the number of sexual partners, to choose partners carefully, to use condoms, or to abstain. While it is very difficult to evaluate whether or not these suggestions have been effective, a small rise in condom usage in casual sexual relations has been noted (Berquó and Souza 1990).

The Link Between STDs and HIV Transmission

The importance of STDs as co-factors for HIV transmission, especially for women, has been largely overlooked (Dixon-Mueller and Wasserheit 1991). From the perspective of the woman, chronic vaginal discharge may be seen as a "normal" nuisance related to her intimate life, one of the many "natural" discomforts associated with being a woman.

"Family women" are often overlooked when it comes to the issue of STDs/HIV/AIDS (Carovano 1991). At the BEMFAM family planning clinic in Brazil, medical staff often ignore "minor symptoms" of sexually transmitted diseases in their patients. If they do not completely ignore the symptoms, they may suggest that the woman be treated at a STD clinic in the public health system, which are among the most deficient and under-staffed health services offered in Brazil. Being treated for STDs and HIV/AIDS is strongly associated with

female sexual deviance. Many women may be reluctant to utilize STD services because they feel uncomfortable attending clinics which are primarily frequented by prostitutes, lower class women and dubious men.

Difficulties with Condom Usage

Many women reported that it was difficult or impossible to implement the recommendation to use condoms to prevent STDs/HIV/AIDS, given the power dynamics and disparity of choice between men and women. According to Maria de Bruyn (1993), "...prevailing power dynamics make self-protection by women problematic at best and very difficult or impossible at worst."

In interviews held with 240 patients attending the BEMFAM clinic (Guimarães and Brasil 1991), the difficulties presented by women in introducing condoms or any other prevention measure were clearly distinct from those of men. If a woman feels that she is at risk, use of the condom depends on the cooperation of her partner. One must bear in mind the obvious: it is not the woman who "wears the condom", but the man. Because the man is usually reluctant to use a condom, the woman is forced to justify her request. She may try to justify condom usage by saying that it is necessary for contraception. However, if a woman is married or in a stable relationship, she has other contraceptive options which may be used with no discomfort to her partner, such as the pill, the IUD, or sterilization. A woman may not be able to justify condom usage for anal sex, a fairly common practice between Brazilian men and women, because contraception is obviously not a consideration for this practice. However, anal sex poses a high risk for STD/HIV transmission, a fact which is not acknowledged by the majority of the population (Voeller 1988).

In addition to offering contraceptive protection, a woman may justify her request for condom usage by stating that it is necessary to protect against STD/HIV transmission. This is a highly sensitive issue, particularly if the woman is married or in a steady relationship. Permanent relationships usually operate on the assumption of monogamy, fidelity and mutual trust. When a woman suggests that she would like to use a condom as protection against infection, this may imply that she suspects that her partner is engaging in extra-marital sexual activity. Condoms are an "unwelcome symbol of extra-relationship activity" (Byron 1991). Furthermore, if her partner agrees to use a condom, her suspicion of infidelity is confirmed. Another problem is that the partner may suspect that the woman has become infected through extra-marital sexual relations. This has serious negative consequences for the woman. If a man is unfaithful, his sexual activity tends to reaffirm his masculine sexual role, even at the cost of STD/HIV transmission. However, a woman's infidelity means that she has not conformed to the passive female role. This may provoke a strong reaction from her partner, possibly involving physical abuse, or, worst of all in the woman's eyes, the end of the relationship.

Condom usage is also an issue for single women without regular partners. If a single woman requests the use of a condom, her partner may believe that she is promiscuous or has a sexually transmitted disease. If a man holds either of these beliefs about a woman, it is unlikely that he will have a future relationship with her. Women attending the clinic repeatedly said that, "a good man is hard to find these days." With this in mind, most women are willing to take a chance and not use a condom, hoping that luck or love will protect them from infection.

When a woman requests the use of a condom from a man, she is acting in a sexually assertive fashion, particularly if she provides the condom. This runs contrary to the role of the "proper" woman who is traditionally subordinate and passive, particularly in sexual matters. There is therefore a need for other protective alternatives that women can use and control. Furthermore, educational messages must also be directed to men, or to the couple, so that some of the burden is lifted from women (Stein 1990; Dixon-Mueller and Wasserheit 1991).

Risk Perception in Brazil

With regard to risk perception in Brazil, the broader cultural determinants that have shaped the face of AIDS in this country must first be explored. In 1982, the first reported cases in Brazil linked the disease to young, middle and upper class, homosexual men. This sent out the message that the American "gay plague" had reached Brazil. Widespread media coverage triggered a great deal of fear and resulting prejudice (Daniel and Parker 1991). The National AIDS Program, which was directed to "high risk groups," also helped to create an image of AIDS that was very removed from average Brazilian men, particularly those from the lower classes. Those who did not identify with the media images may have believed that they were not at risk. Given the emphasis that AIDS is a male disease, women who are not prostitutes may believe that they are not at risk of HIV infection. Women often believe that their main risk of AIDS comes from exposure to HIV-infected blood, or objects that have had contact with blood (dental drills, syringes, cuticle scissors, and so on).

Besides male homosexuals, other high risk groups include male bisexuals, haemophiliacs, intravenous drug uses, male and female prostitutes and those who receive contaminated blood transfusions and/or products. There is also an increasing incidence of HIV/AIDS being transmitted perinatally. However, the archetypal AIDS patient is still considered to be the prosperous, white, male homosexual, working in the world of fashion, entertainment, or the arts. In Brazil, the word *aidético* is used to refer to a person living with AIDS. This word implies homosexual behaviour. The symbolic link between AIDS and male homosexuals, and to a lesser extent, to "deviant" people, reinforces the attitude that HIV/AIDS are not issues for poor men and women, struggling daily to lead "decent, normal lives."

Class, Race and AIDS

In the lower classes of Brazil, a large number of women classified as either black or mulatto, between 15 and 30 years of age, largely illiterate, have become infected through HIV-infected partners, and may in turn infect their babies. Given the stereotypical notion of who gets AIDS, these women are largely invisible, even though they are at an increasingly high risk of contracting HIV/AIDS. Lower class women, as a result of cultural determinants, are less likely to receive an early diagnosis of HIV infection, and are also less likely to receive adequate treatment.

Economic Issues and HIV/AIDS

Lower class men and women may be more concerned with economic survival than with the threat of HIV/AIDS. Over the past 15 to 20 years, Brazil has been facing a social, economic, and political crisis. This has resulted in several deleterious consequences, including high rates of inflation (over 45% monthly), critical unemployment, constant lay-offs, low salaries (minimum wage stands at US$80.00 per month), poor health care, chronic endemic diseases, and rising urban violence. These are immediate survival issues which are usually considered more pressing than the remote risk of HIV infection. Furthermore, with growing inflation and poverty, an increasing number of young women and men in large urban areas have been drawn into the commercial sex market in search of an alternative source of income.

Evaluation of the Partner as a Mode of HIV Prevention

Married women, or those in steady relationships, often do not think of themselves at risk. One of the common HIV prevention methods cited by women relates to the subjective choice and evaluation of partners. One women at the BENFAM family planning clinic, when questioned about the risk of AIDS, replied, "but I *know* him!" (Guimarães 1994). In contrast, female HIV/AIDS patients at the Gaffrée Guinle University Hospital often stated how misled they had been by their partners, what little knowledge they had about their partner's sexual life outside the home, and how they felt betrayed.

Bisexual Behaviour of Men

Social and anthropological research has demonstrated that same-sex practices between men date back to colonial times (Freyre 1946). Despite this fact, women interviewed rarely suspected or mentioned that their partners may engage in bisexual behaviour. The term "bisexual" is largely absent from popular discourse. Many women believed that their men were *macho,* and *macho men* only want women. Most women believed that their risk of AIDS rested solely with their partners' involvement with other women.

Some research suggests that women may be more tolerant if their partners engage in sexual relations with male homosexuals, than if they have relations with other women. It may be tacitly accepted as "things men do" if there is no emotional involvement. Other women are believed to be a greater threat to the family, and possible bearers of illegitimate children (Alonso and Koreck n.d.).

If a male partner assumes the active role during sexual relations with another man, his male gender identity may not be threatened (Guimarães 1977, 1984; Fry 1982; Perlongher 1988; Parker 1990). The virility of the "active" partner, who has sex with a "passive" man, is not questioned. Only the "passive" man is considered to be homosexual. It is also sometimes believed that the active partner is at less risk of being infected from HIV/AIDS. This is an important factor to consider in developing strategies for prevention and control of the epidemic.

Gender Role Expectations

The husband or steady partner who has extra-marital relations may reason that what he does away from home is his own business, as long as he fulfils his prescribed role as protector of the home, and provider of family needs. His sexual activity with others, men or women, are expressions of his virility.

Masculine and feminine gender roles are sharply differentiated, particularly in lower class populations. According to gender role expectations, men should be active/dominant in sexual relations, while women should take the passive/subordinate role. This code has other dimensions. For example, the housewife is valued for her "sexually passive" role, while the female prostitute, who is "sexually active," is highly discriminated against for transgressing the ideal feminine role.

Same sex practices between men follow a similar pattern. The sexually active male, "the insertor," is looked upon positively, but the passive *bicha* (a popular term that refers to an effeminate homosexual) is strongly stigmatized for taking on the "woman's" receptive role (Misse 1979).

The public sphere of work is basically masculine, while the private sphere of the family is feminine (Damatta 1987). The feminine role is linked to motherhood, where sexuality is only visible through reproduction. It is very offensive for a woman to be compared to a "woman of the street," or more popularly, a *piranha* (a small carnivorous fish). The idea that good women are not sexual beings who enjoy bodily pleasures must be challenged. Women should not only been seen as caregivers/reproducers of children or prostitutes.

Conclusion

In order to effectively deal with the AIDS pandemic, the following strategies are recommended:

- Effective prevention and control measures must acknowledge the gender dimensions of HIV/AIDS, including the specific biomedical characteristics of women.

- The focus on the "scapegoats" of AIDS (e.g., homosexuals, bisexuals, intravenous drug users and prostitutes) has made it possible to overlook the gender dimensions of AIDS. We must work towards a fuller understanding of the epidemic, rather than just blaming certain groups. While it may be less sensational and exotic than looking at "deviant" sexual behaviour, the gender relations of "normal" people must be explored. There is an urgent need to find ways for women to meet the challenge of AIDS without destroying their relationships with men.

- The social construction of AIDS, and the extent to which it maintains and reinforces the system of dominance and subordination embedded in traditional gender relations, must be fully examined. A greater appreciation of cultural, social, political, economic, and emotional factors is central to an understanding of why young, black, poor, illiterate women are at a particularly high risk of HIV infection and AIDS.

- An interdisciplinary approach must be taken when dealing with HIV/AIDS. The biomedical and the social sciences must work together. The full range of social, medical, psychological, economic, and political dimensions of AIDS must be addressed. Biomedical data is clearly important in order to gain an understanding of the reasons for the higher rate of heterosexual transmission in women. Many of the physical and physiological characteristics of women in the face of AIDS are relatively unknown. However, the biomedical dimensions provide only part of the picture. Unfortunately, medical findings tend to take precedence over the social and psychological aspects of the illness. The development of an interdisciplinary approach among the medical and social sciences would aid in the construction of more effective prevention and control strategies, for both women and men. If an interdisciplinary perspective had been adopted from the beginning, perhaps the intrinsic role of women in the AIDS epidemic would have been "discovered" sooner. Women other than prostitutes might have seen earlier that they had a risk of HIV infection through sexual activity with their regular partners.

- While women and men tend to follow social and sexual norms, there are many situations where the rules are broken, and the power dynamics of gender relations are inverted. We must understand and expose these situations.

- Members of the research community must strive to inform policy-makers of their research, so that state of the art knowledge can influence public policy.

References

Alonso, Ana Maria; Koreck, Maria Teresa. n.d. Silences: "Hispanics", AIDS and sexual practices. *Differences*: a journal of feminist cultural studies, v. 1. Mimeo.

Berquó, Elza; Souza, Marta Rovery de. 1990. O condom, a anticoncepção e a AIDS. In: *VII Anais, Encontro Nacional da Associação Brasileira de Estudos Populacionais-ABEP*, Águas de São Pedro, v. 3, pp. 469-484.

Bruyn, Maria de. 1993. Gender-related problems of self-protection against HIV infection. *Vena Journal*, 5(1): 6 -11.

Byron, Peg. 1991. HIV: The national scandal. *Ms*, January-February, pp. 24-29.

Carovano, Kathryn. 1991. More than mothers and whores: Redefining the AIDS prevention needs of women. *International Journal of Health Services*, 21(1): 131-142.

Daniel, Herbert. 1991. We are all people living with AIDS: myths and realities of AIDS in Brazil. *International Journal of Health Services*, 21(3): 539-551.

Daniel, Herbert; Parker, Richard G. 1991. *AIDS, A Terceira Epidemia.* São Paulo: Iglu.

Damatta, Roberto. 1987. *A casa e a rua.* Rio de Janeiro: Guanabara.

Dixon-Mueller, Ruth; Wasserheit, Judith. 1991. *The culture of silence: Reproductive tract infections among women in the Third World.* International Women's Health Coalition-IWHC.

Freyre, Gilberto. 1946. *The masters and the slaves.* New York: Alfred Knopf.

Fry, Peter. 1982. Da hierarquia à igualdade: a construção histórica da homossexualidade no Brasil. In: *Para inglês ver: identidade e política na cultura brasileira.* Rio de Janeiro: Zahar.

Gillespie, Marcia Ann. 1991. HIV: The global crisis. *Ms*, January-February, pp. 17-22.

Guimarães, Carmen Dora. 1990. Silêncio sobre mulheres. *Jornal do Brasil*, Caderno Idéias, 28 outubro, pp. 6-7.

1992. O comunicante e a comunicada: a transmissão sexual do HIV. In: Paiva, Vera ed. *Em tempo de AIDS.* São Paulo: Summus, pp. 147-157.

1993. Mulheres, Homens e AIDS: o Visível e o Invisível. In: Parker, R. et al., *AIDS no Brasil*. Rio de Janeiro: Relume Dumará, ABIA, IMS-UERJ, pp. 217-229.

1994. "Mas eu conheço ele!": um método de prevenção do HIV/AIDS. Paper presented at the XIX National Meeting of Brazilian Anthropology, Fluminense Federal University, March 27-30. Unpublished.

Guimarães, Carmen Dora,; Brasil, Vera Vital. 1991. Incentives to encourage the use of the condom. BEMFAM/*AIDS*COM Project, Rio de Janeiro. Report of Phase I and II. Mimeo.

Daniel, Herbert; Galvão, Jane. 1988. O impacto social da AIDS no Brasil: o caso do Rio de Janeiro. Final report. Associação Brasileira Interdisciplinar de AIDS-ABIA and Ford Foundation. Unpublished.

Terto Jr. Veriano; Parker, Richard G. 1992. Homossexualidade, bissexualidade e HIV/AIDS no Brasil: uma bibliografia anotada das Ciências Sociais. *Physis: Jornal de Saúde Coletiva*, 2(1):151-183.

MacRae, Edward. 1990. *A construção da igualdade*. Campinas: Editora da UNICAMP.

Misse, Michel. 1979. *O estigma do passivo sexual*. Rio de Janeiro: Achiamé.

Parker, Richard G. 1991. *Bodies, pleasures and passions--sexual culture in contemporary Brazil*. Boston, Beacon Press.

1991. A relação entre parceiros e o risco de transmissão do HIV no Rio de Janeiro. Instituto de Medicina Social-Uerj and WHO. Final report. Unpublished.

1993. Sexo entre Homens: Consciência da AIDS e comportamento sexual entre os homens homossexuais e bissexuais no Brasil. In: Parker et al., *AIDS no Brasil*. Relume Dumará, ABIA, IMS-Uerj, pp. 129-149.

Perlongher, Nestor. 1988. *O negócio do michê*. São Paulo: Brasiliense.

Sion, Fernando S.; et al. 1992. *Heterosexual transmission of the HIV: Men-women and women-men*. Paper presented at the Women and AIDS Workshop, Institute of Social Medicine, State University of Rio de Janeiro, 29-30 June and 1 July. Unpublished.

Stein, Zena A. 1990. HIV Prevention: The need for methods women can use. *American Journal of Public Health*, pp. 460-462. Mimeo.

Voeller, Bruce. 1988. *Heterosexual anorectal intercourse: an AIDS risk factor*. Mariposa Occasional Paper, n. 10, December.

Love Does Not Protect Against AIDS: Reflections About the HIV/AIDS Epidemic From a Gender Perspective

Elsa do Prado[1]

Introduction

This paper provides some reflections about women and the HIV/AIDS epidemic. The World Health Organization predicts that by the year 2000, there will be forty million people affected by HIV/AIDS worldwide. For many years, AIDS was seen as a disease which only affected homosexuals, drug addicts, and prostitutes. Today, the disease is widespread outside these communities. While HIV/AIDS affects men, women and children, it has unique implications for women.

To date, because the search for a cure has been elusive, there continues to be a need to focus on ways to prevent the spread of HIV/AIDS. Preventive measures involve more than just increasing knowledge levels through education. Preventive strategies should also be concerned with the relationship between men and women, as well as their views about sex. Men and women occupy different positions in society, and society has different expectations of each gender. These factors play an important role in whether or not an individual will be exposed to HIV/AIDS. In order to combat this disease, there must be a radical alteration of our social patterns and sexual behaviours.

Transmission of AIDS

AIDS detrimentally affects the immune system, making the individual susceptible to other diseases and infections. AIDS, transmitted through blood and semen, is primarily transmitted through sexual contact with an HIV-infected person. An individual can also be exposed to HIV/AIDS through a blood transfusion, or through exposure to HIV-infected blood products, such as syringes and infected medical instruments. In addition, AIDS can be transmitted from a mother, through the maternal placenta, to the fetus. Transmission is not possible by kissing, embracing, coughing or sneezing, or by sharing dishes or clothing. To date, evidence suggests that the latency period of HIV ranges from six months to ten years.

Symptoms of AIDS

There is a distinction between primary and secondary symptoms of AIDS. Primary symptoms include swelling of the lymphatic glands, fever, perspiration, weight reduction,

[1] Centro de Salud and Sexualidad "Alternativas", Montevideo, Uruguay.

presence of aphthous mouth symptoms, and chronic diarrhea. Secondary symptoms occur with the further impairment of the immunological system, and include various infections such as herpes, aphthous, and tuberculosis. These are called "opportunistic infections," because they take advantage of a low defensive mechanism. As the disease progresses, an individual will lose a great amount of body weight, and suffer from constant fatigue and diarrhea. Lymphadenopathy will become more pronounced. In the later stages of the disease, pneumonia and skin cancer (Kaposi's Sarcoma) are common.

Women and Biological Factors Influencing HIV Transmission

From a biological point of view, women are almost twice as likely as men to contract HIV as a result of sexual contact with an infected partner. This is due to a number of factors, including the following:

- semen contains a greater amount of HIV than vaginal fluids;
- the vagina and anus are more susceptible to infections than the penis; and
- sexually transmitted diseases and gynaecological infections leave the female without defenses against the virus.

When a woman contracts AIDS, a number of diseases often appear, including cancer of the uterus, pulmonary tuberculosis, and recurrent pneumonia. Transmission of HIV/AIDS vertically during pregnancy appears to particularly affect female fetuses.

Women and Social Factors Influencing HIV Transmission

In addition to their biological vulnerability, women are more likely to contract HIV/AIDS than men because of their subordinate social and sexual positions. Many women do not control how, when, with whom, and how often they have sexual intercourse. The sexual and reproductive rights of women are curtailed throughout the world. Women are socialized to believe that the "ideal woman" suppresses her desires and needs in order to please her partner.

Few women are able to raise the issue of condoms with their partners. The male condom, which is controlled by men, is currently the main prevention method available. Because it is worn by men, women can only indirectly influence its use by convincing their partners to wear one. Even sex workers find it difficult to deal openly with this issue. These women, who depend on their clients for money, have little power in this domain. Because the clients pay for sex, they make the decisions.

It is also difficult for women with few sexual partners, even for monogamous women, to control condom usage. If a woman demands that her partner use a condom, this is a sign of distrust. For some men, not using a condom is proof that his partner trusts him. Women are socially expected to be monogamous, while this is not necessarily the case for men. Men often have sexual relations outside of primary relationships without a condom, exposing both their partners and their children to the risk of HIV/AIDS. While a woman may be aware of this, she may not be able to discuss condom use, because her partner might suggest that she has had sexual relations with other men. Fearful of the reactions of their partners, women therefore risk their physical health, indeed, their lives, to be accommodating to men.

The Search for a Cure

Each day, more people die of AIDS. There is no vaccine and no cure. Numerous efforts are currently underway in the search for a vaccine, or for an efficient medication to bring about a definitive cure. HIV is very complex. It mutates and transforms into new strains and is resistant to all known treatment. There are at least five strains of HIV, which makes research difficult because it is likely that each strain requires more than one vaccine.

Genetic engineering has led to the development of experimental vaccines. If these vaccines lead to positive results, they might be used as prophylactics. That is, they could be used for stimulating immunological responses in non-affected individuals who would then be protected against infection should they become exposed to the virus. These vaccines could be used therapeutically to generate an immunological reaction, arresting the progress of the disease if an infection already exists.

Other studies are being done with anti-retroviral medications. This involves the use of chemotherapy which may slow down the progress of the infection and prolong life. Chemotherapy may also lengthen the period that an individual is free from disease/asymptomatic, as well as reducing discomfort when symptoms are present. AZT, which is very expensive, is an efficient treatment against the lethal pneumonia which is associated with AIDS.

Prevention Measures

Presently, the main prevention methods are:

- the use of the male condom;
- reducing sexually transmitted diseases; and,
- modifying high risk sexual behaviour.

The male latex condom is effective in preventing the transmission of HIV when it is used in a consistent and correct fashion. While information, education and access to condoms are important issues, the biggest hurdle for condom usage is the difficulty that women have in

negotiating the use of condoms with their partners. A women usually does not decide whether or not her male sexual partner will wear a condom. It is not socially appropriate for women to carry condóms, nor to take the initiative for their use. Efforts are needed to encourage men to accept responsibility for practising safer sex. As well as the use of a condom, safer sex involves practices such as sex without penetration and mutual masturbation.

Future research needs to explore prevention methods which women can control, so they can protect their own health, as well as the health of their children. For example, the promotion and use of the female condom and spermicidals with nonoxinol-9, might help to fight the virus. As well, prevention measures need to be encouraged among lesbian couples, such as the latex field or PVC towel, latex gloves, and so on.

Many women have trouble accepting that their husbands or partners could be transmitters of HIV/AIDS. It is as though they believe that marriage, or the state of being in love, protects them from this deadly disease. However, the reality is that many men have intercourse outside of their steady relationships, and expose their steady partners to the risk of HIV. Erroneous beliefs and attitudes need to be modified.

Another important issue relates to the importance of controlling sexually transmitted diseases. The presence of genital ulcers caused by some sexually transmitted diseases increases the risk that a person will get HIV/AIDS through sex with an infected partner. Sexually transmitted disease prevention programs, including campaigns against HIV/AIDS, are therefore important.

The fight against AIDS involves fighting against the subordination of women and other discriminated groups. Improving the social status of discriminated groups will make a valuable contribution in the fight against HIV/AIDS. Research and prevention programs need to focus on the most vulnerable groups in society. We all must work together - men, women, researchers, scientists, health workers, educators, community leaders - to fight this disease head on.

Counsellors' and HIV-Positive Patients' Perceptions of Gender Differences in HIV/AIDS Education and Counselling

Rafael Garcia, E. Antonio De Moya, Rosario Fadul,
Aida Freites, Sara Guerrero, and Cesar Castellanos[1]

Introduction

The purpose of the present study is to qualitatively explore HIV counsellors' and HIV-positive patients' perceptions of likely gender differences in HIV/AIDS education and counselling. Gender differences in this area are beginning to receive special attention as the HIV/AIDS epidemic gains ground in the heterosexual population worldwide. As a result of this progression, large numbers of women and children are becoming infected everyday. There exists a need to understand the extent to which women's sexual behaviour differs from that of men, and whether these differences require differential preventive approaches. In this study, perceptions of gender differences were assessed in a number of areas, including:

- perceived threat of HIV/AIDS;
- reactions to fear campaigns;
- perceived value of preventive action;
- meaning of condom use;
- need for targeting of preventive messages;
- influence of counsellor-patient gender combinations in counselling;
- counsellors' expectations of patient reactions to HIV infection; and,
- psychosocial reactions to HIV antibody detection (e.g., anxiety, confidentiality, resource mobilization and family response).

Gender Differences in Sexual Interaction

A growing body of literature on gender roles and gender differences in social behaviour suggests that females and males may enter sexual relationships with different expectations, attitudes, and habits. These gender differences are thought to be partially due to the tendency of males and females to behave according to their respective gender roles. A. H. Eagly's Gender Role Theory (Eagly and Steffen 1984; Eagly 1987; Eagly and Karau 1991; Eagly and Wood 1991) asserts that gender stereotypes are, in effect, culturally shared expectations of gender appropriate behaviours. Similar forces may operate during sexual

[1] Institute of Human Sexuality, Autonomous University of Santo Domingo (UASD), Dominican Republic.

interactions. According to Airhihenbuwa et al. (1992), gender-based social roles define the nature and type of activities pursued by women and men. More importantly, these roles also define the power differential in heterosexual relationships.

In most, if not all, societies, there are clear differences between the expected and actual behaviour of girls and boys. Serbin and Sprafkin (1987) and Bancroft (1989) have pointed out that boys not only demonstrate more physical activity, rough and tumble play and exploration, but they also have different interests. For example, boys tend to prefer war games, while girls tend to prefer acting out domestic roles. While these type of generalizations may apply to the majority, considerable overlap also exists between the sexes. Gender role stereotypes also vary from culture to culture. Much of the control of women by men in our societies depends upon these stereotyped roles. Androcentrism, a male-centred approach to gender, generally places women at a disadvantage in society (Duke and Omi 1991).

Several recent studies reported findings on gender differences. Weiss, Weston and Quirinale (1993) found gender-based differences in knowledge and learning style about AIDS. Garcia and Renshaw (1987) reported that a double-standard exists in Latin Caribbean child-rearing practices: adolescent males are expected to engage in sexual intercourse with as many partners as possible, while adolescent females are expected to remain virgins until marriage. Therefore, males usually initiate sexual activity earlier than females (Garcia et al. 1992). However, sexual initiation is also associated with ethnicity and socioeconomic status (Seidman and Rieder 1994). Airhihenbuwa et al. (1992) reported that females exhibited high levels of anxiety regarding sexual assault, fear of AIDS, pregnancy and negative social evaluation. Katz, Gibson and Turner (1992) also reported that females feel significantly more sexual anxiety and distress than males. They found that women acknowledged more fear of sexual intercourse than men, and reported more avoidance of situations where they might become sexually involved. Rhodes and Wolitski (1990) provided indirect evidence suggesting that threatening, fear-oriented approaches may have an important role in AIDS education programs for women, if such appeals cause anxiety and lead to the adoption of protective behaviours.

Gender Differences and AIDS

AIDS is increasingly being recognized worldwide as a significant health and social issue for women (Gielen et al. 1994). Due to the rapid increase in the number of AIDS cases among women, research on gender differences in this area is paramount. A need exists for gender-specific, language-appropriate preventive approaches, as well as a need to address the multitude of direct and indirect effects of the HIV/AIDS epidemic on both women and men (Citizens Commission on AIDS for New York City and Northern New Jersey 1991). According to Duke and Omi (1991), women are becoming HIV-infected and ill in increasing numbers. They are usually the primary caretakers of their families, loved ones, as well as friends, when someone becomes sick. Women often find themselves alone in dealing with the day-to-day problems of securing support. If a woman develops a HIV-related illness,

fulfilling these responsibilities may become difficult or impossible. Many women who are ill themselves must also cope with the illness of a partner, sibling, or child. Rosser (1991) asserted that research on AIDS conditions specific to females has received low priority, funding and prestige. Anastos & Marte (1989) suggested that the fundamental questions about the progression of the disease in women have not yet been explored.

Gender differences in AIDS knowledge, attitudes, and beliefs, have been studied extensively in recent years. In a Latin Caribbean society, no gender differences in adolescents' AIDS knowledge were found by Garcia et al. (1992), although a significantly larger proportion of males than females stated they would engage in sexual relations in spite of risk of HIV infection. In Anglo-Saxon societies, Dusenbury et al. (1991) found that there were significant differences between boys and girls on these measures, girls being generally more knowledgeable than boys. Verby and Herold (1993) also found that women had more knowledge of AIDS than men. Harrison et al. (1991) reported that women from four ethnic groups at risk of HIV infection in general did not see themselves at risk for contracting HIV. Corby et al. (1991) reported that, of a group of female partners of male injection drug users, almost all reported engaging in unprotected vaginal and anal intercourse.

Gender Differences and Condom Use

Using condoms may mean different things for men and for women. If this is true, prevalence of condom use may be a function of gender role stereotypes. Maya and Cochran (1988) argued that, for many women, primarily those from lower classes, the role of sex may be seen as a barter in exchange for the financial support of a male partner. A woman may place more value on securing food and shelter for herself and her children than on practising safer sex. Moreover, negotiating condom use with a sexual partner often insinuates promiscuity. If a woman asks her male partner to use a condom, she is either implying that he has been "immoral," or that she has been "immoral" (Nichols 1990). If her partner believes that she has been sexually active outside the relationship, he may reject her. If she implies that he has been involved in extra-marital sexual relations, she risks his anger and outrage.

Sacco et al. (1993) found that although females may indirectly influence condom use decisions, providing condoms is the expected role of males. In their study, men engaged in preliminary condom use behaviours (carrying and keeping condoms at home) substantially more often than women. However, women were less likely than men to view people who carry and use condoms as promiscuous. Lagly et al. (1991) also found that females consistently exhibited more negative attitudes (for example, greater inhibition) with respect to buying, carrying, and keeping condoms at home, and were much less likely to engage in those behaviours.

Methods

At the end of March 1994, two separate focus group sessions, each approximately two hours in length, were held at the Institute of Human Sexuality. One session, conducted by a male psychiatrist, involved seven HIV counsellors (three female and two male psychologists, and two female community nurses). The second session, conducted by two psychologists (one male and one female) involved six HIV-positive patients (one female, five males). The purpose of these sessions was to contrast counsellors' and patients' viewpoints on gender differences in HIV/AIDS education and counselling. A Group Discussion Guide was prepared with eight open-ended questions which represented the main dimensions of this study (see Appendix). Gender differences were assessed concerning the following areas: (1) perceived HIV/AIDS threat; (2) reactions to fear appeals; (3) perceived value of preventive action; (4) meaning of condom use; (5) need for targeting of preventive messages; (6) counsellor-patient gender combinations in counselling; (7) counsellors' expectations of patient reactions to HIV infection; and, (8) psychosocial reactions to HIV antibody detection (e.g., anxiety, confidentiality, resource mobilization, and family responses). Group discussions were recorded and transcribed in order to facilitate individual and group content analysis.

Results

Perceived Threat of HIV/AIDS

Counsellors and patients separately discussed to what extent the perceived threat of HIV/AIDS was a function of gender differences. A few patients insisted that this was an individually-based problem having little to do with gender. However, most other participants were able to identify attitudes and behaviour that could be associated with gender stereotypes and gender roles. In their opinion, women take the threat of infection more seriously because of health consequences to themselves and to their children, and tend to be more cautious regarding intimate sexual relations.

Not being so optimistic, counsellors perceived an increased risk of HIV infection in women, associated with the socially sanctioned but clandestine polygamous behaviour of many men. Many women continue to ignore partners' sexual adventures, have a passive attitude in sexual relationships, do not adopt preventive measures, and have difficulty demanding condom usage, as this is virtually proscribed, at least for married women. Counsellors perceived that there were strong social pressures for women to adopt the mother role as a main avenue to social legitimation. However, this may be a double-edged sword when partners are at risk of HIV infection.

The first crisis experienced by HIV-positive women usually relates to the likelihood of not being able to bear more healthy children. Many women become pregnant even though they are aware of their seropositive status. Social pressures prompt women to have children.

Having a child is also seen as a way of retaining partners. Paradoxically, most women are generally more interested in their children than in themselves, and are more concerned about leaving them orphans than about social stigmatization.

Men generally try to minimize the threat of HIV/AIDS by psychologically displacing the risk to sex workers, and avoiding sexual relations with them. However, they tend not to use condoms with partners who may be engaging in intercourse with other men. In this way, men directly confront danger in order to prove their braveness and manliness. One patient put it this way:

> Us men, we take AIDS as a joke. We are more happy-go-lucky. This is man's nature: male chauvinism. When a man sees a woman, he forgets about AIDS. No matter what problem arises, man says: I can bear it. Many men feel that if the solution is not to have several women, they would rather die of AIDS. If you are a man and get AIDS, people support you and say: He is **a macho,** because he got the disease by doing men's thing: sex with women. I myself used to believe AIDS was a tale, until I got a positive HIV test.

Reactions to Fear Campaigns

Fear campaigns may have differential effects on men and women. Counsellors and patients agreed that gender-based stereotypes and role-prescriptions influence male and female responses to dangerous situations, such as risk of HIV infection. In their opinion, differential child-rearing practices can largely account for differential preventive behaviours. Girls are usually taught that some men are dangerous and to avoid them by maintaining a conservative attitude. In this sense, women gradually learn to recognize potentially dangerous situations. It is legitimate for women to experience fear and they are encouraged to avoid the source of danger. It is therefore expected that women should adopt HIV preventive action when the perceived threat of infection to themselves and their children is relatively high (e.g., "women generally pay more attention to fear-arousing messages").

On the other hand, boys are usually raised as predators who should be feared, feel no fear (e.g., "you are a man, don't let anything frighten you; "be strong and challenge all dangers") and learn to attain goals by maintaining an aggressive attitude. In this way, men gradually learn to dismiss potentially dangerous situations and to attribute physiological arousal, such as trembling, to irrelevant sources (e.g., cold weather, fever, indigestion). They are taught to directly confront (e.g., fight, reject condom use) or be paralysed by the source of danger (e.g., abstain from sex, lose erection). It is expected then, that men would adopt HIV preventive action (e.g., avoid infection, use condoms) when the perceived threat to them is relatively low (e.g., "men pay no attention to fear-arousing messages"). As fear only challenges men, by not using condoms they are able to prove that they do not fear either AIDS or death.

Perceived Value of Preventive Action

Gender differences in the perceptions of HIV preventive action were assessed. Counsellors and patients asserted that these differences may probably be better understood in terms of sexual risk behaviour. In their opinion, women generally seem to be more prone to abstain from sex, to be less assertive in demanding condom use, and to be less eager to end the relationship when the male partner is at real or imaginary risk. Many women also seem to have developed preventive alternatives to condom use, such as increasing sexual activity with steady partners, practising non-penetrative ("safer") sex, and suggesting to partners that they use condoms if they engage in casual sexual relations.

Men have reduced their demand for paid sex with street-walking sex workers, but not necessarily with less professional barmaids (e.g., "men only use condoms when they believe they are dealing with street-women; with home-women, even if they have other male partner(s), condoms are not used"). Men radically reject sexual abstinence, value condom use more, and are more eager to end the relationship when the female partner is at real or imaginary risk stemming from other sources.

Meaning of Condom Use

The differential meaning of condom use for males and females was also discussed. Counsellors and patients felt that women were at a disadvantage, since females who buy or carry condoms were perceived as transgressing role prescriptions (e.g., "not being a sex worker," "not knowing much about sex," "being sexually discriminative," "being devoted to one man"). It is very difficult for women to propose using condoms to steady partners (fiances, lovers, husbands). Proposing the use of condoms reflects that the woman either distrusts her partner (e.g., suspects that he has been unfaithful or has a sexually transmitted disease) or feels guilty about her own sexual behaviour (e.g., has been unfaithful or has a sexually transmitted disease).

If a man suggests using condoms to his steady partner, the woman will likely be suspicious of him, or be offended for being treated as a suspect women. However, this attitude may be gradually changing. Research results suggested that 20% of married women and 60% of sex workers are now consistently using condoms with steady partners, mostly under the pretext of contraception. In this way, men who engage in sex outside the relationship are relieved of the responsibility of making the decision to use condoms with their steady female partners.

Both groups believed that it is socially acceptable for men to use condoms, at least with occasional partners, because it is consistent with gender role prescriptions which label men as womanizers (e.g., "when a man carries condoms, he is seen as a *macho* by other men; because if he carries them, it is because he has several women"). Because condom use is perceived to be related to non-committed, non-procreative sex, the use of condoms is

relatively incompatible with long-term, "trusting" relationships. This may partly explain why men use condoms three times more frequently with casual partners than with wives or mistresses.

Need for Targeting Preventive Messages

The need for targeting preventive messages to male and female audiences was discussed. Counsellors felt that, although the content of HIV/AIDS education should be the same for men and women, different motivational issues should be considered. According to the counsellors, prevention messages geared to women should focus on assertiveness training and empowering women to protect their health and fertility (e.g., "being able to procreate healthy children, raise them and see them grow"). They pointed out that women are usually more concerned about AIDS if they are pregnant, or already have children. An unresolved issue is how to motivate women who are not pregnant, or who do not have, or do not want to have children, to protect themselves.

On the other hand, prevention messages geared to men should focus on the consistent use of condoms with women who are not steady partners, in order to protect the health of partners and children. This can be a powerful message since women sometimes threaten that they will abandon, or even kill, their husbands if their children become HIV-infected as a result of the husband's behaviour. Patients stated that current messages are not tailored to reality, have little effect, and should be more like everyday life dramas, as in television soap operas.

Counsellor-Patient Gender Combinations in Counselling

Counsellors and patients both believed that the expression of emotional responses by patients was associated with the counsellor's gender (e.g., "there are things that happen to women which do not happen to men, as well as women's feelings that men do not understand and vice versa"). Counsellors of both genders are trained to manage equally male and female patients. Patients stated they could establish rapport with either sex. However, there seems to be a tendency for both counsellors and patients to prefer same-sex therapeutic partners for airing intimate issues, such as sexual behaviour and HIV infection.

The men seemed relatively less concerned with the counsellor's gender, while the women appeared to have a decided preference for female counsellors. While women may be able to share their depression with male counsellors, they appeared to be reluctant to cry with them. Men also seemed to express emotions more openly with same-sex counsellors and allowed themselves to cry more often with male counsellors than female counsellors. Men may express sadness and depression in front of women, but usually inhibit emotional responses and do no cry. Nevertheless, neither counsellors nor patients expressed that same-sex dyads were absolutely necessary, as long as rapport could be attained. Both stressed the significance of emotional release by patients, pointing out that counsellors, regardless of gender combinations, can create a trusting atmosphere in which patients feel they are entitled to cry.

Expectations of Patient Reactions to HIV Infection

Both counsellors and patients felt that counselling procedures were based on gender independent assumptions and that male and female HIV patients should be treated in the same way. Nevertheless, counsellors expected women to be more discrete and reluctant to talk about intimate sexual behaviour. They also expected women to be more attentive to AIDS education, to better accept the diagnosis, to be more willing to abstain from sex or to protect a partner, and to be more collaborative in treatment. Men were expected to use more defense mechanisms (e.g., denial) and to reject sexual abstinence.

Response of Patients and Families to HIV Antibody Detection

Both counsellors and patients believed that there were no gender differences in HIV pre-test anxiety levels. Instead, pre-test anxiety levels were believed to be related to the awareness of personal or partner's sexual risk behaviour. Patients stated that "men and women get equally anxious," since in those moments "one is just human, not a man or a woman." Counsellors and some patients also asserted that apparent gender differences in responses to HIV-positive test results can be attributed to personality differences, awareness of risk level, expectation of stigmatization and social condemnation, and quality of HIV/AIDS knowledge.

In contrast, other patients felt that women tended to cry more often and longer than men, expressing sorrow more openly and deeply, since women are "weaker and breakdown more easily," while "men are better equipped for bad times and are more enduring when they feel bad." Some counsellors felt that men used more defense mechanisms, tending to deny or minimize problems, or to respond in more aggressive and violent ways, often threatening to commit suicide or to kill someone. On the other hand, some counsellors and patients believed that, although role prescriptions assume that men should be stronger and more enduring than women, this was not necessarily the case.

Opinions were also divided regarding how easily men and women communicated an HIV-positive test result to close relatives. This could also be influenced by feelings of guilt, based upon perception of the likely source of infection (e.g., sexual indiscrimination, having been infected by lover or spouse, through a blood transfusion). Both groups perceived that family response to HIV infection in one of its members was related to the degree of family stability, the person's economic role in the family, previous attitudes about the person's lifestyle, likely source of infection, or even his/her attitudes toward infection and disease, rather than as a function of gender per se.

Whether or not a person attempts to hide her or his HIV-positive status was believed to be dependent upon the likelihood of personal and family stigmatization and social condemnation. Counsellors stated that men tended to be more distrustful of visits by community nurses to their homes than women. However, after a few visits, men become equally trustful when they experienced changes in family attitudes towards them. Many HIV-positive men live by themselves and only look for family support when their disease progresses to a severe stage.

In many cases, as long as solitary men remain asymptomatic, their families tended to maintain an indifferent and neutral stance, which is in line with role prescriptions. Both groups said that the family, particularly female members, usually provided instrumental support to the patient when necessary. Family response to HIV discordant and concordant couples varied depending on the situation. If the woman was seronegative, her family tended to offer her more solidarity and support. If the woman was seropositive, the woman's family tended to show more anger to the male partner. In a few cases of HIV-positive women in discordant couples, males have received direct pressures from their own families to abandon their partners.

Discussion and Conclusions

Counsellors and patients participating in this study exhibited very similar views on most issues discussed. Perceived gender differences were salient for many of the topics. Gender differences appeared to be related to risk behaviour associated with gender role prescriptions, as postulated by Eagly et al. (1991). Women were generally perceived as being relatively powerless in sexual relations with men, not adopting preventive measures, and having difficulty demanding condom use. On the other hand, men seemed to displace risk perception to women who presumably have the highest risk levels, and continued to engage in unprotected sexual activity with "safer" partners.

According to respondents of both groups, fear-arousing messages would probably be most useful for promoting condom use among women. It was suggested that messages should be related to the protection of pregnancy and motherhood, because women attach great value to motherhood, according to the gender role stereotype. In contrast, fear-arousing messages may be less useful for men, because men, according to gender role stereotypes, are less likely to attend to fear. Women are also perceived as preferring sexual abstinence, while men feel this is objectionable and virtually impossible to obey. Men may accept condom use in sexual relations outside of marriage, while women feel that using condoms carries the stigma of the fallen woman.

Although counselling strategies were not perceived as being necessarily different for either sex, it was recognized that emotional expression of patients seemed to be easier with same-sex counsellors. Counsellors also expected that women and men and their families would respond differentially to the diagnosis of HIV infection. Family response appeared to be dependent upon the stage of the male patient's infection, or upon the woman's source of infection.

It is suggested that further studies be conducted to address issues concerning gender differences in HIV/AIDS education and counselling, and to fully explore the specific effects of gender-oriented persuasive communications.

Appendix: Group Discussion Guide

- Are there any different premises, assumptions and expectations when approaching men and women for HIV/AIDS counselling and education? Which would be the most important in each case?

- In relationships established between an HIV-positive client and a counsellor, are there any differences related to gender (sex)? Are there any differences between same-sex dyads and opposite sex dyads? If so, what advantages and disadvantages exist with each type of dyad?

- When men and women evaluate the threat of AIDS for themselves and their families, do they look at different issues? Which are the most important?

- Do men and women tend to adopt different preventive actions or measures?

- Is there a need to target HIV/AIDS preventive messages to the psychological differences of men and women? Which would be the most effective messages for each gender?

- Do men and women have different reactions when HIV/AIDS preventive messages appeal to fear? If yes, how do families and society teach men and women to respond when they face dangerous situations?

- Does condom use in sexual relations mean something different for men and women? If so, how would this explain why women use condoms less than men?

- In counselling experiences with HIV-positive persons, are there any differences between men and women in the following areas:

    - anxiety when waiting for a HIV test result;
    - reactions when learning of an HIV positive test result;
    - management of confidentiality, secrecy and revealing to others;
    - mobilization of resources (social networks, economic and emotional support); and,
    - family reactions (feelings of guilt, ending relationships, revenge attempts, acceptance, solidarity).

References

Airhihenbuwa, C.O.; DiClemente, R.J.; Wingood, G.M.; Lowe, A. 1992. HIV/AIDS education and prevention among African-Americans: A focus on culture. *AIDS education and Prevention*, 4(3) 267-276.

Anastos, K.; Marte, C. 1989. Women: The missing person in the AIDS epidemic. Health/PAC Bulletin (Winter).

Bancroft, J. 1989. Human sexuality and its problems. London. Churchill-Livingstone.

Citizens Commission on AIDS for New York City and Northern New Jersey. 1991. AIDS prevention and education: Reframing the message (Commentary). AIDS education and prevention, 3(2), 147-163.

Corby, N.H.; Wolitski, R.J.; Thornton-Johnson, J.A.; Tanner, W.M. 1991. AIDS. Knowledge, Perception of Risk, and behaviours among females sex partners of injection dug users. AIDS education and prevention, 3(4) 353-366.

Duke, S.I.; Omi, J. 1991. Development of AIDS education and prevention materials for women by health department staff and community focus groups. AIDS education and prevention, 3(2) 90-99.

Dusenbury, L.; Botvin, G.J.; Baker, E.; Laurence, J. 1991. AIDS risk knowledge, attitudes, and behavioral intentions among multi-ethnic adolescents. AIDS education and prevention, 3(4) 367-375.

Eagly, A.H. 1987. Sex differences in social behaviour: A social-role interpretation. Hillsdale, N.J. Erlbaum.

Eagly, A.H; Karau, S.J. 1991. Gender and the emergence of leaders: A meta-analysis. *Journal of personality and social psychology*. 60, 685-710.

Eagly, A.H.; Steffen, V.J. 1984. Gender stereotypes stem from the distribution of women and men into social roles. *Journal of personality and social psychology*. 46, 735-754.

Eagly, A.H.; Wood, W. 1991. Explaining sex differences in social behaviour: A meta-analytic perspective. Personality and social psychology bulletin, 17, 306-315.

Garcia, R.; Fadul, R.; De Moya, E.A.; Gomez, E.; Herold, E.S. 1992. Sexual behaviour of Dominican adolescents. Monograph of the institute of human sexuality, Santo Domingo.

Garcia, R.; Renshaw, D. 1987. A contemporary prostitution accepting culture. *British Journal of Sexual Medicine*. March, 72-75.

Gielen, A.C.; Faden, R.R.; O'Campo, P.; Kass, N.; Anderson, J. 1994. Women's protective sexual behaviours: A test of the health belief model. AIDS education and prevention, 6(1) 1-11.

Harrison, D.F.; Wamback, K.G.; Byers, J.B.; Imershein, A.W.; Levine, P.; Maddox, K.; Quadagno, D.M.; Fordyce, M.L.; Jones, M.A. 1991. AIDS knowledge and risk behaviours among culturally diverse women. AIDS education and prevention, 3(2) 7989.

Katz, R.C.; Gibson, M.; Turner, S. 1992. Recent findings on the sexual aversion scale (Brief Report). *Journal of sex and marital therapy*. Vol. 18, No. 2, Summer, 141-146.

Maya, V.M. and Cochran, S.D. 1988. Issues in the perception of AIDS risk and risk reduction activities by black and Latino women. American Psychologist, 43, 943-957.

Nichols, M. 1990. Women and AIDS: Issues for prevention. In: B. Voeller, J. Reinisch and M. Gottlieb (Eta), AIDS and Sex - An integrated and biomedical and behavioral Approach. NY: Oxford University Press.

Rhodes, F.; Wolitski, R.J. 1990. Perceived effectiveness of fear appeals in AIDS education: relationship to ethnicity, gender, age and group membership. AIDS education and prevention, 2(1) 1-11.

Rosser, S.V. 1991. Perspectives on AIDS and women. AIDS education and prevention, 3(3) 230-240.

Sacco, W.P.; Rickman, R.L.; Thompson, K.; Levine, B.; Reed, D.L. 1993. Gender differences in AIDS-relevant condom attitudes and condom use. AIDS education and prevention, 5(4), 311-326.

Serbin, L.A.; Sprafkin, C.H 1987. A developmental approach: sexuality from infancy through adolescence. In: Geer, J.H. and O'Donohue, W.T. (Eta.) Theories of human sexuality. Plenum Publishing, New York, 163- 196.

Verby, C.; Herold, E.S. 1992. Parents and AIDS education. AIDS education and prevention. 4(3) 187-196.

Weiss, S.H.; Weston, C.B.; Quirinale, J. 1993. Safe sex? Misconceptions, gender differences and barriers among injection drug users: A focus group approach. AIDS education and prevention. 5(4), 279-293.

Sexual Initiation of School-Age Adolescents in Santiago, Chile: The Implications of Gender, Religion, and Family Structure

Paulina Pino Z., Ramon Florenzano U., and Alfredo Nudman[1]

Introduction

This paper will describe a recent study funded by FONDECYT (Chile) which aimed to obtain a profile of the sexual initiation of school age adolescents in Santiago, Chile, as well as to determine whether gender differences existed. The study also explored the role of religious inclination and family structure in influencing sexual initiation.

Early Sexual Activity and Health Risks for Women

Women who initiate sexual activity at an early age may face a number of serious health risks which can detrimentally affect their physical, social, and psychological well-being (Molina et al. 1992). In Santiago, Chile, there has been a steady increase in the number of pregnancies among young women. Given the large number of early pregnancies, there are an increasing number of babies born who are "illegitimate" (Valenzuela et al. 1992). The unmarried pregnant adolescent woman is often rejected by society, and the vicious cycle of neglect and poverty is usually perpetuated, leading to difficulties for both the mother and the newborn infant (Gonzales et al. 1984; Saurez et al. n.d.).

