# Gender, Health, and Sustainable Development

## Perspectives from Asia and the Caribbean

**Proceedings of workshops held in Singapore, 23 – 26 January 1995 and in Bridgetown, Barbados, 6 – 9 December 1994**

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

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# Foreword

The genesis for these workshops has come from two initiatives. The first initiative was a series of IDRC/TDR-WHO sponsored essay competitions, begun in 1990, on the subject of women and tropical diseases. These three highly successful competitions highlighted the enormous inequities in terms of the impact of tropical diseases on women, and served to demonstrate the almost complete lack of research which has been carried out in this area.

The second initiative came about as a result of the establishment of the Global Commission on Women's Health in 1992. The Commission is being led by The World Health Organization (WHO), with membership drawn from its member countries, including Dr. Maureen Law, the Director General of the Health Sciences Division at IDRC, Dame Nita Barrow, the Governor General of Barbados, and 4 members from the Asia Pacific region. In its quest for funding support, the Commission came to IDRC. IDRC has supported the Global Commission in two ways. The first was through core Secretariat support to Geneva. The second, through one of the substrategies of the Global Commission, which was to reflect and consolidate research agendas in the regions in order to improve the state of knowledge in women's health.

IDRC saw the opportunity to support the Global Commission by facilitating a series of workshops on the subject of gender, health and sustainable development. The first workshop was held in Nairobi, Kenya in October 1993, and the second in Montevideo, Uruguay in April 1994. These workshops represent the third and fourth in the series.

One of the mandates of the Global Commission is to report to major international conferences on the state of women's health. It has done so at the World Conference on Human Rights, at the International Conference on Population and Development, and is now preparing for the 4th World Conference on Women and Development, to be held in Beijing, China in September 1995. The Chairperson of the Global Commission, Dr. Aleya El Bindari Hammad, sits on the Commission on the Status of Women for Beijing, and Gertrude Mongella, the Chairperson for the 4th World Conference, sits on the Global Commission on Women's Health. In addition, the Global Commission on Women's Health has been responsible for preparing a number of issue papers on topics such as adolescent health and aging.

## *Gender and Health in Development*

The first two workshops brought forth a rich and diverse array of research priorities, gaps which need to be addressed, and strategies for overcoming the major roadblocks to conducting this research. We have all learned a great deal. These workshops have served to

bring together the small, and not so small, pockets of excellence in research into connected networks of research. Interdisciplinary teams have been forged, and lessons are being shared.

These activities have also helped to push us a few conceptual steps forward, in two ways.

- by addressing the issue of gender methodologies and their incorporation into research and policy development; and,

- by no longer being content with only dealing with women's health issues, but rather moving forward to the role of gender in health and its inextricable links to a sustainable environment and economic development.

What we are doing by accepting these linkages, is redefining the concept of sustainable and equitable development to include gender, health and human development. Those in the health field might think, surely this is a given. Why do we need to be reminded?

Local indigenous knowledge in both the north and the south has traditionally integrated these three dimensions. But fragmentation due to donor aid and other influences has caused this ability to be lost. We must now reacquaint ourselves with this capacity.

We are now seeing large development projects which have started to factor in environmental impact studies, but it is rare that the health impact is considered. Many know the impact of deforestation on the environment, but the impact of deforestation on the prevalence of malaria or seasonal outbreaks of cholera are not automatically considered or factored into the analysis. Sometimes it is only by accident that we learn of the implementation of such "development" projects, which leaves little time for studied intervention and advocacy.

Economic/agricultural development projects have helped support the entry of large international tobacco companies in Africa. Today tobacco is seen as the most important economic opportunity in countries such as Zimbabwe and Malawi. Yet none of these countries have factored in the human health dimension: by the year 2010, tobacco related deaths will overtake deaths by AIDS in these very same countries. Youth and women throughout the developing world are today the special targets of aggressive social marketing by the tobacco industry.

So we do need to continually make the case for the inclusion of health in sustainable and equitable development (SED), that there are gender issues in health, and that there are environmental impacts on health and human development impacts on the environment. All of this is SED.

How do we make the case for health in SED? We must embrace the approach of developing policies which support health, or "healthy public policies", by accepting that justice and equity are important prerequisites for health (Hancock 1992). Harvard University economist

Amartya Sen has said that it is not the level of wealth a country has which improves the health of its population; rather, it is its committtment to allocating resources to key sectors and groups such as education, mothers, and children.

We must also consider the complex interactions and linkages between health, the environment, and economic development. Michael Valpy writes

> A healthy population is a big economic tangible. Apart from draining less of the public purse, it is physically stronger, mentally brighter, it produces more, creates more, imagines more. It gets out of bed in the morning and goes to work.

While this expanded vision of health has validated the issues which women have always known to influence their health and well-being, the gender inequities remain and are severe.

## *What are these Gender Inequities in Health?*

- Women are more vulnerable to poverty, preventable diseases, uncontrolled fertility, premature death, violence, and illiteracy.

- This is not just due to our biomedical and general socioeconomic situation and differences. More importantly, it is largely due to the visible and invisible discrimination women suffer throughout their lives.

- Women live longer than men, but the quality of their lives is often impaired due to higher rates of chronic illness, disability, alienation, widowhood, loneliness, and poverty.

- There is also a lack of sensitivity on the part of the formal health care system to respond to the specific health needs of women taking into account cultural perspectives. The technological implications which are unique to women and quality of care issues are rarely addressed.

- There is a failure of health research to examine the impact that the physical and biological differences between men and women have on the epidemiology and etiology of disease.

- The reduction in the provision of state-supported health care services, due to economic restructuring in countries of the South, has meant a decline in the quality of and access to services. In these situations, women are less inclined to use formal health care services, and the burden on women to fulfil the role of care provider to the whole family is further increased (Global Commission on Women's Health 1993).

This translates into an inadequate integration of women's interests into decision-making roles and perspectives into the mainstream of health development.

### *Health and the Environment*

In the area of health and the environment, there has been an interesting and powerful shift in over the past six to eight years. That shift was in part influenced by the recognition that there were profound human health effects due to environmental degradation. People realized that this message could help alter the powerful socio-political agendas of governments.

This concern has been sustained and is international in scope. It is no longer the purview of wealthy, industrialized countries. Those in developing countries also voice their concern that the environment will have serious implications for the future health of their children. And yet, the action has been clearly weighted on the environment sector. With increased emphasis on monitoring and cleaning up, the health sector has been left with disproportionately less resources but increasing demands to act as interpreter for the public.

Monitoring and "cleaning up" only have meaning when they can be translated into the human health dimension. What do these levels mean? The public health professional is often the one who is called upon to interpret the information, to help the public weigh real versus perceived risks. For example,

- How clean is clean?
- Should my children be exposed to smaller amounts than the "safe" levels issued by environmental protection agencies?
- If I am pregnant, should I be seeking lower levels?
- What does it mean that the beach is cleaned up or the industrial pollutants reduced? for whom? based on what criteria? who were involved in developing the criteria? based on what evidence?

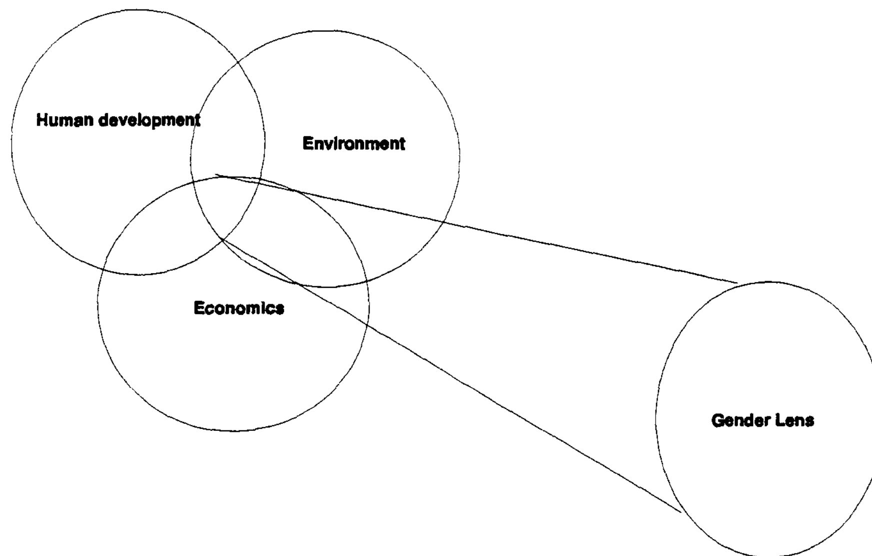
These are all human health dimensions which continue to be critical, yet fail to be part of the global environmental agenda.

Assumptions based on traditional views of environmental health and health protection are, as Trevor Hancock suggests, paternalistic, hierarchical, and non-participatory. Yet, they have guided our understanding, interpretation, and action in environmental health for decades (Hancock 1992). For women, particularly poor women, the impact of dangerous working conditions, poor quality housing, types of energy used, double work loads, and socio-political instability is clearly inequitable. But decisions about what constitutes an environmental hazard, and to whom, continue to be are top down and made by scientific experts. They fail to take into account local level experience, indigenous knowledge, and gender disparities. By incorporating participatory decision-making based on experiences of men and women, improvements can be made.

## *Conclusions*

We need to make the case for health in SED, for gender inequities in health, and for gender inequities in environment, economic, and human development. Human development threatens the very viability of the planetary biosphere, and yet human health requires an environment that is also viable and is able to sustain human life. Economic activity which continues unchecked obviously reduces the viability of the environment, which in turn threatens the "well-being and survival of humankind and millions of other species in the web of life" (IBID 1993).

This framework has been the foundation for the conceptualization of these workshops. By bringing together researchers and policy makers in the disciplines of environment, health, and economic development, we are seeing the emergence of exciting research agendas and policy strategies.

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We wish to express our sincere thanks to the staff and volunteer members of ENGENDER, who contributed their time, energy, and enthusiasm to the organization, management, and running of the Asian workshop. We would like to give special recognition to Vivienne Wee, Programme Director at ENGENDER, whose vision and conceptualization of the significance of gender in development helped to make this workshop a success, and to the dedicated and at times never-ending work of Aileen Kwa and Nutan Singapuri, Research and Administration Officers at ENGENDER, who ensured that the workshop flowed smoothly.

We would like to thank our regional colleague, Annette Stark, Senior Regional Programme Specialist for Health, without whose support and enthusiasm the workshop could not have taken place. We would like to thank Maria Ng Lee Hoon, Senior Regional Programme Officer for Information and Communication Sciences and Systems, John Graham, Senior Regional Programme Officer for Environment and Natural Resources, and Roland Yeo, consultant to the PAN project, for their interest and participation in the workshop. The support services of Lee Lee Tan, Catherine Ndiaye, and Madavan Veerasamy, as well as the rest of the very helpful support staff team, were also much appreciated.

In Barbados, we would like to acknowledge the support and collaboration of Karen Sealy, Caribbean Program Coordinator at PAHO, whose strength of conviction of the importance of women to development was in many ways a catalyst for this particular workshop; Hazel Cheltenham, Women, Health and Development Consultant, who so energetically and tirelessly organized and managed the conference arrangements; and Rosina Wiltshire, formerly head of the Gender Unit at IDRC and now the manager of the Gender and Development Programme at UNDP, who shared our commitment to these workshops.

We are appreciative of the work of Betty Alce, who, 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 lively and constructive discussions. Their discussions and analysis of gender, health, and sustainable development in Asia and the Caribbean will hopefully lead to further collaboration, and progress for research in this area.

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

Janet Hatcher Roberts
Lori Jones Arsenault
Jennifer Kitts

# Perspectives from Asia

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## Opening Statements

## Welcoming Address

**John Graham**[1]

Welcome to Singapore and to the Asian and Pacific Regional Workshop on Gender, Health, and Sustainable Development. The meeting is coordinated and jointly organized by the International Development Research Centre and by ENGENDER - the Centre for Environment, Gender and Development. The Global Commission on Women's Health of the World Health Organization is also collaborating with us.

IDRC, in collaboration with the Global Commission on Women's Health, has held a series of workshops examining gender, health, and sustainable development issues. Since October 1993, workshops have been held in Africa, Latin America, and the Caribbean. This Singapore meeting is the fourth and final workshop in the series.

ENGENDER, The Centre for Environment, Gender and Development, has, as its broad focus, the integration of environmental, gender, and social issues of the development process in the Asian and Pacific region. ENGENDER networks with government and non-governmental bodies, with policy makers, with indigenous communities and others to achieve sustainability of development through a more gender-sensitive and environmentally friendly development approach. We are extremely pleased to be working with them in this workshop.

IDRC itself has a longstanding interest in research relating to gender issues and development. We have a special unit to address this - the Gender and Development Unit. It is an integral part of our program activities, and all research projects which we fund in institutions in different countries are required to address gender issues. The Health Sciences Division is no exception, and many different gender and health issues have received attention and research funding, and this is expected to continue in the future. It is also recognized that major gaps still exist in our understanding of gender and health issues, especially in developing and market transition countries, and therefore much work remains to be done. The goal of "Health for All" will remain a distant goal if gender driven inequalities in health are not removed by incorporating gender considerations in health and other sectors of our economies.

---

[1] Senior Regional Program Officer of Environment and Natural Resources, IDRC's Asia Regional Office, Singapore.

In May 1993, The World Health Organization established a "Global Commission on Women's Health" and IDRC has been working and collaborating with them. 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 gender inequities. We need to increase our understanding of gender, health, and sustainable development issues. More information and research is needed to support policy decisions.

The objectives of this Singapore workshop are:

- to share methods of gender analysis among workshop participants by re-examining research aims, directions, and methods;
- to consider the inter-related dimensions of gender and sustainable development in research activities and policy work;
- to improve our ability to contextualize health within the broader terms which frame the conditions and forces impacting on people's lives; and
- to compare and contrast the issues, conditions, and strategies among countries of the region.

The proposed workshop outcomes are:

- to produce and disseminate the findings from the regional workshops on Gender, Health and Sustainable Development at the Beijing World Conference; and
- to establish a long-term research and action plan and a women's health network in Asia and the Pacific. The network will focus on issues critical to women's health within the context of the Cairo and Beijing Conferences.

The World Conference on Women - Action for Equality, Development and Peace, is to be held in Beijing in September 1995. The main objective of the Beijing Conference is to place the improvement of women's status high on the global agenda. More specifically, the Conference intends to:

- assess the extent to which recommendations of the 1985 meeting in Nairobi on "A Forward Looking Strategy for Advancement of Women" have been implemented, both nationally and internationally; and
- prepare and promote a "Platform for Action" for the remainder of the century.

IDRC has been supporting, both directly and indirectly, a number of activities related to the upcoming Beijing conference. Gender awareness must be enhanced among policy makers, professionals, and others at all levels. An intersectoral approach is required, not only at the macro level but also at district, local, and community levels.

As many of you may know, the World Bank Development Report of 1993, entitled "Investing in Health," pointed to impressive improvements made in health in developing countries over the last twenty years. However, in the poorer countries, 1 in 10 children still die before reaching the age of five. Poorer people still do not have sufficient food, clean water, shelter, or basic education - the necessities for good health.

The World Bank advocated a three-pronged approach for improving health:

- Governments need to foster an economic environment that ensures greater income gains to the poor so that poorer households will be better able to look after their own health needs.

- There is a need to redirect health spending to make it more efficient with more direct benefits to the poor. They noted that too much money goes to tertiary care facilities and too little to low cost, highly effective programs such as those for the control and treatment of infectious diseases. It is estimated that about 9 million infant deaths per year could be avoided through redirecting government spending.

- Governments need to promote a mix of public and private health care delivery systems. There needs to be more competition and efficiency in the delivery of health care services.

Gender issues are not specifically addressed in this strategy. In this workshop, we hope to begin to address some of these issues. I am sure that most participants will find the next four days extremely interesting and we at IDRC would like to thank you for helping us map out an appropriate longer term research strategy.

# Workshop Objectives

**Vivienne Wee**[1]

## *Introduction*

The central objective of this workshop is to challenge health researchers, NGOs and policy-makers to actively incorporate within their research, activities, and policy work, the interrelated dimensions of gender and sustainable development. Participants will therefore be encouraged to re-examine their research aims, directions and methods, so that states of well-being and ill health will be seen in connection to particular types of development processes, to war consequences, and to the effects of the gender hierarchy. This will aptly contextualize the phenomenon of health within the broader terms which frame the conditions and forces impacting on people's lives.

## *Why Focus on Gender in Health Research?*

Disseminating knowledge about more gender-sensitive research methodology and development processes is the overriding aim of this workshop. This is a more important objective than an emphasis on research content. Putting gender on the health research agenda entails a conscious attempt to focus on the inequities in women's health and an emphasis on gendered health impacts.

It is important for health research to focus on women's health and on women as a group distinct from men, since women are generally family care-givers, household resource managers, and the reproducers of society. The state of women's health and well-being contributes directly to the health and well-being of their families, especially children and the elderly, and thereby of the community as a whole.

Furthermore, it is important to put to the forefront what has too frequently been made invisible. Health research (other than reproductive health) is often carried out on male subjects and the results assumed to be relevant to both men and women. The emphasis therefore on women as a group, points to the urgency for health research to be more gender-specific, so that the needs of women can be more appropriately addressed by the health professionals.

---

[1] Program Director, Centre for Environment, Gender and Development (ENGENDER).

### *Defining Women's Health*

Women's health at this workshop will be defined in terms of women's total well-being. This is a holistic approach encompassing all aspects of women's lives, not only their reproductive functions. It is therefore important to address women's total life cycle and the health needs of girl children and of elderly women.

Another way to ensure that women's health is defined holistically in health research is to look at women's life spaces and gendered responsibilities. Because women and men often play different roles in their communities, the life spaces women occupy within and outside their homes can be quite different from those environments and spaces occupied by men. These differing environments and their impact on women's health should be addressed when considering women's total health.

### *States of Health as a Consequence of Certain Development Processes, and the Gender Hierarchy and War*

As stated earlier, states of well-being and ill-health are not separate from the wider societal, economic, environmental, and political processes. Likewise, development processes are also affected by the levels of health of the people. Hence, to effectively and appropriately address health, research should also consider the wider frameworks of development, gender hierarchy, and war.

### *The Inter-Relationship Between Development Processes and Health*

At this juncture of history, there is an urgent need to work toward the rethinking of a new development paradigm that would be more equitable, socially just, and ecologically sustainable. "Development" programs implemented in the last three decades in the Asia-Pacific region have, at least in intent, been attempts to direct developing countries toward the goals of economic growth, social development, and debt servicing. These efforts have been seen as the way in which developing countries could work toward attaining the living standards of the developed world.

Unfortunately, the results of "development" programs and policies over the last three decades have been somewhat more complex and less straightforward than perhaps expected. The results of the "trickle down" economic growth paradigm driving development programs since the 1960s, as well as the "structural adjustments" programs which emerged in the 1980s, have seemingly brought about increased economic growth. This, however, has come at a high price in terms of the overall well-being of large proportions of the populations of many developing nations. Health issues and the concern over diseases must therefore be contextualized within the deeply penetrating development programs and policies that are

being implemented. Development programs which negatively impact on the environment and in turn have negative consequences on the health of the people whose lives these programs set out to improve, cannot be considered sustainable.

The effects of development on health are, however, not one-sided. The health of the population and the equitable distribution of that health within the population also impacts upon the pace and form of development in a country. Hence, when attempting to understand and evaluate development experiences within and between countries, it is important that health as an important variable is not overlooked.

## *Gender Hierarchy and Health*

The gender hierarchy that exists in most societies has led to women's lack of access to equal rights, unequal opportunities to education, and unequal distribution of land and access to resources. Women's status and the value of women's work have also been undermined. Furthermore, violence is being inflicted by states, institutions, and individual men on women. These have untold consequences on women's health and the quality of women's lives. Health research and health policies cannot therefore ignore such structural inequalities with their deep-seated consequences. Also, this gender hierarchy impacts upon the consequences of development. For example, it is women who suffer most from the depletion of food supplies, and women, who, due to their multiple roles and responsibilities, are more susceptible to contracting certain tropical or environmentally related diseases.

## *Effects of War on Health*

Yet another factor which continues to affect the health of women and men, particularly in Cambodia, Vietnam and Laos, is the effects of war. Cambodia, for example, is one of the most densely mined countries in the world. Men continue to be maimed or killed as a result of bombs and mines left in the fields and villages. Women are left with the responsibility of looking after these victims of war as well as their fatherless families. In addition, women have to face the acute social and environmental consequences of war given their capacity as resource managers and providers for their families. The effects of these conditions on women's health should be addressed.

# Gender, Health, and Sustainable Development

**K. Soin**[1]

The world has changed - this is often considered a trite statement but it is very reflective of our times.

In the last 20 years or so, there has been a worldwide economic restructuring which has resulted in the globalization of capital, labour, markets, technology, and competition. In this process, the big actors are states, transnational corporations, and multilateral agencies. Most states are tripping over themselves to embrace the market economy and the growth model of development. Considerations of gender, equity, and sustainable livelihoods are subject to market forces and the incessant and relentless drive toward materialism and consumerism.

In their rush to become newly industrialized countries (NICs), or near NICs, our countries forget that current dominant patterns of economic growth are unsustainable and impinge on the welfare, well-being, and health status of women, the poor, and other disadvantaged groups.

There are many complex linkages between development strategies, ecology, gender, and women's health. This meeting will look at the various linkages and the points of intersection. I will only mention a few.

Health has to be a necessary input to, and goal of, development. It is necessary that women are healthy in order for them to participate fully in development as workers, mothers, and family and community members. Besides being recipients of health care, women are also providers and promoters of health.

A UNICEF Report has shown that a mother's education level, even within the same socio-economic class, is a key determinant of her children's health. Within the family, women continue to bear the major burden of services toward the health needs, nutrition and care of the young and the old.

Besides the framework of family and community health, women also have a role as providers of health care in the organized sector. Here I am thinking in particular of female nurses and female doctors. Their role is especially relevant in some of our traditionally sex-segregated societies.

---

[1] Orthopaedic and Hand Surgeon and a Nominated Member of Parliament (Singapore) since 1992.

Now let us look at the effects of the growth model of development on women and their health. The critical areas that should be considered are:

- women's workload; and
- women's control and access to resources and services.

These critical areas are determined by the gender bias and gender hierarchy that are prevalent in our industrialized societies. The 1993 Human Development Index (HDI) puts Japan first. But when the HDI is adjusted for gender disparity, Japan slips to number 17. With gender adjusted HDI, no country improves its HDI value - what this means is that no country treats its women as well as it treats its men. Women constitute 50% of the world's population, do two-thirds of the world's work and own one-tenth of the world's wealth. We are all raised in a culture that values men's work over women's work and men's lives over women's lives. In the field of health, women receive unequal treatment.

Inevitably, this lack of gender-sensitive attitudes, policies, and programs have adverse effects on women's physical and mental health, women's reproduction, women's sexuality, women's livelihoods and women's old age. The opinion of Jonathan Mann, head of the World Health Organization (WHO) is that "living in a male-dominated society can be hazardous to your health."

Most of our countries - with the notable exception of my country, Singapore - have large agricultural populations. However, with modernization and industrialization, there has been a very rapid rural to urban migration. With this shift, there is likely to be an increase in the number of households headed by females in the rural areas as the men migrate to the cities in search of employment. This results in a greater economic and social burden on women who have the responsibility for the care and health of the children and the aged, often on a reduced family income. Here the role of women as providers and promoters of health is jeopardized.

Land clearing and timber cutting causes deforestation and this forces rural women to search further from home for fuelwood. Deforestation then causes the loss of ground water, and the use of pesticides and fertilizers further damages women's water resources leading to shortages of water for domestic use. This impacts on the health and living conditions of the family while the women are exhausted in their search for water and fuel.

For the women who migrate to the urban areas, they also have to face great hardships as they struggle to survive among the urban poor population that live in the slums of the large cities. In this scenario, some women have to fend for themselves and their families by working in the informal sector. The health problems of self-employed women are often neglected due to their marginalized and invisible position in the work place (Chatterjee 1986).

Many of the rural women who migrate to the urban areas end up with jobs in export processing zones - these women carry out low-skilled jobs with little pay. In many countries that are still aspiring to become NICs, the working conditions are unhealthy with poor ventilation, inadequate lighting, heat, humidity, and overcrowding. "Apart from eye problems, electronic women workers also frequently suffer problems of the skin, lungs and nervous system related to chemicals used in the work process and stressful working conditions" (Asian and Pacific Women's Resource and Action Series on Health).

Also, with urbanisation and the growth of the tourist industry, we have the rise of prostitution including the horrendous effects on the girl child and the globalization of AIDS. Asia is seeing an explosive increase in the number of HIV and AIDS cases from 30,000 to about 250,000 per year. Forty percent of the infections are in women. In women attending ante-natal clinics in Chiang Rai province in Thailand, the prevalence rate of HIV infection is 8%. Most of the HIV infections occurring in women are from their husbands or regular partners. Men visit prostitutes and have sex without condoms and then pass on HIV infections and other sexually transmitted diseases to their wives or regular partners.

Other consequences of industrialization are spiralling environmental degradation, the depletion of renewable and nonrenewable natural resources, and the breakdown of ecological balance. These are not merely questions of national wealth, economic uncertainty or unsustainability of development. Environmental degradation becomes part of human reality and affects women and men, their health and everyday existence.

In the context of this meeting therefore, let us consider the characteristics of development strategies that are sustainable, gender sensitive, and add to the health and well-being of people. To achieve these objectives we have to acknowledge:

- the importance of developing human potential for economic growth; and
- the importance of ecological sustainability.

But we must remember that the strategies to promote ecological sustainability must not run counter to the basic needs and livelihoods of the less powerful in society. Health and education, along with other basic needs, can contribute to raising the quality of a country's labour force which can become critical in determining its growth potential and competitiveness in the long run. Health and education, like much other social infrastructure, only pay off investments in the medium and longer terms. We should recognise that development does not only refer to the kind of growth which can be measured with economic indicators, but also to social and human development of which health is an integral part. The ultimate goal of economic growth should be a development process which improves the quality of life for all, both men and women.

Before I end, it is with the greatest of pleasure that I would like to announce that a regional research and action Network for Women's Health will be launched at this important meeting of experts from the Asia and Pacific region. The Network will bring together all the

regional players in the health arena - practitioners, policy-makers, researchers, managers, and business interests - to address the fundamental gaps in knowledge about women' health issues and access to services at all levels, and to initiate innovative gender-sensitive programs. It is my fervent hope that this Network will be an important catalyst in improving the health status and well-being of women. Women are caretakers of family and community health - this has important implications for the overall socio-economic development of societies and particular attention should therefore be focused on improving the status and health of women.

# The Story of Myrna Colantro

**Violeta B. Lopez-Gonzaga**[1]

Globalization is a Trojan horse that has had, and will continue to have, profound implications for women and children in Asia. There is significant pressure among Asian countries to be "in" the Tiger Economy Club. The elite set of newly industrialized countries has led to a dizzying pace of development in the region. Over the past two decades, the face of many Asian countries has radically changed. Old buildings have been torn down to give way to high rise buildings. Where there were once mangroves, now stand agri-business ventures and five star hotels, symbols of the globalization process. For Asian countries aspiring to be NICs - newly industrialized countries - the pressure is on to industrialize...*fast*.

Philippines 2000 is one such desperate attempt. The drive for industrialization has led the government to frog-leap development efforts. Among the many urgent concerns is the generation of new sources of energy. Being found within the ring of fire and earthquakes, the Philippines has focused on geo-thermal gas as a new source of energy. To provide a concrete illustration of this workshop's theme - Gender, Health, and Sustainable Development - let me share a case study from our on-going process documentation of the Northern Negros Geo-Thermal Exploration project. Let me tell you the story of Myrna Colantro.

Myrna Colantro, a woman in her late 30s, was one of the more vocal opposers of the planned Northern Negros Geo-Thermal Exploration, a project of the quasi-government, Philippine National Oil Exploration (PNOC). Myrna is married with five children. Of the five, only the eldest child, a son, is in school in one of the public secondary schools of Murcia, a municipality located close to the capital of Negros Occidental, Bacolod.

Myrna's family maintains a rice farm and a mulberry plantation. Her family receives assistance from the Murcia Sericulture Federation Association (MURSEFA), a Japanese funded people's organization, in maintenance of their mulberry plantation. The aid comes in the form of cash lending and a monthly rice allowance through the Food for Work Assistance Program. Myrna takes full responsibility of the mulberry plantation, while her husband used to assume major tasks in rice production, like ploughing. With the onset of the Geo-Thermal Exploration project, however, Myrna's husband was drafted as a contract labourer in

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exploration-related activities, such as the establishment of Gabion walls and dike beaching. This contract work has provided Myrna's family with much needed cash for their daily subsistence.

While her husband is involved in the geo-thermal process, Myrna assumes all farm-related work. This includes the heavy work previously done by her husband like land preparation of their upland rice farm, and replanting and weeding of the mulberries. Sometimes, if she has the time, the share she receives from the total number of sacks harvested, can greatly help her in the provision of food for her family. Aside from this, she also assumes domestic chores, but only if she has spare time in the day. Frequently, laundry and food preparation activities are passed on to her 14 year old daughter. While Myrna works on their farm, the children who are out of school and tasked with other chores, take care of the youngest sibling.

With the full operation of the Geo-Thermal Exploration project, Myrna was beset with additional work burdens. As a result of the road construction and digging for the project, Myrna is forced to walk an extra half kilometre to draw drinking water from another spring source. Laundry during rainy days has to be done in another river which exposes her to natural elements during her long hike to the place.

The sleeping patterns of Myrna and her family, especially her children, have also been seriously affected by the drilling operation. The glaring lights and noise from the drilling site has kept her children awake. Having no electricity in their village, Myrna's children were mesmerized and kept awake by the lights and sounds of the drilling. Because of this, Myrna herself has not been able to sleep well. When I interviewed her, she complained about a "floating sense and dizziness" resulting from a lack of sleep.

While the PNOC promised jobs for the residents of Myrna's village, only five women were directly employed by the company, mainly as laundry women and domestic helpers. Though she herself desired to be hired for the regular, salaried job of dishwasher/laundrywoman or cook, the fact that Myrna had finished only grade 4 automatically eliminated her from the selection process (PNOC requires women hired for this post to be at least high school graduates).

# Workshop Papers

# Current Health Status of Women and Children in Vietnam and the Role of the Vietnam Women's Union

Nguyen Thi Hoa Binh[1]

## *Background*

Vietnam, located in southeast Asia, has a population of about 72 million inhabitants, with women accounting for more than 52%. The population density is 195 person/km$^2$ and 80% of the total population live in rural areas. Eighty-seven percent are ethnically Vietnamese, while the remaining 13% are comprised of some 53 various ethnic minorities. The literacy rate is 87%. Life expectancy is 63 years (for men) and 67.5 years (for women). The average age of marriage is 24.5 years (for men) and 23.5 years (for women). Additional socio-economic statistics are listed below.

- crude population growth: 2.18
- crude birth rate: 3.8 births/per woman
- annual per capita income: $240
- proportion of population that is disabled: 10% (due to war, inappropriate use of insecticides, and chemical fertilizers)
- greatest causes of morbidity: malaria, diarrhoea and respiratory infections

## *Current Health Status of Women and Children*

Women account for 52% of the workforce in Vietnam. More than 70% of the female workforce participates in agro-forestry and fishery activities. In the rice-growing industry, women have a number of responsibilities that are usually performed with rudimentary farm tools, including ploughing, sowing, transplanting, tending, weeding, and harvesting. Women in Vietnam often spend 16-18 hours a day at work, while men spend only 12-14 hours. The lack of agricultural mechanization in Vietnam poses an obstacle for family planning programs due to family requirements for many household workhands. High rates of school drop-out among girls is an indication of both high education expenses and the lack of emphasis placed on female education.

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[1] Vietnam Women's Union, Hanoi, Vietnam.

Overwork, combined with low incomes, has led to a decline in the health status of women. The maternal mortality rate is high (110 deaths per 100,000 live births). New deaths have been attributed to a number of factors, including hemophilia, post-natal infection, eclampsia, tetanus, uterine collapse, reproductive tract infection, urinary tract infection, blood infection, anemia, high blood pressure, and malaria.

*Nutritional Status*

Malnutrition is common among Vietnamese women, and is particularly acute among pregnant women. During pregnancy, women gain on average 8.5 kilograms in urban areas, while those in rural areas gain only 6.6 kilograms (the international standard is 10-12 kilograms). According to the National Nutrition Institute, 41% of pregnant women in urban areas are anemic, while about two thirds of pregnant women in rural areas are anemic.

***Complications During Child Bearing and Family Planning***

Complications during delivery in hospitals account for 17% of maternal deaths in Vietnam. Abortion is considered to be a method of family planning throughout the country, and the abortion rate is 45%.

The contraceptive prevalence rate among married couples is 55.45%. Contraceptives are mainly used by women, with the IUD being the most popular device. Due to poor sterilization techniques, 40.2% of women who are inserted with IUDs experience infection.

*HIV/AIDS*

There is an increasing incidence of HIV/AIDS infection in Vietnam. In December 1994, about 2,000 HIV-infected individuals were identified. The main reasons for the increasing HIV transmission rate are poor understanding of AIDS prevention, low condom use, poor sterilization of needles, risky sexual behaviour, and drug addiction.

## Reasons for Poor Maternal Health Status

Many factors contribute to the poor maternal health status in Vietnam:

- lack of or poor access to medical facilities;
- lack of refresher training for health workers, affecting their performance/service;
- poor self-health care;
- lack of appropriate leave before birth, and poor nutrition;
- low frequency of prenatal check-ups (0.8 times per pregnant woman in 1992);
- home labour and delivery without the assistance of midwives;
- poor dissemination of contraceptives; and
- poor nutritional status.

Lack of knowledge about preventive care is a serious problem in Vietnam. Only 14% of women received tetanus vaccinations in 1991. Prenatal check-ups are infrequent. Fewer than 50% of rural areas have health workers who have received training on acute respiratory infection and diarrhoea. Literacy rates are low among women. Personal hygiene practices are poor, and there is a lack of mosquito nets treated with permethrin in malaria-infected areas.

Essential drugs and medical facilities are lacking, services are poor, health centres in remote and highland areas are inaccessible, and health workers are poorly paid.

### *Children's Health*

The newborn mortality rate is 7.6/1,000 live births. Mortality is largely attributed to tetanus. About 17% of newborns are underweight (less than 2,500 grams).

Morbidity and mortality rates among infants under one year of age remain high (46 deaths/1,000 live births). Childhood mortality is attributed to malaria, acute respiratory infection, diarrhoea, tetanus, and measles.

The average mortality rate for children under five years of age is 81 per 1,000 live births. Morbidity and mortality rates among children vary geographically, and are more severe in the highland areas.

### *Government Strategy*

The government's strategy for improving women's health status focuses on decreasing the maternal mortality rate from 110/100,000 live births (in 1990) to 0/100,000 live births by the year 2000.

To achieve this objective, the Vietnamese government promotes a family planning program. Couples are encouraged to have births at an appropriate time (when they are not too young or too old), and to use contraceptives. At present, 40% of Vietnamese women are of reproductive age; this will increase to 70% by the year 2000. Education on health care, nutrition, and pregnancy care for women is being promoted. An important part of the government initiative is Information, Education and Communication (IEC) activities.

To prevent the spread of HIV, the government has extended support to the representatives of the national committee for AIDS prevention. This committee, together with WHO, is conducting a workplan in which the main strategy will be information provision, education, and communication for behavioural change.

The government also aims to minimize the mortality rate for infants under one year of age to 30 per 1,000 live births by the year 2000; it aims to decrease the mortality rate for those under 5 years of age from 81 per 1,000, to 55 per 1,000. Maternal and health care programs will also be promoted.

Five objectives in primary health care will be given priority, including:

- the obtainment of compulsory immunization (85%);
- the elimination of polio (now 0.86/100,000);
- the elimination of tetanus (now 0.27/100,000);
- the minimization of measles; and
- the provision of good diarrhoea treatment.

## *Vietnam Women's Union*

The Vietnam Women's Union was established in October 1930. The Union now has 11 million members from 1,200 women's chapters. The Union includes representatives from national, provincial, district, and commune levels.

The Vietnam Women's Union represents women's legitimate and legal rights, and encourages women to improve their socio-economic position. The Union is involved in drafting laws and policies related to women and children, and in monitoring the implementation of such laws and policies.

Priority programs run by the Union for the 1992-1997 period include:

- upgrading women's knowledge;
- promoting income generation activities;
- developing mother and child health, family planning, and nutrition programs;
- strengthening institutional capacity; and
- studying women's issues for recommendations to policy-makers.

### *The Role of the Vietnam Women's Union*

Since 1989, the Union has launched nation-wide campaigns including "mutual assistance among women for the development of household economies" and "good child-care against malnutrition and school drop-out." These two campaigns have made meaningful contributions toward the improvement of maternal and child health care. About 208,877 training workshops on maternal health care have been provided to 2,757,183 mothers. Funds for children, for malnourished infants, and for school drop-outs have been established. About US $130,000 has been raised for such funds. In 1993, 66,542 children received charity classes, and 97,798 school drop-outs were encouraged to continue their schooling. In addition, the Women's Union also led campaigns on health care, nutrition, and immunization, and widely distributed a booklet entitled "Facts for Life."

## *Conclusion*

In Vietnam, factors such as the rapid population growth rate, low income per capita, and low living and education standards, all affect the quality of health care services. Great challenges are still ahead for the Vietnam Women's Union in the promotion of the health status of women and children.

# Women's Health Activities Toward Health for All by the Year 2000

**Boungnong Boupha**[1]

## *Introduction*

It is evident that women's problems in society and in daily life are increasing. At the present time, women, who form more than half of the Laotian population, determine human values, not only objectively, but also culturally. Because of this great task, they play a crucial role in the struggle for peace, well-being, and progress in society. Since the establishment of the International Women's Union, and the proclamation by the United Nations of 1975 as the International Year of Women, women have pressed forward with hope in their struggle for women's rights, gender equity, and the eradication of any form of exploitation and discrimination. The goal for the future is the complete emancipation of women.

The 1985 adoption of the Nairobi Forward-looking Strategies for the Advancement of Women provided hope to women all over the world, and inspired them to put more effort into actively participating in socio-economic life. However, in many countries, sufficient mechanisms to promote the advancement of women still do not exist. Indeed, women globally, when compared with men, have fewer opportunities for advancement or benefit in all facets of socio-economic life.

Women today are facing new challenges, including:

- obstacles to gender equity in power sharing, in problem solving, and in decision-making, at all levels of society;
- obstacles to gender equity in education, employment, and in accessing health services; and
- lack of national investment in the health sector, particularly in women's health.

Evidence from around the world has demonstrated that investment in women's health is fundamental to improving human welfare and economic growth, as well as reducing poverty. Investment in women's health can contribute not only to sustainable economic growth, but is also an activity for gender equity, health, and sustainable development.

[1] Council of Medical Sciences, Ministry of Health; Member of Executive Committee, Lao Women's Union, Lao P.D.R.

## *Gender Issues in Lao P.D.R.*

Over the past thirty years, Lao people of various ethnic groups, under the leadership of the Lao Revolutionary Party, struggled to liberate the country. This struggle led to the formation of the Lao P.D.R. on December 2, 1975. The foundation of the Lao P.D.R. opened a new era for all Lao people, in particular for Lao women. This is the era of independence, freedom, and equality between different ethnic groups, and between the sexes. From the time of independence, the government of Lao P.D.R. has mobilized all sectors, all classes of people, and all ages and sexes to contribute to the safeguarding and development of the country toward improving the living standards of the population. However, because the country was ravaged by war for decades, the status level of Lao women has remained low. More recently, the role and status of Lao women in society have been properly addressed, particularly in the 1990 Constitution and Law of the Lao P.D.R., which has affirmed the equality rights between women and men in terms of politics, economy, culture, society, and the family.

However, ancient and traditional beliefs and practices continue to be obstacles to the advancement of women. Even women themselves maintain the old ways of thinking. For instance, they often consider themselves inferior to men, and are not bold enough to express their opinions or to protect their rights and benefits. On the other hand, although gender equity has been recognized by constitutional laws, many men still maintain the old attitude toward women, considering them to be the weaker sex and insignificant contributors to national protection and development. Women in many localities continue to lack appropriate education. The illiteracy rate among Laotian women is still high. In addition, women continue to work under severe conditions, are often neglected by their husbands while they are pregnant, and fail to receive proper maternal care. As such, the complete emancipation of Lao women, in which the Lao Women's Union plays an important role, is an issue that must continue to be addressed.

The government of Lao P.D.R. therefore considers women's issues, including women's development and maternal and child health care, to be priority issues that need special attention. There are now eight female deputies at the Supreme National Parliament, and six Ministers or Vice-Ministers in various Ministries, and several Directors or Deputy-Directors of different institutions at both the central and provincial level.

The Lao Women's Union is a political organization of women. This organization, together with other mass organizations (youth and trade unions), forms part of the general staff for the party and government. It is a member of the National Front, and is geared toward bringing about unity, educating women of different ethnic groups, and contributing to national development, struggling for gender equity and justice, and achieving rights and benefits for women and children in Lao P.D.R.

In 1990, the first constitution in the history of Lao society issued a number of different laws in which rights, equality, and benefits for women and children were clearly stated (Articles No. 7, 8, 20, 22, 24). The family law clearly defined women's rights (Articles No. 1, 2, 3, 4, 5, 15, 27), and in 1992-93, the Ministry of Labour and Social Welfare promulgated the adoption of labour laws which defined the working ages for women as 16 to 55, and for men as 16 to 60, without any discrimination with regard to salaries and wages, bonuses, or pensions.

However, the adoption of the constitution and laws is a new phenomenon for Lao people. Therefore, the government, together with other mass organizations, has acted to promote awareness of these laws among the population by organizing seminars, study sessions, and publicity in agencies and departments at the central and local levels. The aim is to make people aware of, able to understand, and obedient to these laws for the benefit of all members of the nation. Step by step, this will help to promote gender equality in practice.

## *Women's Health Activities Toward Health For All by the Year 2000*

### *The Role of Women Non-Health-Workers in Protecting the Health Status of Their Families and Communities*

According to the 1985 population census, women represented 51% of the total Laotian population. Lao women have their own mass organization which is called the Lao Women's Union. Within its officially stated role of liberating women, the Lao Women's Union has assigned itself a number of additional tasks:

- To make every effort to mobilize and unite women of all social strata, and to educate and encourage them to contribute to the fulfilment of the Lao P.D.R.'s two strategic tasks, namely, national defense and socialist construction.
- To enhance the participation of women in the management of the economy, the state, and society.
- To participate in cultural and social work.
- To promote and safeguard the rights and interests of women and children, and create a new type of family.
- To consolidate and improve the organizational apparatus, and to train capable cadres to work on women's affairs.

The Lao Women's Union is a mass organization representing nearly a quarter of the female population (500,132 members in 1990). Members are scattered across the country, and are linked through a network extending from the central level down to the village level.

Facing a new situation of implementing the resolutions of each congress, the Lao Women's Union at all levels has established solidarity among women of various ethnic groups and social strata. It has developed a tradition of patriotism and industriousness among women who become dedicated to the cause of national democratic revolution, which in the past was undertaken by the "mother and aunt generation." In this new period, the Lao Women's Union, shoulder-to-shoulder with men, has contributed with dignity and continuity to the present cause of preserving and building the nation. It promotes women's interests as well as mobilizing their contribution to the achievement of economic and social development goals linked to national traditions. It seeks to ensure that the interests of women of various ethnic groups are not separated from the general interests of the nation, and that the rights and interests of mothers and children are not separated from the implementation of social justice.

Based on the above-mentioned task, most Lao women at the grassroots level actively participate in health promotion activities, always led by Lao Women's Union members. The women - grandmothers, mothers, wives, daughters, aunts, nieces, neighbours - participate by:

- leading primary health care activities for all members of their families;
- taking members of their families for immunization, or for health services when necessary; and
- keeping homes in order.

At the same time, in cooperation with the concerned technical sections, they have mobilized funds for sanitary drainage, providing water supplies and wells, and building water-storage reservoirs, and have stimulated villages to build water closets, to keep animals out from beneath houses, to keep pigs in pigsties, and to promote other sanitation activities. Many times, in cooperation with health technicians, training in birth spacing has been organized, and methods of birth spacing disseminated, together with methods of protecting women and children and others through health education sessions.

Throughout the world, women are the first ones to have direct contact with the nine main components of primary health care: health education, promoting good standards of food and nutrition, water supply, measures for a clean environment, mother and child health care, including birth spacing methods, vaccination, prevention and control of local chronic disease, routine disease treatment, and the provision of essential drugs. In summary, women *non-health* workers, led by Lao Women's Union members, are not only actively participating in health activities, but are building a healthy activities network that contributes greatly to the socio-economic development of the country. In this way, they are, step-by-step, creating a healthy lifestyle in their community, with the aim of reaching the strategic goal of Health For All by the Year 2000.

### *Women Health Workers Protecting the Health Status of Society*

According to the policy and guidelines of the Lao P.D.R. government, the promotion and improvement of the quality of health services is a significant task for national socio-economic development. Health services organization and management are seen as fundamental to continuously improving health services. The reorganization and improvement of the normal operation of the health services network has been emphasized at all levels. This includes the provision of enough essential drugs for prescriptions, prevention, and treatment activities; the improvement of human resources development for health; the authorization of private medical practices and drug stores; a country-wide, free-treatment policy for low-income people; and the intensive production of modern and traditional drugs to meet the basic needs of all public health services. Facing these new challenges, Lao women health workers now make up more than half of the total number of health workers (Table 1). It is interesting to note that, aside from agriculture and trade, health services include the highest percentage of women among its workers.

**Table 1: Female Labour Force by Economic Sector, 1985**

| Economic Sector Labour Force: | Total | Females | % female |
|---|---|---|---|
| Industry | 15,903 | 4,611 | 29 |
| Construction | 10,767 | 1,615 | 15 |
| Agriculture | 1,435,740 | 775,300 | 54 |
| Forestry | 2,699 | 513 | 19 |
| Transport and communications | 11,309 | 1,018 | 9 |
| Post and telecommunications | 2,415 | 604 | 25 |
| Trade and material supply | 25,359 | 15,215 | 60 |
| Other productive sectors | 16,607 | 6,477 | 39 |
| Public sector and tourism | 3,400 | 1,530 | 45 |
| Sciences | 444 | 89 | 20 |
| Education and sports | 30,003 | 10,501 | 35 |
| Culture and art | 4,046 | 1,295 | 32 |
| Health and social welfare | 10,056 | 5,732 | 57 |
| Finance and banking institutions | 4,712 | 1,743 | 37 |
| Government administration | 6,784 | 4,532 | 27 |
| Other non-productive sectors | 11,291 | 3,726 | 33 |
| Total: | 1,601,535 | 834,501 | |

Source: Lao P.D.R. Population Census, 1985.

At the present time, health services throughout the country are provided through 7 central hospitals, 18 provincial hospitals, 121 district hospitals, and 723 dispensaries. Of the 7,068 total hospital beds in service in the country, 700 are in central hospitals, 1,920 are in provincial hospitals, 2,194 are in district hospitals, and 2,164 are in dispensaries.

According to the Statistics Centre of the Ministry of Health, in January 1994 there were a total of 9,970 health workers. Of these, 1,405 were medical doctors (64 with postgraduate training), 2,963 were assistant doctors, and 5,602 were nurses. It was estimated that there were 3.94 medical doctors, 7.05 assistant doctors, and 13.33 nurses per 10,000 people. In addition, there were 16.8 hospital beds per 10,000 people nationwide. Within the health sector, there are also pharmacists, associate-diploma pharmacists, pharmacist-technicians, associate-diploma midwives, undergraduate midwives, and trainers in some fundamental sciences. In addition, there are traditional midwives and practitioners working at the dispensary level, most of whom are women.

Besides acting as health care providers, women and men health care workers at the central level are working at different institutions and centres for the prevention and control of disease, at the School of Health Technology, and at the University of Medical Sciences as trainers. They also work in various departments as administrators or at various pharmaceutical factories as producers of medicines. At the same time, men and women health workers are involved in health research activities (Table 2).

**Table 2: Women and Men Health Workers in Central-Level Health Institutions**

| No. | Name of Health Institution | Total | Female | Male |
|---|---|---|---|---|
| 1 | Department of Cabinet | 53 | 14 | 39 |
| 2 | Manpower Development Department | 16 | 3 | 13 |
| 3 | Department of Curative Medicine | 9 | 2 | 7 |
| 4 | Department of Hygiene and Preventive Medicine | 16 | 4 | 12 |
| 5 | Department of Food and Drugs | 35 | 11 | 24 |
| 6 | Department of Health Care | 22 | 6 | 16 |
| 7 | Cabinet of Council of Medical Sciences | 5 | 2 | 3 |
| 8 | Traditional Medicine Research Institute | 28 | 15 | 13 |
| 9 | MCH Institute | 70 | 51 | 19 |
| 10 | Malariology, Entomology, Parasitology Institute | 33 | 14 | 19 |
| 11 | Epidemiology Institute | 75 | 17 | 58 |
| 12 | Rehabilitation Centre | 120 | 48 | 72 |

| No. | Name of Health Institute | Total | Female | Male |
|---|---|---|---|---|
| 13 | Tuberculosis Control Centre | 46 | 32 | 14 |
| 14 | Dermatology and Leprosy Centre | 29 | 15 | 14 |
| 15 | Health Information and Education Centre | 23 | 7 | 16 |
| 16 | Ophthalmology Centre | 18 | 10 | 8 |
| 17 | Drug Quality Control Centre | 17 | 7 | 10 |
| 18 | University of Health Sciences | 141 | 58 | 83 |
| 19 | College of Health Technology | 80 | 50 | 30 |
| 20 | School of Medicine, Luang Prabang | 18 | 9 | 9 |
| 21 | School of Medicine, Champassak | 27 | 8 | 19 |
| 22 | Preschool of Ministry of Health | 32 | 31 | 1 |
| 23 | Mahosot Hospital | 574 | 387 | 187 |
| 24 | Friendship Hospital | 287 | 184 | 103 |
| 25 | Traditional Medicine Hospital | 14 | 10 | 4 |
| 26 | Medical Optical Centre | 5 | 3 | 2 |
| 27 | Pharmaceutical Factory No 2. | 63 | 32 | 31 |
| 28 | Pharmaceutical Factory No 3. | 113 | 44 | 69 |
| 29 | State Medicine Import-Export Enterprise | 12 | 8 | 4 |
|  | Total: | 1981 | 1082 | 899 |

Source: Human Resources Department, Ministry of Health, November 1994.

In the context of the Lao People's Democratic Republic Health Policy, prevention is stressed, and the important and strategic role of treatment provided by the primary health care services is recognized. In this way, the careful promotion of health services organization and management will assure the well-being of the Lao people.

The Lao health sector has established a global strategy designed to carry out the following tasks:

- reorganize and reform the public health network, regarding each district as a strategic unit;

- emphasize human resources development for health to fulfil the requirements of the Lao public health service;

- develop mechanisms to coordinate with other services;

- administer programs for the control of communicable and non-communicable diseases;

- adjust the number of staff according to the needs of the public health service;

- provide sufficient essential drugs and accurate instructions on the correct use of all medications; and

- support community commitment to primary health care, together with hygiene promotion and environmental protection.

After two years, these strategies have been systematized into nine well-defined work plans:

- administration
- public health services
- mother and child health care
- primary health care
- control of communicable and non-communicable diseases
- water supply, sanitation, and environmental protection
- human resources development for health and resources for research
- consumer protection
- scientific research

Based on the above-mentioned guidelines and strategies, women and men health workers at all levels are playing a great role. In order to achieve the goals of this health strategy and to provide Health For All by the Year 2000, the Ministry of Health, through its health system research supported by IDRC-Canada, has emphasized the use of a scientific methodology for collecting information as a tool for making appropriate decisions and for planning disease control. Such research in the health system will promote high quality health education. As instruction improves the standard of living of health workers, it will gradually improve the condition and quality of health services within the country.

## *Conclusion*

Everyone needs good health, and health could be for all if people are willing to put their effort into participating in health activities. The result will be "good health," not only for the individual, but for the community and society as a whole.

When one considers the particular conditions in the Lao P.D.R., it is clearly still a developing country. The health services network, health personnel, and health facilities, at both the central and the grassroots level, remain insufficient. Offering rural health services at the grassroots level, and carrying out primary health care, therefore requires the active participation of health workers of both sexes, as well as the assistance of many other parties in society. Led by the Lao Women's Union members, Lao women, as grandmothers, mothers, daughters, nieces, aunts and neighbours, play a great role in the family and in the community in providing health education, and in creating an awareness that achieving a healthy lifestyle requires active participation. At the same time, they are bringing to the community an awareness of the importance of child immunization, and knowledge about such things as sanitary activities, family planning, contraception, and methods of birth spacing, in order to care for both individuals and the community as a whole. In this way, they are mobilizing the active involvement of the community for building a health services network, as well as a healthy lifestyle for the community.

Health workers of both sexes should concentrate their efforts in the following areas: preventive, curative and rehabilitative medicine; training and upgrading health and research personnel; improving the production of modern and traditional medicines; improving the organization and management of health services; and conducting health system research according to priority health problems. With mutual understanding and by building a network of regular, collaborative health activities, Lao women, together with health workers of both sexes and other members of society, can work for Health For All by the Year 2000. In the meantime, they can promote gender equity, health, and sustainable development in both the country and in the region.

### *Recommendations and Strategies for a Plan of Action*

The strategies for a plan of action for the immediate future must emphasize the following points:

- Public health policy must be redefined and based on a strategy for Health For All by the Year 2000, through public health care activities at the grassroots level. This requires active participation not only of women but of everyone in the community. At the same time, a greater investment should be made in, and more resources allocated to, rural health services, especially giving attention to women and children.

- School curricula, including medical and health education curricula, must address gender issues and the specific health needs of women. The basic training courses and refresher training courses of all health providers need reorientation to place health in the context of unequal gender status, and to provide women's perspectives of their needs and experiences. At the same time, women of all ethnic backgrounds should be trained in professional skills, so that all health needs can be trusted to them.

- Health system and gender research should be encouraged to focus on priority health problems, particularly child care, malaria, health services organization and management, and gender issues. Step by step, this will help to resolve national health problems, and to alleviate gender inequities in the future.

- Special attention should be given to supporting traditional medicine and traditional midwives to further develop health services at the grassroots level.

- To integrate women's perspectives into health research, a research and information unit should be established in the Lao Women's Organization. In collaboration with the Mother and Child Health Institute, such a unit could assist in the process of broadening contraceptive choice, and in the establishment of national research priorities in reproductive health and gender analysis.

- All must persevere in the struggle to provide women with decision-making and problem-solving power.

- Strategic plans for gender development should be recognized and integrated into all national socio-economic development programs.

All these strategies must be supported by the government as well as by external agencies in order to promote gender equity, health, and sustainable development in Lao P.D.R., as well as in the Asia-Pacific region generally.

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# Women, Children, and Malaria in the Philippines: Would a Community Volunteer Program Work in their Favour?

**Esperanza Espino**[1]

## *Introduction*

Malaria is the single most important tropical parasitic disease in the world today. Presently, 100 countries are burdened by this disease, and some 2.1 billion people are at risk of acquiring it (UNDP/WHO/World Bank 1989-1990). Worldwide each year, there are about 120 million clinical cases, and 500,000 to 1.2 million deaths. Most of these deaths occur in Africa; the rest occur in other countries found along the Earth's tropical belt.

In the Philippines, malaria is endemic in all but 3 of the country's 75 provinces. More than half a century ago, when the population of the Philippines was just 13 million people, 2 million malaria cases were diagnosed, resulting in 10,000 to 20,000 deaths (Russell 1936). Today, with the population more than quadrupled, 13 million people in the Philippines are at risk of acquiring the disease. The reported number of cases is now 100,000, and deaths attributed to malaria are 1,000 per year (Department of Health 1990).

Based on statistics from the Department of Health in Manila, malaria ranks 6th of the 10 leading causes of morbidity (Philippine Health Statistics 1990). Although the Malaria Control Services has been successful in controlling the disease, there are now reports of malaria in areas that had been pronounced malaria-free (including some areas near Metro-Manila). Insecticide resistant vectors, and antimalarial drug-resistant parasites, are additional problems now faced by malaria control services. Furthermore, statistics do not reveal the extent of morbidity that the disease places upon the sick individual. Nor do they show the burden of the disease upon the family.

## *Malaria in the Philippines*

Malaria has been described as a disease of transitional zones and transitional seasons (UNDP/WHO/World Bank 1936). In the Philippines, it is prevalent in the foothills drained by small streams, in mountain ranges where elevation reaches almost 1,000 metres above sea level, in dry flatlands with irrigation canals, and in areas with salt and brackish water (Salazar 1988). The disease, and potential for outbreaks, occurs where there are favourable breeding sites for the mosquito vectors, a susceptible population, and a parasitemic

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individual. In some malaria endemic areas, the cases are most abundant during the period just before the rainy season. In areas where there is no pronounced wet and dry season, the disease occurs throughout the year. Within a municipality there could exist varying epidemiological patterns of disease transmission, which explains the distribution of cases within the area. The variety of ecological conditions observed in the different island groups in the Philippines and the presence of more than one vector species, makes the control of the disease difficult (Salazar and Gomes 1989). The socio-cultural and behavioral factors which put one at increased risk of acquiring the disease makes the problem even more confounding.

In the Philippines, there are generally two types of individuals who acquire malaria: the immunes and semi-immunes who reside in endemic areas, and the non-immunes. The latter venture into malarious areas for various reasons; for example, because they are in search of better job opportunities (such as migrant farmers), because they were displaced from their province of birth due to insurgency (in the Philippines, this is now due to conflicts with some Muslim groups in the Southern islands), because of natural disasters (floods, lahar, earthquakes), and because their profession demands it (for example, military personnel, forest rangers). Local and foreign tourists may also be exposed to malaria. The impact of the disease is felt most profoundly in endemic rural communities where it affects livelihoods and child growth. In these localities, the chronic effects of the disease take the form of days off work, physiological stress on the ill individual (who usually has a marginal nutritional status), and unfavourable effects on the growth and development of children.

The malaria control measures undertaken by the Department of Health are case detection, treatment, and vector control (mosquito nets and stream clearing). In April 1994, the Department of Health malaria control services launched its CLEAN campaign for the control of malaria. This was accompanied by a nationwide launch of the Department's new strategies for malaria control, which are (C)hemically treated mosquito nets, (L)arvicidal fish, (E)nvironmental control, r(A)mos bar, and (N)eem tree. The success of this undertaking will demand much supervision from the malaria control and the rural health unit personnel, not to mention the community's participation to sustain the program. Studies in Papua New Guinea, Guatemala, and Kenya have shown the value of volunteer health workers in malaria control (Ruebush and Godoy 1992; Spencer et al. 1987; Moir et al. 1985). In the Philippines, the control program faces various obstacles such as a lack of trained personnel and equipment to diagnose the disease, poor community participation in the control strategies, and a lack of trust on the part of the community concerning the Department's sincerity in its efforts to control malaria.

### *Research on Malaria in the Philippines (Morong, Bataan and Kabugao, Kalinga-Apayao)*

This section will focus on studies in which the author was involved (either directly or indirectly) and which were carried out in two separate sites in the Philippines - Kabugao, Kalinga-Apayao, a highly endemic area for malaria, and Morong, Bataan, a low endemic area.

### *Kabugo, Kalenga-Apayao*

Although there are 23 priority provinces in the Department of Health's national malaria control program, less than a dozen have malaria transmission levels as high as Kabugao. The people are Isneg, one of the Igorot ethnic subgroups. At the time of the study (1990), there was very little population movement into or out of Kabugao. The district hospital and rural clinic are located in the town, and are reached by boat or by half a day's hike through the mountain. The better-equipped provincial hospital is almost a day's journey by jeep. During the peak of the rainy season, the river becomes impossible to cross. This is an area of stable, although intense, malaria transmission. During the period of research, neither the district hospital nor the rural health unit had the facilities or manpower for diagnosing malaria. Vector control activities were very infrequent.

A point prevalence survey taken in January 1990 showed that the slide positivity rate (number of individuals with a positive malaria smear over the total number of individuals smeared) was 20%; 47% of these cases were among children below the age of 6 years. Nineteen percent of the cases were adults. Splenomegaly was observed in 60% of children in this age group (Gomes et al. 1994). A longitudinal study was undertaken in the area in 1991 to determine the relationship between malaria infection and nutritional status in a cohort population of children 6 years and below. Newborns were also included in the monthly malaria survey. This survey revealed that very young infants in Kabugao became infected with the malaria parasite by the age of 6 weeks. By the age of 3 months, all newborns monitored had a positive malaria smear. This indicated the intensity of malaria transmission in the area (it may also have indicated the number of circulating parasite strains). The study also demonstrated that children who were more than two standard deviations below the normal values for weight and height were found to be parasitemic in every survey, despite anti-malarial treatment administered by the research team during the previous month (Gomes et al. 1990). This situation was not observed in children who were not as severely malnourished.

A parallel study carried out in the same area aimed at developing an algorithm for use by endogenous health workers for diagnosing and treating malaria symptomatically. It showed that the combination, or sequential occurrence, of a group of complaints - fever, chills, and/or sweating - had high predictive values for malaria illness in children below the age of 10 years (Gomes et al. 1994). The predictive values increased during the months when the cohort population were reporting symptoms of acute respiratory infection (for example, cough). Where facilities for diagnosing malaria are lacking, case detection by rural health workers based on symptoms is highly valuable, especially for the vulnerable age groups. When a health worker (or even a volunteer worker) in an area similar to Kabugao encounters a child whose parent or caretaker describes these symptoms, she or he can treat the child with antimalarial drugs with the assurance that appropriate treatment is being given.