As a consequence of this increase in pregnancies, the incidence of induced abortions has risen, which poses additional serious health risks for the affected woman. In addition to the physical risks, an abortion can pose serious psychological implications for the woman due to the shame and guilt attached to this illegal, socially forbidden activity (Cartoof 1992). In some cases, the family may take care of the newborn child. This option, while offering some favourable dimensions, often has a negative effect on the mother/child relationship (Gonzalez et al. 1984; Surez et al. n.d.).

There has also been an increase in the occurrence of sexually transmitted diseases, including AIDS. While most people with HIV/AIDS in the adult population are men, in the adolescent population, men and women are affected equally by this disease. The relatively high rate of HIV/AIDS among the adolescent female population poses a serious threat to the health of young women, as well as an increased risk that HIV will be transmitted vertically from mother to child (St. Louis et al. 1991).

---

[1] Departments of Public Health and Psychiatry and Mental Health, Faculty of Medicine. University of Chile, Santiago, Chile.

Onset of Sexual Relations

Because society has a negative view of early sexual relations among young women, the onset of sexual relations usually occurs later for women than for men. For centuries, this societal attitude toward early female sexual relations remained unchanged. However, during the past decades, there has been a significant change. For example, in the United States, between 1970 and 1989, there was a five-fold increase (from 4.7% to 25.6%) in the proportion of 15 year-olds who were sexually active. In some European countries, young people engaging in sexual activity tend to properly use protective measures including contraceptives (Sikand and Fisher 1992). However, in the USA, pregnancy rates are twice as high as those in Europe and Canada, despite the fact that these countries have similar levels of sexual activity among their youth.

Latin American countries tend to copy patterns of behaviour found in the industrialized countries, especially the United States. There are one hundred million adolescents (between 10 and 19 years of age) in Latin America (22% of the total population). Each year, there are three million adolescent pregnancies, while the number of abortions remains unknown (Interagencia de Naciones Unidas 1995). In most Latin American countries, where high infant mortality rates remain a problem, the growing number of adolescent pregnancies is yet another factor contributing to poverty and lower levels of education among women.

Sexual Initiation and Socio-Cultural Factors

Research has recently explored the interaction between early sexual initiation and social factors. A link has been identified between early sexual activity and low levels of scholastic achievement, low social status, lack of religious principles, and the absence of one or both parents (Wrigh et al. 1991). Mass media and peer pressure are cultural factors which may also influence early sexual relations. Concerning cultural determinants, there are important gender differences with regard to differential beliefs about early sexual relations for men and women. Cultural views on the appropriateness of early sexuality for men and women continue to affect them, although this is starting to change (Morris 1992; Sundet et al. 1992). These cultural views significantly affect whether or not adolescents use contraceptives.

Obstacles to Research on Early Sexual Initiation

In Chile, factors affecting early sexual initiation have not been extensively explored, due largely to the resistance of teachers and parents to this type of research. Furthermore, there are methodological difficulties with this type of analysis, particularly in transversal studies. For example, it is difficult to obtain estimates of the number of young people of a given age who have started sexual activity because the age of sexual initiation is not known prior to the day of the interviews. If these people are excluded from the averages, the sexual conduct of young people tends to be overestimated. On the other hand, sexual activity of young people tends to be underestimated if members of this group are considered to be non-initiates - which occurs automatically if the number of initiated are compared to the total population or

to a certain age group. If such a proportion is calculated with lesser intervals of age, sub-dividing the sample, one obtains estimates with considerable variability, due to the low number of observations remaining in each age group. This situation is aggravated if one attempts to sub-divide the sample by other variables, such as age, religion, and so on.

Objectives of the Study

The objective of the study described below was to obtain a profile of the sexual initiation of school age adolescents in Santiago, Chile, as well as to determine whether gender differences existed. The study also explored the role of religious inclination and family structure. The population of this study sample was taken from the seventy-five percent of adolescents who attend public schools.

Methodology

This study was part of a large transversal study carried out in October 1991, which aimed to assess risky behaviour of school-aged adolescents (between 10 and 19 years of age) in the public and semi-public schools of Santiago, Chile.

A random sample was carried out in three stages, stratified by socio-economic level. Twenty-three municipalities in urban Santiago were classified in four homogeneous levels, employing a multi-variate statistical process (analysis of conglomerates). Known socio-economic variables were considered (Mardones and Diaz 1990). When the communities were divided, it was ensured that each level was adequately represented. The three stages of the process used a sampling framework consisting of the communities, the schools, and the individual grades, as well as all the pupils of the selected grades. Because stratified sampling presupposes a presentation of levels which differs from that existing in the city, the figures have been weighted by corrective factors in order to obtain population estimates (Florenzano et al. 1993).

The instrument employed was the Sample of Risk Conduct in Adolescents. This instrument is an adaptation of a questionnaire used in Minnesota for the diagnosis of health in adolescents (Blum 1989). It consists of seventy questions geared to adolescents, concerning different forms of conduct, preferences and perceptions. Eight questions deal specifically with sexual behaviour, asking about the incidence of sexual relations, age of initiation, preferences (homosexual or heterosexual), frequency of relations, and the use of contraceptive methods. This discussion looks only at sex, age, sexual initiation, the degree of religious influence, and the presence of one or both parents. These questions were answered by 1895 out of the 1904 young people who were surveyed (losses=0.5%).

The univariable analysis was performed using group figures (the technique of actuarial life expectancy tables) in order to obtain curves of sexual initiation from the total sample, and from sub-groups determined by the variables of gender, religious inclination, and family structure (Khan 1983). Cox's proportional random regression technique was employed for the analysis of the joint influence of these variables on sexual initiation.

In the life table, the analysis was organized on the basis of intervals in time (10 to 11; 11 to 12; 12 to 13...and 19 to 20) which, in this case, were equivalent to the age of sexual initiation. All respondents provided information for the first age bracket (10 to 11 years old), and for the successive age groups. They recorded the start of sexual activities in one of these age brackets. If a young person was 14 years old at the time of the survey, and was not sexually initiated, she or he would be recorded as exposed to risk until the middle of the interval between 14 and 15 years of age, and would not have been considered in subsequent intervals. Because all the respondents were born between 1972 and 1981, it was assumed that all age groups were exposed to the same sexual initiation occurrence risk.

Two results obtained with this procedure are easy to interpret: (1) the accumulated probability (P%) corresponding to the proportion of young people who reach the limit of a given age bracket without initiating sexual activity and whose complement (1-P%) corresponds to the proportion of young people who have undergone their first sexual experience towards the end of the period in question; and, (2) the age/specific incidence rate of sexual initiation in each age group.

Results

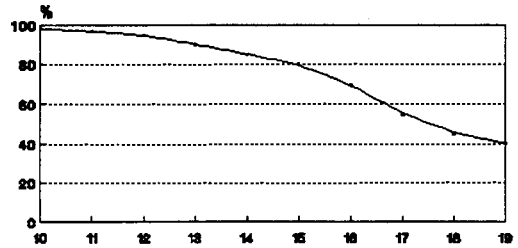
In the transversal studies, the respondents were at different stages with regard to sexual initiation, because they were interviewed at different ages. Non-initiated adolescents reported that, at the time of the interview, they had not had sexual relations; what happened subsequently is not known. The average age of sexual initiation deduced from these people was 14 years (13.8 for males and 15.2 for females).

The "survival" curves describe the persistence of virginity in young people. The complementary graph (1-P%) describes sexual initiation, and represents the total sample for both sexes (Figures 1a and lb).

There was a marked difference between men and women. For males there was an acceleration of the process of sexual initiation from the age of 13, and especially after the age of 15. According to these estimates, only 26.3% of the males will have reached the age of 20 without initiating their sex life. With regard to females, however, the process was fairly slow. Ninety-seven percent of the women had not initiated sexual activity before the age of fourteen. After age fourteen, progressive acceleration occurred. By age 20, the proportion of non-initiates fell to 47.2%. The median age of sexual initiation was 16.7 years in men, and 19.7 years in women. At the age of 18, the risk of having had sexual relations was 2.5 times higher in males than in females.

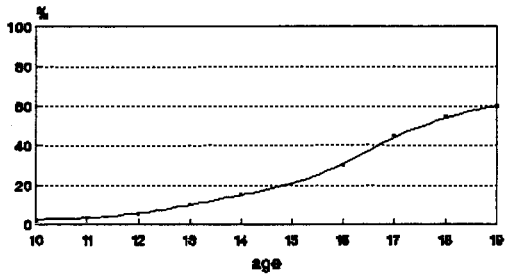
Sexual Initiation in Adolescents
Santiago, Chile 1991

Figure 1a
P(%) IC*



*proportion of young people who have not initiated sexual activities up to the end of each year

Figure 1b
P(%) IC**



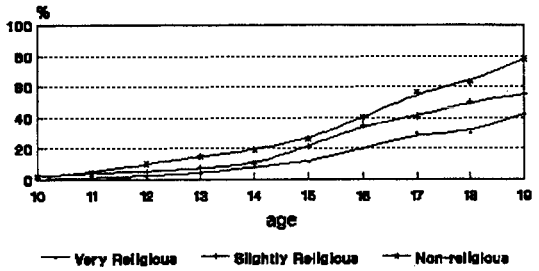
**proportion of young people who have initiated sexual activities up to the end of each year

With regard to religion, young people who consider themselves to be very religious demonstrated a different pattern of behaviour at age 15 than those who labelled themselves as slightly or non-religious. These differences became more marked toward the end of adolescence (Figure 2a). However, there were differences in the distribution of the sexes in the different categories of religious sensitivity. The clear predominance of women in the religious group could explain the lower rate of sexual initiation in this group. The female/male ratio was 2.33 in the religious group, 1.43 in the intermediate group, and 0.92 in the group which defined itself as non-religious. These differences are statistically significant.

Finally, with regard to family structure, adolescents with both or only one parent(s) behaved in much the same way until they reached 13 or 14 years of age. However, after that age, the young people who lived with only one or neither of their parents, differed significantly from those who belonged to two-parent families (Figure 2b). For those who belonged to two-parent families, the median age of sexual initiation was almost one year later than those who did not (19.0 vs 18.1). It is interesting to note that 45.5% of those belonging to two-parent families were still virgins when they reached age 20, compared to 27.4% of those in single parent families.

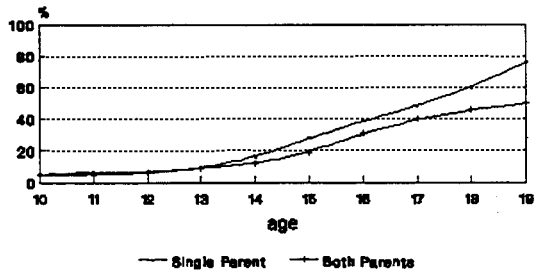
Sexual Initiation in Adolescents According to Degree of Religious Intensity and Family Structure

Figure 2a
Religious Intensity



1-P(%) Proportion of initiates up to end of the corresponding year
P<0.00001

Figure 2b
Family Structure



1-P(%) Proportion of initiates up to the end of the corresponding year
P<0.0058

In order to determine the joint weight of these variables, a multivariate regression analysis (Cox) was carried out. This analysis demonstrated that those who were religiously inclined were less likely to engage in precocious sexual activity, even when considered together with gender. The rate of incidence in the slightly and non-religiously inclined groups was 1.5 and 1.8 times higher respectively, when compared to the religiously inclined group. Furthermore, the presence of both parents was also linked with later onset of sexual relations. The rate of incidence of adolescents who lived with only one parent was 1.4 times higher than those who lived with both parents. With regard to gender, the rate of sexual initiation in adolescence was one fourth the rate in women than it was in men.

Discussion

Study results revealed that the majority of the young people surveyed reported that they commenced sexual relations during their adolescence. For the total sample, the median age of onset was 18.7 years. While there were considerable gender differences, more than 50% of all the adolescents reported that they initiated their sex lives before they were 20 years old. This is significant since we are dealing with young single women who are still in the school system. Does this indicate that there has been a dramatic change in the sexual behaviour of adolescents, particularly young women?

It is difficult to compare the statistics found in this study with other studies carried out in Chile, because of the differences in the analytical structure employed. Nevertheless, it is interesting to compare certain results. An important population-based study carried out with young people in Chile (Valenzuela et al. 1990; 1992), computed the frequency for the first sexual experience up to the age of 24 years. It reported that 6.9% of the women, and 26.4% of the men, had their first sexual experience before they were 15 years old. These results

are similar to the present study (females=4.2%, males=27.2%). It should be remembered that this study took place in the homes, and included young people who had dropped out of the school system. This type of sample would be expected to show a larger proportion of sexually active young people than studies which only include the sampling of school children.

Similar studies carried out in various Latin American countries (Morris 1987) suggest that between 20 and 30% of the female population, and 50 to 60% of the male population, had their first sexual experience before they were 20 years old. In Chile, studies in schools and universities (Rubio et al 1987) have reported values which vary between 7 and 26% for the female sex, and between 31 and 60% for males. In population consultations (Baechler et al. 1983; Kramarosky and Iglesias 1987), which are subject to selective distortions, inconsistent results have been reported which are difficult to subject to comparison. Given the considerable variations between studies, it is difficult to make statements with regard to tendencies, simply on the basis of comparison.

It is also difficult to try to compare situations or tendencies in other countries. In the United States, over the past decade, there has been a proliferation of studies regarding sexual behaviour in adolescents (Centres for Disease Control 1992). For comparative purposes, the Minnesota Adolescent Health Survey, whose questionnaire served as a basis for the present study (Blum 1989), is the most appropriate. In the Minnesota survey, statistics were presented by grade level. At the last grade level, equivalent to the 18 to 20 year age bracket, it was reported that approximately 55% of the women, and 72% of the men, had initiated their sex life. Other American studies have reached similar conclusions (Zelnik and Kauter 1980; Centres for Disease Control 1992). While the differences between the sexes were considerable in the American studies, they were significantly less so than in Chile. A recent study found that, between 1971 and 1982, the proportion of girls between 15 and 19 years of age who have had sexual relations increased by 52% (Hofferth et al. 1987). In Norway, a massive study indicated that the median age of commencement of sexual relations was 18.2 years, which is only slightly higher than the age found in our study in Chile. The study in Norway also was reported significant gender differentials. Younger partners recorded earlier initiation, but in these younger partners, higher precocity was found among the females (Sundet et al. 1992).

While these research findings are important, there is a need to improve our capacity to analyze information obtained at different times and in different places, in order to be able to adjust policies to the development of behaviour. The methodology developed in this analysis facilitates the control of the effect of age (and other variables) and enables better use to be made of the information which is obtained. One thereby achieves more reliable estimates, with improved levels of confidence.

Another important aspect concerns the reliability of information obtained in interviews, and the extent to which this information varies in different socio-demographic groups. The understanding of questions related to sexual activity depends on the level of previously acquired knowledge in the person being interviewed. In this study, the reply to the question

"have you had sexual relations?" depended on how the young person interpreted this question. While it is assumed that the majority of respondents interpreted this question correctly, it is possible that some might have considered different sexual practices besides sexual intercourse as sexual relations.

This understanding of what constitutes sexual relations is related to age, gender, and socio-economic variables. In the United States, to deal with this issue, studies have provided an explicit definition of the term "sexual relations" before starting the survey (Udry and Billy 1987). Reliability of the information is contingent upon a proper understanding of the question, as well as the willingness of the person being interviewed to be truthful. Whether or not a young person is truthful on this subject matter is related to the social acceptability of his or her conduct, which in turn is largely conditioned by gender. In this investigation, great care was taken to ensure that the anonymity of the respondents was maintained, which would ensure fewer false answers. Nonetheless, it is possible that some of the differentials with regard to gender may be less than reported, given the differential societal expectations which continue to exist concerning pre-marital sex. Differential attitudes toward premarital sex are particularly strong in Latin societies, which may explain the differences encountered between Hispanic and Caucasian populations in the United States (Aneshenel et al. 1989).

Conclusion

This study established that the degree of religious inclination, as well as family structure, were less significant factors with regard to sexual initiation than gender. This finding is consistent with literature on the subject (Morris 1992), which indicated that gender, together with ethnic background, have been found to be the major determinants of differences in sexual initiation. In countries where religion is relatively important, many women have conservative attitudes with regard to sexual initiation (Sneddon and Krener 1992).

Given the serious health implications for young women of early pregnancy and sexually transmitted diseases, the health sector must view the issue of early sexual relations as a matter of great importance. Ways of predicting early initiation of sexual activity in adolescents need to be identified. Furthermore, issues of morality should not get in the way of designing policies aimed at reducing the number of unwanted pregnancies and sexually transmitted diseases.

References

Aneshenel, C.S.; Fidder, E.P.; Becerra, R.H. 1989. Fertility and fertility related behaviour among Mexican-American and non-hispanic white female adolescents. *J Health Hum Behav* 30:56.

Baechler, R.; Molina, R.; Silva, C.G.; et al. 1983. Sexualidad en la adolescencia. *Cuad Med Soc (Chile)* 24(2): 60-66 1983.

Blum, R. 1989. Technical report on the adolescent health survey. Adolescent Health Database Project. University of Minnesota, Minneapolis, Minnesota.

Cartoof, V. 1992. Adolescent abortion: correlates and consequences. Adolescent Medicine. *State of the arts and reviews* 3(2):283-298.

Centres for Disease Control. 1992. Sexual behaviour among high school adolescents. MMWR 40: 885-88.

Comite Coordinador Interagencia De Naciones Unidas. 1994. Cumbre Mundial en Favour de la Infancia - La salud maternoinfantil: metas para 1995 e indicadores para su seguimiento. PAHO/WHO/UNICEF/WB/IBD/USAID/FAO. pp 12-13.11.

Coupey, S.; Klerman, L. 1992. Adolescent sexuality: prevention unhealthy consequences (preface). Adolescent medicine. *State of the arts and reviews*. 3(29):ix-xi, 1992.

Florenzano, R.; Pino, P.; Marchandon, A. 1993. Conductas de riesgo en adolescentes escolares de Santiago (Chile) *Rev Méd Chile* 121: 462-69.

Gonzalez, E.; Molina, R.; Romero, M.I.; et al. 1984. Actitud de la adolescente embarazada, de su pareja y de su familia frente al embarazo. *Cuad Med Soc* 23(3):112-17.

Greenberg, J.; Magder, L.; Aral, S. 1992. Age at first coitus. A marker for risky sexual behaviour in women. *Sex transm dis*, 1992; 19(6): 331-4.

Hofferth, S.I.; Kahn, Jr.; Baldwin, W. 1987. Premarital sexual activity among US teenage women over the past three decades. *Fam Plann Perspect*. 19:46.

Howard, M. 1992. Delaying the start of sexual intercourse among adolescents. Adolescent medicine. *State of the arts and reviews*. 382: 181-93.

Khan, H. 1983. An introduction to epidemiologic methods. New York. Oxford University Press.

Kramarosky, C.; Iglesias, J. 1987. Estudio sobre aspectos psicosexuales de la adolescente chilena. *Rev Chil Obstet Ginecol* 52(1): 16-23.

Mardones, F.; Diaz, M. 1990. Una prpuesta de clasificación de las comunas del país según criterios de riesgo biomédico y socioeconómico para medir la vulnerabilidad infantil. Santiago. UNICEF - INTA. 223 p.

Molina, R.; Luengo, X.; Toledo, V.; et al. 1992. La adolescente embarazada en Chile. In: Diagnóstico de la salud del niño en Chile. Asociación Red para la Infancia y la Familia de América Latina y El Caribe. Santiago, Chile.

Morris, L. 1987. Experiencia sexual y anticoncepción de jóvenes en algunos países de América Latina. XII Congreso Latinoamericano de Ginecología y Obstetricia. Guatemala 25-30 de Octubre.

Morris, N. 1992. Determinants of adolescent initiation of coitus. Adolescent medicine *State of the art and reviews*. 3(2): 181-93.

Repossi, A.; Araneda, J.M.; Bustos, L.; et al. 1993. El estudiante universitario frente al sexo: Qué piensa, qué sabe, qué hace? *Rev Méd Chile*. 121, 201-208.

Rubio, L; Shilling, A; Galan, G. 1987. Actividad sexual y métodos anticonceptivos en varones universitarios. *Rev Chil Obst Ginecol* 51: 255-64.

St. Louis, M.E.; Conway, G.A.; Haymor, C.R.; et al. 1991. Human immunodeficiency virus infection in disadvantaged adolescents: findings from the US job corps. *JAMA* 266. 266:2887-91.

Sikand, A.; Fisher, M. 1992. The role of barrier contraceptives in prevention of pregnancy and disease in adolescents. Adolescent medicine. *State of the arts and reviews*. 3(2): 223-40.

Sneddon, I.; Krener, J. 1992. Sexual behaviour and attitudes of university students in Northern Ireland. *Arch Social behav*. 21(3): 295-312.

Suarez Ojeda, E.M.; Roberts, E.; Korin, E.; Cusminsky, M. n.d. Adolescencia y juventud: aspectos demograficos y epidemiologicos. In: la salud del adolescente y el joven en las Américas. *Publicacion Cientifica* No. 489. PAHO/WHO.

Sundet, J.M.; Magnus, P.; Kvalem, I.M.; et al. 1992. Secular trends and socio-demographic regularities of coital debut age in Norway. *Arch Sex Beh*, 21 (3): 241-52.

Udry, Jr.; Billy, JDG. 1987. Initiation of coitus in early adolescence. *Am soc rev*, 52: 841-55.

Valenzuela, M.S.; Herold, J.M.; Morris, L.; Lopez, I. 1992. Encuesta de Salud Reproductiva en adultos jóvenes de Gran Santiago. *Bol. of Sanit. Panam* 112(1): 19-30.

Valenzuela, M.S.; Herold, J.M.; Lopez, I. 1990. Encuesta de salud reproductiva en el adulto joven: experiencia sexual y uso de anticonceptivos en Santiago (Chile). *Rev Med Chil* 118(4):465-72.

Wrigh, E.; Jensen. L.; Olsen, J.; Cundick, B. 1991. The effects of family structure on the sexual behaviour of adolescents. *Adolescence* 26 (104): 977-86.

Zelnik, M.; Kauter, J. 1980. Sexual and contraceptive experience of young unmarried women in the US. *Fam Plann Perspect*. 9: 55.

Besides Carnival and Soccer: Reflections about AIDS in Brazil

Arletty Pinel[1]

Introduction

Suffering can be one of life's most precious teachers; it is through the endurance of pain and impotence that we face the best and the worst in each of us. This proximity with our basic nature gives us the opportunity to evaluate honestly our previous experiences, and to establish strategic guidelines for positive change.

Undoubtedly, AIDS, in itself, is a source of personal pain. Furthermore, its symbiotic relationship with other infectious diseases, and undesirable living conditions, transforms AIDS into a major contributor of social pain. As we move forward through the second decade of AIDS infections, we must ask ourselves, *have we really learned from this disease?* Or, have we become so apathetic that we are willing to accept that nothing can be done?

The first decade of AIDS infections was characterized by the urge to find rapid solutions to the threat. Epidemiological data and medical advancement flourished, but proved to be insufficient on their own. The link between biological and socio-cultural factors of the disease grew stronger as it became increasingly evident that AIDS was a product of behaviour.

AIDS in Brazil is more than a disease, for it denounces the social, economical, political, emotional, and spiritual misery of the system. AIDS is a social and moral phenomenon that discloses the myth of middle class normality, and where the judgement is increasingly focusing on society, and less on the individual.

The appearance of AIDS in Brazil coincided with the end of 20 years of a painful military dictatorship, the rapid and disorganized transformation into an urbanized and industrialized country, and unprecedented economical stagnation. The optimism that inebriated its people as they retook the tortuous road toward democracy, quickly and violently collided with the dramatic decline of Brazilian productivity. The dream became a nightmare almost overnight.

The constant threat of steep inflation, increasing unemployment, and prolonged recession, together with urban overcrowding, environmental degradation, and progressive deterioration of the quality of life, has resulted in the growth of violence, corruption, and general dissatisfaction. The enthusiastic search for well-being that characterized the prosperous

[1] GENOS Internacional, São Paulo, Brasil.

years, has been replaced by disillusionment, indifference, and egocentrism. Destructiveness abounds, and crime, an important indicator of personal and social turmoil, permeates daily life. Multifarious repression has led to the normative incorporation of transgression at the personal and public levels. Liberty and licentiousness have overlapped their meanings, progressively becoming subjects of political manipulations and economic exploitation.

The introduction of AIDS into such a fragile and emotional society, served to exaggerate its alternating phases of profound lethargy, and frantic excitement. The submersion into the abyss of depression can last until carnival (Mardi Gras), a soccer match, or any other event, triggers a cathartic outburst. Like suffering from a manic-depressive illness, the psychotic nature of both extremes confounds the accurate perception of reality.

There was a time when a few days of folly could serve to exorcize daily pains. However, the overwhelming burden of steady socio-economic collapse now affects nearly all the days of the year. The introduction of AIDS also highlighted Brazilian perceptions of the intricate life/death dichotomy; if life is constantly at risk, the future becomes non-existent, or distorted by immediate needs.

AIDS: A Decade of Trials and Errors

Brazilian researchers and policy-makers have proven to be quite productive and creative in their attempts to face the AIDS epidemic. However, despite government edicts which established compulsory notification of AIDS cases (December 1986), as well as the compulsory testing of blood and blood by-products (May 1987), sub-notification is still believed to be high, and an acceptable level of blood quality control has not yet been achieved (Ministerio da Saude 1989). Similarly, despite the fact that AIDS is frequently discussed by all segments of society, the numbers of AIDS cases continues to climb, and there is little evidence that people are actually changing risky behaviour patterns. Just like syphilis became "a serpent reared inside the house without anybody paying attention to its venom" (Freyre 1983), AIDS is progressively becoming as trivial and customary as rice and beans. What has gone wrong?

Prevention has been held as a key element in the control of AIDS. Nevertheless, the entire concept of education, which is based upon the preservation of human dignity, has been greatly reduced to a mere instrument in the attempt to interfere with the transmission of the virus. Despite fourteen years of the epidemic, most of the preventive actions are still limited to isolated projects that repeat the same elementary information. The federal government continues to rely on sporadic mass media campaigns, but their inconsistency, together with the dearth of complementary local interventions, have instilled the idea that AIDS is only a problem when there is an on-going campaign. Although people have become saturated by the bombardment of basic information, they continue to be ill-informed. What they really want to know is *how* to protect themselves, a far more complex issue that simply using a condom.

Preventive actions have not only been dissociated and inconsistent; much time has also been lost in an ideological, scientific, or political *tour de force*. Interventions continue to be based on the grounds of suppositions and imported methodologies, instead of a thorough evaluation of past experiences. Too much effort has been placed on shallow activities that seldom go beyond re-inventing the wheel.

Education is not merely a sequence of acts, nor a proliferation of material; it is a process which provides correct information in an adequate manner, and rescues and fosters respect for human nature and the intrinsic value of life. The notions of self-care, and control over one's life, need to be felt at every emotional level, and not just rationally or intellectually imposed.

Consciousness is essential to prevention. However, for the majority of Brazilians who have not received a minimum of twelve years of schooling, this consciousness has not been developed. Twenty years of dictatorship hampered its evolution, since it was easier to politically, socially, and economically control a mass that neither thought for itself, nor questioned the system. The widespread misery which exists today does not create conditions for the expansion of consciousness.

AIDS prevention is faced with the challenge of confronting the physical and emotional deprivation that leads to a binge behaviour, in the search for the mitigation of existential hunger. Unfortunately, interventions have strongly relied on the exercise of a rational logic that fits the Aristotelian construction of language as a non-contradictory manifestation of thought. They have not taken into account the fact that reality, for the average Brazilian, operates by contradiction, and substitutes logical thinking with emotion.

Health and Spirituality Revisited

The concepts of health and illness cannot be disassociated from socioeconomic, cultural, and political factors. Infectious diseases, such as measles, mumps, and whooping cough, have become part of "normal" childhood; and sexually transmitted diseases in males have become a proud proof of manhood and virility. Similarly, the embedded nature of religion has frequently supported the perception of illness as a "divine punishment, an invitation to penance and conversion" (Barreto 1987). Under these circumstances, prevention is poorly understood, and diseases are perceived as fatalistic events, over which there is little control.

The appearance of vaccines and sophisticated medications transformed the health scene. The pharmaceutical business boomed, the health system swelled beyond control, and physicians and medicaments were culturally bestowed with semi-Godly powers. Surreptitiously, the fundamental concepts of public health were forgotten, and curative medicine replaced preventive medicine. AIDS unveiled, not only the breakdown and inefficiency of the health delivery system (Veja 1991), but the fantasy of a rapid solution or chemical prevention. The incurable disease bluntly hindered the modern version of miracle working.

The limitations of the formal health care system, together with the existing socio-economic crisis, brought about a spiritual revival in Brazilian culture. The absence of rapid and effective responses from science promoted a search for magical solutions. As a result, folk-healing and home-made remedies replaced scarce, ineffective, and expensive medical care; and a variety of faith-healing practices, alternative religions, and sects proliferated, intermingling with the rational aspects of everyday living. Even if superstition and religion could not cure an illness, they could justify its existence.

Society, as a whole, has forgotten its responsibility of providing points of reference that aid in the construction of internalized control. It has preferred to rely on repression, the external imposition of control. In doing so, it has facilitated the substitution of its moral codes by a moralistic discourse. This has created a distortion in the meaning of religion that, instead of transcending the institution and the doctrine to become a true personal experience and one of the elements of personal integration, has become a neurotic illusion contributing to its own alienation. What could be a synergistic solution has turned into an antagonistic movement.

Sex: When Myth Meets Fact

AIDS in Brazil made its debut appearance in Sao Paulo among gay men in 1980, when homosexuality was beginning to gain visibility because of the commercial boom of gay saunas, bars, nightclubs, and pornography. The militant groups of the homosexual movement also played a role, although to a lesser degree (MacRae 1987). Initially, society dismissed the threat as a plot created by the moralistic segments of society to eradicate homosexuality. Soon, it became the long-awaited divine punishment.

The initial misconception of AIDS as a *peste gay* (gay pest) continues, interfering with the general population's acknowledgement of its own risk. It has also served to give the disease a moralistic connotation. This becomes particularly evident when the world looks at Brazilian sexual behaviour with curiosity in an attempt to explain the rise of HIV infection.

Sexual practices are universal, but their significance relies on both cultural relativity and interpretation. Procreative sex acquires its legitimacy through marriage whereby "love and fertility end up mutually identified within the popular mentality" (Mello and Souza 1986). On the other hand, recreational sex is condemned or condoned depending on the circumstances; religion and medicine play a key role in the normative aspects of this behaviour.

The introduction of sexuality into intellectual territory brought about the need to classify conduct in a comprehensible manner. Sexual practices were no longer seen as natural and individual expressions of desire and emotion, but as manifestations of theories that could be generalized in the attempt to explain the origins of disease. Embedded in the search for the cause of AIDS was the need to prevent or cure deviant behaviour.

The pathology-centred, rational approach to sexuality, however, will never be enough to promote the understanding of the behavioural aspects involved in the spread of AIDS. Sex is not a disease. In addition, the transcendental nature of human beings does not suit the fragmentation into labels and compartments that science suggests. Personal and emotional elements are lost when people become objects of theoretical study.

Considering that the perception and/or acknowledgment of an act is frequently discordant of the act itself, the sexual repertoire of Brazilians does not include anything that has not been performed elsewhere in the world. The numerous sexual variations are the same ones that "Krafft-Ebing excoriated, Freud sought to cure, and Havelock Ellis calmly accepted as part of the texture of life" (Brecher 1976).

While Brazil has profited from exploiting the image of being a sexually permissive country, it is, on the other hand, very prolific in the generation of myths and taboos that surround the still-perceived sin-laden acts. The Catholic Church remains actively involved in government policy decisions concerning sex education and family planning, despite its official cleavage from the state during the 19th century.

In general, Brazil is a sensual, not necessarily sexual, country. The pleasing of the senses permeates its music, literature, art, clothing, food, and everyday living. People embrace, kiss, and touch each other frequently, with an intimacy that may be frightening and misunderstood by foreigners, but that enhances the daily celebration of life.

An urgency for data and the need for action characterize the contemporary analysis of sexual behaviour. Nevertheless, the initial premise that Brazilian sexualities are homogenous, intrinsically salacious, and diametrically opposed to those of developed countries, seriously jeopardizes the interpretation of what will be observed. The heterogeneousness of sexual manifestations must not only be recognized, but adequately inserted into the overall context of the situation. If not, the "excessively positivist notions of cultural specificity will limit our ability to recognize AIDS as a complex, contradictory and multilayered discursive construction" (Treichler 1989).

Gender Relations and Interpersonal Dynamics

Despite the transitional state of gender roles, traditional expectations of male/female behaviour continue to characterize Brazilian culture. Men and women are constantly under pressure to conform to their roles, even though such rigidity proves to be inadequate to the evolution of society.

The competitive structure of modern life, together with an excessive pride, distorted the original meaning of "machismo," thus bestowing the word with its degenerated connotation of tyrannical hyper-masculinity. By substituting strength for power, courage for competitiveness, and intelligence for shrewdness, maleness stopped being a synonym of

virtue, and became a synonym of authoritarianism. However, this transformation did not make men any stronger. On the contrary, by centring maleness around a penile function and sexual prowess, society has nurtured an emotional atrophy in men that makes them all the more vulnerable to the dangers of risk-taking.

"Marianismo", the feminine counterpart of "machismo," restricts women's values to virginity, motherhood, and her caretaking ability. The docile and submissive character of "marianismo" stimulated the existence of covert seduction, in opposition to assertiveness, as an almost exclusive way of meeting women's needs. Confrontation is not only considered improper, but is to be avoided, since in could invoke men's wrath. Women have been trapped into a disadvantageous hierarchical structure which leaves them subject to discrimination, sexual harassment, and economical manipulation. It does not matter whether they are the primary caregivers or, in many cases, the main source of family income, women's social vulnerability has superseded their abilities.

The discussion of gender roles in times of AIDS has become limited to either the madonna/whore and provider/profligate dichotomy of female and male sexualities as the expressions of the two sides of the same coin: love and lust (Delumeau 1989; Money 1986); or to their relationship in terms of sexual submission and economical dependency (Fuenzalida-Puelma et al. 1990). Brazilian culture nourishes a romantic fantasy where two individuals meet, fall in love, and become immune to all dangers. Love is almighty, and both men and women are seen as incomplete beings without the complement of each other. Sex is validated through love where there is no room for an infected prince or princess or the need to interrupt spontaneity with the latex of a condom. After all, everything can be justified for love, even death.

Financial limitations and feelings of social impotence seem to fuel traditional male roles that encourage promiscuous behaviour as a relief of tension. Women, on the other hand, have been assimilating this male pattern in their search for sexual assertiveness. This has turned modern love-searching into an anguished competition. In this process, honest communication is substituted by a seduction game where each person shows the fantasy of what they would like to be. People make believe that everything is perfect and under control, which makes it impossible to talk about their doubts, fears, and past sexual relations, without feeling insecure. This elusive behaviour makes it impossible to establish enduring, monogamous, and faithful relationships.

The economic deterioration of the 1980s and 1990s introduced important co-factors to HIV infection. Among them were the dissolution of the nuclear family which facilitated the rise of marginalized groups, and the weakening of the moral transmission role of women. Society has constantly given women the responsibility of maintaining the family structure. However, it has not been successful in adapting itself to the massive participation of women in the work force as a response to financial distress. The rigidity of role expectations has been unfair to women. They not only earn less than their male counterparts, but have been

burdened with the overlap of their caregiving and provider roles. Men, on the contrary, have proven to be less capable of adapting to the new situation. If threatened by a social imposition, they may look upon aggression as an artifice of control. It is the lack of articulation and integration between genders, and not the role conflict itself, that has contributed to the structural changes in the family.

Despite the tradition of passivity, women have also been bestowed with the responsibility of transmitting norms and values to their children. However, the progressive confusion of social identity, and loss of negotiating power, has brought about a random selection of what is to be considered right or wrong, adequate or inadequate. In this process, women cease to be respected and upheld in their customary function, while men shun away from such responsibility. Without guidelines and social support, the construction of proper ethical and moral standards become highly improbable.

Over centuries and cross-culturally, women have been linked to the cycle of life. The notion that they both give and take away life has been manifested by the existence of numerous female deities of death (i.e., the goddess Kali), and the fact that funerary rituals and the care of the dead often relies on them (Delumeau 1989). With the increase of AIDS cases among women, society again looks at them with its ever present ambivalence. On one hand, they are held responsible for the interruption of the transmission chain (Pinel 1991). The initial reliance on a change of male behaviour is rapidly shifting to the expectation that women will continue their traditional care-giving. But these are the times for sharing responsibilities. In the same way that AIDS questions the fragile notions of male supremacy and androcentric determinations, it may well facilitate the training of women as decision-makers in matters that affect them (Fuenzalida-Puelma et al. 1990; Pinel 1991, 1992).

Conclusion

The conceptualization of AIDS as a social problem that must be solved within the realms of a strictly personal, or at the most, medical level, interferes with its incorporation at a decision-making level. We have undoubtedly learned much from trial and error, but the time has come when, if we do not want the past and future decades lost, solid and integrated strategies that can bring about change must be established. Like swimming against the current, society will have to combat hopelessness and helplessness by zig-zagging between scientific rationality and emotional redefinition. Giving AIDS its rightful importance is permitting a positive denouement for this tragedy; an opportunity for pain and suffering to be used as a key for change and growth.

References

Adams, I.K. 1990. The experience of the Street Kids Clinic of Belo Horizonte. Background history. Presented at the First international invitational conference on AIDS and homeless youth: An agenda for the future. San Francisco 25 June.

A fé que move multidoes avança no pais 1990. *Veja* 23 (19) pp 46-52. Sao Paulo.

Anuário Estatístico do Brasil. Instituto Brasileiro de Geografia e Estatística 1989.

Arevalo, E.I.; Fernandes, M.E.L.; Ferreira, G. 1990. Educación sobre el SIDA y la cultura afro-brasilena. *Intercambio*. Organización Mundial de la Salud.

Barreto, A. 1987. Os santos curadores de enfermidades. Universidade Alberta Fundaçao Demócrito Rocha, Fortaleza.

Boletim epidemiológico/AIDS. 1989. Ministerio da Saúde 3 (6) Semana Epidemiológica 49 a 52.

Brecher, E.M. 1976. History of human sexual research and study. In B.J. Sadock, H.I. Kaplan and A.M. Freedman (ed). The sexual experience. Baltimore. The Williams and Wilkins Company.

Cidadaos de rua. 1990. *Veja* 23 (50) pp 32-38. Sao Paulo.

Cities: Life in world's 100 largest metropolitan areas. 1990. Population Crisis Committee. Washington DC.

Crianças e adolescentes. 1989. Indicadores sociais. Vol. 1. UNICEF/IBGE.

Delumeau, J. 1989. História do medo no ocidente: 1300-1800. *Trad. M.L.* Machado. Sao Paulo: Companhia das Letras.

Dilúvio de incompetência. 1991. *Veja* 24 (7) p 56. Sao Paulo.

Dimenstein, G. 1990. A guerra dos meninos: Assassinatos de menores no Brasil. 2ª ediçao. Sao Paulo. Editora Brasiliense.

Em pas e com amor. 1990. *Veja* 23 (43) pp 68-79. Sao Paulo.

Freyre, G. 1983. Casa grande e senzala: Formaçao da família Brasileira sob o regime da economia patriarcal. 22ª ediçao. Rio de Janeiro. Livraria José Olympio Editora.

Fry, P. 1982. Para inglês ver: Identidade e política na cultura Brasileira. Rio de Janeiro: Zahar Editores.

Fuenzalida-Puelma, H.L; Serrano Lavertu, D. 1990. Women and AIDS: Ethical and legal issues; The need for a comprehensive approach. In Bibliografia Seleccionada Sobre SIDA Maternoinfantil. Preparada para la Reunión Internacional sobre SIDA maternoinfantil. Organización Panamericana de la Salud. Sao Paulo.

Henriques, M.H.; Silva, N. do V.; Singh, S.; Wulf, D. 1989. Adolescentes de hoje, pais do amanha: Brasil. The Allan Guttmacher Institute, New York.

MacRae, E. 1987. AIDS: Prevençao ou novo tipo de segregacionismo? *Temas IMESC* 4(1), pp 73-81. Sao Paulo.

Matarazzo, M.H. 1986. Sexual illiteracy and emotional underdevelopment. Presented at the First international congress on sexual development across the lifespan. Montreal.

Mello e Souza, L. 1986. O padre e as feiticeiras: Notas sobre a sexualidade no Brasil colonial. In R. Vainfas (org.) História e sexualidade no Brasil. 1ª ediçao. Rio de Janeiro, Ediçoes Graal.

Ministério da Saúde. 1990. DNDST/AIDS. AIDS boletim epidemiológico 3(11), Brasília.

Ministério da Saúde. 1994. DNDST/AIDS. AIDS boletim epidemiológico 7(4), Brasília.

Ministério da Saúde. 1989. SNPES/DNDST-AIDS, Programa nacional de controle e prevençao da AIDS, Brasília.

Money, J. 1986. Lovemaps: Clinical concepts of sexual/erotic health and pathology, paraphilia, and gender transposition in childhood, adolescence and maturity. New York. Irvington Publishers, Inc.

Morris, L. 1989. Experiencia sexual y anticoncepcional en jovenes en algunos países de América Latina. Conferencia internacional sobre fecundidad en adolescentes en América Latina y es Caribe. México.

Parker, R.G. 1987. Acquired immunodeficiency syndrome in urban Brazil. *Medical Anthropology Quarterly* 1(2) pp 155-175. Washington, DC.

1988. Sexual culture and AIDS education in urban Brazil. In R. Kulstad (ed.) AAS Symposia Papers. pp 169-173. Washington, D.C. 1988.

1989. Youth, identity, and homosexuality: The changing shape of sexual life in contemporary Brazil. *Journal of Homosexuality* 17 (3/4) pp 269-287.

Pinel, A.C. 1989a. Cultural sexual and social perspectives of AIDS in Brazil Presented at the V International Conference on AIDS, Montreal.

1989b. Sexual behaviour of Brazilian men that are clients of transvestite prostitutes. Presented at the V International Conference on AIDS. Montreal.

1989c. Sexuality research in Brazil. Presented at the V International Conference on AIDS. Montreal.

1990. Sexual behaviour in Brazil: A comprehensive compilation of existing data. Presented at the VI International Conference on AIDS. San Francisco.

1991. Consideraciones generales sobre el SIDA y la Mujer. Taller Mujer y SIDA - Red de Salud de las Mujeres Latino Americanas y del Caribe/ISIS Internacional. Santiago.

1992. Sexual behaviour, family planning and abortion in HIV-positive women. Poster presentation. 8th International Conference on AIDS. Amsterdam.

Serra, J. 1990. Existe uma Saída. *Veja* - Ano (23) 30, 58-65, Sao Paulo. 1 August.

1990. Sexo, socos e babás. *Veja* - Ano (23) 26, 50-56 Sao Paulo, 4 July.

Soares, L.C. 1986. Da necessidade do bordel higienizado - tentativas de controle da prostituiçao XIX. In Vainfas, R. (org.). Historia e sexualidade no Brazil, 143-168. 1 ediçao. Rio de Janeiro. Ediçoes Graal.

Treichler, P.A. 1989. AIDS and HIV Infection in the Third World: A first world Chronicle. In Kruger, B. and Mariani, P. (ed). Remaking history. Seattle. Bay Press.

Tudo sobre AIDS. 1987. In Folha de Sao Paulo, Sao Paulo. 22 February.

Vida Miserável atinge. 1990. 44% da juventude. In Correio Braziliense, Brasília. 2 February.

Discussion

Following presentations by Leda Pesce (Uruguay) and Carmen Dora Guimaraes (Brazil), a general discussion took place on the subject of AIDS, Sexually Transmitted Diseases, and Gender. The following points were raised by the workshop participants:

- For years, the same basic issues surrounding AIDS have been discussed. Many of the essentials points have still not been addressed. For example, the link between STDs and AIDS continues to be overlooked. Furthermore, while condom usage may be the best prevention strategy, many people continue to use condoms incorrectly and/or inconsistently. Other intervention/prevention strategies must be developed.

- The role of health care providers dealing with AIDS and STDs is important. Male health professionals may not be very interested in STDs or knowledgeable about its symptoms. Some medical staff are unaware of the link between STDs and AIDS. In the professional training of health providers, gender sensitive courses on AIDS/STDs should be introduced.

- It is not uncommon for women to be reluctant to seek treatment for STDs and AIDS because they are concerned about being ostracized by their community and other women. Health care services must be conscious of this fact and try to ensure that women can be provided with appropriate, confidential treatment in private settings.

- Health beliefs are very important and can be greatly affected by advertising, which tends to promote monogamy as a way to prevent AIDS. There are some women who believe that they are not at risk of acquiring AIDS because they are only having sex with one person. Health promoters therefore need to exercise caution with these types of messages.

- When working with the issues of STDs and AIDS, the sex of the researcher or counsellor may be important. For example, one study of HIV-positive patients found that patients often preferred to have counsellors of the same sex. Emotions may be easier to express with someone of the same sex. Male patients may find it easier to cry with a man, than with a woman.

- Many men and women lack essential information about how their bodies function. Avenues to assist both men and women to learn more about their bodies must be explored. Drawings can be helpful to learn more about anatomy.

- Not enough attention is directed toward the education of young boys and girls about STDs. Some young people, experiencing the symptoms of STDs, may not recognize them or know what to do, or where to go for assistance.

- AIDS can have a devastating impact on the family and lead to the disintegration of the family unit. Women, being the family's health care providers, are particularly affected.

- The male and female social universes affect the spread of AIDS. Women may know that their partners are HIV-infected but may not protect themselves in order to prove their total, symbiotic link with their partners. However, it is much less likely that a man would allow himself to be HIV-infected as a proof of love.

- Women often cope better with being HIV+ than do men. Men sometimes threaten to kill themselves, or the person who informed them of their positive status.

- Women often greet AIDS education interventions with great acceptance and enthusiasm, reporting that they are keen to share their new knowledge. In spite of this, however, many women continue to engage in risky sexual behaviour.

- Negotiation between men and women on the use of the condom continues to be a major issue. Researchers need to look at the ways men and women interact and the extent to which social and economic structures affect their negotiation processes. AIDS is a relational problem, not a behavioural problem. This is especially important, given statistics that show that the majority of women are not able to have sexual relations according to their own wishes (social restrictions on their ability to make suggestions and/or influence behaviour). Women must acquire the freedom and will to ask for prevention measures.

- Increasing communication levels between partners is important. Participants discussed the fact that a lack of dialogue often exists between partners on everyday subject matters. Even less communication takes place with regard to fears and concerns about AIDS. It may be difficult to promote dialogue between partners when they are unable to discuss less-loaded subject matters.

- There was some disagreement about whether or not men and women should be addressed equally in research studies, or whether women should be given special attention. One participant suggested that, while men and women could be separated for the intervention, it is important to focus on men and women as both sexes face these issues. Another participant emphasized that, given the scarce resources of NGOs, it is important to begin with women, especially those from poorer areas. After first working with women, then work should be done with male partners. This participant believed that it is better to start with women because they are often overlooked and also because they are the disseminators of ideas and knowledge within the community.

- One participant stressed that researchers and policymakers need to be careful about the messages they choose. Some messages have been overplayed. A great deal of emphasis has been placed on the use of the condom, but other issues must also be addressed. Priorities must be determined. States and international bodies need to be encouraged to formulate and implement social policies. In order to make a difference, work must be done at both the grassroots and policy levels. Health promotion messages must focus on the protection of rights, ethics and life.

Environmental Stress, Production Activities, Health, and Gender

Gender and Occupational Health in Chile

Ximena Díaz Berr[1]

Introduction

Women are increasingly becoming an integral part of the Chilean workforce. The current labour force is comprised of 1,700,000 female workers, which represents 34.5% of labour participation. Over the past few decades, there has been a significant rise in the number of women working in the paid labour force; between 1970 and 1990, there was an 83% increase in the participation of women. More than half of the 232,000 new jobs created in 1992 were filled by women. Between 1992 and 1993, female employment grew by 8.2%, compared to an increase of 3.8% in male employment.

Continued growth in the Chilean economy will depend on the increasing incorporation of women into the labour force. In the next few years, it is hoped that a further one million women will be incorporated. Furthermore, economic and productive modernization has created a greater demand for workers with traditionally "female" characteristics, such as flexibility, good work habits, and capacity for teamwork.

In spite of the current trends of and future prospects for formal female employment, however, occupational health of the female worker is an area of research (and policy) which thus far has received little attention.

Women in the Labour Market

Unfavourable Working Conditions

Women in the workforce face a number of unfavourable conditions. For example, there are many well-educated women who are unemployed. Women are also paid less than men, despite holding similar positions and educational qualifications. Furthermore, women have been concentrated in temporary lower-level positions despite the fact that, on average, women receive more formal education than men.

For decades, as a result of permissive labour legislation, Chile has lacked employment stability, as well as workers' protection in labour and social security legislation. Low salaries, temporary work, and long working hours, characterize the Chilean labour market. A lack of compliance with minimal occupational health and safety requirements puts workers

[1] Salaried Women in Industry and Fruitculture, Santiago, Chile.

at risk. Machinery and technology which is unsuitable for the physical make-up of Chilean workers is regularly introduced, without protection devices, and/or without the training necessary for safe use. Women in the workforce are particularly affected by the detrimental working conditions found in Chile.

Lack of Recognition of Various Disorders

In Chile, the focus of occupational health has been on work-related accidents rather than on disease. With regard to occupational health hazards, only causal agents directly related to environmental or technical factors are recognized. Only diseases which are a direct consequence of the technical work process are considered to be occupationally-related. Risk factors related to the wider working environment are generally ignored.

"Non-specific" diseases are those which, while not solely caused by the nature of the work, are exacerbated by the effects of the work. Under the current legislation, these diseases are not recognized as being caused by employment and are therefore not subject to protection. The work performed by women often contributes to "non-specific" diseases. Female workers often suffer from discomfort, circulatory diseases, lumbago, nausea, dizzy spells, and emotional and mental disorders. Health insurance plans rarely cover these symptoms, except in an extreme case where the link between the work and the symptom is indisputable. As a result, female workers often do not attend to such health problems until the symptoms have reached a serious level. It is estimated that about 70% of female workers do not visit a physician when ill, due to excessive bureaucracy, poor quality of health care, and lack of money and time (Medel and Riquelme 1992). Due to overwhelming under-reporting, very little information exists on the professional diseases of women.

Lack of Information on the Health of the Female Worker

Unfortunately, due to the lack of comprehensive, reliable and systematic records, there exists a dearth of information about the health of the Chilean worker in general. Even less exists about the health of the female worker. Official statistics concerning occupational health were last published by the Department of Health in 1988, reporting information concerning work accidents, professional diseases, and school accidents. These statistics have not been updated. Furthermore, the information in this publication is of questionable validity as it was obtained from a number of different sources. No agency is responsible for assessing the quality of the information gathered.

Lack of Protection for Workers

In 1968, Chile enacted a social insurance program covering occupational accidents and professional diseases (Law 16.744 - 1968). This program guarantees preventive, curative, rehabilitative, and economic coverage to salaried workers, as well as some specific groups of self-employed workers. Some groups, who are not protected by this law, receive their own

private coverage. However, nearly 50% of the active labour force is not protected under any program. Many workers, particularly women, work either in non-protected jobs or under non-contractual conditions.

According to a survey on national socioeconomic characteristics, 17% of salaried women and 13% of salaried men work without a contract. This percentage is higher among low income groups. Thirty-three percent of low income women, and 25% of low income men, work without a contract. Rural areas also have a high rate of non-contracted workers, especially among low income workers. The largest number of non-contractual female workers work in agriculture, domestic services, fisheries, and commerce industries.

Other Problems With the Current Legislation

A large number of workers do not benefit from Chilean law concerning Professional Diseases and Work-Related Accidents, as the law is based on an outdated concept of work. Conditions of employment in Chile have changed dramatically since the introduction of structural adjustment policies. As a result of these changes, a number of employees no longer fit into the "protected" job categories because the categories are based upon dated characteristics of salaried employment.

When a worker contracts a disease, uncertainty exists concerning who is responsible for paying for treatment of the disease. The administrators of Law 16.744 govern social security against accidents and professional diseases, while other administrators are concerned with Curative Medicine Law. It is often necessary to go through a long bureaucratic procedure to determine who pays, leaving the worker without financial resources while the problem is being resolved.

Temporary Fruit Picking Workers

Fruit picking is one of the most important sources of female employment within the productive sector. It has been estimated that 55.8% of the agricultural workforce, which includes many female fruit pickers, is not provided with accident or medical coverage. During peak periods, approximately 200,000 women practice this type of activity throughout the country. A study of 300 women in the grape-picking-for-export industry revealed that 65% of the women worked with a taskwork contract, while another 14.3% worked without any contract (Medel and Riquelme 1992). In the best of cases, some of these women were protected against accidents and work-related diseases during the months in which they were employed. However, harsh working conditions (for example, 12-14+ hour working days, intense working pace) make it very difficult for female workers to leave their work to attend to a health problem. If they experience health problems related to their hard work following the fruit picking season, protection is no longer provided.

Home Workers

Since the mid 1800s, a great deal of women's work has been designed to be carried out in the home so that women could maintain their household responsibilities at the same time. It is common for other family members to help with this labour as "unpaid workers." Since the introduction of adjustment policies, and the opening of the Chilean market to international trade, there has been an intensification of these working methods in order to reduce labour costs. This working practice is most common in the garment and footwear industries, and to a lesser extent in the food industry. Companies using home workers usually have a long sub-contracting chain. The last and most precarious link is the work performed by women in their own homes, without any contractual agreement, social security, or without coverage against work accidents and diseases.

Little information exists about the size of this sector, or its working conditions. There is also little information available about the number or types of injuries associated with this type of work that affect both the female worker and other family members who share in the home working environment.

Temporary Workers in the Fisheries Industry

Over the past decade, while other sectors of the economy have experienced the effects of the recession, as well as the effects of the opening of Chile to international markets, the export fisheries industry has proven to be very successful. The success of this sector has led to work opportunities for women in fisheries processing. Official agencies (e.g., National Statistics Institute, Fisheries Development Institute and National Fisheries Service) do not collect reliable data concerning the size of the labour force employed by this sector, nor the quality of employment. However, it is estimated that 32.8% of fisheries workers are women. This represents a substantially higher proportion of women than in other branches of industry. A large proportion of women either work without a contract, or are temporarily employed with contracts for the fixed time periods or tasks. Because they are temporary workers, they are not eligible for insurance against accidents or disease, even if they have a contract. They often have no choice but to take the temporary work, work hard to gain the confidence of their employers, and hope they will become permanent workers.

Commerce Workers

Fifty-three percent of the active labour force in the commerce industry lacks protection against work hazards. Over the past few years, the largest employment growth has occurred in commerce. This is therefore one of the areas with the greatest concentration of female workers. Because the labour force has been reduced to small- or medium-sized economic units, this sector has gone through many difficulties organizing itself into bargaining units. This has resulted in a lack of recognition of collective problems, as well as a lack of proposals aimed at improving the present working conditions.

Workers in Private Households

In the service sector, 36.1% of the active labour force is unprotected from injury and disease. This sector is the largest employer of women; therefore, this lack of protection primarily affects women. The occupational group called "personal services", consisting primarily of private home workers, provides employment for one third of the female labour force. A large proportion of these women work without a contract and therefore receive no health coverage or social security protection.

Domestic Work

When discussing female workers, it must be remembered that most women also have significant domestic responsibilities in the home. Household duties include the specific tasks inherent in maintaining the home, as well as administrative responsibilities for the proper management of the household unit. Household duties do not begin and end at set times. Rather, they dominate, in one way or another, the entire day. While working, women invariably are thinking of their home and making decisions that affect the household, as well as the children. At home, women tend to be primarily responsible for domestic chores. The concept of work as "paid activity" tends to overshadow the important work of women that is done at home. The double shift and double load of working both inside and outside the home creates considerable physical and mental stress. Once again, when a women is ill, it is difficult to simply attribute the illness to one factor, when it is probably related to the accumulation of a number of factors.

The Centre for Women's Studies analyzed diseases as a result of stress among women in the garment industry, as well as female fruit workers. Based upon replies provided by the working women, a stress index was constructed based on the presence of three diseases: neurosis, ulcers and gastritis. This was followed by an analysis of factors associated with the stress index. Starting from the control values (women who have never suffered from any of the three diseases), a multivariate logistic regression analysis was undertaken in order to identify risk factors associated with stress.

A number of conditions result from the combined stress of work and home responsibilities. It is therefore important to integrate the notion of household work into the general concept of work, in order to properly determine health risk factors among women. With regard to female workers in the garment industry, the analysis revealed that women who suffer from these diseases were 3.7 times more likely to be economically responsible for the household; two times more likely to be exposed to environmental noise; and 2.8 times more likely to have suffered some type of accident at the workplace. In the case of grape picking women, the analysis showed that female grape pickers were more likely to suffer from stress-related illness if they devoted more than two hours to household work (8.5 times more), if they feared dismissal (3.5 times more), and if they worked in a forced physical position (2.1 times more). On the other hand, in packing plants where conditions are different from those prevailing in the fields, stressful working conditions stem from the rigorousness of the work,

as well as the long working hours. Women working in packing plants were more susceptible to stress when they feared dismissal (3.4 times more) and when they worked in noisy environments (3.9 times more).

Initiatives in Chile Related to Occupational Health

There has been considerable progress made in the understanding of the health of working men and women from an integrated health perspective, as well as from a gender perspective. A number of non-governmental organizations have played a central role in the Work Economy Program: the Centre for Women's Studies, the Collective Woman, Health and Social Medicine and the Women's Institute. Government and universities have placed special emphasis on the study of the work-health relationship.

An important initiative was the creation of a network concerning "Health and Work," which has been integrated into the Latin American Occupational Health Network. This network is comprised of NGO professionals, union leaders, and professionals working in Occupational Health Units of the Ministry of Health. This network strives to generate knowledge about workers' health in order to disseminate this information, as well as to advise government when it formulates programs and policies.

The Workers Unitary Centre (WUC) and technical and professional panels of the Ministry of Health have initiated a broad discussion about occupational health. In July 1991, a national meeting on occupational health was held; unfortunately, it was not repeated in subsequent years. The WUC has created a department on Working Conditions, Hygiene and Safety, which aims to train leaders in this field and create its own statistical centre.

A number of studies in Chile have looked specifically at female workers. The Centre for Women's Studies has undertaken a number of surveys regarding the health of workers in the garment industry, the fisheries industry, and the temporary fruit picking industry. The Women's Institute has conducted research regarding health hazards for women working with computers in the financial sector. A group called Women, Health and Social Medicine conducted research on the health of health workers in the southeastern area of Santiago.

The Ministry of Health has created occupational health units throughout the country. However, these units do not have sufficient resources to ensure that minimal health and safety requirements are being followed. Lack of resources also prevents the Ministry of Labour and Social Security from adequately monitoring work conditions, such as contracts, work hours, payment of salaries and so on.

1992 was designated as the "International Workers' Health Protection Year." The Ministry of Health called upon all sectors to discuss a Strategic Workers' Health Plan. Nine commissions, comprised of government representatives, workers and NGO representatives,

were created to discuss occupational health and safety issues, including "Women and Health." After several months, due to a lack of resources and insufficient interest, all work stopped. The new health authorities have initiated steps toward reactivating this Plan.

Conclusion

Women, an increasingly integral part of the Chilean workforce, face a number of unfavourable working conditions, including poor salaries, long working hours, low-level positions, lack of full-time work, and lack of employment stability. There is also a lack of compliance with minimal occupational health and safety requirements. Furthermore, many workers, particularly women, either work in jobs which are not protected by labour and social security legislation, or work under non-contractual conditions. Under the current legislation, many diseases are not recognized as being caused by employment and are therefore not subject to protection.

Health is often not viewed as a priority area, compared to urgent issues such as salaries, stability of employment, or termination of working contracts. Salaried women are often unaware of the relationship between working conditions and the deterioration of their health, as well the negative health implications of domestic work.

While there has been considerable progress made with regard to our understanding of the health of working men and women from an integrated health perspective, as well as from a gender perspective, there is still a great deal of work to be done. It is important that researchers work cooperatively, unifying approaches and systematizing results, in order to learn more about gender and occupational health. Furthermore, workers need to be mobilized, and these crucial issues must be placed on the public agenda.

References

Cármen Naveillán; Vergara, M.E.; Kulczweski, A.; y García, R. 1992. Estudio sobre la situación de salud laboral de la mujer en Chile. Centro de Ergonomía, Medicina y Salud Ocupacional. Santiago, Chile.

Diaz, Ximena; y Schlaen, Norah. 1992. Mujer, trabajo y salud: Las Trabajadoras de la Confección. Documento Preliminar. Centro de Estudios para la Mujer. Santiago, Chile.

Echeverría, Magdalena; y Bustamente, Christián. La Salud de los trabajadores en Chile Documento de Trabajo No. 76.

Echeverría, Magdalena; y Parra, Manuel. 1991-1992. Salud Laboral: Límites y oportunidades. Economía y Trabajo en Chile.

Informe Comisión Nacional de la Familia. 1993. Santiago, Chile.

Medel, Julia; y Riquelme, Verónica. 1992. Mujer, Trabajo y Salud: Las trabajadoras asalariadas de la fruticultura. Documento Preliminar. Centro de Estudios de la Mujer. Santiago, Chile.

Palomares, Laura Esquivel. 1993. Informe sobre la salud ocupacional en Chile en los años 80. Universidad Católica de Chile. Santiago, Chile.

Plan de Igualdad de Oportunidades para la Mujer. 1993. Servicio Nacional de la Mujer, SERNAM. Santiago, Chile.

Sandoval, H.; Bustamante, C. 1991. Análisis de la cobertur en salud laboral en Chile. Documento de Trabajo No. 78. Programa de Economía del Trabajo. Santiago, Chile.

Sub-Comisión Trabajo y Mujer. Contenido Programático. Concertación por la Democracia. Santiago, Chile.

Health and Work: A Gender Perspective

Jaime Breilh[1]

Introduction

As a result of the implementation of neo-liberal economic and social policies, Latin American populations are currently experiencing a dramatic deterioration in their quality of life, including a collapse in their health conditions. It is increasingly important for organizations to cooperate and consolidate their experiences in the search for better alternatives for development.

The International Development Research Centre (IDRC) has provided a great deal of support for the efforts of many research groups in Latin America. This paper provides a brief synthesis of an IDRC sponsored project which is being carried out by the Health Research and Consultancy Centre (CEAS) in Ecuador. The project, entitled, "Female Work Profiles, Strategies in Survival and Health," is crucial for the planning of strategies aimed at encouraging the health of women in Ecuador. In order to illustrate the range of work carried out in Ecuador, the conceptual bases, the principal operative aspects and the results, as well as the alternatives which were generated over many years of work in Ecuador, will be summarized.

The Need for a Gender Perspective

Several years ago, it became increasingly understood that there was a relationship between suffering and disease as epidemiological problems, and the subordination, discrimination, and underestimation of women in a society built on inequality, not only among the social classes, but also between the genders. With this new epidemiological interpretation, we began to understand that the concept "sex" concerns geno-phenotype aspects, and its use in epidemiological work is necessary to observe aspects of individual physiology or psyche. On the other hand, the concept of "gender" is necessary when reflecting on the social construction of the processes linked to the development of masculinity or femininity.

A thorough discussion of these issues can be found in other papers (Breilh 1992; Breilh 1994). At this point, it should be emphasized that gender as a conceptual category may be operationalized in research, but cannot be reduced to a simple population stratification

[1] Health Research Consultancy Centre, Quito, Ecuador.

resource for comparisons of women and men, or for separating women in order to study the diseases which affect them. Although there are processes which are peculiar to women, a real gender perspective implies investigating the existence of gender problems as determinant factors, in all epidemiological processes.

Starting from this more academic perspective, it is possible to advance towards a political understanding of its importance. Progressive feminist elements have pointed out for many years that an understanding of the concept of gender is important in the development of popular power. There is a close relationship between the general forms of power concentration, and the patriarchal organization of different spheres of collective life. A patriarchal structure is present in the organization of the workforce and in the patterns of housing, eating, recreation, and availability of services. The patriarchal structure also exists in all forms of cultural and political life. A complex interrelationship exists between physiological differences between men and women, and the organization of production, consumption, and domestic social practices.

In addition to the crucial epidemiological and political implications of the gender concept, it also has a further significance. An understanding of gender implications is crucial in the move towards the humanization of society, and the end of subordination in a patriarchal society, which destroys the life and dignity of women, and impoverishes the development of masculinity. Gender inequality not only destroys the human option of a full femininity, but also deteriorates the full humanization of men. Gender inequity leads to the development of a masculinity which is associated with destructive values, and which encourages the consolidation of a world of power concentration and social inequality. It also contributes to the generation of disease.

A close relationship exists among epidemiological, political and human aspects. Epidemiological investigation is necessary to discover social forms of life destruction. Politics is needed in the struggle for the democratization of power, and to resist the regressive proposals of a class-ridden society, in which the most destructive health processes have been institutionalized, and in which the historical hierarchies of patriarchy and class are maintained and recreated.

Many forums and publications have rightly denounced the lack of attention to gender issues in the health area, as well as the over-emphasis of the reproductive life of women. The fields of both medicine and public health have perpetuated the classic androcentric view of woman, which focuses on her reproductive capacity, and which circumscribes her to a singular role of mother. Technicians, investigators and health planners tend to ignore matters such as the "threefold burden" which women suffer. This expression is used to describe the convergence in women of three types of health destroying processes: (1) those linked to remunerated work; (2) those resulting from domestic labour; and, (3) those which are caused by the reproductive physiology of women under conditions of social adversity.

The high levels of maternal mortality in Latin America, which are linked to the social deprivation of women, are undeniable. A recent publication released by the Health Research and Consultancy Centre examined the clear relationship which exists in Latin America between social inequality and maternal mortality rates. (The CEAS prepared its own social inequality index to obviate the distortions of indices found in the PNUD's "Human Development Index"). An examination of the countries in the region demonstrated that countries with higher levels of social development and equality had maternal mortality levels which were up to sixty times lower than countries with greater inequities (CEAS 1994).

To focus simply on the reproductive life of women, when looking at the feminine gender, is to lose sight of the substance of the matter. It is not enough to simply focus on selected diseases which primarily or exclusively affect women. Nor is it sufficient to merely use the concept of gender as a way to statistically stratify and compare males and females. Rather, it is necessary to devise a new human and organizational perspective which can promote life and dignity for all. Epidemiology must be transformed. Gender must be understood as a conditioning factor of all aspects of social life: in the workforce, in the family, in political and cultural relations, as well as in ways of relating with the environment.

The Interrelationship of Gender, Ethnicity, and Social Class

Since the 1970s, the Latin American movement of social medicine, or collective health, has produced significant contributions to the incorporation of gender in epidemiology. The Health Research and Consultancy Centre has made important contributions through its investigative work on women, following an innovative methodological process. The CEAS strives to link theoretical advances to the development of a new praxis. It promotes the incorporation of "new" categories, such as gender, into community health initiatives, with a view to empowering not only the classes, but also the subordinate gender. In this process, care must be taken to ensure that there is not a loss of unity within the social movement.

After much struggle, sectors such as women and indigenous populations have managed to incorporate the concept of gender into political and academic spheres. Even the slow and conservative official sector has been obliged to consider gender issues. While some consensus exists on the relevance of the gender issue, there is disagreement concerning the way it is understood. Even in the most progressive spheres, there is a lack of agreement concerning the conceptual and political consequences of the incorporation of gender.

Within the social sciences, a theoretical belief exists that there is diversity in the social world which requires advancement beyond the orthodox notion of "social class." Categories such as gender and ethnicity were viewed as necessary in order to explore social diversity. A conflict has developed concerning whether social class or gender is the principal category. In certain orthodox political sectors, social class is viewed as the most important factor. In extreme feminist sectors, gender is said to be more important. In the area of health research,

the determinants of the health of the feminine gender need to be looked at globally. The principle category, in my opinion, changes and depends of the subject being studied. Neither social class or gender have an "a priori" centrality.

In the book "Género, Poder y Salud" ("Gender, Power and Health") it is proposed that the debate should be led through two inseparable dimensions: (1) the conceptual dimension, which helps us to understand diversity or plurality; and, (2) the political dimension, which demands consideration of our beliefs about the organization of political struggle.

Formal logic separates plurality from unity. It does not accept that what is diverse can also be united. Either something is diverse, or it is unitarian, and both states cannot exist simultaneously. However, it is possible for diversity and unity to exist together. There is a close connection between the historical movements which promoted the examination of gender, social class, and ethnicity. Neither social class, nor ethnicity, nor gender, is paramount. Rather, the interrelationship between gender, ethnicity, and social class must be acknowledged.

Profiles of Female Work, Strategies of Survival, and Health

In an effort to contribute to the improvement of the health of women in Ecuador, the CEAS carried out, with funding from IDRC, a research project entitled, "Profiles of Female Work, Strategies of Survival and Health." This was an interdisciplinary and highly participative project. Women from a number of different groups participated in the study, including the populations under study, female organizations, non-governmental organizations, congresswomen of the republic, and political leaders. Participatory activities included preparatory workshops, homogeneous groups from the populations being studied, national workshops for the discussion of results, as well as committees to discuss prevention manuals.

The investigation focused on four types of labour: women in the civil service, factory workers, rural working women, and women doing informal work in urban areas. Representative samples were taken from the employees of the central plants of the ministries of the country's capital (n=270), from the workers of nine garment factories in the city (n=315), from rural workers in small production areas (n=270), and from groups of women in the urban labour sector.

Methodologically, the study involved a participative process and combined diverse techniques, such as the use of key informants, the use of homogeneous groups, a collective survey, an individual survey, and workshops. Both qualitative techniques of content analysis and quantitative techniques of figure analysis were employed. The CEAS believes that both qualitative and quantitative methods are important, and that neither one is more important than the other. Both types of procedures should be used. Therefore the project incorporated both qualitative and quantitative techniques depending on the problem being investigated.

Selected Results

By way of example, selected data with regard to stress and women in the civil service will be discussed in this section. Work centres were thoroughly investigated and assessed, and key informants and groups provided preliminary information. It was established that the most destructive employment involved repetitive and dull work, together with a high degree of concentration, too many tasks, and too many different types of tasks due to poor organization. There was also a problem concerning lack of support with domestic responsibilities.

The survey of individuals made it possible to identify some interesting issues with regard to stress. For example, a relationship between menstrual discomfort in a stressful working environment, domestic stress, and the presence of polymenorrhoea (increased menstruation) and anemia was found. There was a significant relationship between repetitive work and interference of menstruation. It was also shown that women who stand a great deal during their work were most affected by stress.

Over 50% of working women carried out a large amount of domestic work with no support of any kind, both during the work week, and on the weekends. Among the workers with a husband or partner, a very small percentage reported that they received help in the home from their partners. Furthermore, a notable difference between the chores that men agree to do, and the chores that women do, was observed. Very few men take part in basic or executive domestic labour (10%), while 27% of men participated in tasks involving family care and attention. The largest percentage of men participated in economic and political tasks.

Discrimination was also manifest in cultural values regarding the distribution of food. Only in two percent of the cases did women receive preferential treatment, while preferential treatment for males with regard to food distribution was frequent.

In order to study the proportion of women who are in a state of stress, a test named EPISTRES[2] was designed and validated. By means of this test, it was established that a high proportion of women were in a state of stress. By using Goldberg's test (GHQ), which has 28 items which help to determine the degree of mental suffering, it was shown that there was a significant proportion of women who were in a state of mental disturbance, clearly associated with stress (see Table 1).

[2] EPISTRES, designed by one of the investigators in the Centre, incorporates 28 items, chosen by means of a factor analysis with rotation of the varimax axes. Its sensitivity and specificity as a predictor has been proven. It covers the factors of remunerated labour, of consumption, of domestic labour, of the affective life, of the body, etc.

Table 1 **Stress and Mental Suffering in Female Civil Servants Quito, 1993**

GHQ Epistres	1 Normal	2 Moderate	3 Severe	Total
1 Slight	97 81.5	19 16.0	3 2.5	119 44.6
2 Moderate	73 52.9	36 26.1	29 21.0	138 51.7
3 Severe	1 10.0	1 10.0	8 80.0	10 3.7
Total	171 64.0	56 21.0	40 15.0	267 100.0

Source: CEAS-IDRC Profiles Study (p=0.0000)

Furthermore, it was possible to verify the expected protective effect of recreation. As Table 2 shows, there was a significant decrease of severe stress in workers with the highest levels of recreation.

Table 2 **Protective Effect of Recreation on Stress in Female Civil Servants Quito, 1993**

Epistres Quality	1 Slight	2 Moderate	3 Severe	Total
1 Poor	44 38.3	67 58.3	4 3.5	115 42.9
2 Medium	36 40.9	49 55.7	3 3.4	88 32.8
3 Good	29 64.4	15 33.3	1 2.2	45 16.8
4 Other	7 46.7	6 40.0	2 13.3	15 5.6
Total	119 44.4	139 51.9	10 3.7	268 100.0

Source: CEAS-IDRC Profiles Study (p=0.07)

However, due to cultural restrictions and lack of time, recreation time for female workers is minimal. The full protective effect of recreation is therefore not realized.

The relationship between stress and the presence of a menstruation disturbance was established. Table 3 shows that there was an increase in polymenorrhoea in workers with greater degrees of stress. The percentage of women with an increase in menstruation was almost tripled in workers with a high level of stress.

Table 3 **Stress and Polymenorrhoea in Female Civil Servants, Quito, 1993**

Menstruates Epistres	1 0-6 days	2 7-12 days	Total
1 Slight	82 91.1	8 8.9	90 41.3
2 Moderate	95 79.8	24 20.2	119 54.6
3 Severe	7 77.8	2 22.2	9 4.1
Total	184 84.4	34 15.6	218 100.0

Source: CEAS-IDRC Profiles Study. (p=0.07)

Table 4 **Polymenorrhoea and Hypohemoglobinaemia* in Female Civil Servants over 40, Quito, 1993**

Hb g/dl Menstruate	1 Low 9.5-13.4	2 High 13.5-18.0	Total
1 0-6 days	11 26.8	30 73.2	41 83.7
2 7-12 days	5 62.5	3 37.5	8 16.3
Total	16 32.7	33 67.3	49 100.0

*Hypohemoglobinaemia according to Blood Bank standards

Source: CEAS-IDRC Profiles Study. (p=0.05)

Polymenorrhoea was significantly associated with the presence of hypohemoglobinaemia (ferropenic anemia) in women over 40 years of age (Table 4).

Stress does not only affect women in their loss of blood. Women who are experiencing high stress levels were found to be most likely to suffer from other processes, such as intercurrent infections (Table 5).

Table 5 **Prevalence of Intercurrent Infections (15 days) According to Degree of Stress in Female Civil Servants, Quito, 1993**

Epistres Infection	ND	1 None	2 Suspicion	3 Present	Total
1 Slight	7 5.9	67 56.3	31 26.1	11 9.2	119 44.4
2 Moderate	16 11.5	80 57.6	26 18.7	17 12.2	139 51.9
3 Severe	0 .0	2 20.0	5 50.0	3 30.0	10 3.7
Total	23 8.6	149 55.6	62 23.1	31 11.6	268 100.0

Prevalence of period (15 last days) and medical valuation

Source: CEAS-IDRC Profiles Study. (p=0.06)

There is an obvious link between a woman's biological processes and the processes which make up her social life. Gender determinants come into play in the rich and dynamic process which characterize each social class. Furthermore, in all social classes investigated, there were common gender aspects which contributed to the quality of life and the epidemiological condition of women. It is very important to examine these matters in depth.

Conclusion

It is increasingly important for organizations to cooperate and consolidate their experiences in the search for better alternatives for development and health. As a result of the knowledge gained during the research project, it was concluded that there is an urgent need to establish a Gender and Health Network in Ecuador. It is also crucial that an epidemiological surveillance system, with the participation of women, is implemented. These two urgent

needs were identified during the first phases of the project, and during its more advanced stages, and, above all, when the national workshops were carried out. The CEAS is currently in the process of designing a new project which could cover these needs.

References

Breilh, J. 1992. La Triple Carga. Quito, Ediciones CEAS.

1994. Género, Poder y Salud. Ibarra, Edicion de la Universidad Técnica del Nort y del CEAS.

CEAS. 1994. Inequidad Social y de Género en los Paises de América Cuadernos de Salud Colectiva, 7.

Gender and Occupational Health in Venezuela

Doris Acevedo[1]

Introduction

This paper explores the living and working conditions of women in Venezuela and the health implications of these conditions. The health status of the female population is influenced by the socio-historical position of women. In patriarchal societies, women experience discrimination and subordination which increases their vulnerability to adverse working conditions. Differential living and working conditions between men and women, even within the same social strata, can cause different health problems. Furthermore, work conditions can have a differential impact on women, due to their specific physical features, including their reproductive function.

The Sexual Division of Labour

The term "work" widely refers to all human effort invested in the production of material goods and consumer services. There is a clear division between work done by men and work done by women. This differentiation originated in the sexual division of labour in family life, and is perpetuated in the social organization of work outside the family.

Within the family structure, men are generally responsible for tasks requiring brute physical force, such as cutting trees, hunting, and so on. They also tend to be responsible for the production of consumer goods which generate exchange value through barter. Women, together with the children, are subordinated to the head of the family. They are responsible for bearing children, caring for family members, and producing material goods which are directly consumed by the family, such as food and clothes, and which do not generate exchange value.

The Working Population in Venezuela

In Venezuela, the working population between 15 and 64 years of age comprises 58% of the total population. When analyzing the workforce, official statistics consider the population over 15 years of age, which is 61.4% of the total (OCEI 1990). In Venezuela, over 80% of men over age 15 are in the formal workforce, compared to 35.6% of women. Of the total number of people incorporated in the workforce in 1990, 30.5% were women (from 18% in 1950).

---

[1] Occupational Health, Carabobo University, Maracay, Venezuela.

Socially necessary work carried out predominantly by women in the informal sector, such as in the home, underlies the fulfilment of work in the formal sector and must be acknowledged (Acevedo 1993). Women participate in the work process in two ways: (1) they engage *directly* in the production of goods and services for public consumption, which has been acknowledged in the statistics cited above; and, (2) they participate *indirectly* through their work at home, in their role in the biological and social reproduction of the workforce (procreation, maintenance and strength recovery of the workforce). Including the work that women do at home, 85.3% of women over age 15 participate in production in some way. Research studies which have addressed the issue of workload in the home report that women work about fifty hours per week in the home, compared to ten hours by men (UNO 1991). In the case of men, if the statistics included the work of men in the household, the percentage of men in the workforce would rise marginally from 80.6% to 80.9%. Therefore, more women than men are incorporated, both directly and indirectly, in the workforce.

The following are some of the features of women's work in Venezuela:

- Women's subordinate position in society is reflected by the dearth of women in positions involving the supervision and direction of others. Out of the total number of workers who are managers, administrators or directors, only 17%, or less than one out of five, are women. Only one out of every ten employers is a woman (Copre 1989).

- Jobs that are predominantly held by women tend to be undervalued and underpaid. The average salary received by women is always lower than that of their male counterparts (UNO 1991). The feminization of occupations traditionally carried out by men tends to devaluate them.

- Social voluntary work is usually done by women, with little recognition and no remuneration. In times of economic crisis, social sector institutions, such as education and health, pressure women to voluntarily contribute their time and energy to social service.

- Women who are involved in the paid workforce continue to also have responsibilities in the home. This double burden of doing work both outside and inside the home leads to a total weekly workload which averages about seventy hours a week (UNO 1991; Oribe 1991; Messing 1991). In the poorer strata of the population, some women work one hundred hours a week or more, which translates into a fourteen-hour day. Little has been done in Venezuelan society to redistribute domestic labour among other family members. There is also a lack of institutional support, such as childcare centres, nurseries and other services.

- Twice as many women than men work in the service area, such as in restaurants, hotels and in domestic labour. Seven times more men than women work in the areas of agriculture, mining, construction and transport (see Table 1). There is a greater diversification of work among men, than among women. Women are concentrated in the so-called "female ghettos." For example, 86% of women are concentrated in the service sector, while 13% are in the manufacturing sector. Characteristics of work in these sectors include minimal decision-making and working with the public, which are factors associated with the accumulation of stress. High stress levels increase the risk of workplace accidents, as well as the risk of cardiovascular disease (Lowe 1989).

Table 1: Average Distribution of the Workforce in Venezuela, According to Sex and Economic Activity, 1990

Activity Area		
	Men	Women
Agriculture and mines	18.2	2.4
Manufacturing industry	16.3	13.8
Construction, electricity, gas, water	13.2	1.7
Transport and communication	8.0	1.6
Finance and insurance	5.1	7.4
Trade, restaurants and hotels	19.2	22.6
Communal and social services	21.1	49.6
Fixing and cleaning services	5.2	0.1
Domestic service	1.1	14.2

Source: OCEI. Workforce Indicators in Venezuela. First Semester. 1990. Caracas, Venezuela.

- The time of life when women are in the formal workforce tends to coincide with the reproductive period. Breilh uses the term "triple load" to refer to the triple responsibilities that women have during this part of their lives: that is, responsibility for reproduction, productive work, as well as domestic work (Breilh 1991). This triple load can lead to detrimental health effects in women which may result in premature aging and death.

- Statistics reveal that 11.6% of men were unemployed in 1990, compared to 9.2% of women in the workforce. Women are less likely to show up in unemployment statistics because they are more likely to be involved in temporary part-time jobs, as well as the informal workforce.

Women and Economic Hardship

Over the past few years, there has been an increase in women's education levels. In general, Venezuelan women have reached schooling levels which are similar to those of men. However, the average income of women is lower than the average income of men, largely because women are situated in low-paying jobs with little prestige (UNO 1991).

Many women have sole responsibility for the family, receiving little or no assistance from their partners. Thirty percent of all families in Latin America are headed by women (UNO 1991; PAHO/WHO 1986). In poorer segments of society, the number of female-headed households is even higher. Female heads of households are particularly disadvantaged. They have lower levels of education and higher levels of illiteracy and unemployment, when compared with male heads of households and women who are not heads of households (OCEI 1990). Families which are headed by women are often in an economically vulnerable situation, and are particularly at risk when an illness or death in the family occurs.

When a country is faced with economic hardship, women are often hit particularly hard. In the family household, women have to cope with limited living space and scarce resources. The deterioration of public services also particularly affects women. Coping with economic hardship often has a high cost on the physical and mental health of women.

Most Frequent Conditions of Work Among Female Workers

The work in which women are most likely to be involved usually requires certain characteristics which have been socially assigned to women, including docility, manual dexterity, capacity to concentrate, patience, and tolerance. There are a number of specific types of work that women are more likely to do than men. The nature of women's work has many serious health implications.

Rapid and Repetitive Movements

There is a high concentration of women in manufacturing industries such as textiles, food, electronics, and chemicals. The assembly line work that women perform in these industries demands quick, precise, and repetitive hand movements. Similar types of rapid and repetitive movements are needed in female-dominated employment in the service and business sectors, such as cashiers, typists, and data processors. These jobs involve monotonous tasks, requiring great mental concentration and little opportunity for communication. The rest of

the body remains standing or sitting in an immobile position. These work conditions may lead to muscular, skeletal and neurological difficulties, such as carpal tunnel syndrome (Messing 1991).

Work with the Public

Jobs in the service and business sectors, including educators, nurses, secretaries and salespeople, require an ability to effectively communicate with people, as well as tolerance. Working with people can have a detrimental impact on a worker's mental health. Typical difficulties include anxiety crises and behavioral changes. People who work in these demanding jobs often have little control over their environment, a factor which has been associated with the appearance of coronary diseases (Messing 1991; Lowe 1989).

Fixed Position

Women are stereotypically perceived as passive, while men are usually perceived as active. It is therefore not surprising that women predominate in jobs which require prolonged standing or sitting. At a work centre involving both men and women, it is not unusual to see men in positions of greater mobility, while women tend to remain in fixed positions, standing or sitting throughout the work day. Muscular pain and circulatory problems are health issues associated with this type of static work.

Monotony and Lack of Decision-Making

Monotony and lack of decision-making are characteristics which are found in almost all types of work where women predominate. The disproportionate percentage of female work with these characteristics is related to the subordinate position of women in patriarchal societies. Eighty to ninety percent of secretarial, teaching, nursing, domestic work, sales and cashier jobs are filled by women. These jobs may involve monotonous tasks, minimal creativity, high stress, and little control over the external environment, of which all contribute to mental health problems.

Sexual Harassment

As a result of the subordinate position of women in society, women may be subjected to sexual harassment. Employers may demand sex in return for access to or continuance in a job, promotions, or salary raises. A woman who is subjected to sexual harassment may suffer mental and psychological damage, as well as adverse physiological reactions, such as gastritis and dizziness. These physical conditions could increase the risk of workplace accidents.

Another difficulty women may experience when trying to find a job is discrimination if they do not measure up to a certain notion of feminine beauty. In Venezuela, advertisements for secretaries and receptionists often require a "good appearance," an attribute which is not demanded of men.

Workplace Accidents

Over the past seven years, 3-4% of the total number of accidents to women occurred in the workplace. The largest number of accidents occurred in the textile, food and clothing industries, which are located in the industrial belt in the centre of the country (Caracas-La Victoria-Maracay-Valencia). Most injuries occur to the upper and lower limbs. There has been a recent increase in the amount of occupational impairment of female workers. The most common occupational diseases are dermatitis, hypoacusia and respiratory diseases. It should be noted that these statistics may not be an accurate reflection of the real number of accidents, given the high degree of under-reporting.

Health Problems of Teachers

Seventy to eighty percent of middle education teachers are women. The author undertook an exploratory evaluation of the health problems and working conditions of educators in the state of Maracay. A review of medical service records of the educators found that the following diseases were most common: depressive neuroses, arterial tension problems and voice problems. The most frequent causes of absence from work were depression (anxiety, psychosis), recurring headaches, functional diaphony, nodules on vocal cords, and high blood pressure. The greatest amount of sick leave was taken as a result of consultations regarding psychiatric problems. These disorders are related to the specific conditions of teaching: working with the public, intensive work day, excessive use of voice, low salary and low social prestige. Women teachers also usually bear the additional burden of caring for their families. With regard to physical working conditions, educators complained about poor lighting and ventilation, heat, over-crowding, lack of drinking water, and excessive noise.

Work and the Reproductive Role of Women

Women who are part of the paid workforce may find that their employment plays a role in the regulation of their sexual and reproductive functioning - sometimes more so than family planning programs. By merely joining the workforce, fecundity is regulated - women who work outside the home have fewer children and more abortions (Ramirez et al. 1991; Saurel-Cubizolles et al. 1991). Certain working conditions such as shift work, irregular schedules, and temperature variations, may change the menstrual cycle of a woman (Messing et al. n.d.). Prolonged standing, shift rotation, long work days and exposure to some chemicals, have been linked to spontaneous abortions among working women. Borges (1993) noted that high stress jobs, and low task control, increases the risk that a woman will experience a premature birth.

A study carried out at La Victoria (Aragua) compared a female group of textile workers with a group of housewives living in the same neighbourhood. The textile workers tended to have poorer living conditions than the housewives. Half of them lived without a partner and were solely responsible for their family. The textile workers also had lower levels of schooling than the housewives. With regard to reproductive health, the textile workers had five times more abortions than did the housewives, as well as significantly lower birthweights in newborns, when compared to women of the same age and social status who worked at home (Borges 1994). Fecundity among the textile workers was also lower than that among the housewives. The researchers concluded that the reproductive difficulties might be linked to the combined effect of several factors. Long working hours at an assembly line, the intensity of the textile workers' jobs, prolonged standing, combined with poor living conditions, and the burden of caring for a family, contributed to these results.

It is not unusual for women, aware of the possible risks that work poses to her fetus, to voluntarily leave her job and return to it after the birth of her child, or resort to unpaid leave (Malenfante 1992; Saurel-Cubizolles 1987). A woman may be compelled to leave her job for the sake of her health and the health of her fetus, due to the absence of, or lack of, implementation of protective measures for pregnant women.

Implications of Changes in the Employment Law

There have been recent changes in the Employment Law, which lengthened the period for pre- and post-natal leave for female workers from 12 to 16 weeks. Legislative changes also prohibit job dismissal during the year following the birth of a child. As a result of these legislative actions, there have been changes in the number and age of women hired in certain occupations, especially in the industrial sector. Some departments in the textile and food sectors have replaced their female employees with men. The average age of female workers is also higher than before (that is, older than the childbearing years). Furthermore, representatives from the Women's House (Casa de la Mujer) of Maracay and from worker training courses report that, in order to gain employment in some industrial companies, women are required to supply a certificate stating that their fallopian tubes have been tied. As a result, numerous women in the highly industrialized area of La Victoria are requesting this operation.

Conclusion

The living and working conditions of women in Venezuela differ from the conditions experienced by men. The sexual division of labour in family life is perpetuated in the social organization of work outside the family. As a result of this division of labour, there are a number of specific types of work that women are more likely to do than are men. Women's work may involve rapid and repetitive movements, working with the public, prolonged standing or sitting, monotonous tasks, minimal creativity, high stress, little control over the external environment, sexual harassment, low pay, and low social prestige. The specific

nature of women's work can have serious implications for the physical, mental and social well-being of women. Work conditions can also have a differential impact on women, due to their specific physical features, including their reproductive function.

References

Acevedo, Doris. 1993. Mujer, Trabajo y Salud. Referencias a la situación venezolana. Salud de los Trabajadores. Vol.1 No 1. Maracay, Venezuela.

Borges, Aismara. 1993. Proyecto de investigación: Salud reproductiva en trabajadoras de textiles. La Victoria, Aragua. Venezuela.

Borges, Aismara; y Acevedo, Doris. 1994. Salud reproductiva en textileras y amas de casa, La Victoria, Aragua, Venezuela. In progress.

Breilh, Jaime. 1991. La Triple Carga. Trabajo, Práctica Doméstica y Procreación. CEAS. Quito.

COPRE. 1989. Oficina de la Ministro de Estado para la promoción de la mujer. La Mujer en Venezuela. Caracas.

Lowe, Graham. 1989. Le travail des femmes et le stress. Conseil consultatif canadien sur la situation de la femme. Ottawa. pp 89. Lowe.

Malenfante, Romaine. 1992. Travail et obligations familiales. Les mesures de protection de la santé des femmes au travail. Table ronde de recherche sur la santé des femmes en milieu de travail. Ottawa. 22 et 23 juin 1992.

Messing, Karen. 1991. La Santé et la securité des travailleuses canadiennes. Labour Canada. pp 47-55.

Messing, Karen; Saurel-Cubizolles, Marie-J.; Bourgine, Madeleine; Kaminski, Monique. n.d. Menstrual cycle characteristics and working conditions in poultry slaughterhouses and canneries. Mimeog. pp 21.

UNO. 1991. Les femmes dans le monde. Des chiffres et des ideés 1970-1990. United Nations Publications. Sales No. F.90 XVII. 3.

UNO. Women. 1991. Challenges to the year 2000.

OCEI. 1990. Indicadores de la fuerza de trabajo en Venezuela. Oficina Central de Estadística e Informática. Caracas.

Oribe, V.; Griselda y colaboradores. 1991. el Trabajo femenino y la salud en cuatro grupos de mujeres en Guadalajara, México. Boletín Oficina Sanitaria Panamericana. 111 (2). pp 101-111.

PAHO/WHO. 1986. Women in the economic development in Latin America. 128-140.

Ramirez, R. Juan C; y Uribe, V.; Griselda. 1991. Fecundidad por grupos ocupacionales en Guadalajara. Carta económica regional. Año 3, No 18.

Saurel-Cubizolles, Marie-Josephe; Gestin, Gwenaïlle. 1991. Housewives, unemployed and employed women: Why different risks or preterm delivery? A French study. *International Journal of Health Sciences*. Vol 2. No 2. pp 83-91.

Saurel-Cubizolles, Marie-Josèphe. 1987. Les conditions de travail des femmes ouvrières pendant la grossesse et leurs ménagements. Les archive des maladies professionelles. No 2. 91-99. Paris.

Discussion

Following presentations by Ximena Diaz (Chile) and Jaime Breilh (Ecuador), a general discussion took place on the subject of Environmental Stress, Production Activities, Health, and Gender. The following points were raised:

- When conducting research, researchers must be careful that they do not add to the already heavy workload of women. While it is important to study women, women should not be seen as a source of cheap labour in research projects. If women are asked to be administrators or project managers, researchers should be conscious that they do not put too many demands on them.

- While some researchers believe that women who work are healthier than women who do not work, this is not always the case, as women in lower classes often must work under poor conditions for survival.

- The extent to which women have a role or control in decision-making is important. Given that there are currently few women occupying positions of authority, women must work together in an organized fashion to bring more women into management and decision-making roles. If women were in positions of leadership, they would have more influence in the fight for better working conditions.

- Women often have little information on the extent to which detrimental working conditions can lead to negative health effects. Women also tend to be unaware of the laws relating to occupational health and safety, and whether or not there is protective legislation. A need exists to disseminate information to female workers. Women also need to fight for increased rights and protection concerning occupational health and safety.

- Many occupationally-related diseases that affect women have not been explored. For example, some researchers continue to believe that the jobs women perform are simple and stress-free, thus not justifying a study of mental stress. It is often difficult to demonstrate how certain occupational risk factors affect women's health, including their reproduction functions. Sometimes one factor cannot be isolated as the singular cause of a disease or illness. Instead, it is often exposure to a combination of several factors that leads to a serious health problem.

- Stress is an important hazard for many women, in both the workplace and the home environment. Women suffer stress in different ways than do men, and the organization of women's work may contribute to increased levels of stress. Household activities and aspects of everyday living, including the structure of family life, increases the burden on women. Women often have higher levels of stress than

men because of the social conditions under which they live, including economic inequality, poverty and marginality. When conducting research on stress, rather than simply asking women if they are experiencing stress, the various factors that lead to increased stress might be documented.

- Women tend to have higher levels of absenteeism from work than men, which is likely related to family pressures. Women should "have the right to get ill" and be able to take time off from work.

- Women's health problems are often not treated seriously. When women ask for assistance with a health-related issue, their requests may be overlooked, and they may be persuaded that there is nothing to be concerned about.

- The importance of addressing the informal working sector, in addition to the formal sector, was noted. However, it was pointed out that an individual researcher cannot look at everything. Some studies might necessarily be restricted to just the formal, salaried workforce. These focused studies could then be used to complement studies in other areas.

- A question was raised concerning how/if prostitution would be classified on an occupational list. In the United States, prostitution is considered to be a category of work (i.e. sex worker). Because prostitutes are currently not listed on occupational lists in Latin America, they may be overlooked when discussing occupational health and safety, even though they are "salaried" workers.

Tropical Diseases and Gender

Considerations for the Prevention and Control of Neurocysticercosis

Elsa J. Sarti[1]

Introduction

Taeniasis and Cysticercosis are infections produced by the adult and larvae phases of the helminths species *Taenia*. There are two species which commonly affect humans: *T. solium* and *T. saginata*, both of which require two hosts to complete their life cycles. Human beings are the final obligatory hosts for the adult stage of both species of *Taenia*, and pigs and bovine cattle the two natural intermediary hosts for the larvarian stage of the parasite (cysticercoes).

Man acquires intestinal taeniasis by eating cysticercoes in raw or undercooked meat of infected pigs. After two to three months, the adult taenias measure several meters and liberate daily (*gravis proglotides*) in the bearer's feces, containing thousands of infecting eggs. The intermediary hosts acquire cysticercosis when ingesting taenia eggs present in the human feces of the bearers. The evolutive phases of *T. solium* that are infectious to humans may develop in cysticercoes, a condition potentially hazardous to life. Consequently, the medical significance of the infection by *T. solium* is greater than that of *T. saginata.*

General Issues

Taeniasis, including cysticercosis, constitutes a public health problem mainly due to the unsanitary and unhygienic habits which determine their transmission. They have penetrated into several countries of the world, especially those in the Asian, African and American continents. Mexico and Brazil occupy a dubious "privileged" position as leaders of taeniasis and cysticercosis infection in the Americas.

A large amount of data on the infections has been gathered in the Americas based on autopsies performed on deceased patients (Neurology and Neurosurgery Services) between 1940 and 1970. Cysticercosis infection rates have been reported to be as high as 4000 per 100,000 inhabitants (Brazil and Mexico). At a later stage, epidemiologic studies were performed, attempting to determine the real frequency of the disease. Through these studies, the existence of transmission to the majority of the American countries has been confirmed.

[1] Direccion Nacional de Epidemiologia, Secretaria de Salud, Mexico.

In the case of Mexico, the most important frequency rates reported through several years may be summed up as follows:

- 2 to 4% neurocysticercosis has been reported in autopsy series;
- 7 to 10% of the persons attending neurology hospitals do so due to cysticercosis;
- 11 to 30% of craniotomies performed for cerebral tumour correspond to the definitive diagnosis of cysticercosis;
- 3 to 13% of serologic positive tests have been reported in several epidemiology studies;
- 0.1 to 7% of taeniasis is identified through coprologic examinations; and,
- 1 to 25% of all cysticercosis is diagnosed through the examination of live pigs.

In Mexico, porcine cysticercosis is responsible for the loss of more than half of the national investment in porcine breeding. A figure of US$1,000,000 has been attached to the cost of infected meat seizures.

Epidemiology

Taeniasis

In Mexico, an obligatory report for this disease was instituted in 1986. From that date, some 13,000 cases have been reported each year. In terms of age groups, the epidemiologic studies show *T. solium* infection in all ages (from 5 to 56 years), with a peak between 16 and 45 years of age. Official statistics reported by the System of Epidemiologic Surveillance have reported that the highest frequencies for *Taenia sp.* are seen in under-15 year olds (54.4 %) and in those over age 45.

In relation to gender, the official figures do not show significant differences, but epidemiologic studies have shown that females present the parasite more frequently. This fact, taken by itself, presents a key research issue. Even if women present a higher frequency, one must also examine the social and cultural background that they represent, resulting in a health issue not only for the patients themselves, but also for their families. Women's roles in the home require that they prepare the family meals, as well as serve them. They are the last ones to eat. Many times they eat during the process of food preparation by nibbling (i.e., eating small quantities at different stages of the cooking process), even when the meat is still raw or undercooked. When pork meat is eaten this way, infection ensues. Moreover, when women prepare and serve food without applying sound sanitary practices, they can become the main source of cysticercosis to the family through the contamination of food with the eggs of *T. Solium.*

One of the main epidemiological problems of this zoonosis is that it does not cause relevant symptoms to appear. Patients rarely ask for medical assistance, and are therefore not diagnosed or treated. Unless they expel proglotides that can be seen, attention is not drawn to the problem, and they do not attend medical facilities. Lack of information increases the

severity of the problem. This situation could be corrected through education for health as a preventive measure operative in the middle term. As an alternative for prevention and control in the short term, the use of the treatment of choice to interrupt the transmission cycle, and therefore prevent intrafamilial cases, has also been suggested.