## *Morong, Bataan*

Morong, Bataan, a low-endemic malarious area, is typical of the majority of the endemic areas in the Philippines. Health facilities for the diagnosis of the disease are usually accessible by foot. The longest distance which one would have to travel is 13 kilometres. The provincial malaria outpost and provincial hospital can be reached by an hour's bus ride. Prior to 1991, when the Research Institute for Tropical Medicine (RITM) had not yet embarked on its major projects in the municipality, the rural clinic did not have a full-time microscopist. A socio-demographic survey in 1989 revealed that 40% of those surveyed had been living in Morong for less than 10 years. The construction of the now mothballed nuclear power plant in the 1980s, and the Philippine Refugee Processing Center, attracted migrants from provinces of southern Luzon, and from the Visayan Island group.

A National Institutes of Health (USA) funded project of the Malaria Study Group of the RITM, disclosed that malaria transmission occurred only in certain hamlets. A cross-sectional survey of the municipality showed a malaria prevalence rate of 1.1% of those surveyed. It also revealed that, although only 2% of the population resides in these hamlets, 50% of the malaria cases were clustered in these areas (RITM 1992). Another important finding was that there were more men than women in the 20 to 39 years old age group who were seeking treatment at the rural health clinic and who were diagnosed with malaria. Furthermore, the cross-sectional survey showed that among individuals with high malaria antibody levels (as determined by immunofluoresence assay), the proportions of either sex in this age group were similar. It is surmised from this finding that, although equally exposed to the disease, the women in this age group were not seeking treatment for the disease at the local health clinic as frequently as the men of the same age group.

A WHO/SER funded study, which complemented the NIH study, showed that local perceptions of the cause and prevention of malaria, and constraints in seeking treatment, weakened the Department of Health's attempts at vector control. In-depth interviews revealed that only 8 of 62 (13%) respondents perceived malaria to be caused solely by the bite of a mosquito. The most common answer of the rest of the respondents was drinking contaminated water. Focus group discussion participants had similar responses. The most commonly believed ways to prevent malaria were to "boil water," "put medicine in it before drinking," and to "use mosquito nets." Self-treatment with antimalarials was the prevailing method an individual or a caretaker of a child took when she or he thought the illness was malaria.

Observations of the health seeking behaviour of 88 febrile episodes in 19 families living in the "hotspots" revealed that, during the observation period, there was no significant difference between sexes in terms of consultation for malaria at the rural health unit. About 75% of fever episodes perceived to be malaria in infants, older children, and adolescents were treated at the rural clinic; the remaining 25% were treated at home. The reverse trend was seen in older individuals (above 20 years). About 73% of the men and 58% of the women treated themselves for malaria at home. These results raise the following questions

if, as discussed above, males and females of this age group may be equally exposed to malaria: Are men more inclined to perceive themselves as having malaria than women and therefore more likely to treat themselves? Or are men truly more at risk of acquiring the disease and recognize the symptoms more often than women because of previous experiences with malaria?

Participant observations of the families in the WHO/SER funded study have revealed nighttime practices which put mothers at risk of acquiring malaria, and poor health-seeking behaviours which worsen their morbidity. In one family which was observed to be always using mosquito nets, the mother would go out of the net at night to prepare milk for her young infant. In another family, the pregnant mother refused treatment because "it might affect the baby." This same mother, after she had given birth, was diagnosed as having malaria and was given medicines. She did not consume the drugs, but instead gave them to her child because she thought the child had malaria.

## *The Community Volunteer Program*

A community volunteer program was developed in January 1994 in Morong, Bataan, with the main goal of bringing services for diagnosing and treating malaria closer to those who needed them. The volunteers were selected after focus group discussions were held in their hamlets (some volunteers were also participants). They were then invited to attend a 3-day seminar. They were taught how to use an algorithm[2] to detect febrile individuals who probably have malaria and from whom they would make a malaria smear. The volunteers set up a system whereby smears would be taken to the rural clinic for reading, and the results would be given to the ill person within 48 hours. The efficiency of the program was measured through the length of time it took for antimalarial medications to reach an individual with a positive malaria smear after the smear was made by the volunteer. Effectiveness was measured through utilization and acceptance of the program. In the year that the program had been implemented, detection of malaria cases increased almost two-fold, and more than 40% of malaria cases were detected by the volunteers. Although there were significantly more males than females who were diagnosed with malaria in the same period, there were slightly more females than males who consulted the volunteers. More than 90% of smear-positive individuals received their medications within 48 hours after the smear was taken.

It is expected that by the year 2000, public health services (detection, treatment, and control) in the Philippines will be devolved from the central offices in Manila to local government units (the municipalities). This move would overwhelm an already overburdened rural health

[2] This algorithm was a modification of that recommended by WHO and incorporated findings from an earlier study in Morong and Kabugao (Gomes et al. 1994). Another addition was an logarithm for a follow-up on the third day of antimalarial treatment.

unit, which currently has difficulty administering primary health care. With careful preparation and planning, the difficulties may be overcome with the use of the community's resources: volunteers or the *barangay* health workers.

What does the community volunteer program for malaria control hold for the vulnerable groups (or high-risk groups)? In areas of high malaria transmission, where facilities for diagnosing and treating the disease are inadequate, case detection based on symptoms (algorithm) by trained indigenous health workers is valuable, especially for the vulnerable age groups (infants and children). No socio-behavioral work has been carried out in Kabugao to determine deeper implications of a volunteer program for malaria control, but it is clear at this stage who will benefit from it.

A regression analysis of data of a cross-sectional survey taken in the NIH study showed that there were three factors associated with a positive blood smear. These were:

- residence in a *sitio* (hamlet) classified to be a hotspot;
- nighttime visits to the forest; and
- high antibody levels.

From the SER study of families residing in these "hotspots," it was observed that if the overnight stay in the forest was for a farming chore, the whole family would sometimes accompany the household head. But if the reason for the nocturnal visit was charcoal-making, catching fish or shrimp in the river, setting traps for birds, or collecting honey, the adult males of the household made the trip. On the other hand, the fact that these families resided in areas of malaria transmission (proven by vector studies), and lived in homes that did not provide protection against the entry of mosquitoes (mosquito nets are irregularly used by most families), make every member of the household equally at risk.

A volunteer program, particularly if the volunteers themselves come from the "hotspots," could reduce morbidity from malaria in these areas by providing immediate detection and treatment of cases. At present, there are 34 volunteers in Morong (25/34 are women). More females than males may have consulted the volunteers because:

- they were more at ease consulting females with whom they could relate, rather than consult the nurse or midwife at the rural clinic; or

- they do not have to travel far from their home to seek treatment, and do not have to stay away from household chores and mothering duties. The volunteer program would also provide treatment for the remaining 25% of children and adolescents who are not taken to the local clinic for proper management.

The impact of a community volunteer program for malaria control may not be demonstrated by epidemiological parameters (e.g., prevalence data), but by decreased morbidity such as duration of symptoms, shortened duration of infection, and alleviation of anemia. In addition,

utilization and acceptance of the program by individuals who otherwise do not resort to conventional health facilities is a measure of effectiveness of the program. In a malaria endemic community, this plays an important role in the overall health status of the individual.

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# Mongolian Women in Health and Development

Nansaljav Gerelsuren and Jambaldorj Erdenechimeg[1]

## *Introduction*

In 1923, the political freedom of women was legalized in Mongolia. Since that time, women have enjoyed the right to elect and be elected, and have taken part in decision-making processes in the social, political, and economic sectors. Since 1990, however, many changes have taken place in Mongolian society. A new Constitution was adopted in 1992 proclaiming Mongolia to be a parliamentary Republic. The Constitution endorses a number of goals including protecting human rights and freedoms, respecting democracy, promoting equal development of all forms of property, and making the transition to a market economy. The resulting processes of privatization, liberalization of prices, and open economic policies have created an economic crisis which is affecting significantly the lives of the people, particularly women and children. There have also been increases in unemployment, poverty, and crime rates.

These tremendous changes in the socio-economic and political life of Mongolia necessitate a detailed gender analysis. Unfortunately, there is a lack of statistical data from a gender perspective, and gender research in general, which are necessary to influence development planning and policies.

## *Country Profile*

Women constitute 50.2% of the total population in Mongolia. Almost one quarter of the total population is estimated to be females of reproductive age. Equality between men and women was granted in the First Constitution of the Mongolian People's Republic of 1924. The new Constitution of 1992 (chapter 16, paragraph 11) states that "men and women have equal rights in all spheres of political, economic, social, cultural and family life, respectively." In addition, women's equality and interests are demonstrated in the labour, pension allowance, family, and health insurance laws of Mongolia. The Mongolian government is now working to implement the Nairobi Forward Looking Strategies for the Advancement of Women.

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Despite recent trends in urbanization, the Mongolian economy is still based primarily on animal husbandry. In rural areas, nomadic and semi-nomadic ways of life are common: approximately 136,000 families are nomadic (more than 15% of the total population). Delivery of services to these families, and to women specifically, is particularly problematic due to poor infrastructure.

*Employment and Ownership*

By the 1990s, the Mongolian government was supporting women's employment by providing vocational, higher and specialised secondary education, and creating and financing numerous children's day-care establishments. As a result, the employment of women increased by 40.2% between 1979 and 1989. By 1992, however, the percentage of women in the workforce began to decline. Table 1 shows the distribution of women in the workforce between 1990 and 1992.

**Table 1. Employment of Women**

| | 1990 | | 1991 | | 1992 | |
|---|---|---|---|---|---|---|
| | number in 000s | % of total | number in 000s | % of total | number in 000s | % of total |
| Total number of women employed | 385.0 | 49.2 | 385.5 | 48.4 | 385.0 | 47.8 |
| Industrial Sector | 256.4 | 44.8 | 261.0 | 44.8 | 269.4 | 44.9 |
| Social Sector | 128.6 | 60.5 | 124.5 | 58.2 | 115.5 | 56.0 |

The processes of economic restructuring and privatization of property began in Mongolia in 1990. Staff reduction and encouraged retirement are among the factors influencing the reduction in women's employment. Since 1990, some 80% of the property designated for privatization has been privatized. In addition, more than 90% of the trade, public catering, and utility service organizations which employ women have also been privatized.

Although Mongolian law enshrines the principle of equal pay for work of equal value, women on average receive lower wages than men. This is related to the fact that women occupy most of the lower paying and non-professional jobs. Although the government has issued some resolutions about flexible working hours for women, improved labour safety, and creating healthy working conditions for women, women continue to work in unhealthy environments.

*Poverty*

Poverty in Mongolia is related to the fall in production, rising unemployment, and the increase in the cost of living. Over the past three years, thousands of women have lost their jobs as a result of privatization and staff reduction. Women now constitute 54% of the total unemployed population. It is estimated that 40,000 women are registered with the labour exchange and are actively looking for a job. At the same time, women have only limited opportunities to get loans to open private businesses.

The number of female-headed households has also increased. According to official statistics, 9,000 of the 37,000 female-headed households contain six or more children. Eighty percent of single women are over the age of 55. Poor families constitute 26.8% of total households; about 21% of families living below the poverty line are headed by women. All these factors converge to perpetuate the feminization of poverty.

The Mongolian Women's Federation is involved in a number of activities aimed at the alleviation of poverty. The Federation is implementing different types of projects for employment and income generation in collaboration with UNFPA, UNIFEM, the Australian government, and private and public sectors in Japan and Germany.

With increasing poverty, there has also been an increase in negative social phenomena such as violence and crime. The lives of rural women have been made more difficult because of decreases in social services in rural areas. While the privatization of livestock was an important move in promoting the development of private property, it also served to increase the amount of unpaid work done by women. The lack of structure linking private owners and the market directly serves to lower the income of rural people.

*Education*

Mongolian women have fared comparatively well in terms of education. About 90% of women are literate. Official statistics indicate that 51% of all people who have received some kind of schooling are women. According to 1993 statistics, women constituted 43.6% of those with higher education, and 58.6% of those with special secondary education. However, today's demand for education has changed. Women need knowledge in marketing, management, computer science, and English. In addition, the new system of payment for vocational education introduced in 1992 will limit the education possibilities and development of potential talents and skills of children of female-headed households and families with low incomes. This will become a particular problem for girls in rural and remote areas.

As a result of the current socio-economic crisis, more than 100,000 children have left school over the past three years. The bulk of drop-outs are in the rural areas, and 38% are girls. The primary tasks facing the Mongolian government in the sphere of women's education are

to introduce new forms of training and search for new education methods to improve the involvement of women in social life. This is particularly important given that many educated women cannot find jobs in their profession and therefore must be re-trained.

### *Health*

Mongolia has a comparatively well-developed health care system which is accessible to almost 100% of the population. The ratio of physicians to population is 26.62 per 10,000. In the past, 97% of deliveries took place in hospitals, but this proportion has declined significantly. Since early 1992, health facilities have been permitted to charge fees for health care services. Currently the health system is undergoing a difficult period of structural transformation, adjusting to new social policies and the realities of a market economy.

During this economic transition period, the percentage of the population living below the poverty line has increased sharply. This is coupled with general ill-health due to communicable diseases, malnutrition, and related deficiency disorders. There is no gender-specific data available on the morbidity rate.

### *Reproductive Health*

Women's special health needs are not being adequately met in Mongolia. There has been little research on women's health needs and public policies are shaped with inadequate recognition of women's perspectives.

According to results of a small-scale medical examination conducted by the Mongolian Women's Federation in cooperation with the Ministry of Health in March-April 1994, 38.2% of women aged 18-49, and 34.5% of girls aged 12-17, suffered from gynaecological and sexually transmitted diseases.

The birth weight of newborns is a very sensitive indicator of the nutritional status and health conditions of mothers. The number of low birth weight babies in Mongolia has decreased over the past few years from 3995 in 1992, to 3095 in 1993. The percentage of low birth weight babies remains at 6%.

The number of maternity rest homes, which provide the most suitable form of medical service to nomadic women, has decreased since 1990 when the privatization process began. Cases of home delivery increased twofold between 1992 and 1993.

Despite some decline in overall and infant mortality levels, there has not been a significant reduction in mortality rates related to pregnancy and child birth. Mortality statistics appeared to decrease from 1989, coinciding with the legalization of abortion. However, this downward trend did not last; women continued to experience a high death toll related to pregnancy and childbirth between 1991 and 1993. An initial analysis based on data from the first eleven months of 1994 suggests that the situation has not improved.

An analysis of causes of maternal mortality for 1989-1992 found that complication related to delivery was the major cause of death, and post-partum hemorrhage was the most important factor. Other causes included toxemia, sepsis, and obstructed labour. Between 1989 and 1992, the percentage of women who died from abortions and associated diseases also increased. The rise in deaths related to associated diseases suggests an overall deterioration in women's health which might be linked to shortages of food and medicine, and lack of health care services. Women are affected by these socio-economic problems more than men because they are the major caretakers of the family, and because these ills add to women's greater vulnerabilities arising from their reproductive and work burdens.

*Under-Five Mortality*

Despite the significant decline in under-five mortality levels over the past 70 years, the mortality rate remains high at 72.7 per thousand live births (in 1993). The predominant causes of infant mortality are pneumonia (65.25%) and gastrointestinal disease (11.3%).

*Abortion*

It is estimated that the number of abortions has increased since the legalization of abortion in 1989. The average age when girls have their first abortion is becoming lower, due partly to earlier sexual involvement. Abortion is used as a method of birth control because contraception is not readily available, and there is a lack of good sex education. Women seek abortions for many reasons including low incomes, inadequate housing, alcoholism, and fear of public disapproval.

*Access to Safe Water and Sanitation*

Inadequate water supply constitutes a major barrier to good health. Based on results from a 1988 study, the people of Mongolia gather drinking water from a number of sources including the centralized pipe network (15.4%), water delivery services (28.3%), distributing points or wells (35.7%), and, in rural areas, directly from natural water sources such as springs, rivers, lakes, and snow or ice (9.1%). Because of inadequate water supply services in rural areas, people face continuous water shortage, and are often forced to depend on unsafe sources. This has a significant negative impact on the health of the population.

***Position of Mongolian Women in Political and Economic Decision-Making***

Government policies on increasing the involvement of women in political and economic decision-making have not been consistent or purpose-oriented. The original policy on women's involvement was enacted following the victory of the People's Revolution in 1921, but was abandoned in the mid 1980s. Between 1931 and 1940, 14 women were elected to the highest state legislative body (the State Baga Hural), 400-600 women were elected to the local Hurals, and 16 women were appointed as ministers, deputy ministers, and chairpersons of specialized departments. In addition, nearly 50% of the people's court representatives

were women. In 1964 and 1985, resolutions were issued on increasing women's involvement in the national economic and cultural sectors. Table 2 shows more recent trends in women's involvement at the national level.

**Table 2. Percentage of Women Involved in Decision-Making in Economic and Social Spheres**

| | 1980 | 1985 | 1993 |
|---|---|---|---|
| Member of the Mongolian State Ikh Hural (Parliament) | 24.3 | 24.9 | 3.9 |
| Deputy of local people's Hural | 28.7 | 31.2 | 9.0 |
| Minister or chairperson of specialized bodies | 2.5 | - | - |
| Deputy Minister or deputy chairperson of specialized bodies | 7.2 | 10.0 | 6.2 |
| Minister, chairperson and departmental chief | - | - | 12.5 |

Resolutions and decisions about improving the social involvement of women which had been observed until 1990 have now been annulled, and no replacement policy has been defined. This is a major reason explaining the decrease in women's involvement in decision-making. Today there are no women in the federal government, or in the provincial and city authority. Women continue to constitute 11.7% of members of the Supreme Court, 11.1% of party leaders, and 10.7% of those in the diplomatic service. This is insufficient given the education levels, intellectual potential, and social activity of Mongolian women.

## *The National System for the Development of Women in Mongolia*

Prior to 1990, the Mongolian Women's Committee had been the central organisation handling women's issues. The Committee was financed from the state budget and it had branch institutions in provinces and districts. During the process of structural renewal, the activities of state and public organisations were concretized and appropriate measures were taken to create a mechanism to address women's affairs.

Since 1992, the State Ikh Hural Standing Committee for Demography, Health, Labour, and Social Insurance and the Women's section at the Ministry of Demography and Labour have been in the process of creating, implementing, and coordinating the state policy on the development of women. They have been working with ministries and non-governmental organisations and have been collecting and analyzing information related to women. Today, women's development issues are settled by officials at ministries responsible for women's affairs and social policy departments at the local governors' offices. However, these officials have not yet gained experience and the offices face staff shortages. On the other hand, there

has been a growing tendency for women to unite on a voluntary basis to establish their own organizations. Since 1990, nine women's non-governmental organisations have been established.

## *Women's Health-Related Activities Undertaken by the Mongolian Women's Federation*

The Mongolian Women's Federation is involved in a number of activities and projects dealing with women's health, including:

- the formulation of proposals on women's health issues;

- the promotion of information and education through the mass media. The Federation has its own journal, newspaper and radio broadcast. Moreover, the Federation works in close cooperation with Mongolian TV in the field of women's health;

- the organization of seminars and training workshops at local, regional, and national levels; and

- the carrying out of small-scale research on family planning and maternity rest homes.

## *Women's Health Concerns*

There are a number of concerns related to women's health which must be addressed in Mongolia, including the following:

- the need for more gender and age-specific data and research on women's health issues;

- the need to sensitize policy and decision-makers, both men and women, to gender issues;

- the need for proper information for women on their own bodies and health, and on the health system;

- the need for education on sexuality, safe sex, and reproductive health in school curricula to minimize unwanted pregnancies and the spread of STDs/AIDS;

- the need for training of traditional birth attendants;

- the need for greater involvement of women and women's groups at all levels in policy-making and in the design, implementation, and monitoring of health programs;

- the need to ensure the availability, accessibility, affordability, and safety of contraceptives;
- the need to ensure quality of care, including accessibility to clinics and providing mobile clinics to remote areas;
- the need to strengthen education, information, and communication on the consequences of abortion and family planning.

In addition, the following recommendations are suggested to improve women's involvement in social life, development planning, and management:

- develop national mechanisms to study and plan women's affairs, and to train personnel;
- obtain statistical data showing the social status of women;
- conduct sociological research to raise the social consciousness and activity of women;
- train women-executives and encourage women's participation in elections.

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# Women's Involvement in a Water and Sanitation Project in Rural Bangladesh

**Bilqis A. Hoque, Shafiul A. Ahmed, K.M.A. Aziz, K.Z. Hasan, and R.B. Sack**[1]

## *Introduction*

Community participation is regarded as one of the key elements to the success of a sustainable water supply and sanitation (WSS) project (White 1992). The active involvement of women in water and sanitation activities, however, has rarely been monitored and documented. During the Mirzapur handpump project (Aziz et al. 1990), some observations were made regarding the involvement of community women. The study was carried out at Mirzapur Thana by the International Centre for Diarrhoeal Disease Research, Bangladesh, in collaboration with the London School of Hygiene and Tropical Medicine.

## *The Project*

The study was conducted in the rural areas of Mirzapur, and was designed as a four year (1984-87) longitudinal study. The intervention and comparison areas were about 5 kilometres apart, and each had a population of about 5,000 people. In the intervention area, the project provided 148 handpumps, 754 twin pit latrines, and hygiene education promoting the use of these facilities. The comparison area received none of these project inputs. Significant improvements were observed in the water and sanitation practices in the intervention area following the project.

## *Women's Involvement*

The study involved women in three steps: (1) consultation; (2) decision-making; and (3) monitoring and maintenance of the handpumps and latrines.

### *Consultation*

The local leaders (mostly male) were consulted before the selection of the project sites. They were informed of the purposes and benefits of the study. They were also told that community participation, particularly from the women, would be encouraged to achieve sustainability. Motivational and consultative efforts were then extended to adult males and females.

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[1] Environment Health Program, International Centre for Diarrhoeal Disease Research, Dhaka, Bangladesh.

A high demand for the free handpumps ensued. The site selection required consultation with leaders, both male and female. There was little interest in the latrines, however, as community members did not regard them as essential. Moreover, unlike the handpumps, the latrines were not free - attempts were made to sell the latrines at 30% of their actual cost. The responsibility of motivating the household members to accept and pay for latrines was given to the housewives. The housewives were engaged in intensive consultation for this purpose, with the project workers maintaining a close advisory relationship.

During the second year, the latrines were distributed at a lower cost to address the financial constrictions faced by the target group. There was some concern expressed about this arrangement, whereby some people paid more and some paid less for the same latrine. In reality, no grievances were expressed.

*Decision-Making*

Both men and women were involved in selecting sites for the handpumps and latrines. Women were given priority over men in selecting sites for the latrines as their ease of access and convenience were important social and cultural factors in changing household practices. The housewives were given orientation in the proper installation of latrines. Thereafter, they were given the responsibility of supervising the installation of the latrines by hired contractors. The contractors were paid only after receiving satisfactory completion reports from the housewives.

*Handpump Maintenance*

Of the 148 handpumps, 30 were maintained by local female volunteer handpump caretakers (FVHC) over a period of 15 months. Three FVHCs were assigned to each handpump. The FVHCs were trained over a two-day program. The other pumps were maintained by pump mechanics.

*Handpump Monitoring*

Local women were also involved in surveys. They were trained to record the number of strokes applied on handpumps by putting stone chips in pots. The project workers monitored the work and counted the chips. The volume of water collected from a handpump was estimated by the number of strokes (counted by the stone chips), multiplied by the discharge rate of the pump per stroke. The local women's involvement minimized the cost of the survey as well as the disturbance factor.

*Latrines*

It was the responsibility of the owners to fence in their latrines. Six months after latrine installation, 486 of the 754 latrines were found to be fenced. The other households were either unable or reluctant to do so. Twelve local groups were formed, each consisting of 2

males or 2 females. These groups were contracted to fence the rest of the latrines at a cost of about US$ 0.27 per latrine. These groups motivated household members to provide materials available in their households (jute sticks, bamboo sticks, or jute sacking) for the fences. They then built the fences at no cost to the household.

Local women were also involved in desludging filled latrine pits. Fifteen women were trained to do the job without contaminating themselves.

## Results

### Handpumps

The performance of the FVHCs in the maintenance of the pumps is shown in Table 1. The efficiency of the FVHCs was well demonstrated. The users were satisfied with their performances and accepted this arrangement for pump maintenance.

The involvement of local women in the measurement of handpump water collection provided a simple, unobtrusive way of monitoring the use of handpumps.

**Table 1. Summary of Pump Maintenance by Women Volunteers and Project Staff**

| | Women caretakers | Project workers |
|---|---|---|
| No. of pumps | 21 | 49 |
| No. of inspection visits | 494 | 1,247 |
| No. of good pumps | 439 (89%) | 1,072 (85%) |
| Pump component replaced/pump/year | 2.6 | 3.2 |
| Estimate water drawn/person/pump/day | 36 L | 33.7 L |
| | | |
| Cost (US$) | 1.5/pump | 16.3/pump |

### Latrines

The housewives motivated members of all 754 households that had latrines to accept and use the latrines. They participated satisfactorily in the construction and maintenance of the latrines. Their participation in the desludging of the pits was remarkable.

## *Discussion*

The community under study was a male dominated society, and most of the housewives were not wage earners. The initial involvement of the entire community, and the subsequent opening of all activities to males and females alike, helped to gain both community support and adequate contact with women. Males were encouraged to watch women's training programs and to assist where necessary. However, many lost interest or could not afford to follow them after a few days, and subsequently left the responsibilities to their female counterparts. All women were permitted to bring their children to the training programs. This women-oriented approach has several planning and sustainability implications: the existing patriarchal social system must be considered; the cultural factors to which most women are attuned must be respected; any resistance from male household members must be overcome; and community/household support for the project activities must be developed.

Local women, who usually had low literacy levels, carried out the maintenance tasks, as did the more highly trained mechanics. There was a significant difference in cost. The users were satisfied with the women's performance.

The women involved in desludging the latrine pits were given financial incentives. At the same time, they were given training which in turn increased their level of pride in the job. They were not classified as the traditional sweeper class. The positive aspect of this involvement is that the technique was transferred to the community through skill development. If the women/household members so desired, they could desludge their latrine pits and save paying the professional cleaners.

The fact that almost all women involved were housewives suggests that their new roles were accepted and supported by the male household members and by society. In earlier phases, there was some local reluctance expressed to women's participation, although that attitude changed with continued motivational efforts and people's confidence in project workers.

In summary, this study showed that social and cultural factors posed no barriers to the satisfactory involvement of women in the WSS project, because appropriate approaches for involvement and training were adopted.

**Table 2. Water and Sanitation Improvement during Mirzapur Handpump Project (1984-1987)**

| | Intervention area | Comparison area |
|---|---|---|
| Handpump coverage: | | |
| pre-intervention | 123 person/pump | 114 person/pump |
| post-intervention | 30 person/pump | 114 person/pump |
| Tubwell water use: (for drinking, cooking, bathing, washing) | | |
| pre-intervention | 3% | 4% |
| post-intervention | 60% | 3% |
| Sanitary latrine use by adults: | | |
| pre-intervention | 1% | 1% |
| post-intervention | 60% | 1% |
| Hygiene education: | | |
| pre-intervention | None | None |
| post-intervention | Yes | None |

**Table 3. Community Participation in Latrine Program**

| Monetary contribution (n=754) | Participation |
|---|---|
| partial/full contribution | 57 (%) |
| No contribution | 43 (%) |
| Site selection (n=754) | 100 (%) |
| Supervision of latrine construction (n=754) | 100 (%) |
| Fence construction with project input (n=268) | |
| 8 female groups | 58 (%) |
| 4 male groups | 42 |
| Local women desludged pits | N=65 |
| Cost: Women paid/pit | US$ 1.3/pit |
| Rate proposed by professional cleaner | US$ 7.5/pit |

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# Reproductive Health in Japanese Society

**Chika Hyodo**[1]

The importance of women's health in the development process has been recognized throughout the world. The document which emerged from the International Conference on Population and Development (Cairo, September 1994) clearly declared the necessity of women's participation in health and development. The fact that this conference recognized that reproductive rights and health are universal concepts for development was a remarkable achievement. This achievement was a result of tremendous efforts made by many people, including women from around the world who work with non-governmental organizations.

The Cairo Conference raised awareness of the concept of reproductive health. We must now move from the theories and concepts developed at Cairo, to practice and concrete actions. The upcoming Beijing Conference is designed specifically to look at women's issues. Women's input on social development issues, as well as women's health promotion, should be more focused than at Cairo.

While the term "reproductive health" is widely known in many regions of the world, including Japan, awareness of the concept of reproductive health has not always translated into better practices. This may be a result of the fact that beliefs and practices surrounding reproductive health vary from culture to culture. In other words, it is not a simple and absolute concept. It may also be because there is an inadequate practitioner-based operational framework for understanding reproductive health issues.

The recent focus on "gender" has added another dimension to the dialogue on reproductive health. In the field of development, the women in development (WID) approach has been used since the 1960s. A gender and development (GAD) approach recently replaced the WID approach as a result of the methodological limitations of WID, which focused only on women as separate from men (Hara 1994). In GAD, the social context of relations between women and men is considered. This approach provides us with a new paradigm for analyzing development, not only in developing countries, but also in developed countries.

In order to analyze the present reproductive health issues in Japanese society from a gender perspective, it is necessary to distinguish between "practical gender needs" and "strategic gender needs." Practical gender needs are those needs which are formulated from the concrete conditions that women experience. They are formulated directly by women in these positions, rather than through external interventions. In contrast, strategic gender needs are

[1] Japan's Network for Women and Health, Tokyo, Japan.

those needs which are formulated from an analysis of women's subordination to men. They are identified to overcome women's subordination, and will vary according to the particular socio-cultural context (Moser 1989).

In developing countries, the approach based on practical gender needs was employed first in the field of development. Only gradually has the necessity of implementing strategic gender needs been recognized.

Looking at the reproductive health services offered to women in Japan, it could be said that the practical gender needs approach has been taken. Within this system, it is assumed that:

- women must be mothers and good child care givers; and
- women are just "those who are provided for" instead of "active participants".

Based on these culturally defined practical gender needs, the Japanese government has been providing "good" health services to promote the health of women. For example, maternal and child health services are promoted by law. Once women become pregnant, monitoring starts with the registration of the pregnancy with the local government, a process which is required by law. More than 90% of pregnancies are registered before the twentieth week, which means that most women learn of the pregnancy soon after conception, and receive support from public health services (Miyaji and Lock 1994). After the birth, regular free childhood health check-ups are provided in the nearest health centre. Public "mother's classes" also serve to provide information to new mothers.

On the surface, these services appear to be ideal and geared toward the needs of women. However, these kinds of services are only provided to women when they are reproducing. It is more difficult for unmarried women or women who decide not to have children to receive sexual and reproductive related health services. These women sometimes face barriers preventing them from seeing a gynaecologist and obtaining contraception. It is also difficult for these women to talk about these barriers. Health care services are needed to meet the broader needs of women, and not just their needs as mothers.

Reproductive health services could be improved through the following strategies:

- Private family planning and sexually transmitted disease clinics, targeted to all women, should be established. They should focus on the needs of women (e.g., needs in adolescence, menopause, and so on) rather than on women's social attributes, such as age and marital status.

- Access to contraceptive services, such as condoms, should be made easier for women. While condoms are sometimes available in vending machines in Japan, it is still very difficult and embarrassing for most women to purchase condoms in public.

- Special health services which care for commercial sex workers who are not included in the health insurance system should be developed, particularly for foreign sex workers.

There are currently few facilities available in Japan to satisfy the needs outlined above. Although women's NGOs have been working to obtain these services, the situation has not improved significantly, even in the face of AIDS.

Urgent action should be encouraged to realize these concrete proposals. Obviously, the bottom-up approach would be very effective, as it has succeeded in many areas around the world. In order to instigate concrete action, several factors must first be addressed. One is the empowerment of women based on IEC (Information Education Communication). Sex education based on human sexuality, which was strongly emphasized at the Cairo conference, is another possible approach. In this case, awareness of one's body at an individual level is crucial.

Another important issue concerns women's participation in decision-making. Women must not remain the objects of decisions made by others in the health care field, but must become active participants in the decision-making process.

Finally, the necessity for research which supports these approaches must be acknowledged. Strategies to overcome the barriers preventing gender-sensitive research in Japan must be overcome. Researchers must also be sure to regularly go back to the field to analyze needs. Gender needs analysis provides a significant basis for developing strategic action, and ultimately for making relevant policy decisions.

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# The Role of Rural Women in AIDS Prevention and Control

**Thicumporn Kuyyakanond**[1]

The Northeast region of Thailand is the poorest area of the country. It has a specific culture and local dialects. Rice farming is the main occupation of the rural people in the Northeast, while upland crop farming predominates in the rainy season. While women usually stay at home, care for children, weave cloth, do agricultural work, and make household materials, men often leave their communities in search for temporary employment.

According to the kinship system in this region, daughters tend to inherit land and homes, and this has resulted in Thai women being the centre of their families. While men are legally recognized as household heads, they acquire this position through their wives. Thai women share decision-making within the household with their husbands, as well as the burden of making a living. Generally speaking, Thai women assume greater responsibility for their families, especially their children, than Thai men. While religious beliefs and cultural values tend to view men as being superior to women, if Thai women want to change attitudes and behaviours concerning something that is important to them, they can exert a powerful influence on their husbands and loved ones.

People working on AIDS initiatives in the Northeastern region of Thailand must be cognizant of two points. First, there is a very high rate of HIV-infection among commercial sex workers. For instance, data from the Ministry of Public Health indicated that, as of June 1991, between 13% and 21.9% of commercial sex workers in the city of Khon Kaen were HIV-positive. Second, there has been a significant increase in the number of reported AIDS cases among women. In 1986, the male to female ratio of AIDS cases was 17:1; by 1991, it was 1.7:1.

This paper reports results from the first phase of a research and intervention project with rural women in the Northeastern region of Thailand. The research included KABP surveys, as well as focus groups, conducted with women in rural villages in Khon Kaen Province. The KABP survey involved face-to-face interviews with 330 village women, and consisted primarily of open-ended questions. The focus groups obtained in-depth knowledge about attitudes, beliefs, knowledge, and personal perceptions.

[1] Northeast Centre for AIDS Prevention and Care, Khon Kaen University, Thailand.

## *Methods*

### *Ethics*

Ethical clearance for this project was obtained from the Faculty of Medicine at Khon Kaen University in Thailand.

### *Sampling*

Two and three stage random sampling was used in this study. In the first stage, twelve villages were randomly selected from a total of 1,892 villages in Khon Kaen Province. Volunteer health workers and communicators in selected villages completed a demographic survey of every household. Based on this survey, about 30 to 40 married women were randomly selected from each village, and were invited to participate in face-to-face structured KABP interviews. In six villages, a third stage was introduced. Ten women were randomly selected from each of two age strata (16-27 years and 30-40 years) and were invited to participate in focus groups, as well as KABP interviews.

### *Field Work Procedures*

Prior to entering each village, the nature of the study was explained to the village leader, and permission to conduct research in the village was obtained from each leader. None of the chosen villages declined participation. A research team member met with each selected woman and explained the purpose and procedures of the research, and obtained agreement to participate from each woman. Each woman was given a date, time, and place for her KABP interview and focus group, where relevant. To preserve anonymity, KABP interviewers and focus group facilitators were not provided with the names of the women who were invited to participate. Women who showed up at their appointed times were considered to have agreed to participate, while those who did not show up were considered to have declined participation. No attempt was made to locate women who did not appear at their appointed time. About 73% (N=330) of the women selected for KABP interviews, and 72% (N=80) of women selected for focus groups, participated in the research.

Eight nurses (all women) from the nursing faculty at Khon Kaen University, who were experienced in village-based research in the region, were trained for this project and conducted the interviews. One of the nurses was trained to conduct the focus groups. Data collection required one or two days in each village - KABP interviews were held on one day, while focus groups were held on the second day. Data collection occurred between November 1991 and January 1992.

### *KABP Interview*

The KABP interview, completed by 330 village women, was administered as a structured face-to-face interview, and consisted primarily of open-ended questions. Open-ended

questions were used to minimize guessing and response acquiescence. Respondents were prodded for more than one answer to each question, and all answers were recorded. Responses were coded in a dichotomous format indicating whether each answer was or was not mentioned.

### *Focus Groups*

Focus groups have many advantages. To begin with, focus groups can serve to reduce the potential power differential which may occur in one-on-one interviews. Focus groups, which have more participants than facilitators, allow conversations or discussions to occur among participants with only occasional direction from the facilitator. The facilitator, in effect, moves into the background, and any perceived difference in status or power between participants and the facilitator tends to be minimized. Focus groups can also serve to bring women together who share similar day-to-day life experiences. In the process of sharing their stories, the women themselves probe, challenge, and share information in greater depth than can usually be fostered in a single interview. In the focus groups conducted in this study, the facilitator took the role of the uninformed outsider, and the women were encouraged to collectively inform her of their knowledge, attitudes, and beliefs, and to explore the issues raised in the survey in greater depth.

Two focus groups were held in each of six selected villages, one with younger women (under age 30) and one with older women (30 years of age and older). Women were divided along age lines to create homogeneous groups in which women were likely to share similar experiences. All sessions were recorded with the permission of participants. No personal, identifying information was included on the tapes. Sessions lasted approximately 90 minutes. A total of 12 focus groups were conducted, involving the participation of 80 women.

## *Findings*

### *Sample Profile*

The populations of the twelve villages studied ranged from 250 to 960. KABPs were completed by 24 to 35 married women per village, with an average response rate of 73% across villages. The women ranged in age from 18 to 53 years, with a mean age of 31.75 years. Eighty of the women also participated in one of twelve focus groups. The sample was homogeneous with respect to occupation (87.5% were farmers) and education (90.3% had completed between 4 and 6 years of elementary schooling) and was typical of rural rice farming regions. Since villages and participants were randomly selected, responses were combined and treated in an aggregate fashion, and can be generalized to rural women in Khon Kaen Province.

## *General Knowledge about AIDS and Sources of Information*

Virtually all of the women studied had heard about AIDS (98.2%). The majority of the women had obtained their information from television (76.1%), radio (60.0%), or printed media such as newspapers, magazines, or posters (23.7%). Very few women, however, reported that they actually knew someone with AIDS (3 of the 330 women).

Eighty percent of the women thought it was possible to tell by looking at a person if he or she was infected, citing the appearance of infected individuals seen on television as evidence. In KABP interviews, however, 75.2% stated that a person might look healthy and still transmit AIDS (no distinction was made between AIDS and HIV). In focus group discussions, several women made a distinction between the infectiousness of those who appeared healthy and those who showed visible symptoms of HIV infection. In these discussions, women recommended a greater degree of caution when in contact with people who showed visible signs of illness. It was reasoned that visible symptoms were indicative of a greater degree of infectiousness. Women who made this distinction were therefore reluctant to be in close day-to-day contact with symptomatic individuals. Sharing of latrines was the greatest area of concern - specific concerns about latrines were expressed more often by older women (over 30 years of age).

Women were divided almost evenly between those who knew a blood test was necessary to identify infection (43.9%), and those who did not know what procedures were required (41.5%). Only 6.9% of the women identified another kind of test or procedure which they felt could be used for diagnosis. In focus group discussions, women demonstrated considerable misinformation about the use of blood tests to identify HIV infection. For example, women stated that they knew they or their husbands were free of infection because they had been tested at some time in the past, or that their husbands were tested before they returned home after an extended absence. In the first instance, women did not understand that an old blood test may no longer be valid. In the second instance, women did not understand that there could be a delay between the time of infection and an HIV-positive test result.

In focus groups, women uniformly recognized that the ultimate consequence of AIDS was death. Over a third (39.4%) of the KABP respondents, however, said they believed in a cure for AIDS. In all groups, women stressed the necessity of obtaining medical care for someone with AIDS and of carefully following the instructions of doctors. There was no evidence, either from interviews or focus groups, of a lack of faith or trust in doctors or medicine to treat AIDS, or that the women might rely on folk or traditional treatments. On the contrary, discussions demonstrated trust and reliance on the medical community to have the appropriate knowledge and strategies to deal with AIDS.

## *Transmission and Susceptibility to HIV*

Specific responses to questions addressing transmission, susceptibility, and personal risk are reported in Table 1.

**Table 1. Responses Volunteered to Questions Addressing Transmission, Susceptibility and Diagnosis (N=330) %**

| **How do you think that people can get infected with AIDS?** | |
|---|---|
| Sexual intercourse | 62.4 |
| Using dirty needles | 51.5 |
| Using injected drugs | 63.3 |
| Newborn from mother | 2.1 |
| Casual contact: sharing toilet | 14.0 |
| other | 6.0 |
| Blood transfusions | 9.4 |
| **What type of person is likely to be at risk?** | |
| Prostitutes | 37.6 |
| Men who go to prostitutes | 27.0 |
| Wives of men who go to prostitutes | 14.8 |
| People who have many sexual partners | 24.8 |
| Gay men | 10.0 |
| Injection drug users | 27.3 |
| People who get blood transfusions | 3.3 |
| When hospitals/doctors reuse needles | 2.7 |
| People who do not know how to protect themselves | 1.6 |
| All other responses | 12.5 |

The majority of women (62.4%) identified sexual intercourse as a mode of transmission. When asked who was at risk for the disease, women most frequently responded that prostitutes (37.6%) and men who have sex with prostitutes (27%) were at risk. It is notable that very few women (14.8%) identified the wives of these men as a group at risk. This discrepancy was also found in focus group discussions. Focus group participants also said

that men who visited prostitutes were most at risk. Focus group leaders had to repeatedly probe before women volunteered that the wives of these men might also be at risk; in several focus groups, some participants denied that wives were at risk.

The use of dirty needles (51.5%), or needles for the injection of drugs (63.3%), were also commonly perceived as sources of risk. Focus group participants engaged in lengthy discussions of needle usage, addressing almost exclusively the use of needles in medical or quasi-medical procedures. There was a great deal of concern expressed over whether doctors, clinics, and hospitals were using clean needles, with some women insisting this was not the case. While standard medical procedures in Thailand recognize the importance of always using clean needles, these women may have been referring to the use of needles for quasi-medical procedures by non-licensed practitioners who are not necessarily trained or governed by the same rules and procedures as licensed practitioners. Villagers may not distinguish between licensed and non-licensed practitioners.

Table 2 indicates the proportion of respondents who correctly identified from zero to four or more modes of HIV transmission. Only 14.5% of the women did not identify at least one known mode of transmission, while 63.6% correctly identified one or two modes.

**Table 2. Respondents Correctly Identifying Multiple Modes of HIV Transmission (N=330)**

| Number of correct responses | N | Percent |
|---|---|---|
| 0 | 48 | 14.5 |
| 1 | 111 | 33.6 |
| 2 | 99 | 30.0 |
| 3 | 28 | 8.5 |
| 4 or more | 40 | 12.1 |
| missing | 4 | 1.3 |

## *Perception of Own Risk*

Table 3 provides a summary of the data on personal risk perceptions and protective strategies. It is clear from the data that prostitution figured prominently in women's perceptions of their own risk status. Less than one third of the women (31.8%) felt that they themselves were at risk of becoming infected. Of the 105 women who did consider themselves to be at risk, 53% identified that their husbands' possible visits to prostitutes were the source of their risk. Of the 225 women who did not feel they were at risk, 73.8%

based their lack of risk on their belief that their husbands did not frequent prostitutes. About 29.8% of the women who felt they were not at risk also said they were safe because their husbands did not travel. In focus groups, participants commonly expressed the belief that travelling away from home was a time when men frequented prostitutes. Instead of stating specifically that a husband did not see prostitutes, women often stated that their husbands "did not travel." Similarly, other women commented that they were concerned because their husbands "travelled a great deal." The ensuing discussions made it clear that the fear of AIDS, or lack thereof, was based on an association between travel and visiting prostitutes.

Injections were the second most frequently identified source of risk; about 18% of the women felt they were at risk due to medical procedures involving injections or transfusions. A further 13.3% identified various forms of casual contact as a source of risk (i.e., sharing toilets, being in contact with infected people in the hospital).

**Table 3. Perceptions of Risk and Protection Strategies**

| | | Percent | N |
|---|---|---|---|
| Do you think you are at risk? | Yes<br>No<br>Uncertain | 31.8<br>60.0<br>8.2 | 105<br>198<br>27 |
| **Why do you think you are at risk?** | | | 105 |
| Husband goes to prostitutes | | 53.0 | 56 |
| Transfusion, injections (medical) | | 18.1 | 17 |
| Casual contact | | 13.3 | 14 |
| **Why are you safe from risk?** | | | 105 |
| Husband does not go to prostitutes | | 53.0 | 56 |
| Husband does not travel | | 18.1 | 17 |
| Woman is monogamous | | 13.3 | 14 |
| Do you think a married woman who suspects her husband is infected can do anything to protect herself? | Yes<br>No | 77.6<br>22.4 | 256<br>74 |
| **What can she do?** | | | 256 |
| Use condoms with her husband | | 88.6 | 227 |
| Not have sex with her husband | | 16.0 | 41 |
| Husband forbidden to have sex with others | | 10.0 | 26 |
| Make her husband use condoms with others | | 4.0 | 10 |

While few women thought they were at risk, 77.6% of the women believed that, if a wife suspected her husband was infected, she could protect herself. Most of these women (88.6% or 227 of 256) identified using condoms when having sex with their husbands as the way in which wives could protect themselves. However, based on the data found in Table 4, very few women (only 28 of the women surveyed) had taken measures to protect themselves from infection. These women tried to encourage their husbands to protect themselves from infection either by not having sex with others, or by using condoms when doing so. Alternatively, the women used condoms themselves in sexual relations with their husbands, at least some of the time. During discussions about condom use in focus groups, women who said they used condoms with their husbands reported that they used them only for brief periods directly following visits by their husbands to prostitutes (e.g., "until the danger has passed"). Discussions revealed that these women did not see risk of HIV-transmission as something continuous, but rather as something short-lived and restricted to specific periods (e.g., following a husband's visit to a prostitute, and when symptoms become "especially bad"). After a husband's visit to a prostitute, some women said they would use condoms for a period of time, to ensure that there were no indications of infection. This behaviour, as well as the use of condoms when symptoms are apparent, was in direct conflict with the statements that one could be infectious without any visible symptoms.

Women who did not protect themselves most often said that their husbands did not frequent prostitutes (45.6% or 134 out of 294). About 26% (79 out of 294) said they did not protect themselves because they themselves were monogamous, without any comment about whether their husbands were also monogamous. None of these women had cited wives of men who go to prostitutes as being at risk.

## *Condom Knowledge, Attitudes, and Use*

While 88.2% (291) of the women claimed they knew what condoms were, only 69.4% (229) reported that they had ever actually seen a condom. Women generally knew where to obtain condoms, with the majority identifying the local health centre (84.6%) or hospital (71.5%) as places where condoms were available free of charge. About one half of the women (50.6%) said they would be embarrassed to ask for condoms. Only 25.8% reported that they had, in fact, talked about condoms with anyone. Among these women, 91 (29.7%) said they had talked about condoms with other women, while 25.3% said they had discussed them with doctors. Results from focus group discussions also found that there was little talk of condom use, either between married couples or among women. The limited discussion which did occur tended to be perfunctory. Women reported that they had merely asked their husbands to use condoms, or that their husbands had told them not to worry because they had used condoms when they "went out."

**Table 4. Steps Taken for Self Protection**

| | Percent | N |
|---|---|---|
| Have you done anything to protect yourself from getting infected? Yes<br>No | 8.5<br>91.5 | 28<br>302 |
| **What have your done to protect yourself?** | | 28 |
| Husband uses condoms with prostitutes | 21.4 | 6 |
| Do not let husband go to prostitutes | 28.6 | 8 |
| Sometimes use condoms with husband | 32.2 | 10 |
| Have sex only with husband | 29.0 | 9 |
| **Why have you not protected yourself?** | | 302 |
| Husband uses condoms with prostitutes | .9 | 3 |
| Husband does not go to prostitutes | 45.6 | 134 |
| Not at risk | 17.0 | 50 |
| Only have sex with husband | 26.0 | 29 |
| No one in the village injects drugs | 2.4 | 7 |

Most women said that the condom was useful for preventing disease or pregnancy. Men were expected to use condoms with prostitutes (67.2%), or specifically to prevent disease (26.6%). However, use of condoms to prevent disease did not extend to sexual activity between husbands and wives, even when the husband had been to prostitutes. Only 3.1% of the women said this was an appropriate use of condoms. In focus groups, women also said that condoms were appropriate for use by men with prostitutes, but were reluctant to address the possibility of using condoms with their husbands if they were concerned about sexually transmitted diseases. As an exception, two women who participated in focus groups were wives of village health workers. These women spoke openly and knowledgeably about condom use in the focus groups and said they had similar discussions with their husbands.

Married village women used condoms almost exclusively for contraception. About 80% of the women who had ever used condoms reported that they most recently used them for purposes of contraception. When the 202 women who had never used condoms were asked why they had not, 59% reported either that they had been sterilized or that they used another form of contraception. In focus groups, women also stressed the contraceptive role of condoms.

### *Sexually Transmitted Infections*

The majority of women in this study had not experienced sexually transmitted infections (STI). Only 10.6% of the women indicated an awareness of their husbands having had an STI, and for all but four of these women, this had occurred only once. Even fewer women reported that they themselves had an STI in the past (3.6%), with only three women in the entire sample reporting this had occurred more than once. Women were able to list their symptoms more often than the specific name of the infection, with genital sores and vaginal discharge the most commonly reported symptoms. All women reported that they had sought medical attention through doctors or clinics.

### *Discussion and Conclusion*

Results from the first phase of this project demonstrated areas of common knowledge and belief among married women in the Northeastern region of Thailand. In addition, results shed light on areas where, while there appears to be relatively sound knowledge, this knowledge is not being applied to personal life experiences.

While married women have not been a group targeted for AIDS education in Thailand, virtually all of the women surveyed had obtained information about AIDS; in particular, information about the major modes of transmission and prevention. This information came primarily from the mass media. In focus group discussions, women whose primary source of information was the radio tended to have more accurate information, while women whose primary source was television had stronger emotional responses to AIDS.

Women commonly identified the two major forms of transmission as heterosexual intercourse and contaminated needles. In both interviews and focus groups, discussion centred on the role of prostitutes in the spread of HIV. Women who felt they were safe from infection based this feeling on the belief that their husbands did not frequent prostitutes. Those women who felt they were at risk of infection similarly based their fear on the belief that their husbands did frequent prostitutes. In focus groups, women who thought they were safe sometimes said they were not certain that their husbands did not frequent prostitutes, or that they probably did, but not often.

Women with husbands who spent time away from the village for employment purposes often answered questions using the times when their husbands were at home as their reference point. It was only when other women in the group raised the issue of the time when men were away from the village for extended periods that these women shifted their perspective and considered their husbands' activities when they were away from home. Women were familiar with the diversity of circumstances and situations in which prostitutes were available and the contexts in which men were likely to engage a prostitute. There was no evidence of embarrassment in these conversations. In a few cases, in fact, the women were concerned that they might embarrass the group facilitator with their language and blunt talk.

These women were aware of the risks which many men, often their own husbands, were taking. They did not, however, often believe that these risks extended to themselves. As a result of denial, or because of a lack of awareness of the full nature of how HIV is spread, few women participating in this study thought that they were at risk. Clearly, this is an area which needs clarification in AIDS educational initiatives. Educational messages concerning the possible transmission of HIV from prostitutes to clients (and vice versa) must also address the possibility of further transmission to regular, long-term partners of both clients and prostitutes.

With regard to knowledge and use of condoms, while most women stated that condoms were a method of protection from disease, there appeared to be some confusion about their use for this purpose. In a series of questions on the use of condoms to prevent AIDS, many women stated that they did not use condoms because they had been sterilized. Further investigations are currently being conducted to determine whether some women think there is a link between the inability to conceive as a result of sterilization and an inability to become infected with HIV.

There also appeared to be some confusion about the possible link between the degree of infectiousness of an individual and visibility of symptoms. While women stated that one could appear healthy and still be infected, they also said that they would use condoms when visible symptoms of HIV infection were "especially bad."

With regard to the link between HIV infection and the use of needles, while women said they had received messages on television and radio about the dangers of intravenous drug use, they were also concerned about possible HIV transmission through the repeated use of unsterilized needles in various medical and quasi-medical procedures (e.g., vaccinations, birth control injections, vitamins, and treatments of various illnesses). These procedures were usually administered at regular health facilities such as clinics, hospitals, and community health centres, where appropriate procedures should be followed. Research findings suggest the need for further investigation on the availability of certain quasi-medical procedures in the villages, and the villagers understanding of what constitutes "safe" and "risky" medical procedures.

# Engendering Occupational Health and Safety

**Labour Resources Centre**[1]

## *Introduction*

Workers are a crucial component of Malaysia's vision to be an industrialised nation by the year 2020. To remain competitive in the export-based industrial sector, which relies on heavy foreign investment, Malaysia practices a low wage policy. Occupational health and safety initiatives tend to be concerned with minimizing costs incurred through the loss of working hours and damage to machinery.

According to the International Labour Organization, Malaysia lost RM 4 million as a result of industrial accidents in 1993 alone. (In 1993, 288,000 industrial accidents and 728 deaths were reported). While this estimate includes compensation and reduced productivity, it does not include the loss of actual human lives and limbs, the loss to families, or environmental costs of poor standards of occupational health and safety. Unfortunately, occupational health and safety is only seen in terms of industrial accidents. Very little information is available on occupational diseases that affect workers over the long term.

In such a scenario, scant attention is paid to the health and safety of women workers, who constitute 47% of the labour force. The working environment poses many risks to women, particularly to their reproductive health. Official statistics and reports do not indicate the number of women who, for example, are victims of industrial accidents and occupational diseases.

The absence of a gender perspective on issues of occupational health and safety is a major concern, particularly given the increased participation of women in the labour sector of Malaysia. This concern has emerged from the Labour Resources Centre (LRC) project on Occupational Health and Safety. The project has been undertaken in collaboration with several trade unions, the Education and Research Association, and the Malaysian Hazards Centre.

[1] Presented by Josie Zaini, President, Education and Research Association for Consumers (ERA), Malaysia.

**Table. 1. Number of Industrial Accidents by Sector, 1986-1990**

| Sectors | 1986 | 1987 | 1988 | 1989 | 1990 |
|---|---|---|---|---|---|
| Agriculture, Forestry, and Fishing | 27,061 | 3,615 | 32,973 | 37,710 | 39,365 |
| Mining and Quarrying | 1,478 | 1,644 | 1,753 | 2,281 | 2,677 |
| Manufacturing and Processing | 29,596 | 32,228 | 39,476 | 46,609 | 56,247 |
| Construction | 5,389 | 3,344 | 2,816 | 2,761 | 3,631 |
| Electricity, Gas, Water, and Sanitary Services | 148 | 149 | 201 | 565 | 873 |
| Commerce | 2,459 | 1,807 | 7,626 | 13,201 | 14,175 |
| Transport, Storage, and Communication | 1,323 | 2,043 | 2,858 | 2,952 | 3,151 |
| Financial Institution and Insurance | | | | | 194 |
| Services | 4,085 | 4,688 | 3,285 | 3,783 | 569 |
| Government Services | | | | | 3,126 |

Source: Department of Labour and Social Security Organisation (SOSCO)

## *Gender in Relation to Occupational Health and Safety*

### *Patterns and Trends of Women's Labour Force Participation (1970-1990)*

Almost half of the Malaysian population are women; of them, approximately 46.8% are in the labour force, compared to 84% of the men (Table 2). It is evident from the table that Malaysian males always show higher participation rates in the labour force, with this being the pattern for all age groups. However, the dramatic change in the female labour force participation after 1970 must be noted - female participation rates jumped from 36.3% in 1970 to 47.3% in 1975. This increase has been sustained to the present day.

In Malaysia, employment expansion and economic structural transformations since the 1970s seem to have had a greater impact on female labour than on male labour. This is primarily because structural changes have created a growth in "female-biased" manufacturing industries, as well as an expansion in the demand for support services which require female labour. Table 3 presents the distribution of the economically active population according to sex. The table reveals that the percentage of females in the workforce is an increasing trend as a result of economic structural changes. The percentage of females in the workforce was 34% in 1981 and increased to 35.6% in 1990. On the other hand, the percentage of males in the total workforce for the same period decreased from 66% in 1981 to 64.4% in 1990.

**Table 2. Labour Force Participation Rate by Gender and Age Group, Peninsular Malaysia 1970-1990**

| | Participation Rates (%) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1970 | | 1975 | | 1980 | | 1985 | | 1990 | |
| Age Group | M | F | M | F | M | F | M | F | M | F |
| 15-19 | 52.3 | 33.0 | 54.3 | 39.4 | 47.9 | 33.5 | 43.7 | 28.2 | 44.1 | 31.4 |
| 20-24 | 87.1 | 41.9 | 94.0 | 56.4 | 91.1 | 54.0 | 90.7 | 58.3 | 89.1 | 63.9 |
| 25-29 | 93.5 | 38.4 | 98.1 | 46.3 | 92.4 | 44.6 | 98.1 | 49.2 | 97.4 | 53.9 |
| 30-34 | 94.4 | 39.0 | 98.9 | 47.5 | 98.0 | 40.5 | 98.8 | 47.3 | 98.5 | 50.2 |
| 35-39 | 94.0 | 40.0 | 98.8 | 52.4 | 98.2 | 42.7 | 98.9 | 48.5 | 98.8 | 47.8 |
| 40-44 | 93.2 | 40.0 | 98.7 | 52.1 | 97.7 | 43.8 | 98.4 | 50.4 | 98.5 | 48.8 |
| 45-49 | 91.5 | 40.7 | 97.2 | 53.2 | 96.6 | 41.4 | 97.9 | 48.7 | 97.2 | 48.5 |
| 50-54 | 86.7 | 36.6 | 93.2 | 49.4 | 92.7 | 36.5 | 93.5 | 40.0 | 93.3 | 40.9 |
| 55-59 | 75.6 | 29.2 | 83.3 | 37.5 | 77.4 | 30.8 | 76.6 | 32.6 | 71.3 | 29.4 |
| 60-64 | 65.2 | 23.7 | 72.0 | 28.5 | 68.6 | 25.0 | 67.1 | 23.9 | 59.9 | 24.0 |
| 15-64 | 83.4 | 36.3 | 86.0 | 47.3 | 86.6 | 39.3 | 84.6 | 44.6 | 84.4 | 46.8 |

M=Male F= Female Source: Siti Rohani Yahya (1993)

In the past, the Malaysian female labour force has predominately been concentrated in the agricultural sector; this proportion has declined rapidly since the late 1970s (Table 4). Almost 68% of the economically active females were employed in the agricultural sector in 1970; however, the percentage declined to 50% in 1980, and was just 28% in 1990. Meanwhile, the percentage of women in the manufacturing sector increased from 8% in 1970, to almost 16% in 1980, and was almost 24% in 1990. Another distinctive increase in female labour participation can be observed in the service sector, where there was an increase from 16% in 1970, to 21% in 1990.

The important role played by women in the growth of the industrial sector of Malaysia can no longer be disputed. The success of the export-orientated industrialisation program (which began in 1970) is premised on women's labour in factories. Two industries, namely electronics and garments, are the main export-earners in Malaysia today, and in both these industries, the majority of production workers are women.

## *Orientation in Labour Policy*

Current government policy considers the workforce to be a crucial asset in the international competition for foreign investments. Recently, the Ministry of Labour was renamed the Ministry of Human Resources. This indicates some re-orientation in the recognition that the growing demand for skilled labour in advanced industries has become a matter of concern. In an attempt to create skilled labour, more vocational training centres have been set up and labour is being organised in this direction.

**Table 3. Distribution of Economically Active Population by Gender, Peninsular Malaysia 1981-1990**

| | Males | | Females | | Total | |
|---|---|---|---|---|---|---|
| Years | (,000) | (%) | (,000) | (%) | (,000) | (%) |
| 1981 | 2792.0 | 66.0 | 1442.6 | 34.0 | 4234.6 | 100 |
| 1985 | 3045.9 | 65.5 | 1601.5 | 34.5 | 4647.4 | 100 |
| 1986 | 3084.1 | 65.2 | 1642.6 | 34.8 | 4726.7 | 100 |
| 1987 | 3166.7 | 64.6 | 1738.8 | 35.5 | 4905.3 | 100 |
| 1988 | 3283.3 | 64.6 | 1799.8 | 35.4 | 5083.1 | 100 |
| 1989 | 3409.0 | 65.0 | 1839.0 | 35.0 | 5248.0 | 100 |
| 1990 | 3565.5 | 64.4 | 1969.0 | 35.6 | 5534.5 | 100 |

Source: Siti Rohani Yahaya (1993)

There have been serious attempts at nurturing the existing foreign investments, and encouraging more investors through perks. The role played by labour is a major one, yet there is not a corresponding concern for safety and health. The rights of workers to have a safe working environment is not on the political agenda.

## *Overview of the History of Occupational Health and Safety*

Occupational health first became an issue in Malaysia in the early twentieth century, with the concern about malaria control in the plantation and mining sectors. The Federated Malay States Enactment of 1926 and the Rump Code of 1933 provided for accommodation, sanitation, health care services, working conditions, and wages in mines and estates. In 1967, the Factories and Machinery Act was enacted. This act provided for the establishment of the Factories and Machinery Department and the setting up the Factory Inspectorate System. An Industrial Health Unit was also established as a part of this move, and this Unit, along with an Industrial Health Officer, remained in the Factories and Machinery Department until 1970, after which they were transferred to the Ministry of Health as an Occupational Unit. The Factories and Machinery Department has statutory powers and has formulated various regulations including the Health, Safety, and Welfare Regulation 1970, the Lead Regulation 1984, the Asbestos Process Regulation 1986, the Noise Regulations 1989, and the Mineral Dust Regulation 1989. In 1994, the Occupational Safety and Health Act (OSHA) was passed.

Prior to the OSHA of 1994, other forms of legislation covering occupational health and safety existed. A 1988 Malaysian Trade Union Congress study of workers' views on occupational health and safety issues found that the majority of workers were not aware of the various pieces of legislation (for example, The Employment Act 1955, The Rump Labour Code 1933, The Factories and Machinery Act 1967, The Pesticide Act 1974, The Environmental Quality Act 1974, and so on). These Acts were inadequate and fragmented, and their enforcement was distributed to several Ministries.