Human Cysticercosis

During the past four years, there have been some 500 confirmed cases of cysticercosis in Mexico. The present national rate for 1992 is 0.61 per 100,000 inhabitants.

In terms of sex, there are no significant differences reported. In terms of age, the productive age groups are those presenting the highest rates (ages 15-44). The techniques used to establish a diagnosis area in the majority of Latin America countries are based on clinical diagnosis. Unfortunately, reporting is not a constant feature and there is marked under-reporting, mainly by hospitals and third-level institutes.

With regards to treatment for cysticercosis, especially for neurocysticercosis, there are a series of therapeutic and surgical alternatives. The first is chemotherapy with albendazol and praziquantel, which have produced the best results. Surgical measures include derivations to solve endocrinal hypertension. The decision between surgical or medical treatments is made depending on the location, size and viability of the cysticerco nodes, as well as the symptoms produced.

Like taeniasis, cysticercosis poses diagnostic problems. The majority of the clinical aspects are due to the affectation of the central nervous system (CNS), and very few to muscular and ocular presentations (not always sought by the doctors). At the CNS level, the manifestations are varied, depending on the number of cysticercoes and their biological stage. The most frequent symptoms are epileptic fits and headache. Over the last few years, computerized axial tomography (CAT) scanning, and more recently magnetic resonance, have contributed greatly to diagnosis confirmation. Unfortunately, however, these techniques cannot be used frequently in the rural and some urban areas. For this reason, a series of immunodiagnostic techniques have been implemented using serology, which is easy to use and read, especially in rural areas. Some studies are being carried out to prove that neurocysticercosis is more frequent in men, but more severe in women, who have a greater incidence of cysticercosis in the central nervous system, and therefore have a clinically more expressive case. Results from these studies, however, are not yet conclusive.

Porcine Cysticercosis

Porcine Cysticercosis is the intermediary host of the taeniasis-cysticercosis complex, so its analyses have important implications. One is that the average life of pigs is 8 months (with some variation for clandestine lots). Since this duration of life is relatively short, pigs provide a key entry point to evaluate intervention strategies for the prevention and control of

this zoonosis, since the time lapse in which pigs become infected is only 4 months. It has also been demonstrated that female pigs present a greater infestation rate than male pigs, while the latter acquire the disease more easily.

Treatment of pigs with drugs of choice has proven to be very effective, but unfortunately the cost of the treatment is higher than the value of the actual pig. It has been recommended that, depending on the number of cysticercoes, the pig goes to the "paila" (death and incineration), which represents large economic losses for both the family and the country.

The problem of porcine cysticercosis is one of the greatest in the taeniasis-cysticercosis complex, due to several factors: in Mexico, only 40% of the pigs are slaughtered in compliance with the regulations, which means that the rest belong to the clandestine sector; the diversity and lack of training of those responsible for the slaughterhouses results in parasites going undetected in many cases; with regard to the type of diagnosis, there is no standardized national or international procedure that determines where to conduct the muscular cuts in the carcass, how many cuts are required or the criteria to determine when an infected animal is routed to the "paila." The majority of the infected pigs are not taken to the slaughterhouses but are handled, processed, and consumed in a clandestine fashion or in the communities, a situation which produces a continuation of the life cycle of this parasite.

If an adequate inspection system could be ensured, the origin of the infected pigs, and therefore the transmission route, could be detected. Often teniasic patients are detected and treatment of choice applied, without knowledge of how/when the disease was acquired.

Epidemiologic Studies

Several findings have resulted from the epidemiologic studies conducted in Mexico. It has been proven that a person infected with *T. solium* is the main risk factor for neurocysticercosis in his/her partner. Adequate (or inadequate) hygienic-sanitary measures have been identified as the points where prevention campaigns must be centred.

At present, a study is being conducted in three rural communities in the State of Morelos in order to devise the best intervention strategy for the later control of this disease. In community A, massive treatment with praziquantel was provided with a single dose of 5mg/k; in community B, the same treatment was applied, but a short Education For Health program was devised and conducted by a team of anthropologists and sociologists. In community C, only education was provided. Preliminary results show that community C had the highest impact on the parasites, when considering infection of swines as a marker for environmental contamination, and mothers as the focal point for producing a change in poor hygienic/sanitary practices. Community A showed a reduction of 21% of porcine cysticercosis, while in community B, it was 45%. In community C (education only), the rate was 100%.

It is important to point out that the education effort focused mainly on women, who showed a higher level of community participation, as well as being the most frequently affected by *T. solium*. They are also the main health promoters at the family level. Therefore, educational efforts addressed to them not only improve their health, but also that of their families.

Control Strategies

There are a series of strategies that make *T. solium* and *T. saginata* vulnerable:

- the life cycles of the two taenias require human beings for their adult stage host;
- infections by taenia are the only source of infection to the intermediary hosts;
- the animals that serve as intermediary hosts can be controlled;
- there are no wildlife reservoirs; and,
- safe and reliable endoparasitic drugs are available.

The WHO has set up two control strategies: (1) long term intervention programs and, (2) short term programs implemented around community treatment of taeniasis in the transmission sources of the disease. The first includes adequate legislation, education for health, improvement in the swine growing practices, increasing the efficiency and structure of meat inspections, and providing adequate sanitary facilities and measures to detect the human reservoirs of taeniasis. The political and economic realities of many communities give little room for hope, so short-term programs with massive treatments have been set up, based on the identification of the centre of the infection, treating all the diagnosed or suspected cases of human taeniasis in order to immediately interrupt the transmission from humans to pigs. In order to maintain this chemotherapy treatment for several rounds, these control activities must be included within the Primary Health Care System. In order to identify and select disease centres for long-term policies, massive chemotherapy must be complemented by aggressive educational campaigns, and significant improvements in personal hygiene and the general sewage of the treated areas.

Experience in Other Countries

The gradual disappearance of *T. solium* in a number of European countries is important evidence of the potential to eradicate this species, even without control measures directed toward the parasite. At the end of the last century in Germany, the prevalence in bovine cattle was similar to the one Mexico presents now. At present, the incidence of *T. solium* in Germany is limited to isolated centres. Factors credited for the eradication of this infection include advances in sewage, improvement of the economy, the advent of breeding pens for swine production, and a rigorous inspection of retail butcheries. In contrast, the prevalence of *T. saginata* has increased over the last 40 years. In 1950, the prevalence in Germany was

0.3%, and at present it is reported to be 2%. This increase may be due to a number of factors including the practice of intensive cattle breeding, a limitation in the inspection of meat, and the popularity of dishes prepared with raw meats.

In Ecuador, the feasibility of community chemotherapy was demonstrated. One hundred thousand people received a single dose of praziquantel. 1.6% reported the expulsion of proglottides. One year after this massive treatment, the prevalence of cysticercosis in pigs at slaughtering time showed a reduction from 11.4% to 2.6%, suggesting that success was achieved by reducing environmental contamination by *T. solium* eggs.

In Mexico, in a study conducted in 1990 at the community of Sinaloa, the population received massive treatment with praziquantel. Before treatment, 1.3% of the people had taeniasis and 72 pigs were found to have cysticercosis. After treatment there were no persons with taeniasis and no pigs with cysticercosis. Intestinal parasites were reduced from 69.2% to 37.5%. There were no adverse effects reported.

Long Term Interventions

Advantages

The decrease of the incidence of taeniasis is palatine and permanent which makes eradication possible. The change in attitudes, beliefs and conducts is achieved through long-term community education programs for health. At the same time, to focus on the mother as the main promoter of health for the family will benefit the family.

Disadvantages

The modernization of the hygienic/sanitary infrastructure is very costly and beyond the economic capacity of most rural communities.

Short Term Interventions

Advantages

The transmission from humans to pigs is interrupted, as well as that to other humans, only if aggressive education campaigns are implemented to improve personal hygiene and the basic sewage system of the population. There are safe and efficient taeniacide drugs. The support of the media is counted upon. The surveillance of porcine cysticercosis is a practical, sensible, and cheap way to monitor and assess the efficacy of population-based control programs.

Disadvantages

Lack of availability of drugs in the local areas for periodical self-administered doses limits treatment. A limitation of local incentives exists, even if the people are aware of porcine cysticercosis, they do not known about the relationship between taeniasis and cysticercosis. Economic losses ensue when pork is seized. There is insufficient cooperation between medical and veterinary services. To administer the drug in 6-month cycles for several years as the means to obtain control becomes cumbersome. Treatment must be provided to the entire population as the affected groups are distributed in all age brackets; treatment of schoolchildren, for example, would be of limited efficacy.

References

Alleyne, George O.; Acevedo, Antonio; Flisser, Ana; Gemmel, Michael; Guarnera, Eduardo; Slazar Schettino, Paz María; Sarti, Elsa; Tkahur, Amar; Willms, Laethe; Goncales Villa; Marcia Franca. 1990. Epidemiologí y Control de la taeniasis cysticercosis en América Latina. OMS/OPS

Flisser, A.; Schantz, P.; Allan, J.; Sarti, E. 1992. *Lancet* Vol. 342, Sept. 748.

Keilback, Nicola; de Aluja, Aline S.; Sarti, Elsa. 1989. A program to control teniasis cysticercosis (T. solium). Experiences in a Mexican village. Acta Leidensia Vol. 57, No. 2 pp 181-185.

Sarti, E. Gutierrez, I. 1986. La taeniasis y cysticercosis en Mexico. (Revisión Bibliográfica). Revista de Salud Publica de Mexico. 28; 556-563.

Sarti Gutiérrez, Elsa J. 1991. La Seroepidemiologí en Mexico, Los Límites de los estudios seroepidemiol Ugicos: Publicación Técnica del INDRE. No. 9 KGD, SSA, Mexico D.F. Docencia y Capacitación. La Cysticercosis.

Sarti, E.; Schantz, P.M.; Plancarte, A.; Wilson, M.; Gutierrez I.; Aguilera, O.J.; Roberts, J.; Fliser, J. 1994. Epidemiologic investigation of Taenia solium taeniasis and cysticercosis in a rural village of Michoacan State, Mexico. Royal Society of Tropical Medicine and Hygiene.

Sarti, E.; Schantz, P.; Lara, R.; Gómez, H.; Flisser, A. 1988. Taenia solium taeniasis and cysticercosis in a Mexican Village. *Tropical Medicina and Parasitology*. 39, 194-198.

Sarti, Elsa; Schantz, Peter; Willms, Kaethe. 1991. Epidemiology of Taeniasis/cysticercosis. Banco Mundial.

Sarti, Elsa; Schantz, Peter M.; Placarte, Agustiin; Wilson, Marianna; Gutiérrez, Ivan O.; López, Alejandro S.; Roberts, Jacquelin; Flisser, Ana. 1992. Prevalence and risk factors for Taenia solium taeniasis and cysticercosis in humans and pigs in a village in Morelos, Mexico. *American Journal of Tropical Medicine and Hygiene*. Vol. 46 No. 6, pp 677-685.

Sarti-G, Elsa; Schantz, Peter M.; Aguilera, Jaime; López, Alejandro. 1992. Epidemiologic observations on porcine cysticercosis in a rural community of Michoacan State, Mexico. Veterinary Parasitology., Vol. 42 pp:195-201.

Schantz, Peter M.; Sarti-Gutiérrez, Elsa. 1989. Diagnostic Methods and epidemiologic surveillance of Taenia solium infection. Acta Leidensia Vol. 57, No. 2 pp:153-163.

Schantz, P.; Sarti, E.; Plancarte, A.; Wilson, W.; Roberts, J.; Flisser, A 1991. Clinical, Radiological and Epidemiological Correlations of Elisa and Immunoblot Assays for T. solium cysticercosis in 2 populations. Mexico. *Supplement of American Journal of Tropical Medicine and Hyg.*, 45, 130-131.

Schantz, P.M.; Moore, A.C.; Muñoz, J.L.; Hartman, V.J.; Shaefer, J.A.; Aaron, A.M.; Persaud, D.; Sarti, E.; Wilson, M.; Flisser, A. 1992. Neurocysticercosis in an orthodox Jewish community in New York City. *New England Journal of Medicina*. Vol 327, No. 10 pp: 692-695.

Schantz, P.M.; Cruz, M.; Sarti, E.; Pwlowski, Z.S. 1994. The Potential irradicability of Taeniasis and cysticercosis. Bulletin of the Pan American Health Organization.

Socioeconomic, Cultural, and Psychosocial Factors of Congenital Chagas' Disease

Octavio Sotomayor, Jenny Davalos J., Freddy Pena C., Rolando Urgel, Melvy A. Vargas B., and Oscar Pinto[1]

Introduction

Bolivia has experienced sharp socio-economic imbalances which have generated significant migratory currents from rural to urban areas. Santa Cruz, one of Bolivia's nine regions, situated in the tropical area of the country, has shown marked economic changes since the 1950s. It has increasingly become an attractive area for the migrant population. The average annual growth rate of the region between 1976 and 1992 was four percent. The population has become concentrated in the capital city, Santa Cruz de la Sierra, which itself has grown at annual average rates of approximately 6.6% in the same period. At present, the city contains about 50% of the regions's population, compared to 35.8% in 1976 (Vargas 1990).

Rural-urban migration has resulted in increasingly poor conditions for urban native workers in general, and for migrant workers in particular. The settlement of migrants in peripheral areas of the capital city, where serious problems already existed in the provision of basic services, has led to low levels of education, and a general lack of information about Chagas' disease and its vectors. Health services are poor with regard to the control of illness, as well as the diffusion of information about prevention practices. This in turn has caused an important change in the distribution of the endemic disease, changing its focus from a primarily rural problem, to an urban problem.

This situation has grown more severe in Santa Cruz over the past three decades, as migrants coming from endemic areas have established themselves primarily in peripheral areas. This phenomenon brings an increase in the potential risk of local non-vector transmission, which has the potential for congenital transmission.

The vast majority of research carried out to date has demonstrated that infection of Chagas' disease in pregnant women and newborn children has a basic biological, clinical orientation. This research has, however, been limited to a small number of cases, and a minority of studies included control groups.

[1] "Dr. Percy Boland" Maternity Institute, IMPB, Santa Cruz, Bolivia.

At Santa Cruz, several investigators have attempted to show the importance of congenital Chagas' disease. Valencia's study (1990) of 1753 individuals demonstrated that there was a general prevalence of 42.95%; 40.92% of the men were positive compared to 44.45% of the women, a difference which is not highly significant. Focusing on women in their childbearing years (between 15 and 39 years), 50.91% of the women were positive, compared to 44.64% of men in the same age group. This difference was larger than in the general population, highlighting the importance of the incidence of congenital Chagas' disease. Azogue (1981) estimated that the incidence rate for newborn children of low birthweight was approximately five percent. In another study carried out at the Neonatology Service of the IMPB (Dávalos et al. 1989), an incidence rate of 3.7% was found in a total of 882 newborn children born in 1989. While this figure may not seem significant when compared to other congenital problems, it is important to consider two important factors which increase the problem: the illness is being extended into areas which were previously not infected; and, the lack of a systematic investigation of Chagas at the health services level reflects the under-valuation of the illness. In fact, in Bolivia, Chagas' disease is included in neither primary health care programs, nor in maternity-child programs. Existing programs are generally directed at detecting transfusional Chagas.

Other risk factors of congenital Chagas' disease include: high urban fertility rates (4 children per woman in 1988, and 5.4 children among illiterate women); early marriage rates among the urban female population (60.5% of women in their childbearing years were married before the age of 20); and, early pregnancies (55.8% of women had their first pregnancy between the ages of 15 and 19 (SIAP 1987). Finally, the poor symptomatology of the illness, and the absence of education, lead patients to believe they are healthy, and therefore they do not follow instructions from doctors.

Risk Factors for Chagas' Disease Infection

A research project studying the socioeconomic, cultural, and psychosocial factors of congenital Chagas' disease is currently being carried out at the "Dr. Percy Boland" Maternity Institute, with the financial assistance of the International Development Research Centre (IDRC). The Institute (IMPB) took on the project since it is the only department in the Ministry of Health in the City of Santa Cruz which oversees the health needs of the whole population. The Institute oversees about fifty percent of all childbirths in the city (Vargas 1990). The project has the following specific goals:

- to determine the socioeconomic and cultural differences in pregnant women, and the effect of these differences on Chagas' infection;

- to analyze behaviours and strategies for pregnant women in the presence of a diagnosis of Chagas' disease infection, particularly as they relate to knowledge, beliefs, expectations, and fears with regard to risks and health care for mother and child; and,

- to coordinate actions with the health services directed to an adequate management (i.e., counselling, education, treatment) of infected mothers and their children.

The initial study group was made up of 803 pregnant women who were studied during their final trimester, and for an additional period of six and one-half months. All pregnant women who serologically tested positive to Chagas were further studied. A serologically negative control group was randomly selected. This study group size is suitable for analytical purposes, taking into account the large number of variables and the complex network of relationships included.

The project was carried out with the participation of a multi-disciplinary team of professionals, structured into three large areas: clinical-laboratory, socioeconomic, and psychosocial.

Methodology

Clinical-Laboratory Component

After their prenatal consultation, an Indirect Hemagglutination Test for Chagas' disease was performed on all pregnant women taking part in the study. The test results were shared with the women during private consultations with the project's doctor. During this consultation, the women also received information on the study and the nature of their voluntary participation, education on Chagas' disease, as well as a referral to the Tropical Disease Centre (to complete a study after childbirth).

A clinical examination was performed on the newborn children of the infected mothers. A micro-method for Chagas' disease was performed ten and thirty days later. A serological test (IFI IfG and IgM), and a xenodiagnosis were done in special cases. Positive newborn children were treated with benznidazole (10 mg/kg/per day for 30 days), with weekly clinical monitoring. At the end of the treatment, a control micro-method was performed; xenodiagnosis one month later, and indirect IgG and IgM immunofluorescence, six and twelve months later. A clinical follow-up was carried out simultaneously. An anatomopathological study of the placenta was carried out in all cases where it was possible to do so.

Socioeconomic Component

An interview was held in the final trimester with each pregnant women who had tested positive to Chagas, as well as with an equivalent number from a randomly selected group of pregnant women with negative test results.

The questionnaire asked about socioeconomic and cultural aspects related to the infection. Information was also obtained about the characteristics of the pregnant women (e.g., age, education level, marital status, occupation, migratory background, knowledge of the illness

and of the vector, and so on), as well as information about the head of the family and the general characteristics of the family (e.g., number and composition of the family, health coverage, education level, quality of housing, access to basic services, and so on). The questionnaire was pre-tested and codified.

Psychosocial Component

Interviews were held with the pregnant women with Chagas' disease, using the Test-Questionnaire for Emotional Exploration (TC2EMCH), in order to ascertain information about fears, apprehensions, hopes, behaviour, family conditions, relationships with health services, knowledge, beliefs, and perceptions. In addition, focus groups were created to provide information on emotional sensibility, behaviour and attitudes, experiences, information received, and the relationship between the participants. The focus groups also provided information from non-verbal communication, such as gestures, looks, positions, and tone of voice. After these observations, questions were answered, information and education was provided, and group therapy was given in some cases. Visits were also made to the homes of the women to sensitize, orientate, educate, and carry out family or personal therapy.

Results

Clinical-Laboratory Component

From the universe of 803 pregnant women, 287 tested positive for Chagas' disease, with a prevalence of 35.74%. Thirty-eight women did not come back for their results even though they were provided with verbal and written instructions.

Of the 249 pregnant women who entered the project voluntarily, 175 gave birth at the IMPB (70.3%), with one case of twins and another of triplets. Twenty-four gave birth at other institutions, while three women gave birth in their own homes. Therefore, a total of 205 newborn children were included in the project.

Of the children born at the IMPB, 161 (or 90.4%) were full-term babies. Eighty-one percent (or 144) had an adequate weight for their gestational age, while two babies (1.1%) had low birthweight for gestational age. Eight children were born prematurely, but all these children had adequate weight for gestational age.

The babies' clinical signs during the physical examination were generally poor: jaundice was diagnosed in 14% of the newborns, hepatomegaly of different degrees in 9.3%, splenomegaly in 6.3%, and paleness in 4.6%.

An initial micro-method was carried out on all newborns, with four positive results. The second micro-method on 121 children gave one positive result in an unweaned baby (six months old). A third micro-method was carried out on 48 children, all having negative results.

Due to the presence of clinical signs, nine children were tested with IFI IgG and IgM. Although all reactions were negative for IgM, there were four positive IgG results. From the total of 205 children that were given as a minimum one micro-method, five were positive, giving an incidence of 2.87%. Of these, three were male and two female; only one was a full-term infant, but had low birthweight. The clinical examination during the months of treatment showed jaundice in two cases, paleness in two cases, and different degrees of hepatomegaly in all cases. Only three cases showed splenomegaly.

In general, treatment was well-tolerated in the newborn children. Only two cases presented abdominal distension and vomiting. In the unweaned baby, however, vomiting was more persistent and provoked weight loss, which led the family to reject the treatment.

Table 1. **Total Population and Pregnant Women Covered by the Chagas' Project, According to Migratory Status**

Migratory Status	1992 Census	Pregnant Women Involved in the Project 1993 - 94		
	Total	Total	Positive	Negative
Population	N= 682929	N= 468	N= 245	N= 223
Migrant	39.7	68.8	72.7	64.6
Native	60.3	31.2	27.3	35.4
Total	100.0	100.0	100.0	100.0

Source: INE; National Population and Housing Census, 1992. Prepared by ourselves on the basis of data from the Chagas' Disease Project, 1994.

Socioeconomic Component

The population of the city of Santa Cruz has been growing at annual average rates of 6.6%. In 1976, the population residing outside the fourth ring represented only 5.4% of the city's population - in 1992, it had risen to 46.6%. This uncontrolled growth of the city has resulted in numerous problems.

Almost forty percent of the people living in the city of Santa Crux are classified as migrants (that is, they were born outside the city). Children of migrants, born in the city, are not included in this figure. New migrants tend to be young men or women, who are economically and productively active. A large percentage of the pregnant women involved in the Chagas' project were migrants. Indeed, over seventy-two percent of the pregnant women who tested positive for Chagas were migrants (see Table 1).

There were no gender differences with regard to the distribution of the population throughout the various rings of the city. Similarly, there was little variation in the number of pregnant women from different rings. However, more than half the pregnant women who tested positive for Chagas' disease resided beyond the fourth ring, which is an economically poor area, with less access to basic services (see Table 2).

Table 2. **Distribution of Total Population, Heads of Family by Gender and Pregnant Women Involved in the Chagas' Project, According to Residence Ring**

Distribution by Ring	1992 Census			Pregnant Women Involved in the Project 1993 - 94		
	Total Pop.		Women as Head of Family			
	Men	Women		Total	Positive	Negative
Population	N= 338605	N= 358673	N= 35321	N= 723	N= 227	N= 496
1st ring	4.2	4.7	6.0	5.8	4.3	7.2
2nd ring	8.5	9.1	10.8	9.3	6.4	11.8
3rd ring	18.9	19.2	20.4	17.8	17.0	18.5
4th ring	20.8	21.4	21.4	19.8	21.6	18.2
Beyond 4th	47.6	45.6	41.4	47.3	50.8	44.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Outside city area				80	60	20
TOTAL				803	287	516

Source: INE; National Population and Housing Census, 1992. Prepared by ourselves on the basis of data from the Chagas' Disease Project, 1994.

The percentage of female-headed homes increased from 20.3% in 1976, to 24.6% in 1992. Only 8.1% of the pregnant women involved in the study reported that they were the heads of their families. There was a higher percentage of female heads of households among those who tested positive to Chagas' disease.

The percentage of uneducated women in Santa Cruz is more that double the percentage of such men. Among the study population, the percentage of pregnant women who had received little or no instruction was even lower than in other populations. Over sixty-eight percent of the pregnant women who tested positive for Chagas' disease had a basic or intermediate educational level, compared to 48.9% of the pregnant women who tested negative. This clearly shows that women with lower educational levels were more likely to become infected by Chagas' disease. Level of instruction may be related to the socioeconomic status of the household, access to basic services, as well as access to information on health care. It must also be remembered that a high percentage of these women were migrants.

While over half the female heads of households took part in economic activities, the overall percentage of women involved in economic activities continues to be lower than men. Among the study population, only 23.1% of the pregnant women were involved in economic activities. A higher percentage of pregnant women who tested positive for Chagas' disease were part of the formal workforce (26.1%), compared to those who tested negative (21.1%).

About fifty percent of the families in Santa Cruz have their own homes, although this does not necessarily mean that the homes are of good quality. The percentage does not vary greatly according to the gender of the head of the family. Nevertheless, a lower percentage (42.3%) of the pregnant women in the study owned their own homes. The high percentage of women who rent their homes may be related to the number of women who work as "maids" and live with their employers.

Among the women studied, there was a general lack of information about Chagas' disease, or about its vectors and transmission. Over 35% of those who tested positive to Chagas had heard of the disease, compared to 29.1% of those who tested negative. With regard to the vector, 91.4% of those who tested positive claimed to know of the "vinchuca," compared to 78.5% of the pregnant women who tested negative to Chagas. Much of the information held about the disease was based on speculation or mythical beliefs. However, 62% believed that their illness was due to the bite of the "vinchuca." Among the mythical beliefs, 15% of the pregnant women believed they were subject to witchcraft (sorcery or some other evil spell), or that they were infected by another person.

Psychosocial Component

Interviews

Two-hundred and twenty women were interviewed. Fifty-one percent were concubines, 33% were married, and 16% had no partner. When informed about their positive status, the women expressed a number of fears including: fear of dying of the disease, fears concerning the birth of the baby, fears about transmitting the disease to other family members, fear of having sexually transmitted the disease to their partners, as well as concerns about the possible reactions of partners. On the other hand, the pregnant women were hopeful that

they could receive a treatment or a cure, follow the recommendations of the doctor, consult a social psychologist, and receive family support. The subsequent behaviour of the pregnant woman was related to protection of the family from the disease, the elimination of the vinchuca, cleaning the house, warning neighbours, and family planning.

The majority of the pregnant women had few resources and lived in marginal neighbourhoods. Their relationship with the health services available in the city was confined to visits when a family member was seriously ill. Visits for prevention purposes were rarely made.

Seventy percent of the infected pregnant women believed that Chagas' disease was a terrible reality which must be faced. Seventeen percent of the women were ambivalent about the disease, while 13% felt that the diagnosis was positive since it would lead to adequate treatment.

Thirty men who were partners of infected women were also interviewed, and their fears related to the disease were discussed. Most of the men did not know how to respond, worried about their partners, as well as about the possibility of becoming infected through sexual intercourse. They hoped that their partner would get well, that the baby would be born healthy, that they had not become infected, and that none of their relations had the infection. The lack of available information on the disease was also highlighted by these men.

Many men worried that their partners would infect their children and warned their children to "be careful of your mother because she may infect you." Many of these men felt that they should have no more children in the future. They also tended to blame the women for the disease.

Focus Groups

Forty women (out of fifty-three possible participants who were between 28 and 34 weeks pregnant), took part in the focus groups. This group of pregnant women expressed fears and anxieties about the birth of the baby, about having infected their other children, about having infected their partner sexually, about social rejection, and about the erroneous information they had received about Chagas' disease.

Apprehensions were due to obsessive thoughts, as well as because of information from family members, relatives and acquaintances. Family members were generally curious about the disease, and tended to learn about it, and then make recommendations for treatment. Acquaintances caused the most distress for the pregnant women since they sometimes gave dramatic descriptions of the disease, of its dreadful symptoms, and the way that it leads to death. Discussing the disease with family and friends, and hearing their stories about others with the disease, led many women to grow more and more apprehensive about the future.

Upon learning that they had the disease, women either exhibited disability and chronic illness, resigned themselves to the disease, or took responsibility for their health care. Fifty percent of the participants declared that they did not have "vinchucas" in their homes, while 30% said that they did, and 20% said it was possible since they lived near houses with "vinchucas." An overwhelming 85% of the participants believed that the health services were not doing an appropriate job to prevent the illness. Ninety percent of the participants asked for information about how to prevent and avoid infection by Chagas' disease.

Communication among participants was good and there was constant interaction concerning their health problem. The women decided to face the disease, and accept the health recommendations and instructions. Questions concerning emotional factors were answered by the social psychologist, while clinical questions were answered by the doctor. The information received by the participants was tailored to their understanding and socio-cultural level. Information on how to prevent the illness related to personal care, cleanliness, housing, and medical care.

Home Visits

Fifty-one home visits were carried out. Twenty-five were aimed at sensitizing the pregnant women who did not come to collect the serological diagnosis. In the other cases, the home visits were aimed at listening to the problems of the pregnant woman or her family (distilling fears, orientating before the diagnosis, correcting erroneous beliefs, and providing positive stimuli related to their health). Five women were psychologically supported because their baby had congenital Chagas.

Conclusion

This project, which is still underway, revealed a number of interesting findings. One of the primary risk factors of Chagas' infection for women of low socioeconomic status is the lack of information about Chagas' disease and the way it is transmitted. While the number of Chagas' infections is not large, it is nevertheless a preventable disease whose transmission is unnecessary. If there are further increases in the number of migrants into Santa Cruz, or other urban and peri-urban areas, the number of uneducated people who are unaware of Chagas will also increase. As a result, incidence and prevalence of the disease will climb. Crowded peri-urban conditions will also hasten the spread of the disease. Further efforts must be placed on upgrading and expanding health services for this growing migrant population, as well as increasing education and knowledge of the disease and its vectors. As was indicated in the paper, women tend to be blamed for both incidence and transmission of Chagas', and without greater awareness, this trend can only bring further stress on this population.

References

Azogue et al. 1981. Transmisión congénita de la enfermedad de Chagas en Santa Cruz, Bolivia. I - Epidemiología. *CENETROP Information Bulletin*, Vol. VII. Single Nr.

Barcuse, A.F.; Eposto, M.O.; Mandel, S.; Souza Martínez F. 1978. Enfermedad de Chagas congénita en áreas no endémicas. Medicine (Buenos Aires) 38:611 - 615.

Bittencourt, A.L. 1976. Congenital Chagas' Disease. *Am. J. Diss Child* 130-97-103.

Dávalos J.; Peña F.; Foianini H. 1989. Chagas congénito. Estudio retrospectivo: julio 1979 a junio 1989. "Dr. Percy Boland" Maternity. National Pediatrist Congress. La Paz, 1989. III Latin American Congress of Tropical Medicine, Mexico 1990.

INE: National Population and Housing Census. 1992. La Paz, Bolivia, 1993.

La Fuente, C. 1983. Longitudinal Epidemiological Studies. Bolivia, Vallegrande, Santa Cruz (Southeast Bolivia) UNDP/WORLD BANK/WHO Special Program for Research and training in tropical disease. Report of the meeting on longitudinal epidemiological studies on Chagas disease. pages 2-10. Rio de Janeiro, Brazil - February 28 - March 3.

La Fuente C.; Urgel R.; Darras C.; Saucedo E. 1985. Uso de tubos de microhematocrito para el diagnóstico rápido de la enfermedad de Chagas y Malaria *Ann. Soc. Belge Med. Trop.* 65, Suppl. 1-95-99.

Salamanca, Valle de Choafa, Chile Parasitología al Día. 11-97-100.

Valencia, T.A. 1990. Investigación epidemiológica Nacional de la enfermedad de Chagas disease. Ministry of Social Security and Public Health.

Vargas, M. 1988. Ciudad de Santa Cruz: Características sociodemográficas de la población. CORDECRUZ/UNFRA/PREALC/OIT. Santa Cruz-Bolivia, 1990.

Zuna, H. Garrón, A.; de Muynck, A.; Balderrama, F.; y Ribera, B. 1978. Endemia Chagásica en Santa Rosita y Villa Rosario. Barrios marginales de Santa Cruz de la Sierra. Bol. Inf. CENETROP Vol. IV Nr. 304 pages 98 - 106.

Zuna, H.; Recacochea, M.; Bermúdez, H.; De Muynck, A.; Cardoso, L. 1979. Infección Chagásica en trabajadores agrícolas temporales y sus familias, proyecto Abapó Izozog. Chaco Boliviano. CENETROP Inf. Bulletin. Vol. V, Pages 16-21.

Gender Differences in the Acquisition of Forest Leishmaniasis

Clara Cárdenas Timoteo and Alejandro Llanos-Cuentas[1]

Introduction

The purpose of this document is to describe the differences between men and women in the acquisition of forest leishmaniasis. The differences are the result of the different economic roles attributed to each sex. Part of the information analyzed is taken from an epidemiological survey completed within a research project currently being conducted in the Kosñipata Valley (Paucartambo Province, Cusco Department) in the Peruvian forest.[2] The findings from this survey point to the need to introduce a gender perspective into studies of leishmaniasis. This is necessary in order to understand this disease in a more holistic way. A gender perspective would also assist in the designing of preventive and treatment strategies which include the active participation of women who have historically been responsible for family health care.

Gender and Health

A gender perspective strives to address the inequality between women and men in terms of their development, as well as the forces which perpetuate or help to modify the situation. With a gender perspective, it is clear to see that there are many differences in the way the health of women is achieved and perceived in comparison to that of men.

When addressing women's health, health plans and programs have been principally concerned with the reproductive function of women. The fact that women have not only a reproductive role, but also a productive one (by helping with the economy of the family), as well as a role in the community[3], is often overlooked. The combined burdens and hazards of the many roles of women are rarely taken into account when health issues related to women are considered, or worse still, when preventive or corrective actions are designed.

---

[1] "Alexander Von Humboldt," Institute of Tropical Medicine, Universidad Panama Cayetano Heredia, Lima, Peru.

[2] A study of the social, economic and cultural factors that have a role in the transmission of mucous/cutaneous leishmaniasis to migrants to the Peruvian forest. Project 920681 TDR/WHO.

[3] A clear example of the managerial role undertaken by women is to be found in the settlements around the larger cities, where the most active popular organizations providing effective relief from deteriorating economics and health are the "mothers' clubs, popular canteens, Milk glass committees" etc., created and run by mothers.

Adopting the WHO definition of health, which recognizes that health is "the state of physical, mental and social well-being of the individual," it is evident that the achievement of good health involves many dimensions: adequate nourishment (meaning the provision and processing of foodstuffs), obtaining water and fuel, good hygienic practices, the care of small children and the sick, and so on. In the majority of households around the world, these activities are mainly the responsibility of women.

When considering the extent of the participation of women in health plans and programs, there are two aspects to be acknowledged:

- Women's condition and participation is "invisible." When one refers to the community, the people, the patients, and the population, the differences within these categories are not acknowledged, and it is assumed that men and women stand on an equal basis. Data collection does not take gender differentials into account, the specific problems of women are not acknowledged, and their participation at decision-making levels is not taken into account.

- The fundamental role played by women in health aspects should also be acknowledged. Their participation is required to implement schemes, thus overburdening their already busy routine. Working proposals generally have to do with children or family health issues without considering the health needs of women. In addition, when planning these proposals, no attention is paid to the women who will implement them.

The health concerns of women, and avenues to ameliorate the health of women, are not adequately addressed. An attempt must be made to make the chores of women less burdensome, and establish consultation and participation mechanisms for women at all decision-making levels.

Acquisition of Forest Leishmaniasis from a Gender Perspective: The Case of the Kosñipata Valley

Kosñipata has become an Andean migrant establishment area. Between June and December 1993, an epidemiological survey and census was conducted, as well as an anthropological survey including seven communities of the valley.[4] The census covered a total of 1901 inhabitants and constitutes the sample for a study currently being conducted that has provided some of the results which have been analyzed in terms of differences by gender. This sample represents 58.5% of the total population of the district which had 3,249 inhabitants in 1990 (Pilcopata Health Centre Census).

[4] These communities are: Pilcopata, Patria, Coloradito, Pelayoc, Atalaya, Tupac Amaru and Chontachaca.

Geography

The Kosñipata Valley is located in the district of the same name, Province of Paucartambo, in the Department of Cusco. It has an area of 3565.78 km^2 (INEI). The average temperature is 23 degrees centigrade. It is classified as an area of high forest. The district has a total of twenty-four communities or hamlets. The majority of these communities have a dispersed pattern of settlement, from one to five kilometres away from each other. This situation makes communication between the inhabitants very difficult.

The main access to the capital of the district is an unpaved road which leaves Cusco and crosses the entire district heading to Madre de Dios. The use of this road is extremely difficult in rainy weather. The usual transportation is by means of cargo trucks. Within the valley, access between the settlements is largely by footpaths, although there are communities which can be reached only through the use of canoes or wading ("oroya"). Telecommunications do not exist, other than the use of messengers.

Social Structure

In the seven communities studied, there was a total of 360 families, with an average of six members in each family. The present population is the product of migratory waves which originated in mountain areas, mainly Cusco, Puno, and Apurimac. The migration waves have increased since 1960, when the penetration road reached Pilcopata, making the valley both a passageway and a stopping place for migrants. The male population constitutes over 50% of the total population, with a masculinity index of 1.15 (see Chart 1). The population is predominantly young, with most of the population being between 15 and 44 years of age. The reduced population in the 0-5 bracket could be explained by the constant turnover of families, rather than by a low fertility rate in the area.

In terms of educational levels (see Chart 2), over one half of the population surveyed (over 6 years old) had at least a basic level of instruction and could read and write. The survey however did not include "operational illiteracy" (i.e., persons who have attended school for one or more years, and who have lost the ability to read or write due to lack of use).

Due to their Andean origin, the majority (65%) of the population surveyed speaks the Quechua language, as well as Spanish, a characteristic shared by men and women.

Chart 1: Population of the Seven Communities Surveyed in the Kosñipata Valley According to Gender and Age Groups

Age Groups	Women		Men		Average	
Age	N	%	N	%	N	%
< 1	29	3.40	39	4.01	68	3.73
1 - 5	152	17.86	168	17.28	320	17.55
6 - 14	234	27.49	242	24.89	476	26.11
15 - 44	341	40.07	377	38.78	718	39.38
45 - 64	76	8.93	114	11.72	190	10.42
65 +	19	2.23	32	3.29	51	2.79
Total	851	100	972	100	1823	100

no information: 78 cases

Source: Epidemiological Survey 1993, Socials Project: 920681,
Instituto de Medicina Tropical, "Alexander von Humboldt"

Chart 2: Educational Level of Population over age 6 (Percentages)

Educational Level	Women	Men	Average
None	18.70	8.05	12.60
One Level or More*	86.37	91.94	87.39
Total	100	100	100
Number of Cases	631	757	1420

* Only primary or primary and more (secondary, higher)

Source: Epidemiological Survey, 1993, Socials Project: 920681
Instituto de Medicina Tropical, "Alexander von Humboldt"

Differential Acquisition of Leishmaniasis by Gender

Kosñipata is considered a high risk area for forest muco-cutaneous leishmaniasis. The local peasants use different terms to refer to this disease: uta, mosquito bite, spider bite, pujio, ukuya, old man killer, sulla uta. In general, the most commonly used term is "uta." There are also several ways in which the settlers classify the disease. These classifications are based on the size, shape and colour of skin lesions.

The disease is not attributed by all to the Lutzomia bite, known in the area as "white back" ("manta blanca"). It is frequently attributed to a spider's bite, contact with stale water, contact with the morning dew, contact with the "toroq" tree, mosquitoes or butterflies. At times, a magical causality is also recognized: lack of payment for land, a signal of God, envy, or fear.

Three kinds of treatment are used by the population: herbs (washing, ablutions, infusions), home remedies (application of heat or acid from batteries), and pharmaceutical drugs (penicillin, merthiolate, glucantime). These treatments may be used simultaneously or one may be preferred until the expected results do not occur. At that time, another one is chosen. The majority prefers herbal treatment as the first option.

Until December 1993, the standard treatment based on Glucantime was provided free of charge, except for symbolic payment for the use of hypodermic needles. All patients, however, do not attend the places where this type of treatment is offered.

Acquisition of the Disease

The results shown by the epidemiological survey indicated that men acquire the disease in greater numbers than women. The disease presents itself with greater frequency in the 15-44 age group for both men and women (Chart 3).

The presence of a high percentage of the population who were "free of disease" at the time of the survey could be explained by the fact that recent immigrants to the valley would have had shorter exposure, and would not have yet show signs of infection. A Montenegro test was applied, with over 90% not presenting the infection. Of those who were infected, the majority suffered from the cutaneous form of the disease.

Chart 3: Distribution of the Population under Census According to Lack of Lesion ("With no Disease") and with Active Lesions or Scars ("With Disease") According to Gender and Age

Age	Women				Men				Total	
	No D		D		No D		D		No D	D
	N	(%)	N	(%)	N	(%)	N	(%)	N	N
-1	30	(3.92)	0	(0)	38	(5.05)	1	(0.48)	68	1
1-5	149	(19.5)	2	(2.46)	170	(22.6)	0	(0)	319	2
6-14	224	(29.3)	12	(14.8)	222	(29.6)	21	(10.1)	446	33
15-44	281	(36.7)	56	(69.1)	250	(33.3)	117	(56.6)	531	173
45-64	65	(8.49)	9	(11.1)	55	(7.32)	52	(25.1)	120	61
65+	16	(2.09)	2	(2.46)	16	(2.13)	16	(7.72)	32	18
Total	765	(100)	81	(100)	751	(100)	207	(100)	1516	288

Without examination = 97

Source: Epidemiological Survey, 1993, Socials Project: 920681
Instituto de Medicina Tropical, "Alexander von Humboldt"

Analysis of the Results and Discussion

Two situations in the Kosñipata Valley help to explain the fact that leishmaniasis occurs more frequently in men than in women, at an age when the productive and reproductive functions of the human being are most intense. To begin with, the daily subsistence activities involve different chores for men and women, and are conducted in different places. Secondly, because of the condition of the Andean immigration hosting area, there is usually a movement of mainly male teams of an economically active age.

In the valley, the preferential habitat of the vector transmitting the disease is the primary wood (Pérez et al. 1991). The peasants state that "...the disease hits when one goes to the farmland or the woods." The adult males spend most of their days in the woodland areas or in the resting farmlands ("purmas"). They perform activities which are considered to be "masculine": agricultural activities, woodcutting, fishing, hunting, and so on. The main activity for the dwellers of the Kosñipata communities is agriculture, demanding long hours

from the adult males. The daily work day is ten to twelve hours long, with small intervals to rest or to eat. The main purpose of this activity is to provide nourishment for the family. Only a few of the families send a part of their produce to the market.

The farms have an average area of thirty hectares per family. Crops grown include rice, maize, "uncucha," bananas, grapefruit, sugar cane, and coca. The coca plant is a profitable crop for the area as it can be harvested two to three times per year and its price in the market is higher than any other product. The harvest of this crop is strongly related to women.

The agricultural system is closely dependent on the rain pattern, a system known as "pluvial" or "low dryland," where the soil is prepared through a slash and burn system. The low dryland system forces the farmer to use great extensions of land to obtain a greater yield. This causes an erosion effect which leads to an accelerated reduction of the fertility of the soils (Aramburu 1982; Villachica 1983). It also increases the risk of developing the disease because farmers have to move continuously to new areas, where the intensity of the transmission is greater, in order to prepare new fields. They must also travel to areas far away from the towns (and are therefore exposed to the vector's bite) to carry out wood extraction, the second most important productive activity of the valley.

The work of the Kosñipata peasant woman is more diversified, and is conducted mainly, but not exclusively, in the house or its surrounding area. Her working day starts at four or five in the morning, and ends at six or seven in the evening. The daily activity of women is not focused on farmland or the woods. This might explain the fact that the disease affects women with a reduced frequency, because women are less exposed to the bite of infected vectors.

Women's work is focused on meal preparations, childcare, housework, laundry, and fetching water and firewood. During the day, women also select and store the products harvested (for example, remove the corn from the cobs or dry the coca leaves). During market days at the capital of the Pilcopata District, it is the women who physically carry the products to the market and sell them. In addition to these activities, all women over fifteen years of age conduct some activities that involve going to the farmlands and the wood, where they may be exposed to vector. These activities occur during certain periods of agricultural activity, when the women actively help their husbands to sow the land, weed and harvest it.

Children over the age of seven go with their parents to help them with their work. Boys help their father with the farming, and girls help their mothers with the housework. At harvest time, the entire family participates fully.

The commercial growing of coca is increasing in the valley. The selling price of coca is higher than any other commodity, and some buyers even travel to the valley itself. It is sold as dry leaves. The harvest of the coca leaves is a typical task left to women because "... we

pull out the little leaves with more care than the men..." This is an occupation carried out in the evenings after the housework is finished. In order to do it, women must travel to nearby farmlands. If the growing of coca continues to increase, the number of cases of leishmaniasis in women may also increase.

Women gather wood in order to have fuel to prepare meals, wash clothes, and so on. To do this, women must travel to the woods and are therefore exposed in the same way as men to the leishmaniasis vector.

Leishmaniasis from a Gender Perspective

As with any other disease or general health problem, leishmaniasis affects women differently that it does men. This can be explained not only by the obvious differences between the sexes, but also because of social, cultural and economic reasons. These can vary in the different cultures, as men and women are situated in different levels and roles. The case of the Kosñipata workers presented here is an example.

A review of the abundant bibliography of studies on this disease existing in Peru from a perspective of gender, reveals that there is very little information on how this disease appears and affects women and men. Even if the item "sex" is included in clinical reports and epidemiological surveys, the results from the majority of the studies are not analyzed in terms of the differences by gender.

Leishmaniasis in Peru is a disease linked to work practices and is acquired during the exercise of this activity (Decree Law N.18846 Accidents at Work and Professional Disease). Because work activities vary in type and conditions for men and women, they are therefore differentially exposed to this disease. There is, however, a lack of detailed and systematized information. Moreover, very little is known in terms of gender differentials in relation to the perception of and information about the disease. There is also little information about attitudes towards treatment, and ways to provide treatment, or about the psychological, social, and economic impacts of the disease from a gender perspective. The information available about these aspects rarely goes beyond a very general nature.

With regard to health research, there has historically been an excessive emphasis on the reproductive aspects of women. Research centred on the health problems of women tends to concentrate on fertility issues, family planning, and more recently, on reproductive health, a concept that includes sexually transmitted diseases, and family and couple issues. While this approach has widened the scope of studies on the reproductive function, it has not exhausted the subject of the health of women as a whole.

When trying to create control programs for the prevention and timely treatment of leishmaniasis, the active participation of women must be considered, because women are directly in charge of the health of the family and the care of the ailing. How can such active

participation of women be achieved when so little is known about how the disease affects them? The thorough study of tropical diseases from a gender perspective has not yet begun in Peru.

References

Aramburu, C. 1982. Expansion of the farmland and demographic frontiers in the high Peruvian forest. In: Aramburu et al. *Colonization of the Amazonia*. Lima CIPA

Centre for Amazonic research and promotion. 1993. (CIPA). Leishmaniasis and temporal migration in the Southeast of Peru (Technical Report) March.

Institute for Tropical Medicine "Alexander von Humboldt". 1993. Leishmaniasis study group. Epidemiological survey of the project: Social factors associated with the transmission of forest leishmaniasis.

Ministry of Health. 1993. Norms and procedures for the control of Leishmaniasis in Peru. Lima PAHO/Italian Coop. MINSA.

Paredes, U. 1987. Health policies and the woman. En: Cambria, C., Dughi, P., and Palomino, N. ed. *Women and health*, Lima: Centre for the Peruvian Woman Flora Tristan.

Pérez, E.; Ogusuku, E.; Monje, J.; Young, D. 1990. Lutsomia (Dipt. Psichdidae) de Pilcopata (Cusco), new registration for Peru and description of Lutsomya deorsa, n.sp. IN: Per. Ent. 33:133-135 December.

Socioeconomic Impact and Gender Differentials of Cholera

Claudia Durana[1]

Introduction

The objective of this paper is to present the main results of an IDRC-funded study of the socioeconomic impacts of cholera in Colombia. In particular, it will explore the differential impact of cholera on men and women in the community under study.

In developing countries, a large sector of the society lives under precarious conditions. The incidence and prevalence of preventable diseases, such as cholera, is an indication of this situation. The socioeconomic factors affecting the health of an individual are directly related to the socioeconomic characteristics of the household, the development level of the community, and environmental conditions. An interdisciplinary perspective, which considers all these elements, would greatly enhance the analysis of the socioeconomic effects of tropical diseases.

Socioeconomic Impact of Cholera

Cholera is an acute, infectious, transmissible disease caused by a gram negative bacillus, the *Vibrio cholerae*. It can appear in both endemic and epidemic forms. The *Vibrio* produces diarrhea which may cause death within hours. The main factors leading to the transmission of cholera are associated with contact with cholera patients living in the same household, and the absence of a basic system of waste management/sewage system at the community level. The primary treatment for cholera is oral rehydration. According to the literature, in areas chronically affected by cholera, the incidence is higher for children, while in epidemic areas, every age group has the same risk of contracting the disease.

The cholera research study is currently taking place in the two largest Pacific Coast cities in Colombia: Tumaco and Buenaventura. These cities were the most affected by the cholera epidemic which occurred in 1991-1992. By 1985, the population of Tumaco had grown to 92,230 inhabitants, with 193,185 in Buenaventura. In Tumaco, the cholera epidemic resulted in 1799 cases in 1991, and a further 641 cases in 1992. In Buenaventura, the numbers were 1244 in 1991, and 277 in 1992. The total number of cholera cases in Colombia during these years was 30,500.

[1] Faculty of Economics, Universidad de los Andes, Bogota, Colombia.

The main objective of the project is to study the socioeconomic impact of the epidemic at the individual, local, regional and macroeconomic levels, analyzing the information from an interdisciplinary perspective in order to develop a holistic understanding of the problem.

Primary Results: Effects at the Household Level

The methodology used for the individual and household level analysis was based on interviews with 250 households which had cholera cases, and the same number of control households which had not had any cases. This methodology allowed for a comparison of the two populations, in order to attempt to understand the socioeconomic factors associated with the disease.

Preliminary data showed that at the household level, the disease had numerous psychological and social effects. These effects ranged from the pain associated with the symptoms of cholera and problems caused by physical disability, to social stigma. All social and economic activities of patients were temporarily affected by the disease; as well, some activities of other family members were also affected. Other preliminary results of this analysis demonstrated both the low sociocultural level of the studied population, as well as a general lack of information about the disease.

This lack of knowledge is not surprising, given that cholera has not been accounted for in the Colombian morbidity profile since the last serious outbreaks which took place at the end of the last century. From the beginning of this century, cholera has not been perceived as a public health problem. During the recent epidemic, even knowledge of cholera by medical doctors was minimal, and most physicians were forced to make a quick study of the disease in order to design adequate control and treatment programs.

In particular, the study found a lack of knowledge among the population about disease contagions (through water and food) and about symptoms of cholera. Preventive measures against cholera, such as sanitary measures and boiling water, were utilized by people as an emergency procedure, not as a permanent behaviour, while adults generally had deficient daily hygienic habits. While people recognized that children were in permanent contact with garbage and wastewater, they generally imputed the cause of the disease to hazard and destiny, an attitude which may be associated with low educational levels.

Life Conditions and Cholera

The life conditions found in the interviewed households were inadequate, as indicated by poverty and a lack of basic services and welfare. In Tumaco, 50% of the houses were constructed at sea level, 90% of floors and walls were made of wood, and 80% threw household garbage into the sea. In Buenaventura, 37% of the houses were constructed over water, most of the floors (59.7%) and walls (66.8%) were made of wood, 66% of the garbage was thrown into the sea, and 60% of the households infected with cholera in this

city drained their sewage and garbage waste directly into the sea. The environmental and sanitation conditions were inadequate, without garbage collection services or a sewage system in 85.9% of the households in Tumaco, and in 77.2% of the households in Buenaventura. The expenditure distribution in both cities reflected that observed in other poor households in Colombia, with a high proportion of household money being used to buy food.

The study demonstrated that there are a number of differences which exist in the level of subsistence in the households with cholera, and in those without the disease. A low socioeconomic and cultural level and environmental stress were found to be common factors in the households with cholera. Incidence of disease further deteriorated the expenditure pattern within these households, as the proportion allocated to purchase food became redirected to health expenditures, such as hospital, transport and medicine. Poverty in these cases was related not only to socioeconomics, but also to racial differences: a large percentage of the population in most of these cities is black.

Effects at the Regional Level

At the regional level, the objective of the study was to analyze and quantify the effects of cholera on the main local productive activities. These are tourism (access of people to Tumaco and Buenaventura) and fishing (the main productive activity in these cities).

The impact of the cholera epidemic on the entrance of people to both cities has been quantified, observing the difference between the "cholera year" (1991) and 1990. The entrance of people decreased in 1991 by 57% in Tumaco, and by 78% in Buenaventura. The income represented by these tourists includes the money spent by those people in hotels on food and other local services. The drop is very significant for Tumaco, which has several beaches that are regularly visited by local tourists.

Fishing activities can be classified as either small-scale fishing, which is the main activity of the lower classes, or industrial fishing. The small-scale fishing activities produce fish for local and some national consumption, while the main market for industrial fishing activity is the international market. The effects of cholera on these activities were calculated, taking into account changes in income during the critical year the epidemic (1991) in the Pacific Coast region. It was observed that the income of small-scale fishing decreased in both cities, falling by US$732,458 in Tumaco and US$2,802,385 in Buenaventura, while industrial fishing income increased by US$6,176,634 in Tumaco, and US$17,801,649 in Buenaventura.

The explanation for the decrease of small-scale fishing income is that demand in the local and national market was affected due to misleading information and publicity about the risk of eating fish from areas affected by the cholera epidemic. Meanwhile, industrial fishing activities faced no marketing problems, and therefore were able to buy cheap fish and export it at a profit, thereby increasing their income.

It can be seen, therefore, that the cholera epidemic in the Colombian Pacific Coast affected not only poor people's health, but also had consequences on their economic activities. More than a disease, therefore, cholera is a social problem which is directly related to poverty and marginality, and can be taken as an indicator of these elements in human communities.

Gender Differentials of Cholera

Bonilla and Vlassoff (1991) pointed out a main element of a gender analytical framework for health research is to recognize that gender differentials do exist. While both males and females in the areas where tropical diseases are endemic suffer from class inequality, poverty, and deprivation, women are particularly disadvantaged due to structural factors within society. They are frequently made completely economically dependent on men and are allotted a considerably lower social status. Consequently, it is important to observe the gender differences of cholera in terms of women as health promoters and preservers in the household, of women's risk of contracting the disease, and in terms of the consequences of the disease for women. Within a broad sociocultural and economic context, researchers must take into account women's economic or productive activities, both within the home and outside, their social roles and interactions with others, as well as their personal attitudes, perceptions, and needs. It is therefore necessary to consider the different effects of cholera upon women.

Gender Differences of Risk

The risk of contracting cholera is also differentiated by gender. The role of women in the promotion and preservation of health in the home may be seen as a factor which affects their risk of contracting the disease. Their roles related to work can be divided into two types: (1) the responsibilities of market-oriented activity, contributing to the household income; and (2) the responsibilities of domestic work as a mother, a wife and a housekeeper (Bonilla 1991). Women living in poor housing, those responsible for fetching water outside the household, and women living or working in households constructed over contaminated water, (as is the case in most of the households located in the studied community), face a higher risk of contracting the disease. Women also risk contracting the disease while caring for other sick family members.

Household Effects when Women are Ill

The economic effects of illness upon women must be measured not only by the consequences to the labour force; effects on the household as a whole must also be taken into account. In every community, domestic tasks are essential to the maintenance of the labour force, including child-rearing and provision of health to family members. During their period of incapacity, women must continue to do some domestic activities which are essential and difficult to defer. Therefore, it usually takes longer for women to fully recover from disease. Women also take less care of themselves while they are ill, as they are more

concerned about child care. On the other hand, if the woman is hospitalized, domestic activities must still be done, so time spent by another family member on these chores results in less time being spent on remunerated work and study. Labour activities of women themselves are deferred or interrupted during an illness, with the respective economic costs.

Effects on Women when Others are Ill

The average hospitalization time of cholera patients was three days, and in most cases there were long periods of convalescence (8-15 days). When other members of the household were ill, women either had to take care of the ill family member or replace him/her at work. Women's working days therefore became longer, their work load became heavier, and some of their own activities had to be deferred. There were also social and emotional costs related to the disease situation. Cholera was perceived as a serious disease for which symptoms appear suddenly, and which can quickly lead to death.

Conclusion

The study on the socioeconomic impact of cholera demonstrated that those most affected by the disease were the poor and underprivileged, because of their low socioeconomic and cultural levels, and the environmental stress caused by the lack of basic services. These effects were also differentiated by gender. In the studied community, many women had to work for paid income because of the low income of other members of the family. Women in these cases also had the main responsibility of carrying out cholera preventive measures in the household, boiling water, cleaning the inside and around the house, and taking care of the children.

Women are largely responsible for health promotion and preservation in the household. A cholera epidemic increases the responsibilities, worries, and work of women. The precarious working conditions at the household level, and the responsibility of caring for ill family members, increase the risk of women contracting the disease. During their own illness period, women's activities are affected, and this has direct implications for other family members.

Gender differences of cholera negatively affect women and the community as a whole, producing economic, social, and psychological costs, taking into account not only women's formal labour activities, but also including household work, child-raising, and health provision for family members. Women should be involved in the planning and implementation of projects and programs of cholera prevention. Measures should be taken in the household, not only as an emergency program during an epidemic, but as permanent activities aimed at improving the well-being of the families, and the community as a whole.

References

Bonilla, E.; Kuratomi, S.L.; Rodriguez, P. y Rodriquez, A. 1991. Salud y desarollo: Aspectos Socioeconomicos de la Malaria en Colombia. Plaza and Jane, Bogota.

Bonilla, E.; y Vlassoff, C. 1994. Gender-related differences in the impact of tropical diseases on women: What do we know? J. Biosoc Sci 26(1 p 37-53. England.

Popkin B. 1982. A household framework for examining the social and economic consequences of tropical diseases. *Soc Sci Med* 16. p 533-543.

Discussion

Following presentations by Elsa Sarti (Mexico) and Jenny Davalos (Bolivia), a general discussion took place on the topic of Tropical Diseases and Gender. The following points were raised:

- Gender issues have been widely overlooked in the study of tropical diseases. One participant reported that, prior to coming to this workshop, she had tried to find studies related to gender and tropical diseases in Peru. During her search, she discovered an overwhelming absence of analysis on this subject. While epidemiological studies have looked at sex differentials, there has been no gender analysis.

- Sometimes the term gender is confused with the word sex, although there are important differences. Research must always introduce the gender variable, which is concerned with social construction and the different universes of the feminine and masculine communities. For example, by considering gender, associations between disease patterns in females and their domestic activities may be uncovered. Women become transmitters of disease through the social role they play in the home. If a woman cooks and does not wash her hands, she runs the risk of contaminating the food. This may lead to the transmission of the disease to other family members when she serves the food. Furthermore, because women usually give the best portions of food to other family members and take tiny amounts of food for themselves, they often suffer from poor nutrition, making themselves more susceptible to disease.

- Women play an important role in the promotion of health in the home and in the community. Men must be encouraged to take on a more active role in health promotion, rather than leaving the responsibility to women. Health should not be seen as a woman's domain.

- Specific cultural practices are very important determinants of the spread of disease. In Peru, men suffer from leishmaniasis more than do women, which may be related to cultural practices and their work activities in the forest. While men are more likely to suffer from this disease, women are often affected more significantly, psychologically and socially. Women are primary care givers. The economic impact of a disease can be severe. A sick male family member increases the burden on the family, especially the female members.

- Different cultures demonstrate different gender patterns. Very different patterns of disease transmission may emerge in indigenous groups.

- Disease means different things for and to women and men. A disfiguring disease may have a more severe psychological and sociological impact on women than on men.

- In an effort to eliminate the spread of disease, health education interventions which focus on teaching mothers and school children preventive practices, including basic sanitation methods, would be helpful.

- Fluctuations in the economies of Latin American countries have led to the availability of insufficient resources to introduce appropriate education or intervention strategies for disease control. This makes it difficult to improve the health situation in these countries.

- The gender component of research cannot simply be added to a study as an afterthought. It must be fully integrated into the research as it is conceived, carried out and analyzed.

- Introducing a gender perspective is not simply about methodology. A gender perspective must also look at the extent to which historical and political factors help to explain patterns of disease. Policies cannot be separated from everyday lives. Social change at a number of levels can lead to a decrease in the prevalence of disease. Increasing the power of women is an important objective. As well, governments must be more democratic and communities must have more power. The direction of health research can only be changed by influencing politicians and decision-makers. It is not enough to simply obtain drugs and education. If we continue to overlook the political dimensions of health, we will never get to the crux of the matter.

Indigenous Peoples' Health Issues

New Models of Participation in Indigenous Peoples' Health

Xochitl Herrera and Miguel Lobo-Guerrero[1]

Introduction

There are a number of phenomena which are endangering the quality of life for indigenous women and the health of their children, including the transformation of indigenous subsistence economies into income generation economies, the continued need for indigenous peoples to gain social and political ground, and the alteration of traditional cultural values. A control program studying the growth of indigenous children under five years of age, carried out jointly by the Etnollano Foundation (a NGO), and the "Vichada Sectional Health Service" (a government organization), with the support of IDRC, has led to a greater awareness of acute family problems. The results of this program will allow for an analysis of associated economic and cultural problems. This paper examines the need for professionals and institutions to assume clear roles in the development and protection of indigenous cultures, as well as the need for a clear delineation of the roles to be played by men and women confronted by sociocultural and environmental changes.

New Models of Participation

Indigenous Peoples in Colombia

Two percent of Colombia's population, approximately 600,000 people, are indigenous. Indigenous groups have historically fought for their physical and political rights. Despite their minority status, there are now important national and regional organizations of indigenous peoples which are represented before the Congress of the Republic. These organizations have assumed a leadership role in terms of local development programs.

Colombia is a country of great cultural diversity. It has eighty different ethnic groups, which, in the majority of cases, have shown a preference to remain distinct. Within the indigenous populations, it has been the men who have taken responsibility for representing their people in different areas and at different levels. Men are found on the boards and committees of indigenous political organizations at the national level. At the regional level, men are found at the negotiating tables where working agreements are reached with the institutes which undertake development programs. Men are also found at the rivers and in the villages, selling food and handicrafts made at home.

---

[1] Etnollano Foundation, Bogota, Colombia.

In many indigenous societies, men have traditionally been in charge of public and commercial matters, in addition to being in charge of other tasks ascribed to their sex through the division of labour. Serious problems arise when this relationship becomes unbalanced. Such an imbalance tends to occur with increased indigenous participation in economic and political areas. This increased political participation separates the men physically and socially from their communities, their cultural values, as well as their families.

As a result of this separation, a series of phenomena have arisen which directly affect the health of the population in general, and of women and children in particular. For example, in many communities, there has been a deterioration of the family diet, an intensification in the use of the soil and natural resources, and a weakening of norms which have traditionally protected the family. These situations have not occurred in all of Colombia's native villages. There are marked differences in social, economic, and political development levels in the different regions. The health situation of mothers and their children, as well as the participation of women in extra-domiciliary contexts, is very different in the region of the Andes, compared to the low-lying land in the East, the Atlantic, or the Pacific. Cultural solutions for social reorganization likewise differ widely from one region to another. Nevertheless, a commonality does exist which needs to be closely examined.

Vichada is an area of eastern Colombia. The population in this area is mainly indigenous (60%) and multi-ethnic, with an important presence from the Sikuani, Piaroa, Curripaco, Piapoco, and Puinave groups. There is also a minor presence of the Saliva, Amorúa and Cuiba communities (Ortiz and Pradilla 1987). Work carried out in the south of Vichada, a border region lying between the plains of the Orinoco and the Amazon forests, raises some interesting issues about the relationship between social transformations and family health.

Communities in this region, like many communities of the rain forests, have faced very rapid processes of change over a very short period of time. They have faced periods of violence, group disintegration, religious proselytizing, and constant trickery by politicians and traders. There has been an intensification of commercial relationships with the non-indigenous world, resulting in the alteration of many cultural values. During the past thirty years, money has become an indispensable element in the lives of the people in these communities.

The situation found in this region does not differ markedly from similar situations in many other parts of the world. There has been a widespread transformation of horticultural and gathering societies into agrarian societies. With these transformations, "men and women alike undergo change in their economic roles; domestic routine and life outside the family are subverted, and a critical reorganization of institutions, norms, and social values becomes imperative" (Martin and Voorhies 1978). The indigenous populations of eastern Colombia are not unique in their processes of change. However, one particular characteristic of these

populations is that they inhabit poor regions which cannot bear large harvests of a single crop without large quantities of insecticide and fertilizer. As Hecht and Cockburn (1993) pointed out, the Amazon forests will never become "the world's granary."

The intensification of horticulture which is occurring in Vichada, poses a serious problem to regional development. The universal pattern of economic change often leads to the social and cultural destruction of a people, as well as the destruction of their environment. The changes may also have serious health implications.

Recently, children of forty-six indigenous communities belonging to five different ethnic groups, were studied. In work carried out with the Piapoco, Sikuani, Puinave, Curripaco and Piaroa, height and weight of children under five years of age was examined. By means of bi-monthly measurements, as well as in-depth medical and anthropological research carried out with each underweight child, it was possible to obtain important insights into the social and cultural problems of these communities.

In this program, malnutrition is not treated in isolation, or individually with patented vitamins, or with "bienestarina" (a complete food produced by the government for free distribution to schools and communities). A child suffering from malnutrition is considered to be an expression or warning signal of a poor family or community situation, originating from a combination of multiple factors.

The growth graph of a community is a learning tool. The identification of an underweight child points to problems within the entire family, as well as in the community. Through these family and community analyses, concrete situations have been unearthed which affect men and women in different ways, and threaten the integrity of the family, as well as having negative consequences for the health of the child population. The following sections describe some situations commonly identified in the background of underweight children.

Replacement of Subsistence Activities by Income Generation Activities

The replacement of subsistence activities with income generation activities is an important transformation for many indigenous communities in this region, and underscores many of the other problems of change. Each indigenous family usually has two or three *conucos* (plots or smallholdings) for home consumption. These traditional *conucos* are sown with a great variety of products, which together constitute a balanced diet and maintain the quality of the soil (for example, pineapple, mapuey, yucca, peppers, seje, lulo, and so on) (Rojas 1992). These *conucos* are turned over communally by the men, under a slash and burn system, and then sown and harvested by the women. In some cultures, the man helps the woman with these tasks. The *conuco* has also been the place where the family, during their working hours, consumes an important proportion of their food, since it is there that women and

children eat insects and ripe fruit, accompanied by mañoco (yucca flour or manioc root), together with dried fishmeal taken daily by the mother to her workplace (Lobo-Guerrero and Herrera 1990).

The products from the family *conuco* do not provide much in the way of a surplus which can be sold, and there is little demand from the traders who ply the river buying or bartering modern consumer goods, such as clothes, batteries, cloth, gasoline, and so on. Both the river traders and the village traders want goods of another nature, such as cocoa, bananas, maize and yucca, which has been processed as mañoco. The tendency which has been observed and analyzed among the families, has been for the traditional *conucos* of family subsistence to become increasingly dedicated to the planting of these commercial crops, transforming them into single crop plots. If one asks a family whether they have a good *conuco*, the answer frequently is: "yes, we have a big *conuco*, full of bananas." This is regarded as something to be proud of, even though it affects the eating habits of the family, substantially reducing the components which provide vitamins and vegetable protein.

Apart from the immediate consequences which this has had on the nutritional status of mothers and children, in the medium and long term, the soil will be exhausted. The soil used for crops in the Orinoco basin, like the soil used in the Amazon rain forests, is fragile and will not bear intensive cultivation for commercial purposes. As men become increasingly engaged in commercial activities, the traditional turning over of the soil is affected, and man-made decisions regarding the use of the soil become paramount.

Women are not necessarily opposed to intensive crops which are produced for sale. Women also need goods from the marketplace which cost money. However, women do not make the decisions with the institutions which are in charge of promoting intensive agriculture in these forest lands. Women are also excluded from the processes of the institutions which oppose this trend. Unfortunately, many government institutions have not adopted policies of sustainable development, and some promote programs of production without considering the potential negative consequences for the ecology and health of the population.

The need for money has led to other serious situations. Farms are abandoned for fishing activities earlier and earlier. Traditionally. this only occurred after the land was prepared for sowing. In December, which is the month in which the men traditionally turned over and burned the soil, many families now leave their homes in order to get ahead of the other fishermen, and obtain enough fish to take to the market. Upon returning to their communities after the summer, these families have little food of their own, and must decide either to move temporarily to another village where they have relatives, or stay in their own village, undergoing hardship throughout the winter. This situation is found primarily in communities close to towns. Detrimental health effects include childhood growth problems.

Loss in the Distributive Value of Food

In the Orinoco and Amazon basin communities, food has more than nutritional value - it also has value as a means of social solidarity. Indigenous cultures have traditionally had systems of exchange based on family relationships, which ensured the circulation of goods and services. Foodstuffs entered these networks of exchange and reciprocity, favouring the diversification of family diet. In the Cuiba tribe, for example, the father-in-law traditionally provides his son-in-law with foodstuffs and "sweet" products, such as honey and fruit, and expects to receive "bitter" products in return, such as yucca and meat (Arcand 1976).

Products purchased with money do not enter this system of exchange and cultural distribution. Rice, bottled milk, and cornflour, therefore, are not exchanged or distributed socially. As the proportion of goods exchanged for money increases, the system of social solidarity based on the distribution of foodstuffs weakens. This affects all families, but particularly those facing difficult situations (women without husbands, families without land, and so on) who traditionally were supported by the exchange of products.

In addition, the frequent visits of government employees, river traders or politicians who buy food in the villages, have begun to give monetary value to traditional subsistence products. There are communities in which fish is no longer exchanged, or where even mañoco is sold among the families themselves. The manner in which this cultural transformation affects the family diet is evident, since the products which the native buys in the marketplace never replace the nutritional values, in terms of proteins and vitamins, which were traditionally obtained from family exchanges.

Transformation of Masculine Roles

Culturally, men have been responsible for hunting, fishing, the exchange of goods with other ethnic groups, negotiating with relatives, and mediating social conflicts. Traditional doctors and leaders have been, and continue to be, men. With very few exceptions, the governing bodies of regional organizations and councils are composed of men. Men learn Spanish in order to be able to negotiate with traders, with institutions, and with farmers in general. Insofar as it is easier to converse with them, government employees and professional coordinators of development programs tend to discuss problems and implement activities through the men.

At present, it is possible to find three or four development programs being implemented simultaneously. Frequently they are guided by different organizations, and may have conflicting interests and aims. Each has its own agent to guide the work and activities within the community. Thus, public health will have a promoter, state education will have a teacher, the religious missions will have a pastor, and the productive units will have a person in charge of the livestock program or fisheries, and so on. The men who do these jobs spend a great deal of their time on institutional activities related to communal interests. The

multiple occupations which these activities imply lead to the temporary absence of the father from the household productive activities related to subsistence farming. These institutional activities are usually rémunerated, which enable the men to buy the products they need at the river market or in the village. It is interesting to note that, in the program of child weight control being carried out, some of the underweight children are the offspring of health promoters or school teachers.

Similar results occur when the family has not sown its harvest in time and has been deprived of its *conuco*, or when its economic aspirations require a larger monetary income (for example, the family needs to buy an outboard motor). The father may then decide to work for a salary. His absence from the community is temporary (three or four months) and during this period his wife and children will live in her parents' home. If she has a *conuco*, she will work it alone, or take turns with one of her sisters; if she has not, she will work on her mother's *conuco*.

For these women, to be without their husbands, or with only partial help from them in the traditional activities of the family, there is a considerable increase in the daily effort of working the land and rearing the children. This is not compensated by improved feeding. These women generally leave their smaller children at home when they go to work, reducing the period of breast-feeding. Although the women may have the produce from the *conuco*, they do not have the protein foods, such as meat and fish, that the husband is usually responsible for obtaining. Insofar as the cultural norm persists which establishes that the man is responsible for relations with other social groups, women will be marginalized. The world of domestic labour has remained unaltered in many of these indigenous communities, while male activities have undergone great changes. The dysfunctional family situations which are brought about by this phenomenon produce a great deal of dissatisfaction, and have encouraged many young women to form homes with Caucasian companions.

Disintegration of the Cultural Rules of Matrimony

The departure of the male population has contributed greatly to the rupture of traditional value systems, which were already strained by the general situation of contact and change. Until only a few years ago, the rules of matrimony held firm, and within these rules the parents were responsible for ensuring that their children chose suitable mates in keeping with the system of relationships, and the norms of distribution and redistribution of these indigenous communities. These systems are quickly weakening. The communities have not had time to generate new cultural institutions to protect the family and meet the needs and expectations of youth. One consequence of this is the increasing frequency of single mothers between 15 and 17 years of age, a clear symptom of deteriorating family structures.

Some of the fathers of these children are indigenous, sometimes from the same village, sometimes from other communities; they are youths who are old enough to form a family and collaborate in economic activities, but who have chosen to travel to the towns, work the

land of colonists, or visit different communities where they have relatives. River traders often have casual relations with single women in the communities or with women whose husbands are absent. They often do not assume their responsibilities after leaving a native woman with child.

When talking to young women in the communities, one realizes that a change in expectations, interests, and values is taking place. These women are no longer prepared to allow their parents to choose their husbands, and they want to be free to choose their boyfriends and the nature of their relationships. If their parents no longer have authority over them, if the traditional channels of moral guidance are breaking down, and if no new mechanisms have arisen to provide answers to the questions raised by the young, then the social future is endangered.

Although the communities do not clearly reject the single mother, they do not provide her with much support. The mother and her child continue to form part of the family, but they do not enter entirely within the system of food distribution, and they are also deprived of much economic support. The problems change a great deal in accordance with the concrete situation in each community. There has been an increase in the onset of prostitution, ill treatment, child abuse, and male alcoholism in some parts of the region. All of this affects child health, and produces dissatisfaction and a low quality of life for women, as well as a breakdown in family unity within the indigenous population.

All of these facts lead to the prediction of serious problems of social health, which overflows the strictly domestic environment of which the woman is the foundation. This is how they see the situation:

> We need money, because we need clothes, soap, gasoline, etc. and in order to obtain it our men must leave the community, because we have not got the time to learn how to speak Spanish; when the men have gone, authority breaks down and the young people revolt. Crops do not produce as much as before because they have to be sown time and time again in order to yield enough for sale; the soil grows tired - and so do we - because the men talk and talk to the white men - but nothing happens - there is no money.

Conclusion

In the indigenous communities of eastern Colombia, there are a number of clearly defined problems as a result of various processes of change and transformation. The program of child growth control was carried out in a systematic manner and with in-depth socio-medical research to support it. The program has proved to be a sound instrument to help understand the complex factors which are affecting the quality of life of families, and the health of mothers and children. These factors can be summarized schematically:

- the indigenous communities need money;

- men are culturally and socially assigned the responsibility of acquiring money and establishing commercial relations with "others" (traders, institutions, colonists, etc.);

- in order to obtain money, economic areas are entered which draw men away from traditional community life; and,

- the commercial decisions which are being taken, frequently encouraged by state institutions and regional politicians, tend to damage cultural systems, affecting:

    - the system of social solidarity which for centuries has protected the family;
    - the complementary nature of male and female roles;
    - the conservation of the soil and its natural resources; and,
    - the quality of life and the health of women and children.

How should this situation be dealt with by professionals and institutions in the health sector? Professionals and institutions interested in the health of indigenous communities need to demonstrate that it is not possible to follow the universal pattern of social development on these lands. Economic problems affect the health of the population. The health sector must take a clear stand with regard to the cultures involved and their development, with regard to the relationship between society and the environment, and with regard to the role that men and women must assume regarding decisions which affect the future.

Methodologically, it is essential that any work which is undertaken regarding the community should originate, develop, and be supported by considerations based on the culture of the population, its history, its experiences and on the transformations it is undergoing. Men and women must participate in these cultural revisions, as well as in the social and family implications of change, since the future concerns them both.

These cultures have shown that they have more experience than the Western world in the reproduction of societies in tune with their forest surroundings. They therefore deserve to be taken into account in the search for modern economic alternatives.

References

Arcand, Bernard. 1976. Cuiva Food Production. *Canadian Sociological and Anthropological Revue*, Vol.13, No. 4. Canada.

Hecht, Susanna; Alexander, Cockburn. 1993. The fate of the forest: Colonists, destroyers and defenders of the Amazon. Ediciones Uniandes. T/M Editores. Colombia.

Lobo-Guerrero, Miguel; Xochitl, Herrera. 1990. Participative research into health: An experience with Sikuani promoters. Sectorial Health Service Agreement of Vichada - Etnollano Foundation. Etnollano Publications. Bogotá, Colombia.

Martin, M. Kay; Voorhies, Barbara. 1978. Woman: an anthropological view. Editorial Anagrama, Barcelona Spain.

Ortiz, Francisco; Pradilla, Helena. 1987. The indigenous population of the Eastern Plains. Introduction to Amerindian Colombia. Colombian Institute of Anthropology. Bogotá, Colombia.

Rojas, Jorge G. 1992. Family feeding and commercial production. A theoretical reflection for a documentary framework on health. Paper presented at the II Seminar on the Evaluation of Projects of the Etnollano Foundation. Etnollano. Villa de Leyva, Colombia.

Women's Participation in the Organization of Community Well-Being

Maria Teresa Castillo and Maria Dolores Viga[1]

Introduction

This paper will present the preliminary results from an ongoing research project supported by the International Development Research Centre (IDRC). This investigation involves both scientific and participative research, and was carried out by the Centro de Investigación y de Estudios Avanzados del I.P.N., Unidad Mérida, and the Social Medicine Department of the Regional Research Centre "Dr. Hideyo Noguchi" at the Universidad Autónoma de Yucatán. The scientific research was carried out by an interdisciplinary team, while the participative research was carried out jointly by the inhabitants from the two communities of the municipality studied, and the members of the scientific team.

The success and efficacy of any policy, program, or community development plan, must consider the population as active subjects of these processes. That is, researchers must recognize and accept that the populations have the capacity to identify their own problems, and the ability to establish the most appropriate actions to solve them.

A holistic conception of research in human ecology is presented. The sociocultural and ecological characteristics of the two populations studied are described, as well as the methodology, and a description of the participative research process carried out by both populations. The participation of women was fundamental to the study. Women demonstrated great effort, time, and interest to solve the challenges faced by the communities for the achievement of family and community well-being.

Ecological, Sociological and Health Assessment: Interdisciplinary and Holistic Research on Human Ecology

The general objective of the project was to improve the health and well-being of the communities studied, through the active participation of community members in the formulation and assessment of activities and programs to meet the needs which they identified. In addition, the project aimed to develop sustainable solutions to priority problems identified by the research team. This has been designed as a long-term project, ten years in length, and was organized into phases. Human ecology, the study of the research,

[1]Human Ecology Section, CINVESTAV-Merida, Mexico.

is an interdisciplinary subject which studies the dynamic inter-relationship between society, nature, and human biology (Wolañski 1990). An interdisciplinary and inter-institutional research team was formed, including physical and social anthropologists, biologists, physicians with different specialties, nutritionists, psychologists, chemists, and sociologists. Research was carried out by these professionals, each in their own relevant areas. Participative research is currently being carried out by the members of the community, who have been trained in participative methodologies, and who are ready to devote part of their time to solving community problems.

Communities in the developing world are subject to different levels of socio-economic poverty. Community well-being has been one of the primary concerns expressed by organizations at the regional, national and international levels. It might be expected that part of this interest would be reflected in adequate health conditions for populations, given that health is a critical element of well-being. However, although state policies have included the reduction of poverty and underdevelopment in their programmatic goals, these programs have been designed and implemented in a manner which is mainly paternalistic, unilateral, and only marginally participative, thus greatly limiting both their efficacy and success. Communities are considered as objects by politicians, and this attitude is in turn reflected in the attitudes of the populations themselves. Populations tend to be more receptive than reactive, depending upon external agents, and often see health programs and policies as something foreign to the community, even when the benefits are directed to themselves.

The success and efficacy of any policy, program or community development plan must acknowledge that the populations have the capacity to identify their own problems and to establish the most appropriate actions to solve these problems. For this to happen, it is important to clearly understand the concept of well-being, which can have several meanings. In the context of this project, the concept of well-being may be considered as a process which changes historically according to the technology available for the society, the social and political relationships between the groups of a given society, and the expectations and goals of the society and the individuals themselves, at a given time. According to Castillo and Dickenson (1994):

> Well-being is a synthetic expression of the conditions in which a society lives and develops. Biological, psychological, social, economic, ecological, cultural and even political factors contribute to establish the well-being of a community in a given time and place.

For these reasons, it is critical to recognize that apart from certain external criteria for the evaluation of changes in the well-being of populations, as well as the specific conceptualization of well-being, local populations must build their own idea of well-being. By identifying its own most important community problems, the community is involved from the beginning in both solving them and understanding what "well-being" means to it.

Although community participation is one of the essential ingredients in improving well-being, it is not easy to change well-being status. Therefore, for the elaboration of the project, it was agreed that in order to achieve the goal of improving general community health and well-being, participative research was necessary as a methodology to establish the elements crucial for active community participation. Participation is understood as "a social process, in which particular groups share some needs, live in a given geographic area, are actively involved in the identification of such needs, and make decisions to identify mechanisms to overcome them" (Rifkin et al. 1988).

To date, two phases of the project have been carried out. The first phase lasted ten months and aimed to lay the general framework of community involvement and direction for the substantive study to follow. At the same time, it sought to obtain preliminary data on the social organizational structure, beliefs, learning systems, and health status of the community, and to identify physical-chemical and biological environmental factors related to the health and well-being of the community.

The second phase was eighteen months in length, and was devoted to obtaining a detailed diagnosis of the status of the community from three aspects: sociological, ecological, and health. With this data, it will be possible to compare changes in the community's status, related to specific interventions made during the long-term project (ten years in length). At the same time, the community initiated a process which would lead to its greater participation in the research to meet its basic needs.

Although it has been important to carry out the above-mentioned diagnosis, feedback from the populations through community workshops, and the participative research process, has been of greater importance. Knowledge of the community, together with the scientific results, were analyzed by the community to help determine solutions for community problems.

Ecological Background and Sociocultural Characteristics

The Ecological Basis

The municipality studied is located in the northern area of the Peninsula of Yucatan, bordering to the north with the Gulf of Mexico. Its main characteristics are its semi-dry tropical weather, the predominance of karstic soils, and the lack of superficial fresh water. The main ecosystems include the deciduous low forest, mangrove swamps, the coastal lagoon, the coastal dune, and the sea, in the area of the continental platform. The municipality has two communities, the Town and the Port, each with different agro-ecosystems. They include agro-habitats such as milpas, backyards, henequen (*Agave fourcroydes*) fields, pastures, horticultural fields, apiaries and coconut groves, at different levels of development and technology.

The Town is located fifteen kilometres from the coast, in an area which was covered by deciduous low forest at the beginning of this century. In order to plant henequen, this forest underwent a severe deforestation, interrupted partially during the mid 1970s. From 1978, the decline of the agro-business led to the abandonment of numerous plots, which were covered again by deciduous low forest. For decades, the economic life of people in the town was based on the henequen agro-business. When this activity collapsed, the socioeconomic effects were severe, and included rising unemployment, a reduction of incomes, and a decrease in job alternatives. The most important consequences were a decrease in living standards, a general impoverishment of the population with a relative homogenization in poverty levels, and an out-migration of the population, particulary to the tourist developments along the Caribbean coast of Mexico. The henequen crisis led the government and the agriculturists to try to develop other productive activities, mainly agricultural, using the few local resources available.

The Port is surrounded by a greater diversity of ecosystems than the Town. However, all the natural resources (the sea, the mangrove forests, the coastal lagoon, the deciduous low forest and the coastal dune) are affected to some extent by human activity. The population of the Port was never as closely related to the henequen agrobusiness as was the population of the Town, thus the former has suffered less from the crisis than the latter.

Sociocultural Characteristics of the Population

According to the census carried out by the project in 1990 (Ortega and Dickinson 1991), the municipality had 2,725 inhabitants divided in two populations: the Town (2,344 persons, in 535 families) and the Port (381 persons, in 87 families). In a sample of 200 families (160 in the Town and 40 in the Port), a survey was taken in 1992/93 from which the data below were obtained.

According to the survey, most of the families of the municipality (71.3%) were nuclear (i.e., they included both parents and their children). Extended consanguineous families (parents, some of their married offspring, their grandchildren, and other relatives) counted for 23.6% of the families. The size of both nuclear and consanguineous families ranged from between four and eight members for 84% of these families. At the municipality level, 51.4% of the population were men and 48.6% were women. In the Port, the percentage of men was slightly higher (53.8%).

The population of the municipality has a strong Mayan cultural background. This cultural basis is, however, undergoing a rapid process of transformation as modernity and cable television have presented alien cultural patterns. As well, many of the young people are emigrating to the tourist areas of the Caribbean coast, where lifestyles are different from the community. Despite this, the population maintains characteristics of the Mayan culture.

Many Mayan houses maintain their traditional design and spatial distribution, although newer houses tend to reflect a different style. An indication of this transition may be observed in the change of building materials. Traditional roofing materials, such as "huano" (leaves of a local palm), straw, fodder, and stone, are being replaced by roofs made of "bovedillas," industrially-produced cement blocks, corrugated cardboard and asbestos sheets, which are much less expensive and require less maintenance than traditional materials. Most of the houses have two rooms; a main room used to hang sleeping hammocks, as well as a smaller room used for cooking and eating. Both rooms form part of the "*solar*," or backyard, in which the toilet is located in the open, along with seasoning and medicinal plants, vegetables, fruit trees, domestic animals such as poultry, and, less frequently, pigs.

Language is one of the basic elements of cultural identity of any society, as it contributes to communal cohesion. In the municipality studied, almost all individuals reported that they speak Spanish. However, the Mayan language was used in daily communication. Forty percent of the population speaks both Spanish and Mayan languages. The percentage of women who speak Mayan and Spanish was slightly lower than men, since women tend to speak only Spanish. This situation could have important sociocultural effects on the population. As mothers teach language to children, it is expected that the Mayan language will disappear from the community because fewer mothers speak the language.

Religion is another sociocultural component which contributes to the maintenance of cultural identity and community cohesion. In the municipality, only 1.7% of the population did not profess some religion. Eighty percent of the people reported that they were Catholic, while 17% reported that they belonged to other religions, such as Pentecostal and Presbyterian. Unlike many other communities in Mexico and other Latin American countries, this religious diversity is not an obstacle for communal cohesion, probably because all of the religions are Christian. By sex, there were fewer Catholic women (48.3%) than men (51.7%). The percentage of women (53.3%) who professed other religions was higher than men (46.7%). In this particular municipality, women may be more prepared to accept new religious concepts than men.

Many young people do not have the opportunity to reach high education levels, since this would require them to leave their communities and abandon their economic obligations to their families. Women have even less opportunity than men to pursue higher education due to economic reasons, and also because families are expected to supervise and protect their daughters from social risks. Only 48.5% of women had received primary education; similar figures were reported for post-secondary school studies. Curiously, however, women had a slightly higher attendance (51%) than men at secondary school. This may be due to the fact that the secondary school is located within the community, which reduces expenses, as well as the real or presumed risks of attending school.

In 1992, about 73% of the men in the productive age group reported involvement in an income-earning occupation. Twenty-two percent were students, and 4% did not report any occupation. Due to the lack of a qualified male labour force within the municipality, the

main occupation for income generation was informal day labour (29% of the economically active population). Fishing (28%) was the second most important economic activity, followed by agriculture (18.6%). The rest of the population (24.4%) was devoted to activities of minor economic relevance, such as handicrafts, trade, and so on.

Fifty-nine percent of women in their childbearing years reported that they were housewives, while 24.8% reported that they were students. Women were devoted primarily to their role as housewives and reproducers. However, they contributed in an important manner to family income, since 29% of the housewives also reported having some other occupation (minor trade and handicrafts) to earn money.

By 1990, the municipality was among the top five with the highest negative growth rate (-1.1) in the state (INEGI, 1990). In general, the productive activities of the municipality as a whole are not enough to meet the needs of the families. However, the situation differs among the two localities of the municipality: in the Port, the population can easily change its focus from one productive activity to another (fishing, salt mines, coconut groves, salaried work), while in the Town, the ecological diversity of the Port does not exist, and thus a different survival strategy has been established, including out-migration.

Out-migration involves both men and women. Since relocating is most attractive to the qualified labour force, the community loses its best men and women who generally do not come back due to the lack of opportunities within the municipality.

With regard to health conditions, severe malnutrition problems exist during infancy and childhood, while obesity is a problem in the second decade of life (Dickinson and Ortega 1994). Nutrition is based on low-protein ingestion, and high quantities of carbohydrates and sugar (Dickinson and Ortega 1994). The main diseases are parasitic and upper respiratory track infections.

Participative Research and its Contribution to Community Health

Two hour meetings were held within each community once a week. Participative research was used in a community-based attempt to solve the identified problems. In order to explain how both communities carried out the problem-solving process, it is necessary to note some central methodological aspects related to participative research. As each community identified a different series of problems related to family and community health, each process shall be described separately.

According to Barquera (1986), the central goals of participative research are that the groups or communities themselves take on the role of researcher and, as such, produce the knowledge which explains their social reality. Based on such knowledge, each group immediately identifies and carries out the actions necessary to modify or transform their social reality to fit their interests.

The methodology requires the conscious participation of the community in a research process developed by the community itself. The main steps of the methodology are:

- to stimulate the people to assume the problems of the community as their own;
- to teach the participants the proper use of the methodology; and,
- to recover the knowledge of the community in order to develop research in an independent way.

It is expected that the development of the participative research process will transform the participants into researchers of their own social reality, capable of analyzing, designing, and carrying out actions to change this reality. Through participative research, the community and its representatives or agents analyzed the situation of the community, identifying the problems they wanted to solve. Two groups from the community were involved and trained in the participative research process. These people were called "Facilitadores" (facilitator, from "fácil," the Spanish word for "easy"), because it was assumed that their training would make the process easier for the community as a whole.

Methodologically, three clear steps should be made when attempting to deal with the problems of a community: **to see**, **to judge**, and **to act**. It is fundamentally important to recognize and consider the knowledge and experience that the group or the population already has concerning the problem to be solved, **to see** its daily representation and dimensions, and to describe its elements.

A workshop was organized after the analysis and search for solutions to the problem. At this workshop, the participants evaluated the participative research process as a whole, assessing the following: the clearness in the application of the **to see-to judge-to act** steps, the attention paid to the opinions expressed by the members of the group, their feeling during the meetings, the quality and convenience of the didactic materials, the motivation of the participants, the causes of out-migration, and the possibility of using the methodology to solve other problems. Suggestions for improvements were also made at this stage. At the end of the evaluation, the progress, successes, and failures were celebrated. The celebration consisted of a general community meeting for a better identification not only of the problems, but of the solutions. When the participative research working group finishes work on the first selected problem, it starts the participative research cycle again for the next problem.

Results: The Town

During the first phase of the project, the community identified nutrition as an important area of study, especially the utilization of natural resources available in backyards in order to improve the nutritional status of family members (Ortega and Dickinson 1991). A group of twenty-two families interested in this issue was organized to begin the participative research process.

These families, particularly the women, have put much effort into the development of the Backyard Program, in which traditional knowledge, provided by elder members of the community, has been recovered. Several modern production systems and technologies have been incorporated, and the available resources are now used in a more efficient way, not only for self-consumption, but also to increase family income through marketing surpluses. In order to decide, organize, and assess the actions undertaken, this group of families held participative research meetings with members of the scientific team and personnel of the Faculty of Veterinary Sciences of the Universidad Autónoma de Yucatán. An analysis of other problems identified by the community and the multidisciplinary team, such as water pollution, was also started.

Results: The Port

In the Port, the population chose the lack of available medical assistance as the first problem to be solved. When the study began, individuals had to travel to the Town, where there is a small governmental clinic [IMSS-SOLIDARIDAD (Mexican Social Security Institute-Solidarity program)], to receive medical care. The Port population did not have efficient access to medical services due to the difficulties and expenses related to travelling to the Town.

The problem was first described in an attempt to analyze and look for possible solution strategies. The community perception of the problem was considered, and the following questions were asked: What is the problem about? How does it manifest itself? How many and which sectors of the population are affected? When did it begin?, and so on. The next step was to judge or analyze the problem, emphasizing its causes and consequences. Members of the project's scientific team, acting as external "attendants," provided information to the community on the situation of medical assistance throughout the Yucatan. Information was provided concerning the way physicians were distributed in different cities and towns of the state, in relation to the size of communities. The third step was to analyze the experience of the community in solving the problem, and the reasons for successes and failures. Several actions and negotiations were then started which were designed to solve the problem.

As a result of these actions, the Coordination of Health Services in Yucatan agreed that a physician should provide consultations two days per week in San Crisanto in the small "House for Communal Health" built by the community. Equipment for the premises was also obtained, including some furniture, a scale, and a supply of basic medicines. Further, it was agreed that a community member would be trained to attend emergencies in the absence of the physician. A Communal Health Program has also been established which focuses on individual health, nutrition, environmental health, and communal health.

These programs have not been the result of external initiatives, but rather have risen from the needs of the community involved. The real possibility for success is related to two central elements: (1) an increased capacity for community self-negotiation based on an acquired

knowledge of the participative research methodology; and, (2) the availability of a scientific team, which provides feedback to the community through community workshops and participative research meetings.

Participation of Women

While some men attended the first community meeting, they did not identify themselves with the activities and instead delegated participation and attendance at the meetings to their wives. During subsequent meetings, more men participated, but this participation was inconsistent.

In the Port group, the participation of one elderly man was outstanding. Despite the fact that he was 87 years-old, he was one of the few active agriculturists in the community and very respected. Although his voice and experience were not revered at the beginning of the group activities, little by little he gained the recognition and attention of the community. Afterwards, during the participative research process, the relevance and value of each community member's opinions were evaluated independently of gender or age.

In the Port, between five and thirty-seven people participated in the weekly meetings. A regular group was formed by people aged between 20 and 87 years, with an average age of 42 years (39 for women and 54.6 for men). Since most of the participants were women (85%), the most frequently claimed occupation was housewife. Among men, represented occupations were day labourers and agriculturists. Most of these people were Catholic, and approximately half the members of the group have consanguineous or political ties among them. In both communities, the community groups investigating the identified problems were constituted mainly by women. The participating women assumed on their own the need to devote their time and effort to the achievement of family and community well-being, primarily concerning health matters. They have incorporated, to the extent possible, the collaboration of their children and their husbands.

Results and Discussion

Despite the diversity of roles performed by women within the family, including reproduction, the care of children, the administration of home expenses, and the generation of material resources for the household, women also assumed the challenge of ensuring a healthy family and community, with better material life conditions. The participative research process in both communities has been developed mainly through the effort, time, and interest of women. This may be partially explained by deeply-rooted cultural practices, in which women are deemed to be responsible for the organizational needs related to the family and the community, such as school, health, religion, and even small production and political participation. Men, on the other hand, place more importance on their participation in production and political processes, and are only sporadically involved in other organizational processes.

To date, there have been no important differences between the two communities with regard to the participation of women. In the Port, women defended the criteria determined by the community, and carried out negotiations with local and state health authorities to obtain medical services for the community. In the Town, the Backyard Program has advanced due to the work of women. In addition, these women have served to motivate and incorporate other members of their families into such efforts.

Although much of the progress made in both communities has been the result of the work of women, it must be stressed that community organization and advancement must not rely only on women. The involvement of men, young people, and children must also be considered in order to fairly distribute the participation for community problem-solving.

In both communities, the participative research process has promoted the generation of new knowledge and behaviours aimed at changing the organization of the community and families, which has increased well-being at both levels. Despite the success achieved, however, these are long-term processes, and much work remains to be done.

Community processes, where the population performs an active role, and where actions are decided by the communities themselves, are notably different from, and more successful than, the more traditional top-down approaches. Participative research recognizes the capacities and underlying experiences of communities, especially women. We must continue to strengthen the participation of both women and men in the communal organization for health, and consolidate the progress made to date.

Acknowledgments

We wish to acknowledge Dr. Federico Dickinson Bannack for his contribution to our professional formation process, and his comments, suggestions and criticisms of this work.

References

Barquera, H. 1986. "Una revisión sintética de investigación participativa." Cuadernos del CREFAL 18.

Castillo, M.T.; Dickinson, F. 1994. "Estado, Ecología y Estrategias de Sobrevivencia en un municipio rural de Yucatán." En *Estrategias de sobrevivencia rural y urbana frente a la crísis y las políticas de cambio estructural.* Economía: Teoría y Práctica 2, 123-132, UAM-X. México.

Dickinson, F.; Ortega, J. 1994. Ecological, Sociological and Health Assessment (Mexico) Phase II (91-0204). Final Technical Report, submitted to the International Development Research Centre, Ottawa, Canada.

GCEUM (Gobierno Constitucional de los Estados Unidos Mexicanos). 1992. Programa de Desarrollo Regional de la Zona Henequenera de Yucatán 1992-1994. Programa Nacional de Solidaridad, Presidencia de la República. México, D. F.

INEGI, 1990. Yucatan. Perfil Sociodemográfico. XI Censo General de Población y Vivienda, Instituto Nacional de Estadística, Geografía e Informática, México, D. F.

Ortega, J.; Dickinson, F. 1991. Ecological, social and health assessment. Final technical report of the first phase of the project, submitted to the International Development Research Centre, Ottawa, Canada.

Rifkin, S.B., et al. 1988. Primary health care: on measuring participation, *Social science and medicine*, 26:9.

Wolañski, N. 1990. Glossary of terms for Human Ecology. Commission of human ecology, international union of anthropological and ethnological sciences. Warsaw, Poland.

Differential Prevalence of Malaria in Costa Rica: Ethnic Origin and Gender

Alvaro Dobles-Ulloa and Catherine Perriard[1]

Introduction

Reliable malaria registers exist for Costa Rica from 1916. Although mortality due to this disease has not been reported in the country since 1963, the morbidity rate has been sustained. Malaria is considered endemic in all areas under 500 metres below sea level. Between 1970 and 1984, the annual parasitic incidence (API) remained below one; however, from 1985 onwards, a rate increase was noticeable, with rates highest between 1991 and 1993 (Health Ministry 1993a; Escobar 1987).

Health Ministry Reports indicated that during the years of API increase, a high percentage of the cases, up to 60% in the first trimester of 1993, were concentrated in the province of Limón on the country's Caribbean coast (Health Ministry 1993b). This province, which also constitutes a region for planning purposes, has almost 35% of the country's indigenous population: 4489 out of a total of 11557 (Bozzoli 1986). Within the stratification approach of malaria (OPS 1981), it would appear important to evaluate a possible differential between the indigenous and non-indigenous populations of the province of Limón.

This proposal clashes with Costa Rican law, the interpretation of which has led to the lack, in malaria registers, of differentiation with respect to ethnic origin of the persons affected. However, the biologist Ramiro Barrantes obtained privileged direct access to bulletins for the years 1980-1990 for the canton of Talamanca. He subsequently managed to differentiate and quantify the prevalence of malaria in the indigenous population of that canton (Barrantes 1994). The comparison of these published figures (Barrantes 1993) with those of the remainder of the malarial area of Costa Rica are the basis of this analysis. The main limitation of Barrantes' figures is that they ended just before the latest and most acute outbreak of malaria.