**Table 4. Percentage Distribution Of Economically Active Population by Gender and Industry, Peninsular Malaysia. 1970-1990**

| | Percentage Distribution (%) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Industry** | M | F | M | F | M | F | M | F |
| Agriculture and Fishing | 49.6 | 67.9 | 37.5 | 49.3 | 28.6 | 33.7 | 28.9 | 28.2 |
| Mining and Quarrying | 2.3 | 0.7 | 1.4 | 0.3 | 1.1 | 0.2 | 0.7 | 0.2 |
| Manufacturing | 9.3 | 8.1 | 11.8 | 16.3 | 13.0 | 18.9 | 15.2 | 24.3 |
| Construction | 3.1 | 0.5 | 6.4 | 1.0 | 10.7 | 1.2 | 8.7 | 0.7 |
| Electricity, Gas and Water | 1.0 | 0.1 | 0.2 | 0.1 | 0.8 | 0.5 | 0.9 | 0.1 |
| Wholesale, Transportation Storage and Communication | 5.0 | 0.5 | 6.9 | 2.3 | 9.7 | 5.2 | 9.9 | 5.4 |
| Services | 18.1 | 16.4 | 22.7 | 19.5 | 19.3 | 21.2 | 18.8 | 21.4 |
| TOTAL | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

Source: 6th Malaysia Plan 1991, Government Printers

Presently, there are fewer than twenty qualified physicians in Malaysia who are knowledgeable about occupational safety and health. Most of them are employed by the government. The industrial health aspect is primarily handled by general practitioners who do not have training in this area. General practitioners obtain contracts from factories on a competitive basis which makes them a managerial partner, and therefore compromises the health of workers. There is also an absence of gender-sensitive legislation.

## *The Concerns*

### *Health and Safety Problems Faced By Women In Various Occupations*

The following are highlights of the problems faced by women workers in a few selected industries.

### *The Electronic Industry*

The electronics industry has played a significant role in employment for women. About 92% of the jobs in this sector are unskilled, 13% are semi-skilled, and 85% of the employment is female. The concentration of women in electronics is no mere coincidence, since the presence of a large, low-wage, female workforce is a well-documented reason for corporate decisions to locate in Malaysia.

The work hours in these electronic plants vary according to location and business demand. Overtime is prevalent in times of high demand, but the industry is subject to wide fluctuations in demand. In addition to long hours and overtime, workers complain about shiftwork, which has become increasingly prevalent with the introduction of automated equipment. In Malaysia, existing legislation against night work for women has been waived

to allow electronics companies to introduce rotating shiftwork and permanent night shift. In addition to the shifts, workers' lives are dominated by production targets. These targets are dreaded by workers because their wages are tied to them.

Because of the hours, the shifts, the fast pace of work, and the pressure from management, many researchers have reported constant complaints of stress and fatigue, although few systematic studies have been undertaken. There are a range of hazards and potential health problems in the electronics industry. The microscope is the most frequent and most hotly debated hazard. A range of potentially hazardous chemicals are also used in various stages of the electronics assembly process, including trichloroethylene, methyl ethyl ketone, xylene, acetone, solder flux, sulphuric acid, and hydrochloric acid. These chemicals can be carcinogenic, teratogenic and/or mutagenic. They may also cause skin and respiratory diseases.

Health problems of shiftworkers include gastrointestinal disorders, nervous disorders, and sleep disturbances such as fatigue, light sleep, and insomnia. An increased frequency of anxiety, confusion, and difficulty in concentrating has also been reported. Shift workers have also complained of being irritable, nervous, depressed, and feeling pressured. Furthermore, shiftworkers exposed to solvents during pregnancy are more likely to miscarry.

*Textile Industry*

Women workers constitute the majority of the workforce in the textile/garment industry. Byssinosis is an occupational lung disease of textile/garment workers who process cotton. In its early stages, the disease is characterised by chest tightness, shortness of breath, or cough. Other problems in this industry includes noise, shift work, thermal environment, chemical exposure, and industrial accidents.

*General*

Some identified occupational diseases include:

- silicosis among quarry workers;
- higher incidence of eyestrain and visual problems among office workers; and
- skin diseases among plantation and sawmill workers.

Women workers in plantations have cited acute effects of pesticides, such as dizziness, muscular pain, itching, skin burns, blisters, difficulty in breathing, nausea, nail changing colour, and sore eyes.

### *Research*

A review of occupational health and safety literature reveals two major gaps: (1) a lack of a gender perspective in the research; and (2) an absence of interventions after studies are carried out. The absence of a gender analysis concerning occupational health and safety issues results from a number of reasons:

- it is a non-lucrative area;
- research is confined to academics;
- there is minimal involvement of women in unions and safety committees; and
- there is an absence of female experts in the area of health and safety.

It is anticipated that the recently passed Act on Occupational Safety and Health will motivate and accelerate research in this area.

Research done to date in Malaysia on women workers include:

- the effects of shift work on female factory workers in relation to their biological functions;
- occupation health hazards faced by women at work;
- blood cadmium levels in pregnant women;
- health status of female factory workers; and
- health, production, and reproduction among electronic workers.

Most of these works are general in nature, and do not provide definitive conclusions. In the electronic and manufacturing sectors, the use of solvents is very widespread and none of the work done involves testing workers for the effects of exposure to chemicals. There is a need for further knowledge of the chemicals being handled, including baseline monitoring of chemicals before they enter the industry, as well as regular monitoring of their effects on the body systems.

## *Legislation*

Legislation provides recognition, protection, and gives remedies. Legislation empowers the individual because it provides a basis for the individual to seek redress. Laws are of no consequence if the machinery of enforcement and other administrative mechanisms are weak, and if those who are meant to be protected by the laws are unaware of their existence.

The Occupational Safety and Health Act of 1994 and its anticipated enforcement is a positive legislative reform toward better safety and health standards at the workplace. The Act provides some protection for the workers whose welfare, health, and safety must be safeguarded if sustainable development is to be promoted.

## *Gender and Legislation*

The Employment Act of 1955 covers employees who earn RM 1,250 per month or below, and who are doing manual work (terms and conditions of service for other employees are covered through their contracts with management). This Act provides some provisions for maternity leave/confinement, but only recognizes pregnancies after 28 weeks. In the private sector, women are entitled to 60 days leave, and have the option to take leave 30 days prior to delivery and 30 days after delivery. In the public sector, entitlement for confinement is 45 days.

In cases of abortion and miscarriage, doctors generally grant some medical leave (for example, two weeks) which is taken as part of the normal entitlement of annual medical leave for all employees. The issue of entitlement to leave for abortion and miscarriage has been a contentious matter. Women's organisations and trade unions have pointed out that the healing process for an abortion or miscarriage takes about the same time as for a normal delivery, and argue that recognising confinement entitlement only after 28 weeks of pregnancy constitutes gender discrimination.

Several progressive trade unions have tried to enhance the entitlement during pregnancy through collective agreements. They have obtained time off for check-ups, special uniforms, as well as exemptions from night shifts. However, trade unions also argue that collective agreements are not the best avenues for addressing the concerns of women's reproductive health. Gender sensitive legislation is necessary to protect women's reproductive health.

The adverse impact of manual labour on women's reproductive health is not recognized. Many women working on plantations experience prolapse of the uterus, which often results from heavy work, such as carrying heavy latex pails and oil palm branches.

The lack of a gender perspective is not only confined to women's reproductive health, it is also reflected in areas of representation and decision-making. The OSH legislation provides for the setting up of safety committees in places of work where there are more than 40 employees. While the legislation specifies the number of employers, employees, and trade unions representatives who should be on these committees, it does not specify the number of women.

In the pursuit of sustainable development, women should be participants in planning and implementing health and safety programs at worksites. OSH legislation and programs must stress the importance of a gender perspective in understanding occupational health and safety. In this context, it is also imperative that a gender analysis be done of ILO Conventions and various UN Codes related to work place hazards and safety.

### *Rights of Workers*

Industrialization does not come with ready-made legislation and codes. In industrialized countries, recognition of work hazards, injuries and diseases, and legislation on safety and health were achieved through:

- strong unions/struggles of workers;
- greater democratic space;
- scientific studies on occupational hazards; and
- public outcry over industrial accidents.

The Labour Resources Centre believes that the best hope for a safe working environment lies in a number of areas.

- Improved socio-economic conditions: A clean working environment at the work place is not the only factor. The environment where workers live is also important. A safe workplace has little meaning to a worker who lives in squatter areas and or in filthy conditions.

- Higher income levels: The base salaries of workers must be raised to provide for a good standard of living if higher occupational health and safety standards are to be achieved. The Labour Resources Centre has found that the most important concern for workers is wages. Workers will even carry out hazardous jobs or use hazardous chemicals if they are paid an allowance for the job. Unions have tried to eliminate hazardous operations through collective bargaining, but companies bypass unions and offer more wages for these jobs. It is a constant struggle to educate both male and female workers. These problems can be addressed with patience, dedication, understanding, and a new approach. A new form of trade union, based upon workers' realities and expectations, is needed.

- Access to the right to organise into democratic and independent trade unions: This provides workers with the collective strength to articulate and assert their concerns and needs.

- Training, education, and involvement of workers in research, analysis, and action-initiatives: The Labour Resources Centre has found that workers' experiences and perspectives are not given sufficient attention.

- Educating workers about the importance of a safe living environment, as well as a safe workplace.

- Empowering women workers.

## *Conclusion*

Empowerment of women is the key to engendering issues of occupational safety and health. Empowerment begins with the recognition of gender equality as a fundamental human right. Research and education programs must reflect the totality of women's working life and address the following:

- the nature of their tasks;
- the environment in which these tasks are performed;
- the effects of these tasks on their health; and
- the time involved, the benefits, the controls, and the discrimination.

All those involved in women's participation in the labour force (e.g., employers, agencies, trade unions, and so on) must create and provide the space for the views of women workers to be heard. Research institutions could contribute their efforts toward work on gender aspects of occupational safety and health and propose interventionist measures to policy makers, workers, and management. The combination of various efforts will ensure that gender and occupational safety and health are placed firmly on the political agenda.

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# Women's Health in Cambodia

Neang Ren,[1] Khieu Serey Vuthea,[2] Chhoy Kim Sor[3]

## *Introduction*

It is difficult to assess the health situation of Cambodian women because there are virtually no reliable statistics that can be used for comparative purposes. The last census was carried out in 1962 when the population of Cambodia was 5.7 million people; women comprised 2.8 million. Since 1962, the situation has changed drastically. Events, such as the war which started in 1970, the ascension to and collapse from power of the Khmer Rouge in 1975 and 1979 respectively, and the subsequent war that has dragged on until now, have dramatically changed the structure of the population. During that time, no population census was able to be carried out, except for some sporadic observations that were done after 1979 in secured areas only. The shortage of statistics, especially about women, force researchers to use estimates made by individuals and international organizations.

Cambodia has a land area of 181,000 square kilometres. A large portion of the land is covered with approximately 6-10 million land mines. The population of Cambodia is estimated to be about 9.4 million, with about 88% of the population living in rural areas. Women comprise around 60% of the population, and about 30-35% of families are headed by women. Women form 65-70% of the rural workforce.

## *Health Problems*

The health care system was in total disarray in 1979. Medical officers were decimated, while hospitals, clinics, and other types of health infrastructure were destroyed during the 1975-79 period.

After 1979, women were exhausted and in poor health as a result of overwork, malnutrition, poor hygiene practices, and disease. However, as they began to rebuild their lives from 1979, more was demanded of them. Lack of resources prevented women from treating illnesses, and their health deteriorated further. Family planning and contraception hardly existed, and pregnancies were frequent. The crude birth rate was 4% per annum. Each

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woman had an average of five children, but it was not unusual to find women with ten or twelve children. This high birth rate had a detrimental effect on women's health and economic situation.

### *Community Health Services (State and Private)*

There are a number of major problems with the state and private community health centres. For instance, health workers at the community level lack techniques and skills, and do not have good relations with people in the communities. They appear not to care. Advice is often poor, and health workers are not dedicated. Treatment is often not timely, and costs are too high. Health workers often persuade patients to receive treatment at home. Health workers lack a sense of responsibility, and they wait passively for guidance from a higher authority.

Health centres lack essential drugs, laboratory materials, and supplies. Private services do not have sufficiently skilled staff, and do not stock or distribute medicines in a controlled manner.

Health centres are sparsely distributed, and good facilities are usually too far away. There is always a lack of transportation. Security is poor, and there are safety risks associated with travelling to health services at night. Due to the lack of infrastructure, sick people often do not arrive at health centres/hospitals in time for proper treatment. At the village level, hygiene is not a priority and many people hold animistic beliefs. Villagers are also uncomfortable with formal Western-based treatment.

### *Health Education*

There is a lack of participation of women in health education due to family obligations, such as food production, raising children, taking care of the elderly and sick, and working the farm land. Women often cannot find time to participate because of poor health or difficult living conditions. The social environment does not encourage women to participate in health education. There is lack of transportation for all health education activities. Health education is hampered by a lack of basic primary and secondary education among rural women. The methods and materials available to health educators are not perfectly developed for the Cambodian situation. People do not follow the health education lessons that they hear, often preferring to follow old habits and traditions. There are very few health educators with the right balance of skills, including the ability to plan a program with the local authorities, and to teach. Security in villages is a constraint for organizing meetings. Lack of transportation is also a barrier for reaching scattered people in rural areas. People with health problems or questions are often afraid to tell health educators due to a lack of trust. Educators from other areas usually do not have a good relationship with villagers.

### *Birth Spacing*

Both men and women lack knowledge of available birth spacing methods, and do not make decisions on practising birth spacing. People still feel that, due to their poor living conditions, more children will give them a more secure future. Health centres disseminate little information on birth spacing. People (men in particular) are not patient to try out contraceptive methods because they have little information on the benefits of birth spacing. Most people in rural areas have very little access to birth spacing materials.

A national birth spacing survey is currently being conducted and estimates on maternal mortality rates should be available by May 1995. This will provide valuable information which will refute or confirm the current figures, which vary from 250 to 1000 per 100 000 live births. These figures come from small local surveys, with small sample sizes. UNICEF has estimated that the rate was 500 per 100 000 live births between 1980 and 1990.

### *Nutrition*

Poverty in rural areas (of living conditions and finances) prevents families from maintaining adequate nutritional levels. Women lack awareness of the necessity of diversity of nutritious foods, and consequently do not take enough care to ensure that they and their families receive a balanced diet. Traditional diets are not necessarily the most healthy. There is also a lack of awareness of the importance of hygiene in food preparation. People with low literacy levels are unable to understand written materials concerning nutrition. Water quality in many areas is poor. In some remote areas, the land is not fertile. Natural disasters, chemicals, or mines, are used or have been used in the past, and crop growth has been adversely affected, leading to poorer nutritional levels. In rural areas, poor infrastructure and communications prevent NGOs from working to improve nutrition. Remote rural areas are far from town centres and markets. People living in remote areas with poor infrastructure cannot travel long distances to markets to purchase a balance of nutritional foods. Skills and techniques for crop growth, livestock raising, and knowledge of seeds are all lacking, and need to be improved. Agricultural fields are in poor condition because of war, bad tools, poor farming techniques, and weak pulling oxen.

### *Environment and Health*

The water quality is very poor in many rural areas. People do not drink boiled water. High environmental pollution levels stem from factories, motor cycles, cars, generators, war, insecticides, and cigarettes.

There is little awareness of issues related to hygiene. Garbage is not removed properly and the people do not know of the importance of proper washing. Left-over food is not properly conserved.

The climate quickly changes because of the destruction of forests. Women suffer from diseases carried by mosquitos, social diseases (AIDS, STDs, tuberculosis), and illnesses related to agricultural chemicals, overwork, and lack of sleep. When women are pregnant, they do not take good care of their health, and they have many children. There is a lack of well-trained doctors. Medicines are often used improperly. Abortion practices are not safe. Existing health centres do not use sterilized needles and other equipment. Social conflicts in the family and neighbourhood cause unrest in the social environment. There is always much noise in urban areas, from cars, motorcycles, factories, and generators.

### *HIV/AIDS*

AIDS started to receive attention in 1991 when one HIV-positive case was confirmed. Liberalisation and the presence of a large number of United Nations peacekeeping forces have undoubtedly contributed to the spread of AIDS. It is estimated that 10% of about 30,000 prostitutes are infected with the AIDS virus. Between 2,000 and 4,000 people are HIV-positive. Poverty and a lack of basic medical facilities, as well as widespread unhygienic medical practices, have exacerbated the problem. The promiscuous habits of many Cambodian men have endangered the lives of many Cambodian women.

The World Health Organization and local and international NGOs are attempting to address this problem with educational programs at all levels, but there are limited available resources. Medical sources believe that the number of women infected with HIV is on the increase.

**Statistic of HIV-Positive Cases**

| | 1991 | 1992 | 1993 | 1994 |
|---|---|---|---|---|
| Among Prostitutes | | 9.17% (19/207) | | 39.4% (84/213) |
| Among STD Cases | | 4.16% (3/72) | | 9.1% (50/634) |
| Among Blood Donors | 0.075% (33/972) | 0.60% (30/5074) | 1.5% (123/8161) | 2.8% (294/10425) |
| Estimation | | 100 - 200 Cases | 2000-4000 Cases | 5000-6000 Cases |

### *Mental Health*

The mental abuse that women have experienced over the last two decades is another issue of great concern. Many women witnessed the execution of their husbands, watched loved ones die of starvation, and were raped and tortured. Furthermore, their sudden change in roles

from homemakers to workers, from the campsites of a foreign land to the wider community back at home, have made their adjustment a trial beyond their mental capacity. Many women are in a state of hopelessness and possess low self-esteem, and the fabric of Cambodian families is in danger of becoming seriously disintegrated. While psychological problems have been documented in surveys conducted among refugees in the camps and abroad, there have been no studies undertaken inside Cambodia. It is believed that many women are suffering from depression and post traumatic stress syndrome.

### *Domestic Violence*

Many parents have little education and do not always provide appropriate support for their children. Due to poor living conditions, rural families often have many children. Husbands and wives do not always understand and trust each other. There are often conflicts between husbands and wives about children who are not related by blood. Domestic violence results in problems such as forced sexual intercourse. Husbands do not respect family planning practices and often force wives to overwork, which leads to serious injuries and sometimes even death.

## *Future Plans*

The recent creation of the Secretariat of State for Women's Affairs (in collaboration with local NGOs) has created and renewed an atmosphere of hope for Cambodian women. The Secretariat's main objectives are:

- to enhance the skills of women through equitable training and education;
- to ensure full recognition and full participation of women at every level of national planning, reconstruction, and development; and
- to create a network for women throughout the country in order to end their isolation. A network of women's representatives will be established to safeguard women's rights and interests at every layer and sector of the government and the society.

It is obvious that these goals cannot be achieved with the current low financial commitment of the government. (The Secretariat of State for Women's Affairs has a budget of 0.12% of the 1994 national budget). Nonetheless, the Secretariat set up four departments (women's rights, women in development, women's health and welfare, and research) in an attempt to achieve its goals.

The Women's Health and Welfare Department is responsible for liaising with the Ministry of Health, and other ministries in charge of women's welfare, to produce gender-sensitive data to direct services toward women. The burning health problems at the moment are the spread of AIDS, the inability to reduce maternal mortality rates, and the high infant and child

mortality rates. A government policy on family planning is being developed. The Department is going to carry out public campaigns and educational programs about how to prevent common illnesses that threaten the lives of women and children.

The Research Department will serve as a research centre which will collect, analyze, and classify information concerning women nationally. This will create useful resources for government's future policy planning and design of women's programs. The department will serve as the contact point that provides guidance to donors assisting Cambodian women.

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# Gender, Health, and Sustainable Development

Ng Yen Yen[1]

The changing social, political, and economic scenarios of many countries in the Asian Pacific region has, and will continue to, radically change the role of women. As countries free themselves politically and economically (for example, China) and strive toward economic progress and development, an increasing number of women in the region will enter the workforce. This trend is exemplified by Malaysia, where the government, due to a shortage of labour, is actively encouraging women to participate in the workforce by offering childcare incentives. In the future, women will increasingly spend more and more time at the workplace, which will affect themselves as well as their families and the wider society.

Occupational health and safety issues involve not only the number of physical injuries and the amount of time off from work due to illness, but also wider issues such as mental health, intangible stresses, matrimonial disharmony, and the provision of childcare. Fully addressing occupational health and safety issues means taking a holistic perspective of women's health and well-being.

There is a need for more research by government and non-government bodies in the occupational health and safety area. Practical tools need to be developed for the incorporation of occupational health and safety principles into the formulation, implementation, monitoring, and evaluation of governmental and nongovernmental policies and programs. There is much ignorance and a scarcity of gender disaggregated data about women's actual roles, their work, and their important contribution to development. This workshop provides an ideal environment for sharing knowledge and experiences so that avenues to encourage research in this area, and bring visibility to the concerns of working women, can be explored.

The countries in the Asian Pacific region can be divided into three major groups: (1) the developed countries such as Australia, Singapore, Japan, Hong Kong, Taiwan; (2) the developing countries such as Malaysia and Thailand; and (3) the under-developed countries such as Vietnam and Cambodia. All these countries have gone through or will go through the various stages of industrialization - moving from labour intensive economies to high technology/low labour based economies. Similar occupational health and safety problems will occur in each country, but at different times, and with different degrees of severity.

[1] Medical doctor and appointed Senator to the Malaysian Parliament, Malaysia.

Malaysia aims to be a fully developed country by the year 2020, and is focusing on high technology industries such as the electronics, microelectronics, computer and information technology industries. These industries employ more female workers than male, and in some factories as much as 75% of the workforce is comprised of female workers. While women represent a crucial component of the Malaysian labour force, most women workers are concentrated in low skilled, low paying, labour intensive assembly line jobs. In 1990, only 1% of Malaysian women could be found in administrative and managerial positions.

While the Malaysian government created an Occupational Health and Safety Act in 1994, no special efforts have been made to address the needs and concerns of women workers. There is a lack of awareness of the health and safety issues facing female workers. These issues must be taken up at both the governmental and non-governmental level. It is hoped that research on the health risks associated with women's work, as well of the articulation of the needs of working women, will lead to a greater awareness.

Health risks of working women can be categorized into general health risks and specific risks relevant to a particular industry.

## *General Health Risks*

### *Overload*

An overload of tasks at work may be compounded by home responsibilities, especially among Asian women, as women's traditional roles have been in the home.

### *Role Conflicts*

It can be complex for women to balance their multiple roles in the home and in the workplace, especially for married women with children. Two decades ago, French and Caplan found that role conflict among women was associated with higher cholesterol and smoking levels.

### *Spillover*

The blurring of work and home boundaries, more pronounced for women, can lead to high stress levels. Working women who are also trying to cope with responsibilities in the home may suffer from migraines, nervousness, and depression.

## *Specific Health Hazards*

Specific health hazards vary depending on the type of work performed and the working conditions.

*Biological*

Yeast, bacteria, and viruses may be transmitted in the work environments of hairdressers and laundry cleaning workers.

*Chemical Hazards*

Workers may be exposed to dyes, hairsprays, solvents, specific chemicals, pesticides in the agriculture industry, and so on. Chemicals used in the electronics industry may cause skin disorders.

*Physical Hazards*

Workers in the textile industry may be exposed to noise, radiation, dust, fumes, excess heat, and humidity.

*Musculoskeletal*

Office workers may suffer from repetitive strain injury.

*Visual Problems*

Eye strain, headache, and blurred vision is associated with work using video display units.

*Reproductive Hazards*

Reproductive problems may result from exposure to chemicals and radiation. For example, battery workers may be exposed to lead, and electronic plating workers may be exposed to mercury. Spontaneous abortions are more frequent among workers in the electronics industry.

*Cancer*

Higher cancer rates are found among workers in the asbestos industry, while the prevalence of cancer in other industries is not well documented.

*Family Harmony Hazards*

Many industries are located in strategic places such as industrial complexes to meet the needs of the industry and to obtain cheap rent. The family life of women workers may be disrupted if women have to move close to their place of work.

Managers and executives also face occupational health issues, and inroads and successes in this area will greatly empower women in other levels of the workforce. There has been very little work done in this area. The finding of Cooper and Melhuish in 1980 and 1984 found that Western women executives were subjected to a greater number of work related mental and social hazards. However, professional women tended to have higher self-esteem, and better mental health, than homemakers of a similar educational status. The health hazards of managers and executives may lead to a higher incidence of coronary heart disease, migraine, nervousness, and divorce. While female and male managers and executives face common stresses, the additional pressures that women face from the home and social environments lead to compounded health risks.

Gains for women executives in the field of occupational health and safety may also lead to the empowerment of the majority of women who are in lower levels. As women leaders become more sensitive to gender issues, the socialization process in corporations, professional bodies, and governments will change. Women need to develop skills to deal with politics, and need to participate and assert their rights. Women must also encourage and support other women in the workforce.

While in 1994 the Malaysian government provided tax deductions for organizations that provide childcare facilities, the response to date has been lukewarm. Concerned about this, I recently asked a doctor from a very established bank why he did not consider starting a childcare centre for his staff. He was very surprised at the question, and said that nobody from his organization had asked for it! This example highlights the importance of ensuring that employees are knowledgeable and assertive of their rights concerning occupational health and safety.

The Occupational Health and Safety Act passed in Malaysia in December 1994 specifically states that the members of the National Advisory Council to the minister must be represented by at least one woman. This is a step forward to improve the health and safety of women workers. While all involved industries must have an occupational health and safety committee to monitor and supervise the workplace, there is no stipulation stating that these committees must have women representatives. This gap must be addressed in the near future.

There are a number of research priorities that must be addressed. For instance, it is important that there are sufficient human resources trained in occupational health and safety issues. What is the current situation? What recommendations should be made concerning education and training programs? To what extent is the childcare incentive working? To what extent are both male and female workers, the community, and the public at large, knowledgeable about occupational health and safety issues?

The Malaysian Women's Affairs Division, under the Ministry of National Unity and Social Development, has a policy to enhance the status of women, and is responsible for identifying priority research areas for women. It has held several seminars on gender sensitization, as

well as seminars about how to incorporate a gender perspective in development planning, especially within the government sector. While issues such as maternal health, reproductive health, education, economics, social rights, and domestic violence have been addressed, it has not yet focused on occupational health and safety issues facing women. However, the Malaysian Women's Affairs Division is open to research proposals concerning gender, occupational health, and sustainable development.

As mentioned earlier, occupational health cannot be based solely on a scientific framework; it must encompass the various aspects of wellness including mental health and family health. Non-clinical parameters are more difficult to define. Occupational health and safety is also very much related to social organizations of medical care and the distribution of power in societies. A multifaceted approach will lead to a better understanding of the issue. As more and more woman enter the workforce in the Asian Pacific region, challenges concerning women's health and safety in the workforce must be taken up in a cohesive structured manner, so that women will be duly protected.

# Selected Aspects of Women's Working Conditions in Vietnam

**Nguyen Ngoc Nga**[1]

This report reviews research studies on Vietnamese working women carried out by the National Institute of Occupational and Environmental Health (NIOEH) in Vietnam.

There is an increasing number of women working in the formal sector throughout the world, including Vietnam. The percentage of women in the workforce of Vietnam increased from 5% in 1955, to 27.8% in 1965, and to 45% in 1985. Today, women comprise over 50% of the workforce. In some occupations, women make up the majority of workers (see Appendix I), for example:

- Education: 66%
- Medical/Science: 72%
- Clothing industry: 74%
- Weaving: 85%

## *Some Physiological Characteristics of Vietnamese Female Workers*

Table 1 illustrates the physiological parameters of female workers, compared to male workers. At the same age and weight, female musculo-force is lower than male musculo-force by 30-35%. The amount of red blood cells, hemoglobin, and blood volume in women is lower than in men. Therefore, to carry out physical work, women's cardio-frequency must be higher at the same working power. PWCmax of men is about 2500 Kcal/8 hours, while the PWCmax of women is only 1800 Kcal/8 hours.

[1] National Institute for Occupational and Environmental Health, Hanoi, Vietnam.

**Table 1. Some Physiological Parameters of Vietnamese Female Workers**

| Parameters | Male | Female | Ratio(%) |
|---|---|---|---|
| Height (cm) | 160 ± 4.8 | 150 ± 4.2 | 93 |
| Weight (kg) | 50 ± 4.0 | 45 ± 4.5 | 90 |
| Chest-circle (cm) | 78 ± 5.0 | 74 ± 4.0 | 95 |
| Vital Capacity (BTPS) | 3.9 ± 0.5 | 2.7 ± 0.4 | 69 |
| Musculo-force (kg): - Hand | 34.0 ± 6.0 | 22.5 ± 4.8 | 66 |
| - Body | 93.5 ± 16.5 | 58.0 ± 12.6 | 62 |
| Cardio-frequency (beat/mn) | 70 - 80 | 75 - 85 | |
| Blood Volume (ml/kg) | 71.2 ± 6.0 | 61.0 ± 7.5 | 86 |
| Red cells (million/ml) | 4.2 ± 0.4 | 3.8 ± 0.2 | 90 |
| Hemoglobin (g/l) | 14.6 ± 0.6 | 13.2 ± 0.5 | 90 |
| $VO_2$ max (ml/kg/mn) | 49.1 ± 5.8 | 39.5 ± 5.9 | 80 |
| PWCmax (kcal/8 hours) | 2500 | 1800 | 72 |

## *Working Conditions*

### *Microclimate*

The working conditions of women may include excessive heat, excessive humidity, working in the open air (e.g., construction, farm-work, salt-production), working underground or in a tunnel (e.g., mining, construction), or in a workshop (e.g., pencil making, weaving) (Table 2). In many workplaces, women are involved in heavy physical work.

Research carried out by the National Institute for Occupational and Environmental Health found that when the environmental temperature increased by 10°C (from 25°C to 35°C), the working capacity of women declined by 18%. Working at high temperatures during the work shift caused workers to sweat 0.3 - 0.4 litres/hour, and sometimes over 0.5 litres/hour.

### *Physical and Chemical Factors*

In many factories researched by the NIOEH, the equipment and machines were old, and working positions were not well organized. Many hazardous factors exceeded recommended standards by many times.

**Table 2. Microclimate**

| No | Type of work | Air temperature (°C) | Humidity (%) | Air velocity (m/s) |
|---|---|---|---|---|
| 1 | Concrete making in the tunnel | 30.5 - 32.0 | 86 - 96 | <0.5 |
| 2 | Weaving | 33.4 - 40.0 | 50 - 83 | |
| 3 | Shovelling coal underground | 30.0 - 31.0 | 98 - 100 | <0.5 |
| 4 | Drying pencils | 40.0 - 42.0 | 50 - 60 | |
| | Working in the open air | 30.0 - 35.0 | 70 - 85 | |

**Table 3. Working Environment in Some Small-Scale Industries**

| Factors | Number of sample | Number of samples exceeding recommended standards | Percentage (%) |
|---|---|---|---|
| Microclimate | 38 | 13 | 34 |
| Dust | 33 | 29 | 88 |
| Noise | 75 | 26 | 34 |
| Toxic gases | 34 | 9 | 26 |

Dust was the most frequent type of pollution at workplaces. Many samples collected from workplaces exceeded recommended standards by 2-20 times, and sometimes by much more (Table 3).

New technological processes often led to a marked reduction in pollution levels in the work environment (e.g., reduction in dust, toxic gases, and noise). However, in many places, hazardous factors were still over recommended standards. Because of the advantage of new technologies, many heavy physical operations were eliminated.

When new imported technologies operated in closed rooms with air conditioners, the microclimate was generally comfortable. However, air quality was sometimes poor. Our investigation showed that in some workshops, the concentration of $CO_2$ was 2-4 times higher than recommended standards. Additionally, the difference between the outside temperature and the room temperature was sometimes over $10^0C$ (for instance, in the summer) which could adversely affect the health of workers (Table 4).

While there has been an increasing use of video display terminals (VDTs) in Vietnam, there has been little research on potential harmful effects of VDTs. The results of our study showed that there was a significant low-frequency electromagnetic field around VDTs at 52-90 centimetres from the screen, which posed health hazards.

**Table 4. Work Environment in Some Industries with Imported-Technologies**

| | Microclimate | | | Dust | Noise |
|---|---|---|---|---|---|
| | Temperature (°C) | Humidity (%) | Air velocity (m/s) | (m/m³) | (dab) |
| 1. Cotton factory | | | | | |
| - Outside | 30 - 32 | 65 - 70 | 0.2 - 1.2 | | |
| - Inside | 26 - 27 | 54 - 59 | 0.2 - 0.5 | 3.2 - 13.4 | 72 - 94 |
| 2. Textile mills | | | | | |
| - Outside | 30 - 32 | 65 - 70 | 0.2 - 1.2 | | |
| - Inside | 29 - 30 | 60 - 65 | 0.2 - 0.5 | 6.4 | 78 - 90 |
| 3. Candy factory | | | | | |
| - Outside | 29 - 33 | 86 - 87 | 0.2 - 1.5 | | |
| - Inside | 31 - 37 | 84 - 94 | 0.2 - 1.2 | 0.9 - 1.2 | 71 - 89 |
| 4. Shoes factory | | | | | |
| - Outside | 30 - 33 | | | | |
| - Inside | 26 - 35 | | | 0.7 - 4.8 | 74 - 95 |
| 5. Printing house | | | | | |
| - Outside | 33 - 37 | 76 - 80 | < 0.5 | | |
| - Inside | 24 - 26 | 59 - 64 | < 0.5 | | 76 - 101 |
| 6. Post office | | | | | |
| - Outside | 33 - 37 | 76 - 80 | < 0.5 | | |
| - Inside | 27 - 29 | 52 - 57 | < 0.1 | | |

## *Work Load*

In Vietnam, heavy physical work is common. In general, the loads associated with agricultural and industrial work were the heaviest. Loads carried on the head were found to detrimentally affect the vertebrae of workers (especially in the neck region). The X-ray examination of female workers who carried coal on their heads showed that 28% suffered from vertebrae degeneration while 10.6% suffered from genital prolapsus.

## *Occupational Diseases and Work-Related Symptoms*

In Vietnam, there are sixteen compensated occupational diseases. Among these recognized diseases, silicosis, noise induced hearing loss (NIHL), and skin diseases were most frequent. Table 5 illustrates the number of patients suffering from silicosis and noise induced hearing loss, as diagnosed by the National Institute for Occupational and Environmental Health over the past few years.

**Table 5. Silicosis and NIHL**

| | Silicosis | | | NIHL | | |
|---|---|---|---|---|---|---|
| | Male | Female | Total | Male | Female | Total |
| | | | | | | 262 |
| Examined persons | 958 | 2797 | 3755 | 228 | 34 | 56 |
| Number of patients | 204 | 207 | 441 | 46 | 10 | 21.31 |
| Percentage (%) | 21.29 | 7.4 | 10.09 | 20.17 | 29.41 | |

There is an increasing use of pesticides in Vietnam. While there were few cases of acute poisoning among those exposed to pesticides, in some cases pesticides could be traced in breast milk. Measures to prevent exposure to pesticides should therefore be taken.

In many occupations, musculo-skeletal disorders might occur as a result of the monotonous motion of small muscle groups combined with adverse working posture (Table 6).

**Table 6. Musculo-Skeletal Complaints after a Work Shift at a Printing House and a Post Office**

| Point | Percentage of workers who complained |
|---|---|
| Nape | 38.9 - 56.9 |
| Shoulder | 48.0 - 55.6 |
| Back | 50.0 - 77.8 |
| Chest | 44.4 |
| Limbus | 47.2 |
| Wrist | 52.8 - 83.3 |
| Finger | 52.8 - 72.2 |

The X-ray examination of women who had worked more than 10 years in a prolonged sitting position showed many cases of degeneration of the $L_4$ - $L_5$ vertebrae.

## *Housework*

An investigation of the amount of hours spent doing housework by the workers found that women spent from one to six hours a day engaged in housework activities, which sometimes involved heavy physical work. Increased levels of housework were associated with having children.

## *Conclusion*

Results from research carried out by the National Institute of Occupational and Environmental Health showed that the health of women workers in Vietnam was affected by a wide range of factors.

Women workers were exposed to hazardous agents in the workforce such as heat, toxic gases, noise, dust, and chemicals. The major problems in small-scale industries and in old factories were dust, noise, bad microclimate, and physical load. Characteristics of work in industries with new imported technologies included the monotonous motion of small muscle groups, poor air quality in working rooms, exposure to video display terminals, and a significant difference in indoor and outdoor temperatures.

Women often engaged in heavy physical work, particularly in the industrial and agricultural sectors, as well as in the transportation sector. Heavy physical workloads combined with improper work posture resulted in a remarkable number of injuries. Additionally, women had significant responsibilities within the household which compounded their workloads.

## Appendix I

### Percentage of Female Labour Force

| No | Occupation | Percentage (%) |
|---|---|---|
| | **Total** | **52** |
| 1 | Stat./Fin./Eco./Plan | 48 |
| 2 | Technical/Staff | 25 |
| 3 | Agriculture/Staff | 31 |
| 4 | Science/Education | 66 |
| 5 | Arts/Culture | 35 |
| 6 | Medical/Science | 72 |
| 7 | Law | 23 |
| 8 | Secretary/Clerk | 46 |
| 9 | Energy | 22 |
| 10 | Mining | 31 |
| 11 | Metallurgy | 19 |
| 12 | Electro/Mechanics | 15 |
| 13 | Chemical Industry | 44 |
| 14 | Paper Industry | 52 |
| 15 | Building/Glass/Material | 51 |
| 16 | Wood Industry | 27 |
| 17 | Printing/Publishing | 50 |
| 18 | Weaving Industry | 85 |
| 19 | Clothing Industry | 74 |
| 20 | Leather/Wool | 51 |
| 21 | Food | 55 |
| 22 | Building | 23 |
| 23 | Agriculture | 53 |
| 24 | Forestry | 54 |
| 25 | Fishing | 14 |
| 26 | Transport | 0.9 |
| 27 | Telecommunication | 25 |
| 28 | Public Service | 28 |

# Abortion Experiences of Korean Women and the Implications for Public Policy

**Kasil Oh**[1]

## *Introduction*

Korea is a small country with a population of more than 43 million people living on a peninsula of less than 100,000 km$^2$. Buddhist and Confucian beliefs have strongly influenced the living and thought patterns of Koreans. Today there are also increasingly large numbers of Protestants.

During the early 1950s, the Korean war resulted in the total destruction of the country. However, the population was able to recover completely from the war. The country's rapid industrialization and economic development since the 1970s is a model to other developing countries. Industrialization and economic development have affected overall living conditions, and have greatly influenced the thought patterns and value systems of the population.

The successful population control policy in Korea is a result of purposive social action. The burden of contraception has been accepted by women, with 77% of contraception being practised by women. There is a high rate of induced abortions resulting in many physical and psychological health problems. In addition, the practice of selective abortion has resulted in a sex imbalance due to the strong son-preference in Korean society.

## *Family Planning in Korea*

In the 1960s, Korea had one of the highest population densities in the world. In 1961, the Korean government designated family planning as one of its top priority policy areas in its five year economic development plan. The success of this family planning program is well documented. Fertility rates were reduced from 3% to 1%, and Korea has been showing less than replacement rates since 1990. Policy makers in Korea are now discussing the possibility of revising the longstanding fertility control program (Kong et al. 199O). Because the government was so eager to meet its objectives of reducing the size of the population, it did not pay enough attention to the contraceptive methods being utilized. Many policy makers feel that it is now time to explore more effective and safe methods of contraception in Korea (Kong et al. 1992).

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Three hundred million women worldwide do not want any more pregnancies, yet do not use effective contraceptive methods. Korean women are no exception. Many Korean women choose abortion as a way to limit the number of children they have because they consider the various contraceptive options to be too complicated, to have too many side effects, or because they think their male partners will be unwilling to use them (e.g., condoms).

According to 1991 national data, 53% of all Korean women of childbearing age had experienced at least one induced abortion. One can assume that mortality and morbidity rates among these women are high. Many induced abortions are performed because the sex of the fetus is thought to be female. Recent medical technological advances now allow for the identification of fetal sex during the first trimester of pregnancy. As a result of the high number of abortions of female fetuses, there is now a severe imbalance of the sexes.

It is difficult to estimate the exact number of abortions in Korea because abortions are carried out mainly in private physicians' offices. Secretive and unsafe abortion practices are dangerous to the psychological and physical health of women. This is a serious women's health issue.

This paper reviews existing qualitative and quantitative studies concerning the abortion experiences of Korean women. Data was extracted from the biannual national survey by Kong in 1992, and from in-depth interviews of women who have experienced induced abortions (Lee and Koh 1994; Lim 1991). The results presented in this paper may be used for the development of family planning and women's health policies.

## *Facts about Induced Abortion*

According to government reports, in 1964, 7% of women of childbearing age (15-44 years old) had experienced at least one induced abortion. By 1967, this number had doubled to 14%. It further increased to 30% in 1973, and then to 53% in 1991.

Another study reported that the total marital induced abortion rate (TMIAR) among currently married women of 20 to 44 years of age was 1.2 in 1964, 2.1 in 1973, 2.9 in 1979, and 1.9 in 1991. More than half of those women who reported that they had abortions had repeated abortions.

In 1990, the abortion rate was highest among 15-19 year old women (200/1000), and lowest in the 45-49 year age group (2/1000) (Table 1). There are differences between women residing in urban and rural areas. While the overall rate was 2.9 per woman, the abortion rate of women residing in the urban area was 3.1, while that of rural residents was 1.8.

**Table 1. Age-Specific Rate of Marital Induced Abortions in 1990.**

(Unit: Thousand)

| Age | Total # (in 000s) | Urban # (in 000s) | Rural # (in 000s) |
|---|---|---|---|
| 15-19 | 200 | 235 | -- |
| 20-24 | 186 | 187 | 181 |
| 25-29 | 112 | 116 | 96 |
| 30-34 | 60 | 61 | 52 |
| 35-39 | 21 | 22 | 22 |
| 40-44 | 6 | 4 | 11 |
| 45-49 | 2 | 3 | -- |
| Total martial induced abortion rate | 2.935 | 3.140 | 1.810 |

Another new trend is the growing number of unmarried women receiving abortions. According to a report from private physicians, approximately 33% of total induced abortion patients were unmarried women. The same study reported that 94.4% of abortions for women between 15 to 19 years, and 71.2% of abortions for women between 20 to 24 years, were for unmarried women.

Why do Korean women have such a high rate of induced abortions? Many researchers have pointed out that the results-oriented family planning program is the source of the problem. Policy makers, eager to meet fertility control goals, ignored maternal health and ethical issues. Family planning workers recommended induced abortions to the majority of women experiencing unwanted pregnancies. Many women then did not use any contraceptive methods to avoid unwanted pregnancies. As Table 2 indicates, the main reason given for induced abortion is the termination of unwanted pregnancies.

The studies revealed that there were no strong social or religious objections in Korea to induced abortions. Over 88% of women who had experienced an induced abortion in the past stated that they would have an abortion again in the case of an unwanted pregnancy, while 66.9% of women who had never had an abortion stated that they would have an abortion in the case of an unwanted pregnancy. Some of the characteristics associated with acceptance of an induced abortion were increased age, less education, more children, and no religious preference.

**Table 2. Reasons for Induced Abortions (%)**

| Number of Abortions | 1 | 2 | Over 3 |
|---|---|---|---|
| **Reasons** | | | |
| Unwanted pregnancy | 59.2 | 73.4 | 85.0 |
| Health problems | 15.2 | 9.0 | 6.4 |
| Spacing | 13.2 | 8.1 | 2.6 |
| Others | 12.4 | 9.5 | 6.0 |
| **Decision made by** | | | |
| Self | 27.8 | 27.9 | 29.7 |
| Agreement of the couple | 70.8 | 71.3 | 70.0 |
| Others | 1.4 | 0.8 | 0.3 |

Most of the respondents agreed that induced abortions should be performed if the pregnancy is the result of rape or sexual violence. About 85% of the respondents agreed that unwed women should have abortions. Surprisingly, 31.9% of women who had at least one abortion, and 24.8% of women who never had an abortion, stated that it was acceptable to have an abortion if the fetus is known to be of the unwanted sex.

In Korea, many people do not differentiate between termination of pregnancy and avoidance of pregnancy. In particular, older, less educated women with large numbers of children still believe that abortion is a contraceptive method. Furthermore, about 20% of women with higher education levels, as well as Catholics, also had the same misconception.

## *Abortion Experiences*

The high rate of induced abortions among Korean women has been overlooked by Korean policy makers. While they have been eager to quantify their successes, they have paid less attention to women's experiences, feelings, interests, and needs.

Abortion cannot be separated from everyday life. The high rate of induced abortions among Korean women is related to their rate of sexual activity and contraception use. Thus, it is necessary to understand sexual patterns. Contraceptive failure resulting in an unwanted pregnancy may lead to an abortion. To encourage increased contraceptive use, the side effects and inconveniences associated with contraceptives should be reduced. Many women complained about difficulties associated with less than perfect methods of contraception.

> I cannot adjust to the loop. When I had the loop inserted, my period was very heavy. I felt weak and tired all the time, so I got it removed. Then I became pregnant. I had to have an abortion.

> When I took oral pills, I felt like I was pregnant... constant nausea and vomiting and I felt dizzy. I could not take it. I tried a loop and I had terrible back pain with it. Then, we tried a condom, but it caused a vaginal infection. So...I had to have two induced abortions.

Many women attempt to use the rhythm method after they experience difficulties with more effective contraceptive methods. The rhythm method is often unsuccessful because women do not have time to calculate their ovulation cycle, and men, interested primarily in sexual intercourse, rarely ask women if it is a "safe day" to have intercourse.

Many Korean women believe that contraception is a women's responsibility, and that it is too much of a sacrifice for men to share this responsibility. Most women therefore do not ask their male partners to use contraception. Another fact that interferes with women's assertiveness in contraception is societal attitudes toward women's sexuality. Because it is considered to be improper for women to show any sexual desire, it is almost impossible for women to ask men to use contraception. Acknowledging their readiness to use contraception means that they are eager to have intercourse.

> I do not want to purchase condoms when we are out of them. It looks like I am actively seeking intercourse or show too much interest in sexual activities.

Many women who have experienced abortions do not enjoy sexual intercourse, and fear that they may get pregnant again. However, they do not refuse their husbands' request for sex, since many believe that "it is a married woman's duty to meet her husband's sexual needs."

> I often avoided and refused, ...sometimes did not respond at all. Then there was marital conflict....but I could not refuse my husband because it is my duty as a wife.

Frequent refusal of intercourse by the wife can cause marital conflict and the husband may have adulterous relationships outside of marriage. Because of this fear, many Korean women cannot refuse unprotected intercourse or ask their husbands to use contraception. Also, many women believe that male sexual desire is a natural uncontrollable instinct.

> It's not just me. Many friends told me that they risk pregnancy and have intercourse because they are afraid that their husband will find someone else if they refuse.

These women would rather risk unwanted pregnancies and induced abortions than lose their husbands. In this patriarchal society, male virility represents male authority and power, and should not be damaged. This is one of the main reasons why the vasectomy rate is so low even though it has been proven to be safe. Many women expressed their fear of having an induced abortion, as well as shame related to the failure of contraception. This shameful feeling is rooted in the belief that the responsibility of contraception belongs to women only, and they therefore did not perform their duty well enough. When a woman experiences an

unwanted pregnancy, she often faces the blame of others as well as the burden of pregnancy. Some women only take on the responsibility of self-care after they have experienced several unwanted pregnancies and abortions.

> After my fifth induced abortion, I finally had enough sense to have a tubal ligation.

Many women expressed complex feelings after the abortion, including depression, loneliness, isolation, fear, anger, shame, and the need to be heard and understood. Watters (1980) stated that it is better for a woman's health to terminate an unwanted pregnancy than to have an unwanted baby.

> I never felt guilty since I never thought I was killing a human being. I think it is more responsible to terminate a pregnancy than to have a baby for whom I cannot give better care.

Because the responsibility of childrearing in Korea belongs primarily to women, women may feel free and safe after an abortion. Many women consider abortion to be part of the natural process married women have to go through. Many feel helpless in their sexual relationship with their husbands, and feel obligated to follow their husbands' desires.

## *Problem Statements*

There is a close relationship between abortion practices and societal ethics and sexual norms. A lack of information on effective contraception options leads to unwanted pregnancies, and often induced abortions. Many women in Korea think an abortion is an easy solution when faced with an unwanted pregnancy.

Medical advances allow many couples with no sons to identify the sex of the fetus, to have an abortion if the fetus is female, and to have at least one male child (Kim 1990). When young mothers have reared the desired number of sons, they usually decide to have a tubal ligation. This practice has created a severe imbalance in the sex ratio.

From 1981 to 1988, the male to female sex ratio increased 9.7%, and further increases are expected. Some of the factors associated with this sex imbalance are: a patriarchal family system based on Confucian beliefs, capitalistic ethics, a lack of a feminist perspective, a permissive attitude toward induced abortion, and structural problems related to the unequal social status of females in relation to males.

Filial piety is the most important value system in Korea. Continuation of the family name by the male descendant is a key aspect of filial responsibility. More than half of all Korean women feel it is their major responsibility to produce a male heir who will continue their husband's family name, and they feel guilty and shameful when they fail to do so. These women feel that it is their fault if they do not have a son.

Some have argued that rapid economic development based on capitalism has also contributed to the sex imbalance. The Korean government set out an economic campaign focused on having a better life. The family planning campaign also placed a strong emphasis on small

family size, using the phrase, *two children, the better life*. In a society which places great importance on having a son in the family, the emphasis on having a small family can lead to increased sex imbalances.

The lack of a feminist perspective in family planning policies is another reason for the emphasis on abortion. Generally, there are two types of policies related to women. One type of policy is aimed at women, while the other uses women to meet its goal. Obviously, the Korean family planning program fits into the latter category. While the family planning program has shown great success in its results, the policy makers did not consider women's welfare in their planning, implementation, and/or evaluation process.

The permissive attitude toward induced abortions in Korea is also an important factor. In Korea, induced abortion was legally prohibited in 1953. However, in 1973, the law was amended to permit abortions before 28 weeks of gestation in the case of a medical problem. The Korean government then moved to accept abortion as an effective method for fertility control. This permissive attitude toward abortion was a worldwide trend at that time, due to population pressure in many countries. According to one report, the fertility reduction in Korea from 1960 to 1975 was equal to the rate of induced abortion. There is no difference in the attitude toward abortion between men and women in Korea. When men and women were asked, "Do you have to give birth to the child just because you are pregnant?", 75.7% responded negatively. Almost half of all couples reported that they thought their abortion was a wise decision.

Korea has been slow to accept gender equality. The Minister of Political Affairs has attempted to strengthen administrative policies related to women and to increase women's political participation. Following this policy, family welfare divisions were opened at city and county levels. Also, a review board was established for policies related to women. Since then, several important policies have been written and implemented.

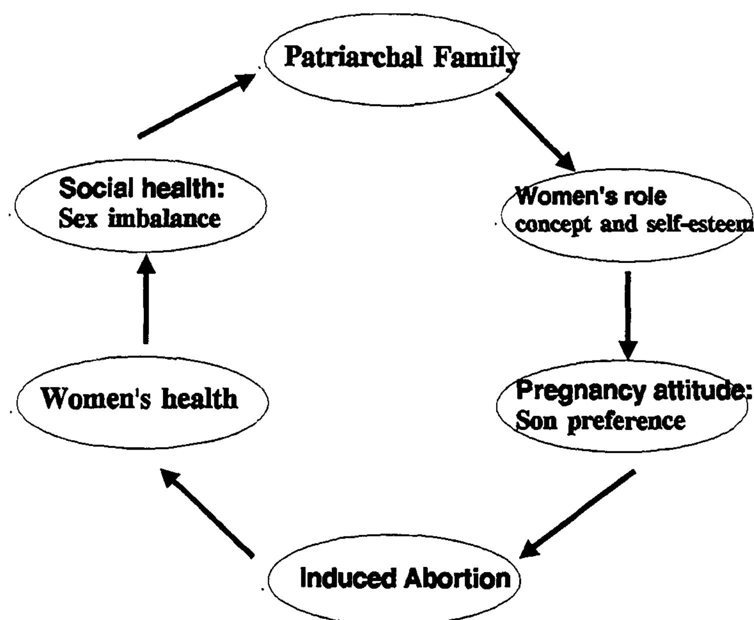
Some of the important legal and policy changes were the Equal Employment Law in 1987, the Equal Inheritance Law in 1989, and the Infant and Child Protection Policy to increase the number of daycare centres in low income areas. These laws and policies are important first steps to amend longstanding gender inequalities in Korea, and to provide equal opportunity to men and women for education, employment, and inheritance. However, too many problems still exist in the legal and structural areas to claim true equality. The 1989 family law still permits a patriarchal system. The employment and social systems interfere structurally with women's career advancement and limits those occupations in which women can work. These problems may require changes in societal attitudes as much as changes in policies. Some women stated that, because they did not want their daughter to experience the same discrimination that they experienced, they were hesitant to have a daughter.

## *Conclusion*

As shown below, the high rate of induced abortion among Korean women is a circular process.

Policies must consider a number of issues, such as increasing women's self-esteem and changing the patriarchal value system. Women-oriented policies should not only solve the problem of societal suppression of women's rights, but should also secure the free and equal participation of women in social and economic activities. As Mr. Garti, Secretary General of the UN, proclaimed,

**Figure 1** Induced Abortion Among Korean Women




> We have many tasks to improve the status of women around the world. It is imperative for us to understand the complete roles of women and establish policies to include them in social development.

## *Suggestions for Action*

- The previous family planning program was a government policy. It is time to develop multidimensional individualistic, family, and societal approaches. It is necessary for women to feel that they are important members of society and are responsible for the health of the future society.

- It is necessary to provide public education which accepts contraception as part of everyday life. To do this, the needs and demands of new generations must be understood.

- A family welfare program should include family education to promote family development and health.

- Changes should be made in the social structure to promote full participation of everyone in society, including equal access to employment and to decision-making processes.

- Social policies should be developed to solve the consequences of sex imbalances and to prevent further sex imbalance associated social problems.

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# Gender, Reproductive Health, and Sustainable Development: The Philippine Context

**Trinidad S. Osteria**[1]

## *The Gender Basis of Reproductive Health Analysis*

The early 1990s witnessed a proliferation of literature on gender issues in health development. Demographers and social scientists examined the relative role of female status, autonomy, patriarchy, and rights on demographic changes (particularly fertility and mortality). Equality of the sexes implies bilateral decision-making with regard to many domestic issues. Female status is reflected in the degree of women's access to and control over material (including food, income, and land) and social resources (knowledge, power, and prestige) within the family, in the community, and in society at large (Dixon 1978). Gender stratification indicates that traditionally males make the decisions and control the resources of society such as wealth, knowledge, technology, skills, food, health, and prestige (Safilios-Rothschild 1980). Mason (1984) extricated the areas where gender inequality pervades: (1) prestige; (2) power; and (3) access to and control over resources (Mason 1984). Gender inequality is viewed as a multi-dimensional phenomenon which serves as the basis for the model that encompasses the determinants and interrelations in reproductive health.

- The extent of the male's control over the female is a dimension of gender inequality deemed as the proximate variable in health changes. The household becomes the decision locus regarding reproduction - the focal point for resource generation and distribution.

- Male dominance is mirrored in the differential control over material and social resources largely within the economic and kinship context.

- Prestige is epiphenomenal. While it may be influenced by the resource inequality of the sexes, it is not regarded as a causative factor in such disparity.

Class intersects gender in demarcating female mortality, morbidity, and health status. Some gender-related variables that would have implications on reproductive health are differential mortality, age at marriage, preference for sons, property ownership and inheritance, village exogamy, patrilocal marital residence, sexual double standard, emphasis on women's

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physical appearance, egalitarianism in the husband-wife relationship, differentials in employment opportunities, labour force participation rate, concentration in the informal economic sector, occupational/income differences, education, and access to resources (Mason 1984).

Female autonomy and seclusion are linked to eventual contraceptive use. The husband's decision about the number of children will have an impact on fertility control. The choice of contraception and its use hinge largely on the equality in the relationship between the spouses. In a *machismo* culture, high fertility is equated to sexual potency and female subordination, although there are situations where fertility decisions are left to the wife, together with child raising, as a result of gender delineated roles (Mason 1984).

There are uncertainties in women's reproductive lives, so that making decisions about their own health becomes difficult. Often they feel that life events are not within their control. Few understand much about their own physiology, let alone controlling their fertility. Even after several years of marriage and children, they understand little about reproduction except that it is related to sexual relations. When husbands disapprove of their wives practising contraception, women would hardly defy this decision (WHO 1994). The study of gender issues in reproductive health is clarified by the discrimination against women when their status depends on their capacity to bear children. When women are prevented from enjoying their legal, social, and cultural rights, they are disadvantaged with regard to access to health care. Early marriage and sexual initiation lead to exposure to sexually transmitted diseases. Adolescent pregnancy contributes to lower infant survival, a larger number of children, and psychosocial problems (Ford Foundation 1991).

## *Reproductive Health Defined*

The 1994 International Conference on Population and Development (ICPD) defined reproductive health as:

> A state of complete physical, mental, and social well being and not merely the absence of disease or infirmity. It therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights of men and women to be informed and have access to safe, effective, affordable, and acceptable methods of family planning of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (United Nations 1994).

The Programme of Action stemming from the ICPD stressed the importance of the advancement of gender equity, the empowerment of women, the elimination of all kinds of violence against women, and ensuring their ability to control their own fertility. The rights of women are an inalienable, integral, and indivisible part of universal human rights. Their

full and equal participation in civil, cultural, economic, political, and social life and the eradication of all forms of discrimination on grounds of sex are priority objectives (United Nations 1994).

## *The Situation of Women in the Philippines*

The traditional role of women in Philippine society is motherhood. In childhood, the ascribed role for girls is mainly housekeeping. Mothers are the primary care givers. More recently, they are able to participate in the economic, socio-cultural, and political development of the country. In the 1990 census, there were 30 million females, half of whom were of reproductive age (between 15 and 49 years). Of those in this age group, 61% were married. Female life expectancy in 1990 was 66 years, four years higher than that of males. Females live longest in the National Capital Region and Central Luzon. The Food and Nutrition Survey in 1993 revealed that the nutritional intake of pregnant and lactating women was less than the recommended daily allowance, except for niacin. Aside from inadequacies in energy and protein, Filipino women also suffer from micronutrient deficiencies. Anemia occurs among 45% of pregnant women and 51% of lactating mothers (Dixon 1978).

## *Gender-Power Relations Within the Philippine Context*

Within the Philippine context, the fundamental elements in husband-wife relations are love, understanding, trust, and affection. Filipino wives with inadequate economic support find solace in a large number of children as old age security. The relative freedom enjoyed by women is shaded by another phenomenon — the double standard of morality which frequently results in infidelity by the Filipino male. A male in the Philippines is valued for perpetuating the family name. Since the father is often out of the house, the male child is attached to the mother who then spoils him. Maleness is associated with the role of bread-winner and masculinity, the latter evidenced in the ability to procreate. Men are more prone to gamble, indulge in excessive drinking, and engage in illicit relationships. Women are believed to approximate the ideal of womanhood - closeness to God, hardworking, faithful, and loyal (UNICEF 1993). Rapid urbanization leads to the nucleation of the family with equal decision-making power between husband and wife. Romantic love and freedom of choice are the operating principles in mate selection. Filipinos tend to be endogamous. Early marriage is linked to the perceived value of children, while education and employment opportunities raise the age at marriage or reduce its probability. Husbands and wives have their own dominant areas of influence. Decisions regarding household matters such as domestic chores, child care, budgeting, and expenditures are generally the autonomous domain of the wife. Decisions regarding livelihood and the provision of economic support are under the control of the husband. Egalitarianism is inherent in the bilateral nature of the kinship system that supports and protects the women. Children are viewed as gifts from God, an inherent component of marriage, and a joy to parents. They are living proof of male virility, a symbol of sexual potency, and old age security (Go 1993).

## *Reproductive Health Concerns in the Philippines: The Gender Dimension*

Women in the Philippines, particularly those who are poor, face a number of reproductive health problems, such as reproductive tract infections (RTIs), complications of pregnancy, fetal wastage, sexual violence, and poor maternal nutrition. The fact that many women still face reproduction related morbidity and mortality - both preventable - due both to social and economic factors and to gender-related antecedents, reveals a lack of access to adequate health services. The young woman who dies in first childbirth at age 15 likely incurred obstructed labour or haemorrhage associated with malnutrition or chronic anemia. Chances are, she received less food and health care than her husband. Few child survival or maternal and child health programs even recognize such gender differentials as a problem, let alone seek to combat them. The older, higher parity woman who dies in childbirth not only accumulated the disadvantages from adolescence, but may have been weakened or depleted by previous pregnancies. Lack of information about her physiology, sexuality, and reproductive health makes her vulnerable to both physical and emotional abuse. Equity and a strong sense of dignity are precluded (Greer 1987).

### *Adolescent Pregnancy*

During this difficult period in life's transition, the predominant health problems include respiratory, gastrointestinal, and viral diseases. Little attention has been given to the problem of malnutrition. Puberty means increased nutritional requirements which are recognized more for male adolescents, the potential work force. In the 1992 National Nutrition Survey, females aged 13 and above had higher rates of anemia and iodine deficiency than males. A mother with iodine deficiency runs higher risks of delivering a child with congenital anomalies, including mental retardation. Biologically and psychologically, the female adolescent is still unprepared for pregnancy. These handicaps remain for young mothers who survive subsequent pregnancies.

One important development in adolescence is coming to terms with one's sexual identity. Recognizing one's sexuality has been viewed as a male sphere in the country. The media presents sex as hedonism with the exhortation that it is "dirty" and "immoral." Drug intake is often initiated in adolescence. Although prevalent among urban males, an increasing number of females are also brought into this dependency (Tan 1992). The phenomenon of teenage pregnancy is a fast emerging concern. In the Philippines, adolescents constitute 20% of the population, and young women between 15 and 24 years of age make up almost half of the total women in the reproductive age group. The adolescent group (15-19 years) contributes less than 10% of all live births in the country. However, a large number of illegitimate births occur to women 15-24 years of age (Go 1993). The disadvantaged status of the teenage mother affects the health and welfare of her children. Her underprivileged position tends to be repeated in the lives of her daughters. The values imbibed as a result of the father's absence could have a direct effect on the child. This is compounded by society's rejection of mothers who are abandoned by their partner (Buvinic et al. nd). With

modernization and urbanization, traditional systems, such as extended family networks that once regulated sexuality, have eroded. Young people become exposed to diametrically opposed messages regarding sex roles from peers and the family.

The age of menarche has dropped due to improved nutrition. In the Philippines, the decline in onset of menstruation was notable - from 16 years in 1943 to 13 years in 1990. This indicates a lengthening of the reproductive span and earlier exposure to pregnancy. A relatively high prevalence of fetal loss among adolescents has been observed. Among those less than 20 years of age, 12.2% of the women reported some fetal loss (NSO 1993). Adolescent contraceptive use remains low. The Philippine National Demographic Survey in 1993 revealed that the contraceptive prevalence rate for women 15-19 years of age was 1.3%. In terms of usage of modern methods (oral contraceptives, IUD, injection, diaphragm, foam, jelly, condom, and sterilization), the percentage was 1.2 and current usage was 0.7%. For modern methods, oral contraceptives were used most frequently, followed by the IUD (NSO 1993). Of women aged 15-19, 7% had begun childbearing, 5% were already mothers, and 1% were pregnant for the first time at the time of the survey. At exact age 18, 10.3% had begun childbearing; at age 19, nearly a fifth of the group (19%) started building their family. Rural teenagers were twice as likely to experience teenage pregnancy as their urban counterparts.

In Western Mindanao, cultural factors impinging on women's roles and status partially explain the high proportion of teenagers bearing children (13%). Teenagers in urban areas with recreational and educational facilities have alternatives other than childbearing. Teenagers in the city may also have more exposure to information and methods regarding family planning and safe sex. The Philippine data showed that education tends to depress fertility in the earliest childbearing years. The percentage of childbearing was 15% among women with no education, compared to 2% among women who had higher education. Despite the overall low teenage pregnancy rate, the magnitude is immense in light of the fact that in the 1990 census, about 5.5% of the country's population were 15 to 19 years of age (NSO 1993).

### *Rape, Sexual Assault, and Violence Against Women*

Rape (criminal, incestuous, marital), prostitution, and wife beating have been considered as violence which completely subjugates women, leading to physical and psychological trauma. Gender-based abuse of women transcends social boundaries. It covers physical, sexual, and psychological assault by a male, sexual exploitation of female children, and prostitution. Violence is a deep-seated phenomenon which is traced to power imbalances between men and women, gender-role delineation, and social institutions. It cannot be addressed without examining the gender-based cultural beliefs and social structures that perpetuate such violence. The domination of women is considered the essence of masculinity. There are individual factors that predispose to violence: inebriation, childhood trauma, parental violence, and chronic poverty. The persistence of the subordination of women can explain the overall pattern of abuse (Population Council 1994).

In addition to husbands prohibiting women from seeking health care, violence often leads to unwanted pregnancy, sexually transmitted diseases, fetal loss, mental disability, and injury (Heise et al. 1994). Childhood sex abuse predisposes the adult to deviant behaviour, such as smoking, alcohol abuse, promiscuity, and prostitution. Abuse victims may suffer post trauma stress, depression, anxiety, sexual dysfunction, split personality, and obsessive-compulsive behaviour. Early sexual experience increases a woman's chance of future abuse through her lack of self esteem. This inhibits her use of contraception. When the husband disapproves of contraception, women either reject it or use it without his knowledge. Early sexual abuse is related to weak gender power relations. Rape can lead to unwanted pregnancy. In certain cases, violence occurs during pregnancy and this has been linked to poor maternal health, pregnancy complications, miscarriage, and stillbirth.

The 1993 Philippine Safe Motherhood Survey revealed the increasing social concern about domestic violence against women. Each respondent in the survey was asked if anyone close to her had ever been hit, kicked, slapped, or physically hurt. Furthermore, respondents who reported physical harm were asked if this was done during pregnancy. Results indicated that 10% of women had been physically harmed by someone close to them; one third of these abuses occurred during pregnancy. Domestic violence was most frequently reported by women less than 20 years of age (15%), and least frequently by the most educated respondents. The problem occurred in both rural and urban areas. Two-thirds of the respondents reported that they had been abused once or twice in their lifetime, with no difference by age, education, or residence. Fifteen percent reported being hurt 3 or more times a year. About 3% of the women reported ever having been physically forced to have sex with a man. Of the rape victims, 60% did not seek help. Close to one quarter sought assistance from relatives, and 15% went to a friend. Younger women were less likely to seek help. Respondents who did not participate in decisions on how household income was spent were more likely to report physical abuse by their partners compared to those who did (10% vs 5%). Women who reported that their husbands had sex with other women were more likely to report physical abuse (14% vs 4%) (NSO 1993).

The root of sexual violence is the social and cultural milieu of a country. Specific normative guidelines by gender are expressed in values and lifestyles that reinforce such sexual abuse. There is a general perception that "men are men" - prone to strong sexual desires which are uncontrollable and need to have an outlet, while women are expected to have relatively fewer sexual needs. Hence, sexual indulgence, polygamy, and adultery on the man's part are tolerated, and even viewed as a normal right. The commercial sex industry emphasizes the debasement of women.

### *Sexually Transmitted Diseases (STDs), Reproductive Tract Infections (RTIs) and HIV/AIDS*

Reproductive tract infections (RTIs) have been broadly defined to include sexually transmitted diseases (STDs), including endogenous infections caused by the overgrowth of organisms normally present in the reproductive tract (bacterial vaginosis and vulva vaginal

candidiasis), and iatrogenic infections due to unsafe abortion, and poor delivery practices, pelvic examinations, and IUD insertions (Brunham and Embree 1992). Extremely high prevalence rates of STDs are found among female commercial sex workers. STD levels in a population are related to the rate at which new sexual relationships occur in the population, rather than the number of sexual exposures per partnership. Despite the central importance of sexual behaviour in determining the epidemiology of STDs, surprisingly little is known about the quantitative aspects of sexual behaviour at the population level. Urbanization is of significance to the epidemiology of STDs, since it is linked to the large scale migration of women of reproductive age as well as the increase in commercial sex. Most pelvic inflammatory diseases (PIDs) are due to infections that start from the lower reproductive tract (e.g., gonococcal or chlamydial cervicitis and bacterial vaginosis) and result in irreversible sequelae such as infertility, ectopic pregnancy, and chronic pelvic pain. Induced abortion, stillbirth, or delivery facilitate the entry and spread of pathogens into the upper reproductive tract, leading to sepsis (Maheus 1992).

*The Gender Factor in RTIs*

The occurrence of RTIs has a strong gender dimension. Sexual contact, usually intercourse, is necessary for transmission. Thus, lessons learned on how to modify unsafe sexual practices can be applied to reduce the risks. Second, RTIs discriminate biologically against women. Anatomic differences make RTIs more easily transmissible, yet more difficult to diagnose in women. STDs are more frequently asymptomatic in women than men, and clinical symptoms are more subtle in women. Even worse, the long term complications in women are far more common and serious. The intrinsic gender breakdown also exists with unplanned pregnancy, as women obviously bear the entire burden of health risks associated with it. Third, a power imbalance between the sexes favours men. Women frequently have little power over when, with whom, and under what conditions sexual relations occur. This situation influences whether any preventive measures are used against RTIs. The woman's status depends on her role as a wife and mother. If RTIs impair her reproductive capability, she is stigmatized. Fourth, the groups most likely to be affected by RTIs and unplanned pregnancy are younger women with lower incomes. The poor represent those at greatest risk for sexually transmitted infections. If men are willing to use condoms properly, protection against transmission is ensured by preventing direct contact with semen, genital discharge, genital lesions, and infectious secretions (Cates and Stone 1992).

Avial (1992) has raised a number of gender related questions in reference to STDs:

- What are the prototypical sexual behaviour patterns associated with high STD rates?
- How accessible are STD health services for men and women?
- In societies marked by high STD rates, to what extent do gender power relations play a role?

- What are the implications of women's social status on preventive interventions at the individual and aggregate levels?

The unprecedented increase in Filipino female labour migration to the Middle East and adjoining Asian countries has implications on the transmission of RTIs. Literature abounds on the domestic violence and sexual abuse these women experience. Sexual exploitation occurs against many who leave to work as entertainers and domestic workers, and who are then forced into prostitution. In the early 1980s, domestic and international prostitution was considered a service industry that exposed Filipino women as well as street children to high risks of sexually transmitted diseases. Sex workers in the lowest social category tend to be more prone to the transmission of sexually transmitted diseases (Tan 1992). Current AIDS prevention programs for women have been designed exclusively to reach those in the sex industry. Women engaged in prostitution have been identified as one of the main sources for transmitting HIV and a risk group that threatens the general population (Carovano 1992).

The potential for perinatal HIV transmission, although infrequent, is of concern in a study in which over two-thirds of the prostitutes reported at least one pregnancy prior to diagnosis; of these, one-third continued with their pregnancy even after learning that they were infected with HIV-1 and were counselled on the risk of perinatal transmission (Manaloto et al. 1991). As of September 1990, the Philippine National AIDS Prevention and Control Program reported 191 HIV-AIDS cases. Among the 160 Filipino cases, 107 (67%) were women, most of whom were young and sexually active. Infected females can transmit HIV-1 heterosexually to their partners and pass the virus to the children through the perinatal route. A study of condom use among male sex workers revealed more cautious attitudes and increased condom use with male clients compared to female clients (Resurreccion n.d.).

*Fetal Wastage and Pregnancy Loss*

Women's sexual attitudes and behaviour influence pregnancy termination decisions. The Safe Motherhood Survey (1993) revealed an average number of 4.4 pregnancies per woman. Of this, 0.5 ended in wastage (0.4 for early loss and 0.1 for still births). The average number of live births was 3.9. Less educated women were more likely to experience a loss. The perinatal mortality rate between 1983 and 1993 was 27.1 perinatal deaths per 1000 stillbirths and live births. Of the 25% of respondents who suffered an early pregnancy loss, 7% reported having had an induced abortion. Since reporting increases with age and number of pregnancies, it is possible that abortion is used more as a means of avoiding unwanted higher order births. Nearly 10% of early pregnancy losses occurred among women with 4 or more pregnancies.

As to the method used, 67% of those who reported having an induced abortion took a bitter drink or tablet to resume their menses. The bitter concoction usually consists of roots and herbs and its effectiveness is unknown and may result in complications. Nine percent

reported having hard abdominal massage to resume their menses - a common practice among women with higher parity, low education, and residing in rural areas. The gender disparity is evident as women take responsibility for decisions regarding their pregnancy termination.

Many women do not have access to safe pregnancy termination services, leaving them at more serious risk. Due to the illegality of abortion in the country, providers are reluctant to offer safe methods of pregnancy termination. It was reported that in 78 hospitals accredited by the Philippine Obstetrics and Gynaecology Society (POGS), 25% of maternal deaths were attributed to induced abortion. If deaths due to unsafe abortion occurring in non-accredited hospitals and in the communities had been counted, the figure would have risen to 50%. Those women who underwent abortions were primarily unemployed housewives with little education from the lower socio-economic class. The maternal mortality ratio was 213 deaths per 100,000 births for the 1980-86 period, and 209 deaths per 100,000 births for 1993. The greatest mortality risks occurred among women 35 and over (Tadiar 1994).

### *Obstetric Complications and Reproductive Morbidities*

Complications during delivery may be a function of gender differentials in nutritional status as a result of intrafamilial food distribution, lack of antenatal services, and physical labour. Results of the Safe Motherhood Survey revealed that respondents reported vaginal bleeding, convulsions, and high fever during at least one of their pregnancies. Prolonged labour was the most frequently reported problem, followed by massive vaginal bleeding. Fewer than 10% had a caesarian section delivery and a retained placenta. The most common problems reported postpartum were severe lower abdominal pain followed by a foul smelling vaginal discharge. All symptoms of complications were more common for births resulting in perinatal deaths except those with caesarian sections due to obstructed labour. Prolonged labour occurred twice as frequently when there was a perinatal death (Festin 1993). The uterine prolapse rate was higher for women with more than 6 pregnancies, less than a high school education, and living in rural areas. Access to health resources in most families is more child-oriented than female-focused. When programs offer women the opportunity to bring their partners, the men tend to have a half-hearted attitude. The prevention and management of pregnancy complications is felt to be the woman's domain. The cultural perception of morbidity helps to explain women's conditions in poor or rural communities. The workload is so heavy — in the field, at home, and childrearing — that the morbidity threshold recognized by the women is very high within the health-illness continuum in order to ensure their availability for work. Therefore, women will endure a lot of pain and discomfort before they seek medical attention. This partly explains the low level of utilization of health services by women (Okojie 1994).

### *Access to and Utilization of Health Services*

The adequate utilization of health services is attributed to a multiplicity of factors, such as availability, distance, cost, quality of care, social structure, and health beliefs. Many of these factors are intertwined with gender inequality. Women of low socio-economic status

cannot make a unilateral decision to seek health care. The decision is made either by the spouse or mother-in-law, particularly in terms of "appropriate" care during pregnancy and childbirth. At times, patriarchy brings restrictions to women's mobility. Cost and distance considerations are also interrelated with gender inequality. Sick children are more likely to be taken to the health facility; women are unwilling to go to service points for their own health, since their absence will disrupt household and economic activities. In most cases, it is the traditional birth attendant who can conveniently meet these needs.

The geographical disparity in antenatal care is marked in the Philippines. In Western Mindanao, 29.4% went to a traditional birth attendant (TBA). The proportion in Central Mindanao was 22%. The less educated the mother is, the more likely it is that she will consult a traditional birth attendant. A third of the mothers did not receive a tetanus injection and 20% received only one dose. About 72% of births were delivered in the respondent's home, implying that a large proportion of high risk births did not receive medical attention during delivery. A majority of women with higher order births delivered at home. In metropolitan Manila, 90% of births were attended by a professional, while in poverty-stricken regions — Cagayan Valley, Bicol, Eastern Visayas and Mindanao — less than 40% were attended by a health professional (Philippine National Survey 1993).

### *Unmet Needs in Family Planning*

The total fertility rate (TFR) in 1993 was 4.1 children per woman — indicative of a slight decline from 4.3 children in 1988. The general fertility rate (GFR) was 138 live births per 1,000 women aged 15-44 years and the crude birth rate (CBR) was 29.7 births per 1,000 people. A higher TFR was obtained in rural areas. Birth intervals were shorter for younger women (median of 19 months for those less than 20 years of age). By contrast, those 30 to 39 years old reported a median birth interval of 31 months.

Virtually all currently married women knew about family planning methods (97%). However, there was a significant gap between knowledge and use. Despite 97% knowledge of method, the ever use rate for currently married women was 61.1%, and current use, 40%. Usage has been primarily female-biased. Discontinuation rates were highest for the condom (59%), followed by withdrawal (41%) — methods which require male involvement.

Unmet need has been defined as the percentage of currently married women who do not use any method of family planning, and who do not want any more children or intend to space their next birth. The unsatisfied demand or unmet need was 26%. It was observed that 68.9% of currently married women were in at least one of the following high risk categories: having a birth below 18 years of age and above 34 years; having a birth interval of less than 24 months; or having a birth order of more than 3. Therefore, a majority of women in the past five years were at an elevated mortality risk (Philippine National Survey 1993).

Making choices about the course of one's own life asserts a woman's fundamental human dignity. Family planning is a basic human right, although many women are unable to exercise it. Public perceptions of women's roles can be influenced by media depictions showing women succeeding in new roles. Likewise, women should be encouraged to discuss reproductive decisions and health with sexual partners. Men should understand their own and women's reproductive health needs, share reproductive decision-making, and take more responsibility for reproductive health, contraceptive use, and their families' welfare. The reproductive decision reflects tradition, religion, community norms, family structure, household economics, and the value of children. Within marriage, men have a say in women's decision to use contraception and the number of children a couple can have. Women's choices reflect their own needs. Providers cannot assume to know what women need and want.

To develop appropriate services, program managers must ask clients what they want and design programs effectively. As a result of women's marginalization, men and mothers-in-law play a dominant role over the couple's fertility decisions. Women find it difficult to discuss family planning with their husbands, since non-conformity is met by hostility. Their dependence upon their children in old age perpetuates the need for a larger family that represents insurance against crisis. Hong and Seltzer (1994) argued that there are a number of potential effects of contraceptive use:

- increased autonomy and self-esteem - a sense of control over fertility and other areas of life;
- an ability to plan for the future — a sense of self worth and independence;
- physical and psychological well-being and the ability to obtain a desired level of education; and
- a greater degree of equality with a spouse.

The degree of personal autonomy depends on the available options and decisions (Population Council 1994). For some women, discussing the subject of contraception with their partners or with others means running the risk of being viewed as promiscuous. The rhythm method is inconvenient since refusing sex means that the partner will go to another woman. Barrier methods are appropriate for women with sufficient negotiating powers. There are studies showing loss of sex interest after the use of hormonal contraceptives. Bleeding as a result of NORPLANT indicates sexual unavailability. Men feel that decreased sexual pleasure is an unacceptable feature of fertility regulation. Most family planning providers seem completely unprepared to deal with these sexual issues effectively. Cultural attitudes toward female sexuality shape the structure of family planning services to the exclusion of single women and unmarried adolescents. These inequalities should be evaluated within the organization of society in which they are an intrinsic part. Access to health care is merely one of the social dimensions where gender inequality is manifested (Okojie 1994).

## *Empowerment, Reproductive Health, and Sustainable Development*

The 1979 International Convention on the Elimination of All Forms of Discrimination Against Women recommended to countries "to pursue by all appropriate means and without delay a policy of eliminating discrimination against women particularly in the field of health care to ensure access to health services including family planning." Eliminating gender inequalities in health involves policies to improve women's status, increase their autonomy, and ensure the availability of health services. The convention's recommendations included:

- recognizing that women know what method is best for them in the context of their family dynamics and sexual lives;
- providing services that address their responsibility as care givers;
- being aware that adolescents and single women are also likely to need reproductive services; and
- encouraging women to discuss matter of sexuality, fertility, contraception, and disease prevention with their spouses/partners.

Counselling and services must be provided for men such as information on withdrawal, condom use, and vasectomy. Dialogues and collaboration should be arranged with women to promote self-esteem and autonomy in planning for their health needs.

Empowerment has three elements: (1) the growth of critical consciousness; (2) the development of capacity to effectively transform reality; and (3) the enabling of women as a social force to structurally change their lives in a meaningful way (Killan 1988). Information and skills, as well as the ability to use them in problem solving, should be promoted. Through group action, women will be able to influence the policies and social structure that perpetuate their disadvantaged position in society. Empowerment can be operationalized through education. It will contribute to a development strategy involving more equitable distribution of resources and power-sharing. This approach emphasizes the need for women to critically analyze their life situation and use their experience to act on it. Process skills (e.g., analysis, organization, and mobilization) are important if participation and self reliance are to be achieved. The community at all levels should address harmful gender-related practices and develop appropriate responses (Henriquez-Mueller 1991). Empowerment requires becoming conscious of multiple sources of discrimination and committing to changing them. Mobilizing women into local organizations and networks empowers them to move beyond suffering in silence to define publicly and collectively their own interests, their needs, and concerns. Women need to get organized and forge linkages with larger organizations and generate the political will to command institutional changes. Actions should incorporate women's perspectives, interests, and willingness to create and nurture links from approaches that consider the variety of cultural, socio-economic, and political circumstances. McCormack (1992) posited that when primary health care is taken up in

good faith and women's skills are genuinely enhanced, women achieve a higher social status. With the teaching of health skills, their legitimacy to command technologies in the community is underscored. This becomes social empowerment. The task is to systematically know the reproductive health care roles of women and to acknowledge them.

Gender definitions are historical constraints affecting women's lives, framing their differential opportunities, conditioning and rewarding them differently. The reproductive role of women represents a sphere where major gender differences are established. These issues should be reassessed within the human rights framework. A focus on the social aspect of gender inequalities is crucial to the process of change — whether this occurs through major reorganizations of societies or by the way individuals and groups change their ideas and behaviour. If women, through successful mobilization efforts, can develop a sense of self, it becomes even more important to understand how socialization for inequality begins and why it is so pervasive. These are crucial to understanding the persistence of inequality and basic strategies to change (Henriquez-Mueller 1991).

Philippine society perceives women's reproductive roles as important. Their health is located within a gender relations nexus — their status within the family, the community, and the larger socio-economic environment. Filipino women are confronted with a legacy of gender-based structures that evolve into a seemingly vicious cycle slowing the rate of their own development, subordinating them to the reproductive sphere of life, and affording minimal chance to harness their potential for their development. This cycle must be curbed if they are to be the beneficiaries and participants in health development (Papanek 1990).

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# Improving Utilization of Health Care Services by Increasing Community Participation

**Bounlay Phommasack**[1]

## *Introduction*

Lao People's Democratic Republic is a land-locked country, with a total population of more than 4.5 million inhabitants. It borders on China, Myanmar, Thailand, Cambodia, and Vietnam. There are socio-cultural and behavioural differences between the various regions as a result of the geographical layout of the country, together with its ethnically diverse population. About 80% of the population lives in rural areas. Communicable diseases, which hamper the health status of the population, include malaria, dengue haemorrhagic fever, diarrhoea, and respiratory infection.

The government of Lao P.D.R. wishes to alleviate poverty and to decrease its disease burden to improve productivity (World Bank 1990). There are very high morbidity and mortality rates resulting from parasitic diseases. As a result, development policies have been targeted to the rural population, particularly those groups at risk, such as children under five, pregnant women, and agricultural workers. *Health For All* though primary health care has been adopted as a goal.

Health For All policies aim to achieve the progressive improvement of people's health. Each country interprets and implements the policies in a different way depending on the country's social and economic characteristics, health status, prevalent diseases, morbidity patterns, and the state of development of the country's health system.

The international conference on primary health care strongly reaffirmed that "health," which is a state of complete physical, mental, and social well-being, and not merely the absence of diseases or infirmity, is a fundamental human right. It also noted that the attainment of the highest possible level of health is a most important global social goal. Realisation of this goal requires the action of many other social and economic sectors, in addition to the health sector (Alma Alta 1978).

However, while putting this policy into practice, the Lao P.D.R. government found that there were both general and specific problems influencing the normal functioning of the district health system, including:

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- shortages of drugs at health centres;
- a lack of financial support;
- low technical competence of staff; and
- poor interaction with the local community.

Consequently, there is high patient attendance at urban hospitals, bypassing first line health services. This had led to overfunding of urban hospitals, and underfunding of rural facilities.

## *Improving Utilization of Health Care*

### *Objectives*

The Department of Public Health has designed a project which aims to address these issues. The primary objective is to strengthen the relationship between the Department of Public Health and local communities. In particular, the project will focus on women's groups, both in the villages and at a district level. In addition, the project will report on and discuss methods of strengthening district health systems through community participation.

### *Materials and Methods*

Four rural health centres in two remote districts of Vientiane municipality have been selected to run the project. Problems pertaining to the under-utilisation of health facilities and low immunization coverage have been selected as issues to be discussed among the team (which is composed of district medical officers, chief district hospitals, health centre staff, leaders of villages surrounding the health centres, and representatives of Lao Women's Union). The team devised solutions for the improvement of these situations, taking into account feasibility issues.

Increasing technical and management skills among health centre staff through in-service training at provincial hospitals will enable them both to increase their technical knowledge and to provide better services to the community. Areas of training included pediatrics, gynecology/obstetric wards, well child and sick child clinics, emergency, and so on. To ensure the continuous functioning of the health facilities, a revolving drug fund, together with a list of essentials drugs, have been installed in each of the four health centres.

Monitoring and supervision carried out by district health management teams is relevant for the health centre staff. Target groups of women were invited to participate in the planning of the health project.

### *Results*

Through permanent and comprehensive dialogue about the basic health services with women's groups, it was found that utilisation rates at these four health centres had been drastically increased, from 8 to 64 times higher than previously. Immunization coverage was

also increased. Through regular village visits, talking with women, planning with them, and asking for their commitment in the development of health, environmental sanitation was also improved. This is demonstrated by the availability of new latrines in each village, the increased practice of drinking boiled water, of removing animal excreta outside houses, and of using it as a natural fertilizer to be put in the rice fields.

## *Discussion*

Political will is a precondition for the success of all national programs. The Lao Women's Union represents a formidable proponent of social mobilisation for all programs where women and children are central (such as EPI, MCH, water supply, environment sanitation, hygiene, food, and nutrition). In a country which suffers both horizontal and vertical partitioning, the Lao Women's Union network appears to provide a means of promoting communication and exchange of experience between various segments of society (World Bank 1990).

Interface with the community (women in this case) and the strengthening of the quality of care (with a better supply of essentials drugs) attracted more patients to the health centres. Prior to the introduction of essentials drugs to these four health centres, patients had to travel long distances to seek care in the town, requiring a lot of time and expense.

The active involvement of the women's group in motivating the mothers to bring their children to immunization sessions, through both fixed centres and mobile clinics, has resulted in the drastic increase in immunization coverage.

The provision of good quality of care by health centre staff, together with effective essential drugs, can minimize irrational drug use among local people. Comparing the cost of travelling to town to seek care, with cost recovery for essential drugs, treatment at the health centres is suitable for patients.

WHO defines the health centre (HC) as an element of the district health system (DHS). The district health service element (the professional component of DHS) is to be the point of interaction between the service and a defined community to which it supplies comprehensive health services. Accordingly, the health centre is defined not in terms of its technical components, but rather in terms of its ability to establish human relationships in the community in question (Mercenier nd).

The successful achievements, and the gradual improvement of quality of care, depend on staff attitudes (district and health centres staff), the team approach, staff motivation, and women's participation. In addition, the support system should be continuous.

Involvement of women in the planning of health related activities at the village level is considered to be critical for sustainability. Therefore, the following points related to long term community participation should be considered: communication, access to information, representativeness, resource mobilisation, and decision-making.

The Alma-Ata declaration in 1978 was the culmination of a long period of field work and research concerning the optimisation of health care, sustained by a long term vision. The definition of primary health care (Article 6 of the Alma-Ata declaration) evokes a dynamic equilibrium between people's autonomy and responsibility on the one hand, and the effectiveness and efficiency of the health services on the other. It makes a plea for participatory decision-making in health matters. Such continuous participation requires "interface" channels of dynamic interaction between health care providers and the people (Van Balen nd).

This seeks to integrate the needs of the people and those of the health workers in such a way that all elements are taken into account. Such elements include people's demands, the social cost of the underlying problem, and the effectiveness of the people's solution, as well as the effectiveness of the health service solutions and the respective efforts required (Van Balen nd).

In poor countries, it has become obvious that free care cannot be delivered in an adequate way when resources are insufficient. Many local initiatives, often by nongovernmental organizations, showed that reasonable patient charges improve acceptability of health care, simply by making essentials drugs and other materials available. Likewise, it was shown that real dialogue and real interaction between the health care providers and the people increased both autonomy and self help (Van Balen nd).

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# Husband and Wife Dynamics and Barriers to Condom Use

**Anthony Pramualratana**[1]

## *Introduction*

Among married couples, the topic of extra-marital sex is probably one of the most taboo subjects. In Thailand, however, the main mode of HIV transmission is through sexual activity, and extra-marital sex by husbands has been found to be a key factor in the transmission of HIV to wives. There is evidence that the next wave of the epidemic, namely paediatric HIV and AIDS, is already underway (Brown and Sittitrai 1993; Brown et al. 1994).

While condom use may provide effective prevention of HIV transmission in marital relationships, the condom is not widely used in Thailand. Thailand's rapid fertility decline has come about through an effective public health infrastructure promoting the oral contraceptive, female sterilization, the vasectomy, and more recently, injectable contraceptives. Among the married population, the condom has been largely viewed as a method of prevention of sexually transmitted diseases rather than as a contraceptive method.

Condom use has been reported to be inconsistent among the general adult population. Type of partnership has been found to be the strongest predictor of consistent condom use. Condom use is significantly less consistent with regular (multi-visit) commercial sex partners than with casual (single visit) partners (Morris et al. 1994b). In a survey of men in the general population, 30% reported a commercial sex partner in the last six months, and 17% also had a wife and/or other non-commercial partners. Consistent condom use was less than 30% with commercial partners, and effectively zero for non-commercial partners (Morris et al. 1994a).

The present paper focuses on husband and wife dynamics and barriers to condom use. This paper is part of a larger study entitled *The Influence of Male Peers and Wives on Thai Male Extramarital Sexual Behaviour* funded by the Rockefeller Foundation. The objective of this paper is to explain the social context of husband-wife dynamics which contribute to condom use barriers.

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## *Research Methods*

In order to collect qualitative information on the influences of wives and male peers on married Thai males' attitudes and behaviours with respect to commercial and non-commercial extramarital sex, 14 focus groups and 47 (21 male and 26 female) in-depth interviews with married men and women were conducted. The focus groups concentrated on prevailing norms, attitudes, and general observations, while the in-depth interviews explored personal behavioural patterns. The in-depth interviews were conducted among Bangkok urban residents in middle class occupational groups (6 females and 4 males) and in two provinces in the Central Region (Lopburi and Kanchanaburi). In each province, in-depth interviews were held among provincial town residents and among residents of rural villages within a 30 kilometre radius of the town (Lopburi urban males - 6; Lopburi urban females - 5; Lopburi rural males - 3; Lopburi rural females - 6; Kanchanaburi urban males - 4; Kanchanaburi urban females - 5; Kanchanaburi rural males - 4; Kanchanaburi rural females - 4). The present report draws exclusively on the discussions which occurred in the in-depth interviews on the topic of condom use in marital relationships.

## *Findings*

### *Wives' Knowledge of Husbands' Extramarital Sex, Irregular Condom Use and their Resignation to the Situation*

One key issue emerging from the study results concerned the acknowledgement on the part of wives of their husbands' extra-marital sexual activity. Although not all female informants acknowledged that their husbands had or were presently engaged in extra-marital sex, a fair number did. Many expressed resignation to a situation which they seemed to be unable to change. There were varied responses concerning either direct knowledge of husbands' extra-marital sexual behaviour or indirect knowledge or suspicion:

> He does not like condoms. "If I have to wear a condom why would I want to go for commercial sex." I have gotten STDs from him many times before...everyday now he is with his minor wife...I really have no energy to be mad any more.
>
> Sometimes he uses it [condoms], sometimes he doesn't. I once asked him why he doesn't use [condoms]. He said because the woman is not a commercial sex worker. But what if she was in the past, what would he do? He said that he was confident [of not getting STDs/AIDS]. But thinking about it, there is a chance of getting [AIDS]. Sometimes I am afraid if he would come and have sex with me, I would say no because I am afraid of AIDS, I was just joking [to him], of course.

Many women appeared to have very little negotiation power concerning condom use with their husbands. In certain situations, some women even empathized with their husbands lack of acceptance of condoms because of a perceived lack of sexual sensation associated with condom use:

Q. Let's say when he goes for commercial sex and he uses a condom like this, do you think it is acceptable?

A. Sometimes maybe, but sometimes I would never know. In my mind, to go for commercial sex and use a condom well...it is like one would not want to do it.

For some women, these forms of resignation were complemented by a self-consoling hope that their husband acted responsibly and considered the security of his wife and family by using condoms:

> He should prevent [use condoms], he should be responsible. If my husband is responsible then I may leave him alone. He likes it this way [engaging in commercial sex], if he is responsible to the family and wife...

These discussions suggest that some women did not believe they could change the behaviour of their husbands regarding either their desire for extra-marital sex or their inconsistent condom use. Even when wives were knowledgeable about the extra-marital sexual behaviour of their husbands, and requested the use of condoms, the ultimate decision or power over behaviour change seemed to belong to the husband. Negotiating skills or power on the part of the wife seemed to be absent in marital relationships where the husband was the dominant partner.

Q. Tell me really, has he ever used a condom with you?

A. Never, but sometimes I want him to use it. But he says why should he use it, he does not like that and then he gets angry...Sometimes we quarrel. To even mention that he may get AIDS he gets angry.

Q. Have you ever asked him to use it [condoms] with you?

A. Yes...he said that it would be like when he goes out for commercial sex. When men go out to commercial sex, they mostly use condoms. He said it would seem like I am not his wife. That is why he does not want to use it, he will not use it [with me].

Regardless of whether wives had indirect or direct knowledge of extra-marital affairs by their husbands, condom use negotiation was extremely limited. Even when husbands were confronted by their wives concerning extra-marital sex, the issue of consistent condom use was never quite clear. Condom use within the marital relationship was the sole prerogative of the husbands.

### *Wives Rarely Talk About Condom Use with Husbands*

Based on results from in-depth interviews, both men and women stated that they occasionally discussed condom use, especially in commercial sex encounters. However, serious discussions about condom use within the marital relationships were rarely undertaken. Some husbands also stated that they had never discussed the issue of using condoms in marital relationships. They also did not discuss it among themselves. One male informant stated that his wife had never discussed using condoms with him because she realized that he was a clean person.

Q. Has your wife ever talked to you about using condoms after you frequent commercial sex?
A. She knows what kind of person I am, a person who is very clean, she knows.

Q. So, she has never given you advice?
A. No, never.

Q. Have you ever talked to your wife about condom use?
A. No, never...

Q. So you never discussed it and she never asks?
A. She never asked...

Q. She does not have to say anything then, you know what to do?
A. It is my own responsibility.

Q. So your wife has asked you about going out to commercial sex, right?
A. Yes.

Q. And you said you went, but not often, but has she asked you about whether you use condoms or not?
A. She has never asked me about that at all.

He doesn't use it [condoms]...he says that there is no feeling, he doesn't like it except when I find out that he has been to commercial sex, then I would force him to use it...if I don't mention it, he won't use it...but really he should use condoms [with me].

Wives rarely directly confronted their husbands about condom use. Wives merely hoped that their husbands would use condoms because it was their responsibility to their family. Women were also likely to turn a blind eye to extra-marital activities and confronted husbands only if they found concrete evidence that their husbands had been engaging in commercial sex activity. Ultimately, however, wives seemed to have limited power over their husbands' decisions to use condoms.

In discussions about reasons for not using condoms with spouses, respondents stated that they were currently using oral contraceptives or were sterilized, or that they were confident that their spouse was "clean."

Q. So why don't you use it?
A. Because I am confident that I won't get anything [STDs or AIDS].
Q. Do you use it [condoms] with your wife?
A. Mostly no, because we know each other, there is nothing to hide.
Q. Have you ever used it [condoms]?
A. No, I have never used it [condoms].
Q. What about your previous wife?
A. With my previous wife, I never used it...she took the pill.
Q. Why haven't you used condoms with your wife?
A. I don't know what to use it for because I am confident that she has no disease.

Q. Before she got sterilized, what method did you use?
A. The pill.
Q. Does anybody use the condom for contraception?
A. They take the pill, the injection.
Q. They don't use condoms?
A. No they don't, they get injections and use the pill.
Q. And with your husband, did you use it [condoms]?
A. No.
Q. Why?
A. I guess because I think that he is not promiscuous.

For many wives, the lack of complete information regarding their husbands' extra-marital affairs limited either their desire or their attempts to discuss condoms. In situations where extra-marital affairs were acknowledged by the husband, and discussion of condom use was initiated by the wife, condom use was still seen as the prerogative of the husband even though both acknowledged the risk of contracting STDs/HIV. Such barriers to condom use were further enhanced by the view that condoms were not necessary in marital relationships because they were already using more effective forms of contraception.

## *Barriers to Condom Use in Marital Relationships*

### *Creation of Suspicion and Mistrust*

When asked what would happen if one spouse asked the other to use condoms, informants said that this request would certainly arouse the suspicion that extra-marital sex had occurred. It was reported that suspicions concerning extra-marital sexual behaviour would lead to concerns about possible sexual transmitted diseases, including AIDS.

> [If a wife asks her husband to use condoms] he may think that she is unclean.

> I would not be confident whether he has AIDS or not. I would be suspicious of him or he may be suspicious of me.

> [If he wants to use a condom with me] I would say that he was behaving abnormal and went for commercial sex (laughing) and that he is bringing an STD to me.

### *The Lack of Sexual Sensation*

Another barrier to condom use which was mentioned by our male respondents concerned the lack of sexual sensation during sexual intercourse with the use of condoms.

> The condom blocks friction, it blocks any feeling.

> I think [for the wife] it should be the same as the husband...no friction...flesh on flesh...

> It is a shame to wear it, it gets in the way.

Interestingly, the female informants never clearly stated their own opinions regarding lack of sensation. Instead, they stated what they felt their husbands thought of using condoms.

> It is like a picture that one cannot touch, like a picture of some fruits that one cannot eat. It does not provide for any feeling...this is what my husband says.

> Men always don't like using it.

This issue of lack of sensation is pervasive among the general male population in Thailand and is a major barrier to condom use in commercial and non-commercial sexual relationships. An overwhelming majority of respondents in a recent study stated that they did not use condoms because of the lack of sexual sensation or because it did not feel natural (Podhisita et al. 1994).

### *Already Using Other Forms Contraception*

The effective promotion of other forms of contraception, such as oral contraceptives, sterilization, and injectables through government health outlets, is a major reason why married couples do not consider condoms.

> Married Thai men and women would mostly not use condoms. When we want to prevent [births] we would use oral contraceptives, so we would not use condoms at all.

> Q. Have you ever used it [condoms] with your wife?
> A. Never, only talked about it. She said she doesn't want it, she is afraid of it and has never done it...she uses the pill.

> If to use birth control, mostly women would not have to use condoms, they take the pill, the injection or sterilization. If they want children, then they stop taking [the pill], no need to use condoms.

### *Situations Where Condom Use is Acceptable*

There were discussions on situations where condom use was acceptable. For instance, the period after childbirth when the wife does not want to continue taking oral contraceptives was mentioned. Although rare, some informants also stated that condoms may be considered if they were to be used as the main form of contraception.

Interestingly, condom use may receive some attention by the husband if the wife finds out that he has been engaging in commercial sex. Though the husband may not agree to it, the wife may then have more bargaining power if she suggests that he use condoms when they have sex together. Some of the wives suggested, hypothetically speaking, that their husbands might agree to use condoms if they had engaged in commercial sex.

Some informants stated that they might consider using condoms if their wives wanted a change in flavour. Condom use in this context was not related to disease prevention, but was seen as a sex aid.

## *Perceived Risks*

Logically, one would think that those who believe themselves to be at high risk of STDs/AIDS would be those who would consider seriously using condoms in their marital sexual relations. Data from our in-depth discussions found that those women who thought they were at some risk of HIV transmission would consider using condoms with their husbands, but would only push for condom use for a while, after which they said they would resign themselves to the situation.

### *Little Chance of Getting AIDS*

In discussions concerning the possibility of acquiring AIDS, responses varied. Interesting, almost all male informants stated that there was no chance that they would get AIDS. Some men may have been reluctant to acknowledge the risk of AIDS because such acknowledgements may be like condemning oneself to die. Men reasoned that they were not at risk because they did not engage in commercial sex, although it was unclear when they stopped, how much they engaged in commercial sex before they stopped, and whether they still went to commercial sex workers occasionally.

> I won't get AIDS because I don't go for commercial sex.
>
> There is no risk because I have never engaged in commercial sex, never messed around with other women.
>
> I don't think I will get it...I don't mess around I just stay at home. I don't fool with others on heroin like that.
>
> Q. Do you think you will get it [AIDS]?
> A. I won't get it...because I am worried about the future, I am not old and still able to care for my children...I am confident because I don't go for commercial sex.
>
> I have little chance because I don't really like to go for commercial sex.

Women's views about their chances of acquiring AIDS from their husbands were sometimes the same as the men:

> Q. Do you think you have a high or a low chance of getting AIDS?
> A. I don't know, I just know that my husband does not engage in commercial sex.
>
> I don't think I would get it [AIDS]...because he does not go for commercial sex...I am sure.

> There is no chance, I can assure you, there is no chance, so long as my husband is the way he is now there is no chance whatsoever...

It is clear from the above that not all men engaged in commercial sex, and not all women thought that their husbands engaged in commercial sex. Such individuals believed that there was little risk of getting AIDS.

### *Some Chance of Getting AIDS*

There were a fair number of female informants who stated clearly that they were at risk of acquiring AIDS from their husband because he engaged in extra-marital sexual relations. It was unclear what they planned to do to encourage their husbands to stop this activity or whether negotiation about condom use would be successful.

> It is not certain, sometimes when using a condom it may leak and one can get it [AIDS]...it is uncertain, difficult to say because my husband goes for commercial sex.

> I am afraid but I think I won't get it [AIDS]. I am just afraid I will get it from my husband when he goes for commercial sex and I don't know about it.

> I would get it [AIDS] from my husband, a very high chance...I think a very high percentage.

> About 50% [chance of getting AIDS] because my husband is like this...if he makes a mistake with some woman who likes to have sex [with many men], and then he has it [sex] with me, so I am very afraid, fifty-fifty.

These comments show that many women perceived themselves to be at some risk of contracting either STDs or AIDS from their husbands. They feared this because they were knowledgeable about his extra-marital relationships. In addition, they stated that they were uncertain about whether he would consistently use condoms when engaging in extra-marital sexual relations.

## *Conclusion*

Government campaigns to promote safer sex in marital relationships are problematic with regard to condom use. This is mainly due to past practices of using other "more effective" methods of contraception. With husbands still engaging in extra-marital sex, and often using condoms inconsistently, transmission from husbands to wives, and from women to their offspring via perinatal transmission, represent serious problems in the continuing AIDS crisis. Wives often have very little power in negotiations with their husbands about condom use, even in situations where extra-marital sex is acknowledged and consistent condom use is uncertain. Discussions on condom use are rarely undertaken, and when discussions do occur, they usually happen in an indirect or joking fashion.

Mistrust and suspicion of infidelity represent major barriers to condom use. The lack of sexual sensation associated with condom use was also reported as a barrier. The extent to which some wives accepted or resigned themselves to extra-marital sexual activity on the part of their husbands, despite acknowledged increased risks of contracting STDs/HIV, was another serious issue. At this time, it is difficult to imagine an intervention which could empower women in condom use negotiation without causing marital disharmony.

Campaigns to motivate married couples to discuss condom use, extra-marital sex, perceived risk of STDs/AIDS, and sexual responsibility may be more appropriate. Campaigns must promote open discussion among married couples and should also emphasize that the initiation of such discussions should be undertaken by husbands, as a demonstration of their responsibility to their family.

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# Does Education Empower Women for Health and Sustainable Development?

**Santhat Sermsri**[1]

Empowerment through formal education is regarded as a decisive force to improve the lives of women, as well as their families. In Thailand, families with better educated women experience less illness and hospitalization, when compared with families with less educated women.

The education of mothers is considered to be a very important factor influencing child health. A study on mortality and morbidity differentials in Thailand revealed that infant and child mortality levels were higher among mothers with less educational attainments (IPRS 1985). Other factors besides education are, of course, important. For example, rural women, no matter what their educational attainment, were found to have higher levels of child mortality and morbidity, compared to women in urban areas.

In Thailand, the decline in fertility over the last thirty years is not only due to the accessibility of fertility control techniques, but also to the improvement of education of Thai women. Extensive research has demonstrated an inverse relationship between fertility and education levels (Sermsri et al. 1989). Women with higher levels of education tend to get married at later ages, and therefore reduce the number of childbearing years within marriage. Better educated couples are more likely to use contraception to reduce fertility (Knodel et al. 1982; Goldstein et al. 1972). Married women with high education levels often decide to delay having children because they are aware of the career trade-offs usually associated with bearing and raising children.

There is an interaction between the educational attainment of women and health-related decision-making power within the family and the community. Educated women/mothers may have greater decision-making power on health and related matters within both the family and the community, be more knowledgeable about disease prevention and treatment, and be more likely to adopt new codes of behaviour which improve the health of children. Educated women may be more involved in community activities generally.

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## *The Role of Non-Formal Education*

Research tends to measure educational attainment as the completion of various formal schooling systems. Women may be asked to indicate what level of education they have completed, for example, primary, secondary, college, university, and so on. Some school experience, but without formal completion, is usually not counted.

Additionally, most research has not addressed the role of nonformal education (for example, in-house training, occupational training, community education, home handicraft training, religious training, and exposure to educational media) in improving the health status of women. However, the level and quality of nonformal educational activities may have an impact on individual responses to health matters. In order to enhance the understanding of education impacts, further research should assess the influence of nonformal educational activities on women's health and well-being.

Researchers must also fully understand changes in the Thai educational system since 1978 in order to correctly interpret education obtainments/attainments (Wongsith and Knodel 1989). In 1978 Thai compulsory education expanded from four to six years. Secondary and upper level education was also redefined to consist of more years. Secondary education is now divided into two levels. The lower level consists of three grades (1-3) and the upper secondary level covers another three grades (4-6). This system is quite different from the previous education scheme.

## *The Social Status of Women Within the Family*

Female household decision-making power is not exclusively dependent on education. While education can influence decision-making of women within the family, other factors are also important, including the social status of women within the family, determined by social norms and institutionalized by family structure, which vary from culture to culture.

In Thailand, because of economic factors, many families are unable to maintain a separate household, particularly in the early years of marriage. A newly married couple may live with the wife's or husband's parents. When the couple moves in with the husband's family, domination by a mother-in-law may affect how a woman cares for her infant. For example feeding practices and other health-related practices may be influenced by the mother-in-law.

Through observation and in-depth interviews conducted in a small village in Yemen, Myntti (1992) found that the authority of women in a family and her social relationships with her husband and other family members was a crucial determinant of child nutritional status. Women with higher social status in families tended to have more decision-making power regarding the nutrition of children.

Education may affect the social relationship between a woman and her mother-in-law. Further research needs to assess the extent to which the education of women decreases the authoritative roles of mothers-in-law especially in relation to health and sustainable development.

## *Elements for a Proposed Study*

A study of the impact of both formal and informal education of women on health is proposed, using both qualitative (e.g., focus group discussions) and quantitative techniques.

Married women aged 15-44 years of various educational levels will be purposively selected and their prenatal care activities and child health status will be examined. Nonformal education activities including short and long term training, special occupational training, religions practices, and exposure to educational media, will be identified as explanatory variables. The analysis will assess the extent to which nonformal and formal education affects prenatal care activities and the child health status.

The extent to which a woman's social status within a home affects prenatal care and child health will be analyzed. Differences between single generation families and multi-generation families will be assessed. The following variables will also be incorporated: the relationship to household head, number of births (birth order), size of household, membership in community activities (groups), and socio-demographic characteristics.

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# Population Development and Reproductive Health from a Gender Perspective

**Lin Tan**[1]

## *Introduction*

The links between reproductive health and population and development are not clear-cut. It is easier to understand the relationships between population, development, and reproductive health when they are viewed from a gender perspective.

Since the first World Population Conference in Bucharest in 1974, through to the recent International Conference on Population and Development in Cairo, the research community has sought to deepen and systematize population concepts and strategies within the larger field of development. In this process, the establishment of the concept of gender, and the strengthening of consciousness in women's development, have played important roles. Over the past twenty years, the international society, most governments, and most demographers have reached a basic common consensus that the population problem is not an isolated problem, but is instead an important component of a comprehensive development problem. Additionally, women's development is one important aspect within population development. Any population project, population policy, or practice, should aim to accelerate long-term, sustainable development between the population and the society, economy, environment, and culture, to improve the quality of life for all.

Reproductive health is an important indicator for measuring quality of life, particularly for measuring women's life quality. It is also the main component of population development. According to the definition provided by the World Health Organization in 1948, "health" refers to a complete state of well-being and not merely an absence of disease. At the International Conference on Population and Development in Cairo, WHO recommended that

> reproductive health should refer to the normal state of the reproductive system and to the physical, mental, social, behavioral and other aspects involved in the functioning and working of the reproductive system; it does not simply refer to a lack of illness or physical weakness.

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Good reproductive health care means that people have the right to obtain reproductive health knowledge and services, and that they are treated with respect. Reproductive health includes planned birth, maternal and infant hygiene, child care, and knowledge of how to prevent sexually transmitted diseases, including HIV/AIDS.

Gender analysis permits one to examine differences in the health of women and men which may be linked to various factors such as unequal opportunities for development, the inequality of social status, and sexual discrimination. When looking at population, development, and reproductive health from the gender perspective, a number of problems are discovered.

## *Childbearing, Planned Birth, and Reproductive Health*

Women's position in society directly or indirectly influences their ability to participate in childbearing, sexual conduct, and fertility rate decisions. Since the Second World War, there has been an increased awareness of population issues. In the course of social and economic modernization, the decline of the death rate precedes a decline in the birth rate. That is, the decline of the birth rate has a retarding feature. If no corresponding restraining measure is taken, a continuous and rapid increase in population will result.

Governments and scholars are placing increased importance on family planning. Experience has shown that wide propagation of family planning knowledge and technical services can help to control population growth. However, long-term practices in population control and family planning have made it evident that the population problem cannot be solved by exclusively focusing on contraception. Connections between population growth, and social, economic, cultural, and environmental factors must be recognized, particularly the connections between population and women's status. Only when women's position and rights in society are respected, and when the health of women and their children is protected, will a reduction in the fertility rate be realized. Reduced fertility rates are closely linked to coordinated development between population and society, economy, culture, and environment, and the improvement of the quality of life for all. Contraceptive knowledge and technical services must be provided. In addition, the rights of women and children must be respected, and contraceptive services, dissemination of information, maternal and infant hygiene, and child care services should be strengthened.

Over the years, population control and development has been a process of continuous discovery and acknowledgement of women's issues, as well as a process of discovering the connections between population, development, and reproductive health. For instance, in recent years, some practical applications have appeared in China, such as the models of "three sheng" (production, living, and childbearing), and "three you" (hereditary improvement, fine child care, and good education). A new thinking about population and family planning has developed, and women's perspectives have increasingly been considered.

The notion of "population control" has been replaced by the idea of "population development," while "planned birth" has been replaced by the concept of "reproductive health."

### *Women, Population, and Reproductive Health from the Mortality Point of View*

A declining death rate is another important component of population development. It has very obvious and direct connections with reproductive health, particularly the maternal death rate which is directly concerned with women, and the infant and child death rate. In addition, the dissemination of reproductive health knowledge and the strengthening of sexually transmitted disease services have very important roles in controlling the incidence of AIDS-related deaths.

China is a large developing country with a large population. Regional disparities exist both in women's status and the development of population, society, and economy. In poverty-stricken and mountainous areas where women have a relatively low social status, lowering the maternal and infant/child death rate remains an important task. In border areas and large cities, the prevention and treatment of AIDS is also an important priority. To successfully accomplish these tasks, women's reproductive and general health needs must be prioritized.

### *Population (age/sex) Structure and Reproductive Health from the Female Point of View*

In most developing countries, there is a fairly high fertility rate and therefore a fairly large proportion of people under the age of 15 years. The reproductive and general health needs of infants, children, and teenagers, particularly females, therefore need special attention. Because a large proportion of people will soon be entering the sexually active and childbearing period, reproductive health care for this segment of the population is very important.

In many countries, because adult males are seen as important labour force resources, their health is protected through insurance and their death rate is comparatively low. But the health of women and children, particularly that of pregnant women and infants, can be secure only when reproductive health care has been strengthened.

Among older people, older women are more likely to find themselves in poor living situations than are older men. Their health needs are also more likely to be neglected by society and by their families. Because many diseases which afflict the aged are partially the result of poor reproductive health care received during the reproductive period, improved reproductive health care would also be beneficial to the quality of life of the older population.

Irresponsible sexual behaviour can result in many problems, such as unwanted pregnancies and children, as well as the transmission of sexually transmitted diseases. These consequences can endanger the health of women and children and can affect the quality of the circumstances under which they live. Strengthening reproductive health care may help to decrease the emerging chance of such problems.

Because China has a large population base, even though the fertility rate has declined nearly to replacement level, every year there is a relatively large new population added, most of whom live in rural areas. The size of the population in their reproductive years is very large. As this group ages, the health system will have to deal increasingly with the special problems of the aged. We must therefore pay attention to the construction of a social security system for the older population, as well as the present health needs.

Reproductive health care services are not a "miraculous cure" for all problems. However, they certainly need to be strengthened. This is particularly the case in areas where women's position is relatively low, and social and economic conditions are relatively less developed.

## *Conclusion*

Adopting a gender perspective, it is clear that the relevant variables of population development have direct and indirect connections and influences on reproductive health. Only when these linkages are acknowledged can we adopt corresponding policies, countermeasures, and appropriate enforcement plans to achieve coordination and development between population and society, economy, and culture.

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# Macroparasitic Infections in Meghalaya, North-East India

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## *Introduction*

Unlike microparasites (comprising viruses, bacteria, and protozoans), the macroparasites, which include helminth and arthropod metazoans, generally multiply within their definitive host, and have a relatively longer generation time. Macroparasitic infections, therefore, usually have a persistent nature with the host being repeatedly exposed. The severity of disease caused in the host is therefore determined by the degree of repeated exposure (Anderson and May 1979).

Macroparasites are a major cause of concern to human health in developing countries such as India, where a humid tropical climate, unsanitary environmental conditions, and unhygienic living habits of the lower socio-economic strata prevail. Socio-economic and cultural factors including housing, occupation, food habits, age, and sex of humans, have been found to be among the most important factors influencing parasite transmission and persistence (Nelson 1972; Kochar et al. 1976; Nwosu 1983). In the context of Meghalaya, a north-eastern state in India, the unique ambient climatic conditions favour parasite survival and viability for a longer time period, and thus a prolonged risk of infection to community inhabitants (Yadav and Tandon 1989b). Efforts made to assess the extent and prevalence of infections of macroparasitic origin in India primarily involve surveys undertaken by teams of workers of the Indian Council of Medical Research across various parts of the country (Biswas et al. 1978, 1980; Das et al. 1981; Datta et al. 1981; Paul et al. 1982). While some of these studies indicate a sex-related predilection of certain infections (Bhatnagar et al. 1982; Garg et al. 1982; Mahanta and Laskar 1983; Chandra 1984; Gnana Mani et al. 1993), others (Jain et al. 1989) do not reveal any influence of sex on prevalence. This paper aims to summarise some of the studies with which the North-Eastern Hill University has been associated for more than a decade, and to briefly provide information of the problems of macroparasitoses in Meghalaya.

## *Study Site*

The State of Meghalaya is located approximately between latitudes 25 10'N - 26 12'N and longitudes 89 49' E - 92 45'E, bordered on the north and east by Assam, and on the west and south by Bangladesh. Physiographically, Meghalaya is divisible into three sections: the Western - Garo Hills, the Central - Khasi Hills, and the eastern - Jaintia Hills. The highest

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altitudes in these sections of the plateau range from 1350 to 1967 metres above sea level. The region experiences a subtropical to subtemperate climate during the year. The temperature usually reaches its maximum during mid April - mid May (32.5°C at Tura, Garo Hills and 24.1°C at Shillong, Khasi Hills). During the winter season in the central upland zone, particularly in and around Shillong, the temperatures drop as low as 1-2°C. Relative humidity is very high, and rains are distributed relatively evenly over most parts of the year, with a very short dry season (November to January). Cherrapunjee and Mawsynram platforms in Khasi Hills receive the maximum rainfall in the world, with an annual average of about 11,400 mm. Shillong and adjoining areas receive an annual average rainfall of 2400 - 3000 mm.

Meghalaya is predominantly inhabited by tribal peoples who constitute about 85.5% of the total population. They represent three main communities, two of which follow a matriarchal system. The literacy rate among the rural people is 41.05%, while that of rural females specifically is only 37.12%. Eighty percent of the people are dependent upon agriculture for subsistence. Pig raising on a free range basis is widely practised, and cats and dogs are kept as pets. Use of open areas for defecating, and use of paper for self cleaning are common practices among these people. Anemia among the females, and acute gastro-enteritis among the general population, emerge as the main health problems.

## *Major Helminth Infections*

Helminth parasites pose a continual and unacceptable threat to the life of their host. Although there are numerous infectious diseases affecting Asian populations, intestinal helminth infections outnumber all others (Stoll 1947; Cross and Basaca-Sevilla 1981). Helminth infections in this study pertained mainly to domestic livestock in the region. However, emerging from it are many infections which have a zoonotic potential and consequently biomedical significance. Parasitic eggs or larvae are passed through the faeces of their hosts. The environment is thus contaminated with millions of new parasites daily. For some, the transmission pathways involve vertebrate or invertebrate vectors in which some phase of their development occurs, and which in turn become the source of infection to the final host. The major helminth infections of plausible zoonotic value, reported from cattle, sheep, goat, and swine hosts over a period of more than a decade, indicate that there are 5 nematode, 5 trematode, 3 cestode, and 1 acanthocephalan infections occurring in the region (Table 1). These infections have a variable prevalence, considerably high for some and insignificant for others (Roy and Tandon 1991a,b, 1992a; Yadav and Tandon 1989a).

**Table 1. Major Helminth Infections of Zoonotic Potential Prevailing in Meghalaya**

| Parasite | Common Name | Means of Infection |
|---|---|---|
| **Nematodes** | | |
| *Necator americanus* | Hookworm | Skin |
| *Strongyloides stercoralis* | Threadworm | Skin |
| *Trichuris trichura* | Whipworm | Oral |
| *Gnathostoma spinigerum* | | Fish |
| *Ascaris* | Giant roundworm | Oral |
| **Trematodes** | | |
| *Fasciolopsis buski* | Intestinal fluke | Oral |
| *Gastrodiscoides hominis* | Pig intestinal fluke | Oral |
| *Opisthorchis noverca* | | Fish |
| *Artyfechinostoma sufrartyfax* | Echinostome fluke | Fish |
| *Eurytrema pancreaticum* | Pancreatic fluke | Oral |
| **Cestodes** | | |
| *Taenia saginata* (Cysticercus bladderworm) | Beef tapeworm | Beef |
| *Taenia solium* (Cysticercus bladderworm) | Pork tapeworm | Pork |
| *Echinococcus granulosus* (Hydatid cyst) | Dog tapeworm | Oral |
| **Acanthocephala** | | |
| *Macracanthorhynchus hirudinaceus* | Spiny headed-worm | Insect |

Information collected from various medical agencies in Meghalaya revealed a high prevalence (80-100%) of ascariasis in subjects from rural/suburban areas reporting to the hospital for treatment of suspected worm infections. Surveys based on reports from primary health centres and/or civil hospitals revealed the prevalence of ascariasis (1.45 - 3.6%), along with infections of hookworms (2.5 - 2.6%), *Strongyloides* (0.12%), and *Trichuris* (0.5%), with no reports of toxocariasis. Our coprological investigations based on random sampling also revealed a high prevalence of ascariasis (45-62.5%) in the Garo Hills and East Khasi Hills districts of the state. A sex disaggregated analysis of the prevalence of *Ascaris* and other worm infection, however, did not indicate any significant or consistent difference with

respect to males and females (Table 2). A recent estimate of the incidence pattern of some common diseases in India showed that ascariasis affected well over 16% of the country's total population. Earlier studies from South-East Asia have also established that differences in prevalence rates of ascariasis among Indians is accountable to varied cultural and dietary habits (Bidinger et al., 1981; Crompton et al. 1985).

**Table 2. Sex Disaggregated Prevalence of Helminth Infections in Meghalaya**

| | | No. (%) of positive subjects | | |
|---|---|---|---|---|
| Infection | Sex | Garo Hills<br>M (n=1586)<br>F (n-1773) | Jaintia Hills<br>M (n-11,508)<br>F (n-14,329) | Khasi Hills<br>M (n-5,892)<br>F (n-4,581) |
| Ascaris | M | 49 (3.08) | 161 (1.4) | 164 (2.78) |
| | F | 59 (3.32) | 215 (1.5) | 223 (4.86) |
| Hookworm | M | 44 (2.77) | 299 (2.08) | |
| | F | 40 (2.25) | 376 (2.62) | |
| *Strongyloides* | M | 4 (0.25) | | |
| | F | -- | | |
| *Trichuris* | M | 6 (0.37) | | |
| | F | 11 (0.7) | | |

## *Pediculosis*

Louse infestations, especially among the socio-economically poor sections of society, is a common problem in India (Hati et al. 1974, 1978; Bhattacharya et al. 1976; Chakraborty et al. 1981). Investigations carried out in different climatic zones in India have revealed that pediculosis is more common in hilly areas than on plains (Hati et al. 1979).

In an epidemiological survey, the research team sought to determine the prevalence of lice infestation by age and sex of two socio-economically distinct groups of people sharing the same climate in Shillong, the state capital (Roy and Tandon 1992b). Among a total of 536 poor and 437 middle class individuals surveyed, the overall prevalence of lice was found to be 59.7% and 15.79%, respectively. *Pediculus humanus humanus* (body louse) emerged as the predominant species, followed by *P.h. capitis* (head louse), *Phthirus pubis* (pubic louse) being the least prevalent. In a sex disaggregated analysis of the infestations, both *P.h. humanus* and *P. pubis* showed a higher prevalence among the male individuals, whereas *P.h. capitis* occurred more frequently among females. Poor hygiene and over-crowded living conditions favour transmission and perpetuation of these ectoparasites in the study area. In

addition, very infrequent changing or cleaning of clothes, infrequent bathing, and a scarcity of water also contribute to higher rate of pediculosis among the poor section of the population.

## *Gender-Based Analysis of Macroparasitoses*

There is a need for a thorough and in-depth investigation of gender-related physiological influences on macroparasitic infection in humans. Most of the prevalence data indicates that, in general, females have lower rates of helminth infections than males. It is believed that sex hormones play a determining role in increasing resistance to these infections. Susceptibility to infection reportedly increases during late pregnancy. High concentrations of progesterone and prolactin are considered to cause a depressed immune response (Lloyd 1983). As indicated by experimental studies involving *Trichinella spiralis* (Reddington et al. 1981), *Strongyloides ratti* (Bailenger et al. 1984; Kiyota et al. 1984) and *Dipetalonema vitae* (Reynouard et al. 1984), sex hormones affect the immune system of the host. The sex differences, if any, in the prevalence of macroparasites in the area of the present study seem to be more of a reflection of socio-cultural practices than of physiological differences and exposure to the infective agents. A mass awareness, understanding, and appreciation of the relationship between these biohazards and human health must be generated. A mass health education program seems necessary, particularly for the rural and suburban women so as to make them aware of the risks and modes of transmission of infection, and to encourage them to assume responsibility for self protection.