Barrantes also distinguished the prevalence of malaria among the Amerindians of Talamanca according to gender. Unfortunately, the figures published by the Ministry of Health did not make this distinction. This renders a comparison with the situation with respect to gender in the rest of the malarial area impossible.

---

[1] Epidemiology Unit, Tropical Disease Research Programme. Health Sciences Faculty, National University. Heredia, Costa Rica.

The questions examined were: Is the prevalence of malaria significantly different between the indigenous population of Talamanca and the rest of the population of the malarial area of Costa Rica? If so, in what direction? Is the prevalence of malaria significantly different between men and women within the indigenous population of Talamanca? If so, in what direction?

The working hypotheses employed were:

- that the prevalence of malaria is significantly lower among the indigenous population of Talamanca than among the rest of the population of the malarial area of Costa Rica; and,

- that within the indigenous population of Talamanca the prevalence of malaria is not significantly different between men and women.

Materials and Methods

In order to analyze the differential between the indigenous inhabitants of the canton of Talamanca, and the rest of the inhabitants of the malarial area, one contingency table was elaborated for the period 1980-1985, one for each of the years 1986, 1987, 1988, 1989 and 1990, one which summarizes the five years mentioned separately, and one which summarizes all of the above.

The absolute number of cases in the indigenous population of Talamanca (Barrantes 1993) was placed in square A. The result of subtracting this figure from the estimated number of indigenous inhabitants in the canton of Talamanca was placed in B, using the year 1986 as a base and the most reliable figures available (Bozzoli 1986). For the table corresponding to 1980-1985, 10% for each previous year was subtracted successively from the base and the sum was allocated; for each subsequent year, 10% was added successively. The result of subtracting the absolute number of cases in the indigenous population of Talamanca from the absolute number of cases in the country was placed in Square C. The result of subtracting the three previous figures from the estimated population of the malarial area according to Health Ministry figures was allocated to D. The X^2 test was then applied to these tables.

In order to analyze the differential between gender of the indigenous inhabitants of the canton of Talamanca, the same series of contingency tables as those used in the previous analysis was set up. The absolute number of cases in males from the indigenous population of Talamanca was placed in A, and the absolute number of cases in women from the same population (Barrantes 1993) was allotted to C. The result of subtracting the previous figures from the respective portions of the total population were placed in B and D, according to how they affect the latter (total population) in proportion to the "sex ratio" of the three ethnic groups present (Barrantes 1993). The population base for 1986 was divided into 2372 Bribri

with 1.09 male/female; 464 Cabécar with 0.92 male/female; 30 Teribe with 0.82 male/female. This signifies 54% females and 47% males, the ratio applied to the other periods. In the same manner, the X^2 test was carried out on these tabulations.

Results

Contrary to expectations, the malarial prevalence was significantly greater in the indigenous population of Talamanca than in the rest of the population of the malarial area, both in the period 1980-1990 as well as in the subperiods 1980-1985 and 1986-1990. The respective X^2 were 8829,43621; 3,81105663 and 19304,8294 with significance levels between 0.05 and 0.025 for the first, < 0.0005 for the other two (one-tailed hypothesis). With the latter, it was only possible to affirm the same for the year 1990 individually ($X^2 = 175,166058$ with a significance level $< 0,0005$) since for each of the other years, the expected number of cases in the indigenous population was less than five.

Also contrary to the expected, malarial prevalence was significantly higher in males than in females from the same indigenous population of Talamanca, both in the period 1980-1990, and the subperiod 1986-1990. The respective X^2 were 18,1907734 and 19,3842313 respectively with significance levels between <0.0005 (two-tailed hypothesis). For the subperiod 1980-1985, the expected number of cases in men or women of the indigenous population resulted in less than five. Within the subperiod 1986-1990, the malarial prevalence can be said to have been greater in the males of the indigenous population of Talamanca than in the females of the same population for each individual year, except for 1987 when the distribution observed corresponded fairly well with that expected.

Discussion

The first working hypothesis had predicted that the indigenous population of Talamanca would present a lower malarial prevalence than would the rest of the population in the malarial area. The results showed the contrary. The second working hypothesis had predicted that there would be no significant differences in the prevalence of malaria between men and women within the indigenous population of Talamanca. A significant difference was found, showing the prevalence in males to be higher than that in females. Some tentative elements of explanation for both phenomena, expressed in environmental, socioeconomic, and cultural terms, as well as in those of access to health services, are offered below. The statements which are not accompanied by a reference correspond to direct observations of the authors.

Environmental macro-characteristics have remained relatively stable within the indigenous reserve of Talamanca in comparison to the substitution of forest by banana plantations outside the indigenous reserves in the rest of the malarial area. However, on a smaller scale, use of the land has varied during the last fifteen years, above all in the most densely populated valleys situated at less than 100 metres below average sea level (Vargas 1989;

Borge et al. 1991). The general tendency has been to go from varied, seasonal crops for self-sufficiency, to permanent monocultures, principally plantain (*Musa balbisiana*), destined for trade.

The micro-environment of the workplace has therefore been modified: flooding, increase in marshy lands, uniformity and reduction of covering vegetation, reduction of alternative hosts, creation of passages or pathways between formerly isolated work camps. It maintains, in a more permanent manner, characteristics favourable to proliferation of the vector and to transmission of the disease. Work characteristics have also been altered as changes have been made from the cultivation of several plots by one particular nuclear family, who only made use of the manpower of extensive family members during short periods of intensive labour, to an almost permanent and fundamentally masculine intensive exploitation.

In the lowlands nearest to the communication waterways, plantations belong to latinos and "rich" Amerindians. There, "white" manpower hired outside the reserve joins together for long periods with indigenous workers hired inside. The latter includes populations from high, isolated valleys which presumably had previously had only very limited contact with malaria. Many Amerindians, especially the young, prefer to go directly to the large banana plantations as these departures have the acquired characteristics of initiation into manhood.

The reduction of masculine labour in the lowland plots used for self-sufficiency has been substituted almost purely and simply by the increase in the consumption of goods obtained in shops, using part of the income acquired by the salaried man. The perverse effects of this situation have already begun; in places where substitution is greatest, dental health and nutritional standards are deteriorating (Bremes 1989; Mata et al. 1986). An additional unwanted consequence is the increased dependence of women on men, which is partly compensated by female labour outside the home, mainly in the service industry.

In the highlands, the above-mentioned situation is not as serious, and is less regular; the principal compensation mechanism is the increase in the number of hours and intensity of work carried out by women and children to keep the family lot productive, which in any case belongs to the woman, culturally speaking, and secondarily to the children, as in a matrilineal filiation system the husband belongs to a different clan. Here also there is evidence of seasonal or definitive emigration of female labour, particularly in girls less than 20 years old, who find work in the lowlands primarily in the service sector.

The settlement pattern has also been modified, especially in the lowlands, increasing the population density as houses are built closer together and nearer to the service centres (including that of health). Density has also increased inside houses due to the fact that they seasonally receive outside workers, relatives, or strangers.

The characteristics of the residential micro-environment are also conducive for the transmission of malaria since they do not offer sufficient protection against contact with the vector. In more isolated areas, this is even more accentuated as the houses normally do not have any walls at all.

Systems of active search and reporting of malaria cases inside and outside the indigenous reserve of Talamanca are comparable, although difficulty of access would tend to inflate the number of non-indigenous patients. Therefore, the increase of reported cases and of the proportion of masculine ones after 1985 would appear to reflect a real change in the disease's behaviour, and not an improvement in the reporting systems, or an intensification in the active search for patients (these changes only occurred after the 1991 earthquake and affected both the indigenous and non-indigenous population similarly).

It is possible that malaria has maintained a sustained but low-key presence for a long time in the indigenous population. Indirect evidence of this is the fact that malaria is included in the indigenous nosology with several proper names. Although inside it is considered a disease coming from outside and, more precisely, from "white" people and from the sea, the cognitive, attitudinal, and practical system (in its double aspect: ritual and etnophytopharmalogical) provides a niche for it. Thus, individual shamans can carry out practices for the remission of symptoms for individual cases, and "white" medicine is only used when the problem takes on epidemic proportions. In these circumstances and in many cases on the shaman's recommendation, the sick move to state health services: community health auxiliaries, district health posts, the integrated cantonal health centre, or, as a last resort, to the Costa Rican Social Security provincial Hospital in Limón.

It is also when the disease takes on epidemic proportions that the "white" health system intervenes directly in homes with a prophylactic end, administering oral doses of chloroquine. This activity is carried out by the Ministry of Health through auxiliaries who are of great merit but badly trained and, in the majority of cases, lacking in knowledge of indigenous languages and cultures. However, it appears probable that the women ingest doses of chloroquine more regularly than the men as they are more often at home when the auxiliary visits; this would result in a differential protection in favour of women.

The only moderate success of this intervention is also due, in part, to the idea that ingesting something which provokes real, unpleasant symptoms with the intention of preventing the apparition of potential, eventual symptoms is foreign to indigenous conceptions.

Conclusions and Recommendations

Contrary to the working hypothesis, it can be concluded that the prevalence of malaria presents various differentials disadvantaging the indigenous population of the canton of Talamanca, in comparison with the population of the rest of the malarial area of Costa Rica. Furthermore, within the indigenous population of the canton of Talamanca, the prevalence of

malaria presents differential values disadvantaging men in comparison to women. Although some elements of explanation can be enunciated, as has been the case here, these are incomplete and unsatisfactory as long as their association with the disease cannot be demonstrated and whilst the situation of the population of the rest of the malarial area of Costa Rica remains unknown.

It is recommended that malaria registers be kept and published in such a way as to make possible, at less expense, differential analyses according to ethnic origin and gender. The objective is to better orientate public health policies, not to encourage unfounded discrimination. It is also desirable that the present analysis be extended to 1991, 1992, and 1993, and continued later, as well as extended to other indigenous populations included in the rest of the malarial area. If the analysis was restricted to the province of Limón (Atlantic Huetar Region), more subtle differences could be perceived. It would be equally necessary to complete the documentary research with field research carried out with an ethnographic approach which complements analytical epidemiology and vectorial populations entomology.

The conclusions emerging from this analysis should be sufficient to attract the attention of the health authorities to the fact that malaria treatment and prevention policies cannot and should not be generalized. On the contrary, these policies should highlight the existence of important differences between ethnic origins and genders, besides the merely biological. It is equally important to point out the possibility of complementary and concerted cooperation between official Latin services/action and traditional therapeutic practices.

References

Barrantes, Ramiro. 1993. *Evolución en el Trópico: Los Amerindios de Costa Rica y Panamá*. Editorial de la Universidad de Costa Rica.

1994. *Comunicación personal* (abril).

Borge, Carlos; Camacho, Carlos; Dobles, Alvaro; Villalobos, Victoria. 1991. *Propuesta para el desarrollo del valle de Talamanca*. Asociación Costarricense de Antropología.

Bozzoli, María E. 1986. *El indígena costarricense y su ambiente natural*. Editorial Porvenir.

Brenes, William. 1989. "Epidemiología de la caries dental en poblaciones amerindias en transición sociocultural." *Vínculos*, vol. 15, n. 1-2, pp. 45-57.

Escobar, Francisco. 1987. *A Social Scientific Analysis of Intervening Factors within the Malaria Disease Dynamics: The Costa Rican Case. Final Report* Social Research Centre.

Mata, Leonardo; Murillo, Sandra; Jiménez, Patricia; Martínez, Miguel A.; Reyes, Lilliana; García, María E. 1986. "Estado nutricional del niño amerindio guaymí de Limoncito, Costa Rica, 1979." pp 177-184 in: *Memorias del Primer Simposio Científico sobre Pueblos Indígenas de Costa Rica*. CONICIT.

Ministerio de Salud, Costa Rica. 1993a. *Evaluación Epidemiológica por años.*

1993b. *Reporte. Casos de malaria por región y localidades positivas.*

OPS, Organización Panamericana de la Salud. 1981. *Malaria en las Américas. Informe Final.* Washington.

Vargas, Jorge L. 1989. "Talamanca, la ocupación aborigen del medio ambiente: aportes para un desarrollo sostenible y duradero." *Vínculos*, vol. 15, n. 1-2, pp. 69-83.

Health Among the Mapuches of Chile

Teresa Durán P., José Quidel L., and Catriquir C. Desiderio[1]

Introduction

This paper is based upon results from a recently concluded project (April 1994) entitled, Quality of Life, Health, and the Environment[2]. This project explored the inter-relationship between perceptions of the environment and perceptions of well-being, within indigenous Mapuche explanatory systems of health and illness. The research, carried out with a team of Mapuche professionals knowledgeable about their own culture, studied several aspects related to the health of the Mapuche population, including: cultural notions and means of expression; the nature of inter-ethnic contacts with government services; and, projections for the future, taking into account official development plans, and the role of private or quasi-official development initiatives, in connection with the current legal position of indigenous populations in Chilean society.

From a theoretical perspective, the work was based upon concepts found in Dialogical Anthropology (Tedlock 1991), which stresses the need for a horizontal dialogue between groups of peoples. It also emphasizes the importance of recognizing and incorporating the symbolic dimensions of non-Western dialogue when working with indigenous populations (Arnold et al. 1992). Special attention has also been paid to understanding the way in which men and women relate to one another within the Mapuche culture (Londoño 1993). With regard to the sociocultural dimensions, the work was based principally on the Social Structure and Individual Behaviour theory (Stuchlik 1976; Stucklik & Holy 1981).

Background

The Mapuche was the only indigenous group to maintain socio-cultural and territorial independence until the end of the last century. Other ethnic groups in the country either underwent massive crossbreeding, as in the case of the Atacameños, or disappeared almost completely, as did the Kahuaskar.

---

[1] Catholic University of Temuco, Temuco, Chile.

[2] The project, financed by the International Development Research Centre, was carried out through PAESMI by the Department of Anthropology, between 1992 and 1994.

The Chilean government used military strategies to dominate the Mapuche from the second half of the nineteenth century. Beginning with forced settlement laws (1866 and 1881), the Mapuche population was obliged to submit to a "Chilean" lifestyle. Today, the Chilean parliament does not recognize these ethnic groups as indigenous populations. While acknowledging the special cultural and historical situation of the Mapuche, the Parliament states that they must solve their development problems within the juridical and institutional context of the national society and culture.

Health and Disease Among the Mapuche

In order to execute the Quality of Life, Health and Environment Project, it was hypothesized that perceptions of the environment, as well as beliefs about well-being, could be recorded, with a view to explaining phenomena about health and disease among the Mapuche. However, the possibilities of understanding these cognitive and cultural beliefs were limited by socio-structural differences between the Mapuche culture and the culture of the Western world.

Magical-religious concepts of health and illness, and the relationship between people and the environment, have been documented since the earliest recordings of the Mapuches. This knowledge has different levels of complexity, ranging from the level which characterizes objects, animals or man, to the explanatory or interpretative level. Mapuche terminology has been used to describe geo-ecological subjects, or curative ceremonies, such as the *machitun* (Pineda & Bascuñan 1973). Over the past two decades, together with advances in the social sciences, experts have linked the type of data recorded and its systemization, to the kind of theoretical and/or methodological approach described by the author. Over the past five years, the Mapuche themselves have made efforts to share their philosophy with others (Marileo 1992; Huenchulaf 1992; Ñanculef 1991). They have also been involved in external investigations with the same objectives.

Traditional Mapuche knowledge and practices have been maintained (Oyarce 1988). Oyarce (1988) believes that this continuation is due to the fact that the Mapuche traditional system "is based on the magical-religious nucleus." American anthropologists, among others, have drawn a causal link between the magical-religious character of the Mapuche cosmovision, and sustained survival of the Mapuche over time (Faron, 1961; Dillehay, 1990).

There are few descriptions of this system and its links with other spheres of culture and social life. Dillehay (1990) attempted to link the concepts of time, ritual space, and the ecological order, in a more structured and systemic fashion. Other authors have described the medical system without considering the epistemological relationship to the "folk knowledge and/or model and action" (Stuchlick 1976; Stuchlick & Holy 1982). Many authors, such as Montecinos (1985), have discussed general concepts about the "Mapuche medical model" or "Mapuche medical system," classifying illnesses and describing the main therapeutic ceremony (*machitun*), including a presentation of some "medicinal herbs." In

these investigations, efforts are focused on translating ethnographic materials into a Western understanding of health. For example, self-care is considered to be a "prophylaxis," and not an important aspect of the Mapuche educational system, inherent in their philosophy of life. Other studies presented the characteristic features of the identified system. Montecinos and Conejeros (1985), for example, stated that "the Mapuche people have known since ancient times formulae for the curing of illnesses through the herbarium." Women have been identified as being closely linked to the sacred, with a unique capacity to manipulate the natural and the supernatural (Montecinos & Conejeros 1985).

Kümelen Condition: "To be Feeling Well"

Every time *pentukun* (a greeting) occurs, both in rural and urban areas, among both men and women, is it customary to ask how the other person is or feels. Gender differentiation in greetings is established by identifying family positions or relationships. For *pentukun* to take place, the people must be of the same culture and language (Durán 1986), and must have enough time and space to meet. If an individual is "feeling well," this is expressed with the term *kümelen* or *kümelkalen*. *Kümelen* means that "there are no problems in the family," "no one is sick," and "the crops are doing well." This state implies a sense of wholeness; it does not only involve physical well-being (*tremolen*). This *kümelen* state also means that the person is alert, an indispensable condition in order to stay well, given the different influences (physical, religious, ritual) operating in an individual's environment.

A state of health depends on an individual's capacity to maintain a balance. It also depends on the way community members interact with the environment. The state of health involves the group, and concerns the various dimensions of social and spiritual life. Therefore, the state of health might correspond to what experts now call "quality of life." The *kümelen* state requires at least three conditions: (1) to have what is necessary for subsistence; (2) to do what everyone else does, in terms of equality and reciprocity; and, (3) to be alert to one's own behaviour and to the behaviour of others.

If a person alters or ignores these necessary conditions, he or she puts the state of *kümelen* at risk. Extreme poverty, the lack of the essentials necessary to live, being too different from the majority, or not controlling negative influences, leads to a lack of balance, and even illness.

Ethnolinguistic research understands *kümelen* as an existential state. The Mapuche team ratified that this state may be expressed through the following conducts:

- to be happy;
- not to be ill, or to be particularly healthy (*tremolen*);
- to feel a sense of self-satisfaction and acceptance, a deep joy at being alive; and,
- to have a sense of purpose or a will to do what must be done (*newenkülen*).

This psycho-socio-cultural state is understood to be a matter of education. The Mapuche model of man (the *kimche*) must be taught from an early age, in order to avoid the emergence of personalities which, by departing from the model, may damage the community (Catriquir & Durán 1993). Adults are encouraged to exercise social control over children and adolescents so they do not "become odd" (*kangewey weluduam)*, or mistakenly search for their own needs (*wekufuche*). A Mapuche education, under the responsibility of the family, aims to teach children and young adults "a straight way of thinking" or *kiñe nor rakiduam*, as well as to educate children about all aspects of life through personal experiences (Hilger 1957). Children are taught, for example, how to care for the body, how to deal with new situations, how to avoid risks, and how to carry out various jobs according to their age or sex. Children learn that physical survival has many components, and that an individual has personal responsibility for his or her survival.

Chem anta kutrankuley

Illness is understood as "a negative state into which one part or the whole body falls" (*kütrankülen*). In the case of an illness, the first step is to discover what area of the body is unwell (*chem anta kütrankuley*). The illness takes the name of the affected area. An explanation for the illness, as well as a remedy, will be sought. When the cause is unknown, concerns arise which may be resolved through dream messages (*peuma*), which generally point towards the intervening agents (*ngenruka*) or the closest family members (*trokinche*). Depending on how the illness manifests itself, the most frequent suggestion will be to go to the *machi*, in the valley's *lof*, especially if an illness is suspected to be due to malevolent forces (*wesakutrán*).

Physical illnesses are distinguished by gender, and it is recognized that diseases can have their origin in the sex of the sufferer. Illnesses pertaining to the menstrual cycle are called *fillküyen* or *küyentun*, while testicular hypertrophy is called *paguakutran*. It is also understood that culturally-determined activities can cause sex-specific illnesses or diseases. Thus, it is accepted that men have accidents or *allfeñ* resulting from their work in the fields, while women suffer from visual discomfort due to excessive weaving (*furrikutran*), or from being regularly subjected to smoke from the cooking stove (*ngekutran*). With regard to spiritually-influenced diseases, sex differentiation operates in another way. It is believed that men and women can both be victims of disease caused by negative influences (*wedakutran).* However, there are certain conditions affecting men which are caused primarily by women. For example, there have been cases of women who have taken revenge against men who abandoned them after marriage, by inflicting injury to their genital organs by means of ritual harming practices.

Gender differences were also recorded in the case of natural diseases, and in situations when official health services were used. During a random sample of hospitalized adults, it was observed that the stronger the feelings of ethnic identity within the family unit, the less the disease altered gender-differentiated functions and duties. Thus, if the patient was a

man/husband/head of family, his eldest son would take over his duties, rather than the mother, who must continue to fulfil her own functions of supervising the harmony of the family group.

The function of the shaman or *machi*, seems to express itself more fully in women. If the function is performed by a man, he is expected to adopt "feminine traits," either in speech, gestures, or by wearing feminine apparel. The transition from the social role of wife, mother, or daughter, to that of shaman, is considered to be "natural" for women. Research suggests that the predominance of female shamans is related to the fact that the accompanying spiritual entity is male and demands female complementarity. The spirits of the machi are believed to be helpful in the diagnosis of individual or collective diseases, as well as to indicate appropriate treatments.

Gender is also relevant when it comes to curing diseases. While disease classification can be clearly explained by men and women through knowledge and cultural practices, the curative process rests mainly with women.

The female gender is associated with "sensitivity, energy, harmony and smoothness," while the male gender is associated with "strength, organization, initiative, and support." This gender differentiation determines the social activities of each sex. The sexes assume specific unchangeable roles. Therefore, the relationship between the genders in the field of health and disease adheres to defined patterns.

Health Care in an Inter-Ethnic Context

Today, different medical systems operate depending on whether or not the area is urban (official system) or rural (indigenous system). Health and disease are defined according to different ways of thinking depending upon the system. The official system predominates independent of the validity or effectiveness of the indigenous system. The indigenous system coexists with the official system. There is a lack of systemized knowledge available about the relationship between the two systems.

In the official system, statistical indicators of morbidity and mortality are used for the whole population. Based upon these indicators, institutional circles are of the opinion that health among the Mapuche is deficient, even though it is improving if the increasing care provided by the system is considered. The regional infant mortality rate (IMR) was 21.4% in 1988, compared to 15.9% in 1991. Temuco's IMR was 16.8% in 1988, and 12.3% in 1991. Nueva Imperial's IMR was 24.2% in 1988, and 18.4% in 1991. The Nueva Imperial community has the largest aboriginal population and the highest levels of poverty. Nueva Imperial also showed an increase in biomedical risk rates between 1988 and 1991, which was higher than that recorded for Temuco during the same period.

Data analysis from the last census of aboriginal settlements throughout the region confirmed that "infant mortality is significantly higher in said settlements; estimates made for 1985 show a figure which is twice that of the country and 5 times higher than in high class communities of the Metropolitan area; the 1988 expected life span at birth was 63 years, and this corresponds to the general rate in the country between 1970-1975" (Oyarce 1988).

National health services have either not reacted to this data at all, or have done so slowly. Since the 1980s, when international organizations such as the WHO and PAHO began organizing personnel training sessions addressing the need to acknowledge the inter-ethnic characteristics of the region, particularly in the case of health care[3], only two important programs have emerged to try to approach the coexistence of medical systems. These programs, called the Attention to the People Program and the *Amuldungun* program[4], were both activated by specialized technical personnel from the health services and indigenous collaborators known as "Intercultural Facilitators." There were problems in some areas with large indigenous populations and extreme poverty, due to a lack of communication between the Mapuche population and technical personnel. In 1991, the Ministry of Health responded to these concerns, as well as to demands for the recognition of alternative medical practices. In January 1992, a traditional medicine unit was formed within the department. It should be noted that, in the work program set out by this unit's national commission, the indigenous medical system is not identified within the context of traditional medicine.

Within the region, concern for the health of the Mapuche has gradually been included in the national institutional framework in a far more definite manner. Within the units supporting the four programs which are the cornerstones of the Attention to the People Department, there is a program known as "Mapuche." A doctor, an anthropologist, and an intercultural facilitator work in this program in four communes of the region. Attempts are being made to train teams in understanding the aboriginal perspective, especially the models explaining health and disease.

The motto of these teams is *Health for all by the year 2000.* According to the intercultural facilitator, one of the greatest achievements of the program to date has been the ability of people in the communities to understand the contribution of official medicine, and acknowledge that both systems of medical care are important.

The *Amuldungun* program, which began in 1993, focuses on the incorporation or relocation of Mapuche health personnel, in order to create an intercultural medical service in response to the Mapuche population's demand for official health services in regional hospitals. While this program is being evaluated at present, it was considered to be highly suitable from the

---

[3]The author participated in these initial sessions, together with colleagues from the department, providing anthropological methodologies for the recording and analysis of cases.

[4]Amuldungun means: "we're talking about what people know" (approximate translation).

start. Cultural communication between the Mapuche people and the official services has not been overcome by the dispensing of medical treatment, according to reports by Mapuche personnel of the team participating in the Quality of Life, Health, and Environment project.

In the private sector, there are at least three other programs guided by concerns about health among the Mapuche: the Household Medicine program, the Peasant and Indigenous Woman program, and the Health Monitors program[5]. The common characteristic of these programs is that they have considered the region's rural areas and have attempted to incorporate the participation of peasant and indigenous women. However, their methodologies and results have not been linked permanently with the relevant institutional sectors (Health and Education).

Health, Identity and Culture

In order to fully address the health situation of the Mapuche in Chile, the complexity of the health-disease relationship must be understood not only within the ethnic communities themselves, but also within the official health care services. It is also very important to consider how development plans for these ethnic communities are conceptualized, and to what extent these plans effectively deal with the health situation.

It is increasingly evident that the Mapuche people wish to restore the lifestyle in which they lived, in order to achieve a psycho-cultural balance. They also wish to create better conditions to communicate with others, who currently do not understand the true nature of their problems. The Mapuche people must be more conscious of the value and role of their own vision of the world (Vidal 1989).

This research has increased our understanding of the importance of the concept of health in the life of the Mapuche people, and how "development" with "aid" from different sources may in fact contribute to the reappearance of old failures, unless deep thinking is done about their way of life. Together with the Mapuche people, we must examine the contemporary lifestyle from a gender perspective, in order to reconstruct a complementary relationship, so as to overcome inequities and disharmonies derived from contemporary living conditions.

References

Augusta, Fray Félix J. 1934. Araucan reading. San Francisco Press. Padre Las Casas, Chile.

[5]The institutions which have backed these programs are the Italian Cooperation, the PEMCI, and the Methodist Dispensary.

Catriquir, D.; Durán, T. 1993. Some Mapuche educational principles (unpublished).

Dillehay, Tom D. 1990. Araucania: present and past. Editorial Bello. Santiago de Chile.

Durán, Teresa. 1986. Mapuche identity. A problem of life and concept. In Indigenous America Vol. XLVI, 4:691-722.

1994. Mapuche settlement and community. Factors of continuity and change (to be published in Indigenous America).

Faron, Luis. 1961. Mapuche social structure: institutional reintegration in a patrilineal society of Central Chile. Illinois studies in anthropology No. 1. Illinois University Press Urban.

Grebe, M.E.; Fernández, J.; Fielder, C. 1970. Myths, beliefs and concept of disease in the Mapuche culture. In psychiatric and psychological record for Latin America, 17(3): 180-193. Buenos Aires.

Grebe, María E. 1975. Taxonomy of Mapuche disease. In Nueva Epoca, 2: 27-39. Santiago U. de Chile.

Gumucio, Juan Carlos. 1988. Anumka pu pullu. In record of languages and literature. University of Frontera Temuco.

Hilger, María I. 1957. Araucanian child life and its cultural background. Smithsonian Institute, Washington, 1957.

Huenchulaf, Mauricio. 1991. The land. The world is only one. In Mapuche People, environment and non-government organizations. pp 27-34.

Ñanculef, J.; Gumucio, J. 1991. The task of the machi: content and expression. In NÜTRAM No. 25, pp 3-12. Ediciones REHUE, Santiago.

Montecinos, S.; Conejeros, A. 1985. Mapuche women, traditional knowledge in curing common diseases. Women and Health Series No 2, Ediciones CEM.

Oyarce, Ana M. 1988. Health among the Mapuche. Experiences No. 3, 1-44. PAESMI. Santiago de Chile.

Oyarce, Ana M.; Ñanco, José Ibacache. 1992. Mapuchemongen. Life of the people of the land. Cultural Interaction in Health Manual. Temuco.

Pineda y Bascuñan, Francisco. 1973. Happy Bondage. Chap.XIX, pp 105-110. Editorial Universitaria. Santiago de Chile.

Painemal, Galvarino. 1993. Introduction to the Mapuche and the Animal. To be published in the records of the 3rd International Convention on Natural Resources.

Stuchlik, Milan. 1976. Life on a half share. Mechanisms of social recruitment among the Mapuches of Southern Chile. C. Hurst and Company, London.

Stuchlik, M.; Holy, L. 1981. The Structure of folk models. Academic Press, pp 1-34.

Vidal, Aldo. 1992. Demographic and cultural situation of the rural Mapuche population in Chile: critical fluctuation in reproductive systems. In On Indigenous Cultures: Language and Identity. Catholic University of Temuco.

1992. Sociodemographic indicators of the rural Mapuche population. Crisis in societal reproduction? In Current Mapuche Society and Culture. IDRC. Soc. Mapuche Lonko Kilapán, pp 207-257.

Discussion

Following presentations by Xochitl Herrera (Colombia) and Teresa Castillo (Mexico), a general discussion took place on the topic of Indigenous Peoples' Health Issues. The following points were raised:

- A sexual division of labour usually exists among indigenous peoples. Men usually hunt, while women usually manage the crops and play an instrumental role in harvesting. Women may also collect edible products and insects.

- While it is true that men have a great deal of public power, the power of women in their communities should not be overlooked. While women work hard, men have to do many difficult things as well, including fasting for days while they are hunting.

- Environmental crises, such as drought, can seriously impact on the lives of indigenous women. Women may be forced to go to the city with their children in search of work. They may be forced to beg for money to survive. They may also have to leave their children in the care of others while they go out to work.

- When indigenous populations enter the labour market, serious changes may affect their sustainable development model for managing the environment. For example, changes in agricultural practices may lead to serious land erosion. Changes may lead to less productive land which creates problems for future development. The traditional variety of crops may be left aside and a community may instead focus on only one cash crop. As a result of changes in family crops, many people may suffer from malnutrition and children may experience growth deficiencies. These types of problems occur as a result of bad management of resources, not because of a lack of land.

- A need exists for more research exploring how equality between men and women is affected when a community enters the Western market economy. When indigenous people enter the labour market, a greater amount of inequality often results. Women play an important role in traditional cultures, compared to their marginalized role in the market system. Strategies to help women maintain their power and position when their communities enter the labour market need to be developed.

- Urban communities can learn a great deal from indigenous communities. Many participants stressed that it is crucial that researchers have a thorough understanding of cultural values when devising methodologies, carrying out and analyzing research. When conducting research involving rural indigenous women, many urban analysis methods may not be applicable. For example, in Ecuadorian rural communities, it is not uncommon to see a man riding a donkey while the woman walks alongside. A

historical separation of labour may exist which may be more egalitarian than the division of labour which exists in urban societies. Viewed from an external perspective, the heavy work that women perform, such as carrying firewood, may suggest domination. Before making such an assessment, a researcher must be intimately familiar with the community.

- Alternative means of communication with indigenous communities need to be explored. For example, group techniques and games may encourage active participation, rather than passive interaction. While individuals may be initially reluctant to engage in what appears to be child-play, increased participation may result once the ice has been broken. For example, one participant described a game which was initiated to help researchers see problems from the perspective of the community. The researcher pretended he was a blind man and covered his eyes and began walking. As the blind man encountered obstacles, they were seen as symbols for community problems and explained to the researcher by the community members.

- A discussion took place concerning the role of gender research in indigenous communities. One participant felt that researchers should be careful not to focus on gender issues if the community does not view them as important. Indigenous communities may be more concerned with the profound loss of traditional cultural values and the extent to which this impacts on their health. Another participant felt that gender issues should be studied even if individuals in the community are presently unaware of their importance.

- One participant suggested that the domination of women by men in indigenous cultures, including violence in relationships, is related to the Spanish conquest and the historical culture of domination and conquest. Many indigenous men are concerned that the women of their communities prefer Spanish men over indigenous men. Men therefore dominate women as a way of trying to prevent them from moving toward the Spanish, which would result in the eventual assimilation of the Indian race. To maintain the Indian race, the process of discrimination and domination over women is perpetuated.

- Some indigenous people are reluctant to defend a gender perspective, because they are also concerned with their identity generally as indigenous people. Indigenous women may be reluctant to contradict the general interests of indigenous men, as it would hinder their attempts to present themselves as a united front.

Health Care Providers

Gender Differentials and Primary Health Care

Constanza Collazos V.[1]

Gender, Health Services, and Primary Health Care

The division of labour, based on biological differences and grounded in a patriarchal ideology, has restricted women to the private/domestic sphere, under conditions which have historically legitimized the subordinate position of women. This subordination has had serious effects on women's public and private lives, with repercussions in the home, in the paid workforce, and in cultural and educational spheres. It has also had negative implications on the health of women. Gender stereotypes and sexual discrimination affect attitudes, behaviours, and activities, which lead to differential health risks for men and women, as well as different degrees of accessibility to health services.

Health services have traditionally focused on illness and the biological functions of individuals. Medical, educational, and research activities have concentrated on the search for treatments or cures for very specific ailments. This specific biological focus helps to explain why health institutions have focused on the reproductive function of women, while other aspects of women's health and well-being have been largely ignored. Women's bodies are treated only in their reproductive capacity, their natural functions are medicated, and phenomenons resulting from social and cultural factors are treated as psychiatric conditions. Health systems face other problems such as inadequate facilities, inadequate professional training, poor remuneration for health professionals, and lack of social commitment.

Although primary health care activities attempt to be innovative, these activities have not escaped from health reductionism, or from considering women as instruments. Many institutions emphasize "healthy lifestyles," ignoring cultural, social, economic, and political factors that have implications for women's health. Health activities are regularly confronted with numerous administrative, political, and financial difficulties.

Even with an integrated orientation, adequate administration, and an excellent team, primary health activities are still limited in achieving their goals. This is a result of problems related to health delivery, especially in rural areas. Insufficient attention has been given to women's health issues. Indeed, women's health is now considered one of the most critical problems in Latin America.

---

[1] Investigadora del Centro de Investigaciones Multidisciplinarias en Desarrollo (CIMDER), Cali, Colombia.

Health programs should be guided by a recognition of the existence of different requirements by different groups. Special intervention strategies should be developed for these groups. Given the recognition of the social and biological differences between men and women, health interventions specifically directed to women are not only encouraged, but necessary (de los Rios and Gomez 1992).

Women as Health Agents

The role of women has historically been limited to the private and domestic field. Women have been largely denied a place in formal economic work outside the home. Socialization has led women to fulfil the role of procreator, and beliefs, morals, customs, and habits have perpetuated the subordinated position of women in society. Dora Cardaci (1992) identified three aspects of women's "informal" work related to health: women work as health providers, as educators, and as mediators of the conventional health system.

> As a provider, the woman is responsible for guaranteeing domestic surroundings for the maintenance of health and recovery of illnesses. This includes the guarantee of a safe atmosphere: a warm and clean house where family members are protected from illnesses and dangers, where children, young people and adults are offered a balanced diet, in quantity as well as quality, in order to cover their nutritional needs. This, as well, assumes to provide a social environment that could allow adequate growth and health. It is a woman's role to maintain family harmony inside a home and to diminish the anxieties and tensions that emerge when these relationships don't go well. Home as a refuge, as a mean against all kind of violence, is "typically" a woman's responsibility. The second dimension of their role in the informal health system derives from the first one. When struggling for their family health, the woman also carries out an educational task. She fixes rules for dieting and discipline and transfers a specific "culture" which should contain health and illness, risks and benefits for the members of the family group. The domestic responsibilities of the woman for the health of others, places her in constant contact with medical staff, social workers, health technicians, etc., making her a mediator between them and her family members.
>
> If these workers are women, they will have in common with the patient the responsibility of health and family harmony, but these aspects are hidden, neutralized; the established relationship is enhanced by that situation but is not identified and doesn't emerge because of a shared "gender blindness."

Responsible for the well-being of the family, women often ignore their own illnesses and health. A woman's everyday routine is full of small waivers of herself which are acts of giving herself up to others.

Local Health Systems and Women's Participation

The importance placed on a biological understanding of women's health and illness has undoubtedly shaped the knowledge of health agents with regard to women's health at all

levels, even at the community level through voluntary personnel. In order to transform this situation, the full involvement of women is required. The local level is essential to the processing of social outcomes related to health.

Primary health care needs to be reviewed, and the risks related to the assigned social roles of men and women need to be considered. These socially-defined roles should be considered in the development of health promotion and prevention programs. Intervention methods directed at women in the primary health care field need to be reviewed. "Invisible" problems, such as violence against women, need more attention. Effective interventions, aimed at the prevention of accidents which may occur at a local level, should be introduced. The health risks for women associated with stress, overloading of tasks, and feelings of guilt, cannot continue to go unnoticed within primary health care (de los Rios and Gomez 1992).

It is not enough, however, to simply organize social services. Rather, it is necessary to work in society itself, in pursuit of health development at the local level. The definition of women's health within the concept of primary health care begins with the recognition of the capacity of women to decide, to choose, to select and influence the maintenance and preservation of their own health. Decisions about their health are established as a conscious act and as a commitment to themselves. This does not mean the loss of their rights to decide and/or demand medical attention from public institutions; nor does it make them responsible or "guilty" for their mental, emotional, or organic dysfunctions; nor is it considered an answer to the complexity of social, economical, cultural, and political proceedings, which can lead to negative health implications. The act of a woman taking care of her own health is sustained by her ability to recognize herself as an individual, to find herself worthy, to strengthen her self-esteem, and to regain the power to decide about her own health. The participation of women is indispensable for the transformation of health services, especially at the local level.

Promotion of and Self-Care for Women's Health

The health sector must act in an integrated manner with other social sectors. Traditional restrictions with reference to the treatment of illness and the promotion of "healthy lifestyles" must be overcome. Given that the concept of health and well-being implies the idea of healthy lifestyles, the promotion of health is not exclusively the responsibility of the medical sector.

In order to overcome inequity in health care, social conflicts must be solved. Services and conditions that may lead to illnesses and discomforts must be changed. Health goals must be defined. Health education should be based on ideas, beliefs, ethics, attitudes, relationships, institutions, knowledge, and technologies which allow human beings and communities, not only to survive, but to live with dignity (Rozental 1992).

Because of the social subordination of women, in order to achieve the evolution of new health education, it is essential to find ways to redefine a woman's role, purposes, and her participation in decision-making. A transformation of the roles ascribed to the different genders, social groups, and social classes, is needed. We must work towards mutual respect between men and women, as well as an understanding of differences, not from the point of view of inequality or discrimination, but from characteristics, specifications, and individualities of each sex. The participation of the woman acquires new characteristics, shades and dimensions (Arango 1992). The woman as an acting social being redefines her means of participation. A woman needs to care and make decisions about her own health, based on the recognition of

> ...her capacity to decide about her body and her health (physical, mental, and emotional) according to her development as a human being, as a social being, from the point of view of her reassertion as a person, and in the prospect of her personal growth, based on her individual necessities that leads to her making conscious and permanent decisions...(Arango 1992)

Self-care, specifically with regard to women, counteracts class, ethnicity, territoriality, and culture, which prevent homogeneity within the health field. One cannot ignore the complex history of life which accompanies each person, through which each individual has gained affections, dislikes, interests, and options.

In the establishment of strategies aimed at transferring health responsibilities, and encouraging the self-care of communities and populations, there is a risk that there will not be a corresponding transference of authority on goods, finances, and decisions (PAHO 1992). Health education needs a new concept with a gender approach in the promotion of health support and in the prevention of violence against women. Changes to the social rules and norms that are promoted from a very early age through public and medical institutions might lead to the redefinition of men's and women's behaviour in relation to health.

Proposals for interventions are not enough to achieve a more equitable relationship in health, if they are limited to the confines of socially-defined gender roles that are influenced by the health sector and primary health care. Interventions in accordance with political and legal policies, and with the state and society, play a fundamental role in the process of defeating discriminatory barriers against women (de los Rios and Gomez 1992).

To strengthen women's participation and their leadership in health, it is necessary to rescue their creative potential in a constructive sense, reinforce their identities, citizenship and acquisition of power as health agents, with the attendant rights and duties.

Building the Ideal

When asked to participate in health programs, women offer their services much more than men. Despite their already long and arduous working day, they volunteer to assist in health

programs. Is this cooperation a result of socially-defined and established duties, poor valuation of their work, or because of some other factor? Why are women drawn toward working collectively in groups to achieve some desired goal?

Although there have been many mistakes made, primary health care efforts for women's health have contributed to the personal development of hundreds of women. The actions taken and the requests to participate in health care have been avenues for women to achieve personal advancement, and to enter into other social areas which are traditionally regarded as out of reach for women. Whether or not personal development is an objective of the health program, women establish their own dynamic relationships, and make their own discoveries about the world, even though they may not completely understand what health is all about, or the reasons why certain preventive actions are taken. This in itself encourages us to continue working, to keep learning and understanding, to amend mistakes, and learn from them. We have to start now, not tomorrow.

A participant of an education and development program in primary health care on a sidewalk of the Municipality of The Tambo, Department of Cauca, Colombia, provided the following account:

> We attended the Program, we found out that it was not about first aid, we learned that health is a very important aspect, that we have to learn many things, not learning how to treat illnesses, but how to prevent them. And that really encouraged me to go on week by week up to where we are.
>
> In the course of these fifteen months attending the Program, I have only missed two Tuesdays. On those two days when I couldn't come, I felt very distressed, worrying about what I missed. During one of those days, there was the filming in the Romelia; that day I was mad and wanted to quarrel with every member of my family, because I couldn't go, because I was working. That Program has helped me a lot, because as a person, although I am still a little shy, I already speak to others and we deal with each other, we feel like equals, and the fact that everybody knows what I know, is very nice. It is also nice to deal with the people of our community, to go and teach them. Sometimes we are welcomed, sometimes we are not, but at the end they understand what we are teaching them. For example, when we dealt with installation of sanitary toilets, they at first used to fill up the toilets, but later on they understood the necessity, the importance of installing a toilet, because we explained to them the risks that they were exposed to for not having an installed sanitary toilet.

Conclusion

Many actions have been developed in the field of primary health care and in the linkage between gender and health practices. These actions are strengthened if concepts of health are integrated, and the traditionally subordinate and restricted views about women move toward a vision of rights equity and equality. Such initiatives should strive to do the following: to improve the services and quality of health institutions in order to fulfil local medical needs, in accordance with values and beliefs of women and men; to educate the personnel which

work in the organizations in pursuit of a humane, integrated, and thoughtful program; to work together with other sectors in order to achieve integrated goals that will help to improve the status of individuals; to strengthen local identities, and influence decisions of other levels; to acknowledge the differences between people and human groups in order to encourage specific and selective approaches. They should also promote a notion of health which integrates popular knowledge and traditional practices. The commitment that women have to this change is evidenced in their willingness to participate in an active way, choosing, influencing, and making decisions about every situation that concerns their lives. Governments should ensure that they do more than just express goodwill, but also take concrete steps to contribute to such change.

References

Arango, P. Yolanda. 1992. La promocion de la salud y la mujer: un analisis sobre sus limitantes y posibilidades. Reunion Latinoamericana de promocion de la salud. Organizacion Panamericana de la salud. Santa Fé de Bogota, Colombia. Noviembre 1-11.

1991. Salud, y autocuidado: una toma de decisiones de la mujer frente a su vida. Reflexiones para un debate. Documento organizacion Panamericana de la salud. Washington, DC. Agosto.

Araujo, Maria Josefa. 1992. Los servicios de salud publica. Mujer Fempress. Especial. Santiago, Chile.

Arias, Londono Melba. 1991. Derechos de la muder y la familia en la nueva constitucion. Organizacion panamericana de trabajo. Cali, Colombia. Noviembre 6-8.

Barroso, Carmen. 1989. Mujer, salud y desarrollo. Manuscrito. Julio.

Brems, Susan; Griffiths, Marcia. 1993. Health women's way: learning to listen. The health of women: A global perspective. Eds. Marge Koblinsky; Judith Timyan; Jull Gay. Boulder. Westview Press.

Cardaci, Dora. 1991. Mujeres, cuidado de la salud y violencia. Mujer, salud y autocuidado. Memorias. Organizacion Panamericana de la salud. Programa regional mujer, salud y desarrollo. Programa desarrollo de servicios. Grupo Latinoamericano de trabajo. Cali, Colombia. Noviembre 6-8.

Charkiewicz-Pluta, Eva; Hausler, Sabina. 1991. Construyendo el mundo juntas. Mujeres, el medio ambiente y desarrollo sostenido. Institute of social studies. Department of Women's studies. University of Utrecht. Septiembre.

Cohn, Amelia. 1993. Conocimiento y practica en salud colectiva: El desafio permanente. Cusadernos médico sociales. CESS. Argentina. No. 64 Julio.

Collazos, V. Constanza. 1992. Evaluacion participativa. Escuela de madres en el Tambo. Transcripcion. Documento Borrador. CIMDER. Julio.

1992. Escuela de madres: hacia la construccion de una neuva convivencia. Memorias foro nacional de salud comunitaria. Fundacion Santa Fé. Santa Fé de Bogota.

1990. Atencion primaria de salud en Buenaventura: el aporte de la mujer. Boletin CIMDER, Vol. 1, No. 10, Marzo.

De los Rios, Rebecca; Gomez, Elsa. 1992. La Mujer en la salud y el desarrollo. Un Enfoque alternativo. In Women, Health and Selfcare memoirs. Latinamerican Working Group. Cali, Colombia, November 6-8, 1991. Panamerican Health Organization, Washington, DC. September. pp 107-108.

1991. La mujer, la salud y el desarrollo: un enfoque alternativo. Organizacion Panamericana de la salud. Documento. Marzo.

EPAS. 1991. Pontificia Universidad Catolica de Chile. Educacion papa el autocuidado en salud. Oficina de promocion de la salud y autocuidado. Vol. VII, No. 2, Junio.

Franco, Saul. 1991. Violencia, derechos humanos y salud. Seminario de derechos humanos y salud. Mexico. Julio.

Germain, Adrienne; Ordway, Jane. 1989. Control de poblacion y salud de las mujeres. Equilibrando la balanza. IWHC. June.

IDRC. 1992. An agenda 21 organization. 1992. A backgrounder on current activities.

Loewe, Ricardo. 1988. Atencion primaria a la salud: revision conceptual. Revista de salud publica de Mexico. Instituto Nacional de Salud Publica. Vol. 30, No. 5. September/October.

Londono, Argelia. 1993. Proyecto para la implantacion de programas communitarios en los sistemas locales de salud para la prevencion y la atencion de la violencia contra las mujeres y las ninas en el entorno intrafamiliar en distintos paises de la region. Documento. OPS. Santa Fé de Bogota.

Luppi, Irene-Belmartino; Bloch, Susana; Carlos-Boggio, Gabriela; Schapira, Marta. 1993. Servicios de salud. Investigaciones evaluativas. Desarrollo methdologico de un proyecto en curso. Cuadernos médico sociales. CESS. Argentina No. 64. Julio.

Malagon de Salaqzar, Ligia; Becerra and Calle Jaime. 1988. Escuela de madres. Soluciones para prevenir y curar en casa. CIMDER, Cali, Colombia.

Ministerio de salud de Colombia. 1992. Salud para las mujeres, Mujeres para la salud. Revista a Vivir. No. 1, Deciembre.

Naciones Unidas. UNICEF. UNIFEM. 1992. Situacion de la mujer en el mundo. Tendencias y etadisticas 1970-1990, en estadisticas e indicadores sociales. Series K, No. 8. Nueva York.

Newsweek. 1992. La mujer al poder. Informe especial. Summa edition 59.

Organizacion Mundial de la salud. 1991. De Alma - ATA al ano 2000. Reflexiones a medio camino. Ginebra.

Organizacion Panamericana de la salud. 1991. Mufer, Salud y Autocuidado. Memorias. Programa Regional Mujer, Salud y Desarrollo. Programa Desarrollo de Servicios. Grupo latinoamericano de trabajo. Cali, Colombia. Noviembre 6-8.

1991. Orientaciones estrategicas y prioridades programaticas 1991-1994. Oficina regional de la OMS. Washington, DC.

1990. Las condiciones de salud en las Americas. Salud de la mujer.

Osorio, P. Flor E.; Castill, O. Olga L.; Lizarazo, B. Maria O.; Ramirez, R. 1993. Jefatura Femenina de Hogares. El caso de Montelibano. Avances 5. Instituto de estudios Regionales. Pontificisa universidad Javeriana. Santa fé de Bogota. Agosto.

PNUD. 1992. Desarrollo humano: informe 1992. Tercer Mundo Editores. Sante Fé de Bogota, Colombia.

Presidencia de la Republica de Colombia. 1991. Consejeria para la juventud, la mujer y la familia. Lineaminetos hacia una politica integral de la mujer Colombiana. Colombia.

Rathgeber, Eva M.; Vlassoff, Carol. 1991. Gender and tropical diseases: A new research focus. *Soc. Sci. and Med.* Vol. 37, No. 4.