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# Improving Women's Quality of Life: Enhancing Self-Image and Increasing Decision-Making Power

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Effectiveness of programs which promote human resources and development, either in a sectoral or an integrated manner, depend on the extent to which different segments of society are brought under their impact, irrespective of gender, geographic location, and caste/class affiliation. However, where inequalities are an integral part of a society, the effectiveness of development programs often fall short of expectations. It is in this context of human resources that the status of the female half of society needs to be considered (Kerawalla 1994).

Gopalan (1987) has said that a major reason for the under-development of Indian society is the poor status accorded to women. Lack of education and special skills for employment has reduced them to a subordinate role in the family and society.

Sex differences of men and women are related to procreation and biological reproduction. Sex differences are found in all mammals. However, humans have interpreted and reshaped their physical and social environment through symbolizing, and sex differences are expressed as gender. Concepts of gender are thus cultural and societal interpretations of sex differences. Every culture has prevailing images of what men and women are supposed to do (Rehman and Biswal 1993).

In India, women's bodies have been equated to their reproductive functions. In Hinduism, the symbolism of Goddesses as mothers reflects the place in society which men have chosen to give women. Culturally, women have been assigned the role of caregivers and denied the right to any other productive role in society. Because women's work is centred around reproduction, child care, and nurturing, this serves to reinforce the sexual division of labour and the invisibility of women.

An examination of Hindu mythology and tales of Goddesses throughout the ages reveals that the intellectual capacity and productive roles of women, including leadership positions, have been gradually de-emphasized and replaced with the image of a self-sacrificing, nurturing, long-suffering, obedient wife and mother, whose entire personality and existence is tied to male family members, starting with the father, then the husband, and subsequently her son(s). This has ultimately allowed the dominance of men, while women have been assigned

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a place where they have no voice and no control over their own bodies. Over the ages, Hindu women have come to accept and venerate this image as the appropriate role for themselves.

As an individual grows, sex-linked attitudes and beliefs develop. Early in life, traits of passivity, dependency and helplessness are established in women. In keeping with this gender-defined role, a woman or other family members may underplay her achievements in order to maintain the status quo.

As women increasingly enter the workforce, household burdens have not decreased. Women feel responsible for doing both home and work-related jobs efficiently, and this is often done at cost(s) to women.

Women today have a pivotal role primarily in household related tasks. Women's health status can be viewed as one side of a coin, with the other side being represented by the health of the family as a whole. While women are in a commanding position over household resources (e.g., in their responsibility for distributing food), they are often neglected by their own hand, and are in a disadvantaged position relative to other family members.

### *Overview of Women's Status in India*

Despite the women's liberation movement over the past few decades, the female mortality rate still exceeds the male mortality rate. The decreasing number of females in society, compared to males, indicates the risks females face at most ages. The health status of women in India is indicated by low birth weights (Gopalan 1987), low life expectancy (Census of India 1986), high frequency and duration of illness episodes (Khan et al. 1982), and high maternal mortality rates.

### *Education*

Societal values prevailing among a majority of the population creates a climate in which parents are generally reluctant to invest in the education of girls (Kerawalla 1994). UNESCO data on illiteracy rates for the 15-19 year age group, collected between 1978 and 1982, showed considerably higher illiteracy rates for females (29.2% in urban areas, 66.3% is rural areas) compared to males (17.9% and 39.6%).

Gender disparities persist in school enrolment, particularly at the post-primary level. Poverty coupled with low private returns are largely responsible for the reluctance of parents to invest in the education of their daughters. Greenhalgh (reported in Karkal and Pandey 1989) pointed out that education is one of the "gifts" given to children by their parents and fundamentally belongs to parents rather than children. Investing in the education of children has traditionally been seen as a loan to be repaid by children by fulfilling a number of obligations, such as obedience and large contributions to the family economy. Daughters are educated so that they can return much of the "investment" before marriage. They are sent

out to work as soon as possible so they can contribute to the family economy, including the education of their siblings, especially brothers. While the education of daughters is expected to help in the marriage alliance, education of daughters as a value in itself has had very little recognition.

The Department of Post Graduate Studies and Research in Home Science (SNDT Women's University, Bombay, India) has been working with a slum community in the city. The perception among the predominantly Muslim population in this slum is that girls/women should not be educated because it will make them more vocal, independent, autonomous, and cause them to "talk back" to their elders.

### *Health and Nutrition*

Low social status, poor dietary intake, and poor antenatal care contribute to the poor health status of women. The health costs associated with childbearing can be tremendous. For instance, 50-60% of a woman's reproductive life (200 months out of 360 months) may be spent in pregnancy and lactation.

Sex discrimination has special significance for girls born into families that already have a surviving child, particularly among low socio-economic groups (Das 1975). The health and nutritional needs of girls of high birth order are more likely to be neglected than those of low birth order.

Levinson (1983) observed that gender was the most statistically significant determinant of infant mortality levels in poorer households in Punjab. While gender discrimination also occurred in better-off households, in poorer households, the effects of discriminatory practices were greatly exacerbated by poverty.

Studies indicate that male children tend to be breastfed longer, while girls are weaned earlier. Because of the shorter period of breastfeeding for girl children, mothers are more likely to conceive shortly after the birth of a girl child, which has tremendous implications for the health of girls.

### *Regional Variations*

Nutritional equity between males and females appears to improve from North to South, and the gender differential is much less among adults in the western states of Maharashtra and Gujarat, and the southern states of Andhra Pradesh and Tamil Nadu.

In an in-depth study of two villages in West Bengal, Sen and Sengupta (1983) demonstrated that besides *a priori* differentials, the benefits of development were also inequitably distributed among males and females.

### *Access to Food and Health*

Girls and women generally have less access to food than boys and men. A survey in India by the National Committee on the Status of Women found that women in 48.5% of the households ate after men. Ritual "fasting," which also influences food intake, is more common among women than men.

Food deprivation is part of the socialization of girls; it is seen as part of their deferential role that they will continue to play as future daughters-in-law. Parents often explain that discrimination against girl children is part of their training, so that they will know what is expected of them in the homes of their in-laws. This necessary training is viewed as part of a proper upbringing (Karkal and Pandey 1989).

Focus group discussions conducted with adolescent girls in the urban slum adopted by this Department for a IDRC-UNICEF sponsored "Urban Nutrition" project, revealed that the girls felt they had experienced discrimination since the age of five. While mothers drilled the sacrificial role into girls with regard to food intake, male family members who generally ate first reportedly did not consider whether there was sufficient food for the whole family, and were generally insensitive to the needs of the females, including female siblings.

A quantitative study of 100 married and 100 unmarried adolescent and post-adolescent girls showed that their calorie intakes were inadequate compared to the recommended levels. While a majority of the married girls had energy intakes in the range of 1000-1250 calories, only 37% of the unmarried girls fell into this range (Marathe 1993).

Energy intakes of these girls were positively and significantly influenced by educational status and decision-making power. Decision-making power, including the ability to purchase foods and allocate and utilize resources, was linked with greater food availability. While decision-making power was influenced by the type of family and the educational status of the girls, there was no difference found between the married and unmarried adolescents.

In multi-generational families, girls had less say in household matters because of generational differences. While half of the girls in multi-generational families had some say in health care matters, the head of the family had ultimate decision-making power. More unmarried girls (42%) had freedom to take part in social functions than did married girls (32%). Most girls had little freedom about when they should conceive; it was generally expected that they should bear a child within the first year of marriage to prove their fertility.

Anthropometric measurements suggested that married girls were slightly worse off than the unmarried girls (Marathe 1993). For instance, mean body weights of the married adolescent girls were lower than the unmarried girls, as shown in Table 1.

**Table 1. Mean Weights of Urban Slum Adolescent Girls**

| Age/Yrs | Unmarried | Married |
|---|---|---|
| 14-16 | 38.6 ± 5.7 | 40.4 ± 4.4 |
| 17-18 | 42.1 ± 5.7 | 39.9 ± 6.2 |
| ≥19 | 46.5 ± 8.3 | 40.4 ± 6.2 |

The lower body weights of the married girls suggests that their growth had been compromised. Body weight was significantly influenced by energy intake, educational status, level of consumption of fruits (considered status foods) and processed foods (such as bread and biscuits).

Comparisons of types of illness among married and unmarried girls found that respiratory tract infections were present in a similar proportion of married (34%) and unmarried girls (33%). There was a higher incidence of major illnesses such as jaundice, typhoid, and malaria among married adolescents (31%), compared to the unmarried (22%). Similarly, a higher percentage of married girls had low hemoglobin levels (see Table 2).

**Table 2. Hemoglobin levels of adolescent girls from urban slums**
**Haemoglobin (g/dl)**

| % Subjects | < 10 | 10-11.4 | > 11.5 |
|---|---|---|---|
| Unmarried | 13.8 | 23.6 | 62.5 |
| Married | 30.5 | 25.8 | 43.5 |

## *Health Services*

Access to health services for women is an area which is relatively neglected. Maternal and child health services tend to be top-down bureaucratically organized clinics. Health services for women usually emphasize and cater to the reproductive health needs of women, while little effort is made by the health sector to help women realize that they are persons in their own right, with their own personal health needs. Women's health needs are given less attention within the structure of health service provision than the health needs of children and men. Furthermore, their quality is poorer, and more often than not, women's needs are subordinated to population control programs.

With regard to maternal and child services, women living in rural areas are disadvantaged. The viewpoints of urban-educated health workers and physicians, with their theories on anatomy and physiology, disease and treatment, are often very different than the viewpoints of rural women. This gap can present a barrier to the utilization of health services.

Additionally, the hospital oriented, highly centralised health care system tends to emphasize curative treatment over preventive measures. Curative care tends to look at the isolated individual client. However, an integrated approach which looks at health problems within a wider context, and beyond the walls of the hospitals and clinics, may be preferable.

Young women (daughters-in-law) have little individual decision-making power with regard to either their own health, or the health of their children. However, health planners, practitioners and educators disregard this fact, and treat childbearing women as individualized patients. In fact, women's social relationships offer differing opportunities for action.

Gender sensitive government policies and legislation are needed to remove the barriers to women's development. There is a need for greater representation of women in local elected bodies. Suggested reform initiatives often have good intentions to alleviate problems related to poverty and the lack of facilities/incentives/opportunities for women in various spheres of life. However, the difficulty lies in the lack of political and sometimes bureaucratic will to implement these programs in their true spirit. Dole programs, which require immense amounts of funds, create an "expectation syndrome" in the poor, while simultaneously leaving less available funds for other initiatives to improve health, well-being, and the quality of life.

### *Improving Women's Health*

Effective health programs for women require new perspectives and changes in health priorities at different levels:

- within households, to improve the position of female members in comparison with male members;
- within hospitals and clinics, to view women as persons rather than as procreators, and bearers of children;
- within the community, to raise the consciousness of women about their own personal needs; and
- at bureaucratic and policy levels, to ensure that policies and programs at a number of levels are more gender sensitive.

Focus group discussions conducted with adolescent girls in the slum revealed that they did not trust government hospital services. The general opinion was that "health is not affordable to the poor."

Lack of female doctors in private clinics and government hospitals was another problem. Two thirds of the girls never went to a male doctor unless absolutely necessary. Their mothers would get prescriptions and medicines on their behalf by describing the symptoms to the doctors.

The girls were clearly able to identify factors contributing to good health, e.g., education, environmental cleanliness, personal hygiene, size of the dwelling and people residing in it, food availability, availability and utilization of resources, promoting greenery, and communal harmony. While the girls interviewed in the slum community were socially isolated, they had a natural capacity to think in terms of wider issues affecting their lives. It is this natural intellectual capacity that needs to be nurtured and fruitfully used in making "health services" more user-friendly for women.

Discussions held with the community workers about women's health needs and strategies for action brought forth a number of issues.

- Women's health needs cannot be met by focusing on the health sector alone. Along with the traditional approaches of providing access to nutrition and education, empowerment of women in various spheres is needed.

- Some women are more vulnerable and deprived than others. In the slum adopted by this Department, women were particularly vulnerable because they often had been abandoned by both husbands and society itself. The needs of destitute girls and women are of special concern.

- Women need to be encouraged to break the culture of silence and to negotiate space for themselves within the household.

- In a "closed" community with restrictions on female mobility, like the one in the slum adopted by our Department, formation of women's groups provides women with the opportunity to come out of the household as a first step. As one community worker explained,

  > "In the beginning women would be absorbed in household affairs and often said they had no time to participate. When some of us got together and started a preschool centre and skill training program, women became curious. Today we have many women who find that they can manage their household activities and tasks better and spare 2-3 hours. More importantly, they feel this spare time is to be devoted to themselves. The [women's group] has gradually helped women to voice their inner feelings first in the group and then [they are better able] to speak within the family."

The community workers felt that increasing the self-confidence and self-esteem of women was one of the major results of our project. From their own experiences, they felt that neither education alone nor opportunities to earn, give a woman self-confidence. It is the

external recognition by others followed by internal (self) realization that builds self-esteem. Once a woman has self-esteem she begins to "find the person within the woman," and starts to take responsibility for her own health needs.

Community members directed a number of suggestions to functionaries of government programs, such as educators:

- look beyond the visible constraints of education and income;
- look at family size, how the woman dresses;
- be sensitive to care constraint issues;
- look for the subtleties in each home/family; and
- use an individual approach since each family is unique.

While group meetings and group sessions for educational purposes are important, small informal meetings, and more importantly, meeting the woman individually in her home, are essential.

The women's group in this community appears to be emerging as a social support mechanism, and is demonstrating indigenous ways in which girls and women can be sensitized to their needs, rights, duties, and responsibilities. Women have been successfully motivated to limit family size, and to recognize that, by having a large family, a woman is punishing herself.

Girls between the ages of 12 and 18 years have been identified as those most in need of support and opportunities. As an example of a program directed to girls, in skills training class, the Koran is interpreted for the girls in terms of health issues, hygiene, education, responsibilities, rights and duties of a woman to herself, to her family, and to the community.

A basic needs strategy for women in developing countries should assist women to contribute more effectively to the satisfaction of the basic needs of their families, within the framework of their traditional responsibilities. Additionally, women's work burdens need to be alleviated, their economic independence increased, and they need to be more equitably integrated into the community beyond the narrow circle of the family. There is a need to focus on both material needs (e.g., food, health, shelter, education) and non-material needs (decision-making participation, cultural needs, self-realization).

### Areas for Further Research

Certain aspects pertaining to women's health still remain to be addressed fully:

- women's perceptions of their own physiology and how these perceptions affect their recognition of their specific health needs and their decisions to seek health care;

- the concept of "normality" and what defines positive health;

- the linkages between onset of menstruation, pregnancy, childbirth, and menopause with women's status and their role in society - the implications for physical, psychological, and social well-being;

- perceptions and attitudes of health care providers about health care services and systems, as well as their gender sensitivity;

- the conditions under which women's self-esteem and decision-making power, leading to domestic autonomy, can improve;

- to what extent education in itself influences the health status of women (as a result of the new ideas and knowledge that it imparts). Or is improved status of women as a result of education related to the corresponding improvement in their autonomy in decision-making?; and

- whether health status can be improved to a greater extent by mechanisms to return primary responsibility for health to the individual, the family, and the community, rather than through increasing dependence on medical services.

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# Achieving Community Health Development: Some Issues and Their Implications

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## *Introduction*

At the 1978 Alma-Ata Conference, the objective of achieving "health for all" was set for the Year 2000. With less than a decade remaining until the target date, the Philippines, among many other developing countries, must consider a new deadline. Health in the Philippines is still regarded as being in a "precarious" state, and the widespread presence of organized local groups which are actively involved in community-based health-care management has yet to become a reality. While there are many "success" stories of the application of community health development approaches, they are basically small-scale, unconnected, and geographically-confined experiences. At the same time, the requisites for putting a nationwide effort in place to establish viable and sustainable community-based health-care systems are still being fully identified, understood, and tried out.

This paper presents a synthesis of a retrospective process analysis of four Philippine rural *barangays*[2]. The study provides yet another set of experiences related to community health development. The first initiatives for community health development in these *barangays* took place nearly 10 years prior to the study. In two *barangays*, a variety of health-focused and related activities were coupled with almost sustained and directed work, through the efforts of a nongovernment organization. One site (Masiit) received from the organization an uninterrupted presence of almost 10 years, while the other (Gulod) could claim a total of about 5 years. In the two other sites (Patong and Kaingin), activities focused only on the training of community health workers under the government's primary health care program. The four *barangays* also received medical missions or health outreach programs of other nongoverment agencies, in addition to being provided health and related services under regular government programs.

## *Initiatives and Strategies for Community Health Development*

The four *barangays* also became settings of non-health-focused projects and programs. Among these were the development of crop and livestock production, formation of cooperatives, and infrastructure development. Some of these articulated social developmental

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[2] *Barangays* (villages) are the smallest geo-political units in the Philippines.

goals, and sought the formation of peoples' organizations capable of managing local resources. Moreover, community residents themselves acted to address some of their needs and problems through collective efforts or the formation of community associations. It can be asserted, therefore, that the study sites were within the mainstream of development initiatives and assistance, whether in health or other concerns.

Community health development is generally expected to lead to two major changes in the community: improved health status of individuals, households, and the community, in general; and enhanced capability of organized local groups or peoples' organizations to attend to the community's basic health-care needs. The latter may be reflected in the community's heightened awareness of health problems and needs, and the capability to take action to address these problems and needs. When community health becomes the entry point of community organization or institution-building activities, it is also envisioned that local management capabilities will eventually extend to non-health concerns (WHO 1981).

Because of data limitations, it is not possible to measure the changes which took place in the four communities after 10 years of community health development experience. The health conditions and local health-care management capability obtained in these communities at the time of the study, however, could indicate the extent to which community health development efforts, as well as other development initiatives, had become part of the community development processes. As contained in the Declaration of Alma-Ata, the health conditions include at least:

> education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; prevention and control of locally endemic diseases; appropriate treatment of common diseases; and the provision of essential drugs.

There were no discernible differences in community health conditions among the four *barangays* studied. Neither were there significant differences between the two sets of communities, that is, the settings of a nongovernment organization's health programs and the targets of the government's community health workers' training. A number of basic health aspects persisted as areas of concern except, to a certain extent, in Patong, a government-assisted site. This *barangay* appeared better off in terms of the presence of sanitary toilets and safe water, cleanliness of surroundings, and access to and use of health services. But this community also did not have any problem with endemic disease, and had slightly better physical accessibility and socioeconomic features than the three other *barangays*.

The inadequacy of household and community efforts to maintain environmental sanitation was both visible and perceptible by scent in Masiit, Kaingin, and Gulod. In the case of Patong, regular maintenance of a clean and tidy appearance constituted the most prominent collective action for health of its residents. Other health aspects, however, remained essentially the responsibilities of individual families and households.

Sanitary toilet facilities were lacking, except in Patong where over 80% of households owned water-sealed toilets. The two sites which were long-term project sites of a nongovernment organization had very low figures (9% in Gulod and 49% in Masiit). The absence of sanitary toilets in Masiit was particularly problematic, given that the *barangay* was located within a schistosomiasis-endemic area. The fourth community (Kaingin) likewise had a low proportion of households (46%) with sanitary toilets. Again, except in Patong, the presence of sanitary toilets in the communities studied resulted from external initiatives and assistance. Households from the three *barangays* had a long and repeated history of receiving toilet bowls and, in some instances, rice, under food-for-work programs from both government and nongovernment agencies. As the figures show, however, the assistance did not seem to have inculcated among households the importance of having sanitary toilets.

Safe sources of domestic water within easy reach of residents were only available, at least to the extent that water services remained uninterrupted, in the case of Patong. This *barangay* had access to a local water district providing mostly individual household connections. In Gulod, Masiit, and Kaingin, the majority of households relied on rivers, streams, springs, and open wells. Most of these sources, but particularly those in Gulod which had a hilly terrain, entailed some amount of hiking and were of questionable potability. In spite of the schistosomiasis problem in Masiit, some households continued to tap the river for their domestic water needs, particularly for bathing and laundry. Gulod and Kaingin both used springs which were developed into systems with concrete tanks and communal faucets, but which did not supply the entire *barangay*. Community efforts to improve domestic water sources were quite evident in the case of spring development projects. The efforts also helped to identify mechanisms for operating and maintaining the system.

Malnutrition was prevalent, with first to third degree reaching a total of 35 to 60% of children covered by weight surveys. Outside the irregular food supplies from government and nongovernment agencies, there were no other direct intervention activities. Community efforts to address the malnutrition problem were sought through health education and proper nutrition campaigns targeting mothers. These were conducted by government and non-government organizations. In the case of Gulod and Masiit, health education classes for mothers and other household members were conducted as part of the community health development activities. Moreover, there were unsuccessful attempts to popularize the planting of vegetables and other food crops in home lots and communal gardens for household consumption. The latter would have been important to the food supplies in Masiit, Gulod, and Kaingin, which were not diversified.

Widespread and sustained health education activities were not part of the experiences of the four communities. Health education classes were held formally only in Masiit and Gulod as part of the work of nongovernment organizations. The reach of these classes, however, did not seem to be extensive. In Gulod, only about one-third of households were represented in the mothers' classes held in 1987-89. In Masiit, the formal classes, conducted in 1982-83 and again in 1988, were limited to community health workers, who in turn provided

occasional "echo" seminars to other residents. In both Kaingin and Patong, health education was provided informally by the rural health midwives as part of their consultation-treatment sessions in the *barangay*.

Community health workers, including trained birth attendants, were found in the four *barangays*. Gulod and Masiit had the most active volunteers, five and six, respectively. Patong and Kaingin had only one each. These workers were among a number who had been identified and trained over the years. Gulod and Masiit health workers underwent more intensive and lengthier training sessions, and also received refresher courses. With the exception of the trained traditional birth attendants who were approached for pre- and post-natal care, the health workers' major services centred on dispensing whatever medicines were placed under their custody, and preparing referral slips for or accompanying patients to government health facilities. Thus, the Gulod and Masiit health workers, who had access to more supplies, were also the most sought in their respective communities.

A number of essential drugs had become available to the *barangay* residents through the community health workers, although the supplies came irregularly and in what were considered by the communities to be inadequate amounts. In the case of Masiit and Gulod, *botika sa barangay* projects of community health groups also improved the available supplies. The presence of the *botika* in Gulod appeared to be quite important to the residents because of their difficult access to the town centre, and the absence of small stores carrying inventories of essential drugs.

Except Gulod, owing to its physical-access problems, the communities studied had easy access to government and private health facilities. Nonetheless, these facilities generally came at the end of a chain of a disease management strategy which began with self-treatment and home care (using a combination of drugs and herbal preparations), followed by traditional healers and, sometimes, more traditional healers. Cases which were brought to health facilities or professionals were generally those perceived to be serious or in need of emergency attention. Preventive care in the form of immunization was accepted by residents, but they would not go out of their way to seek or demand the service. It seemed that the initiative for providing the service had to come from health workers, who also had to provide the service within the *barangay*.

In all four *barangays*, there were no community health organizations actively engaged in identifying, pursuing, and sustaining health-related activities which were either promotive, preventive, or curative. Community health organizations were formed in Gulod and Masiit through the assistance of nongovernment organization workers. These groups became busy with health and related activities immediately following their formation, which was also a period of intense presence of the agency workers. In Gulod, after the agency pulled out of the area, signs of inactivity appeared among the groups formed. If the *barangay's* first experience (1979-81) with a community health development program were to be a basis, the continued existence of the health groups formed during the second experience (1987-90) was not to be expected. In Masiit, the community health organizations had been transformed into

multifunction groups, and appeared to have been focusing their efforts on non-health concerns, mostly income-generating and issue-advocacy activities. The extent to which these groups could turn around and become health-focused groups anew remains to be seen.

The health as well as other development experiences of the four communities, and the conditions leading to health found at the time of the study, raise a number of issues related to the implementation of the community health development approach. The Gulod and Masiit experiences are particularly important in highlighting these issues because of the intensive and long-term presence of a community health program carried out by a nongovernment organization. The issues, in turn, provide insights on the strategies and processes to be employed by implementing agencies, both government and nongovernment, in pursuing community health development, and the implications of these on the policies, capabilities, and resources needed to be developed or enhanced within these agencies for an expanded and more effective action.

The issues could be grouped into the following topics: the processes and activities involved in community health development, community organizations for health-care management, roles and tasks of community health workers, and collaboration among development agencies. The following discussion presents the implications of these issues on national programming for community health development.

## *Processes and Activities*

As seen in the experiences of the four *barangays*, particularly those of Gulod and Masiit, a number of the key activities involved in the process of community health development appeared to have logical sequences, while others could be undertaken without specific order. Broadly categorized, these activities pertain to the community diagnosis or analysis and project implementation phases.[3] These phases are neither discrete nor culminating, but take an iterative cycle.

### *Community Diagnosis*

The community health development efforts in Gulod and Masiit began as activities aimed at introducing the program and its staff to the community. This community entry and integration stage served to enable the field workers to develop an initial understanding of local conditions, to know and be known to the residents, and to gain their trust and cooperation. This activity was pursued through house calls on, and informal interviews with,

[3] Site selection is an important first phase in any program, whether community health development or others. A nationwide implementation which comes in stages, as may be dictated by available resources and the concern to gain agency competence, has to balance the immediacy of the need for health interventions and the learning opportunities available in potential sites.

*barangay* leaders and other residents, as well as visits to different parts of the *barangay*. It also involved group or community meetings for an introduction and discussion of the objectives of the program in the *barangay*.

In Gulod's first experience with a community health development program, a more formal community diagnosis took place nearly a year after the entry of the nongovernment agency field staff. The study was conducted by the agency workers and volunteers, with the results presented to the community residents in an assembly. A similar scene took place in the second community health program in the *barangay*. In Masiit, the formal community diagnosis also took place much later after the community entry of the agency field workers, and was carried out with the participation of community health workers. Both the Gulod and Masiit community analyses used surveys of households, involving both quantitative and qualitative data.

It is not clear how the formal community diagnosis influenced what needed to be done in Gulod and Masiit, as determined by the residents themselves. The sequences of activities and events in the two sites indicated that the major project activities were begun even before the community diagnosis was completed. Interestingly, the community analysis and planning undertaken in the two *barangays* did not form part of the community memory of events related to the community health development efforts. Community participation in formulating the diagnostic methodology and tools, and analyzing these to come up with the initial project plans, was not evident.

The two experiences raise several questions relative to the community's role in the project planning stage:

- when should community diagnosis take place?
- how could this be carried out systematically (that is, what methodologies and tools should be used)?
- what strategies could be employed so that community members could be involved as data sources and data users?
- how could a direct link between community diagnosis and project planning be achieved under a participatory framework?

As noted from various development efforts, community diagnosis as a project planning tool in participatory settings is expected to provide an initial and immediate, yet systematic, understanding of specific conditions. This understanding should lead to the identification of appropriate activities, strategies, and approaches by both the project staff and the community members. The community members' participation in the planning phase is also expected to encourage a more active and effective involvement in the implementation phase. A participatory community diagnosis thus also becomes an important initial step in community capacity building.

Community diagnosis serves the purposes of two groups, namely the outsiders, who initiate development activities, and the community members, who will carry out these activities. Members of implementing agencies and resource institutions, including research organizations, which provide assistance to communities, need to develop a good knowledge of the settings of their activities. This knowledge enhances their roles as facilitators of technically appropriate and community-based action. On the part of the community members, gaining a common understanding of their environment, its resources, problems, and potentials, serves the needs of collective problem solving and decision-making. At the same time, it engenders greater responsibility for sustaining the development work (WHO 1991).

Experiences in community health development, as well as those in other fields, have generated a collection of methods and tools for community diagnosis (see for example, Khon Kaen University 1987; Scrimshaw and Hurtado 1987; Chambers 1992; International Institute for Environment and Development 1992). The main themes reflected in many of these methods and tools include the need for rapidity and iteration, more emphasis on qualitative than quantitative data, inclusion of indigenous measures and analytical tools, use of local indicators, and presence of multidisciplinary or diverse perspectives. Participatory community diagnosis implies the involvement of community residents in all phases of the activity, from identification of the types of data to be collected to the analysis of these data for project planning. Outsiders serve as facilitators and co-learners.

In the case of community health development in the Philippines, the challenge for the Department of Health and nongovernment organizations concerned is to work together in developing and using a community diagnosis process that is appropriate, systematic, and community-based. This implies gaining the skills for integrating technical soundness and participatory mechanisms within the process.[4] But the availability of methods and tools become useful only when coupled with the presence of well-trained users. Hence, a further concern will be the development of more competence among the field staff of the Department and nongovernment organizations in facilitating a participatory community diagnosis process.

### *Initial Community Projects and Activities*

The community analysis which takes place at the outset of community work becomes the basis for the identification of community problems and needs, and decisions regarding the corresponding actions to be taken. This analysis could answer such questions as:

[4] Technical competence may not be a problem among organizations such as the one focused in this study, which was staffed by medical doctors and other health professionals, and assisted by student-volunteers from medical and allied fields. But for many other nongovernment organizations venturing into community health development, acquiring competence in working with health issues and problems, particularly among community organizers and other field staff, is an imperative.

- what activities are appropriate for initiating community health development?
- where and when should these activities be undertaken?
- who should be involved in carrying out these activities?
- who should contribute or do what?
- what strategies and mechanisms need to be employed in pursuing these
- activities? and
- what other activities should be implemented as a follow through or to sustain the initial work?

When conducted under a participatory setting, the analysis logically incorporates the active involvement of the community in planning, which could bring about an effective and sustainable community-based action.

The research findings indicate that it could be difficult to design activities specific to the needs and capabilities of a community when the assisting agency already has a set of activities formulated for the area, or is guided by funding requirements and constraints. Preplanned community work may be reflected in the types of activities initiated and the scheduling of these activities. It may also be seen in the manner in which these activities are carried out.

For instance, the major activities in Masiit were undertaken almost simultaneously with those in six other sites. In addition to the training of health workers, activities focused on the control of pulmonary tuberculosis even before a systematic community analysis was undertaken. While it cannot be denied that the disease was a critical problem in these areas, there must be some compromise as to what the members of a particular community wanted to do at that time, and what they could be assisted to do as a group to foster capability building. Needs for immediate technical intervention could be addressed initially outside community health development activities or under regular health service delivery schemes. As the group develops and strengthens its organizational skills, it should logically turn its attention to critical health problems and needs.

The Gulod experience likewise suggests a lack of determined effort in ensuring a fit between local conditions and the implemented community projects. While separate organizing work was pursued for the different *sitio*, this did not seem to have been based on real differences between these areas. The same activities were undertaken in these areas, with almost identical schedules. For example, a meeting would be held in the morning in Sentro, and a similar meeting would be conducted in Bakod in the afternoon or the following day. Many of the activities of the groups organized in the different *sitio*, such as leadership seminars and community health workers' training, were also held as joint sessions. The evidence points more to a scheduling of activities which address the agency workers' concerns for manageability and cost effectiveness, rather than the community members' needs and pace.

The 1987-90 community health program in Gulod was initiated with a focus on maternal and child health. Thus, the community organizers immediately sought out women for participation in mothers' classes, which were conducted separately for the different *sitio*. Day care centres were also established almost simultaneously in all *sitio*. Without de-emphasizing the importance of targeting mothers and children in community health and the key roles women play in health promotion and maintenance, issues could still be raised concerning the community's participation in deciding what health-focused activities need to be carried out at a given time. This also relates to the issue on which groups and individuals could and should take the initial lead role in community activities for health (Oakley 1989).

The experiences of Patong and Kaingin with government health programs revealed how the absence of community participation in the identification and conduct of activities, as well as the selection of the participants of these activities, could mitigate the impact of these activities. In the case of Patong particularly, the selection and training of *barangay* health workers appeared to have been performed perfunctorily. None of these workers became functional, but the community members did not seem too disappointed either. Their noninvolvement in the selection of health workers appeared not to have brought about a concern about what eventually should happen to these workers and their expected roles in the community.

A similar apathy was revealed with regard to programs for the provision of sanitary toilets, which were implemented repeatedly by various groups in Kaingin and Masiit. These programs came with specific plans concerning what needs to be distributed free to households (toilet bowls), who would determine the recipients (*barangay* officials and community health workers), and what the recipients' roles counterparts would be (providing labour and materials for the pit and housing for the toilets). The dole-out nature of the programs was obviously unable to create a sustained concern for the presence of sanitary toilets, as indicated by the number of such facilities in the two *barangays*.

The experiences of the four communities in community health and other development programs indicate that community residents placed a high priority on projects involving infrastructure development. Externally assisted projects of this nature received great interest and participation from the residents. Most locally initiated projects also involved construction or putting up facilities and structures for community use. While recognizing that the potential employment opportunity in infrastructure projects with external assistance, as well as the visible results of these projects, was a strong incentive for the residents' interest and involvement, it can also be argued that the ability of this type of project to mobilize community participation could prove significant for community health, as well as other development initiatives. Assisting agencies may do well to consider this project type as entry points, but conscious efforts must be made to use community participation as a mechanism toward capacity building. A weakness revealed by the four cases was that, although infrastructure projects elicited widespread participation in the form of voluntary group work and, in some cases, contribution of materials which could be obtained in the

locality, no effort was made by the development agencies concerned to use these projects for capability building or organizational development. Thus, community participation became merely the "ends" and not the "means" for development.

Voluntary group work as a regular feature of community life was noted in all sites. It was most evident in cleanliness and beautification activities on roads, open areas, and home lots along major roads, particularly in connection with coming *barangay* festivities and visits of outsiders, especially government officials. Group work also played an important part in the construction of such *barangay* facilities as chapels, basketball courts, pavement, and stages where community gatherings could be held, whether or not outside assistance was received for the purchase of materials and technical supervision. In all this, however, group work was manifested as a transitory and as-the-need-arises community effort, rather than as part of a continuing collective action to address local problems and needs. It still remains for development workers and organizers to assist in the transformation of the community's spirit of group work into a mechanism for sustainable change.

## *Community Health Organizations*

The formation of community organizations which will manage health and related activities is a major objective of community health development efforts. These organizations are expected to take responsibility for identifying, planning, implementing, and sustaining community activities related to basic health care management. Important to these organizations is the capability for going through an iterative process of analyzing local conditions, ascertaining problems, and acting to solve these problems (WHO 1991). This in turn raises a number of questions.

- What then is community organization for health development?
- What is the appropriate community organization for health, in terms of membership composition and leadership structure?
- When should this be organized?
- Should health-focused activities be integrated into existing groups?
- Should the functions of health groups be diversified?
- When should the diversification to other non-health tasks occur?
- What activities could community health organizations take on to ensure their sustainability or continued presence?

Community organizing work in Gulod and Masiit was undertaken separately for the different residential clusters. In the more recent Gulod experience, three organizations were formed in each of the built-up areas located on distant hills; in Masiit, separate groups were organized in the built-up areas found on each side of the river cutting across the *barangay*. The strategy appeared significant in mobilizing high participation rates from the residents. It obviously took into account the distance and difficult access between the built-up areas, which could discourage the residents in one area from attending group activities held in another area. Having organizations in the different built-up areas also brought about the

formation of small groups, which would demand less complicated organization management structure and skills as the groups were composed of members with expectedly more commonality and a history of regular interactions.

In both Masiit and Gulod, the formation of health-focused organizations occurred within the first year of the entry of the community organizers into the *barangay*. In Masiit, these groups initially involved the trained health workers, and were later expanded to include other community members. In Gulod in 1979-81, the *Munting Pangkat Kristiano,* or Basic Christian Communities, became the initial organizations; in 1987-90, the members of mothers' classes constituted the community health organizations. In the two periods, the community health workers were selected from among the members of these organizations.

*Sustainability*

The first batch of Gulod organizations had been established for a year when organizing work in the area was discontinued. These groups became inactive soon after the community organizers left the *barangay*. With regard to the mothers' groups, immediately following their formation, plans were drawn up for their projects and activities. One group worked for the construction of a health centre while another put up a *botika sa barangay*. The groups were also involved in initiating day care centres and in undertaking centre feeding and supplementary food rationing activities for malnourished children. These activities kept the associations very busy, particularly the leaders, who were also involved in leadership training and related seminars. However, when the health centre was built, the *botika* became operational, one batch of children was graduated from the day care centres, and food supplies from the government became scarce. Inactivity began to set in among the organizations. The associations appeared unable to initiate activities which would take the place of the mothers' classes.

Unfortunately, the beginnings of inactivity of the Gulod mothers' groups also coincided with the withdrawal of the community organizers. Considering the active presence that the community organizers had played in the initial activities, and the articulated continued assistance expected of them by the organizations, it is difficult to imagine that the organizations would still be able to pursue their other planned activities, including toilet construction and a spring development project. In pursuing their tasks, the organizers were not only providing constant reminders to the organizations to work toward the completion of the initial projects, but were also instrumental in seeking external funding support and in mobilizing nonorganization members to contribute to or participate in the projects.

In Masiit, the first year following the formation of the health organizations was devoted to training the community health workers. The community activities undertaken, such as education campaigns on tuberculosis control and the establishment of herbal gardens, were part of the health workers' training program. Other group activities were initiated after the completion of the training, and the expansion of the organization membership outside the community health workers. This organizational expansion was brought about by an

expanded thrust in the work of the assisting nongovernment organization. From a health-focused program, the agency extended its activities to incorporate non-health concerns, particularly livelihood projects. It initiated not only the expansion of *barangay*-based associations, but also the federation of these groups into province-wide organizations. About that time, the nongovernment organization also expanded its area of operation in the province.

The reorganized Masiit groups subsequently undertook community projects. In addition to such health-related activities as toilet construction and *botika sa barangay*, the associations engaged in collective farming and bio-intensive gardening. The nongovernment organization made funds available for these association projects, as well as for livelihood activities of individual members, including pig raising and small-scale business enterprises. The *barangay*-level livelihood projects were generally expected to contribute to the operation of the rice mill and cooperative stores which were established at the town centre as part of the activities of the federation. At the time of this study's fieldwork, the associations were still pursuing some of the projects, although repayment problems were being encountered with regard to the loans provided to these groups as well as to their individual members by the nongovernment organization.

Several issues are highlighted by the experiences of the Gulod and Masiit associations. One concerns the sequencing of the formation of a community association and the identification of activities which require an organized group for their planning and implementation. The turn of events in Gulod suggests that forming an organization so that it could immediately define and implement community activities tended to become project-focused and accomplishment-oriented, especially if these activities were receiving support from agency workers. The association could become driven toward achievements and concrete results, instead of attentive on gaining skills in project planning and implementation. This could explain why after having completed a project or being frustrated in continuing an activity, the Gulod associations appeared at a loss in setting subsequent directions and tasks. This story of newly formed organizations taking on a project, completing it, and then retreating to inactivity is repeated many times over in the experiences in non-health-focused development initiatives of the four *barangays* studied. Common to these experiences was the absence of a systematic and sustained organizational skills development.

It has been demonstrated repeatedly elsewhere that community health organizations could not be sustained unless their activities were carried out in pursuit of self-governance, instead of simply implementing projects, especially if these projects involved a "blueprint." This means not only matching the group's activities with community-perceived and prioritized needs, but also locating the activities within the organizations' self-defined, albeit evolving, functions (Uphoff 1986).

The other issue proceeds from the first, and concerns the relationship between a community organization's active status vis-a-vis the assisting agency workers' presence. It is not difficult to conclude that the workers' presence and ability to bring in external assistance

enabled the Gulod and Masiit organizations to actively pursue various activities and projects. Activities after activities, or even activities with competing schedules, were undertaken in Gulod during a two-year period. In the case of the organizations in Masiit, the pacing of projects appeared less hurried, at least until funds for the livelihood projects were made available. Nonetheless, the identification and implementation of the activities which took place in this *barangay* involved the active participation of community organizers. These workers are indeed expected to provide a "prodding" presence in the community so that the development process is facilitated and hastened. But in pursuing this role, organizers may also need to regularly reflect on the extent to which they influence community events, and how these events contribute toward developing problem-solving and other organizational capabilities among the groups they work with. Their presence should also be a constant reminder to these groups that the pursuit of projects and activities is part of their skills enhancement.

Another issue pertains to the membership composition of community health organizations. While the Gulod groups began from the mothers' classes, the projects and activities carried out called for the involvement of other community members. This, however, did not bring about a reconsideration of the membership composition. Membership dwindled from the initial list (representing a total of about one-third of households), but no efforts were made to take in new members. In Masiit, the membership composition of the organized groups was redefined in accordance with the changes in the assisting nongovernment organization's development program thrust. From an association of community health workers, the Masiit groups could be said to have been transformed into a broader-based people's organization. (The health-focused groups were still being considered as existing under this organization). The membership composition of an organization is an issue which may need to be raised repeatedly among its members and the larger community as well. The participants in the activities undertaken by an organization should be able to ascertain its appropriate membership composition. Moreover, widening the membership base should be a concern if initial health-focused activities were to become the core of the entire community's health development.

A related issue concerns organizational leadership and the process of developing more leaders. In the Gulod groups, leaders remained unchanged for two years, despite the declining membership participation in organization activities. In the case of the Masiit groups, the changes in the membership composition and leadership structures of the organizations brought about changes in leaders. Almost yearly elections were held in these organizations, although the elections did not radically change the leadership core. The Masiit organization officers were also occasionally convened for leadership training sessions. In their work toward the formation of community organizations, development agencies should also be challenged to go beyond assisting in the identification of potential and initial leaders. The election of organization leaders is a process which organized groups may need to go through regularly and in short intervals. This will result in either of two conditions — a succeeding generation of leaders (or "second-liners") is identified, or a fresh mandate is received by existing leaders. In either case, leadership is strengthened.

The continuing active status of the organizations in Masiit appeared to have been brought about by both the continuing assistance of nongovernment organization workers and the diversification of work to include non-health activities. The community organizations, through the assisting nongovernment agency, gained access to external funds which could be used for these activities. Future events could allow an assessment of the extent to which external funds, more than organizational capabilities, kept the groups active. Nonetheless, the inactivity of the groups as health-focused organizations could already be viewed with some concern, and efforts may need to be undertaken to bring them back to their original functions. Findings from studies of originally single-task-focused irrigation organizations which became multipurpose indicated more weaknesses than advantages brought about by the shift. At the same time, those which were able to make the transition were organizations that had long been carrying out a single-focused task and had demonstrated a competence for maintaining this task (Veneracion 1984).

### *Legalities*

The acquisition of legal personalities is an issue often raised concerning community organizations. The Masiit and Gulod organizations had differing experiences. The former had a legal personality, being part of federations of *barangay*-based groups in the province; the Gulod groups did not reach such a stage. The experiences of the groups in the two *barangays*, however, do not provide evidence for or against formal registration. None of the activities undertaken by the community groups actually called for a legal personality, nor were there planned activities which could not be carried out because of the absence of formal status. The value of a legal personality may thus come as the community organization gains competence for carrying out activities which may require more extensive interactions with other formally organized groups. A formal status may also be necessary as the organization attempts to secure large-scale external financing assistance.

## *Community Health Workers*

A common element in the health development experiences of the four communities studied was the presence of community health workers. These workers were looked upon as key players in the community's pursuit of community health development. The *barangay* health workers under the government's primary health care program were also regarded as the community's frontliners for health, as well as the government health workers' aids in the *barangay*. Several issues surface in assessing the presence and roles of community health workers in the four sites. These pertain to their selection and training, their qualifications for and performance of their jobs, and the locus of their accountability. The relationship or link of the health workers with external support systems also becomes important, given their limited technical skills and the community's health service needs.

The selection of community health workers in Gulod and Masiit involved a broader local participation than those in Patong and Kaingin. In the last two *barangays*, the rural health midwife selected the *barangay* health workers, with the concurrence of the *barangay* chief.

Community organizers in Gulod and Masiit discussed with the residents the criteria for selecting the potential health workers and assessing the candidates. In identifying potential health workers, the community organizers recognized the importance of traditional healers. The final selection of the initial batch of health workers was undertaken in community meetings. (In Masiit, succeeding batches or replacements were selected by the trained community health workers in consultation with community organizers.) The participatory nature of identifying community health workers appeared important, as indicated by the larger proportion of workers from the two sites who remained in their jobs. In Gulod and Masiit, about one in four of those who received training was found to be still in the post; in Kaingin, one in six; and in Patong, none of the three who were trained pursued the job.

Moreover, the inclusion of traditional healers as potential community health workers seemed to be a significant decision. In Gulod, among those who kept their posts were the traditional healers who were involved in the first community health workers' training program. As seen from the profiles of health service providers in the communities studied, traditional healers tended to maintain their calling until retirement, that is, upon being too old to perform healing tasks. Some had been serving their communities for as long as 40 years. This suggests a need to understand further traditional health practitioners, particularly with regard to the motivating and other factors related to their long, continued service. More important, the participation of traditional healers in community health development efforts may need to be given more consideration (Uphoff 1986; WHO 1981).

The community health workers in Gulod and Masiit received more intensive training than did those trained through the government program. The training activities of the Gulod and Masiit health workers also included immediately sharing their knowledge and skills with the community members, for example, through participation in onsite medical clinics organized by the trainers' group and conducting *barangay* seminars. In the case of the Masiit health workers, refresher courses were also provided. The more active status of the Gulod and Masiit health workers, compared with those in Kaingin and Patong, may thus be attributed not only to the participatory nature of their selection, but also to the communities' involvement in activities related to their training. The latter allowed the community members to develop a continuing interest in the work of the health workers. And certainly refresher courses could be useful both for improving the skills of the health workers and keeping them reminded of their functions.

The community health workers serve as the bridge between their community and the formal health system. They are therefore expected to play a balancing act so that the needs and expectations of both groups are met (Ofuso-Amaah 1983). Because of the assisting nongovernment organization's link with local health units, official recognition of the Gulod and Masiit community health workers was readily obtained. This enabled the health workers to formally establish their link with the health system. On the part of the communities, the health organizations provided the health workers' support in reaching out to the rest of the community. The health workers were expected to serve as motivators and catalysts in the

community's pursuit of health development. Their assistance was not limited to delivery of health services, but needed to include the more important aspects of identifying community problems and needs, and formulating action to address these.

The inactivity of the health groups, particularly in Gulod, may be used to argue that the health workers may not have fully internalized their roles as motivators and catalysts for community health-care management. In Masiit, the organizations could have undertaken health-focused activities, in addition to the livelihood and related projects, had the community health workers been more aggressive in carrying out their functions. This implies a further reexamination of the roles and functions of the community health workers vis-a-vis the community health groups. While community health workers may not necessarily occupy general positions of authority in community organizations, they are also in leadership roles in the sense that they serve as community motivators for health and as a bridge to the larger health system. Continuously emphasizing these roles to the health workers as well as to the larger community could further bring about not only longevity in their service, but a more active and relevant position.

### *Collaboration Among Development Agencies*

The initiatives for community health development may come from either government or nongovernment agencies. Eventually the two groups need to come together, as nongovernment organizations are expected to fade out of a community after achieving their institution-building tasks, while government agencies continue to sustain the work, as both enablers and service providers.

In Gulod and Masiit, where a nongovernment organization took the development initiative, linkages between the organization and the Department of Health, as well as between the organization and other groups working in the area, were established. The Department of Health played a role in many of the activities undertaken in these *barangays*, with the linkage generally forged through the efforts of the nongovernment organization staff.

In Gulod, the training of *hilots* (traditional birth attendant) was undertaken in coordination with the Department of Health. The practicum of the trainees was conducted in a government hospital. Moreover, through the representation of the nongovernment organization, funds for the construction of a health centre were provided to Gulod by the Department. In Masiit, training of health workers was likewise conducted with assistance from the local health offices. These health workers eventually developed a functional referral system with the district hospital.

What could be a key to the good linkage between the community and the Department of Health was the transition of some of the nongovernment organization staff to positions within the Department. In Masiit, one of the agency members who initiated activity in the *barangay* was then also connected with the district hospital, eventually becoming its chief. The presence of a former staff member of the nongovernment organization, and with whom

they had worked very closely, appeared to have encouraged the community members to actively access Department of Health services because of a perceived "direct line" to the agency. In Gulod, the nongovernment organization's medical doctor who was assigned to the *barangay* had strong ties with the provincial health office, and later joined this office. The transition was also welcomed by the residents for they considered this as having an additional facility which they could access. (The *barangay* was covered by the city health office, but the difficult physical access to its facility often forced residents to locate alternative government health facilities.)

While the basic ingredient of the Masiit and Gulod experiences on linkage with the Department of Health may not be too easily replicated, a lesson learned could be the significance of establishing a working relationship with the Department (or the government agency concerned) at the beginning of a nongovernment organization's community work. This could allow a smooth interface of roles from the nongovernment organization to the Department, and the development of a functional relationship between the community and the Department, making it unnecessary for the two agencies to go through a "turn-over" phase.

In the case of the linkage among nongovernment organizations, the Gulod and Masiit experiences direct questions on the nature of the linkage and the extent to which this should be sought. In Gulod, the major assisting nongovernment organization initially coordinated with other nongovernment organizations working in the area, with the former taking care of the health aspect of a broad-based and multi-issue community organizing. In Masiit, the assisting nongovernment organization established similar collaborative work with other nongovernment agencies. Subsequent events, however, revealed potential difficulties of tie-up arrangements. In Gulod, political issues brought about by the community organizing approach contributed to the agency's problems in reaching some groups in the *barangay*, and its temporary pull-out from the area. In Masiit, the discontinuance of a joint project of two nongovernment organizations led to a misconception among community residents that they needed to choose between the two groups organized by the different agencies.

Coordination among nongovernment organizations working in the same community is recognized as important toward sustainable development. The long-term implications of joint activities, however, may need to be assessed at the outset of these activities so that the accomplishments made by the organizations involved do not become dissipated when a parting of ways becomes inevitable. One concern that nongovernment organizations may need to consider in determining their areas of operation could be the presence of other nongovernment organizations working in the area, and the nature of the activities being undertaken so that a duplication of efforts does not take place. A vast area of the country is still regarded as unreached by development initiatives. Nongovernment organizations may do well to disperse themselves, instead of working in the same areas and causing confusion among community members.

## *Some Concluding Statements*

As gleaned from the experiences of Gulod, Masiit, Patong, and Kaingin, achieving community health demands a lot of investments from a variety of participating groups. The collaborative efforts demanded of development agencies, government and nongovernment, need to be intensive and well-delineated. Each group must bring into a partnership relation the appropriate organizational structures, resources, and competence, within a premise of being equal partners of local groups and communities in defining the goals and process of development. Much has already been said about community participation in all phases of development, and the present cases can only provide further evidence of the importance of this requirement. The four cases likewise reiterate the perspective that community health development means investing heavily on local capability building. Activities aimed at addressing health problems and needs remain meaningful and sustainable when undertaken as a component of the development or improvement of the organizational skills of local groups.

The experiences of the four *barangays* also point out that the process of pursuing community health development is a long one, and the results may be neither immediately visible nor measurable. However, it cannot be categorically stated that 5 or 10, or a given number of years of development work in a community, is enough to bring about *developed* community health. But the pursuit of development is a pressing one, and urges a quickening of the process. The investments are evident, and as is the need for strategies which are more community-based and conscious of capability building.

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# Traditional Customs, Cultural Beliefs, and Perceptions Toward Antenatal Care in Rural Myanmar: A Qualitative Approach

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## *Introduction*

Antenatal care has been defined by the World Health Organization as having one or more visits by a trained person during pregnancy. Antenatal care permits the screening of a predominantly healthy population in order to detect early signs of risk factors associated with pregnancy, followed by timely interventions (Rooney 1992).

Maternal mortality is still a leading cause of death for women of child bearing age in developing countries, including Myanmar. Theoretically, antenatal care may reduce maternal mortality and morbidity either through the detection and treatment of pregnancy-related or intercurrent illness, or through detection of women who are at risk for complications of delivery, and ensuring that delivery takes place in a suitably equipped facility. Hospital case series (Boes 1987), and confidential enquiries into causal pathways in maternal mortality, have frequently identified lack of antenatal care as a risk factor (Walker et al. 1986). Case control studies of maternal death in developing countries have also shown an association with lack of antenatal care (Bhatia 1985). It has been generally agreed that antenatal care is associated with a favourable pregnancy outcome (Greenberg 1983; Thomas et al. 1991).

The World Health Organization (1989) reported that, in some developing countries, more women are seen by health workers during pregnancy. Antenatal visits could therefore be the ideal opportunity for reaching out to women and addressing health issues related to women.

In Myanmar, 68% of pregnant women receive antenatal care, spread out between 20 and 40 weeks gestation (Report on Community Health Care Project Evaluation 1993). Women's traditional customs and cultural beliefs toward pregnancy, as well as their perceptions of the importance of antenatal care, are important determinants of whether a woman seeks antenatal care. To increase the acceptance of antenatal care, health education programs, as well as communication strategies, need to take into consideration traditional health beliefs.

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## *Research Approach and Study Design*

A rural area in Kyaukpadaung township (in central Myanmar) was chosen as the site of study. The study population consisted of currently married women of reproductive age (15-49 years) and their husbands, residing in four villages in Kyaukpadaung township. Dimensional sampling was utilised and homogenous groups were categorized as follows:

**Table 1. Outline of Study Population**

| | Parity | |
|---|---|---|
| Woman's age (in years) | 1 - 3 | 3 + |
| ≤30 | 1 group | 1 group |
| 30 + | 1 group | 1 group |

Four groups of women (6-8 women in each group), and four groups of respective husbands, were randomly selected. Focus group discussions were carried out under the guidance of trained moderators. In-depth interviews were carried out with female elders and traditional birth attendants.

Prior to conducting the study, the demography and population of Kyaukpadaung township were studied with the assistance of the Township Medical Officer of Kyaukpadaung. The villages were categorized into those having relatively easy access to roads and transportation and those which were far from roads. Two villages which were easily accessible, and two villages which were more remote, were selected randomly. The Township Medical Officer asked the basic health services staff assigned to these villages to make a list of women who conformed to the given criteria.

The team of researchers arrived in Kyaukpadaung township and were taken to the village which would be the headquarters for the team. In that village, the team met with the local health workers - the health assistant, the lady health visitor, and the midwives. The team leader explained the purpose of the visit and asked them for their help in the recruitment of participants. The timing for the focus group discussions was also selected, so as not to interfere with their daily activities. The site for the meeting place was in the yard of the headman of the village.

The team then randomly selected 7 women, under the age of 30, having less than 3 children, and their husbands, from among the women in the village who had these characteristics. They visited the homes and explained the purpose of the focus group discussion to the women and their husbands, and asked them to come for the focus group discussion the next day at 9:30 in the morning.

The same procedure was carried out in the remaining three villages to obtain the required study population. Eight focus group discussions were held in these villages. In each of these villages, in-depth interviews were conducted with older women.

All sessions followed the same discussion guidelines that had been previously prepared, based on what the researchers believed would yield the information desired. The guidelines had been tested on women living in periurban areas in Yangon. Some modifications in the way the questions were phrased were made over the course of the discussions based on experience from prior discussions.

## *Findings*

The presentation of the findings is organized in a chronological order, starting from an awareness of signs of pregnancy and perceived dangers of pregnancy, the traditional customs and cultural beliefs toward pregnancy, and the perceived merits and demerits of antenatal care.

### *Symptoms of Pregnancy*

Most of the women were aware of the symptoms of pregnancy. They noticed such signs as loss of appetite, nausea, vomiting, and cessation of menstruation in the early months. Some also stated that they had headaches and became dizzy easily. They stated that they became more sleepy and wanted to eat different kinds of food in the later months of pregnancy - for instance, sour mangoes, other sour foods, and hot and spicy foods. A few stated that they had wanted to eat strange things during their pregnancy such as raw kernels of rice, ash, and coal. They also stated that the ends of their hair became dry and brittle once they conceived.

### *First Person Consulted*

Most of the women either told their husbands or mothers first.

### *Confirmation of Pregnancy*

The women confirmed that they were pregnant by waiting up to three months after the cessation of menstruation. Then they either went to the traditional birth attendant, the auxiliary midwife, the midwife, or the lady health visitor. Some stated that five months after menstruation ceases, the baby starts to move inside and that is confirmation of pregnancy.

### *Feelings Toward Pregnancy*

Feelings toward pregnancy varied depending on the birth order of the child. For the first pregnancy, the feelings were happiness, a feeling of importance, and fear of the dangers of pregnancy. The husbands felt happy but were also concerned about the health of the mother and child. The following comments were made:

- "I was happy when I first became pregnant. I felt I was a more important person than before."
- "I was scared when I first became pregnant. My husband was also worried."

For subsequent pregnancies, which were unplanned, both husbands and wives were not happy because they felt that it was expensive to have a lot of children. Some stated that when they knew they were pregnant again, they were unhappy, but when they saw the newborn baby, they felt happy again. The following comments were made:

- "When I became pregnant again, I felt disheartened."
- "We are poor and cannot afford to have many children."
- "If I have too many children, I cannot look after them well."
- "I cannot work as much as I want to, if I am pregnant."
- "After the second child, I don't even want to stay together with my husband."
- "My husband cried when he knew I was pregnant again."

*Perceived Dangers of Pregnancy*

Most of the women perceived pregnancy as a natural process. They felt that edema during pregnancy was normal and that it would subside after delivery. Some women stated that "a pregnant woman or a woman in labour already has one foot in the grave." The women identified the following problems and dangers associated with pregnancy: bleeding before delivery, miscarriage, abnormal presentation of the baby, big baby, bleeding after delivery, adhesion of placenta, fits associated with pregnancy, varicose veins, jaundice during pregnancy, and high blood pressure.

The women also stated that women who were very short or who had a narrow pelvis were most likely to have a difficult labour. They also perceived that if they were "weak," they would have a prolonged labour.

The perception that edema was a normal phenomenon, and that it was not a dangerous sign, was expressed by most of the women. They stated that by taking a concoction of a ginger-like herb and turmeric, the edema would subside. Even if it did not subside during pregnancy, they stated that it usually subsided after delivery. They perceived edema as more of a nuisance, making them heavy and prone to injury, rather than a danger.

Husbands felt that pregnancy was a time when one had to take better care of the woman, and this was more important during delivery. They felt that from the beginning of pregnancy, until the time the baby is delivered, women need special care.

### *Traditional Beliefs Toward Pregnancy*

Most of the women believed that pregnancy was a normal phenomenon. The husbands believed that women should not work as hard as usual during pregnancy, and should be given priority. They believed that if a woman feels heavy during pregnancy, she will give birth to a boy, and if she feels light, she will give birth to a girl. The grandmothers believed that the more children one has, the more helping hands you will have. Others believed that you were fortunate to become pregnant. Women also believed that "children are treasures," and if you have no children, people would remark that you are a "barren and useless woman." They believed that "you are looking toward the graveyard three times a day when you are pregnant." Some also stated the saying that "a man going on a raft on the river and a woman becoming pregnant face dangers."

### *Traditional Customs During Pregnancy*

Most women accepted that pregnancy was a normal experience, but that there were certain practices and behaviours that one should observe during pregnancy. The following are some of the traditional customs:

- "You must not lift heavy weights during pregnancy - otherwise you'll break the baby's back."
- "You must not bend and pick up things, in case you hurt the baby."
- "You must not bathe after mid-day."
- "You must try not to get caught in the rain. Otherwise you'll get aching joints."
- "You must not bargain when you shop. If you do, you'll have difficult labour."
- "You must not mend baskets which have holes."
- "You must not handle water that has dripped from the threshold or a zinc roof. If you do, you'll have tingling and numbness and aching joints."
- "You must not go to a funeral when you are pregnant."
- "You must not handle dead bodies."
- "If the wife is pregnant, the husband must not climb trees."

Regarding these customs, there was no difference between the beliefs of the younger women and the beliefs of female elders.

### *Traditional Beliefs Toward Food*

The following were the traditional beliefs toward food, which the women expressed regardless of age and parity:

- "Don't eat hot and spicy food. Eat a lot of fruits and vegetables."
- "The vegetables that you have to avoid are cucumber and bitter gourd - if you eat these you will have bleeding."
- "If you eat twin bananas, you'll deliver twins."
- "Don't eat bitter food - otherwise you'll get cough and tightness of the chest."
- "Don't eat salty food - you'll get edema."
- "Eat all kinds of fish and meat."
- "I don't avoid any food during pregnancy - it's only after delivery, that I don't eat certain kinds of food."
- "Drink coconut-water - it will make the delivery easier."
- "Don't eat lizard meat or frog meat during pregnancy."

Most of the women stated that they did not have any food taboos during pregnancy except for avoiding hot, spicy, and bitter food. Their perception was that during pregnancy you can eat anything, and only during the puerperium do you need to avoid certain foods. Women elders also had the same traditional beliefs toward food.

### *Perceived Need for Antenatal Care (ANC)*

Most of the women in the study group felt that if they were healthy, they did not need antenatal care. Women below the age of 30 years, with three or fewer children, felt that antenatal care was needed, and their husbands felt the same. They stated that if they went for antenatal care, they would get vitamin injections and tablets. Some women above the age of 30 years with a parity of 1-3 felt that ANC was needed to keep both mother and child healthy. Others felt that ANC was needed only if there were problems. Women who had a parity of more than 3 felt that if they were healthy, they did not need ANC. Those who went for ANC stated that it was so that the midwife would help them in the case of a difficult delivery.

- "A woman needs antenatal care to see if the baby and mother are all right."
- "Only if something is wrong, otherwise, there is no need for antenatal care."
- "If you have not booked with a midwife and you go and call them if labour is difficult, they usually scold you. So it's better to book with them."
- "If I am healthy, I do not need antenatal care."
- "If you have antenatal care, you will have an easy delivery."
- "I go for antenatal care because I am worried about miscarriage."

*The Place and the Person for Antenatal Care*

When asked where they went for ANC and who they booked with, the following responses were obtained:

- "I went to the subcentre for antenatal care."
- "I went to the rural health centre."
- "I booked with the midwife."
- "I booked with the lady health visitor."
- "I booked with the auxiliary midwife (AMW)."
- "I went to the traditional birth attendant to be examined."

Most of the women in the subgroup below 30 years of age and with less than three children, booked with either the midwife or the lady health visitor. Those over 30 years of age and with more than three children, and those below 30 years with more than three children, tended to book either with the midwife or the auxiliary midwife. Women over 30 years with more than three children usually booked with the auxiliary midwife, and only one went to the traditional birth attendant.

There was no difference in the place and person for ANC between accessible and remote villages.

It was interesting to note that the majority of women in all four groups stated that they used a TBA for their delivery, if it was uncomplicated.

*Services Provided During Antenatal Care*

On being asked what services were provided during ANC, the women stated:

- "I received small grey tablets that smelled like iron rust."
- "I was weighed and my abdomen was palpated."
- "The lady health visitor took my blood pressure and tested my urine."
- "I was given vitamin injections."
- "I was told to eat more food."

Most of them stated that they received the ferrous sulphate tablets but did not take the tablets regularly because they forgot to do so. Others stated that they did not like the smell.

*Time of Booking*

When asked when they started to have antenatal care, most of them started taking antenatal care from about the fifth month of pregnancy when the baby first started to move.

*Merits/Demerits of Antenatal Care*

Women who took ANC felt that it enabled them to detect any problems at an early date and also to have an easy delivery. The husbands felt that by taking ANC, the baby would be safely delivered and the mother would have less problems.

Neither the women nor their husbands felt that ANC had any demerits. The women, however, stated that sometimes they could not have regular ANC because it interfered with their work schedules.

## Discussion

In this study, most of the women were aware of the symptoms of pregnancy. A qualitative study conducted in a periurban area in Yangon also found that most women were aware of the symptoms of early pregnancy (Ba Thike et al. 1994).

With regard to the perceived dangers of pregnancy, they echoed a saying in Myanmar that "the most dangerous venture for a man is riding the timber raft as it flows down the river, whereas the most dangerous venture for a woman is childbirth" (Nan Oo 1991).

A study carried out in a periurban area in Yangon on ANC utilization (Ba Thike et al. 1994) showed that those who did not use ANC were those who had easy deliveries in the past, or who believed that subsequent visits were not important. They felt that ANC was beneficial for the mother and baby and also for the detection of any problems. In this same study, most women felt that if they were healthy, they did not need ANC, and that ANC was necessary to see whether the mother and baby were all right.

With regard to the place and person for ANC, the majority of women in both accessible and remote villages booked with health personnel. This is because in Myanmar, the midwives have to travel to all the villages under their jurisdiction. Thus, even if the pregnant woman cannot go to a health facility, the midwife will actively look for her.

In a study in Kungyangon township, it was found that pregnant women received ANC from the midwife providing MCH services to that village but had domiciliary deliveries with the TBA (Tin Moe et al. 1993). A similar finding was also noticed in this study.

The time of booking did not differ between the women in this rural area and those from a periurban area in Yangon who did their first booking at 5 months of pregnancy (Ba Thike et al. 1994).

This study showed that there are some traditional customs and cultural beliefs toward pregnancy and antenatal care which have a positive effect such as:

- not lifting heavy things during pregnancy;
- eating a lot of fruits and vegetables; and
- not avoiding any foods during pregnancy.

Health personnel could reinforce these customs and beliefs and in so doing promote the health of pregnant women.

Some of the beliefs which could be harmful to the pregnant women included:

- regarding edema as a normal phenomenon; and
- not going for antenatal care if the mother is healthy.

Health personnel should educate pregnant mothers to be more aware of edema as a danger sign and to value and use antenatal care service regularly. In this way, maternal mortality and morbidity can be reduced, and the health of the mother and child improved.

There are other customs and beliefs which are neither harmful nor beneficial. Turmen and AbouZahr (1994) stated that formal health care services may need to adapt their working methods to accommodate traditional practices that are not detrimental to health.

## *Conclusion*

As women stated in the focus group discussions, there are effective traditional sayings that keep the community, the family, and the individual alert about pregnancy and delivery. Thus, awareness of the traditional customs, cultural beliefs, and perceptions toward antenatal care would greatly benefit health personnel in their communications with women in the community.

A study on a wider scale and with a greater scope will be conducted in 1995 to determine the knowledge, beliefs, perceptions, and practices related to birth traditions in a rural area. This study will enable the health workers to have a better understanding of the women in the community, and help them to motivate the women to seek care and utilize existing ANC facilities. In this way, women can be supported with health technologies that will improve the quality of maternal health services, leading to a reduction in maternal mortality and morbidity.

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# Women and their Perceptions of Environment and Health

**Harjanti Yudomustopo**[1]

## *Introduction*

In order to achieve sustainable development, Indonesia requires a development plan that considers not only economic factors, but also environmental and demographic factors. In addition, the perceptions of women and women's groups should be integrated into development plans in the effort to achieve sustainable development.

The broad guidelines of state policies from 1978, 1983, and 1988 stipulated that women are equal to men, and should have the same opportunities to actively participate in national development. To this end, the Indonesian government has undertaken large-scale efforts to increase the level of women's education, and to improve the health status of mothers and children. While women's participation in national development has increased, there is still room for improvement.

Both men and women have the right and responsibility to participate in the management of the living environment (Article 6 of Act No 4/1982 on the Basic Provisions for Environmental Management). However, the "National Basic Strategy of the Enhancement of the Role of Women in Development Towards the Year 2000" reported the following:

- insufficient participation of women as motivators and managers of the environment and as environmentalists;

- insufficient knowledge among women about the management and conservation of the environment;

- in terms of housing and the environment, shelter is largely unsatisfactory, and is therefore a constraint to the optimal development of women's potential; and

- generally, the social, economic, and cultural conditions in both vulnerable rural and urban areas are not favourable for the optimal development of the potential of inhabitants, especially women.

Women have a central role in the household environment. They are sensitive to environmental issues relating to the family, the household, and surrounding areas. Women can therefore play an important role in environmental conservation (Salim et al. 1990).

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Women also play a key role in the socialization of children and can teach them respect for the environment. In addition, women have a strategic role in the community, and can help to increase community awareness of environmental issues.

## *The Study*

### *Some Conceptual Issues*

This section will define key ideas being employed in this study, such as health, gender relations, environmental degradation, cultural ecology, and perception of environment.

Health has been defined as not merely the absence of disease, but as a state of complete physical, mental, and social well-being (1975/WHO in Yudomustopo et al. 1993). This definition allows for the consideration of cultural, economic, social, political, and environmental factors, as well as biological and genetic ones. The adopted definition of health also creates the space for a discussion of the role of gender and gender relations in health (Tsikata 1994).

The environment greatly affects health. Poor sanitation, contaminated river water, groundwater, and drinking water can create ill health. Exposures to physical and chemical hazards increase the risk of accidents and poisoning. In this study, health was measured by a questionnaire, as well as through secondary data from the Public Health Center (PUSKESMAS) and the village office.

Environmental degradation includes negative changes in the environment, including the human environment and the ecology. Degradation can take the form of water and river pollution, inadequate sanitary facilities, poor housing conditions, and improper waste disposal.

The concept of cultural ecology (Steward 1969; Yudomustopo et al. 1993) relates to the interaction between human perceptions, attitudes, and behaviour, and their life-supporting system. Emphasis should be placed not only on the causes of a river's ecosystem pollution, but also on matters concerned with the management of such consequences. While watershed management is important, attention should also be given to the socio-cultural and economic reasons that push a population to carry out activities that are deteriorating the water body watershed.

In this study, perceptions of environment and health refer to:

- knowledge and beliefs about river condition and the types of activities that cause river pollution;
- knowledge about health implications as a result of river pollution; and
- attitudes toward others who bathe in the river, and toward river cleanliness activities.

### *Research Sites*

The study was conducted in two villages which were purposely selected, namely Semanan and Rawabuaya, West Jakarta. The two villages are both located along the Mookervart riverbank, facing the economic road to Tangerang, West Java, and the ringroad to the Jakarta International Airport, Soekarno-Hatta.

Semanan village covers an area of 5.98 square kilometres. It has a population of about 22,000, with a population density around 3,638 people per square kilometre. Rawabuaya village covers an area of 4.67 square kilometres. It has a population of 21,382, with a population density of 4,578 people per square kilometre. In the past, most people earned their living from agriculture. Now, however, most wage earners are private employees and entrepreneurs. Since 1970, industries have grown rapidly, which has led to increased urbanization, a scarcity of agricultural land, and scattered housing areas.

The general housing conditions and the environment, including the sewage systems, are unhealthy in both villages. Typically, household discharge from kitchens, bathrooms, and laundry activities flows directly to the drain.

Certain diseases pose health problems in both villages. As shown in Table 1, upper respiratory diseases were most common in both Semanan and Rawabuaya, followed by skin diseases.

**Table 1. Prevalence of Diseases, 1990**

| No. | Disease | Semanan | Rawabuaya |
|---|---|---|---|
| 1. | Upper respiratory track | 56.89 | 51.48 |
| 2. | Skin diseases/allergy | 4.37 | 12.59 |
| 3. | Gastroenteritis | 4.03 | 6.29 |
| 4. | Otitis & mastoiditis | 3.43 | 1.90 |
| 5. | Gastritis | 3.23 | 5.20 |
| 6. | Orthopedic | 3.09 | 2.79 |
| 7. | Conjunctivitis | 3.02 | 2.79 |
| 8. | Dental carries | 2.82 | 1.29 |
| 9. | Neurologic | 2.69 | 1.90 |
| 10. | Other diseases | 15.89 | 13.77 |
| | Total | 100.00 | 100.00 |

Source: Statistic Office West Jakarta, 1990 and 1991.

The number of health facilities and health professionals in Semanan and Rawabuaya are summarized in Table 2.

**Table 2. Number of Health Facilities and Health Professionals in Semanan and Rawabuaya Villages, 1990**

| No. | Health facilities and health professionals | Semanan | Rawabuaya |
|---|---|---|---|
| 1. | Hospital | - | - |
| 2. | Public health centre | 2 | 1 |
| 3. | Maternity hospital | - | 1 |
| 4. | Medical hospital | 1 | 2 |
| 5. | Family planning clinic | - | - |
| 6. | Maternal and child health centre | - | - |
| 7. | Integrated health post | 15 | 13 |
| 8. | Family planning post | 2 | 13 |
| 9. | Dispensary | 1 | 3 |
| 10. | General practitioner | nd | 14 |
| 11. | Specialty surgeon | - | - |
| 12. | Midwives | 2 | 4 |
| 13. | Traditional midwives | 2 | 4 |
| 14. | Laboratory | - | - |

Source: Statistical Office West Jakarta, 1990.

### *Sample and Data Collection*

Samples were taken by way of quota sampling. Respondents consisted of 300 heads of households or homemakers with children aged 12 years and under (completed by 176 women and 124 men). While the sample size was not very large it was believed that the perceptions and behaviours of the sample populations reflected general perceptions and behaviours.

The questionnaire included both closed questions and semi-open-ended questions. The questionnaire was pre-tested in one particular area before the main survey was carried out. Interviews were carried out in a face-to-face situation.

## *Research and Discussion*

### *Respondents' Profile*

More than half of the respondents in both Semanan (58%) and Rawabuaya (59.33%) were women. Most respondents were Muslim. They were from different ethnic groups: Betawinese, Sudanese, Javanese, Batak, Padang, and others. Both Semanan and Rawabuaya were dominated by three ethnic groups - Betawinese (52% and 41%), Javanese (28% and 28.67%) and Sundanese (12.67% and 26%), respectively. Most respondents were 21-40 years old - the youngest respondent was 19, while the oldest was 68. Most respondents were indigenous to the region (48% in Semanan and 32.67% in Rawabuaya), the rest being migrants from Java and other districts.

Most families were comprised of more than four people (63.3% in Semanan and 74.6% in Rawabuaya). In Semanan, most respondents (60%) had lived there for 1-5 years, while the length of residence for the rest of the respondents was 5-10 years. In Rawabuaya, the length of residence varied - 41.3% had lived in the community for more than 15 years, 24% had lived there for 10-15 years (24%), and 17.3% had been there for 5-10 years.

Generally, men had attained higher education levels than had women. Most women in Semanan (77%) and Rawabuaya (77%) had low levels of education (elementary school or unschooled), while 15% in Semanan and 9% in Rawabuaya had completed junior high school. The rest had completed high school; a very small percentage had university training (Table 3).

**Table 3. Level of Education Among Respondents, 1992**

| No. | Level of education | Semanan | | | | Rawabuaya | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Women | | Men | | Women | | Men | |
| | | F | % | F | % | F | % | F | % |
| 1. | Unschooled | 5 | 5.75 | 15 | 23.8 | 10 | 11.24 | | |
| 2. | Elementary school | 62 | 71.26 | 26 | 41.27 | 60 | 67.42 | 19 | 31.15 |
| 3. | Junior High school | 13 | 14.94 | 5 | 7.94 | 8 | 8.99 | 32 | 52.46 |
| 4. | High school | 6 | 6.9 | 14 | 22.22 | 11 | 12.35 | 6 | 9.84 |
| 5. | University/ Academy | 1 | 1.15 | 3 | 4.77 | | | 4 | 6.55 |
| | Total | 87 | 100 | 63 | 100 | 89 | 100 | 61 | 100 |

**Table 4. Status of Employment Among Respondents, 1993**

| No. | Employment Category | Rawabuaya | | | | Semanan | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Women | | Men | | Women | | Men | |
| | | F | % | F | % | F | % | F | % |
| 1. | Unemployed | 56 | 62.9 | - | - | 45 | 51.7 | 1 | 1.6 |
| 2. | Government/Army official | 1 | 1.1 | 5 | 8.2 | 2 | 2.3 | 4 | 6.3 |
| 3. | Government/state enterprise | - | - | 1 | 1.6 | - | - | 2 | 3.2 |
| 4. 5. | Private sector/ Labourer | 15 | 16.8 | 38 | 62.3 | 26 | 29.9 | 23 | 36.5 |
| 6. | Business/ entrepreneur | 17 | 19.2 | 27 | 27.9 | 14 | 16.1 | 32 | 50.8 |
| | Retired | - | - | - | - | - | - | 1 | 1.6 |
| | Total | 89 | 100 | 61 | 100 | 87 | 100 | 63 | 100 |

Table 4 shows that most women in both villages were unemployed, with a greater percentage in Rawabuaya (62.9%) than in Semanan (51.7%). The number of government officials, civil and military, was about the same in both areas (1.1% in Rawabuaya and 2.3% in Semanan). The percentage of male entrepreneurs was 50.8% in Semanan. About 19% of the women in Rawabuaya were entrepreneurs. About 62% of male workers in Rawabuayan were non-governmental workers, while 29.9% of women in Semanan were non-governmental workers.

## *Housing and Sanitary Conditions*

### *Size of Land Plot*

The size of land plots where people built their homes were characterized into four groups: (1) less than 51 square metres; (2) between 51-75 square metres; (3) between 78-100 square metres; and (4) over 100 square metres. More people lived on larger plots of land in Semanan than in Rawabuaya.

Homes were divided into four categories: (1) less than 25 square metres; (2) between 26-50 square metres; (3) between 51-75 square metres; and (4) over 75 square metres. A higher percentage lived in homes in the first three categories in Rawabuaya, while homes over 75 square metres were more common in Semanan (28.67%). There was a higher percentage of home owners, or those paying instalments for ownership, in Semanan than in Rawabuaya.

## *Housing and Sanitation*

One quarter of respondents in Rawabuaya lived in homes located less than 25 metres from the river, while in Semanan, the number was about one-third. Sixteen percent of the population in Semanan, and 9.33% in Rawabuaya, lived more than 100 metres from the river.

The floors of the houses were similar in both Semanan and Rawabuaya. Half of the houses had tiled floors, one-third had cement floors, and a very small percentage had mud floors.

Slightly more brick-walled houses were constructed in Semanan (62.67%) than in Rawabuaya (40.67%). Bamboo walls predominated in Rawabuaya. More than 80% of the houses in both Semanan and Rawabuaya had tiled roofs.

The presence of a bathroom in or around the house was slightly more likely in Rawabuaya than in Semanan. Public bathrooms were more concentrated at the river edge in Rawabuaya. In Semanan, there were few public bathrooms situated at the river's edge. In Rawabuaya, public bathrooms were used by 26% of the respondents, while 22% of the respondents used such bathrooms in Semanan.

About 35% of the respondents enjoyed in-house latrines equipped with septic tanks. The rest directly disposed of their waste water in the river. About 1% of respondents in Semanan and Rawabuaya defecated in their garden.

Water is, of course, an absolute necessity for life. However, water can also act as a carrier of disease. With regard to drinking and cooking water, the majority of respondents in Semanan (71.67%) bought water from water sellers, while in Rawabuaya, 66% used water from a pumping well, and only a small percentage (14.67%) bought from the water sellers. For bathing, toileting, washing of clothes, and cleaning of cooking and eating utensils, the majority of respondents used water from pumped wells. None of the respondents in Semanan used the river water for their daily activities, while in Rawabuaya, a very small percentage (0.67%) used the river water.

## *Perceptions, Attitudes, and Behaviours Toward Environment and Health*

In the two communities, variables that collectively influenced people's perceptions of their environment and health included socio-economic status, duration of stay, cultural background, and rate of mobility. Levels of education had a different influence on the people's perception of the polluted canal river (Table 5).

**Table 5. Influence of Level of Education on Perception Toward River Pollution, by Sex ($N_1$ = 139 $N_2$ = 136)**

| No. | Level of education | River pollution (very polluted) | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Rawabuaya | | | | Semanan | | | |
| | | Women | | Men | | Women | | Men | |
| | | F | % | F | % | F | % | F | % |
| 1 | Unschooled | 10 | 11.9 | - | - | 5 | 6.17 | 14 | 25.45 |
| 2 | Elementary School | 60 | 71.44 | 15 | 27.27 | 57 | 70.37 | 21 | 38.18 |
| 3 | Junior High School | 4 | 4.76 | 32 | 58.18 | 13 | 16.05 | 5 | 9.09 |
| 4 | High School | 10 | 11.9 | 6 | 10.9 | 5 | 6.17 | 12 | 21.82 |
| 5 | University/ Academy | - | - | 4 | 3.65 | 1 | 1.24 | 3 | 5.46 |
| | | 84 | 100 | 55 | 100 | 81 | 100 | 55 | 100 |

Those with low levels of education, which constituted more than half of the women in both studied areas (71.44% in Rawabuaya and 70.37% in Semanan), perceived the canal water as very polluted. They assessed water pollution from the water's odour, colour, or both.

The perception of water pollution based on visual parameters reflected an "unscientific" concept of water pollution, related to their low levels of education. University educated respondents (a very small percentage) judged water pollution based on "scientific" knowledge, such as formal pollution parameters, and not based on the colour and/or odour.

Duration of residence also influenced perceptions. Those who had resided more than 15 years in the villages perceived the canal water as very polluted. In in-depth interviews with informal community leaders, most felt that water pollution was related to the uncontrolled disposal of industrial waste, while a smaller proportion felt it was caused by household waste. In-depth interviews revealed that increased population density, as a result of the growing numbers of new settlers, had led to a scarcity of open spaces, where waste was usually dumped.

About 60% of the respondents had lived in Semanan for more than one year, and 80% of these people felt that there was a relationship between water pollution and living along the river watershed. They were aware that the polluted condition of the river was caused to

some extent by the existence of human settlements along the river watershed. This was confirmed by respondents who had been living in the community for more than one year (1 to 15 years). The same was also true with regard to the Rawabuaya respondents. About 62% of the respondents who had been living in the area for more than 15 years stated that such a relationship existed (Table 6).

**Table 6. Presentation of Three Main Variables. Mean Scores and Values of Levels of Knowledge, Opinion, and Attitude**

| Variables/ subvariables | Semanan | | Rawabuaya | |
|---|---|---|---|---|
| | Partial means score | Correlation | Partial means score | Correlation |
| 1. Opinion on river's condition | 4.87 | Good | 4.90 | Good |
| 2. Opinion on river's pollution, based on visual parameters | 3.66 | Moderate | 3.61 | Moderate |
| 3. Opinion on the relationship between river pollution and disease | 4.00 | Moderate | 3.82 | Moderate |
| 4. Knowledge on the types of disease caused by river pollution | 3.15 | Moderate | 3.78 | Poor |
| 5. Knowledge on kinds of river polluting activity | 3.27 | Moderate | 3.25 | Moderate |
| 6. Knowledge on types of significant pollutant load | 3.47 | Moderate | 3.34 | Moderate |
| 7. Knowledge on sources of pollution | 4.45 | Good | 4.25 | Good |
| 8. Opinion, that living along the riverbank can cause environmental pollution | 3.32 | Moderate | 3.24 | Moderate |
| 9. Opinion on the cleanliness responsibilities | 3.99 | Moderate | 4.04 | Good |
| 10. Opinion on each other's behaviour concerning waste disposal into the riverwater | 2.84 | Poor | 3.38 | Poor |
| 11. Opinion on obligation to maintain river's cleanliness | 4.89 | Good | 4.86 | Good |
| 12. Attitude toward other people's habit of washing, bathing, and toilet | 4.71 | Good | 4.38 | Good |
| 13. Knowledge on kinds of social participation in cleanliness | 3.87 | Moderate | 3.62 | Moderate |
| Mean Score | 3.87 | Moderate | 3.73 | Moderate |

Based on the t-test result, with a 95% confidence level, insignificant differences in perception between women and men were found (Table 7).

About 94% of men and women in Rawabuaya, and 100% in Semanan, believed that the water pollution was related to common diseases found in the communities. Most felt that environmental pollution, particularly watershed environmental pollution, was associated with the existence of watershed settlers.

**Table 7. Results of Data Analysis and t values Between Men and Women, 1992.**

| | Rawabuaya | Semanan |
|---|---|---|
| Mean women | 3.71 | 3.84 |
| Mean men | 3.76 | 3.93 |
| Variance | 0.099 | 0.257 |
| N women | 87 | 89 |
| N men | 63 | 61 |
| t (comparison) | 0.96 | 2.04 |
| t (table) | 2.06 | 2.06 |
| | P. 0.05 | P. 0.05 |
| conclusion | insignificant | insignificant |

**Table 8. Respondents' Attitudes Toward Their Children Bathing and Toileting in the River**

| No. | Attitude | Rawabuaya | | | | Semanan | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | women | | men | | women | | men | |
| | | F | % | F | % | F | % | F | % |
| 1 | Forbidden | 79 | 88.76 | 48 | 78.69 | 60 | 68.97 | 56 | 88.8 |
| 2 | Not forbidden | 9 | 10.11 | 13 | 21.31 | 16 | 18.39 | 5 | 7.37 |
| 3 | Do not know | 1 | 1.13 | _ | _ | 11 | 12.64 | 2 | 3.75 |
| | Total | 89 | 100 | 61 | 100 | 87 | 100 | 63 | 100 |

Generally, children who lived alongside the river enjoyed playing, bathing, and even toileting in the river. Women as mothers and educators took responsibility for the safety of their children. This study indicated that most women in Rawabuaya (88.76%) and in Semanan (68.97%) forbade their children from these activities. A small percentage did not forbid their children from engaging in these activities (10.11% in Rawabuaya and 18.39% in Semanan) (Table 8).

Perceptions concerning the behaviour of others using the river as a dumping disposal, and concerning community obligations to maintain river cleanliness, were relatively good. As indicated in the above table, women, were more likely than men to directly warn those who disposed their garbage into the river (Table 9).

As indicated in Table 10, most respondents were aware that river cleanliness was also part of their responsibility, and that public participation should be realized through collective efforts such as regular river clean-ups. The majority of both women and men took part in environmental activities such as the clean river program. The percentage of women participating in environmental cleaning activities was slightly lower than the number of men. This might be due to the amount of time and energy that women had to direct to their domestic activities.

**Table 9. Percentage of Respondents Based on their Opinion on Each Other's Behaviour Concerning Waste Disposal into the River.**

| No. | Attitude | Rawabuaya | | | | Semanan | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | women | | men | | women | | men | |
| | | F | % | F | % | F | % | F | % |
| 1. | Indifferent, keep quiet about it | 29 | 32.58 | 44 | 72.13 | 45 | 51.72 | 41 | 65.08 |
| 2. | Directly warn | 48 | 53.93 | 17 | 27.87 | 32 | 36.78 | 19 | 30.16 |
| 3. | Report to cleaning authorities | 12 | 13.49 | - | - | 8 | 9.2 | 2 | 3.17 |
| 4. | Do not know | - | - | - | - | 2 | 2.3 | 1 | 1.59 |
| | Total | 89 | 100 | 61 | 100 | 87 | 100 | 63 | 100 |

**Table 10. Respondents' Participation in River Cleanliness Activity, 1992**

| No. | Participation | Rawabuaya | | | | Semanan | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | women | | men | | women | | men | |
| | | F | % | F | % | F | % | F | % |
| 1 | Participating | 85 | 95.5 | 60 | 98.36 | 61 | 70.11 | 62 | 98.41 |
| 2 | Not participating | 4 | 4.5 | 1 | 1.64 | 17 | 19.54 | 1 | 1.59 |
| 3 | Do not know | - | - | - | - | 9 | 10.35 | - | - |
| | Total | 89 | 100 | 61 | 100 | 87 | 100 | 63 | 100 |

## *Women and Their Knowledge Concerning Health*

The majority of the women experienced health disturbances such as fever, headache, and influenza (Table 11). Prevalence rates of diarrhoea, assumed to be related to poor sanitation and water contamination, were relatively low in both studied areas (7.87% in Rawabuaya and

4.6% in Semanan respectively). The higher percentage in Rawabuaya might be because the river segment in Rawabuaya was more polluted than in Semanan. The majority of the respondents in both villages (73%) went to the PUSKESMAS for medication. In Rawabuaya (16.85%), the next choice was going to a paramedic, while in Semanan, they preferred self medication (17.91%). Only 1% reported that they went to traditional healers. The main reason cited for going to the PUSKESMAS for medication was because it was affordable (43-45%). Secondly, respondents reported that patients would only get better after seeing a doctor, and receiving an injection or pills. Between 12-15% of respondents were of the opinion that they could die if they did not see a doctor, or their illness could become worse. Some 11-14% stated that they had tried self medication but failed, so that in the end they went to the PUSKESMAS.

**Table 11. Morbidity Rates Among Women in Rawabuaya and Semanan Villages, 1992**

| No. | Diseases | Rawabuaya | | Semanan | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| 1 | Fever/headache | 28 | 31.46 | 35 | 40.23 |
| 2 | Skin diseases/allergy | 2 | 2.25 | 1 | 1.15 |
| 3 | Diarrhoea | 5 | 5.62 | 3 | 3.45 |
| 4 | Upper respiratory tracks | 3 | 3.37 | 5 | 5.75 |
| 5 | Influenza | 26 | 29.21 | 24 | 27.59 |
| 6 | Fever/headache/influenza | 18 | 20.22 | 17 | 19.54 |
| 7 | Do not know | 7 | 7.87 | 2 | 2.29 |
| | Total | 89 | 100 | 87 | 100 |

While the majority of women knew that water pollution could have a negative impact on their health, their knowledge of water-related diseases was relatively low. While both Semanan and Rawabuaya respondents were familiar with common diseases such as flu, cold, and fever, their knowledge of diseases such as diarrhoea, skin allergy, and gastrointestinal disturbance was low. Unfamiliarity with water-related diseases was probably due to the fact that rates of prevalence of such diseases were low because of low domestic consumption of river water. However, they were aware of several kinds of medicines commonly used to overcome diarrhoea or gastrointestinal disturbance and skin allergy. In addition to modern medicine, they reported that they used traditional medicines such as herbs and tea water to overcome diarrhoea disturbance (11.24% in Rawabuaya and 47.13% in Semanan). With

regard to skin allergy, most respondents reported that they used antibiotic cream and purol powder, while a small percentage (1.13%) in Rawabuaya reported that they used traditional medicine (Table 12).

**Table 12. Level of Women's Knowledge of Medicine in the Rawabuaya and Semanan Villages, 1992**

| Diseases | Name of medicine | Rawabuaya | | Semanan | |
|---|---|---|---|---|---|
| | | Frequency | % | Frequency | % |
| Diarrhea | - Oralit<br>- Anti diarrhoea tablet/powder<br>- Traditional medicine<br>- Oralit/tablet/ trad medicine | 31<br>28<br>10<br>20 | 34.83<br>31.46<br>11.24<br>22.47 | 22<br>16<br>41<br>8 | 25.29<br>18.39<br>47.13<br>9.19 |
| | Total | 89 | 100 | 87 | 100 |
| Skin diseases/ allergy | - Antibiotic cream<br>- Purol powder<br>- Traditional medicine<br>- Antibiotic cream/ powder/trad medicine | 49<br>20<br>1<br>19 | 55.05<br>22.47<br>1.13<br>21.35 | 39<br>35<br>-<br>13 | 44.83<br>40.23<br>-<br>14.94 |
| | Total | 89 | 100 | 87 | 100 |

## *Conclusion*

From this study a number of conclusions can be drawn.

- The majority of respondents had a "moderate" understanding of environment and health issues. About 41% in Samanan and 27% in Rawabuaya village had a "good" understanding of environmental and health issues.

- Women's rate of perception on environment and health issues was slightly lower than men's. However, this difference was not statistically significant.

- There was a link between income levels and education levels, which influenced the level of knowledge and perception about environment and health. Low levels of knowledge about environmental sanitation, health, and water pollution, and its implications for health status, led to a negative impact on the level of perception on environment and health. In this respect, education will constitute a relevant intervention to overcome this situation.

- Women frequently suffered from fever, headaches, and influenza. Prevalence rates of diarrhoea, gastro-intestinal and skin allergic diseases, assumed as having a relationship to poor sanitation and water contamination, were relatively low in both study areas. This may be because the majority of respondents did not use the contaminated river water for their daily activities.

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# Other Workshop Activities

## Workshop Discussion Notes

### *Holistic Approach to Women's Health*

A holistic perspective to women's health was advocated. Women's health issues should be addressed "from the ovum to the neck of the femur." We should start "from the ovum" and look at the state of women's health before conception. Factors such as a woman's nutritional status and her exposure to environmental hazards affect not only her health, but also the health of the fetus. Preference for sons, found in many societies around the world, may result in the selective abortion of female fetuses when new technologies such as amniocentesis are abused. A holistic perspective should embrace the entire life-span of women, and address crucial issues affecting older women such as osteoporosis. When an older woman breaks her hip, this is often the beginning of a serious decline in her health.

### *Gender and Sex*

"Sex" refers to the biological differences between men and women. "Gender," on the other hand, relates to the socially defined and learned characteristics of men and women that can actually be shared by both sexes. Notions of gender appropriate behaviour vary from culture to culture. While in some societies women are expected to be quiet, one participant said that in the Philippines it is culturally acceptable for women to talk as much as men. There is no gender discrimination about a child's right to speak. In Malaysia, to look straight into a man's eyes and smile may be interpreted as an invitation to have sexual relations. However, in the Philippines, a woman can smile at a man and this has no sexual innuendo attached to it.

Gender roles also characterize the sexual division of labour. Gender relations refers to the sets of behaviours that are seen as appropriate for men and women, both inside and outside the household (e.g., women should do the housework, while men should work outside the home). Notions of gender can change over time, and vary from culture to culture. Gender is hierarchy. According to one participant, there is a system of "gender apartheid" throughout the world.

### *Factors Influencing the Decision-Making Power of Women*

Many participants said that increasing the decision-making power of women within the household is a crucial component to ameliorating their health status. One participant suggested that research should explore the extent to which a woman's decision-making status

is affected by her income generation power. For example, when Filipino overseas domestic workers return to the Philippines and become the economic supporters of their families, does their decision-making status within the household change?

Another participant argued that it is not income generation alone that affects decision-making power. Women from very well off households often have no right to make decisions within the family. Increasing a woman's self-esteem can lead to increased decision-making power and improved health. A woman's perception about her value in the family and society has to change. When a woman's self-esteem improves, increasingly she feels able to make more household decisions, and begins to put forward her viewpoints within the family.

### *Education, Empowerment, and Health*

It was agreed that education can empower women and lead to health improvements. While much research has demonstrated a link between women's educational opportunities and improved health, most research has focused on the influence of conventional education systems. Participants agreed that the impact of non-formal education on health must also be addressed.

One participant said that the link between higher education and better health standards may be correlated to better income levels - indeed, income may be the determining factor. Families with higher income levels are more likely to be able to afford to send their girls to school for longer periods of time. Better off families may consider the education of children to be an investment for the future. In poor families, however, there is no extra money, and children often get taken out of school to work as child workers.

### *Poverty*

The poverty that many women face seriously affects their health. To survive, women may resort to life threatening strategies. For example, one participant said that in the slums of Calcutta, women reportedly have abortions for the purposes of selling their fetuses to European medical schools. Women put their lives at risk to obtain money to improve the living conditions of their families. Likewise, poor women may leave their countries of origin to work as overseas contract workers. According to one participant, "this is yet another path to self destruction."

Poverty affects a woman's available life choices. Poor girls may be married off earlier because their families can no longer support them. Marriage may be seen as a strategy to counter poverty. Engaging in prostitution and entering into hazardous occupations are other strategies to cope with poverty. For women living in poverty, the choice may be between a dangerous job with no occupational health and safety protection, or no job at all. Women are more likely than men to be forced into these life threatening strategies because they have fewer available choices.

## *Importance of Motherhood*

In many cultures, a woman still gains status by being a mother, especially by being the mother of sons. For example, researchers from Myanmar and India pointed out that there are economic and social incentives to have children - children are believed to be "helping hands" or status givers. The cultural push to have children exists despite the fact that maternal mortality rates in most developing nations are very high. Having a child is seen as a normal hazard that a woman undergoes - "a woman's fate is to brave childbirth." State policies may try to change the family planning behaviour of women by offering disincentives. But these policies are often unsuccessful because they do not fully address the *incentives* that motivate women to have children.

## *Who Is Responsible for Health Care?*

As transitional economies such as Vietnam, Cambodia, Laos, China, and Mongolia, move from centrally planned economies under socialist governments to market economies, the issue of who is responsible for health care is raised. In some cases, user fees have been introduced and more and more men and women are having to pay for essential health services. Because employment opportunities are not equally available to men and women, women are more disadvantaged in having to pay for health services.

One participant said that when quality health care for women is not available in industrialized countries such as Japan, the issue is pure ideology. It is not that the government cannot afford decent health care for women, it simply does not want to provide it for ideological reasons.

One participant said that the state should be responsible for health care. Health is a basic human right recognized in various international conventions that many countries in the Asian region have signed. Increasingly the state is abdicating its responsibility and privatizing health care.

## *Is Gender Analysis A Luxury?*

The question was raised concerning whether gender analysis is a luxury when looking at countries that are struggling to find an economic footing. In response to this question, one participant said that "gender analysis is not a luxury, it is a necessity." In transitional economies, more importance should be placed on gender and health issues, and not less. For example, in countries where the state is increasingly unable to provide the social and health services that it used to provide under a centrally planned economy, this usually means that women are burdened with more health care responsibilities. Without a healthy population - without healthy men, children, and women themselves - development will be hampered. It must also be remembered that in many countries it is the women who make up the majority of workers in textiles and electronics factories.

## *Development Processes*

Countries in the Asian-Pacific region are at different levels of development and have different health needs. Emerging countries have the opportunity to avoid the pitfalls that other countries made in process of the development. Countries often look at what has been done before, without addressing the weaknesses of past directions. We need to point out past pitfalls so emerging countries do not repeat the mistakes that more developed countries have made.

Women need to think about the kind of development and the kind of society they want. If women are not in control of development, then development processes tend to exploit the gender hierarchy. Policy-makers and politicians tend to be men, and tend not to put gender equity at the forefront of development processes, despite that fact that their countries may be signatories to conventions calling for the elimination of all forms of discrimination. Governments may be most concerned with increasing their country's gross national product. For example, to encourage foreign owned companies to locate in Sri Lanka, the government has stated that there will be no trade unions in export producing zones. "We need to go beyond this short-sided view of economics, and look at more long-sided accounting." During the transition to cash economies, poor households and rural women may lose resources and benefits while others gain unless deliberate interventions are made on their behalf.

Women tend to be in the informal, unwaged or poorly paid workforce, while men tend to be in the formal paid workforce. Women are often drawn into the informal sector because of their reproductive role. They take on part time or casual work so they can earn money as well as look after their children and household responsibilities. The money they earn in the informal sector, or in part-time work, is less than what men earn in the formal sector. Development which does not put gender equity at the forefront will exploit this type of situation. For example, in newly industrialized countries, economic growth has occurred as a result of the cheap labour of women. Electronics and textiles factory employees are predominantly, if not exclusively, women, because women can be paid less money. Women's labour in the informal sector has already been devalued so that when they are drawn into the factories to work as full time labourers or shift workers, their wages are lower. The undervalued labour of women has made growth possible in many countries of Asian region.

Various approaches have been proposed to move toward a society with increased gender equity. According to one approach, women have not been able to fully compete with men because they have not been given the same educational opportunities. It is posited that if women received the same education as men, they would be able to compete on a level playing field. However, strategies which have given women increased educational opportunities without dealing with the systematic discrimination that women face have failed.

## *Environmental Life Spaces*

The concept of environmental life spaces was introduced. For example, where does a man or a woman, a girl or a boy, a female baby or a male baby, stand twenty-four hours of the day? Men's and women's life spaces are different and this may lead to differential exposure to diseases and illnesses, including tropical diseases. This is tied to the gender division of labour. For example, who does the animal herding? Who picks up the cow dung? Who slaughters the animals? Who cleans the clothes and utensils in the river?

The mapping of life spaces is useful for environmental health research. For example, researchers could look at how many hours the studied population spends each day at an office, in the field, at home, and so on. How often is the population exposed to certain hazards? Do they live in close proximity to a toxic waste dump? If the population lives near a toxic waste dump, which members of the population (e.g., men, women, children) are at home all day and most exposed to the dump?

Researchers must be conscious of the socially differentiated universes of men and women. Mapping of social relations can be done by asking people who they interact with to see where that person is located. At meal time, does the person eat alone or with others? Who do they talk to during the day and how often? If a researcher documented, for example, that during an entire month certain workers (e.g., non-unionized) at a factory never talked to management, this might lead to recommendations/interventions aimed at increasing the opportunities for management and non-unionized workers to meet and discuss the needs of workers.

Mapping of life spaces can help to uncover the realities of women's lives. For example, it may reveal that female factory workers have no time to eat lunch properly because the canteen is too far away from the worksite. Or it may show that women have no time to go to the toilet at the factory because there is only one toilet for 200 women.

Time is a resource and there are often differences in the way men and women use their time. Women usually have competing demands on their personal time (e.g., children, household responsibilities) that prevent them from, for example, going to a health centre. Women's time also tends to be more fragmented than men's.

To sensitize researchers to the concept of "life spaces," it was suggested that researchers could begin by looking at their own lives and assessing how they use their time.

## *Resource Entitlement*

Participants agreed that the gender bias in resource entitlement is another key issue (e.g., who is entitled to the use and disposal of resources such as food, health care, and education). Even in countries where there is no shortage of food, it may still be possible to find poorly

nourished people because some people are not entitled to the food. Who is entitled to health care as a resource? If water is a scarce resource, there may be a gender bias concerning who is entitled to use the water (e.g., who is entitled to have the first bath and have more changes of clothing).

### *Access to Health Care*

Many factors affect the access of women to health centres, such as distance to health centres, and restrictions on female mobility. In some cultures, women and girls are disadvantaged because they are not allowed to leave their homes or visit women in the next row of houses, much less travel on their own to a health clinic. Women may fear going to a health centre because they are afraid of forced contraceptive use as dictated by the state. Women, especially the very poor, cannot afford to take time off from daily activities to go to the health centre.

The hours when the clinic is open may not be sensitive to the gender division of labour and the timing of the work of men and women. For example, as a result of the daytime responsibilities of women (e.g., walking to the well, feeding the chickens, collecting firewood, and so on) it might easier for women to visit the clinic in the evening instead of in the daytime when the clinic is usually open.

Women often have to wait long periods in the waiting room to see providers and may only get a few minutes of the provider's time when they finally get to see her or him. As a result, women often report that they prefer traditional healers.

Gender factors may affect the cultural acceptance or non-acceptance of therapeutic measures. For example, if a woman has head lice, what does the culture think about a woman with a bald head if she has to shave off all her hair to get rid of head lice?

### *Beyond the Health Sector*

When looking at the health status of girls and women, researchers also have to address factors affecting women beyond the health sector. For example, living in a rural area will have an impact on the availability of health services since health centres tend to be concentrated in urban sectors. Religion and tradition can affect women's health. Lack of mobility as dictated by religion may affect a woman's access to care. Religious ideas may shape contraceptive use. Cultural preference for sons can affect the health of women. In traditional Chinese society, the societal importance placed on sons often meant that, if a woman had a daughter, she would quickly try for a son. In parts of India, girls of a higher birth order may be most disadvantaged.

## *Mediating Institutions*

Mediating institutions stand in the way of all relations between men and women. As a result of the various mediating institutions, there are no pure relationships between men and women. The first mediating institution is *family, marriage, kinship, and sexuality (including father-rights and mother-rights).* With regard to sexuality, female orgasm is a physiological potential, but gender relations may make it impossible for a woman's physiological potential to be expressed during her entire lifespan. While men are encouraged to express their sexuality freely, women are supposed to be pure, chaste, and naive about sexual matters. With regard to family and kinship ties, in some cultures women do not have parental rights - the child belongs entirely to the father's lineage and the mother is viewed as a vessel responsible for bearing a child. In Taiwan, if a woman undergoes a divorce, she has no right to sue for custody of the child. This also has an impact on how women and men relate (as well as how parents and children relate).

Another mediating institution is *state politics*. Population policies have a direct impact, for example, on the way women and men interact. When men and women are in bed, "political figures are in bed with them telling them how many children they should have."

Another mediating factor between men and women is the societal system of *economic production and ownership (access to food, land, money).* If the husband of the family is the breadwinner, and the wife is dependent on him, even in the best of relationships, this may affect their relations. While women work very hard, they often do not own the fruits of their labour. Women do two-thirds of the work around the world, but own one-tenth of the wealth. This affects relationships.

Another mediating factor is *society, culture, and religion*. Gender relations are affected by whether or not safe abortions are available to women, whether or not contraception is available, and whether or not health care is available. Mediating institutions of society tend to be dominated by men and tend to favour men's interests over women's interests. Overwhelmingly, mediating institutions are patriarchal.

## *Transnational Processes*

The transnational processes that link different countries were widely discussed. One participant said that it is impossible to do purely health research - sociopolitical processes and global forces must be addressed.

For instance, people from Singapore, Japan and Taiwan are involved in the sex trade at the Thai-Cambodian border and the spread of AIDS has followed trade routes. Additionally, with the increased mobility of labour, there has been a corresponding increase in STDs (e.g., entertainers go abroad and contract AIDS).

The Filipino domestic worker is now ubiquitous in Singapore, Hong Kong, and increasingly in Malaysia. Women in Singapore have been able to enter the modern industrial workforce in part because of the assistance of Filipino domestic workers. This has been at the expense of the traditional Philippine household. With the increased number of women going overseas to take on work, many Filipinos have been deprived of the traditional nurturing role of the Filipino woman, and this has led to an increase in dysfunctional families. The professional woman from Singapore who has the help of a domestic worker from the Philippines is linked to a remote barrio in the highlands of the Philippines, because the mother from that barrio is in Singapore doing her productive and reproductive work. Taking on overseas contract work has implications for a woman's total health and well-being. Many women reportedly return to the Philippines with severe psychological problems as a result of the physical and psychological abuse they have been exposed to. According to one participant, "they have been reduced to slaves...this is a new wave of slavery."

We cannot look at countries of the region and the development process in isolation - instead, we must be aware of the transnational development processes. Governments from low growth countries think that they will someday be high-growth countries like Singapore. However, Singapore has become what it is as result of certain transnational factors. For instance, a significant percentage of the labour force of high-growth countries like Singapore and Malaysia is foreign (e.g., plantation workers from Bangladesh in Malaysia).

One participant said that Thailand is now dipping into the forest reserves of Burma because the Thai forests are nearly exhausted. This has implications for the workloads of women from the hill tribes of Burma who depend on the hunting and gathering of natural resources for their survival.

### *An Intersectoral Approach*

The importance of taking an intersectoral approach, and linking gender as a system of inequity with other forms of inequity, such as class and ethnicity, was raised. All women suffer some degree of discrimination, but some women suffer various forms of discrimination. According to one participant, "Diseases of women are not the same as diseases of men. Diseases of the rich are not the same as diseases of the poor. Diseases of urban people are not the same as diseases of those living in rural areas."

The feminization of poverty is a global phenomenon. The majority of the world's poor are women. The United Nations estimates that 60% of the world's one billion rural poor are women, and there are a growing number of female headed households living in poverty.

With regard to ethnicity, in the United States, black women are the worst off. During the plantation era, black ghettos used to be situated beside plantations - today they are situated beside toxic waste dumps and chemical plantations. Black women in the United States have

20 times greater exposure to toxic carcinogens than white women. One participant said that "if you are a poor black women living in the United States, you are right at the bottom of three ladders."

### *The Ethics of Research*

The ethical dimensions of the research process were discussed. According to one participant, "researchers must be responsible and responsive to the community being studied." To begin with, community members should identify their priorities and determine the research agenda.

Another participant said that researchers should take steps to fully understand the people being researched. For example, people from a working class background may consider a certain amount of aches and pains to be normal. As you move up the socioeconomic ladder, the threshold of pain changes and people become more sensitive to health problems. Without a full understanding of the community being studied, it may seem incomprehensible that those living with few food sources, or without clean water, find this acceptable.

Researchers should also ensure that the results from research serve to empower the people who are studied. All research should have an intervention component. Main messages and key concepts should be popularized and translated into ordinary terms that community members can understand and benefit from. The goal of gender-based research is empowerment through knowledge. The poor remain poor because of a lack of information and strategic connections. Women should also be encouraged and provided with the skills and knowledge to become effective researchers at the grassroots level.

Participants agreed that the community being studied should always be informed of research results. It is unethical to conduct research on AIDS by interviewing migrant workers and commercial sex workers, and then not inform those who were interviewed of the results. According to one participant, many researchers in the past have exploited community members without giving back to the community - "Many have received Ph.Ds and reaped honours because of the time and labour sacrificed by community members, without empowering the people being studied."

### *Linking Research to Policy*

The importance of going beyond research reports and ensuring that research results are translated into action was stressed. Researchers should go a step further and package their 200-page papers into 5-page policy documents, and ensure that key policy people are aware of the results. Developing nations of the region cannot afford to do research "just for the sake of it."

We must also remember that legislators are not poor people - we therefore have to present the realities of women's lives to policy makers.

Many policies are top-down, and grassroots women are unaware of policies. One woman explained that in part of India, there are more and more female politicians, but these women tend to act as puppets for their husbands' views and beliefs and just put forward the opinions of their husbands.

One participant from India provided two examples of how research results and public pressure have led to legal and policy changes. In Bombay, research demonstrating that couples used amniocentesis for sex determination and selectively aborted female fetuses led to the legislative banning of this practice. In the state of Tamil Nadu, public awareness about the level of female infanticide led to a state policy stating that all unwanted female babies will be cared for by the state.

### *Interdisciplinary Research Teams*

Participants agreed on the importance of forming interdisciplinary teams of researchers (e.g., medical researchers and social scientists). However, sometimes it is not possible to form an interdisciplinary team (e.g., due to financial constraints) and researchers need to explore other options. One participant said that researchers who are trained in the pure sciences can learn to look at their data from a new perspective. Even without social science training, as a human being, a researcher can "uncover the human dimension" and do social science research.

The importance of using both qualitative and quantitative data collection techniques was stressed. Researchers need to have several data sets (such as surveys, key informant interviews, focus group interviews, life histories, and so on) to obtain a holistic and gender sensitive perspective.

One participant stressed that researchers doing qualitative research must record their data. Time and time again, researchers do focus groups, for example, and do not transcribe their results. Recorded results are essential so that they can be shared with others.

### *Framing Initiatives*

One participant said that we need to be careful about how we frame initiatives to help women. For example, women have been successful in acquiring child care centres at places of employment in some countries because they have sold the idea to employers by convincing them that it will increase workers' productivity and minimize turnover. If the message was structured in a way that did not focus on the benefits to the employer (e.g., focused on the benefits to women and children), employers might be less receptive.

### *Changing the Attitudes of Men*

Much discussion centred around interventions aimed at women, but sone participants stressed that we must also work to change the attitudes of men. Educating men is important because they often hold so much decision-making power within families and society. Women may appreciate interventions by researchers that advocate changes on the part of men to improve the health and well-being for men and women.

## Placing Gender on the Research Agenda: Some Guiding Questions

### *Some Guidelines*

- The following are some questions you can use to aid you in evaluating the extent to which your research is gender-sensitive.
- Some questions may be more relevant to your particular area of research than others.
- Locate these questions in the community or communities you have studied.
- Draw out the health implications of these questions.
- Consider the relevance of these questions to your research in terms of conceptualization, methods, and analysis.

In your research, have you taken into consideration the following questions? Are you documenting these gender differences in your research? Have you analyzed the health consequences of the gender asymmetry that exists between men and women?

### *Reproductive Health and Reproductive Rights*

1. What is the life expectancy of women relative to the life expectancy of men in the community or communities you have studied?
2. What are the maternal mortality rates in the community or communities you have studied?
3. What are the infant mortality rates in the community or communities you have studied?
4. How many children on average do women bear in the community or communities you have studied?
5. Is there a preference for sons relative to daughters?
6. What factors affect women's reproductive choices?
7. Who helps women during childbirth?
8. Is there any difference in the treatment of women who bear sons versus those who bear daughters?
9. How do women deal with unwanted pregnancies?

### *Nutrition*

1. Who decides on what crops to cultivate, who farms them and who gets the money for the produce?
2. How would you compare the nutritional intake of boys and girls, men and women?
3. Who eats first, who eats last?
4. What cultural taboos are there surrounding menstruation, pregnancy, and childbirth?

5. What factors affect gender-differentiated nutritional levels?
6. Do women suffer from specific health problems resulting from nutritional deficiencies, such as chronic anemia, night blindness, bone deformities, etc.?
7. What, if any, nutritional supplements are given to women during menstruation, pregnancy, lactation, and menopause?

### *Environment*

1. Do women and men in the community or communities you have studied occupy the same life spaces, given their often gendered socio-culturally determined roles and responsibilities?
2. Do the effects of environmental degradation have similar consequences on the health and livelihoods of women and men?
3. Do women and men possess the same knowledge about the environment? Is it the men or the women in the society who are often the primary resource managers?
4. What are the main contaminants in the environment? Do environmental pollutants and environmental disasters have similar consequences on the health of men and women?
5. Do women and men have the same rights, entitlements, access and control over land, habitat and resources? What are the consequences of unequal access to land and resources on women and on women's health?
6. Do women and men have equal access to the planning and management of the natural and built environment, the work and the home environment?

### *Work*

1. What are women's hours of work and leisure, relative to men's time-use?
2. What constitutes women's work and men's work?
3. What are women's income levels compared to men's income levels?
4. In what sectors are women employed, compared to men?
5. What are women's economic assets, e.g., property, land, business enterprise, equipment, vehicles, luxury goods?
6. What are female literacy rates compared to male literacy rates?
7. What is the extent of women's physical mobility outside the home, compared to men's mobility?
8. What is the health impact of particular development processes on men and on women?

### *Violence and Hazards*

1. What is the incidence of violence against women in the community or communities you have studied?
2. What are the attitudes of society to women who are victims of violence?
3. What kind of health care is given to women who have suffered violence?
4. What occupational and environmental hazards do women face, as compared to men?

### *Health Care*

1. Who has the responsibility for providing the family with clean water, nutritious food, and a hygienic environment?
2. Who provides health care in the family? Who looks after sick babies and children, the handicapped and the elderly? Who looks after men when they fall ill? Who looks after women when they fall ill?
3. Who makes decisions for the family about the need to seek care outside the home?
4. The 1977 Plan for Heath Care Services in India states "Indian mothers, like mothers elsewhere, are selfless and ready to sacrifice anything for the welfare of their family." What are the health consequences of such "sacrifices" to the women themselves?
5. What are the attitudes of society to women who are ill, menstruating, pregnant, post-natal, lactating, or menopausal? What kind of health care is there to address their health needs in these specific conditions?
6. What taboos are there in talking about women's health problems?
7. Who are the health practitioners providing health care to the community or communities you have studied?
8. What factors affect women's access to health information and facilities?

In addition to the questions above, draw out some other significant gender-related questions based on your research experience.

## Research Gaps and Priorities

### Research Gaps

effects of urbanization and industrialization

effects of migration

links between socio-economic and political situations and health of women

impact of social development/welfare policies/programs on women

needs analyses of specific groups:

- children in difficult circumstances
- lifecycle studies of women
- special needs of the elderly (quality of life and aging)

impact/effects of ecodegradation

male attitudes to gender sensitivity

lack of focus on women's total health and wellbeing

lack of lifecycle analyses

insensitivity to women's concerns

women's occupational health and safety - exposures and outcomes

special hazards faced by women

informal and formal sector work

women headed households

women as local resource managers

less value given to women's work

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utilization/acceptance of health facilities

information on women in national and regional levels

lack of baseline and statistical data

how to encourage community participation

awareness of gender issues among policy makers

need for data disaggregated by gender

exclusion of women as research subjects

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lack of knowledge on health care itself

exclusion of women as researchers

lack of awareness education

lack of gender training in formal education

## Research Priorities

specific topics:

- tropical infections (and links to pregnancy)
- street-children
- environmental health
- mental health
- child growth and development
- using available technology for reproductive research
- prevention of AIDS/STDs
- attitudes to and behaviours about breastfeeding
- OHS
  - occupational health and safety for women in both informal and formal sectors
  - human resources development for OHS
  - need to look at gender component of legislation pertaining to occupational health and safety
  - health implications of women working in export-producing zones (e.g., no trade unions)
- expectations of women re: health services

community health care

women's changing roles

women's awareness of their own health

women's participation in the management of environmental health

accessible training in gender methodology (short courses)

gender sensitization in policy, program delivery and research

including men in gender sensitive training

bring gender issues to the attention of bureaucrats and politicians

political advocacy training for women

gender sensitive legislation to protect women's health

interpretative research on women's feelings, experiences on employment and the environment

education of husbands about gender sensitivity

importance of interdisciplinary research

# Recommendations and Strategies

## *Policy Makers*

| Recommendations | Strategies |
|---|---|
| increase awareness of policy makers (especially those at the top echelons) of the gender implications of socioeconomic and political realities on the health of women (including industrialization, war, urbanization, migration, occupational health hazards and environmental health) | conduct research and disseminate information which is gender sensitive and makes economic sense to policy makers<br><br>develop appropriate implementation programs |
| formulate gender sensitive policies | lobby/advocacy work (e.g., by women's research/information groups) |
| create/strengthen departments/ministries in charge of women's affairs | gender sensitive training for policy makers |
| develop appropriate mechanisms for promoting the advancement of women (e.g., have policies aimed at the increased political participation of women) | lobby wives of policy makers<br><br>establish a special national committee and national network |
| create gender sensitive legislation to protect women's health | networking of NGOs and governmental organizations |
| | increase the number of women leading government departments |
| | ensure representation of women at all levels of policy making (e.g., have a fixed number of seats in government) |
| | create a lobby network for women's issues |
| | create a monitoring and evaluation system of policies impacting on gender and health |
| | enact policy/legislation to ensure the equitable distribution of resources among men and women |

## *Research Institutions*

| Recommendations | Strategies |
|---|---|
| ensure that research projects are gender sensitive and that they highlight the social status of women | use research methods/techniques which will allow gender disaggregation |
| encourage the establishment of interdisciplinary research teams and projects | establish a commitment to link disciplines and to create proposals based on priority needs of the new discipline of interdisciplinarity |
| incorporate cost-benefit analysis into research on gender and health issues | conduct gender sensitization training programs for researchers (e.g., training on gender sensitive research methodologies) |
| allocate more funds to research on women's issues | create a network linking regional research institutions |
| ensure that a holistic approach is taken to research on women's health | establish a centre for women's information dissemination |
| conduct more action research that interfaces with government agencies from the initial stages to ensure a sense of ownership and accountability on the part of the government | popularize research findings |

## *Professional Bodies*

| Recommendations | Strategies |
|---|---|
| ensure that services delivered are gender equitable | lobby |
| ensure greater representation of women in senior positions | provide gender sensitive training to professionals/include gender sensitization issues in orientation sessions |
| form linkages between professional bodies based on issues of concern to women | ensure representation of women in professional training, employment and promotion opportunities |
| link professional bodies with community level workers | encourage the inclusion of gender specific data and information gathering in the work of professional groups (e.g., doctors' records and reporting) |

## *Teaching Institutions*

| Recommendations | Strategies |
|---|---|
| incorporate gender issues, including research methods and tools, in curriculum at all levels of education<br><br>provide incentives at household and community levels to encourage the education of girls<br><br>provide nonformal education for girls and women | training of trainers at all levels in gender sensitive education<br><br>disseminate gender sensitive information to both men and women |

## *NGOs*

| Recommendations | Strategies |
|---|---|
| encourage gender sensitive work programs by incorporating gender sensitive research and documentation<br><br>provide gender sensitive training for the community and government organizations<br><br>network between NGOs for role definition, sharing of experiences and responsibilities<br><br>establish links with other national, regional and international agencies in order to strengthen advocacy efforts in gender, health and development issues<br><br>lobby policy makers and decisionmakers (nationally, regionally and internationally) with regard to gender issues<br><br>create a database of research information<br><br>create a monitoring and evaluation system of NGOs to ensure responsibility of NGOs to communities | gender sensitive training<br><br>forums, seminars, workshops<br><br>enlist the resources of research institutions to provide NGOs with information |

## *Communities*

| Recommendations | Strategies |
|---|---|
| understand and improve the perceptions of the community towards themselves, their environment, and women's issues<br><br>empower communities/women to become local resource managers<br><br>ensure equitable resource distribution among women and men<br><br>encourage communities to get involved in women's health issues<br><br>promote community awareness of gender issues (especially among men)<br><br>promote the empowerment of women<br><br>improve community health, especially women's health | NGOs and GOs to assist in community organizing process<br><br>GOs to develop capabilities to respond to empowered communities<br><br>lobby leaders, heads of community<br><br>use research methods which encourage community participation<br><br>use process oriented methods<br><br>train target members in the community<br><br>use the media for the interest of women<br><br>develop outreach projects |

## *Other*

| Recommendations | Strategies |
|---|---|
| *Donor Agencies* | |
| be gender sensitive | give gender sensitive training |
| have flexible time frames for moving funds | educate donor agencies that participatory development needs time |
| be holistic | |
| develop agenda on basis of countries' needs | involve countries in agenda setting |
| *vulnerable groups (single mothers, aged, handicapped, etc)* | |
| increase group awareness of gender and health issues | |
| increase government support | use the media |
| *mass organizations (trade unions, youth groups, etc)* | convene special meeting points/clubs |
| put gender issues/problems in action plans | |
| raise awareness | use the media |
| *Religious bodies* | link activities with NGOs and GOs |
| advocate gender issues at community level | use meetings to raise consciousness |

## The Asia and Pacific Women's Health Network

### *Objectives*

An Asia and Pacific Women's Health Network was formed at the workshop with the following objectives:

- to address fundamental gaps in knowledge about women's health at all stages of their life-cycle;
- to promote gender-sensitive health policies, research, and care delivery; and
- to empower women in the articulation of their own health needs and their capacity to provide health care for themselves and for others.

At its most basic level, the Network will serve as a clearinghouse for information on women's health, and coordinator of regional health research and activities with a focus on women. At a more advanced level, the Network will seek to bring together a critical mass of convergent efforts to bear on a comprehensive range of women's health issues to improve the health and well-being of women of the region. The Network will give special attention to health issues resulting from rapid economic development in the countries of this region.

### *Structure of the Network*

The Network will function at the Asia and Pacific regional level. At the international level, the Network will have a special relationship with UNIFEM which is currently working to implement the Women's Development Agenda for the 21st Century and is interested in developing a Women's Health Program within the Women's Development Agenda. The Network will aim to support the work of UNIFEM by being a two-way channel that will enhance the responsiveness of macro-level policies by providing an upward flow of women's health needs and concerns from micro and meso levels.

In addition, the Network will connect with international NGOs (such as the International Women's Health Coalition, CARE, etc.) and international agencies (including IDRC, WHO, the World Bank, FAO, UNDP, etc.).

The Network will itself be inclusive rather than exclusive, growing to meet the needs of its members. Metaphorically, it will be like a fishing net, with every additional member being another knot strengthening and building the Network's collective knowledge, capacity, and impact. It will be composed of organisations and individuals from all sectors and levels who

are interested in women's health issues. It may include nongovernmental organisations, practitioners (doctors, nurses, therapists, etc.), policy makers, existing networks, business representatives (food industry, pharmaceuticals, medical equipment manufacturers, etc.).

A Secretariat, based for the current time at ENGENDER, will co-ordinate activities, facilitate linkages, and disseminate information through the following activities:

- information-gathering and information-sharing
- research
- advocacy and co-ordination of strategies
- training and education
- facilitation of funding

Task Forces may be autonomously formed around specific issues and strategies at the initiative of Network members. These Task Forces may be based at any node of the network, including the Secretariat. These Task Forces will be encouraged to develop a regional outreach through the Network.

At the national level, Network members will be encouraged to form Working Groups on Women's Health that will be national in scope, with special efforts to include those located far from national capitals and to link with existing groups and institutions in the country. The National Working Groups will, by their very nature, have cross-cutting interests on specific issues and strategies, and will form a geographical complement to the Issue-based and Strategy-based Task Forces. Thus, while the Task Forces will foster international co-operation and synergy on common issues and strategies, the National Working Groups will encourage interdisciplinary linkages, as well as interaction between centre and periphery within the country.

## *Funding Sources*

The Secretariat will raise seed money for the co-ordination activities of the Network. In the first phase of its work, additional funding for the activities of the Task Forces and Working Groups will have to be solicited by themselves from a variety of donors depending on the nature of the activity. The Network will draw on its own strength and connections to assist Task Forces and Working Groups to obtain funds for activities by sharing within the Network members strategic information about available funds and sources. One way of disseminating such information would be the establishment of a database of donor information, both electronically and in hard copies.