Rifkin, Susan B. 1981. The role of the public in the planning management and evaluation of health activities and programs including self-care. *Soc. Sci. and Med.* Vol. 15A.

Toledo Llancaqueo Victor. 1992. Salud y desarrollo. Mujeres Mapuches. Revista de la red de Salud. ISIS International No. 1.

UNICEF. 1993. Presidencias de la Republicas de Colombia. Consejeria para la juventud, la mujer y la familia. "Politica Integral para las mujeres." Arte editorial, Sante Fe de Bogota. 8 de Marzo.

1991. Taller regional sobre atencion a la mujer y a la nina. Preparacion del Plan de Accion para la capacitacion en género del personal de UNICEF. Programa regional capacitacion de la mujer papa el desarrollo. Cali, Colombia. 26-28 Junio.

1989. "El Ajuste Invisible. Los efectos de la crisis economica en las mujeres pobres." Oficina regionals para América Latina y el Caribe. Programa regional participacion de la mujer en el desarrollo. Editorial Gente Nueva. Colombia. Abril.

UNFPA. 1989. Incorporating women into population and development. Knowing why and knowing how. State of the world population report.

UNICEF-PKRPMD. 1988. Dos dialogos sobre la mujer. El encuentro de organizaciones y redes no gubernamentales y el encuentro de agencias gubernamentales que trabajan en pro de la mujer en América Latina y el Caribe. Editorial gente nueva. Bogota, Colombia.

UNDO/World Bank/WHO. 1992. Work plan of the task force on gender an tropical diseases. Special program for research and training in tropical diseases. (TDR).

Valli, K. Fairouz. 1992. Combatting inequality. *Health action issue 2.* September.

Velasco, G. Gloria; Mesa, R. Lucrecia; Gonzalez, Maria Helena. 1993. Practicas y Creencias de la mujer respecto a su cuerpo y salud. CAMI. Cali, Colombia.

Wijeyaratne, Pandu; Rathgeber, Eva M.; St-Onge, Evelyn. 1992. Women and tropical diseases. IDRC, Canada.

Health Promoters: Invisible Providers of Care

Ilta Lange, Alicia Aguilo, and Carmen Barros[1]

Introduction

This paper is a secondary analysis of research on health promoters which explored the motivations and expectations of health promoters, as well as the way they perceived their roles and relationships with their communities, and with their health teams. The study was carried out in two communities that are served by a community outpatient clinic in Santiago, Chile.[2] This paper, based on the research results, includes a gender perspective.

Reflections Made by the Research Workers

It is interesting to note that the research unconsciously began from a masculine-oriented perspective. Masculine language dominated, with the Spanish word "monitores" being used, which refers to masculine monitors or health promoters, as opposed to "monitoras," which refers to feminine monitors. During the first study group, it was realized that all of the health promoters were women. Even though there were no male monitors, it was difficult to use the feminine word for monitors. This demonstrates how society has been socialized to use the masculine form of words in daily language. Without realizing it, researchers contribute to the perpetuation and reproduction of sexist cultural patterns.

Reflections Based on Observed Reality

This section discusses perceptions regarding the role of monitors, stressing their own and society's ambivalence in defining this role, and in judging its effects. According to classical gender stereotypes, health care is a woman's role (Salinas 1988). When the outpatient clinic decided to initiate a training program for health monitors, it was not surprising that women responded favourably to this decision. However, because women feel that this role is an extension of the tasks socially assigned to them as women, they are neither paid for their work as health promoters, nor is the value of their contribution fully recognized. The health monitor role is considered to be "naturally" feminine and is undervalued. Consequently,

[1] School of Nursing, Universidad Catolica de Chile, Santiago, Chile.

[2] The research is being carried out as part of the Kellogg International Leadership Program (KILP) by a team of professionals from the Faculty of Medicine, Social Sciences Division, Universidad Catolica de Chile.

while women are initially motivated to assume that role, they subsequently become discouraged by the lack of recognition they receive. This negatively affects the stability, continuity, and effectiveness of their work.

The answers provided by female health providers during the research project highlighted the lack of social recognition of the role of health promoters. The women were asked what they had disliked most about their previous community "voluntary work." Seventy-five percent pointed out elements related to the way other people reacted to their wish to help, mentioning apathy, lack of cooperation, criticism, ungratefulness, and the fact that their work was not recognized by the community which they were serving. They also mentioned the lack of team work, negative statements made by the other monitors, and their poor organization as a group. Some women mentioned that they felt manipulated by authorities and political manoeuvres. They also mentioned the existence of administrative obstacles in the health services which affected their effectiveness.

On the other hand, all the monitors pointed out that the positive relationship established with the members of their community allowed them to help others, which made them feel good, helped them to make good use of their time, and enriched their development as human beings. The main motivations for taking on the role of health promoter mentioned by the sixteen women who were interviewed were:

- the expectations of personal development which could be attained through further training; and,
- the perception that this work represented an opportunity to do something useful for the community.

For those women who felt motivated by the expectation of personal development, training made them feel more self-reliant, and better able to face certain daily situations. For example, they stated that prior to being monitors, they did not feel confident to speak in public, or to discuss issues with physicians or with other health professional or public authorities. After being trained, they were able to overcome this obstacle. They also stated that training strongly increased their self-esteem, and that they now felt capable of undertaking important tasks. All of the women indicated that training was an enriching experience.

Training not only provided the female monitors with the chance to acquire knowledge on specific subjects; it also positively affected their self-reliance and increased their self-esteem, as well as their autonomy to make decisions. From a gender perspective, it contributed to the improvement of the position of women in society.

Another reflection concerned the way in which monitor training programs were evaluated. Traditionally, there is an evaluation of whether or not the relevant knowledge and skills have been adequately acquired. In addition to this type of evaluation, it is also crucial to assess

other changes undergone by the person who has been trained, such as changes in self-image, self-esteem, and so on. In other words, the evaluation process must also be geared to identifying any changes in the development of new potentials.

The unconditional willingness to help others, which was expressed by the monitors who were mainly motivated by the desire to do something useful for their communities, was surprising. It reflected the cultural mandates directed to women in terms of "what is expected of them." According to Daskal (1990), there are many expectations of women, including:

- having the vocation to serve;
- containing, accompanying, understanding, enduring, and keeping quiet;
- not expecting any praise;
- never refusing any request made by others; and,
- not being interested in money.

With regard to money, it was found that half of the monitors interviewed did not expect any economic compensation for their work. Furthermore, they emphasized that their work was voluntary, and that they were proud of it. They stated that if they were paid for this job, it would lessen the value of their work. The monitors who indicated that they would like to be paid, expressed that they would use the money to reduce the expenses incurred in performing the work, or to buy implements necessary to carry out their work better. According to Coria (1991), in Chilean culture, money is "silenced" and omitted by women, and this "silencing" is neither ingenious nor harmless. Thus, it may be concluded that acting as monitors permits women to expand their restricted domestic environment and to value themselves in a way that does not violate the prescribed cultural patterns. It does not, however, significantly modify their social recognition.

Health monitors perceived that one of their responsibilities was to provide cognitive and emotional support (Lin and Ensel 1989). Cognitive aspects relate to the provision of health promotion and prevention information emphasizing the importance of a healthy lifestyle, helping to decide when to go to the health services, stressing the importance of continuity of care, and of complying with the health programs and indications given by the health team. Health monitors provided emotional support by listening to the members of the community who seek their help, and by supporting and understanding them. Both kinds of support provided by the monitors were accepted by the members of the community as "normal" or "natural" roles for women because health is a subject that concerns women, and women are culturally expected to provide emotional support.

These cognitive and emotional aspects related to the work of health monitors lead to two reflections:

- Health organizations must be cautioned that if they direct health related messages to women, they will contribute to the perpetuation of the idea that family health is primarily or exclusively the responsibility of women (Williams et al. 1981). This is consistent with PAHO's perspective that the woman's image as the only one responsible for health should be changed by more equitable criteria, to avoid assigning roles based on the division of labour and sexist responsibilities (OPS 1981).

- The belief that health promoters have more and better opportunities of providing social support, especially emotional support, than health personnel who work in a clinic, becomes true because the health promoters have more opportunities to establish frequent and timely relationships with the community members, with whom they share a common cultural background, common experiences and a common language.

It is also worthwhile to analyze the tasks carried out by the monitors as health providers. The monitors interviewed in this study said they were responsible for the following tasks: providing first aid, controlling blood pressure, going very early in the morning to the outpatient clinic to ask for an appointment for a person who needs it, carrying out surveys, participating in scabies and lice prevention campaigns, and sending high risk people to the outpatient clinic or to the emergency room. Clearly, health promoters feel responsible for a great number of activities. They risk being perceived and treated as resources that can be drawn upon until exhausted. In the case of the women interviewed, their work as monitors was additional to their work at home. Most women were married and had children. None of the women had any help at home, and some even had additional jobs. Despite the heavy workloads, monitors did not complain about their work, and instead said that they found this voluntary activity to be rewarding. These women did not challenge the culturally accepted notion that women should endure such conditions.

There has been some discussion surrounding the notion that health care coverage could be expanded to lower-income sectors by using the work of health monitors. Female health monitors are seen as a positive way to expand access to health services, increase activities related to health promotion and prevention of disease, and to improve the levels of continuity and timeliness in health care. Health promoters are viewed as a link between health professionals and the community, and a way to improve the effectiveness of professional care. Health monitors serve to explain and reinforce messages given by the health team. However, this use of health monitors to replace the functions of the formal health team, means that some community members would receive technically under-qualified medical care. Furthermore, the use of female health promoters to make health services more widely available, may also be seen as a cheap way to provide health care. The formal health care system could save significant expense if voluntary health care providers are used instead of paid health professionals. Instead of exploiting female health promoters, efforts are needed to enure that their work is fully acknowledged, and that they are adequately remunerated for their work.

References

Coria, C. 1991. "El Sexo Oculto del Diner." Editorial Paidos, Argentina.

Daskal, A.M. 1990. "La Vida Cotidiana de las Mujeres." En Isis ed. *El malestar silenciado. La otra salud mental.* Santiago. Ediciones de las Mujeres 14: 83-99.

Journal of Social Issues. 1985. 40 (4).

1985. 41(1).

Lin, N.; y Ensel, W. 1989. Life Stress and Health: Stressors and Resources. *American Sociological Review.* 54: 382-399.

OPS. 1991. Talleres sobre Salud y Género. Cuaderno No. 4 Mujery Communicacion.

1991. Cuaderno No. 5. *Mujer y Salud.* pp 11.

Salinas, J. 1988. Experiencias de Participacion Communitaria en Salud y Nutricion: Notas para un Analisis. *Rev. Chil. Nutr.* 16(3): 279-285.

Williams, A.; Ware, Y.; Donald, C. 1981. A model of mental health, life events and social support. *Journal of Health and Social Behaviour 22.* pp 324-336.

Psychosocial Determinants of the Use of Maternal-Child Health Services in Areas of Poverty

Maria Bonino[1]

Introduction

This work is part of a larger investigation[2] currently taking place, which studies the use of maternal-child health services in areas of extreme poverty in Montevideo, Uruguay. This research is being undertaken for the School of Medicine at the University of Uruguay, with the support of the International Development Research Centre (IDRC).

The study area which was selected suffers from relatively high levels of malnutrition, infant mortality, unplanned and high-risk pregnancies. The research team set out to investigate the various factors which may lead to the inadequate use of existing health services. The results from this study will allow for better training of health personnel, as well as the reorganization of services to ensure that they are more suitable to the needs of women in the area.

The project was designed to be carried out in two stages: (1) an initial qualitative stage aimed at learning more about the variables, indicators, and categories associated with the use or non-use of health services. In this stage, which has already been carried out, individual and collective interviews were held with women in the area, and with health personnel; and, (2) a second qualitative stage aimed at carrying out a multi-variate study of this information on the basis of a poll of the area (this is currently under development).

"Use of health services" refers to the use of health services by women for gynaecological care, the control of pregnancy and childbirth, as well as for the care of children up to two years of age. A number of independent variables which might affect the use of health services were explored including geographic, functional, technological, psychosocial, and socio-demographic.

This paper refers exclusively to the psychosocial factors that were found to be associated with the inadequate use of maternal-child health services. There was a close interrelationship between many of the different variables which influence the use of health services. The first

---

[1] Faculty of Medicine, Universidad de la Republica, Montevideo, Uruguay.

[2] "Beliefs and Practices of Women in Relation to the Use of Mother-and-Child Services". The research team is also composed of Luis Faral, MD, Renée Richero, MD, and Cristina Terra (Psychologist).

stage of this study demonstrated that the use of health services for pregnancy control and for care of infants was carried out inadequately, while gynaecological and puerperium care was virtually non-existent. Childbirth is almost entirely institutional.

Isolation and Undervaluation

The majority of women in the study area lived in conditions of extreme poverty. Recent research (Pablo 1989) demonstrated that poverty has many manifestations, including unemployment or under-employment, malnutrition, school dropouts, and alcoholism.

An important source of work for many men and women in the area is the collection and separation of what the rest of society throws away. Rubbish is part of the environment and daily life, and affects the self-perception of the people of the area.

> Because it's terrible, all the shacks which have pigs and have horses, they throw all the rubbish there. There are many that throw it down from the bridge, and when the river swells, it carries everything away ... I have already spoken to them to clean the rats, [sic] but if it becomes a rubbish dump again the rats come back.

Living conditions influence perceptions about the world. Negative living conditions can contribute to feelings of frustration. Harsh living conditions can also lead to feelings of undervaluation and isolation, which are important psychological variables affecting the attitudes of women about their health, and whether or not health services are used. A member of the health personnel made the following association between living conditions, undervaluation and negative attitudes, and the use of services:

> I admit that if I myself had to live in the situation in which they live, I would act the same way ... because pigsties are better than many of the shacks of these people here ... it is difficult to have self-esteem that way, everything points to your undervaluation as a person ... that is why I understand that attitude ... that is why I think that the important thing is education.

While harsh living conditions generate feelings of undervaluation for both men and women, discrimination against women can make the feeling more acute for women. A member of the health personnel analyzed the problem in the following way:

> ...they do not take care of themselves as people, they belittle themselves as women. They feel the obligation to have children, to have a partner, but they have no self-respect. The other day I heard one saying to another "but if your husband did not want you to come, how are you going to have an IUD put in? Three children is nothing my dear." And every now and then they appear beaten up, by the husbands or by the elder sons. Because once the father goes, the chief is not the mother, it's the eldest son...

There was a discussion about whether patriarchal values prevail when a woman is the stable figure in the family and the man an absent member, or whether the situation is more like a matriarchy (Mazzotti and Tricotti 1985). Based upon the information gathered during the interviews, men were perceived as having the physical "power" to hit, as well as the

psychological power to choose a woman, and to leave her for another woman. On the other hand, women usually have possession of the children. A community leader who brought together a group of neighbourhood women described the situation:

> A woman here does not take care of herself at all. The husband or the children always come first, for the children she does have time. But as for herself, nobody takes care of her, nobody cares that she doesn't feel well, they see her as an object. They say "what should I go and see the doctor for, I waste time."

Women usually do not recognize or express their personal undervaluation, except if they have undergone a process of change through participation in community groups. When women were asked about health care, this undervaluation could be inferred from comments that they had a "lack of time," or were "not able to leave the children alone." It could also be seen in the total absence of personal or collective projects except those tied to motherhood. Women said that they "give everything to [their] children" and that "the only thing [they] have in life is [their] children."

In addition to the undervaluation associated with being poor, with living in a particular neighbourhood, and with being a woman, another important element was isolation. The women in this area were isolated from the rest of the society in Montevideo because of where they lived. They were also isolated from the men of their neighbourhood, because only women tend to remain in this area all day. This isolation had dramatic effects on the personalities, attitudes, and beliefs of young girls and women. According to one woman, they were "totally isolated, only one bus gets here, and nothing at night." Going downtown or merely getting out of the neighbourhood was a complex activity to carry out. These problems should be considered when exploring alternatives for health interventions. Another problem, according to one woman, was "shyness, the bashfulness of getting close to other women to chat. There is very little dialogue here between neighbours, rather each one closes in on her own things."

Social Barriers to the Use of Services

Little Value Attached to the Importance of Preventive Care

Many women reported that they did not go for regular gynaecological care, or for care during the puerperium stage. A neighbourhood women's organization held a poll in the area and "found that over 70% of the women did not know what a Papanicolaou test was and had never had one." Lack of information was related to the lack of importance which was attached to prevention. The majority of women admitted that they only went to the doctor when they were in pain. According to one woman, "sometimes I take Novemina [a strong pain killer] and it doesn't go away. I try not to go. I know I am hurting myself."

According to community women and health personnel, health education activities were few and virtually non-existent outside the health centres. The importance of routine gynaecological care was not well understood. After childbirth, only some women were informed that they should go for regular check-ups.

The majority of women stated a clear difference between what they did for themselves, and what they did for their children. "I went to the pregnancy check-ups as a duty, because I think it is a duty to do it for the welfare of the child." "One thinks of going, wants to go, but afterwards one starts thinking at home and does not go. One does take the children, I think that we give more importance to our children than to ourselves." The testimonies gathered suggest the need to broadly educate women about the importance of regular gynaecological care, as well as care surrounding childbirth. The role of self-esteem, an important factor affecting whether or not women seek care for their own health, should be considered when implementing educational health programs.

Women's Fears of Check-Ups

That Diseases will be Discovered

Some women expressed concern that diseases would be discovered during check-ups and they did not want to know about them. "My mother-in-law died of cancer of the uterus. My sister-in-law left behind five children, she died of cancer of the uterus. I'd rather not know. I don't want to know." The recent inclusion of blood tests as part of regular check-ups may lead to other fears. According to one woman, "if they are going to do the HIV, I'm not going - what if I've got AIDS?"

Of Procedures

Some women feared gynaecological procedures, especially women going for gynaecological care for the first time who had heard about the bad experiences of other women. "The students were there, they undressed me, they all touched me. I am scared to go back." "My sister told me that they were going to cut me up from top to bottom - and so I never went." Many women do not go for check-ups because the doctor "checks them up, and puts his finger in [the vagina]..." Better education of women, as well as more sensitive behaviour on the part of physicians, are necessary to deal with these obstacles.

Of Habits Being Found Out

Some women were concerned that they would be scolded by health professionals because their lifestyle and behaviours would be deemed inappropriate. According to one woman, "the doctor should not scold one for taking the child [who is] dirty because if she goes for an emergency, she's not going to be thinking that she should wash him beforehand." Another woman reported that her "sister was three months pregnant and when the doctor went out to

call her she was smoking and she got scolded. And right then and there she did not go in." Other women said that they felt concerned about their level of cleanliness and type of dress, and felt that it would be too much effort to "get ready" to go to the clinic.

Mistrust

Of Outsiders

Some women felt the weight of the stigma associated with coming from a very poor neighbourhood. They may feel that they are not valued by society, and they may also not value themselves. A community leader described the problem in these words: "... we are people although nobody recognizes us as people. Here too there is love, rivalry, struggle, work, scarcity." Another community leader reported the following:

> There always appears to be a distance between the one that goes for the check-up and the one that is the doctor. I do not think so, I think that we are all human beings and we are all the same ... In a neighbourhood there are all sorts, people who worry about their children and those who don't ... It is important that the doctor is prepared so that there isn't that distance.

There was a barrier between those living in the neighbourhood, and those who came from the outside, because of the way society marginalizes the people from the neighbourhood. Some people have been working with the neighbourhood for many years, and have gained the trust and respect of the population, and therefore "belong." According to one person, "the thing is that Father Cacho belongs to us, Father Cacho belongs here, like Violeta, those people are already ours..." Another woman, when discussing a family doctor who has been working for years in the area, reported that, "with him it's different, he explains everything and you understand it all; it's as if he was one of us, as if he belonged here."

Lack of trust of outsiders generates fear:

> These people lack that trust in the doctor a lot ... There are things that stop them from having that trust, to find that doctor that you feel as a truly human person. People lose faith and do not go to the doctor because they are scared. Like me, I went to the traumatologist at the Police Hospital and they treated me so bad, so bad, that I didn't say anything, I came back home and never went back.

In Medical Diagnoses

Some women reported that they did not trust the diagnoses of health care professionals. Many women stated that they had received inaccurate diagnoses in the past: "The doctor told me that it was gas and I was pregnant"; "He told me that I was pregnant and it was the gall bladder"; "The doctor never told them the truth, he told them they were fibromas so that they would not have an abortion." Other women, however, greatly appreciated their doctors: "For me, the most important things are God and the doctor"; "What happens is

that one tells the other and so on, and the word gets round and people believe what the person is saying and do not believe in a doctor, who is a person who has studied and knows a lot more."

In Contraceptive Methods

Many women reported that they did not trust certain contraceptive methods, or the advice they received about contraceptives: "They told me not to take pills while I was breastfeeding because the kid becomes gay"; "I feel that hormones go to the kid and that hurts him"; "The pills they give you at the Pereira Rossell are no good, they are faulty"; "My sister-in-law's sister got an IUD and she got a massive cancer in the uterus." These comments suggest that women need more up-to-date, accurate information on contraceptives.

Many women had a fatalistic attitude towards life, and this was reflected in their attitudes about contraceptives. According to one woman, "we cannot provide for anything, the children that have to come, come." Women's ambivalence toward family planning might also be tied to the mixed feelings they have towards pregnancy itself. Motherhood provides these women with their only "personal project," their only source of identity, and their only personal "possession." On the other hand, an excessive number of children creates an economic burden for the woman. The unconscious desire for maternity is therefore coupled with a conscious desire to control the number of pregnancies. The failure of contraceptives was not seen as a "terrible thing," and doctors were rarely consulted on family planning or on the proper use of contraceptive methods.

Lack of Social Support Networks

Social networks refers to the set of contacts, both formal and informal, with relatives, friends, neighbours, and so on, through which individuals maintain their social identity, receive emotional support, material help, services and information, and develop new social contacts (McKinlay 1990). Several researchers have explored the important role that social networks play in fostering the physical and psychological health of people (Ricardo and Castaneda 1990). In this study, it was reported that, "the woman lacks the support of the family, someone to tell her to go to the doctor, to take care of herself, no one worries about her." One woman said that, "what happens is that I went to the hospital by myself, I have no one to take me and so on, so I stopped going." According to another woman, "I cannot leave four children on their own. Women need to be told to go for their own good and for that of the baby, someone to support her, to support her at all times."

Isolation and the difficulty in establishing relationships with others may be a direct barrier to the use of the medical services. Social organizations and some community leaders may be able to play an important role in providing support with regard to the use of services: "We told her to take the child for a check-up, we were on top of her all the time for her to take him"; "We help women get their health certificate, sometimes we give them money to take the bus when they don't even have enough for that, for them to go for some examination";

"If we need something today we can talk to Marta, if we need medicine or we have a problem"; "Because she gets around, she talks to one, talks to another and gets us what we need."

Apathy and Depression

The women interviewed made a clear distinction between their "stupidity" in not consulting doctors with regard to gynaecological care or care surrounding childbirth, and the "slovenliness," "laziness," or "idleness" implied by not taking children to a check-up. Women seemed to be aware that not taking their infants for check-ups may cause damage to the child. According to one woman: "I think I don't go just because of being lazy, silly, but slovenliness is something different ... it's being dirty, slack ... Not taking a child, that's being sloven, there is nothing more important than your child." When examining the reasons for this slovenliness, women cited the difficulty in getting up, the lack of patience in waiting for their number to be called, and the difficulty in walking three or four blocks to the clinic. One woman reported: "I didn't go for my check-up out of laziness, for not getting up at five in the morning, I'm used to getting up at ten. During a pregnancy you sleep a lot, and what was it to me if the hospital is so close. But I did not get up. And time went by, and by, and you don't go for your care."

Through interviews with women, this project sought to find out why some women appeared to be struck by this sense of apathy toward health care. These same women who were unconcerned about their own health care also tended to have difficulty maintaining a job, and were reluctant to participate in community activities, and to engage in social networks. Some believed that the explanation was rooted in socialization practices: "I think this goes back to what she saw in her home"; "I think it is something you inherit, in the sense that they are a symbol of your family. I myself, for example, we were eleven very close brothers, we all helped each other, and that is the way I am with my children." For other women, there was more behind this apathy:

> There's something behind this. Because I cannot believe that they do not worry about knowing whether the baby is coming along all right or not. I cannot believe they do not care. I think they are alone, that someone should tell them to go to the doctor. If you ask them why they do not go they can't tell you why, they cannot give an explanation for not wanting to get treatment...
>
> There are a lot of women here that are ill. Sometimes physically and sometimes spiritually. That is the worst illness, it is to always think bad ... They let themselves be bogged down by problems ... nerves used to dominate me, but now I dominate myself.

Some women interviewed, like the woman quoted above, reported times in their lives when "I spent all my time lying in bed, I had no strength to get up." However, the women did not link this depressive state with their lack of control. In fact, none of the interviewed women

recognized their "laziness" or "slovenliness" as apathy, which is part of a depressive state. According to Bernardi and Mouriño (1991), a number of life conditions of women may work together to produce a state of depression or apathy. These adverse conditions include:

- extremely hard living conditions, which act as stressing situations;
- isolation or lack of social support; and,
- personal histories that condition a vulnerable psychological structure.

Some women may have difficulties verbalizing their problems and this adversely affects their psychological health. For other women, childhood experiences of violence, rape, or incest, may be factors relating to their apathy or depression (Ferrando 1992). In a study conducted in Chile (Magdalena 1993) addressing childhood diarrhea in a population of extreme poverty, a clear association was found between the development of acute diarrhea and "the general average of the population with neurotic symptoms, the highest points corresponding to answers expressing anxiety, depression and its somatization ..." An American study (Joyce 1988), which reviewed the histories of seventy women who had not had prenatal care, concluded that "the psychosocial barriers of depression, negation, and fears" were more powerful factors affecting the use of prenatal care than "external barriers such as the lack of medical insurance or transport."

For women living in permanently difficult situations, where change seems impossible, apathy and depression may be a way of maintaining a distance from reality. As McKinlay (1974) pointed out, "the knowledge, attitudes and practices of people living in situations of extreme poverty can be seen as answers that are consistent with, and understandable with regard to, the problems directly associated to their position in the social structure..."

Conclusion

There are a number of variables which are obstacles preventing women from seeking regular preventive gynaecological care for themselves, as well as care surrounding childbirth, and care for their newborn infants. The negative living conditions of poor women may adversely affect their attitudes, feelings, and beliefs about reality as a whole. Lack of self-esteem, and the difficulties of interacting with others, may contribute to fear, mistrust, lack of information, and lack of appreciation of health care services. For some women, in addition to the obstacles mentioned above, apathy and depression may be serious stumbling blocks. Another barrier may be the high cost of transportation to a health centre.

Any project that sets out to address the barriers to the use of health care services by women should carefully consider psychosocial barriers. The devaluation of women generally, and poor women in particular, as well as their isolation, needs to be addressed. Support and respect of health professionals, as well as individual and collective support from formal and informal social networks, are important ways of increasing the use of health services by women.

References

Araya, Magdalena. 1993. Proyecto prevención diarrea persistente, Informe final Instituto de Nutrición, Universidad de Chile.

Bernardi, Ricardo. 1988. Vulnerabilidad, desamparo psicosocial y desvalimiento psíquico en la edad adulta" in *Revista Uruguaya de Psicoanálisis*, No. 67.

Ferrando, Jorge. 1992. Pensando en la educación popular ed. Nordan, 3rd. Edition. Montevideo.

Joyce, K. 1988. Internal and external barriers to obtaining prenatal care. Brown S. (ed) Prenatal care, Institute of Medicine, National Academy Press, Washington D.C.

Mazzotti, Mariela; Tricotti, Lilian. 1985. Las familias, las mujeres y los niños, un camino a recorrer in las familias, las mujeres y los niños, estrategias de superación de la pobreza en América Latina FICONG-CIEDUR, Buenos Aires.

McKinlay, J. 1974. Social psychological factors affecting health service utilization consumers incentives for health care, Selma Mushkin, ed. PRODIST. New York.

1990. Quoted by infante castañeda Claudia Utilización de Servicios de atención prenatal: Influencia de la morbilidad percibida y de las redes sociales de ayuda in dalud pública de México July-August Vol. 32, No. 4.

Bernardi, Ricardo; Mouriño, Pérez. 1991. Diseño y validación de un instrumento para valorar el entorno psicosocial in *Salud Pública de México* January-February. Vol. 33, No.1.

Terra, Juan Pablo. 1989. Creciendo en condiciones de riesgo, los niños pobres del Uruguay CLAEH-UNICEF, Montevideo.

Knowledge, Attitudes, and Practices of Women Concerning Pregnancy and Birth

Giovanna Chiarella[1]

Introduction

This paper is based on an investigation that is part of a research process proposed by the Latin American Perinatology Center (CLAP) to identify a series of factors which could contribute to the better development of the CIAES Perinatal Health Development Project (DESAPER). The CIAES (Health Research, Advice and Education Center) is carrying out research based on a qualitative research model generated by the institution. It is also writing a proposal for the analysis and processing of information, aimed at planning and executing interventions in the health field.

Utilization of Services

The study area, the Tropical Chapare, is a region in the rural area of Cochabamba (Bolivia), with an estimated population of 66,443 inhabitants. Its population has the special characteristic of being formed by numerous migratory peoples descended from different ethnic groups (Quechua, Aymara, Oriental and others) which co-exist in the same geographical area. As a result, a variegated cultural conglomerate exists.

There is evidence suggesting that indigenous peoples are reluctant to seek attention from the established health care system (formal model). Even though it seems quantitatively adequate in relation to the established population of Chapare, there exists a clear under-utilization of the system on the part of the region's inhabitants. The following operational hypotheses were proposed in order to explain the possible reasons for this under-utilization:

- *economic factors*: could be limiting access to the desired services, which are appropriate from a non-financial perspective;
- *social factors*: could be limiting the use of technically appropriate services which are rendered in an inappropriate manner; and,
- *cultural factors*: might limit the use of services which are not appropriate to the medium in which they are inserted.

[1] Health Research, Advice and Education Center (CIAES), Cochabamba, Bolivia.

These three reasons are complementary. Social and cultural factors, involving the training of human resources and the rendering of services, may require the most change within the health system. The investigation aimed to shed light on some of the reasons why indigenous women do not use the health system.

Perinatal Health Development Project (DESAPER)

The study was carried out between the months of August and September 1993, in the area of Tropical Chapare, which corresponds to Health District III, in the Cochabamba Health Unit. The identified problem was the following:

- A good supply of health services existed, which were organized and administered from a western perspective (bio-medical basis). However, there was a poor demand for this system, because of beliefs, attitudes, and practices deriving from another set of perceptions.

The traditional and western health systems contradicted each other in some cases, and complemented each other in other cases. The basic purpose in carrying out this type of analysis was to identify intervention strategies which would permit the closing of the gap between these two systems.

Methodology

Different qualitative techniques were used, based on information provided by inhabitants of the rural area. To carry out the study, DESAPER personnel and a group of pollsters were trained in focal group techniques, and in conducting in-depth interviews.

- *Structured Observation*: consultation observation guide; educational talks; observation guide; service user satisfaction survey.
- *Work with Focal Groups*: selection criteria sheet; recruitment sheet; discussion guide.
- *In-Depth Interviews*: in-depth interview guide.

Features of the Women in the Study Group

The study group was composed of women in their childbearing years (15-49), who had lived for at least two years in the area, and with at least one child born alive. The women had little or no experience or acceptance of the formal health system, were able to undergo not more than one pre-natal check-up, and gave birth at home.

Summary of Study Group

The average age of women in the study group was 27.5 years. More than half of the women were married, only 9% were single, and the rest were concubines. The average number of children born alive to women in this group was 3.8. Although 55% had received some primary education, 33% had received none at all. Only 12% had received secondary education. Eight percent were members of a Mother's Club.

General Features of Women Belonging to Reference Group

The reference group was composed of women in their childbearing years (15 to 49 years), with at least one child born alive and over two years' residence in the area, who had accepted the formal health services, with a minimum of prenatal examinations and/or institutional births.

Summary of the Reference Group

The average age of women in the reference group was 28 years. Sixty-three percent were married, with only 4% being single. An average of 3.1 children were born alive to these women. Although the same percentage of women (55%) had received some primary education, 31% also had received some secondary education. Twenty-two percent were members of a Mother's Club.

Ethno-Physiological Model

With the assistance of findings from previous investigations (CIAES 1991), an ethno-physiological model was generated which allowed for an explanation of a series of beliefs, attitudes, and practices associated with the reproductive cycle of the Cochabamban woman.

It could be seen that the health-disease process was considered as the starting point for a balance of elements which compose the world, where *one element is not negative or positive in itself, but in relation to the moment, to its place in time, and to its capacity to move opportunely*. In this way, the beliefs and behaviour model of the women of Tropical Chapare has three factors which are elemental symbols: *space, time and movement*. Health is the relative balance among these three elements. This balance will be different at different times, such as during pregnancy, at birth, and during the breast-feeding stage.

Physical constitution appeared to be a highly important indicator of the health of mother and child. There were two distinct categories: strong women and weak women. Strong women were seen to have more blood in their bodies, which accumulates during pregnancy, lessens the possibility of a bad birth, and increases the chance of a good birth. It was felt that these women would have healthy children, and would be able to carry out certain tasks such as working, lifting weights, walking, and so on.

Weak women were believed to be thin, pale (anemic), without much blood flowing in their bodies, had difficult deliveries, required more care during pregnancy and the puerperal stage, could not work, and would have weak children.

Theoretical Support for the Investigation

Through the methods and techniques of qualitative research, it is possible to obtain answers which explain the "why" of a group's beliefs, attitudes and practices. Qualitative research has the following characteristics:

- it is flexible, allowing for the development of concept and model throughout the investigation; the data gathered need not always prove pre-conceived hypotheses or theories;
- it provides the possibility of investigating essential elements and people as a whole, not as variables;
- data integration is carried out from the point of view of the informants themselves; and,
- it rejects pre-established prejudices and beliefs, trying to see facts or processes as if they were occurring for the first time.

The Health Research, Advice and Education Center (CIAES) proposed an action plan in order to implement programs at a national level. This action would be based on the availability of basic informal expenditure data generated by the potential beneficiary population, which would allow for the identification of the community's priority needs. Thus, it would be possible to plan actions for involving the population in the execution and implementation of the program in order to achieve a greater impact on its health situation.

In this paper, the authors describe the knowledge, attitudes and practices of the individuals interviewed, without making any judgements as to their merits.

Findings

Pregnancy

Awareness of Pregnancy

Study Group: Most of the women became aware of their pregnancy at an early stage, due to the absence of menstruation. No laboratory procedures were habitually used in the area. With regard to attitudes toward pregnancy, the first child usually caused feelings of happiness; subsequent ones caused concern, or sadness, due to financial problems. Husbands shared the same feelings, although most of them were indifferent.

Reference Group: The absence of menstruation was the first sign of pregnancy, as well as nausea, vomiting and rejection of food. In this group, the majority confirmed their pregnancy with urine tests and medical examinations in the first and second months. Feelings expressed were similar to those in the study group. Husbands or partners showed happiness at the news and in some cases, concern. Indifference also existed.

Special Care During Pregnancy

Study Group: Most of the women considered pregnancy as a normal and natural period, which required special care (activities which must not be indulged in and those that may) and which caused a change in their normal life. They said they must not lift heavy weights, eat hot foods, be exposed to too much sun or fire, or sleep during the daytime, as this could cause the "magre"[2] to rise after the birth and cause the death of the mother. They considered that walking would help to promote an easy birth and that they must eat well (not in quantity) so that both mother and child kept healthy.

Reference Group: Only half considered pregnancy as a special moment, the rest said it was not, because they had to continue working just the same. Food and activities were similar to the study group. The women mentioned certain needs regarding the baby's clothes, and they saved money for the birth and pre-natal care.

Special Care Regarding Food

Study Group: Certain types of foods were considered dangerous because they could cause a difficult delivery, stomach pains, bleeding or harm to the child. These foods included: pork, spicy food, oregano, fats, onions, bread, tangerines, oranges, and garlic. The best foods were considered to be beef, eggs, milk and vegetables. The majority felt that it was not good to gain too much weight because this would result in the woman not being able to walk and tiring too easily, the birth would become difficult, and the "wawa" (baby) would grow too much.

Reference Group: Foods considered dangerous were similar to those in the study group. Bees' honey and purple banana were also mentioned. These women believed that they must not gain too much weight because it made walking difficult, they looked "ugly," and the baby grew a lot, causing it to get blocked and making the birth difficult. Most of these women had their weight checked at the hospital, by doctors or nurses, or at public scales.

Pre-Natal Care

Study Group: Even though none of these women went for a pre-natal check-up, they acknowledged that every woman should have herself examined in order to know how she and

---

[2] The "magre" is a mythical "organ" they believe is formed during pregnancy, behind the navel, which could "rise" and cause death by asphyxiation.

the baby were progressing. However, some indicated that they did not want these examinations. The reasons most frequently put forward were: they were poked everywhere; they were scared; money was spent; doctors didn't know anything; they went for nothing; nothing was hurting; and they were embarrassed to be seen by the male doctor.

Those who did go to be examined, did so because they were not feeling well. They said their stomach was touched, they were weighed and measured, but they did not know "why". These women were dissatisfied because "they looked at us all over"; they didn't feel better; they were scolded; they were charged too much; and they didn't receive any explanations. On the other hand, some were satisfied because pain was eliminated, and they were told how the baby was progressing.

Concerning ferrous sulphate, these women did not know what it was for, they did not like it, it made many of them vomit, and they thought it might harm the baby. Concerning the Tetanic Toxoid vaccination, they said it was good and prevented infections in the child.

Reference Group: All the women in the reference group stated that pre-natal care should be effected during pregnancy in order to know how the baby is progressing (health, growth and position). These examinations should be carried out from the third month and should occur at least three times. However, these women were dissatisfied because: they weren't told anything; they didn't understand; they were frightened; only the doctor did the controls; "he told me I had to have a Caesarean"; and, it was expensive. Most of the women were checked at the hospital and by the doctor.

Reactions to ferrous sulphate were similar to those of the study group and they too considered the anti-tetanic vaccination important.

Pregnancy Complications

Study Group: The great majority did not recognize complications or problems in pregnancy that placed the mother's or the child's life at danger. In general, the attitude assumed in situations of risk was to go to the hospital, to the midwife, or to the local sanitary post to find out what was wrong and try to get better. Few said that they resorted to their husbands. They agreed that "weak" women were more likely to have complications.

Reference Group: Only a few women were aware of the signs of danger during pregnancy; haemorrhage and "blocked child" were the signs commonly mentioned. In general, these women went to the doctor or the "specialist" to be cured.

Accessibility to the Health Services

Study Group: For the great majority, it was difficult to reach a health service centre. Reasons cited included: lack of transportation; distances were too great; it was too expensive; embarrassment; they didn't like hospitals; and their husbands didn't want them to go. Those

who did reach the services, did so on foot, and they said that when they got there "it was closed" or "the doctors weren't there."

These women preferred to go to state hospitals because they were cheaper, or to hospitals administered by religious orders where they "are kind" and it was cheap, or to private clinics because they were "faster."

The changes they suggested were "make it bigger, more personnel and beds," "it should be women who attend to us," "they should not close when they go out," and "we should be well-treated."

Reference Group: Over half said they had no difficulty in reaching the centres; however, they pointed out that distance and transportation problems were limiting factors. Choice of type of service was made on the basis of cost and of whether the attention was good and fast.

Delivery

Study Group: Generally the women recognized the start of labour (becoming ill) because of pain in the stomach, elimination of the "seña" (cervical mucus) and back pain. Actions carried out before delivery were basically walking and preparing instruments for the attention of the child and for use during delivery (swathing cloth, aniseed "mate" tea, thread, diapers). Generally the husband attended the delivery, helped by his mother, mother-in-law or some other relative. On rare occasions, the midwife attended the delivery. They showed awareness of very few of the problems for the mother or the child which may have arisen during delivery. Some referred to: heavy haemorrhage; "the baby doesn't come out, it's blocked or it's too big"; the placenta doesn't come out; the cord is wrapped around the child's neck; the child's feet may come out.

Very few of the women said they had problems during their deliveries. Those that did, were cared for either at the hospital or at home by their husbands.

To ease labour and delivery, they used herbs such as orange blossom, "cedrón," coca leaves, wheat, camomile and "paico," which they prepared as "mate" tea. The use of labour-inducing substances was guided by advice from the chemist or the midwife. Most preferred delivery at home because it was free of charge, only their husband was able to see them, which caused less embarrassment, and they could take "mate" and walk.

Reference Group: Awareness of the start of labour was similar to that described in the study group. The husband was the first person they turned to for help during labour. There existed however, a lack of knowledge about the danger signs during delivery. Some mentioned haemorrhage, narrow hips, cord circling and prolonged labour. They did mention that when problems arose, the principal limitation to getting to the hospital in good time was lack of transportation.

Knowledge of herbs and teas was similar to that of the study group. These women accepted and used labour-inducing substances which they acquired from the chemist, and which were recommended by the doctor and the chemist. The main delivery site was the hospital, followed by private clinics and medical posts. The women were attended by a doctor or nurse because it was seen as safer. Cost varied from US$40 to US$50.

Care of the Newborn Child

Study Group: In most cases, the baby was handed to the mother immediately after birth and most babies were bathed after delivery. After the bath they were wrapped in diapers and swaddled in a "chump."[3] The cord was cut with scissors, sometimes with a piece of glass, a razor blade, or a broken piece of tile or ceramic, and then tied with cotton or woollen thread.

Reference Group: Due to the fact that most of the mothers in this group had their deliveries at the hospital, descriptions about the care of the newborn child were rare.

Afterbirth

Study Group: Once the baby was expelled, the placenta must quickly follow. If it did not, the person in charge of the delivery cooperated with the following manoeuvres: pressing the stomach, rubbing the woman's back with oil, offering cummin "mate" tea, making the woman blow into a bottle, tying a string around the big toe. Once the placenta was expelled, it was washed and buried in a shady spot.

It is important to note that if the child was a boy, the placenta was buried in the coca patch, and if it was a girl, they washed and buried it in the kitchen. If this rite was not adhered to, the following problems were said likely to arise:

- the child will be irresponsible and dirty;
- the child will be alcoholic;
- the baby may sicken and die; or,
- the mother may sicken.

The women said that following this ritual with the placenta gave them feelings of security.

Reference Group: As the delivery was institutional, most of the women said they did not know what became of the placenta after the birth. Some of those who were attended privately said that the placenta was returned to them, and they then followed the rites described.

---

[3] A "chumpi" is a woollen swaddling cloth which is used to wrap the mother's stomach with and also the child.

Puerperal Stage

Study Group: After the baby was born, the women remained in bed for a few days, and after a month, returned to their normal tasks. They knew of certain care routines they must follow: not to touch water, not to lift heavy weights, not to walk, not work too much, and protect themselves from the sun and the wind. They also felt it was necessary to avoid "fresh and hot" foods, onions, bananas and alcoholic beverages because they "stop the flow of the dirty blood from the birth." On the other hand, chicken broth, potatoes, quinua, eggs and broad beans were seen as healthy foods.

Reference Group: General care during this stage was similar to the care described for the other group. These women usually returned to their usual tasks after a month. Diet was similar to that of the study group.

Breastfeeding and Complementary Feeding

Study Group: Feeding the child during the first hour of life was limited to elements which "cleaned" the body (the father's or elder brother's urine), or which calmed stomach aches (aniseed "mate" and coca leaves). Mother's milk was given during the first day. The feeding bottle was practically not used at all in feeding the baby.

The mother's breast was offered immediately after birth. Sometimes it was given only from the second day, on the advice of the mother or mother-in-law. The first milk is named in various ways, such as: "corta" (short), "suero" (serum), "nata" (cream), first milk, yellow milk. It is considered to clean the stomach. Only a few discarded it, "for the child to grow quickly and healthily." Complementary feeding was started in the third month and was based on soups, normal food, fruit, potatoes, and ice cream.

Reference Group: Most of the mothers did not give the child anything during the first hour. Then they began with aniseed "mate" tea, to clean the stomach and prevent colic. This was generally offered in a feeding bottle, usually on the advice of the nurses. The use of the feeding bottle to give powdered milk was quite frequent, although some women breastfed. In this case, they also gave the first milk; few discarded it.

Like the study group, these women started complementary feeding towards the third month. In many cases, the recommendation to start at this age was given by the doctor.

Family Planning

Study Group: Women who discussed the need to avoid pregnancy did so considering their financial situation and the difficulties of raising children. The great majority did not discuss the subject with their husbands, and became pregnant without being aware of it. The most common number of children born by these women was between two and five.

Knowledge about contraceptive methods was extremely rare; the best-known is through menstruation dates control. Knowledge of modern methods (IUD, condoms) was almost non-existent. The women who had discussed the subjects had generally done so with female friends, and very rarely with their husbands.

Reference Group: Women in this group expressed the need to use some method of family planning, though many stated they knew of none. As with the study group, the average number of children for these women was two to five. They generally talked about family planning with friends, and very rarely with their husbands.

Conclusion

Results obtained during this investigation confirmed the initial belief that, while there is an appropriate supply of services and health programs, there is a low demand from the population. Women of the Tropical Chapare use the health services of the formal system infrequently due to the fact that hospital practices contradict with beliefs of what constitute desired practices with regard to their health. Socio-economic reasons, such as geographical inaccessibility, and the financial difficulty in paying for the services, also hindered their use of the services.

One of the principal objectives of this research was to identify and explain the behaviours of women during their reproductive cycle. This required comparisons between two systems, which have developed specific ways of handling the health-illness process. There are instances in which the two systems complement one another. In other cases, the systems are very different and in opposition, which leads to the under-utilization of services.

The following charts highlight the ways in which the traditional and western systems differ in their practices and beliefs related to pre-natal care, labour and delivery.

Contradictory Knowledge and Practices

Pre-Natal Care

Traditional System	*Western System*
We are afraid of the hospital	There is ill treatment and scolding by doctors
We are "poked" all over	Complete examination (breasts, vagina)
Weight loss/swelling of feet not dangerous	Emphasis on swelling and weight loss
We are embarrassed to be attended by a male	Attention generally by a male

We spend our money	The service is charged for
We have to go only when we feel discomfort	Greater emphasis on prevention
We go to know how the baby is placed	Information is not given, or is very complex
Hospitals are very far away	They are often closed
They do not give us any information	They are weighed, measured, etc. Sulphate is given. Little explaining is done
They talk about things we do	Traditional concepts are not understood. They do not know what (traditional words) are
Respect for conception	Lack of respect for the woman's reproductive role; "you breed like a rabbit."
Because we feel ill, we want to be given medicine	Generally they are given nothing, or a prescription

Labour

Traditional System	*Western System*
We walk	Not allowed to walk
The correct position is vertical	They are made to lie down
We wrap up warmly	Not allowed to be dressed
We do not undress	They are undressed or given a hospital gown
At home it is warm	In hospital it is generally cold
We close all doors and windows	Everything is open
We take "mates" to help us in labour	Nothing is allowed to be consumed
Relatives prepare the instruments and clothes (swaddling cloth, scissors, thread, etc)	Preparation by hospital personnel
Nobody examines us	Many people examine them
We are not shaved	Trichotomy is carried out
If the baby is blocked we are tossed in a blanket	Tossing is not effected

Delivery

Traditional system	*Western system*
Our home is warm	Delivery room is cold
We deliver fully dressed	Only a gown is worn
Relatives attend to us	Attention by strangers
Personalized care, with affection	Impersonal care
We squat on our haunches	Gynaecological position
No enema is administered	Enema is administered
Every comfort is provided	Complaints of discomfort
It is free	Service has a price
Only our husbands attend to us	Many people watching
We are not cut	Episiotomy carried out
We are cared for best	Care of mother and child according to needs
Baby is bathed immediately after birth	Baby is not bathed
We use a "chumpi" to swaddle ourselves and the baby	Only diapers are used
The placenta is given an important destiny	Placenta is thrown out
We swaddle ourselves so the "magre" will not rise	"Magre" is not taken into account

A Need for Research on Women's Health

Jasna Stiepovich and Julia Ramírez[1]

Introduction

In Chile, the subject of women's health has not received much attention. The majority of available studies concerning women's health focus on problems related to the reproductive process (generally from a biological perspective). Therefore, the necessity arises to create a conceptual framework that allows for the formulation of policies and actions designed to improve the health and living conditions of the female-child, female-adolescent, adult-female, and senescent-female, from a holistic perspective. Biological, cultural, social, economical, and political conditioning must be taken into consideration. This report reflects upon these particular sectors that suppliers of health care and human resources will have to confront in order to establish future research that will generate a profile of the real health needs of women.

Health in Chile

The health care sector in Chile consists of two sub-systems: the public and the private. The public sector serves 70% of the Chilean population. In 1991, the population was estimated at 13,385,806 inhabitants, of which 30.6% were under fifteen years of age, and 6.1% was over 64 years old (Ministerio de Salud 1993). The female population constitutes 50.4% of the total inhabitants in Chile.

The Ministry of Health is the highest institution at the national level responsible for the formulation of policies, strategic programs, and ethical and administrative norms concerning health. These policies, programs, and norms are oriented toward achieving full constitutional health rights for the population. The Subsecretariat of the Ministry coordinates the execution of programs on health for the public sub-sector, which is made up of twenty-seven decentralized health services.

The model for health care adopted in Chile is based on specific populations, with particular programs designed to reach selected segments of the population. As an expression of an effective health policy, the principal programmatic lines allow the objective channelling of health care resources. In 1992-1993, the priority programmatic lines were as follows (Ministerio de Salud 1992):

---

[1] Department of Nursing, Faculty of Medicine, University of Conception, Chile.