## *Activities*

At the Workshop, the following activities were proposed, discussed, and accepted by the Network members.

## *Information-Gathering and Information-Sharing*

1. Building databases
2. Facilitating linkages between Network individuals/groups
3. Show-casing success stories and lessons learned
4. Coordinating popularisation of information
5. Coordinating and producing a Network newsletter
6. Developing and managing an electronic bulletin board (INTERNET through IDRC's PAN network)
7. Organising Network meetings every two years with rotating location
8. Conducting process documentation of Network activities and strategies
9. Distributing of information to those at the periphery
10. Achieving information for public access in libraries

## *Research*

1. Coordinating of trans-national research activities
2. Monitoring allocation of national-level health budgets, actual expenditures, and research funding

## *Advocacy*

1. Coordinating advocacy of policy makers at international, regional, and national levels
2. Gender sensitizing health research, services and policies
3. Channelling women's health concerns to UNIFEM as our UN advocate
4. Lobbying governments to allocate resources in health budgets in gender-sensitized and appropriate ways

### *Training*

1. Developing training modules (e.g., gender sensitization, care of aging women, community health monitoring)
2. Encouraging sharing of training materials and modules (including the "training of trainer" modules) for translation, popularisation, and tailoring to local needs
3. Professionalization of women health care givers, including nurses, midwives, traditional birth attendants, etc.
4. Ongoing training to network members at biannual meetings

### *Funding*

1. Fund-raising for establishment of the Secretariat
2. Mutual assistance in fund-raising efforts of the network members, including the Secretariat, task forces, working groups, and others

3 Dissemination of information on funding sources

## *Proposed Structure of Network and Process of Networking*

International level: World Bank; FAO; UNIFEM; IWHC; IDRC; UNDP; WHO.

Regional level: Asia & Pacific Women's Health Network - issue-based task forces (e.g., osteoporosis, AIDS, occupational health, environmental health, health care systems)

National level: National Working groups linking with existing work, institutional bases, etc.

## *Proposed Issue-based Task Forces*

1. osteoporosis (OESTRA)
2. occupational health
3. AIDS
4. environmental health
5. health care systems
6. tropical parasitic diseases
7. reproductive health
8. women against tobacco

## *Proposed Strategy-based Task Forces*

1. women's empowerment and participation
2. sustainable mechanisms of development
3. community-based research
4. policy advocacy
5. communications and information-dissemination

# Appendicies

## GENDER, HEALTH AND SUSTAINABLE DEVELOPMENT WORKSHOP

**Singapore**
**January 23-26, 1995**

# AGENDA

Monday January 23

| | |
|---|---|
| 7:00-8:30 | Welcome reception for visiting participants |

Tuesday January 24

| | |
|---|---|
| | *Opening Ceremony* |
| 9:15-9:30 | *Welcome*<br>**Vivienne Wee**, Program Director<br>Centre for Environment, Gender, and Development (ENGENDER) |
| 9:30-9:45 | *Opening Address*<br>**John Graham**, Senior Regional Program Officer (Environment and Natural Resources) and Member, IDRC Gender and Sustainable Development (GSD) Liaison Committee<br>Representing **R.W. Spence**, Regional Director, Asia Regional Office |
| 9:45-10:00 | *Address*<br>Guest of Honour **Kanwaljit Soin**<br>Nominated Member of Parliament, Singapore<br>Director, Centre for Environment, Gender, and Development (ENGENDER) |
| 10:00-10:15 | *Address*<br>SEAMEO Jasper Fellowship Awardee for 1994<br>**Violeta Lopez-Gonzaga**, University of Philippines |
| 10:15-10:45 | Tea |
| 10:45-12:30 | Focus: *Objectives of the Workshop*<br>Facilitator: **Annette Stark**, Senior Regional Program Specialist (Health), Health Sciences Division, IDRC<br><br>*Background to the workshop:*<br>**Janet Hatcher Roberts**, Senior Program Specialist |

*Background to the workshop:*
**Janet Hatcher Roberts**, Senior Program Specialist
Health Sciences Division, IDRC

Introduction and expectations of participants

*Discussion and adoption of agenda including*:
- an introduction to a grid of workshop topics
- nomination of a drafting team of rapporteurs

12:30-14:00 Lunch

14:00-16:00 Focus: *Gender analysis: perspectives and methods*
Facilitators: **Vivienne Wee** and **Violeta Lopez-Gonzaga**

Plenary: *What, why and how? Concepts, aims and methods in gender analysis*

Small groups: Role play

Plenary: *Discussion of issues arising from the role play*

16:00-16:15 Tea

16:15-17:00 Plenary:
- Preview of the guiding questions for review of research issues through a gender lens
- Preview of proposal for the formation of a long-term research and action women's health network in Asia and the Pacific

18:30-21:30 Welcome dinner hosted by IDRC

Wednesday January 25

9:00-9:15 *Highlights of the previous day* (rapporteurs and facilitators)

9:15-10:45 Focus: *Contextualizing health in*
- development processes
- the gender hierarchy
- society and culture

Facilitators: **Janet Hatcher Roberts** and **Vivienne Wee**

Plenary: *An overview: Country case studies*
Open discussion

| | |
|---|---|
| 10:45-11:00 | Tea |
| 11:00-12:30 | Small group discussions: *Contextualizing health.* Review of participants' research issues through a gender lens using the guiding questions provided. |
| 12:00-14:00 | Lunch |
| 14:00-14:30 | Plenary: *Report of small group discussions* |
| 14:30-15:15 | Focus: *Linkages between Health, Gender, and Development*<br>Facilitators: **Annette Stark**, **Maria Ng Lee Hoon**, Senior Regional Program Officer (Information Sciences and Systems)<br><br>Plenary: *Case studies to highlight the linkages between health, gender, and development*<br><br>The health consequences of war<br>• Communicable diseases<br>• The health consequences of population policies<br>• The health consequences of poverty<br>• Other case studies |
| 15:15-15:30 | Tea |
| 15:30-17:00 | Small group discussion: *Linkages between health, gender, and development*<br><br>*Review of participants' research issues through a gender lens using the guiding questions provided* |

Thursday January 26

| | |
|---|---|
| 9:00-9:15 | Highlights of the previous day (Rapporteurs and Facilitators) |
| 9:15-10:00 | Focus: *Linkages between Health, Gender, and Development*<br>Facilitator: **Vivienne Wee**<br><br>Small group discussions continues |
| 10:00-10:45 | Plenary: *Report of Small Group Discussions* |

| | |
|---|---|
| 10:45-11:00 | Tea |
| 11:00-12:30 | Focus: *Research priorities, gaps, contexts, and methods*<br>Facilitator: **Janet Hatcher Roberts** |

Small group discussion of country situations:

- Where are the priorities areas of research on gender, health, and sustainable development
- Where are the gaps in research?
- Why do these research gaps exist?
- What kind of research approaches and methods would be appropriate for these priority areas and research gaps?

| | |
|---|---|
| 12:30-14:00 | Lunch |
| 14:00-16:00 | Focus: *The Formation of a Long Term Research and Action Women's Health Network in Asia and the Pacific*<br>Facilitator: **Vivienne Wee** |

Small group and plenary discussions of country situations:

- What are women's long-term health needs?
- To what extent are these needs being met?
  How can a regional research and action network help meet these needs?
- What additions and amendments can be made to the proposal for such a network?

| | |
|---|---|
| 14:00-14:15 | Tea |
| 17:00-21:00 | Evening Tour of Chinatown |

Friday January 27

Focus of the day: *Presentation, Discussion and Adoption of Draft Report of the Workshop and Future Directions*
Facilitators: **Janet Hatcher Roberts** and **Vivienne Wee**

| | |
|---|---|
| 9:00-9:30 | Presentation of the draft reports (Rapporteurs) |

| | |
|---|---|
| 9:30-10:45 | Small group discussions of the draft report, focusing on strategies and recommendations to specific target groups:<br>• Policy-makers<br>• Research Institutions<br>• Teaching Institutions<br>• Professional bodies<br>• NGOs<br>• Communities<br>• Other groups |
| 10:45-11:00 | Tea |
| 11:00-12:30 | Plenary: *Report of Small Group Discussions* |
| 12:30-14:00 | Lunch |
| 14:00-15:30 | Plenary: *Integration and Synthesis of the Participants' Contributions into the Draft Report (Rapporteurs)* |
| 15:30-15:45 | Tea |
| 15:45-17:00 | Plenary: *Adoption of the Draft Report*<br>Where do we go from here? Future direction of the network. |

## GENDER, HEALTH AND SUSTAINABLE DEVELOPMENT WORKSHOP
## Singapore
## January 23-26, 1995

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# Perspectives from the Caribbean

## Opening Statements

# Opening Address

**Hon. Elizabeth Thompson**[1]

I am honoured by PAHO's invitation to address you at the commencement of this very important workshop on *Gender, Health, and Sustainable Development*. The timing of the workshop itself will prove to be very critical, for we in the Caribbean region are at a period where rapid developmental changes have been taking place in every aspect of our social, economic, and political lives, and where we are forced, often without the necessary preparation, to adapt to these changes. The changes of which I speak are wide ranging, from NAFTA to the role of the woman in modern Caribbean society. Today, women in particular have a different perception of themselves, and the traditional role which they have played in society has undergone, and continues to undergo, tremendous change. Yet, while the focus in medicine, particularly in the United States, has recognized that women's health needs specific and careful attention, we in the Caribbean have not kept pace.

We Caribbean people, because of our very close-knit societies, have been governed by a variety of unwritten laws. These laws determine our mode of dress, the places we go, the activities in which we become involved, and the way how we make our money. Our traditions, customs, mores, and values place us into particular modes according, in most cases, to our upbringing and backgrounds, and more so according to our sex - whether we are male or female. This value system can sometimes act as constraint, resulting in uneven development among various sectors and groups within our societies. This is still true of many Caribbean islands although, perhaps, not of all.

The modern Caribbean woman is in a better position to take advantage of educational and employment opportunities. She can now enter into domains previously dominated by men, yet these strong cultural traditions and norms, such as the Lodge and exclusive male clubs, often act as deterrents to the progress of females. In order for us to develop into highly productive societies, we must consciously fight against these traditions and establish equality for all and equal access to all opportunities.

Concepts of development have been traditionally associated with economic growth. Very little attention has been paid to the social, legal, and political inputs which contribute to the developmental process. Even less attention has been given to the correlation between health and development. In recent times, a more all-embracing approach has been adopted, and the term human development is now accepted internationally. The 1990 United Nations Human Development Report clearly states that development must focus directly on people, and not

[1] Minister of Health, Barbados.

be restricted to the increase of income and wealth. Development must be concerned with enlarging people's choices for the realisation of long and healthy lives, achieving educational levels to allow them to function adequately, and having access to economic resources to allow for a decent standard of living.

Whatever potential we possess as a people, there can be no development unless we are healthy. Violent and gang-related activity which cause our young men to be the victims of knife, cutlass, and gunshot wounds remove some of our fittest members of society from the labour force. The anti-social behaviour of begging, stealing, and vagrancy often exhibited by many parros constitutes a threat to economic development. Much money is spent caring for those with chronic but preventable diseases, such as diabetes. Between July 1993 and June 1994, Bds $1,836,000 was spent on drugs alone in the care of diabetics. People who lose limbs or vision through chronic illness cannot enjoy full personal development, for their disabilities impact adversely on the quality of life they enjoy. In addition, the vast sums spent on the care of these persons, are best applied to something else in a small developing economy. Disease epidemics prevent tourists from coming, resulting in loss to the economy. Maintaining good health care for a nation's people is therefore the first major step towards sustainable development.

When the question of health is examined in the Caribbean context, it is found that when compared with men, women bear an unequal burden of preventable health problems. In fact, the 45th World Health Assembly noted that "women - across all age lines, geographical boundaries, and stages of development - bear a disproportionately greater burden of preventable health problems than men." This disadvantage was attributed to a broader inequality of women with respect to men in terms of social and economic status, which is reflected in women having less access to basic resources for the promotion and protection of their health. While this may not be true of women in Barbados, women's health is still deserving of special attention, for women are still the child-bearers and child rearers. Our people are our greatest resource, and we must pay special attention to all women who reproduce and care for the nation's youth.

In the Caribbean, the changing roles of women is an important factor in this greater burden being carried by women. In addition to being the bearer and rearer of children, and having in most cases sole responsibility for the upkeep and daily maintenance of the home, the preparation of meals and the care of all other household members, women are for the most part now earning a living outside of the home. Many women are in effect performing two full-time jobs with little or no social support to assist them to cope physically, mentally, or emotionally with this added strain. It is not surprising then, that although women can expect to live longer than men, during their lifetime, they also face more chronic disease than do men.

Chronic non-communicable diseases have been found to be the main cause of death among women in the Caribbean. Deaths due to diabetes and diseases of the circulatory system are consistently higher in females than in males. These most recent health profiles should not be

interpreted to mean that women should restrict their activities to the home and community, for there is no doubt that they have been contributing to the social, economic, and political development of our region in spite of the disadvantages in gaining access to education and training, and to the means of production.

Steps taken to improve women's health should be seen as an investment in the overall development of our human resources, since women's role is such a pivotal one in our society. It is therefore critical that special emphasis be placed on gender in health planning and to the impact which gender-related variables have on the health of our women. We must focus not only on the treatment and cure of diseases in women, but attention must also be focused on preventing health problems such as early or multiple pregnancy, cancer, diabetes, hypertension, sexually transmitted diseases, and many of the social and medical ills which cause our women to suffer.

We also need to pay attention to the psychological and emotional health of the females in our society. Despite the strides being made by women in the corporate, political, and professional spheres, there is still the underlying belief that the place of the woman is in the home. As a result, working women are pressured into doing two or three times as much as their male counterparts to prove their capability. Further, many working women are not relieved of the functions which traditionally fall to them - care of the children, household chores, grocery, shopping, and so on. We are also faced with an absence of emotional support as many of our men opt out of life. Many of today's under-achievers are male, many of those standing idly on street corners are men. Women still need the emotional support of men and they are not getting it. This is causing them much stress which is being compounded by the pressures of the work place - the glass ceiling and sexual harassment being two of these.

In recent times we have been hearing of female executives in Barbados frequenting bars after working hours to relax and have a drink. It is not now as unusual as before to see women smoking. In the more developed countries, a rise in the incidence of lung cancer is being observed among women. Many professional women are choosing to have casual sexual liaisons over stable long-term relationships. It seems that the behavioural patterns associated with success among males are being adopted by females, in keeping with their move up in society and the need to feel acceptance at that level.

The successes of women, or shall we say, the more even distribution of occupational roles other than those in the low production and low paid brackets, have been accompanied by new forms of emotional and psychological pressures aimed somehow at instilling in women a permanent sense of guilt.

The increase in the number of young men who choose not to become involved in productive activity but rather to line the sidewalks of our streets daily is partially being attributed to the success of females in the social and economic spheres, and to the absence of the mother's constant presence in the home. I do not subscribe to this view, for our women have always

worked as maids, shop assistants, hucksters, tying and loading sugar cane, selling fried fish at Baxters Road, as nurses, teachers, seamstresses, selling pudding and souse, cakes and sweetbread from homes. Instead, I believe that the reason for our social decline lies in the use of the nuclear family in the middle class setting which alienates and excludes grandma, auntie and the matriarch of the family who was previously responsible for the care and upbringing not only of her immediate family, but also many of the children of the village. She taught manners, social skills, values, and the rudiments of good behaviour. Today she is abandoned in the Geriatric Hospital or the Queen Elizabeth Hospital.

Just recently at the UWI Cave Hill graduation ceremony, Chancellor Sir Shridath Ramphal observed that 61% of the university entrants were females and described this as "a great achievement for the society in terms of gender equality and for the particular advancement of women." Sir Shridath went on to question whether young men were underachieving, and the ramifications of this trend for the future of Caribbean societies.

I am not denying that there is a serious problem today among our young males. We must be very careful, however, not to stigmatize our young women and mothers by attributing our social decline to their career successes. Instead, let us look for the real root cause of this disaffection among our males.

The development of our region is dependent on the full participation of both men and women in the social, economic, and political arenas. We want to ensure that, as far as is possible, issues associated with women such as teenage pregnancy, violence against women, rape, child abuse, sexual harassment on the job, and occupational health problems, are thoroughly examined and measures implemented to prevent their occurrence. On the other hand, lawlessness among youth, especially among young men, must be corrected. Every male should be able to participate fully in the developmental process without being hindered by the effects of alcohol and drug abuse, or by being diverted into criminal activity.

The health profiles of our peoples must be maintained in order to realise the full economic, social, and political potential of Caribbean states. Of course, when we speak of health, we are not just talking about the absence of disease, but rather of the total well being of each individual. My Government recognises that our people are the greatest resources for development. We see ourselves as being responsible for the creation of a culture of excellence in human resource development, as we seek to lay a strong foundation for the empowerment of our people. This goal will involve the promotion of healthy lifestyles as preferable to the treatment or cure of disease.

The fact that we in Barbados and in the wider Caribbean have inherited a number of inequalities which have been ingrained into every fabric of society cannot be overlooked. We must all seek to address these inequalities as we strive for the maximisation of our greatest resource - our people.

I highly commend the Pan American Health Organisation for the work which it has been doing in recognising the impact of gender inequalities on health and development and more so by seeking to address these inequalities through research, and the planning of programmes and workshops throughout the region.

This new and bold initiative by PAHO is the natural follow-up to its promotion of Maternal and Child Health care throughout the region. Evidently PAHO has recognised that total health care extends beyond the care of the mother and child into the wider areas of nutrition, environmental and occupational health, and chronic diseases. Over the coming days, the impact of gender issues on these aspects of health care will be examined in addition to the identification of research gaps which inhibit the provision of total health care to our people.

I wish also to commend the International Development Research Centre of Canada, which is collaborating with PAHO in this project. I feel confident that your deliberations will be very successful. Both as a Health Minister and as a woman, I am keenly interested in this workshop, and I sincerely wish you well. I would also like to invite you, both participants and facilitators from other countries, to take some time out of your busy schedules to enjoy some of our Barbadian life and hospitality. You will find that our women are excellent cooks and their culinary skills will both delight and sustain you.

# Welcome Address

**Karen Sealey**[1]

Earlier this year, at the Global Conference on the Sustainable Development of Small Island Developing States, the Director Designate of PAHO, Sir George Alleyne, spoke on the role of women in development.

> No state, and particularly no small-island state, can afford to misuse, or not use, to the fullest, the talents of its women in all fields. But the role of women is of particular importance in relationship to health and the environment. Women as promoters and protectors of their own health, and that of the family, are important in the achievement of national goals. The manner in which women participate in the pertinent discussions and decisions will vary from state to state - the important thing is that it happens.

In the same sense, and using Sir George's speech both as context and reference, the important thing about this workshop on *Gender, Health and Sustainable Development* is that it is happening. And for that, the fact that it is happening (some of you might be saying at long last) I wish to thank our collaborators in the sponsorship of this workshop. I would also take the opportunity to welcome the representatives of the International Development Research Centre (IDRC).

IDRC has been extremely supportive of research in health-related matters in the Caribbean. We are collaborating on a project on *Managing Health Technology*. We continue to discuss ways in which we can strengthen the links among the participating countries of the Caribbean Cooperation in Health (CCH) Initiative, IDRC, and PAHO. We have identified health promotion, specifically the control of chronic diseases, and health and hospital planning and management, as areas in which this collaboration can take place.

We are also grateful to the Carnegie Corporation for funding and supporting the Women, Health and Development project within the Office of Caribbean Program Coordination. This workshop was built around the project, which also helped us to define and refine some of the key issues involved in the analysis of gender, health, and sustainable development. Dr. Cheltenham, coordinator of the project, will provide an overview later in the program.

However, long before the Carnegie project, there were persons in the region and within PAHO who were very concerned about, and dedicated to, drawing attention to and resolving the issues of women, health and development.

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[1] Caribbean Program Coordinator, PAHO, Barbados.

One of these early advocates and activists is with us today in the person of the Governor General of Barbados, Her Excellency Dame Nita Barrow. Dame Nita has been a champion of issues relating to women, health, and development, and even now is actively involved in the WHO Global Commission on Women's Health. It is with considerable pleasure and a great deal of satisfaction that I welcome her here today.

I also welcome my colleagues from the other United Nations and regional institutions and agencies, all of whom have appreciated the need to maximize our resources and focus their application in the key areas of development. In this regard, I want to single out the cooperation and support from UNICEF, UNIFEM, and WAND, to welcome their representatives here, and to thank them for their support. Their intimate knowledge of the areas to be covered helped to ensure that this IDRC and PAHO workshop builds on the experiences to date and seeks to move the Caribbean agenda forward.

This workshop is extremely significant as an indicator of the growing appreciation of the importance of the inter-relationship among women, health and sustainable development as both concepts and as realities. It is said that only healthy families can contribute to national development. Healthy families mean healthy women. There is no room or time - and there is certainly no need - to explain or justify our focus on women's health.

While we at PAHO approach research from a gender perspective, acknowledging that men also have serious and urgen problems, all objective analyses at a regional basis point to the need for placing priority on women's issues as they relate to health and development. It does not matter what the entry point is: sustainable development, health, or women's issues. The importance is focusing on women's health *now* to foster sustainable development.

If the issues relating to gender and health are to be mainstreamed into the development process, we must acknowledge the urgency for objective information about women, health, and sustainable development. As a first step, data must be disaggregated by sex. Through IDRC, we are emphasizing and focusing on the need for developing or using appropriate methodologies to produce reliable data and to organize the information which we now have. We have to understand and use the right methodologies to get the kind of data that will be useful, relevant, and comprehensible to the planners, policy- and decision-makers. Just as the three streams of women, health, and development merge into one area of growing concern, we must in the same way merge research, policy, and delivery of care.

In welcoming the participants of the workshop, I would like to point out that you represent the three different, yet equally important, areas of research, policy, and delivery of care. This is a mix which we hope will be cemented into a working relationship and compounded into a way of life. This process must be underpinned by action or operational research, continuously interacting with planning and implementation. This workshop is a watershed where all the different streams meet, merge, and converge, and out of which me must chart the course, determine the direction, and fashion the flow of future events. I am sure that the synergy necessary to achieve this goal will be generated within the workshop.

## Objectives

- Review and identify gender and health research in the Caribbean.
- Clarify concepts of gender in health research.
- Identify road blocks and impediments to gender and health research and implementation of recommended action.
- Identify successful methodologies used in gender and health research.
- Develop a draft research agenda for the Caribbean region which addresses priority issues related to gender, health, and sustainable development.

## Expected Outcomes

- draft research agenda for the Caribbean region addressing priority issues and key policy implications related to gender, health, and sustainable development.
- publication of papers and summary discussion of the workshop proceedings.

# Gender Issues in Caribbean Health Systems

# The State, Gender, and Health Care Services: Barbados and Grenada 1979-1983

**Patricia Rodney**[1]

## *Introduction*

Socio-historical analyses of health care systems in the English-speaking Caribbean reveal a number of commonalities stemming from similar colonial and post-colonial experiences (Achilles 1987). Most countries in the region, including Barbados and Grenada (prior to 1979), had health care systems based on the British model, representing three different levels of care: primary (basic services, health education, preventative care), secondary (acute care), and tertiary care (chronic/long term). Prior to independence, policy development was usually carried out extra-regionally, without the presence of a coherent overall policy to lead to the integrated development of health care services in the region, and with very little input from the national level. As such, public policy failed to address the primary health care needs of the vast majority of the Caribbean working-class. Each national government tackled the problem of basic human needs individually by responding to crises in different sectors of the economy. Adjustments made to the health care systems were based not only on the countries' socio-economic situation, but also both on the priority each state placed on health and health care and the political will of those with power. Despite the creation of health-related policies at the national levels, however, developments in Great Britain continued to be a heavy influence on the structures which were built.

During the colonial period, health care systems in the Caribbean focused on curative services provided predominantly through urban-based hospitals. Rural populations were treated at "dispensaries" (similar to outpatient clinics) which operated on a weekly or monthly basis. Public health measures were confined mostly to containing and treating epidemic and endemic communicable diseases. The attainment of national independence, however, permitted the rapid growth of state ownership and control in the social sector, resulting in the provision of new and improved welfare services including health, education, community development, old age pension, and national insurance.

The development of these services, however, did not change national social structures. With the establishment of state health policies, priority was placed on the training and re-training of health personnel. Health services focused primarily on maternal/child health, and concentrated on pre- and ante-natal care. Traditional midwives were replaced by hospital-trained and based midwives. This massive systemic restructuring was carried out

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within the existing responsive medical model of care, without equal expansion and promotion of a preventative model. There is currently a lack of formal and informal health education and promotion programs which emphasize preventive measures that are gender specific. Policies are designed by men with little regard for, or understanding of, women's concerns. Consequently, women continue to suffer high morbidity rates from preventable diseases such as hypertension, anaemia, and obesity (Antrobus 1991).

### *Study Focus*

The focus of this paper will be on the developments which occurred in the health sector during the 1979-1983 period, and the perceptions of Barbadian and Grenadian working class women about the system's ability to meet their health needs. The women's views were also compared with their perceptions of the policy changes and/or reversals which occurred after the study period. The study illustrated how two post-colonial states, with different approaches to their socio-economic, political, ideological, and cultural development, assumed different aspects of PHC and promoted different (though fundamentally similar) health care models.

Both states, recognizing the need to better serve their respective populations, and in response to other internal and external influences, adopted the Primary Health Care (PHC) model in accordance with the Alma Ata Declaration of 1978 (Barbados Development Plan 1979-83). Although the Declaration emphasized that "primary health care [is] to be essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation...", the study highlighted that in both cases health policies have dealt inappropriately with women's issues; in fact, the states have been instrumental in making women "invisible." By investigating the development and subsequent implementation and management of health policies by the two states, and focusing directly on the women's views about the states' policies, the study attempted to understand the existing inequities and whether the models adopted by Barbados and Grenada were appropriate, or were appropriately adapted, for the delivery of Primary Health Care to the benefit of women. Barbados used the British National Health System Model and Grenada, the Alma Ata Primary Health Care model with socialist influences.

The research underscored that in the exploration of the social relations of women to the state, and the effects of state policies and practices on women, the analysis itself must encompass and contextualize many important elements which go beyond economic and political structures. An examination of such factors as reproductive responsibilities, gender, social and cultural identities, images and practices that shape everyday behaviour, symbolism, and place in political culture are also important (Beckles 1990).

### *Social Determinants of Women's Health*

Women's health has been confined specifically to issues of reproductive health which do not encompass women's entire reality. "Women have both general health needs, the same as the rest of the population, and health needs that are specific to them as women" (Blackburn 1991). For the purpose of this study, health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity" (Bolles 1987). In addition, race, age, social and economic status, ideology, geographic or regional location, the physical environment, politics, and health policies (Briggs 1992) are now known to contribute to the overall health of an individual and should be considered in the development of an adequate health care system.

Various studies have demonstrated that women's health could be jeopardized by diverse influences, such as legal rights, education, employment, housing, social class, occupation, food and nutrition, and environmental factors. Yet women's health care programs continue to ignore these factors and continue to be tied mainly to their reproductive/productive roles (Burke 1977).

The majority of women in the Caribbean are employed in jobs that are low paying and considered an extension of women's domestic roles. Reports have shown that women are more likely to be exposed to occupational health hazards and risks, depression, poverty, sexism, sexual harassment, domestic violence, and lack of support services.

The failure to view women's health holistically is not surprising, Weinensee's (1986) observation is that "[w]hat has been traditionally accepted in western culture as health care in reality is medical ill care." Weinensee argues that "health professional are not conceptually well equipped to study health, they have virtually no vocabulary or classification of functional capacity in health, and, while they have concentrated appropriately on the control and study of disease, they now must attend to positive health maintenance." Furthermore, even "nurses accept but do not strive for this positive goal. Instead they concern themselves with illness ... paying more attention to mal-adjustment and physical ailments than other areas of deprivation which influence well-being" (Clement 1987).

### *Methodology and Methodological Issues*

The study adopted an interdisciplinary methods approach which is essentially sociological, but also possesses several socio-historical characteristics. It integrated standard sociological structured interviews and anthropological unstructured in-depth interviewing techniques. This combined approach facilitated a comprehensive and holistic understanding of the women's concrete situation. It began by examining the historical data, followed by current views and perceptions of the health care system, its policies and services, and then the underlying medical and political assumptions which guided these states' health policies. To ensure that women's voices were not silenced through the intrusion of traditional and mainstream methodological research tools and expectations, open-ended, semi-structured

interviews were used because they "explore peoples' views of reality and allow the research to generate theory" (Convergence 1982). The "voices" of Barbadian and Grenadian women as "expert-informants" were central to the research process, as it was important to understand their perspective of primary health care services. One very important dimension of the study is that people were asked to reflect on aspects of health care policy implemented and services delivered almost a decade ago, and to compare those with the current health policies and services. As such, one stipulation made for selection of these interviewees was that the candidates were at least in their mid-twenties.

## *Barbados Health Care System*

PHC services include care to the elderly, disadvantaged, and those suffering from chronic diseases (Copperstock et al. 1991). SHC and THC were/are provided mainly through the Queen Elizabeth, Psychiatric and Geriatric Hospitals, and include those medical care services which cannot be provided through the polyclinics. The health care system in Barbados may appear to be well organized and managed; however, a closer look reveals it to be fragmented. As with other systems in the region, health care in Barbados is stratified into three levels (PHC, SHC, and THC), and operates on a 2-tier system, with services being provided by both the public and private sectors. Each sector is independently financed. As a result, there is heavy competition for control over the provision of services, and quality consistency is lacking. The Ministry of Health is the chief provider of public health services. The government health sector is financed primarily through general revenue; in addition, user fees are collected at the hospital for laboratory, X-ray, and drug services. The public sector provides X-ray and laboratory services to the private sector through the government hospital. The private medical sector, which has no statutory responsibility, provides predominantly curative services and some maternal and child health services. Statistics show that Barbadians spend approximately 6% of their personal budgets on health care (Cottingham 1984). This would imply that more use is made of the government services; however, unfortunately there are no official statistics available on the number of patients seen by private medical practitioners (Health Development Plan 1988-93).

### *Health Care Financing*

During 1976-1979, the Barbados Labour Party (BLP) government spent on average 14.1% of the combined current and capital account on health care. This figure represented a decrease in expenditure from previous years, when government spent an average of 16% per year. The level of national expenditure in a particular social service is usually a fair indicator of the importance government attaches to that sector (Doyal 1983). Using this premise, it may be fair to say that Barbados has placed a high premium on health care. However, it is interesting to note that the major portion of the 1983 health budget was allocated to the expansion of the Queen Elizabeth Hospital, which is the main provider of acute medical care. This under-emphasis on PHC runs contrary to government's adoption of the Alma Ata Declaration of 1978 and stated commitment "to decentralize medical care as much as possible by the establishment of PHC through a network of polyclinics which when fully developed

should be able to meet more than 80 percent of the demand for health services in the comprehensive health care delivery system" (Ellis 1986). In order to build the polyclinics, the government borrowed heavily from international sources (Ferguson 1990), but in amounts comparatively smaller than allocations made to THC in general. Even with the demand for polyclinic services, however, the majority of health care practitioners are middle class, have offices that are urban-based or within close proximity of the urban population, and are medically focused.

### *Health Policy and Administration*

The BLP government in its Development Plan of 1979-1983 admitted to inequities and inefficiencies within the administration and delivery of health services. The Prime Minister, Tom Adams, described the present health services as "pauper medicine", noting that a strategy was needed to reach those who might have been by-passed by economic growth. The Development Plan conclusively declared that neglected areas of the health care system could only be addressed by a change in policy direction towards the provision of Primary Health Care. It is obvious that such an approach would also cost less since it is much more expensive to treat illness after it occurs than if it is prevented in the first place. The government declared that the Plan strongly supported the view that health is a fundamental human right and that the attainment of the highest level of health is an important social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. Further, the Government viewed health services as an essential component of the socio-economic system and considered that services should be targeted to protect and improve health at both the individual and community level (Gillings 1987).

### *National Health Service (NHS): The BLP's Proposal*

A National Health Service (NHS) system was proposed in the BLP's Manifesto. According to the Barbadian government, the decision to implement the NHS system and establish the polyclinics was in keeping with its goal of decentralization and integration of services at the community level, to ensure "that every person has access to all facets of the country's health services and that the ability to pay for services at the time of delivery will not be a determining factor" (Graham, H. 1984). NHS had several operational guidelines (Graham, N. 1984).

- to operate within the framework of the present National Insurance Scheme
- to assign each citizen to a doctor of choice
- to ensure that each National Health Service medical practitioner would maintain a register or panel of patients
- to ensure that patients would not pay fees directly to the doctor
- to remunerate doctors on a "capitation basis" (a fixed sum per year for each registered patient)
- to reduce and standardize the price of drugs prescribed by doctors

Established in 1980, the Barbados Drug Service was the first aspect of the NHS program to be implemented. Its mandate was to develop mechanisms for the containment and reduction of drug costs. The next phase should have been the implementation of the General Practitioner Service within the polyclinic framework to encourage the rationalization of health care delivery at the primary, secondary, and tertiary levels and to promote a needs-based system (Harley 1987). Polyclinics were expected to function as an integral component of the NHS.

> [The] plan was to have doctors working in the polyclinics in order to provide care to people who could not afford to go to a private doctor. Prior to the development of the polyclinics concept, the health centres mainly provided Maternal and Child Health Services and we had hoped to expand that service to include a walk-in clinic with services for senior citizens and other special clinics...(Harley 1987).

In addition, the government wanted to discontinue doctors' role of being both GPs and specialists. The Minister of Health stated that the proposed NHS would be more cost-effective by integrating the finances of the fragmented district out-patient clinics (which would be abolished), the walk-in clinics of the Queen Elizabeth Hospital, and the polyclinics. The District Medical Officer positions would also be abolished when the National Health Service Board's services were fully established (Harley 1987).

*NHS: Implementation Problems*

The NHS plan was, however, strongly opposed by the Barbados Association of Medical Practitioners (BAMP) from the outset. Efforts to make the polyclinics more functional and to get general practitioners into the communities fell short. In fact, the NHS was never fully implemented and was abandoned by 1986.

Two BAMP officials involved in different aspects of the NHS negotiations stated that "there were several reasons why the doctors were unhappy with the BLP administration."

- A similar NHS in Britain was inefficient. Although services were initially free, people were gradually paying more for care.
- The lower pay would have demotivated general practitioners to the point where their performance would be mechanical.
- The government was trying to exert too much control. For example, private practitioners would be accountable to the government, and their hours would be dictated.
- The proposed plans for the introduction of the NHS were made without prior consultation with the Association (Harney 1985). Although the BLP had commissioned the Kaiser Foundation International to study the feasibility of NHS, the Foundation failed to consult with BAMP.
- The government had not addressed several important issues of importance to the Association, including remuneration and terms of service.

## *Grenada Health Care System*

Prior to the revolution in 1979, Grenada's health care system was structurally similar to that of Barbados and most other colonial models, with both the private and public sectors providing primary, secondary, and tertiary health care. Similarly, as in Barbados, most doctors and therefore services were located in the capital. There was an emphasis on curative measures, basic medical care was not available to all Grenadians, and the cost of private care was expensive and thus inaccessible to the working poor, the majority of whom were of African descent.

In November 1981, the Ministry of Health reported that it had inherited a poorly managed and maintained health system. Several specific problems were noted:

- poor medical coverage of health care services, particularly a critical shortage of doctors and other trained health workers;
- an acute shortage of existing services, supplies and equipment;
- low quality public health services as compared to the private sector;
- very little preventive medicine or strictly remedial type services;
- problems in environmental health, shortage of trained public health inspectors, junior inspectors, and equipment; and
- dilapidated and inadequate health care facilities and physical infrastructure in many institutions.

### *Development of Primary Health Care (PHC)*

On the adoption of PHC, the People's Revolutionary Government (PRG) began a process of identifying health needs and gaps in services, as well as investing more in PHC initiatives. De Riggs, a former Deputy Minister of Health, stated that

> The PRG government [sic] had a deeper or more realistic understanding of health in the context of Grenada. We realized that we did not need to do housekeeping but to change and reorganize the system. We saw health not as a tokenism but as an investment in the development of Grenada.

After a thorough assessment of the inadequacies of the inherited system, the PRG engaged in rebuilding the health sector. This included repairs to existing facilities, establishment of more PHC centres, and training of health personnel. In the 1981 New Year Address to the nation, one year after the revolution, Maurice Bishop (then the Minister of Health as well as the Prime Minister) outlined some of the gains achieved in health care.

> The revolution's most impressive advances in 1980 were in the areas of public health and popular education. Thousands of poor and working people benefited directly from these gains. For the first time in our history, the masses can now enjoy free basic medical care at governmental hospitals, clinics and health stations around the country. Instead of one clinic as before the revolution, our people now have the services of seven dental clinics, one for each

> parish. Over forty persons are now being treated daily by eye specialists at the Eye Clinic, and for the people of Petit Martinique, 1980 produced regular and very often weekly visits of doctors and dentists.

A decentralized, well integrated system developed under the PRG. Primary health care centres were enhanced to provide new and better services in the capital as well as in rural areas, and all PHC services were coordinated in some way to SHC and THC services. The PHC services were provided by general practitioners through five health centres, 23 health stations and out-patient departments in the three general hospitals. The health centres, equivalent to the Barbadian polyclinics, are normally run by trained nurse/midwives and provide a range of services. The health stations, also staffed by trained nurses, offer only basic services and are located in rural areas within a three mile radius of a village. The services offered at the health centres and health stations include daily dressings, ante-natal clinic, child welfare clinic, District Medical Officer's clinic, immunization, domiciliary midwifery, and home visiting. Those offered only at health centres are the post-natal clinic, clinic for sexually transmitted diseases, psychiatric clinic, dental clinic, diabetes clinic, and hypertension clinic (Joseph 1981).

### *Health Care Financing*

Under the Gairy administration, about 70-75 percent of the 1978 health budget was invested in the three hospitals, while the remaining 25-30 percent of the budget was spent to service the 35 health centres and medical clinics around the country. Reports claimed that in order to correct this situation, the PRG began to invest more of the health budget to PHC, specifically in health education and promotion, rebuilding, and personnel retraining.

In 1981 and 1982, the health budget as a percentage of the GDP was 4.9 percent and 5.0 percent respectively; this was equivalent to approximately 14.7 percent of the total government budget. The rejuvenation process in the health care industry was facilitated by consultant expertise, and financial and material assistance obtained from various regional and international sources. The fundamental result of all this development was country-wide free medical coverage for the first time in Grenada. In addition, the quality of health facilities had improved greatly, as had the level of "health-community interdependence and inter-relation" (Jules 1992).

## *Women's Perspective of the Health Care System*

This profile highlights the commonalties and differences in the lives of sixty working-class women. The global picture presented of these women provides a more holistic view of the social, cultural, economic, and political constraints which impact on their daily lives and consequently on their health and well-being. The profiles are also significant in that they allow one to understand why working class women make choices, informed or not, that may be ultimately beneficial or detrimental to their health.

Of the sixty women interviewed, 45% were Barbadian and 55% Grenadian. Several parameters were used to establish the socio-economic status of the women: age, race, family status, family size, support systems/child-care, educational attainment, employment status/job satisfaction, financial situation, housing conditions, transportation, religion, leisure time/relaxation, and organization/group membership. To put the views and opinions of the women in context and to fully appreciate the health care system as a whole, these women's perspectives of the use of both private and public health services are compared. People who chose to pay for private health care often did so as a result of a previous negative experience or because of a particular perception about the state clinics.

Of the sixty women interviewed, forty-two had only used the state health clinics (20 Barbadians, 22 Grenadians); six had previously used the state services but now only utilized private services (3 Barbadians, 3 Grenadian); eleven had always used private services (5 Barbadians, 6 Grenadian); one Barbadian woman had previously used private services but now utilized public services; and two women exhibited no loyalty to either and utilized both at various times (1 Barbadian, 1 Grenadian). During the interview process, the women who utilized the government clinics were asked to critique the state health care system. This included commentary on the overall quality of the system during the 1979-83 period, and comparison of services delivered in that period with those they were presently receiving. The women who used the services of private doctors were asked to justify their choice.

## *Public Health Service Users*

### *Service Availability*

### *Human Resources*

Both Barbadian and Grenadian women complained about the lack of health care personnel in the state clinics. The shortage in Grenada, however, seemed to be more acute and could be explained by the return/deportation of the Cuban doctors and other foreign health care personnel after the US invasion in 1983.

### *Doctors*

From observation, there seemed to be a shortage of doctors in the Barbadian polyclinics in relation to the number of patients seeking attention. This could be attributed to the low status and lack of incentive given to doctors working in PHC. The polyclinics were mainly staffed by junior doctors and non-Barbadian doctors. Sixteen (63.6%) of the Grenadian women complained of similar shortages, which did not exist during the PRG.

### *Drug Services*

During the PRG period drugs were available and free in Grenada. Several of the Grenadian women claimed that the drug supply had since become limited.

### *Service Satisfaction*

#### *Waiting Time*

Most of the women (Barbadian and Grenadian) complained of the long waiting periods endured during visits to the state health clinics. This particular service delivery problem seemed to be a consequence of the personnel shortages, especially at rural clinics. The Grenadian women reflected on this particular problem and generally agreed that the situation had worsened since 1983.

Barbadian women found their situation in 1992 to be quite the opposite, conceding that there was a marked decrease in waiting time. They attributed this to the transfer of PHC services out of the hospital and into the polyclinics, and to the introduction of an appointment system.

#### *Doctors*

During the 1979-83 period and until 1992, Barbadian women who used the state health services seemed satisfied with the polyclinic doctors. The Grenadian women, however, expressed some dissatisfaction with the current (1992) personnel, claiming that under the PRG (1979-83) doctors were far more accessible and had a more caring attitude. The Cuban doctors, in particular, were singled out for praise by all of the Grenadian women who had used the health centres/stations at one time or another.

#### *Nurses*

During both the period under review and in 1992, nurses were viewed positively by all the women who used the state health clinics. Nurses were generally seen as "caring" and capable of providing reasonable service, despite the personnel shortages experienced at the clinics.

#### *Sensitivity to Women's Health Issues*

In 1992, the majority of women stated that they were either given inadequate information or no information at all with respect to health issues or concerns they had as women, and that not enough was being done generally in the area of women's health. A number of the responses by the Barbadian women highlighted the need for the development and promotion of "woman-sensitive" health education.

Post 1983, more Grenadian women complained about the lack of gender sensitive information and felt ignored/neglected. Several programs previously introduced by the PRG had been abandoned, including health education classes, preventative services, community meetings, and the milk program.

*Quality of Care/Service*

The women expressed mixed sentiments about the quality of services offered by state health clinics. In 1992, most of the Barbadian women were satisfied and had noticed incremental improvements in the system. However, some Barbadian women felt that both doctors and nurses focused on presenting problems without seeking the underlying causes. Some women expressed a need for a more personalized touch, complaining that the nurses were too busy to talk with them. However, most of the criticism was levelled at the doctors.

Twenty of the Grenadian women complained about the quality of care provided by the present state health centres (1992), noting there had been significant deterioration since the 1983 period. Although they attributed this to a number of other factors, most mentioned the "lack of interest" shown by doctors as they carried out an examination and/or medical procedure.

*Information Sharing/Communication*

In 1992, all the women interviewed complained that little information was made available to them by the clinic personnel, a criticism that is consistent with their comments regarding the lack of health education on key issues affecting their health.

*Infrastructure/Facilities*

In 1992, Barbadian women were generally satisfied with the state facilities. Their satisfaction stems from the fact that all the clinics in Barbados were either refurbished during the study period or plans were set in place to build new ones. Grenadian women on the other hand complained about the poor physical conditions of the buildings in which the clinics were housed, adding that there had been no attempt to carry out repairs. High noise and fume levels were a source of annoyance for women who used the major urban health clinic.

***Service Accessibility***

*Transportation*

Few Barbadian women identified transportation as a barrier to accessing health care services. This could be attributed to two factors: women generally attended the polyclinics located in their local parish, and Barbados has a good public transportation system. The availability and accessibility of public transport also allowed the women who used private health care services (usually located outside their areas of residence) to travel to the outskirts of Bridgetown, where a large percentage of private doctors are located.

In contrast, Grenadian women identified the lack of transportation as one of the primary barriers to accessing services. They claimed there was a shortage of state-owned transportation in certain areas, and that the privately owned "mini-buses" targeted the high density urban areas. Women who lived in rural areas experienced transportation difficulties to a greater degree.

*Finances*

One of the advantages of the state health care system in Barbados is that basic services have always been free, ensuring access to the economically disadvantaged. During the PRG regime, Grenada's payment policy was similar. However, the present government state health care services are provided on a fee-for-service basis. The Grenadian women complained about paying for dental and other medical services which had been provided free of charge by the PRG.

*Service Comparability to Private Health Services*

The seven Barbadian women and eleven Grenadian women who chose to use private health care services over state's services strongly defended their position, identifying several critical reasons. Most of the women raised the issue of the long waiting times in the clinics. The women also raised a number of more specific concerns that question the credibility of state health services. These included problems related to:

- staffing and staff attitude;
- amount of personal attention received;
- level of trust in the staff;
- quality, reliability and continuity of care; and,
- issues of class and religious/political persuasions.

## *Private Service Users*

The comments and opinions of the private clinic users are categorized using the same groupings. The women who used private clinics were highly critical of the state health clinics. In fact, most were so dissatisfied by services provided by these clinics that they went to great lengths to obtain private services. Most of the Barbadian women saved their money to make these visits, although some of them "resorted" to the public clinics when they could not afford to pay. Others who had established a relationship with their doctors made arrangements to pay in instalments, and the few who absolutely refused to use the polyclinics under any circumstances waited until they could "afford" to get a check-up. The women also felt that "payment for service" was synonymous with good care and prompt service. The six women who claimed that they had always only used private doctors did so because they received a "thorough" examination and their overall health and well-being was considered.

## *Summary*

The Grenadian system between 1979-1983 appears to have been more holistic, with a focus on health promotion and education, and an emphasis on system coordination and linkage of the health sector with other social and economic issues (Jules 1992; Ferguson 1990). In order to ensure parity within the health care system, the PRG encouraged active public participation as a way of demystifying and democratizing the system of medicine and health care. However, it may be concluded from the women's responses that health issues have not been approached in a holistic manner in either state. Presenting problems were/are treated without taking into account other health-related problems, gender specific issues facing women, and the socio-economic realities of their lives. Since most professionals viewed health only in the context of the "absence of illness", they neglected to advise ongoing preventative care. This myopic perception of health was reflected in the few health education services available, and the limited information sharing and communication which occurred between provider and client. Professionals felt that women did not need and/or would not understand their conditions and therefore neglected to communicate relevant, user friendly, and sensitive information to them.

During the 1979-83 period, Grenadian women, through community involvement and participation, were more likely to obtain health information and education from a number of other sources. Barbadian women, on the other hand, lacked this empowerment and depended mainly on professionals.

A custom that seemed to be more prevalent among the Barbadian women was the double medical care sought from both private care and state health services. This dual accessing of services not only highlighted the lack of continuity in care, but shows the fragmentation, lack of organization, and poor management of the health care services. This lack of coordination and integration has encouraged poor accountability, information sharing, and lack of professional responsibility by practitioners. Further investigation of women who use private health care services is needed, as there seems to be an over-utilization of these paid services by women who are economically disadvantaged and can least afford it. Those women who "saved" for their visits to private practitioners were, in particular, endangering their health.

The high political stability of Barbados and the ideological similarities of the BLP and DLP meant that the transition between these two government in 1986 was relatively smooth and had little impact on the health care delivery system. As a result, the quality of services in Barbados remained consistent and little differentiation could be made by the women about services offered in the different time periods.

In Grenada, the situation differed drastically. Grenada was governed by parties that differed fundamentally in their ideological and political views. During the pre-study period, Grenada's health care system was largely underdeveloped. However, during the 1979-1983 period, significant progress was made by the PRG. Services were improved to a point were they compared with those delivered in other parts of the region, and, in the cases of health

education and community participation, were more advanced. The gains were, however, reversed and services generally deteriorated after the invasion of 1983 and the return of a more conservative political government.

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# WAND, Promoting Behaviour Change, and Gender

Nan Peacocke[1]

Medical professionals, health practitioners, academics, and researchers are increasingly acknowledging that society is afflicted by a governing ethos based on the inequitable distribution of economic and social production. Some will testify that this must change if this species is to survive. At the same time, some community groups and women's organisations are working from a growing understanding of the interlinkages associated with disempowerment. They too believe that both our thinking and our practices must change.

This paper is based on an earlier workshop discussion concerning the question of how people do or do not accept information, technical inputs, knowledge, and even understanding, to change their behaviour. I want to enter from a women's movement perspective and, drawing on WAND's experience, suggest that another essential ingredient for behaviour change is a sense of entitlement. What makes it possible for individuals to change their behaviour under circumstances, and within a culture, which exert pressure on us to act in an particular way, even when we have the knowledge and even the resources to do otherwise?

WAND's programs can only be as successful as the quality of their relevance to women's lived experience (both of women living in the mainly rural communities with whom WAND works and of WAND staff). The participatory methodologies WAND employs, and the planning of the unit's programs, are designed to enhance a dialectical relationship between program and concept.

For the purposes of this paper, two definitions used in our work are presented. Within WAND, gender is seen *as an analytical tool.*

> Defined as an analytical tool, Gender is: A means of investigating unequal relations in a society which disempowers women's interests by devaluing the work women are socialised to do and by undermining the struggles of women and men who resist this status quo.

This definition has been used in conjunction with a Caribbean team involved in the production of radio and print material for the regional public education campaign leading up to the Beijing 4th World Conference of Women, September 1995.

A second definition used in WAND's work is of health as wellness, as used in *Toward Total Wellness. Women in the Caribbean: A Selected Bibliography of Periodical Articles.*

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> The concept "total wellness" expands on the World Health Organisation's definition by placing gender issues into the more conventional definition. The term was adopted by WAND via the National Black Women's Health Project and the Boston Women's Health Collective, USA, where it originated. The concept is integral to the theme of women's empowerment and methodologies which enhance self esteem in the context of community self reliance. There is a political dimension to the concept, relating as it does most centrally to the notion of women's empowerment through taking charge of their own health, whether it be mental, spiritual, physical or emotional. The concept encompasses a range of issues impinging on overall wellbeing, such as diet, environment, economic security, reproductive health and so on.

WAND's central program, called Communities Organizing for Self Reliance (CORE), uses participatory methodologies in community development (needs assessment, program planning, and decision making). Applying the definition of health as wellness, facilitators provide a space to which women can bring their everyday lived experience and be validated. Each person's life, while unique, has a particular identity in a shared economic, political, and cultural context.

Understanding this context, and learning the skills to enable action for change, is empowering for an individual. When this happens on a community scale, even greater potential for change exists. The problem arises when the individual or community, in possession of a sense of entitlement and motivated to action, comes into conflict with forces attempting to maintain the status quo. In a society where AIDS, unemployment, and the destruction of coral reefs must be acted upon, our lines of habitual/enforced behaviour must be traced to their source: the power dynamics operating in race, class, and gender relations.

I wish to read, by way of illustrating my point, part of an interview I carried out recently with a member of the Red Thread Women's Development Organization in Guyana. Red Thread has successfully invested in programs aimed at both income generation and increased educational levels. Women have gained knowledge about the value of their labour in the household and community, and its contribution to the national economy. This new-found confidence has a ripple effect altering, for example, women's interaction both with men and with other women.

C.J. (a woman whom I interviewed) related to me her participation in a workshop on breastfeeding. She had been asked to attend because of her experience in a feeding program run by Red Thread.

> I went to a workshop on Thursday and Friday. When I get there I said to myself "What! Is what (the team leader) d'send me here for"? It was sheer doctors, sheer 'up there'! When we get into small group discussion I had to tell the doctor who was the facilitator, 'I think we starting wrong.' I said, 'Let us look at the chronic diseases first.' And she ...(C.J. raises her eyebrows indicating the doctor's surprise that C.J. would offer an alternative approach)...and the rest of the nurses that were there...(C.J. flaps her hands mimicking the nurses' shock at C.J.'s contradicting a doctor). I tell you twenty minutes and they can't start yet! Then, you know what the doctor say? 'Ok, let's start how C.J. said we should.' You know, when we started we had a smooth flow of discussion.

> In my evaluation I said, 'You know what? I personally feel this workshop here hasn't achieved its aim. We had needed more grassroots people at this workshop, because the grassroots people could tell you the doctors and nurses about breastfeeding and tell you why they are not breastfeeding babies.' Even though one of the decisions they came up with that they are going to give the mothers four months maternity leave so they could breastfed the babies. I said, 'That four months still can't do anything because the mothers ain't getting proper food to eat.'

C.J.'s understanding of the social determinants of health, and her ability to speak to them in a situation which would have inhibited one with less of a sense of entitlement, point the way forward in terms of the methodologies needed for the expansion of concepts of gender, health, and sustainable development into changes in behaviour.

## Discussion

Following the presentations, a general discussion took place on the topic of Gender Issues in Caribbean Health Systems. The following points were raised.

- The key question related to the issue of how gender issues can be placed on the priority agenda of policy makers at a time when governments, particularly the OECS governments, are grappling with the more immediate issues of health care financing and health care reform. In the face of diminishing donor aid and scarce financial resources, these governments are contemplating choices of privatization of services and increased user fees. The latter was described as having serious implications for universality of access, particularly for women and children who use these services most frequently.

- The point was raised that research methodologies have generally tended to treat specific gender issues as confounding factors. A related issue arose on the question of how ready and willing are we as health professionals, epidemiologists, professors, and so on, to be retrained in our methodologies to better address the importance of gender and health.

- Although it was agreed that Caribbean health care systems must be reoriented to better meet the needs of women, it was also acknowledged that the medical profession would likely not provide support for policy changes, which it would see as the imposition of an external system. It was not believed that the medical profession would be willing to lessen its own power within the community. This in turn results in a lack of power (decision-making and financial) being available to the lower echelons of the health care system.

- The point was raised that women's organizations must be treated as equal partners in any policy development. However, these organizations have not tended to see health as a policy tool. Only now are they realizing that health must be treated as a social dimension, in addition to poverty and violence.

- In addition, and more importantly, women themselves must be involved in and informed of policy changes in order for them to be successful. The group acknowledged that patients and medical staff often view the same problem from different perspectives. For example, an attempt to introduce an appointment system in Barbados failed in part because elderly women who were lonely and saw a chance to socialize in the health clinics resisted the change. They tended to go to health care centres in morning, and often stayed much of the day. From the health care workers' point of view, however, the appointment system was necessary to improve quality of

care. Far too many patients were arriving at the clinics each day for them to receive proper care. If the health care workers could provide holistic care, rather than "assembly line/symptomatic care", then patients would not need to return to the centres so often.

- The process of decentralization of health care services has rendered many Caribbean systems unable to meet the needs of the people. The opinions of general population are not considered to be part of the decision-making process, even though it is these people who will determine whether or not a new system will function. Utilization patterns are based on what existed previously, and many people are resistant to change.

- The question was asked, whether the issues raised in the presentations (such as poor relationships between patients and health care workers) relate only to women's experiences, or whether they are universal quality of care problems which seem to be more pronounced in women. Although men are less likely to go to the health clinics, have studies been carried out to examine the male perspective? What social determinants/issues make these problems gender issues? What makes the issues different for women? Given that many women deal with female health care workers, why are their relationships unsatisfactory?

# Impact of Gender Factors on Nutrition

# Gender and Nutrition

**A.W. Patterson**[1]

## *Introduction*

Biologically, the human race is divided into two sexes, mainly for purposes of reproduction. The capacity to reproduce is essential for sustainability, but is not sufficient. In instances of uncontrolled growth, it may actually be inimical. The non-reproductive roles of the biological sexes have given rise to discussion concerning the division of non-reproductive roles, the reward for labour, and the recognition of the value of these roles. Because women have seen themselves as the disadvantaged sex, they have forced the discussion of gender issues onto the political agenda in a pursuit of justice and equity.

Health may be seen as one link between gender and sustainable development. Health is promoted as an instrument of peaceful development, of cooperation, and as a champion of equity. The Caribbean Cooperation in Health has selected seven priority areas for special attention, one of which is food and nutrition. What has food and nutrition to offer to the issues surrounding gender, health, and sustainable development?

Balanced and adequate nutrition is an important building block in sustainable development. It is essential for the continuous renewal of physical and intellectual competence of the human resources which are responsible for maintaining the environment, social order, and the accumulation of wealth. Together with education and the organization of science and technology, nutrition forms an important basis of the productive structure. In modern societies, this structure is strongly influenced by political power, ideology, values, and customs, and is controlled by the legal institutional framework. This matrix is extraordinarily complex and can only be sustained by constructive thought and goodwill on the part of humanity.

## *Issues in Human Nutrition*

The International Conference on Nutrition identified eight major issues in need of further study and action.

- improving household food security
- preventing and managing infectious diseases
- caring for the socio-economically deprived and nutritionally vulnerable

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[1] Caribbean Food and Nutrition Institute, PAHO, Kingston, Jamaica.

- promoting healthy diets and lifestyles
- protecting consumers through improved food quality and safety
- preventing micro-nutrient deficiencies
- assessing, analyzing, and monitoring nutrition situations
- incorporating nutrition objectives into development plans and programmes

The role of human nutrition is to ensure the continuous renewal of the physical and intellectual competence of humans. Food is the vehicle for the performance of this function. To ensure sustainability, food must be produced, consumed, and biologically utilized. Household food security, or the ability of households to provide enough safe and nutritious foods to meet the needs of individual household members, is a goal of health and sustainable development.

## *Food Production*

The production of food is the main business of farming communities. A sizeable body of literature exists concerning the contribution of women farmers to the world food supply. Research has documented that small farmers play a crucial role in global food production, particularly in less-developed countries and in the production of food for the poor. Within the small farmer group, women's participation is central. Overlooking it can distort development efforts to strengthen sources of food and social stability. The picture which emerges from the developmental literature is that women predominate in food cropping, in subsistence agriculture, and in hoe cultivation. Recognition of the role women play as food producers, however, remains inadequate for sustainable development planning. Problems of land tenure, credit, and labour prevail. The patterns of migration in the Caribbean have a further detrimental effect on Caribbean small farm holdings, regardless who migrates. Foreign exchange earned through agricultural production for export often go to luxury goods and imported food, which is more expensive and of lower nutritional value than domestically produced food.

The catastrophic effects of hurricanes on the Caribbean economy, based on a monoculture, are also well known. Food production is not normally perceived within the health sector portfolio, but is nevertheless of fundamental importance to nutrition. If nutrition is of concern to health, then health must take a serious interest in food production. As with many developmental issues, the concerns and solutions of food production are multisectoral. Caribbean political structures, however, do not encourage such activity. There is a dearth of research into, and policy initiatives for, the development of multisectoral models. A need exists to incorporate nutritional objectives more comprehensively into development plans and programmes.

Despite the importance of women in the agricultural sector, little information has been gathered concerning women's health status in CARICOM countries. Data derived from a small study carried out in Jamaica did not reveal any specific health problems in this occupational group. Women farmers appear to be subject to the same illnesses common to

all women of the same age in the same society. In the English-speaking Caribbean, the bibliography reviewed does not contain any investigation of the effects of pesticide/agricultural chemical use. Research in other countries, however, contradicts these results, demonstrating instead an increased prevalence of respiratory and skin disorders. This points to the need to include health education and information on illness preventing skills in agricultural training packages.

### *Food Availability*

Data available from food balance sheets suggest that there is an adequacy of food at the national level. Historically, however, Caribbean countries have depended heavily on food imports to meet basic food needs. The major food commodities imported are wheat and rice, meat and meat products, dairy products and eggs, fruits, vegetables and legumes. Domestic food production consists primarily of vegetables, rice and corn, legumes and root and tuber crops. Livestock production is limited, and while poultry and swine industries have increased in importance over the past two decades, these industries are heavily dependent on imported feeds and other inputs for survival. The fishing industry also remains largely underdeveloped, although in recent years interest has increased in aquaculture. The 200 mile exclusive economic zone mandated by the Law of the Sea should add much to the availability of natural marine resources as a source of food. Researchers need to promote the development of a food and nutrition surveillance system which can provide timely data for decision-making. Systems which concentrate only on nutrition or only on food do not make the necessary linkages between the results of poor nutrition and their causation due to certain nutrient deficiencies and/or excess in the food available for household consumption. The epidemiological pattern of disease which results is particularly detrimental to the health of women.

Much of the research on nutrition has concentrated on food availability at the national level. Information concerning food availability at both the household and individual levels is lacking, as is anthropological data documenting the centrality of women in food marketing, preparation, and distribution within the household. Data from household expenditure surveys taken periodically by the countries, and from the food component of the annual Survey of Living Conditions, assist in filling the gap concerning what households are eating, although they are unable to define individual consumption. Expenditure data, moreover, are only a proxy for consumption. In spite of this limitation, data analyses suggest that lower income households have an almost impossible task of obtaining the required dietary allowance of calories and proteins. This information, together with a continuous monitoring of basic food basket costs, has influenced both the level of minimum wages in Jamaica and client criteria for the food stamp program.