- *Maternal - Prenatal* - improving quality care during pregnancy, especially in high risk groups: increasing the early detection of cervical-uterine cancer; progressive implementation of specialized clinics for pregnant adolescents; greater access for the population to responsible paternity; improving quality of care during childbirth; and increasing survival of newborns.

- *Infant - Adolescent* - increasing the coverage and quality control of the healthy child: improving accessibility and efficiency of the investigation of risk groups; increasing attention given to priority high risk groups (children less than six months, the malnourished, carriers of chronic illness); evaluation of psychomotor development in pre-school children under two years; and strengthening of community education.

- *Adult* - strengthening of programs for chronically ill patients: arterial hypertension, diabetes militeus, alcoholism, tuberculosis; implementation of activities promoting health and prevention of illness in the working adult population; development of health care models geared to the senior adult population.

- *Mental Health* - increasing early detection of and intervention on mental disorders and risk factors: drinking problems, emotional disorders, adolescent pregnancy, drug consumption; developing mental health programs for children and adolescents.

- *Oral Health*

- *Environmental Health*

These pragmatic lines place special emphasis on the maternal-infant group, favouring binomial care for mother and child, and for the school-age population or adolescent.

In recent years in Chile, it has been possible to detect important changes in health indicators, which is a likely consequence of:

- the increasing level of education in Chile, with an average education rate of 76%;

- health policies aimed at priority groups;

- the adoption of scientific and technological advances which have not only been progressively incorporated into health care, but which have also improved the living conditions of communities;

- important advances in environmental sanitation such as: drinkable water for 95.2% of the urban population and for 73.3% of the rural population, sewers for 73% of the urban population; and,

- a progressive stabilization of the Chilean economy, which has allowed for a major contribution to health care costs which, in 1990, were $1,315 million ($1,000 per capita), figures which are nonetheless lower than those of developed countries: the United States of America with total health care costs of $690,607 million ($2763 per capita), and Canada with a contribution of $51,594 million ($1,945 per capita) (Banco Mundial 1993).

Health and Gender

At present, life expectancy at birth for Chileans is 75.6 years for women, and 68.5 years for men. In 1991, the mortality rates for Chilean adults (15 to 59 years) rose to 214 (65.6%) for men and 112 (34.4%) for women (Ministerio de Salud 1991). It is interesting to note that the mortality rate for men was 91.2% higher than for women.

When comparing hospital expense figures for the year 1991, for both the public and private sectors, it can be observed that, of the total expenses of US$1,387 million, 64% corresponded to women's and 35.9% to men's health care. It is important to point out that 65% of the "female expenses" were concentrated in the 15-44 year old age group. It is interesting to note that, although the great majority of expenses related to women's health care were a consequence of "reproduction", it is possible to observe that US$139 million more in hospital expenses were spent on women than on men for mortality not associated with sex.

Statistics of hospital expenditures generate a good approximation of the causes of morbidity which effect the Chilean population. These figures raise several questions:

- Do women in Chile access health services more often than men?
- Which factors determine the differences in mortality and morbidity between men and women?
- Does a relationship exist between higher hospital costs for woman and their progressive incorporation into national economic production?

The incorporation of women into the workforce is not free of risks. In addition to biological health issues associated with the female sex, there are other issues which arise from her changing role in society, her self-esteem, and the need for fulfilment beyond the functions of mother, spouse, and housewife.

Currently, the workforce in Chile includes 1,700,000 women, resulting in a participation rate of 34.5%. In 1980, the inclusion of woman in the formal economic sector was 29.4%. The figures indicate that the majority of productive age women perform unpaid labour. Sixty-five percent of women (3,172,000) are devoted at present to continuing the pattern of their biologically-defined identity: mothers, wives, and housewives.

Cultural traditions maintain a gender-based division of labour. The responsibility for domestic work is attributed to the woman, while the man focuses exclusively on economic activities. The woman is responsible for care of the home and family, regardless of whether or not she participates in the labour market. This reality represents a double workload for many Chilean women. They are forced to take on excessive responsibilities: that of the home, and those deriving from a highly competitive labour environment, especially in those economic activities where women are just gaining positions traditionally reserved for males.

This double workload can cause significant stress for women. The stress can stem from one or more of several factors: cultural changes, conflict of roles, incongruency of status, forced vital changes, group changes, social rejection, and deprivation of physiological necessities, such as sleep.

Psychological stimuli with enough intensity and duration can cause great psychosocial demands on a person. When his or her neuroendocrine, psychological, and social resources are strong enough, and exceed the demands made on them, the person may be said to have adapted to a particular situation. When the perceived demands exceed the available resources, however, poor adaptation ensues. This produces an exhaustion of the adaption mechanisms, predisposing the individual to maladjustment which may significantly alter the quality of their life.

Therefore, new questions arise:

- Do differences exist between the health of women involved in productive activities and that of women who devote their time solely to the care of their family?

- What is the health profile of Chilean women devoted to the care of their families, considering independent variables such as education level, socioeconomic level, and number of children?

- What is the health profile for Chilean women performing economic activities, considering independent variables such as education level, socioeconomic level, number of children, work achieved, and work accomplished in the home?

It is also necessary to investigate the effects within the family when the woman makes the decision to re-enter the workforce:

- Does the involvement of women in extra-domiciliary economic activities affect the health of the family unit?

- Are there any effects on group dynamics within the family? How do these effects manifest themselves within the family unit?

Another research area which has not been deeply explored in Chile relates to the women who have lived their lives through their children and husband. In the mature stage of their lives, they begin to experience various losses: the absence of their children, the end of their reproductive life, the first signs of aging, realizing that their relationship as part of a couple has deteriorated over time, finding themselves alone, living day after day in their solitude without finding the motivation to determine what to do with their own life. Furthermore, in this stage, many of these women are confronted with the loss of their spouse, experiencing the process of widowhood, which itself is considered to be highly stressful (fifth highest stressor on the Holmes and Rahe "Social Readjustment Scale"). It is therefore necessary to focus our attention on the emerging senescent female population. Little is known about the problems that they face in life, of the socio-psychological and cultural factors that affect them. These problems are likely the source of many mal-adaptation illnesses in older women.

The questions arising around the topic of women's health need to be confronted in the short term in Chile in order to devise a theoretical framework which would allow attention to be focused on specific needs of women's health, considering their social, cultural, and environmental contexts. Only with sustained attention can effective and efficient answers be provided. Because of its complexity, women's health should be addressed in a multidisciplinary and holistic manner which underlines the need for promoting qualitative research. This allows for a greater understanding of "how a woman lives her own health," uncovering diverse phenomenons: "how she experiences her sexuality," "how she experiences the birth of her children," "how she experiences her menopause," "how she experiences her condition as a woman."

The phenomenology offered by Hussel provides a look at the world of experiences, facilitating the view of things as they are revealed to people. It is necessary, according to Martins (1990), to get to the essence of the phenomenon. Phenomenological research offers the possibility of understanding the meaning of a phenomenon through the descriptions that the subjects who have lived the experience provide, thereby revealing facets of the phenomenon which were previously concealed. This proposal does not attempt to disqualify positivism; both tendencies have to be addressed and should coexist for a greater understanding of the phenomenons of life.

As a final reflection, it is necessary to shift the focus of research to the starting point for a greater understanding of the problems of women's health: The Formation of Human Resources in Health. Attention should be centred on the nurse as a human resource. Women comprise seventy percent of the labour force of the public sector providing health care in Chile (Area Salud de la mujer 1991). This figure reflects the fact that health is generally conferred by woman and that nursing has traditionally been a woman's profession.

The nurse has been a pioneer in adopting the philosophical bases of the holistic concept of humans; in motivating important curriculum changes and incorporating social sciences and behaviour in the development of subjects. This vision permitted the banishment of the medical model as the curriculum core, being substituted by the process of nursing, which was adopted in its entirety by the academic entities developing nursing in the country.

Women's health has not been absent in the training of the male/female nurse; however, continued special emphasis should be given to the problems of health deriving from the reproductive process. Some academic units have made an effort to include subjects on "Women's Nursing," where a conceptual framework revolves around the situation of women from a biological, psychological, social, and ethical-legal perspective as a first approach, in order to provide attention to nursing care for women in health and illness, considering their integrity and their condition as women.

Given that nursing duties are mostly carried out by women, some questions surface:

- Since the majority of nurses are women, why has the topic of women been explored so little?

- Does being a female nurse constitute a comparative advantage in greater understanding of the health problems of the female population?

Women, health, and research constitute a triad that providers of health care and developers of human resources should confront with greater aggressiveness in order to start changes in health care for women in their distinct stages of life, thereby making an impact on their well-being, which undoubtedly would be felt in the entire community.

References

Documento Republica de Chile. 1992. Ministerio de Salud. Division programas de salud.

Estadisticas de Egresos Hospitalarios. 1991. Ministerio de Salud. Instituto Nacional de Estadisticas. Chile.

Informe sobre el Desarrollo Mundial. 1993. Banco Mundial.

La salud de las mujeres trabajadoras de salud. 1991. Area salud de la mujer. Santiago.

Martins, Joel; et al. 1990. A fenomenogia como alternativa methodlogica para pesquisa, algunas consideracoes. Rev. Esc. Enf. USP. Sao Paulo, 24(1): 139-147.

Situacion y Atencion de Salud en Chile. 1993. Ministerio de Salud, Santiago, Chile.

Discussion

Following presentations by Constanza Collazos (Colombia) and Ilta Lange (Chile), a general discussion took place on the topic of Health Care Providers and Gender. The following points were raised:

- Women are the primary health providers - to their families, to their communities, as well as to health institutions. While the work of women is indispensable, it is often not given the recognition that it deserves. In the family, a woman's role as health provider is often overlooked. Furthermore, voluntary community health work of women has a low profile and is often unrecognized. In the formal health care system, women work as nurses, paramedics, midwives, and auxiliary assistants. Nursing is not valued because it is perceived to be a feminine activity, and is carried out largely by women. If a man chooses to be a nurse, he will be in a disadvantaged position. The inequitable treatment of women as health care providers needs to be addressed.

- A potential methodological problem relates to the possible discrepancies between what people say they know, what they say they do, and what they really do. Women are often aware of what they *should* be doing to stay healthy; they are aware of what they should respond in an interview situation. However, for various reasons, they may not be able to carry out desired health practices. Researchers therefore need to find ways to learn about the gap between desired intentions and actual practices. Women need to share their impressions about the difficulties that prevent them from exercising positive health behaviours. It may be helpful to ask questions such as: "What are the problems or obstacles that you face in fulfilling what you know should be done?"

- It is necessary to address what actions are needed, who defines these actions, and who carries out the actions. It is important to allow the community to define their own needs, rather than impose needs on the community. For example, when selecting health monitors and promoters, members of the community should play a prominent role in the selection process. Health monitors should only be introduced if the community has expressed a need for them. Otherwise, the monitors will not be respected or valued, which will present obstacles to their work.

- A bridge must be built between community desires and health services. It is important to have a group of monitors who are responsible to the community. This can bridge the gap between the community and health services, and help to promote positive changes in health services.

- Women's health activities at the community level are crucial and need to be acknowledged and valued. In rural areas, women may start out as health promoters or providers, and then move on to other roles. Women should be given more opportunities to diversify their activities.

- Health providers should focus more on prevention than on curative aspects of medicine.

- It is important to find ways to encourage men and women to depart from their traditional spheres (e.g., men in the public sphere, women in the private). Men should be encouraged to engage in traditionally female domains and vice versa. For example, men, who usually have more leisure time than women, should be encouraged to participate as health providers. Family roles in the home also need to be distributed more equitably.

- Interventions should inform both men and women about important health promotion activities, and should encourage men to take a more active participatory role in family health matters. For example, many women are unaware that lack of good prenatal care increases their risk of having problems during pregnancy. Their partners, also unaware of the importance of this activity, may not encourage them to attend prenatal care services. Men, as well as women, should be informed of the importance of such health practices.

- Health monitors are often dissatisfied with their work and find it very difficult. Avenues to help female monitors to improve their situation and make their work more gratifying need to be explored.

- There is a need for further research concerning the mental health of health providers.

- Further research needs to explore the differences between traditional and modern systems of health care. Each system has positive and negative aspects. For example, women may be reluctant to attend hospitals for deliveries because of drawbacks inherent in the modern health care system. Many women report that they are afraid of hospitals and doctors. Some women report that doctors yell at them. Other women object to vaginal examinations, or may be ashamed to let a male doctor see them without clothes. Doctors may not provide adequate explanations, and may not show proper respect to women. The traditional delivery method is quite different from the modern method. A woman can stand vertically during a home delivery, while she must be horizontal in a hospital. In the hospital, a woman cannot wear her own clothes and has to be shaven. In the traditional system, the placenta is viewed as a continuance of life and therefore washed, burned, and buried, while in the modern system, it is dumped in a waste basket.

Working Group Discussions

Principle Goals for the Workshop

- To share experiences and research results
- To introduce and reinforce gender-sensitive methods and analyses to researchers

Working Objectives

- To identify key gaps in gender and health research in Latin America
- To identify roadblocks/impediments to gender and health research in Latin America
- To identify priority areas for research
- To develop "example" research proposals (based on one of the priority topic areas)

Outputs of the Workshop

- Priority areas for research
- Improved capacity for gender analysis
- Publication of a manuscript which will be:
    - shared among researchers who participated
    - shared among other researchers and policy advisors who may wish to collaborate with workshop participants
    - a contribution to the Global Commission on Women's Health and the Beijing Conference

Working Group Discussions

Workshop participants were divided into two working groups and asked to consider gaps in health research with respect to gender differentials, as well as obstacles hindering health research from a gender perspective. In addition, each group was asked to consider what, from its point of view, were the priority research areas with respect to gender, health, and sustainable development.

All participants agreed that the gender perspective needs to be studied in depth, and that the exchange of information and experiences that occurred at the workshop needs to continue. The participants had a great variety of experiences and had been exposed to diverse situations in Latin America. Researchers need to jointly explore the similarities that exist in different Latin American countries, as well as the differences. The establishment of a network of researchers interested in gender issues is necessary. Researchers need to build upon the findings of other researchers working in Latin America. It is hoped that further sharing among researchers will lead to the development of comparative research studies that will increase understanding about gender, health, and sustainable development, from a Latin American perspective.

Working Group I

Part I: Definition of Research Gaps

The first task the working group assigned to itself was to define "research gap." The group decided that the use of the English word "gap" was confusing, given that its translation in Spanish referred more to an "empty space" or "hiatus." After some discussion, it was agreed that the best terminology would be the Spanish word *brecha*, defined as

> *lo que hace falta investigar en el area de salud y genero* (what is missing in research in the area of health and gender)

This definition involves, then, areas which have not been researched, and the necessity of developing/defining new lines of research/investigation.

Part II: Identification of Research Gaps (Brecha)

In order to prevent any predefined limits being placed on what were considered to be research gaps, the group agreed that each participant would write down individual gaps as he/she saw them, within the context of his/her own research. After all the gaps had been presented and put on the board, the group then collectively decided how each should be classified. It was interesting to note, given the varied educational and experiential backgrounds of the participants, that the gaps could quite uniformly be fit within identifiable classification areas, often with considerable overlap and/or complementarity. The following provides a succinct summary of the contributions made by the participants:

1. Information Systems

- a lack of adequate national level gender-based statistical information systems

2. Training

- a lack of training and gender-sensitization for health care providers within the formal health care system

3. Methodology

- a lack of research on and operational methodology for the implementation of new participatory epidemiological surveillance systems as a means of empowerment

4. Perception

- a lack of research on health service users' perceptions about the health process (i.e., a non-medicalized point of view)
- a lack of research on health service users' perceptions on the quality of health attention received

5. Policy

- lack of study on the factors conditioning the (non)participation of women in public discussions for health sector decisions
- absence of a women's health policy with a gender perspective

Part III: Lines of Research

After analyzing each area and the gaps within them, the group identified priority lines of research needing a gender perspective. This was quite difficult to do, given each person's personal perspectives and biases. Identified priority research areas include the following:

- ***Occupational Health***: double workload
  domestic/informal work
  reproductive and sexual risks and hazards
  occupation-related disease and injury

- ***Risk and Prevention Factors for Health***

- ***Parasitic and Tropical Diseases***

- *Violence*: domestic
  homicide/suicide
  role of health services
  mental abuse

- ***Accidents***

- ***Mental Health***

- ***Sexual and Reproductive Health***

- ***Alcoholism, Drug Addiction and Tobacco Use***

Working Group II

This working group was very heterogenous. Some participants had already had a great deal of experience with gender issues, while others had only recently begun to work in this area. This diversity of exposure was reflected in the discussion, which took place in a highly democratic atmosphere, with the very different viewpoints being treated with equal respect.

What is Gender?

The first issue discussed by the group concerned the need to clarify exactly what is meant by the word "gender," and how it relates to health research. The following points were raised:

- Gender is about the subordination of the female sex and the historical roots of patriarchal power.

- Gender relates both to what is masculine and what is feminine. Gender identity is related to the socialization process. Some participants felt that the word gender has a strong feminine bias and is used primarily to talk about women. Men should also be discussed. While men tend to dominate women, they also face sex-specific problems (for example, they die earlier than women; they feel they have to be macho). Both the similarities and differences between men and women should be researched.

- When looking at gender issues, we cannot forget that women also have great power and strength. This needs to be addressed in a fuller way.

- Traditional expectations of how males and females should behave have severe consequences for men, as well as for women. For example, through gender socialization processes, boys are taught to bottle up their feelings. The resulting implications for society are obvious: violence levels are much higher among men.

- When researching indigenous cultures, it may be difficult to determine what is equality and what is inequality. Researchers must thoroughly understand the culture in order to understand the gender relations.

- Gender crosscuts class, age and ethnicity. Addressing gender issues brings about a revolutionary way of thinking, in the same way that addressing the concept of class was revolutionary when it was introduced. There is also an inter-relationship between gender, race, and class based on power.

What is Sustainable Development?

The group also discussed the term "sustainable development" and the way that it integrates with gender and health. The following points were raised:

- All research should be sustainable. Communities should be able to continue the research process after the researchers have departed.

- In order to achieve sustainable development, it is necessary to integrate a gender analysis into research.

- Women, as family leaders, are key influencers of sustainable development.

- Health is key to sustainability. We must begin from the perspective of healthy human beings. The level of health in communities is dependent on models of sustainable development. Deterioration of the environment leads to the destruction of health. Research must look at how environmental changes affect morbidity and mortality. It must also address how environmental changes affect men and women differentially.

- The link between harsh economic policies, poverty, environmental degradation and deterioration of life quality was discussed. Women and children are particularly affected by poverty, which is more than just a decline in material and physical conditions, but also psychosocial. Self-image and self-reliance are affected by poverty. The link between violence against women and poverty was also discussed.

The Link Between Research and Policy

A discussion on the link between research and health policy followed. Many participants stressed that good research data can also be used for political purposes. Data can be a powerful tool and can be used to influence decision-making with regard to important health policy decisions. However, it was cautioned that, if researchers have political objectives, they need to ensure that their methodology is not contaminated with ideology.

Obstacles Hindering Research on Gender and Health

The working group discussed various obstacles which hinder research on gender, health and sustainable development. Obstacles include the following:

- Health institutions do not pay enough attention to gender issues. There is a lack of institutional and financial support for these issues.

- Many participants said that they lacked the necessary tools to incorporate a gender perspective. They lack basic information and understanding about gender issues. There is a lack of good research and quantitative information and a dearth of recent publications and updated bibliographies published in accessible languages. A need exists for more, and a wider dissemination of, publications in this area. Researchers need to be trained in this area. They are unaware of methodologies, techniques and specific instruments for studying gender dimensions.

- Some rigidity exists concerning what constitutes appropriate research. Many researchers are not convinced that it is useful to work from a gender perspective, and are therefore resistant to incorporating a gender analysis. The subject area tends to be monopolized by females; many men are not interested in the area or do not view it as legitimate.

- There are difficulties concerning the definition of "gender," and confusion concerning the differences between gender and sex. Gender involves the interrelationship between the masculine and the feminine.

- A better definition is needed to clarify and elaborate on the relationship between gender and other social categories, such as race and ethnicity.

- Obstacles that confront female researchers need to be addressed. For example, many female researchers are unable to have families because of the demands of their work.

Avenues to Improve Research

The participants then discussed various ways that health research may be improved, including the following:

- Methods to establish bridges between research and the cultural wealth of communities need to be explored. Researchers should strive to ensure the full participation of the populations being studied in the design of the research. Priority research areas should be determined by the populations being studied.

- Important research results need to be better applied to interventions.

- The gender of the researcher team members may affect or bias the results.

- A need exists for more legislation and governmental support with regard to gender and health issues. There is a need for more participation of women in the formulation of legislation and policies.

- The effects of research on sustainable development should be at the forefront. Environmental issues, including the impact of deteriorating environmental conditions on the health of men and women, are paramount.

- Research should incorporate ethics to protect the dignity and rights of human beings.

- Researchers should not just diagnose problems, but should also attempt to turn research into action.

Priority Research Themes

A need exists to establish priorities for health research from a gender perspective. The following is not intended to be a complete list of priorities, but rather a sampling of some of the areas which were deemed by group members to be important:

- gender relations among indigenous groups and peasants;
- the health effects on men and women of working conditions;
- evaluation of intervention methods;
- health problems specific to men;
- the impact of mass media/communications on gender relations;
- violence against women and assessing preventive strategies;
- the link between declining health and the degradation of moral and ethical values in society, as well as the loss of cultural identity;
- interventions for increasing women's self-esteem;
- gender and mental health issues;
- the effects of colonization, as well as the effects of excessive urbanization, on the health of men and women;
- the influence of government policies on the health of populations;
- how traditional gender role expectations and divisions between men and women can be changed;
- the impact of poverty on the health status of women;
- gender issues with regard to the sexual conduct of adolescents; and,
- the effect of pesticides which are controlled and used by female farmers.

Related Topics and Initiatives Informally Presented at the Workshop

Gender Analysis and Health Research

Gender and Development Unit[1]

Introduction

The following outline will highlight some key elements of gender analysis and methodology, particularly related to health research. Incorporating a gender perspective into any research process is crucial if the research outputs are to lead to sustainable policy decisions. The focus on gender analysis is not on women alone, but rather on gender relations. Gender analysis takes a holistic approach to structural conditions and their impacts, and therefore emphasizes relations and processes, as well as roles.

Gender Research

- Gender does not mean women.

- Gender is a socio-cultural construction; it refers to what society defines to be male or female, which results in differential:

    - male and female roles;
    - male and female responsibilities;
    - male and female knowledge bases;
    - male and female position and status within society;
    - male and female attitudes and perceptions;
    - male and female access to and use of resources and information;
    - male and female participation in decision-making; and,
    - social codes and attitudes governing male and female behaviour.

Implications for Health Sciences Research

The questions put forward by a gender analysis approach build on the social, cultural, political, economic and ecological constructions of gender relations. Research incorporating a gender perspective must also take into consideration the implications of women's subordinate position in society and the subsequent conditions they face. For health research in particular, the implications of these differences in relation to the following factors (differentiated by gender) must be closely examined and taken into account for the development of sound policies:

---

[1] Gender and Development Unit, Corporate Affairs and Initiatives Division, International Development Research Centre, Ottawa, Canada

- definition of health and well-being;
- vulnerability to and manifestation of certain diseases;
- responses to illness/disease;
- access to and use of health care information, services and facilities;
- control in decision-making on personal and family health matters; and,
- participation in policy-making and resource distribution.

Some Methodological/Practical Implications

- Data must be desegregated by sex.

- Biological differences become significant to the extent that gender biases, and the dominance of males in decision-making and research leadership, ignore their implications. For example, water pumps have been installed in many communities which have proven to be useless. Although women tend to be responsible for water collection, these pumps have primarily been designed and located for use by men. In addition, many AIDS programs have been gender blind, as one of their basic premises has been that women can ask their partners to use condoms even though in many cultures this is socially unacceptable.

- Research team composition is an important methodological issue given pervasive gender biases and sensitivities.

- Sampling, testing and evaluation procedures must incorporate an appreciation of gender differences and implications. Timing of interviews must build in a recognition of which respondents will be available, given roles and responsibilities in particular contexts (for example, in an agricultural community, a relevant sample is likely to be skewed if interviews are conducted when most women are in the fields).

- Premises of all research must be filtered through a gender lens, even if the project focuses on women.

Research Example

A Chagas study evaluating incidence among pregnant women and prevalence of vertical transmission was carried out sampling only pregnant women. It was designed to inform those women who were infected, and those whose babies were infected. The women were to be advised on where they could obtain treatment. The following gender-related questions need to be asked:

- will pregnant women, informed that they have Chagas disease, be able to access care, given their multiple roles and responsibilities and social constraints?

- how will existing gender biases affect their spouses/partners' responses?
- what changes in methodology need to be incorporated so that the women involved the study are facilitated in seeking care?
- what changes need to be incorporated in sampling and orientation so that they are not viewed by their spouses as responsible for infecting the children and household?

Case Study: Adolescents and Sexually Transmitted Diseases

The participants were asked to consider how they would approach the research topic of *Adolescents and Sexually Transmitted Diseases* from a gender-sensitive perspective. Considerations from a gender perspective include the following:

- Both girls and boys are at risk of STDs. The risk may be different for the sexes due to biological and sociological differences. A research study could look at the extent to which adolescent males and females are vulnerable to STDs. Vulnerability to STDs may be influenced by a number of factors including: attitudes about femininity and masculinity; age of onset of sexual relations; and knowledge levels. The differences between adolescent boys and girls with regard to these factors could be explored.

- Sexual initiation patterns may be an important consideration. Boys may be pressured by male role models, such as fathers, to have sex early or to have sex with prostitutes, while girls may be pressured to abstain from early sexual relations. There may be gender differences in the way that parents talk to their sons and daughters about the risk of STDs, which may affect vulnerability. Boys may have more initiative in sexual relations, while girls may be more passive. Condom usage may be affected by gender issues. Questions should explore why young people do not use protection, and what gender differences exist in this area.

- Qualitative participatory research using focal groups could be done initially, with a view to designing a pilot program on how adolescents could be better educated and trained.

- Gender differences must be recognized at every point throughout the research. Adolescent boys and girls should be involved in the entire research process, including the formulation of methodology.

- Gender differences may affect whether or not girls and boys admit to having a STD. The level of privacy for the study, and whether or not participants have to go to special STD clinics, may affect the results. Recognizing that girls may not share certain things in the presence of boys, and vice versa, it may be helpful to divide the boys and girls into different focal groups.

- Researchers should also be aware of the timing of the focal groups. Boys and girls have different workloads. In order to capture the desired population, timing is important. If the research is carried out during the day when women are working in the fields, or when they are at home working, key elements of the population may be missed, which can affect the outcomes of the research.

Healthy Women Counselling Guide/Healthy Communication with Rural Women

Ane Haaland[1]

Rural women in Africa often have many complaints about the care they receive from health care workers in their communities. They frequently accuse them of being impatient, rude, and careless. They also complain that health care workers charge exorbitant prices for medicines and services. As a result of these problems, rural women, to a large extent, care for their health problems at home. They tend to only turn to the health centre when the problem prevents them from taking care of their daily activities in the home; even then, the health centre is not necessarily their first choice.

Why does the behaviour of health care workers toward their fellow sisters often lack compassion? How can the health behaviour and choices of rural women for different diseases, in a variety of situations, be explained? Finally, what can be done to ameliorate the problems? By gaining an understanding of the perceptions of health care workers, women, men, and community leaders, can solutions be found to build improvements which people define themselves, take responsibility for, and practice?

These are some of the questions on the agenda of the Gender Research Program of the Special Program for Research and Training in Tropical Diseases (TDR) of the World Health Organization (WHO). The Gender Research Program is strongly supported by IDRC, and by the World Bank. IDRC is one of the TDR's main partners on gender research issues. The cooperation between IDRC and TDR includes a joint annual award for the best research paper on Gender and Tropical Diseases. The topic this year is *The Female Client and the Health Provider.*

African women researchers are currently engaged in two series of action research studies to investigate these questions:

- the *Healthy Women Counselling Guide* studies are being carried out in Sierra Leone, Kenya, and Nigeria; and
- the *Healthy Communication with Rural Women* studies are being done in Uganda, Senegal, Zambia, and Mozambique.

---

[1] Special Program for Research and Training in Tropical Diseases (TDR), World Health Organization (WHO), Geneva, Switzerland.

- the *Healthy Communication with Rural Women* studies are being done in Uganda, Senegal, Zambia, and Mozambique.

Healthy Women Counselling Guide (HWCG)

The objective of the *Healthy Women Counselling Guide* is to understand how rural women look at their own health problems, how they learn about health, what they see as potential improvements in their situation, and how knowledge can be given to them to help them deal better with their health.

Based on the findings from the studies, an educational approach will be developed. The information to be given to the women will be based on their own perception of the problems, and will attempt to build bridges between traditional and modern medicine. It will be offered to the women through channels they have identified as credible and useful regarding advice on health issues.

In the next phase of the research, the effect of such an educational approach on women's health will be measured. A special feature of the study is the cooperation with health advocates/communicators from the planning stage. The educators/implementors can then ask questions which are important for finding out what kind of educational approach should be developed. Further information on the study, including the core protocol, can by obtained from TDR.

Healthy Communication with Rural Women (HCRW)

The HCRW is a qualitative research method designed to assist health care providers to identify problems related to the way they deal with women, particularly the reasons behind their actions, and what they themselves can do to improve the situation.

The method was developed in South Africa by Dr. Sharon Forn, and Ms. Khosi Xaba of the Women's Health Project at the University of the Witwatersrand. In a series of six weekly workshops (each 2 1/2 hours in length) conducted in the health facility, the health providers are asked to describe and analyze the problems they face in providing health care to rural women, and how these problems affect the quality of care they are able to give. They also discuss the status of women in society, and women's unmet health needs, and how these factors affect the way they treat female patients. Then, in the last workshop, the health workers discuss and decide what they can do themselves, and as a group, to improve the situation, and which problems they need assistance with from the outside.

One of the special features of this method is that the whole process of the research belongs to the health workers. They define the problems, the causes, and the solutions. The researchers function as facilitators, guiding the discussions, asking follow-up questions, and making sure everybody gets a chance to participate. Working together in a group to develop

solutions functions as a process of awareness building and empowerment. The health workers develop confidence that they can actually deal with a major part of the problems themselves.

During the research, a variety of qualitative research methods are used as discussion starters: role playing, case studies, poems, drawings, and prioritizing tasks. The method is powerful in encouraging health workers to talk about problems they know exist (like overcharging, not giving patients the full dose of medicines so that they have to come back and pay another user's fee) - but would not talk about in individual interviews. They can be painfully honest when the intention clearly is that they themselves will solve the problems, rather than having them reported on by a researcher over whom they have no control.

In April 1994, a protocol development and training workshop was conducted in Jinja, Uganda, by Sharon Forn and Khosi Xaba. The workshop was sponsored by TDR, and supported by IDRC and the World Bank. It was arranged by Dr. Jane Kengaya-Kayondo at the Uganda Virus Research Institute, in cooperation with the Ministry of Health. Five research teams were trained, and four of these (Uganda, Senegal, Zambia, and Mozambique) have now started their studies. The results will be available by October 1994.

The next stage will be to conduct studies to measure the exact outcome of the health workers' process of change on the pattern of women's use of the health services, and ultimately on women's health. The protocol for the study is available from TDR, and from Dr. Sharon Forn. The protocol would also be appropriate for countries in Latin America and Asia.

Discussion

The following points were raised following Ane Haaland's presentation:

- When conducting research, people are more likely to open up if they are confident that a change will result from the research. Researchers have a responsibility to ensure that something will happen as a result of their research.

- Many problems can be solved with actions at the community level by local inhabitants. It is important to first identify problems from the perspective of the community members. They may be able to solve their own problems with a little assistance (for example, community members may ask who they can approach to get some training).

- The presenter was asked how much time was spent during the workshops with health care providers. The presenter responded that weekly workshops, of two hours in length, occurred over six weeks. In these workshops, health workers decided what they wanted to change. Many health workers were experiencing difficulties, and were not motivated to deal with their female clients. They were led through a process which aimed to empower them to deal with their difficulties. The process had an immense effect on their motivation to work.

- One participant asked how improvements in the way health providers treat women could influence mortality rates and disease patterns. The presenter responded that, if health care providers did a better job with their female clients, women would be more likely to use services and medicines more effectively, and would take charge of their own health, which would undoubtedly lead to positive health gains. Effective care by health providers can lead to a decrease in the amount of disease experienced by women. Presently, health care workers are not used to the full extent possible because women often do not follow their advice.

- There are gender inequities in the way health care providers treat women. It was suggested that a workshop should be held which would be devoted to the status of women in society and how this affects the female client. Women have many unmet health needs and may be reluctant to attend health centres. It should be acknowledged that male health providers often treat women poorly. For example, they may become impatient with women of low educational levels, and be anxious to finish with them quicker.

- One participant asked how the researchers were able to ascertain information with regard to the "baggage" that the health care workers carried. The presenter explained that the health care workers were asked to draw the river of life as a way of explaining the factors that influenced their decisions to become health care workers.

- The importance of attending to non-verbal communication (i.e., body language) was discussed. It is estimated that fifty to eighty percent of communication occurs through non-verbal cues.

- The importance of nontraditional qualitative research methods, such as role playing, was discussed. Creative methods can elicit information that would otherwise never be gained through traditional interview methods. The presenter noted that participants were willing to participate in role playing and that no one has refused to participate.

- The importance of finding avenues to assist women who do not go to health clinics was discussed. A need exists to find out where these women get their health information (i.e., from their neighbours, the radio). What sources of information are deemed to be credible?

GENDER, HEALTH AND SUSTAINABLE DEVELOPMENT WORKSHOP

Montevideo, Uruguay
April 26-29, 1994

AGENDA

MONDAY APRIL 25

18:00 Meet at the hotel lobby to receive and cash per diem cheques

19:00-21:00 Welcoming Reception at the IDRC office

TUESDAY APRIL 26

Chair: *Anthony Tillett - IDRC, Uruguay*

09:00-10:30 **Welcome and Opening Address**

- Anthony Tillett
  Regional Director
  IDRC Regional Office for Latin America and the Caribbean
  Uruguay

Introduction

- Silvio Gómez
  Health Sciences Division
  IDRC, Uruguay

- Pandu Wijeyaratne
  Health Sciences Division
  IDRC, Canada

- Rosina Wiltshire
  Gender and Development Unit
  IDRC, Canada

- Ane Haaland
  TDR/WHO
  Switzerland

TUESDAY APRIL 26 (cont.)

10:30-10:45 Coffee

10:45-11:30 **The state of activity of the proposed Global Commission on Women's Health**

- A. El Bindari Hammad - WHO, Switzerland

11:30-12:00 **Objectives and Overview of agenda**

- Janet Hatcher Roberts - IDRC, Canada

12:00-13:30 Lunch

Chair: *Constanza Collazos - Colombia*

13:30-14:45 ***Plenary I - Focus Presentations***:

AIDS, Sexually Transmitted Diseases and Gender

- Leda Pesce - Uruguay
- Carmen Dora Guimarães - Brazil

14:45-15:00 Coffee

15:00-16:15 ***Plenary II - Focus Presentations***:

Environmental Stress, Production Activites, Health and Gender

- Ximena Díaz - Chile
- Jaime Breilh - Ecuador

16:15- 17:30 ***Plenary III - Focus Presentations***:

Tropical Diseases and Gender

- Elsa J. Sarti - Mexico
- Jenny Dávalos - Bolivia

18:00 ***IDRC video presentations***

WEDNESDAY APRIL 27

Chair: *Elsa Sarti - Mexico*

08:00-09:15 *Plenary IV - Focus Presentations*:

Indigenous Peoples' Health Issues

- Xochitl Herrera - Colombia
- Teresa Castillo - Mexico

09:15-10:30 *Plenary V - Focus Presentations*:

Health Care Providers

- Constanza Collazos - Colombia
- Ilta Lange - Chile

10:30-10:45 Coffee

10:45-11:30 *Plenary VI - Panel Discussion*

Discussion and implications of Day 1 focus presentations in relation to workshop objectives

Discussants:
- **Rafael García - Dominican Republic**
- **Clara Cárdenas - Peru**
- **María Molina - Paraguay**
- **Giovanna Chiarella - Bolivia**
- **Alvaro Dobles - Costa Rica**

11:30-13:00 *Discussion of specific objectives and Orientation to working groups*

- Pandu Wijeyaratne - IDRC, Canada
- Janet Hatcher Roberts - IDRC, Canada

- Disease and Gender
- Health, Environment and Gender

Working group discussions begin

13:00-14:30 Lunch

WEDNESDAY APRIL 27 (cont.)

14:30-17:00 *Plenary VII* -

Gender Analysis - Introduction, Orientation, Methodological Issues

- Rosina Wiltshire - IDRC, Canada

THURSDAY APRIL 28

08:00-09:00 *Informal Presentations*:

Women and Health in Canada: Highlights of Experience

- Janet Hatcher Roberts
  Health Sciences Division
  IDRC - Canada

Healthy Women's Counselling Guide

- Ane Haaland
  TDR/WHO - Geneva

09:00-12:00 *Working groups continue*

12:00-13:30 Lunch

Chair: *Silvio Gómez - IDRC, Uruguay*

13:30-14:30 *Plenary VIII* -

Working group feedback

14:30- Afternoon in Montevideo

FRIDAY APRIL 29

09:00-09:30 *Plenary IX* -

Research Proposal Development: Issues, Gaps and Future Action

- Rosina Wiltshire - IDRC, Canada
- Janet Hatcher Roberts - IDRC, Canada

09:30-10:30 *Small group work*

10:30-10:45 Coffee

10:45-12:30 *Working groups continue*

12:30-14:00 Lunch

14:00-15:15 *Plenary X* -

Presentation of and Feedback on proposal outlines

15:30-17:00 **Conclusion and follow-up**

- Pandu Wijeyaratne - IDRC, Canada
- Silvio Gómez - IDRC LARO, Uruguay
- Rosina Wiltshire - IDRC, Canada

Gender, Health and Sustainable Development Workshop

Montevideo, Uruguay
April 26-29, 1994

PARTICIPANTS

Doris Acevedo
Professor, Unidad Salud Ocupacional
Apartado Postal 4810
Maracay 2101 A
Venezuela
Tel/Fax: (58-43) 464 150 (Home)
Tel: (58-43) 333 509 (Office)

Roberto Bazzani
Asistente de Programa
División Salud
IDRC/CIID
Plaza Cagancha 1335 P. 9
Casilla de Correo 6379
Montevideo, Uruguay
Tel: (598-2) 922 031/34
Fax: (598-2) 920 223
E-Mail: rbazzani@idrc.ca

María Bonino
Facultad de Medicina
Universidad de la República
Montevideo, Uruguay
Fax: (598-2)98 59 59

Jaime Breilh
Director Centro de Estudios y
Asesoria en Salud (CEAS)
Roca 549, Depto. 602
Quito, Ecuador
Fax: (593-2) 566 714
Tel: (593-2) 562 674/243 039 (Office)
E-Mail: jbreilh@ceas.med.ec

Jaime Calmet
Centro de Investigación y Promoción
Amazónica (CIPA)
Av. Ricardo Palme
666D Miraflores
Lima 18, Peru
Fax: (51-14) 458 661

Clara Cárdenas
Universidad Peruana Cayetano Heredia
Instituto Medicina Tropical "Alexander Von Humboldt"
Grupo de Estudios de Leishmaniasis
Apartado 5045,
Lima 100, Perú
Fax: (51-14) 823 404
Tel: (51-14) 823 910 (Office)
(51-14) 644 213 (Home)

Teresa Castillo
Sección de Ecología Humana
Centro de Investigación y de Estudios Avanzados
CINVESTAV
CP 97310, AP 73 "Cordemex"
Mérida, Yucatán, Mexico
Fax: (52-99) 812 923/812 919
Tel: (52-99) 812 960/812 903 (Office)
(52-99) 810 045 (Home)
E-Mail: dickinson@kin.cieamer.conacyt.mx

Constanza Collazos
CIMDER
Universidad del Valle
Facultad de Salud
Apartado Aéreo 3708
Cali, Colombia
Fax: (57-23) 542 484/542 491
Tel: (57-23) 542 477-91 (Office)
(57-23) 520 307 (Home)

Giovanna Chiarella
Directora CIAES
Centro de Investigación, Asesoría y Educación en Salud
Av. Ramón Rivero # 0770
Casilla de Correo 5073
Cochabamba, Bolivia
Fax: (591-42) 55 437
Tel: (591-42) 56 070
E-Mail: ciaes@unbol.bo

Jenny Dávalos
Instituto de Maternidad
"Dr. Perry Boland R."
Ministerio de Prevision Social y Salud Publica
Casilla 1548
Santa Cruz, Bolivia
Fax: (591-3) 346 766
Tel: (591-3) 326 220 (Home)

Ximena Díaz
Coordinadora de Programa
Centro de Estudios de la Mujer
Purisma 353
Santiago, Chile
Fax: (56-2) 735 1230
Tel: (56-2) 777 1194

Elsa Do Prado
Centro Salud y Sexualidad
ALTERNATIVAS
Chaná 1844
CP 11200
Montevideo, Uruguay
Tel: (598-2) 487 974
Fax: (598-2) 495 651

Alvaro Dobles
Escuela de Medicina Veterinaria
Universidad Nacional
Apartado 304-3000
3000 Heredia, Costa Rica
Tel/Fax: (506) 237 9735
Tel: (506) 282 5047 (Home)

Teresa Durán
Directora
Departamento de Antropología
Universidad Católica de Temuco
Casilla 15-D
Avenida Alemania 0211
Temuco, Chile
Fax: (56-45) 234 126
Tel: (56-45) 222 089 (Home)
(56-45) 213 441 Anexo 308 (Office)

Claudia Durana
Centro de Estudios de Desarrollo Económico
CEDE
Facultad de Economía
Universidad de los Andes
Apartado Aereo 4976
Bogota, Colombia
Fax: (57-1) 284 1890
Tel: (57-1) 215 4503 (Home)

Fay Durrant
Especialista Principal de Programas
División Ciencias y Sistemas
de la Información
IDRC/CIID
Plaza Cagancha 1335 P. 9
Casilla de Correo 6379
Montevideo, Uruguay
Tel: (598-2) 922 031/34
Fax: (598-2) 920 223
E.Mail: fdurrant@idrc.ca

Aleya El Bindari Hammad
Special Advisor on Health and
Development Policies in the
Director-General's Office
CH-1211, Geneva 27, Switzerland
Fax: (41-22) 788-0346

Luis Faral
Facultad de Medicina
Universidad de la República
Montevideo, Uruguay

Nea Filgueira
Coordinadora General
GRECMU
Miguel C. del Corro 1474
Montevideo, Uruguay
Tel/Fax: (598-2) 41 64 15

Rafael García
Instituto de Sexualidad Humana
Universidad Autónoma de Santo Domingo
Antiguo Hospital Marión
Santo Domingo, Republica Dominicana
Fax: (1-809) 689 4081
Tel: (1-809) 541 4517 (Office)
(1-809) 566 9328 (Home)

Silvio Gómez
Representante de Programa
División Salud
IDRC/CIID
Plaza Cagancha 1335 P. 9
Casilla de Correo 6379
Montevideo, Uruguay
Tel: (598-2) 922 031/34
Fax: (598-2) 920 223
E.Mail: sgomez@idrc.ca

Carmen Dora Guimarães
Post-Graduate Program in Social Anthropology
Museu Nacional
Federal University of Rio de Janeiro
Rio de Janeiro, 20942, Brazil
Fax: (55-21) 224-8664
Tel: (55-21) 266-6680 (Home)

Ane Haaland
WHO/TDR
CH-1211, Geneva 27, Switzerland
Fax: (41-22) 788-0839
Tel: (41-22) 791 3812 (Direct)
(41-22) 791 3789 (Secretary)

Janet Hatcher Roberts
Senior Program Specialist
Health Systems
Health Sciences Division
IDRC
250 Albert Street
Ottawa, Ontario
P.O. BOX 8500
K1G 3H9
Tel: (1-613) 236 6163 Ext. 2014
Fax: (1-613) 567 7748
E-Mail: jhatcher-roberts@idrc.ca

Xochitl Herrera
Fundación para el Etnodesarrollo de los
Llanos Orientales de Colombia
Carrera 13, No. 146-50
Apartamento 501
Bogota, Colombia
Tel/Fax: (57-1) 216 8586 (Home)
Tel/Fax: (57-1) 258 9146 (Office)

Lori Jones Arsenault
Research Assistant
Health Sciences Division
IDRC
250 Albert Street
Ottawa, Ontario
P.O. BOX 8500
K1G 3H9
Tel: (1-613) 236 6163
Fax: (1-613) 238 7230
E.Mail: ljones-arsenault@idrc.ca

Jennifer Kitts
c/o Health Sciences Division
IDRC
250 Albert Street
Ottawa, Ontario
P.O. BOX 8500
K1G 3H9
Tel: (1-613) 236 6163
Fax: (1-613) 238 7230

Ilta Lange
Directora, Escuela de Enfermería
Pontificia Universidad Católica de Chile
Casilla 6177 Correo 22
Santiago, Chile
Tel/Fax: (56-2) 552 2039 (Office)
(56-2) 552 5407 (Office)
Tel: (56-2) 205 0120 (Home)

Miguel Lobo-Guerrero
Fundación para el Etnodesarrollo de los
Llanos Orientales de Colombia, ETNOLLANO
Carrera 13, No. 146-50 Apartamento 501
Apartado 55455
Bogota, Colombia
TEL/Fax: (57-1) 258 9146 (Office)

María Molina Cabrera
Alter Vida - Centro de Estudios y
Formación para el Ecodesarrollo
Artigas 960
Casilla de Correo 2334
Asuncion, Paraguay
Fax: (595-21) 207 246

Freddy Peña
Instituto de Maternidad
"Dr. Perry Boland R."
Ministerio de Previsión Social y Salud Pública
Casilla 3632
Santa Cruz, Bolivia
Fax: (591-3) 346 766
Tel: (591-3) 520 022 (Home)
(591-3) 339 779 (Office)

Leda Pesce
Coordinadora Area Salud
Movimiento "Paulina Luisi"
18 de Julio 540
C.P. 37000
Melo, Cerro Largo, Uruguay
TEL/Fax: (598-462) 3397

Alice María Pineda
Centro de Investigaciones y
Estudios Superiores de la Salud
Av. de los Repuestos 15 varas al Sur
Managua, Nicaragua
Fax: (50-52) 97-324 (OPS)
Tel: (50-52) 75-020 (Office)

Arletty Pinel
GENOS Internacional
Av. Paulista 1499 Lj. 31
01311-200 Sao Paulo, SP
Brazil
Fax: (55-11) 283 0468
Tel: (55-11) 815 9704 (Home)
(55-11) 287 7473 (Office)

Paulina Pino
Depto. Salud Pública
Facultad Medicina
Universidad de Chile
Casilla 16117
Santiago 9, Chile
Fax: (56-2) 274 6444
Tel: (56-2) 229 6535 (Home)
(56-2) 204 7848 (Office)
E-Mail: ppino@med.uchile.cl

Graciela Saprisa
GRECMU
Miguel C. del Corro 1474
Montevideo, Uruguay
Tel/Fax: (598-2) 41 64 15

Elsa Sarti
Directora de Investigación Epidemiológica
Dirección General de Epidemiología
Secretaría de Salud
Francisco de P. Miranda #177 - 7° Piso
Col. Lomas de Plateros
CP 01480, MEXICO, D.F.
Fax: (52-5) 593 9292
Tel: (52-5) 684-8886 (Home)
(52-5) 651 8261 (Office)

María Cristina Sosa
Directora
Movimiento "Paulina Luisi"
18 de Julio 540
C.P. 37000
Melo, Cerro Largo, Uruguay
Fax: (598-462) 3397

Jasna Stiepovich
Dean of Nursing
Faculty of Nursing
Universidad de Concepcion
Casilla 603
Concepción, Chile
Fax: (56-41) 228 353
Tel: (56-41) 234 985 Ext. 2829 & 2820

A.D. Tillett
Director Regional
IDRC/CIID
Plaza Cagancha 1335 P. 9
Casilla de Correo 6379
Montevideo, Uruguay
Tel: (598-2) 922 031/34
Fax: (598-2) 920 223
E.Mail: atillett@idrc.ca

Panduka Wijeyaratne
Principal Program Officer
Health Sciences Division
IDRC
250 Albert Street
Ottawa, Ontario
P.O. BOX 8500
K1G 3H9
Tel: (1-613) 236 6163
Fax: (1-613) 238 7230
E-Mail: pwijeyaratne@idrc.ca

Rosina Wiltshire
Senior Program Officer
Gender and Development
Corporate Affairs and Initiatives Division
IDRC
250 Albert Street
Ottawa, Ontario
P.O. BOX 8500
K1G 3H9
Tel: (1-613) 236 6163
Fax: (1-613) 238 7230

OBSERVERS

Irmajean Bajnok
Director, WHO Collaborating Centre
Mount Sinai Hospital
600 University Avenue
Toronto, Ontario
Canada
M5G 1X5
Fax: (416) 586-8830
Tel: (416) 586 5274

Pamela Hartigan
PC/PWD
Pan American Health Organization
525 Twenty-Third Street N.W.
Washington D.C.
20037-2897
Tel: (1-202) 861-3405
Fax: (1-202) 223-5971

Argelia Londono Vélez
Programa Mujer, Salud y Desarrollo
Organizacion Panamericana de la Salud
Calle 95 No. 9-80
Santafé de Bogotá, Colombia
Fax: (57-1) 218-0696
Tel: (57-1) 616 0177 (Office)
(57-1) 613 5194 (Home)

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 scholary 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.