## *Poverty*

The issue of food availability brings issues of poverty, hunger, and health sharply into focus. The literature highlights the relationship between gender and poverty in the Caribbean. Women-headed households have been an ongoing feature of West Indian family life from the earliest days of its history. It has been argued that this group of women constitutes a special subgroup among the poor which is worthy of the full attention of policy-makers. Researchers commend the Caribbean Census because as it provides a model for the kind of data which can be generated by national censuses, it also offers compelling evidence of the disadvantaged position of women who head households, particularly in the latter part of their life-cycles due to the migration of daughters. This subgroup is distinct from the entire female population, as well as from males who are household heads. There are also some descriptions for the coping mechanisms employed by poor women to enable them to feed their families, and of the extraordinary degree of flexibility in organizational strategies which allows them to adapt to the economic environment. Poverty is a major cause of undernutrition, which remains of public health concern in some parts of the Caribbean. Poverty is also a major cause of environmental degradation, particularly with reference to sanitation. Such situations increase the health problems of the poor. The synergism between infection and malnutrition often results in death. Though infant dealt from gastroenteritis may be thwarted by the use of oral rehydration fluids, there is no report of a reduction in the incidence of the disease. Use of oral rehydration fluids, however, is useful in that it reduces the number of children having to be admitted to hospital, which in turn reduces health care costs. The aim of the health sector, though, is a state of health for all and not simply the reduction of health care costs. Adjustment policies have now become sensitive to the need to retain expenditures on vital social sectors such as health and education. It is important to ensure continuing improvements of the social indicators - life expectancy, infant mortality, nutrition, and education.

## *Individual Food Consumption*

There is a paucity of individual food consumption data in the Caribbean, due mainly to the expense of food consumption surveys. As an alternative, many countries in the region are considering as an initial step, the determination of food consumption patterns through food frequency surveys such as the one being undertaken in Dominica. Food frequency questionnaires for different age ranges are being developed, piloted, and validated. The Caribbean Food and Nutrition Institute (CFNI) has recently undertaken a revision of the Food Consumption Tables so as to include some indigenous foods not previously included. The data is secondary, having been derived from Food Consumption Tables in the U.K. and U.S.A. from sections entitled "exotic" or "ethnic" foods. The new compilations are scheduled for printing next year. The newly incorporated foods are planned to be included in a software package, probably using the newest version of the package called "Nutritionist IV." Training in the computer technology will be necessary. It is hoped that in the future prepared foods in portions served will also be analyzed.

Caribbean women have adopted the recommended multi-mix principle and frequently prepare one-pot meals which have the advantage of saving on fuel and reducing household chores. An analysis of the composition of foods as served rather than as purchased will be a practical way of assisting researchers who are investigating food consumption practices in the Caribbean. Shortage of financing has caused delays in the implementation of these useful advances. The examination of food consumption practices and their biological consequences have become urgent, given the current epidemiology of nutrition-related health problems.

## *Culture and Tradition*

Although considerable knowledge concerning nutrition-related disorders has been widely disseminated by the CFNI in the Commonwealth Caribbean, required behaviour change has lagged behind the acquisition of knowledge. The occurrence of undernutrition simultaneously with obesity and chronic diseases within households points to a maldistribution of food, or to a deficiency in the safety or an imbalance in the nutrient content of the food consumed within such households. Targeted social communication to specific audiences holds promise of facilitating the internalization of knowledge and making the giant step between knowing and doing. Cultural practices emphasize the use of salt, of simple sugars, and of fats in the diet. The preservation qualities and caloric enrichment of these practices, which may historically have been a necessity, are no longer relevant in modern societies and have become deleterious. Indigenous foods rich in complex carbohydrates, fibre, beta carotenes, and other vitamins, and which are also low in cholesterol, are rejected by the population as "poor people's food". Yet it is precisely these foods which are needed. Research into how to overcome these traditional and cultural perceptions is of paramount importance to the management of non-communicable diseases. The challenge is made greater by the pervasive presence of foreign television promoting less nutritionally appropriate alternatives. Women and youth are particularly exposed to these advertisements. Health research in nutrition communication presenting credible, tasty, healthy, affordable, and convenient snacks and meals would greatly facilitate a needed behaviour change.

## *Nutrition-Related Health Problems*

The most prevalent nutrition-related health problems among adults are iron deficiency anemia, obesity, hypertension, cardio-vascular disease, cerebrovascular disease, cancers, and diabetes. In each of the Caribbean countries, these are among the leading causes of death. Prevalence is several times higher in women than in men. A substantial body of research exists showing a causal relationship between nutrition and these diseases. An excessive caloric intake from animal fats, and a low consumption of complex carbohydrates, fruits, vegetables and legumes, appear to be the major imbalances. The burden of disease from the so-called chronic non-communicable diseases is several times greater than that due to childhood communicable diseases. A recent Jamaican health sector assessment completed by the Centre for International Health, Boston University, states that overall socio-economic development and effective maternal and child health strategies have shifted the pattern of

illness from acute to chronic. Demand and need for chronic health care is outpacing the ability of society to pay. Limited resources, particularly public resources, mean the poor face the greatest risk of receiving inadequate care.

There is an urgent need to research and develop systematic programmes for the management and control of obesity and chronic diseases. Delaying the onset of chronic diseases requires the adoption of positive, healthy lifestyles and life skills in all population groups irrespective of age, sex, or social status. Such a lifestyle change will be most effective if it is internalized from childhood. To inculcate such skills in schoolchildren requires the collaboration of school teachers at all levels of the educational system, supported by operational research to develop a methodology for an application of relevant experiences drawn from different countries.

Policy directions and the national allocation of resources are critical components in developing and implementing such programs. Intersectoral action is a prerequisite. The participation of school teachers in monitoring the nutritional status of schoolchildren, and of physical education teachers specifically in developing physical exercise skills for students, is recommended. The inputs of health professionals, particularly nutritionists and social communicators, are required. Intersectoral training and team building is necessary for such collaborative work. Changes in nutritional status in the Caribbean require that increasingly more information be provided to consumers using social communication techniques to aid in conscious decision-making for their nutritional health. Obesity in adults cannot be controlled without adequate knowledge, a conscious decision, and voluntary behaviour modification. Women may need to revisit their traditional roles in the homes, schools, public health clinics, and in the community generally in the face of this new challenge which threatens them primarily.

## *Conclusion*

The concept of sustainable development has been brought into focus by a realization that the excessive consumption patterns of some segments of humanity cannot be tolerated by a finite earth, and that conservation and development must go hand in hand. The poor and disadvantaged are losing hope. Aided by a drug culture, violence and destruction are the order of the day. While we work towards the new ethic of sustainable development, we need to ensure that there will be generations to inherit the earth, generations endowed with the physical and intellectual competence which are the hallmarks of health and balanced nutrition.

# The Elderly in Jamaica: A Gender and Development Perspective

Denise Eldemire[1]

## *Introduction*

What is development? Human development is broader than simple economic development, which is defined by the 1990 World Bank Report as a sustainable increase in living standards encompassing material consumption, education, health, and environmental protection.

In a broader sense, development is understood to include equality of opportunity, political freedom, and civil liberties. The overall goal of economic development is therefore to improve living standards as measured by an increase in per capita income, whereas the overall goal of human development is to increase the economic, political, and civil rights of all people. The main challenge of development is to improve the quality of life. Development means more than higher incomes; it encompasses better education, higher standards of health and nutrition, less poverty, a cleaner environment, more equality of opportunity, greater individual freedom, and a richer cultural life.

Education, technology, and openness all have complex relations to development. Human development and poverty alleviation on one hand and economic growth on the other hand seem to reinforce each other.

## *The Elderly*

The population aged 60 and over, often referred to as "the elderly", are an important sector of society to be considered in any discussion of development. Unfortunately, until recently they have been either ignored or forgotten. In many instances, discussion of this age group has been negative, focusing on them as a burden to social security systems through their perceived need of long term care and health care. Rarely are the elderly seen as a resource. This assessment needs to change, given that statistics do not support the dependency argument. For example, in Jamaica alone 88% of the over 60s are physically functional and 92%, are mentally competent (Eldemire 1993).

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Growth of the elderly population is a new experience for Caribbean policy and program managers, as it is only in the past thirty years that many Caribbean countries have begun experiencing the declining fertility and mortality rates that contribute to an ageing population. Population ageing began in the Caribbean in the 1960s. Today, seven Caribbean territories, including Jamaica, exceed the world's average.

It is important that the value of cohort analysis in investigating social change be recognized, so as to inform planners with relevant information. The demographic variables mentioned, including fertility, migration, and infant mortality, affect the base of the population pyramid. Predictions can therefore be made to permit planning fifty years in advance.

A key question is, what is the economic effect of the ageing of the population; that is, what is the relative cost of maintaining younger versus older dependents. Before the question can be answered, the term dependency as applied to older people needs definition. Presently, economic considerations are the main consideration while the social aspect has been ignored. Furthermore, the way the dependency rate is calculated conveys a negative impression of older persons, as it assumes all old people contribute to aged dependency. This is significant, as the dependency ratio provides useful information for economic and social planners. Many interpret the ageing of the population in terms of the "burden of dependency." Kinsella (1993) has suggested using the Parent Support Ratio (PSR), which calculates the burden of the very old as a true indicator of dependency. This methodology may be useful for developing countries.

The challenge to policy makers is to find ways to measure true dependency in situations where a person is dependent in one way (financial) while contributing in another (social). The reverse is also possible, as elderly people with money may require support services but according to traditional measurement may not be classified as dependent.

Another issue concerns calculating the economic effect of dependency. Is the relative cost of maintaining young persons the same as older dependents? Ratios are a useful starting point, and could be refined to take into consideration the elderly as playing a role in the economy through their expenditure and consumption patterns, and through their productive work whether paid or voluntary.

Development is a very broad concept and women play an important role in both home-level and macro production. The changing role of women and their contribution to development, especially in the informal agriculture and garment sectors, suggest also that the presentation of labour force statistics will need to change to reflect such contribution. The United Nations report on the world's women 1970-1990 notes that if women's unpaid work in household and family care was included in labour force statistics, their share of the labour force would be at least equal to that of men. It further states that if the same were included as productive outputs, global output would increase 25-30% (UN 1991). Mainstream developmental policies also do not target these sectors, and so often deny women an increase in opportunity.

It is important to note that changes in the presentation of census and statistical information can be made, as the data is routinely collected and therefore available. It is the way it is presented that needs to change.

### *General Characteristics*

Another important reason for addressing the elderly is that their numbers will continue to increase, particularly the "old elderly" (those over the age of 75). This group represents the fastest growing segment of the elderly population (UN 1991).

Change needs to be informed by facts, and the age/sex distribution of the elderly population is important. In many populations, the female population increases substantially in the "old" old age group, versus those under 75.

To date, when presenting household information, the emphasis has been on the number of adults and children per household. The family unit is not described according to the number of elderly per unit or by the role and function of such persons. This will need to change, given the ageing of the population and the changing role of elderly women.

The way the elderly are perceived will also need to change. They contribute to development in two other significant ways. First, they are consumers, and as such contribute to economic development. Second, they are voters and could contribute to political development, such as with the American Association of Retired Persons (AARP) in the United States.

Furthermore, the persistently negative image of old persons as being sick and dependent leads younger generations to fear ageing, despite the facts of physical and mental competence, and therefore not even address the issue much less prepare for retirement.

### *Specific Gender Implications*

Having stated that the majority of the elderly are in fact mentally and physically functioning, there are some male-female differences to be considered, particularly with regard to social development policy.

The shift to a gender approach in the study of the elderly is welcomed, as the previous approach of "Women and Development" focused mainly on reproductive and child care matters and by extension, on women in the reproductive age group. The older woman has been essentially ignored, menopausal issues not addressed, and the contribution of older women as grandmothers, child carers and rearers, and housekeepers, not given adequate recognition. Such activities are a resource and a contribution to development, as they allow other family members to be productive. They also serve to raise the next generation of workers.

It is important to recognize that the contribution of women shifts with increasing age. The productive responsibilities of younger women diminish with age, while older women have more time to participate in productive management and community activities, while at the same time assuming leadership and training roles in families.

United Nations (UN) meetings in 1991 looked at the question of the integration of women into the process of development, reinforcing the importance of women's activities. These activities are twofold, including both reproduction and family care, and those of a demographic, economic, and socio-cultural nature that are essential to the survival and development of society. The meeting stressed that ageing, and particularly elderly womens' contributions, have been overlooked, even though they make significant contributions both visible and invisible.

Among the old elderly, females greatly outnumber males; in fact, the ratio of widows to widowers is 3:1. In addition, since females have a longer life expectancy, most women need to anticipate and plan for a period of life alone.

Females traditionally are the caregivers. As the population ages, the carers will eventually need care themselves: so the question is, who will care for the carers?

Women in developing countries are generally less educated and are paid less than their male counterparts. Therefore, the female, even when head of household, may contribute less economically than would a male. As such, female-headed households are generally poorer. There is also evidence from the survey of living conditions (SLC) that the female-headed household is larger (1992).

Yet there is a positive side, and one must guard against assuming that the female is automatically more in "need" than her male counterpart. Survey data for Jamaica indicates differently. The survey found that although 68.4% of females compared to 29.6% male did not have a spouse, they were much less likely to live alone (13% compared to 20.9%) (Eldemire 1993). This suggest that the household role of the grandmother is recognized at least by her own family, which is prepared to keep her within the unit, extending the family to as many as four generations. The findings also emphasize the importance of family as a source of support.

This would suggest that the needs of older people differ by gender. The females may have economic needs, while the men have social and emotional needs. Policy needs to be aware of these important gender differences. The findings raise questions about the role of the male in the family, and provides suggestions for family life programs aimed at strengthening the family, particularly the role played by the male in his earlier years. While another paper addressed this in detail, a few points need to be made.

There are gender differences in health status in the Jamaican population. Females were more likely than males to have at least one chronic disease, particularly hypertension (55.4% females and 30.3% males). In addition, females were more likely to be overweight (40%: 30%), (Eldemire 1993). The finding suggest that a gender approach is needed for the adequate provision of health care and for healthy lifestyle campaigns. In addition, the importance of healthy people for production, which has been stressed by the World Bank Report on Health (WBR 1992), means that adult health must be targeted. The disease found in the older population began in middle age, and therefore, would have affected "development."

No discussion of the impact of ageing on development would be complete without some discussion of the need for research. The paper has already identified the need for a cohort approach and a gender approach.

In addition, little is known about pensions and pension coverage in developing countries, including Jamaica. The World Bank in a 1994 report on averting the old age crisis has identified a number of questions which need to be answered.

Each country will need to determine its own research agenda. Other areas identified for research in Jamaica include the informal contribution of older women and the issue of caregiving.

Research also needs to begin by identifying what has already been done. Recommendations must be followed-up. There are many UN and WHO documents with papers prepared by experts and with recommendations - 1992 was a particularly active year.

In conclusion, therefore, it is important for countries to be aware of their elderly population, to be sensitive to the gender issues and to convert concern and awareness into a policy and program which recognizes the value of the elderly as resources rather than burdens.

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## Discussion

Following the presentations, a general discussion took place on the topics of Gender and Nutrition and the Elderly. The following points were raised.

- Lower income groups face an almost impossible task of acquiring sufficient (and appropriate) daily food and nutrition, even though "native" foods are readily available in many instances. Unfortunately, native foods are associated with poverty, and people are therefore reluctant to rely on them.

- Poor nutrition is particularly detrimental to women's health. Policy makers must be made aware of the need to incorporate nutrition objectives into development plans.

- The use of oral rehydration is popular in the Caribbean for gastroenteritis treatment. It must be recognized, however, that while this process may reduce health care costs (and deaths from dehydration), it does not reduce disease incidence. Even though marketing of oral rehydration for the management of children with gastroenteritis remains strong, the real cause of the problem, inadequate sanitation, remains unresolved.

- Research on women's health has tended to focus on their reproductive years. Health conditions of the elderly therefore remain understudied and misunderstood.

- While most elderly people no longer take part in the formal work sector, they continue to play an important role in the economy as consumers. Some continue to work in their own businesses. Yet policies have been set which refuse loans or mortgages to people after they reach the age of 60. Given the productive role of the elderly, policy changes are urgently needed.

- Society needs to change its view of the elderly as a burden. Eighty percent of the elderly are in a good state of health, and continue to maintain a massive set of skills and resources. We should see the elderly as a resource. The question was raised, whether any organizations in the Caribbean have looked at the issue of utilizing the resources of the elderly. Within universities, retired physicians are often coopted for teaching and tutoring. There are a number of clubs through which the elderly can offer their services as teachers. It has been suggested that a skills databank be created to match needs and services.

# Gender, Environmental and Occupational Health

# Gender Perceptions of Stress: A Comparative Study of Male and Female Physicians[1]

E.M. Davis[2]

## *Introduction*

Although definitions vary by discipline, stress is universally viewed as a condition that imposes strain on an organism. According to Hans Selye, "stress is a state manifested by a specific syndrome which consists of all non-specifically induced changes within a biologic system" (in Davis 1993). To the physicist, stress was initially thought of as a stimulus, strain being the response. In physical terms, stress is proportional to strain only to a certain limit, beyond which the yield point (upper tolerance limit) is reached. Whether the explanation of the physicist or physiologist is used, it is evident that stress beyond a certain level leads to potentially deleterious changes in the body. It can be said that stress is the common stimulus underpinning all adaptive responses in the body. When stress results in positive adaptation, it is termed eustress. Negative stress is described as distress.

Psychologists and sociologists have categorized stress into physical, psychosocial, and psychological classes; examples of each are ordinary stress, developmental stress, and unique life stress, respectively. Such classification has permitted the measurement of otherwise subjective and perceptive indices, in addition to measurable biological parameters.

Stressors are classified generically by two types (Everly 1986). Psycho-social stress can be described as situational. One example is waiting in a supermarket line. Biogenic stress, on the other hand, is capable of initiating a response through some electrical or biogenic process, and has no relation to higher interpretive areas of the brain.

Stressors exert their response on the body through the mechanism of mediation: stressor (stimulus) → stress response (physiologic mechanism of mediation) → target organ signs/symptoms (pathologic effect). As perceptions of stress may be gender specific, this study looked at a number of subjective stressors which affect both male and female physicians, such as job, finance, relationships, children, and health, and compared the responses between them.

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[1] This paper was originally presented at the Caribbean Academy of Sciences Meeting, Georgetown, Guyana, May 1994.

[2] Faculty of Medical Sciences, The University of West Indies, St. Augustine, Trinidad.

## *Materials and Methods*

Twenty-five male physicians in Trinidad and Tobago were selected on the basis of two qualifiers, namely urban locality of practice, and a minimum five hour workday. Areas of specialization were not identified prior to selection. The physicians filled out a preliminary survey to determine their socio-behavioural status. Four major sections were included in the questionnaire.

- general biodata, including anthropometric data
- social activities, including such items as hobbies and major life events over the previous year
- lifestyle, incorporating the subject's own perception of his health, participation in exercise, and affliction with any acute or chronic ailment (including substance use and abuse)
- work attitudes, dealing with areas of specialization and expertise, length of working day, projected worklife, sick leave, holidays, and five areas perceived to cause both minor and major stress

A similar questionnaire had previously been administered to female physicians (Davis 1993).

## *Results*

In this study, most of the male physicians were married and within the 41-50 year old age group. Most of the female physicians were also married, although they were younger, within the 31-40 year old age group. There were twice as many fathers among the male physicians than mothers among the female physicians.

Eighty eight percent of the male physicians stated that they had at least one hobby; all of the female physicians indicated that they had hobbies. The use of sick leave was minimal in both groups over the past year, and a smaller percentage of male physicians had taken a holiday. Sixty percent of this group of male doctors planned to continue working in medicine for at least 20 years, with only one respondent having plans to retire within the next five years. Similar indications were made by the female doctors.

This survey represented a wide range of areas of expertise, ranging from general practice, to the traditional fields of internal medicine, surgery, obstetrics and gynaecology and pathology, through epidemiology, industrial and emergency medicine, and other areas. Eighteen percent of the sample had two areas of special interest, and all but three of the respondents worked between 5 and 12 hours per day. These three persons worked in excess of 12 hours daily.

Two thirds of the men polled claimed that they had suffered symptoms of professional burnout at some stage of their careers, compared to 50% of the female sample. All but one of the respondents enjoyed their jobs. Two of the three physicians who practised 12 or more hours daily suffered burnout.

At the time of polling, one third of the participants had already implemented plans for stress relief, while the remainder had plans to do so. Approximately 20% more females had implemented stress relief plans than males.

The results indicated that the greatest areas of minor stress in male doctors were job-related. Finance was the next highest ranked area, although it was ranked almost three times lower than job-related stress. In terms of major stress, job stress again polled highest, but was followed more closely by finance.

There was a 12-fold difference in child-related minor stress perception between males and females, and a two-fold difference in major stress. Health was a minimal, minor stressor in both groups, and was not perceived as a major stressor in either (Table 1).

**Table 1. Comparison of Minor versus Major Stressors in Male and Female Physicians.**

| *Minor* | | | *Major* | |
|---|---|---|---|---|
| Male % | Female % | *Stressor* | Male % | Female % |
| 21.7 | 32.0 | Job | 31.6 | 36.0 |
| 8.7 | 36.0 | Finance | 26.3 | 32.0 |
| 4.3 | 36.0 | Relationships | 5.3 | 20.0 |
| 4.3 | 48.0 | Children | 10.5 | 20.1 |
| 4.3 | 20.0 | Health | 0.0 | 0.0 |

## *Discussion*

Several similarities were found between the male and female physician samples, such as urban practices, solo practices, prime decision-making in the work environment, and a minimum five hour work day. In both samples, the term "relationships" was interpreted to include spouses and significant others. No attempt was made to further disaggregate. The male survey found that relationships were seen to be an insignificant minor or major stressor. In contrast, however, the female physicians perceived relationships to be an approximately nine times greater minor stressor and four times greater major stressor than their male counterparts. Other studies have revealed that "marriage significantly reduces hospital admission rates for men, but does not for women" (Russo and Sobel 1981 in Davis 1993). It would thus appear that "relationships" are less stressful for men than for women.

It is said that the most difficult problem for working women is to provide quality care for children. When a woman chooses to be an employed mother, she requires more self-confidence, motivation, and energy. In a study of employed women's anxiety, depression, and hostility levels according to their perceived career and family role commitments, Light (1984 in Davis 1993) found that "women who step outside the socially ascribed roles of wife and mother by placing careers before families will experience emotional turmoil and stress."

The fact that there were no suicidal ideation or attempted suicide in the male cohort, compared with 20% and 4% respectively of the females, tempts the postulation that women may be under greater stress, but are usually able to overcome it. Barnett (1987 in Davis 1993) suggests that life expectancy for women, in spite of greater stressors, is greater than for men, probably because they are emotionally more expressive. Another postulation is that men may be better able to cope with the demands placed on them. The latter point may be due to the lack of role strain, which is the term used for the conflict faced when a woman must choose between the demands placed on her by her profession, her maternal obligations, her role as a wife, and being a person in her own right (Pfeiffer 1983 in Davis 1993).

From this study, it is proposed that there are few differences in gender perceptions of major stress as it relates to occupational and economic parameters. No differences were detected with regard to health (zero % in either case). Significant differences were noted, however, with respect to relationships and children.

Further studies need to be undertaken, with larger a sample size, to determine whether

- the findings from these two initial surveys are representative of a wider group of male and female physicians;
- the findings in physicians would be any different from non-physicians who are in what are perceived to be high-low stress occupations; and
- gender is the important factor, or if it is individual stress perception.

It is interesting to note that although the female physicians appear to be undergoing greater stresses than their male counterparts, they appear to substantiate the conclusions put forward in the preliminary survey: that because they are independent and self-financing, they are empowered to cope with role strain and to adapt to changing circumstances and situations.

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# Health Promotion in Jamaican Public Hospitals

Winsome Segree[a], Bendley Melville[a], Hyacinth Allen[b1]

## *Introduction*

Under the Health Sector Initiatives Project (HSIP), the Jamaican Ministry of Health introduced a training program for senior administrative staff in the early 1990s. The major thrust of this program was to create "vibrant organizations" using modern management principles and techniques. Training was conducted in collaboration with the Management Institute for National Development (MIND) and the Association of University Programs in Health Administration (AUPHA). The program was carried out on a phased basis, starting with the hospitals in the southwest, followed by those in the northeast and the southeast. The training commenced in December 1992, and was completed by July 1994.

The Health Promotion Resource Centre (HPRC) at the University of the West Indies has been intimately involved in this new initiative, by planning the curriculum for the client service component of the course. The research component was also refined and conducted by the Centre. It was felt that the implementation of strong management principles, together with staff empowerment to bring about change, provided the foundation on which to build a health promoting hospital, as articulated in the Budapest declaration of 1992. This concept is based on the provision of high quality medical and technical services in an atmosphere of general staff well being, and a clean, safe, and healthy environment.

In collaboration with MIND and hospital staff, HPRC conducted a survey to assess the status of health promotion activities in the hospitals, the environment of the hospitals, and the general well-being of staff. This paper describes the findings from that survey.

## *Methodology*

The survey was carried on a phased basis so as to coincide with the training schedule. The survey was therefore first carried out in hospitals in the southwest followed by those in the northeast and southeast . The sample consisted of 1126 hospital staff from 22 of the 23 public hospitals in Jamaica.

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[1] (a) Health Promotion Resource Centre (HPRC), University of the West Indies, Jamaica.
(b) Health Sector Initiatives Project (HSIP), Ministry of Health, Jamaica.

A stratified random sampling procedure was used to select the sample population. The hospital staff was first stratified by category; up to five persons were randomly selected from each category to take part in the survey. The questionnaire was self administered; in order to increase the reliability of the results, the staff was encouraged to answer the questionnaire anonymously. Over 90% of staff returned the questionnaire. Information was collected on socio-demographic status, self reported perceptions of health, self-esteem, happiness at home and work, and stress levels at home and work. In addition, a 21 item scale was used to collect information on staff perception of the physical and social environment in the hospital. Data were analyzed using the SPSS/PC+ Version 5.0 statistical package.

### *Results*

The majority of hospital respondents were female, and nearly half were 40 years and over. In addition, most of the respondents in the three areas had been working at their respective hospitals for more than five years.

Sixty-five percent of the respondents reported that they were very happy at home. In contrast, only 17.4% said that they were very happy at work. More respondents reported that they were very stressed at work (30%) than those reporting being very stressed at home (2%). More women than men reported being very stressed.

Forty eight percent of respondents reported that their self esteem was high or very high, while the same percentage reported that they were healthy or very healthy.

The most popular health promotion activities reported by respondents were the provision of healthy meals for patients (72%), the provision of medical care for staff (59%), and the provision of information on healthy eating habits (49%). Health promotion activities least mentioned were the provision of an occupational health nurse/hygienist who could monitor heat, vibration, noise, gases, and dust; the provision of alcohol, smoking, and drug policies; and the provision of opportunities and facilities for staff and patients to do physical exercise.

Those aspects of the hospitals' physical and social environments which were given poor ratings by the respondents included noise levels, availability of space, physical appearances, levels of mosquito/fly/vermin infestation, level of discipline, and levels of security and safety.

### *Discussion*

The results were generally consistent across the three geographical areas. Visits to the hospitals verified the results of the survey. This indicates that health problems which could be addressed by health promotion strategies are common across public hospitals in Jamaica. National policies designed to address these issues will therefore be applicable throughout the country.

Strategies to address the issues raised must take into account that the majority of staff are women over the age of 30 who have worked in the health service for more than five years, and who are either nurses or ancillary staff.

The major health issues identified were stress at work, environmental problems such as noise levels, deterioration in the physical appearance and cleanliness of the surroundings, safety and security, and information and amenities to promote a healthy lifestyle such as exercise facilities and the provision of an occupational health specialist. As women advance in age, malignant and chronic diseases such as chronic pelvic inflammation, hypertension, diabetes, heart disease, obesity, and arthritis gain prominence over issues related to child bearing. Services to address the illness of these workers must therefore be appropriately oriented to respond to their needs. In addition, action is needed to improve the physical environment and general safety of staff, and to provide programs which address life style issues and level of stress in the work place.

# A Historical View of Occupational Health, Gender, and Sustainable Development

Kamala Dickson[1]

Systems of health care have evolved gradually from a body of knowledge passed on through millennia in oral traditions and informal apprenticeship. Much of the knowledge of therapeutics must have come from those gathering fruits, leaves, and roots who noted the effects of these natural substances on bowel action, sleep patterns, urination, breathing, and pain. Women were particularly able to note and analyze this body of knowledge through their care of babies, children, and the elderly. It was likely that this knowledge was then disseminated by the itinerant traders who linked one civilization with another. Perhaps these same traders' observations of patterns of illness, climate, and the layouts of villages and towns contributed to the well designed, sanitary cities of early civilizations. Those persons who showed skill in the management of illness and injury were likely to be commandeered by the rulers to treat themselves and their families. The scale of payments set down in Sumerian and Babylonian codes shows that even then it was more profitable to take care of the affluent than the poor, as long as one had a good track record of success. From care of the family there is a natural progression to care of retainers and the armed forces. Here perhaps we see the first (and still dominant) occupational medicine, that of the treatment and protection of soldiers responsible for guarding and extending the wealth of the realm and those who controlled it.

The Romans provided hospitals for their sick forces in the far flung provinces; protective clothing was devised in the form of shields and chain mail, and the cumbersome suits of armour worn by the knights but not by the foot soldiers involved in hand-to-hand fighting. Plagues and venereal diseases are normal ware camp followers, but the primary concern of leaders has been to have a large enough force on the battlefield. Troops were fed at the expense of the local inhabitants. The first hospitals in the British territories were those for the armed forces.

In Jamaica, the Kingston Public Hospital was established to treat the poor whites; the affluent were better off with home nursing. In the french colonies also, hospitals were initially for the expatriate community. In times of war, hospitals which cared for the less affluent turned out their patients to make room for wounded and sick soldiers. In France during the revolution, and in Grenada when under enemy fire, finances set aside for the civilian population in these hospitals was also appropriated by the armed forces.

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The battle field has provided opportunities to practice crude surgery and to try new modalities of treatment, as at the seige of Turin in 1536 when boiling oil for cauterization ran out and a new and less traumatic dressing was devised. Nursing took the leap forward to professionalism during the Crimean war, when more troops were lost on the sickbed than on the battlefield. The use of blanket immunizations was developed to protect troops from infectious diseases; when antibiotics were first developed, the initial supplies were for the treatment of soldiers' wounds, and for their syphilis and gonorrhoea infections. Concern for children's health, and for that of mothers, became an issue for legislation only when there was a shortage of fit young men to fight in the Boer War. Fear of Germany's growing martial power led to consideration of the health of future recruits, and feeding programs and child welfare clinics were established. Soldiering must surely be the oldest male-dominated profession. Research therefore has focused on related occupational risks, their treatment, and possible prevention. Even now, it is the leaders of armed forces who have access to the properly equipped shelters to be used in the event of nuclear war.

How was occupational health developing otherwise? Although the ill effects of various occupations were recognized early, the presence of a large reservoir of labour negated any incentive to correct conditions. Profit and power have too frequently determined the path of medicine.

Many early civilizations depended on slave labour, for whom only minimal care was needed as long as there was a steady replenishment. The physically strong were selected. As slaves were used for arduous labour in the West Indies, the traders preferred to ship males rather than females, and the early ratio was near to 10 men to each woman. However, this imbalance of the sexes corrected itself over time as the women lived longer than the men. When the slave trade became threatened, the importation of women, with hopes of reproduction, was more popular.

Similar considerations ruled the early demand for male indentured labourers. However, it was realized that the workforce would be more settled and likely to sign up for second term if they had established a family. Physical health was dealt with in slavery by use of "simple medicines." Although planters were supposed to provide hospitals over time, these were often crude buildings which became holding areas and served to isolate not only the sick but also those under punishment; to the slaves they were known as "hot-houses." Doctors were employed to visit the estates at regular intervals and were paid a capitation fee to do so, but since knowledge of disease processes was limited, specific medications were rare and the training of these physicians was frequently of low standard. The value of adequate diet and housing were only appreciated by a few plantation owners. Propagation of this idea did not make for popularity with their peers.

In the UK itself, the industrial revolution resulted in the most degrading urban slums with no sanitation, inadequate water, poor ventilation, badly constructed housing, and limited food supplies. The poor were forced to accept appalling conditions of work in the factories, where children were employed from the age of seven, and were crippled by their inadequate

diets, lack of sun and exercise; sometimes they were even bound to the looms. Conditions did not begin to improve until an epidemic in 1784 drew the attention of those outside the industry. The Factory Act of 1802 was the first of a series over the next 100 years to address conditions of work and safety in the work place. It was not until 1878 that children under ten years of age could no longer be employed. Compulsory breaks were added to the working day. At the same time, limits were set on the employment of women and the conditions under which they could work. As such stringent conditions did not apply where only men were employed, the employment of women became limited, as women were more valued for their reproductive possibilities.

Although factory-related occupational health was slowly developing in industrialized countries, such concern was not evidenced in the colonies. Even before the identification of infectious diseases and their prevention or cure, western medicine was considered as a tool for the civilization of backward peoples. Its application was all too often controlled by political and economic considerations. Malaria and sleeping sickness adversely affected the ability of the colonisers to live and to exploit the land for cultivation of export crops, and the control of these diseases became a target of the colonial powers. In Vietnam, workers were used as laboratories to test theories of infection for malaria and its affect on the growth of children and the health of workers. Research was directed to diseases that limited workers' productive potential, but the health of the population at large was not of prime concern.

Whereas in Europe and North America the provision of safe water, proper sanitation, adequate housing, and better nutrition had together improved the well-being of the whole population long before the advent of antibiotics, these measures were not applied except for within the expatriate communities. Measures which would have improved resistance to disease were always considered too costly and the payoff too longterm. We perhaps see the same attitude with money poured into research on AIDS, a disease that in the West initially involved men. Solutions to infections which kill many times that number in the "third world" still await the necessary funds for research and its application. Water supplies are still inadequate and housing lacking. As indicated in surveys carried out by public health students in Jamaica, both rural and urban populations perceive the supply of adequate water, sanitation, and housing as basic to their health. Factories set up in areas of cheap labour often operate under conditions that would not be permitted in the employers' countries.

Occupational health in the factory and field requires an educated workforce which is prepared to demand safety and to cooperate with safety procedures. Trade unions have been a significant force but are largely dominated by men. Even the unions have not always appreciated that the risks to the worker are often carried home to the family, as with asbestos workers. Trade unions depend on numerical strength for their power, and unfortunately there are many occupations where there is a surplus of potential workers and only small numbers are employed in any one venue. This is perhaps particularly true of the domestic workers upon whose shoulders many women have stood to reach a professional level in the business world and even politics. Domestic workers, who are primarily women, are exposed to the multiple risks of the home environment where most accidents occur. These

include exposure to poisons in pesticides and cleansing materials, high risk of falls, long hours on their feet, frequent expectations to work overtime and on holidays so depriving their own families, all often for inadequate remuneration. In this era of increasing opportunity, many women have opted out of being fulltime housekeepers, but yet have not necessarily improved conditions for their proxies, and men have not yet accepted their full share of care for the home environment and for parenting.

At the same time, women have tended to enter the male dominated workforce under male conditions. Safety clothing may be in sizes suitable for men but not for shorter, slimmer women; work benches may be of inappropriate height; recreational facilities are geared to male dominated sports and to hours when children need care. Hours of work clash with children's time out of school, children's welfare and immunization clinics are open during the "normal" working day, holidays are shorter than school holidays. Suitable clothing is based on that of the male and what is considered suitable by the male employers. Thus, in some occupations women are expected to serve a decorative function, to wear high heels even though these cause serious longterm problems, stockings are de rigueur in a tropical environment, and wearing of uniforms often applies only to the female staff. Women often do the manual labour as in agriculture, clerical work, and nursing, and are in more direct contact with pesticides and other toxic substances and infected materials. Labour saving devises are often taken over by the men, as in driving tractors and other motor transports, and the operation of factory machinery. While the state has less to spend on social services, the insurance companies will provide coverage that is frequently tied to the place of employment and the employee. Both in Mexico and in Israel, health services are run by trade unions; the unemployed miss out on even this care.

Occupational health needs to take cognizance of the possibilities of variations in the use of time and of the need of the worker to earn, so as to provide for the emotional needs as well as the physical needs of the family. Research into the benefits of time sharing and flexibility of hours is lacking. Governments preach breastfeeding, but rarely provide adequate legislation to make this feasible for working women. Yet the children of today are tomorrow's workforce.

Workers need education regarding the risks and the precautions necessary for protection in the home as well as the factory or mine, education that must be ongoing and supported by necessary legislation. Which of us does not risk health in the pursuit of our occupations?

## Discussion

Following the presentations, a general discussion took place on the topic of Gender, Environmental and Occupational Health. The following points were raised.

- In the Caribbean, 40% of women in the workforce are in the informal sector. As such, they receive no support or guidelines in terms of health and safety. Contract work, which usually warrents no benefits or support, also affects far more women than men. Many women make a living by huckstering, often taking their babies with them on the streets, where both are exposed to an excessive daily lead intake. Few children of women working in the informal sector receive adequate (or any) immunization because their mothers have neither the time nor the ability to leave their "spot" to go to a health clinic.

- Within the more formal occupational system, health standards and services are focused on male workers. Breastfeeding facilities are not often provided. Health clinics are usually open only between the hours of 8 a.m. and 4 p.m., when many women are at work. The different health needs of men and women as they relate to the workforce remain generally misunderstood. However, as changes in the labour force become evident, with women moving into jobs at all levels, these differences will continue to demand attention.

- Free trade is an important issue that is not being addressed in terms of gender and occupational health. Questions were raised about how free trade will impact on the harmonization of guidelines and standards (that is, upward or downward harmonization), and, more specifically, what the impact will be on women workers.

- The point was raised, that as women become increasing involved in the formal occupational sector, and subsequently become more financially independent, the level of domestic violence also rises. Some men feel threatened by the growing success of women in the workplace, particularly as they are becoming unemployed in larger numbers. Other participants were wary of linking domestic violence with women's independence, however, and preferred to link it to the globalization of violence.

- One participant noted that women themselves must accept some of the blame for the generally low occupational status of women. Professional women sometimes maltreat their domestic workers, pay them poorly but expect overtime work, and will not provide them with the means for attaining extra education.

# Gender and Reproductive Health

# Multiculturalism, Women, HIV/AIDS, and Development

**Asha Kambon**[1]

## *Introduction*

This paper seeks to explore the issue of multiculturalism and its impact on women who are affected by HIV/AIDS, in the context of development. At the same time, it seeks to contribute to discussions on the cultural and socio-economic barriers which impede efforts to both care for women who are affected by HIV, and to prevent and control the spread of HIV among women.

It is hoped that this paper will lead to a greater appreciation of those individuals and groups who fall outside the dominant cultures, but who must be reached with prevention and care programs. The paper is committed to the notion that disease is more than the infection of an organism, that it is also "a reflection of how we live as a society, what values are important to us, how well we plan and allocate resources, and how sophisticated we are in our understanding of the interrelatedness of all of society's elements" (Valdiserri 1989)

## *Culture and Development*

Paulo Freire defined culture "not as a luxury nor a simple aesthetic appreciation, but the sum total of the solutions supplied by human beings to the problems environment sets them." By culture this paper refers, therefore, to every aspect of life: know-how, technical knowledge, customs of food and dress, religious beliefs, values, languages, symbols, socio-political and economic behaviours, indigenous methods of taking decisions and exercising power, and methods of production and economic relations. In considering the failure of development strategy, Thierry Verhelst, in his book *No Development without Roots*, points to the missing dimension of culture, which could give coherence to development. Culture is therefore increasingly being recognized as an important element, perhaps even the key element, in shaping the global future (Wallerstein 1993).

Development has been defined as a creative process whose central nervous system is located in the cultural sphere; it is ultimately a matter of neither money, physical capital, foreign exchange, nor of getting prices right, but rather the capacity of a society to tap the roots of popular creativity, to free up and empower people to exercise their intelligence and collective wisdom for the well being of present and future generations (Levitt 1992).

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[1] Economic Commission for Latin America and the Caribbean (ECLAC), Port of Spain, Trinidad.

Traditional notions which simplistically equated development with modernization are fast losing ground; so too are mechanistic interpretations of growth which suggest that marginalised groups will become participants in and beneficiaries of the development process through the trickle-down effect. During this last decade of the 20th century, it has become clear that attempts at modernization and development have not always resulted in fostering the extent of social integration which had been envisaged, as many societies face the close of the century engulfed in serious internal conflict.

It has been advocated that development is about increasing people's choices, and that it should be weaved around people and not people around development. People's participation, not an event but a process, is deemed to be the most essential ingredient to development (UNDP). There is little argument that new models of sustainable human development are needed to invest in human potential and to create an enabling environment for the full use of human capabilities. This has been expressed as an integrated approach to development, which advocates that environmentally sustainable growth with equity in a democracy is not only necessary but is possible, and must be advanced simultaneously rather than sequentially if development is to be achieved. (ECLAC)

This paper posits the view that for HIV prevention and care to be effective, there must be an alternative approach to development within societies. It suggests that

- people's participation,
- increasing people's choices,
- tapping the root of popular creativity,
- freeing up and empowering people, and
- ensuring growth with equity (ethnic, cultural, gender, etc.)

are notions which must become working tools for those involved in the prevention and care of women affected by HIV. These notions take on even greater significance when functioning outside of the dominant culture and within a multicultural environment. Why? Evidence from the past two decades of HIV prevention and care work seem to point to the fact that powerless and or poor groups of people (no matter on what part of the globe they exist) are going to be more susceptible to the ravages of HIV.

## *The Pluralistic Context of Trinidad and Tobago*

Trinidad and Tobago is described as a classical plural society with approximately 80% of the population being divided equally between African and East Indian ethnic groups. The other 20% of the population is comprised of Chinese, Syrian/Lebanese, and European-mixed populations. As diverse as its racial makeup is, are its mix of religious denominations. The 1980 census reports that 33.6% of the population denoted themselves as Roman Catholic, 25% as Hindu, 15% as Anglican, 5.9% as Muslin, 3.9% as Presbyterian, and 16.6% as other (Trinidad and Tobago 1991).

Pluralism has been defined as a condition in which members of a common society are internally distinguished as distinct aggregates or groups by fundamental differences in their cultural practices. It simultaneously connotes a social structure characterized by discontinuities and cleavages, and a cultural complex based on systematic diversity (Smith).

Pluralism is expressed in several ways, through the practice of religions that reflect or embody different forms of worship, different belief systems, and contrasting social practices; through the practice of competition based on race or ethnicity, practised in the form of discrimination and favouritism; through the education or health care systems which may structurally favour one group over another.

Pluralism can be both beneficial and problematic. As a source of enrichment through diversity for a society, it is beneficial to all. But mere cultural or racial differences within a social system does not by itself indicate dysfunctional pluralism. It is when devotion to race and culture becomes so intense that a disassociation takes place, or when cultural or racial differences lead to patterns of exclusion or discrimination, that it can be said to be dysfunctional.

## *HIV/AIDS in Trinidad and Tobago*

Trinidad and Tobago reported the highest number of AIDS cases in the English-speaking Caribbean in 1994, and the seventeenth highest number globally in 1991 (PAHO 1992). It is the southernmost twin island state in the Caribbean sea, and as such forms part of that geographic location which was ranked fourth by Mann et al. (1992) among those geographic areas which possessed an excess of adults infection with HIV in comparison to their proportion of the global population (2.6% of HIV infected population, 0.6% of global population) (Mann et al. 1992)

The cumulative number of reported AIDS cases (1983-August 1994) in Trinidad and Tobago is 1,657, with 1079 reported deaths (Trinidad and Tobago 1993). This results in a case fatality ratio of 65.1%. The major mode of transmission of HIV is through sexual contact, with heterosexual rather than homosexual/bisexual activity accounting for the larger percentage of cases. By mid 1994, 65.2% of HIV infections were ascribed to heterosexual activity when a risk factor was identified (Trinidad and Tobago 1992).

Women comprise 49.5% (1992) of the total population in Trinidad and Tobago. Women of child bearing age (15-44) form 47.9% of the female population (Trinidad and Tobago 1993). Of all reported adult cases of AIDS in Trinidad and Tobago, women represent 25%[2]. As at March 1994, the male:female ratio of AIDS cases was 2.7: 1, which indicates a dramatic shift from the 9:1 ratio of 1985, when the first cases of AIDS were seen in women. The

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[2] Among the 19 countries in the Caribbean region for whom CAREC collects data, Trinidad and Tobago (412) ranks second to the Bahamas (578) with regards to the highest cumulative number of AIDS cases reported among females (1982-March 1994) (PAHO/WHO 1992).

proportion of total annual adult cases being contributed by females therefore rose from 10.0% in 1985 to 36.6% in 1992 (Lewis unpublished). The majority of adult female cases (85.5%) occur between the ages of 15 and 44 (Lewis unpublished).

For January-August 1994, paediatric cases represented approximately 6.4% of the cumulative total number of cases. In 1992 alone, 6.4% of the total cases where a risk factor was identified were transmitted from an HIV-infected mother to her child (Lewis unpublished).

In Trinidad and Tobago, AIDS is the second leading cause of death among the female population aged 25 to 34, malignant neoplasms being first (tying with injury and poisoning). Among men in that same age group, it was also the second leading cause of death in 1992.

### *Status of Women*

In comparison to women in many areas of the world, women in the Caribbean enjoy a significantly better standard of living. Although some three quarters of women aged 25 and over in much of Africa and Asia are still illiterate, the average in the Caribbean subregion is 16%. Many countries of the subregion can boast of full literacy. The data indicates that women had achieved 13% representation in parliamentary assemblies by 1990. This compared fairly well with countries elsewhere (ECLAC 1994).

In terms of women's health, measured by life expectancy at birth and maternal and infant mortality, the Caribbean subregion compares favourably with its industrial neighbours to the north, and its life expectancy has been higher than that of countries to south, although in the present economic environment, new trends seem to be emerging.

In the economic sphere, it is not surprising to find that women are playing a key position as economic decision-makers in the subregion. This may be attributed to women's long and significant history of participation in the labour force, and to the educational status which they have achieved. The data collected suggests that women represented 25% of the total own-account workers and employers in 1980, 29% in 1985, and 35% in 1992 (ECLAC 94).

Unfortunately, new economic circumstances in the region are sharpening the cleavage in patterns of income distribution. Thus, while bright general pictures can be painted, large numbers of the population live outside of that reality. This has resulted from increasing national debt burdens. Debt servicing, which became pronounced in the eighties, continues to be a burden on the countries of the subregion into the 1990s. In 1992, the quantum of Caribbean Foreign Debt stood at approximately US$ 21 billion. It is unfortunate that the very policies aimed at restructuring the economies have threatened gains made in the areas of health, nutrition, education, and employment.

Employment statistics tell the story. Female unemployment rates generally exceed those of males. In St. Vincent and the Grenadines, Grenada, and Trinidad and Tobago, unemployment rates for females were 20-30% higher than those for their male counterparts.

The female unemployment rate is especially high for women under the age of 30, precisely the time when the responsibility of women for young children is at its highest.

These high unemployment rates have pushed large segments of the female labour force into the informal sector or into the low wage export producing sector, as women in the Caribbean devise strategies to survive. Estimates are that between 30 and 50% of all employment is in the informal sector. In Guyana it is reported that the informal sector provides income for approximately 60% of the economy; in Haiti it is as high as 93%.

Economic conditions in female headed households (FHH) vary considerably, but often these women are the most impoverished. The *World Bank 1992 Report on the Caribbean Region* reported that over 40% of Caribbean households are headed by women. Country reports providing statistical data on FHH for 1992 move from a low of 22.0% in Belize to a high of 43.9% in St. Kitts/Nevis. The Bank report indicated that almost 90% of the heads of FHH have only a primary school education. Some 38% of them work in the informal sector.

Of concern to women is the question of migration. The World Bank has estimated that the Caribbean has the highest rate of migration in the world. Peculiarly worrying about the migration patterns are the significant number of women who migrate. A report from the Dominican Republic indicates that some 52.1% of the migrants during the 1985-91 period were women, most of whom were young, middle class, and well educated.

Although this is a region comparatively more peaceful than many regions of the world, some countries have become recipients of refugees and displaced persons. The Belize report indicates that civil wars in neighbouring Guatemala, El Salvador, Honduras, and Nicaragua have caused many thousands of refugees, displaced persons, and economic migrants to cross into Belize, creating a multiplicity of social, economic, cultural, and environmental problems. In addition to those issues mentioned above, women in the Caribbean are concerned about the escalating culture of violence and the continuing violence against women.

In Trinidad and Tobago, a demographic and health survey conducted in 1987 indicated both that women in rural areas were less likely to use contraceptive methods than women in urban areas, and that the use of contraception among women rose dramatically with education. The study also found that while 68% of women with full secondary certificates were using a contraceptive method, only 41% of women with less than primary education were current users of some method of contraception.

A situational analysis of women and children in Trinidad and Tobago for 1989 indicated that there was a significant number of women who had not completed full secondary level education. Among women in the 25 to 34 age group, as much as 62%, and in the 35 to 44 age group some 80%, had not completed full secondary education (Henry and Demas 1992). A more recent study completed on the secondary school population in Trinidad and Tobago,

*Placement Patterns and Practices*, indicated that significant numbers of young people aged 11 to 16 were out of school, and that young females were by far the most significant group who fell out of the school system (Jules 1994).

This author agrees with other researchers (Valdiserri; Worth) that there are two kinds of variables (culture and economics) affecting the low and middle income Caribbean women's choices, both of which are are structural.

## *Culture and Sexual Behaviour*

Despite its annual carnival, which is renowned for "feting" in the streets and apparent freedom of the flesh, Trinidad and Tobago is a conservative society in which the discussion of sex is still taboo, particularly when initiated by women and youth.

The plural nature of Trinidad and Tobago introduces a complexity in family forms as compared to more culturally homogeneous societies elsewhere in the Caribbean. Sexual unions span a wide range of options, of which formal monogamy with registered marriage is only one variant. There are common-law unions of man and woman that may be stable and which at some stage may be formalized as marriage through the official system. Visiting unions exist in which a man and woman are stable sexual partners but do not cohabit; some men may be engaged in formal marriage or common-law unions, while still maintaining visiting unions elsewhere.

In the islands' matri-focal system, grandmother is the head of household, and adult children reside with her while engaged in visiting or common-law unions, resulting in the presence of a number of grandchildren in the household. Since Islam sanctions polygamy among men, there are also such marriages among Moslems in Trinidad and Tobago, both among the Indian and the African community.

Women often find themselves in what are termed 'serial' monogamous relationships, with one single partner for a period followed by another. These relationships usually result in children, creating a home in which a mother lives with several children from different fathers. On some occasions the father of the last conceived child may be present in the home; often no father is present. It is a common belief among women that a man will stay in a relationship if the woman has his child, although the number of single headed households do not bear this out. The Government CSO household survey (1990) indicated that some 20% of households are headed by women who have full responsibility for the management of the household, without the support of a full time male partner (Henry and Demas 1992).

In an article on *Minority Women and AIDS: Culture, Race and Gender*, Dooley Worth stated:

> Culturally determined values influence how individual perception of AIDS are selected, how attitudes towards high-risk behaviour are formed, how habits that characterizes high risk behaviour are developed and how risk reduction information will be processed.

This belief about male response to children by low and middle income women in Trinidad and Tobago often impinges on the women's willingness to use a condom or any form of contraception which may prevent conception in a new relationship.

The demographic and health survey of 1987, conducted among women in Trinidad and Tobago, hinted that the barriers to condom use were cultural. Knowledge was not a problem: more than 90% of women involved in a sexual union were familiar with condoms. Availability was not the problem: very few women in the study cited problems with obtaining condoms, which are readily available through the 102 government health centres scattered throughout the twin island. The study concluded that "it is somewhat surprising that disapproval by partners was not mentioned more often as a problem with specific methods, particularly with the condom" (Family Planning Association of Trinidad and Tobago 1987). The study continues "one possible reason for this is that respondents may be reluctant to give the impression that their partners influence their thinking about contraception" (Family Planning Association of Trinidad and Tobago 1987).

Low and middle income women were found to depend on male validation for their sense of self worth; therefore, what partners felt was right or wrong about sexual expression influenced both the women's thinking and action. Thus, many women would not introduce a condom into a relationship lest their own fidelity be questioned.

Condoms are still viewed culturally as a device to be used with the person who is not your main partner. This view was expressed very clearly by one woman who, in response to the notion of encouraging safer sex between herself and her visiting partner, said "at this age if he tried to use a condom I won't want that, it would mean that something is wrong, either he doesn't trust me or he is doing something [wrong]" (Trinidad and Tobago 1992 unpublished). A condom use assessment study conducted at an STD clinic among men in Trinidad, July 1989 supported that view, when it found that "men were more likely to report using condoms with casual partners than with regular partners" (Trinidad and Tobago/CAREC 1989).

This view was further substantiated by a CAREC study which concluded that

> ...it is virtually unheard of for men to use condoms with their wives. For a man to use condoms with his wife or for her to find them in his belongings is still a sign of infidelity. Thus the promotion of regular condom use during each sexual act with primary partners has created a major stir in the Caribbean (Lamptey et al. 1992).

One woman involved in a visiting relationship expressed a lack of ability to control this most critical aspect of her life. In response to getting her partner to practice safer sex, since she was unsure of his other relationships, she said "all I does do, I does pray a lot" (Trinidad and Tobago 1992 unpublished).

Another woman expressing her hopelessness at the situation, asked "what you think about, when you are living with somebody and you tell them about AIDS and they say "what it is - it doesn't have anything like AIDS" (Trinidad and Tobago 1992 unpublished).

The expressions which these women articulated regarding their inability to adopt risk reduction behaviours are rooted in cultural and socio/economic dynamics and not simply their own personal weaknesses, character flaws, or "immoral" behaviour.

## *Economics and Sexual Behaviour*

Trinidad and Tobago's economy has undergone severe strains as the central government expenditure continued to decline between 1982 and 1990, in keeping with the economic recession after the boom years of the late 1970s and early 1980s. The social sector has suffered significant reductions in financial resources: from TT 2.94 billion for 1981 -1985 to TT 1.4 billion for 1986-1990 (PAHO/WHO 1992).

Coupled with the structural adjustment programs which the government has been forced to implement, this has placed a number of burdens - in the form of increased cost of food, transport, and public utilities - on poor families which are increasingly headed by a single mothers with four or more children and an elderly parent in their care.

Although an estimated 69% of the population is considered urban (1990), there are sectors within urban areas where a rural atmosphere has been retained, and where the small population is engaged in more rural-type activities. A study on poverty in Trinidad and Tobago suggested that some of the areas with the highest percentage of their population living below the poverty-line were rural (Henry and Demas 1992).

The study also indicated that slightly over 20% of the households throughout Trinidad and Tobago were living below the poverty line in 1988, and that households headed by women and those households with many children or with high dependency ratios would have already experienced the negative effects of the structural adjustment programs being implemented by the government. Trinidad and Tobago does in fact have a high dependency ratio of 61.8% (1989 figure) due to increased school attendance, high unemployment in the 15-24 year age group, and out migration of adults (PAHO/WHO 1992).

Historically, and especially during the period of the enslavement of Africans and the indenture of the East Indians in the Caribbean, women contributed to the labour force while continuing their reproductive roles. Today, women comprise approximately 35% of the current labour force. Twenty-three percent of that labour force is unemployed. This represents 8% more female unemployment than male, which stands at 15% (Trinidad and Tobago 1991).

These increasingly difficult socio-economic circumstances circumscribe many women's lives, and leave them vulnerable. Heavily depended upon by children and the elderly, without employment or appropriate skills for what little employment is available, a woman becomes herself dependent; dependent on her partner/partners for sustenance for herself and her children.

The implications of economic recession and structural adjustment on the control of HIV infection is an area that requires further exploration. A recent study in Africa concluded that these twin factors may further aggravate the transmission, spread, and control of HIV infection in two major ways: directly increasing the population at risk through increased urban migration, poverty, women's powerlessness, and prostitution, and indirectly through a decrease in health care provision (Sanders, Sambo 1992)

Many women currently find themselves with their traditional means of livelihood eroded, their skills marginalized, and their dependency on male partners increased. The 10 year period of economic well-being which was enjoyed by the entire society during the oil boom of the mid seventies (Trinidad and Tobago is an oil producing country) have left a lingering taste for high cost North American consumer items and expectations for the way of life usually found in urban environments, and as seen on North American television (92% of households have televisions). This has led, in part, to the out migration of many women in search of employment and an improved quality of life, resulting in an increase in the male to female ratio from 99 to 110 males per 100 females, and an increase in women's participation in the informal labour sector.

Poor women now hustle to make a living and put food in their children's mouths, by working as wayside vendors, hucksters, suitcase traders, domestic workers, sex workers, and/or drug mules. Women in these trades face the vagaries of the elements, harassment by state authorities, and even imprisonment. Their main preoccupation is with survival. Their personal safety and health is at extreme risk, and they generally fall outside of the health education circle.

Wooley has argued that AIDS education which promotes "safer sex" may actually threaten behaviour patterns that women of African and Latino descent in North America link with their survival. This would seem also to be valid for the poor Caribbean woman. Risking alienation from their partners by suggesting safer sex practices to avoid a disease which still seems far removed is not a risk they are prepared to take. Feeding children and keeping a roof over their heads is high on their agenda, even if that means sleeping with a new partner in exchange for whatever support he provides during the period of time he spends with her.

The socio/cultural barriers, many brought to the islands by early missionaries, have their roots in male dominance. Gender roles have evolved which allow a man to have more than one partner before and after marriage, but which restrict a woman to virginity before marriage and fidelity afterwards. Because large numbers of women are unable to fulfil this role, strong feelings of guilt and worthlessness reinforce a sense of powerlessness.

Norms which label a woman "loose" if she initiates discussion on sex or suggests condom use, and which suggest that a woman must take "what a man has to give" or "bear it for the children's sake", are still the prevailing views among rural women. In this environment, it is much easier for men to protect themselves against HIV infection than for a woman to do so.

The dependent condition in which she finds herself is exacerbated by a socio-cultural world view which proscribed a gender role to her, which is passive and non threatening/non teaching/non initiating in relation to her partner.

## *Conclusion*

It appears that what is needed, are programmes which take a more holistic approach to HIV prevention and care intervention. Such an approach must include interventions for greater economic and cultural self reliance on the part of women, and must encourage new perceptions of gender roles among both females and males. Interventions must be cognizant of the cultural roots of development; in other words, indigenous methods of decision-making, world views, practices, family forms, religious beliefs must be considered.

Inroads must be made with new associations which have meaning for women's lives, and programs must reach women where they are - in the market place. New techniques, such as popular theatre, which can empower as they impart new information and which are rooted in the culture of the people, need to be given greater prominence in HIV/STD prevention and control education approaches for low income urban and rural women.

New experiences of control and empowerment which have been brought by new forms of economic survival must be articulated and identified for women. These can be used to broaden their understanding of self and increase a women's sense of self worth. Men also need to be reached in a manner which enables them to face the realities of changing gender roles and the empowerment of women. In efforts to empower this generation of women and men so that each can have equal influence for positive living, we can not forget the youth. Youth must be a major area of focus in the Caribbean, as over 30% of the population is younger than 15 years old. This paper cannot support strongly enough the need to involve young people in this joint effort and to begin education about matters of human sexuality, gender roles, and respect for cultural diversity at an early age.

For cultures and societies outside of the dominant culture (as well as those within), this is a period of tremendous transition. The strains are obvious as traditional support mechanisms fall apart and traditional values and norms are challenged by new and different ones. Responses are two fold: easy acceptance and resistance.

HIV and AIDS have increased the pressure on societies to survive. The challenge is to best manage the fallout from that pressure in such as way that the sexuality of everyone's life does not deteriorate, but improves.

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# Geographical and Medical Barriers to Family Planning Services in Rural Jamaica

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## *Introduction*

It is widely accepted today that the removal of economic and social constraints to the rights of women is one means of bringing about improvement in their health status. Equally important is the provision of family planning services, as they form a crucial segment of women's overall reproductive health needs. The responsibility for preparing and promoting Jamaica's family planning program rests with the National Family Planning Board (NFPB), a statutory body enacted in 1970. With the phasing out of donor agency support on which the program previously depended, the NFPB developed a five-year plan which prioritized key issues and interventions. An increase in the effectiveness and sustainability of the program was the plan's major goal.

This goal is to be accomplished through the encouragement of the private sector - private physicians, pharmacies, and non-governmental organizations (NGOs) - to play a greater role in the delivery of family planning services. At the moment, about 60 percent of persons seeking family planning services do so through the public sector. It was felt that many of these consumers could pay commercial prices and, by encouraging them to do so, the public sector would be better able to serve those without the necessary financial resources.

An increase in private practitioners' participation was also seen as important to understand their attitude and skill level, as well as their service delivery practices. It is increasingly being recognised that some policies and practices, based in part on medical rationale, inhibit the use of family planning services. Medical barriers include "contraindications", prohibitions based on spousal consent or other eligibility barriers, process hurdles such as laboratory tests, provider biases, and regulatory barriers. These were necessary safeguards and prescribing practices three decades ago, but are now considered unnecessary barriers to access.

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## *Purpose*

A research study was designed to collect baseline information on family planning service delivery in Jamaica. The study had a number of specific objectives:

- to identify all service delivery points (SDPs) for family planning, their hours of operation, and services offered;
- to identify under-served areas;
- to assess service delivery practices of private doctors to determine consistency of care given to family planning clients; and
- to determine if private providers are basing service delivery practices on up-to-date scientific contraceptive information.

## *Methodology*

The research design incorporated a three-phase process. Phase one involved collecting and reviewing lists of service providers. In phase two, the lists were verified and updated. The final phase involved fieldwork to further validate and complete the lists, as well as to administer the private physicians' questionnaire.

The initial stage of the research design called for a careful review of lists of service providers obtained from a number of sources, including the Ministry of Health, the Medical Council, the Pharmaceutical Council, FAMPLAN, and NFPB. The lists were reviewed and validated by cross checks against other sources. For example, the list provided by the Medical Council of Jamaica, the most problematic, was checked against those of professional associations such as the Medical Association of Jamaica, the Association of General Practitioners, the Medical Alumnae Association, and with pharmaceutical distributors. Listings were then taken to Senior Public Health Nurses in each of the parishes for further verification.

Face-to-face interviews with private practice physicians were then carried out. A questionnaire was administered to all general practitioners (GPs), as well as to those specialists likely to be involved in the delivery of family planning services. Four groups of physicians were targeted - GPs, obstetricians/gynaecologists (OB/GYNs), surgeons and urologists. Four hundred and seven of 418 physicians agreed to be interviewed.

Non-traditional outlets for condoms such as bars, nightclubs, and hotels were excluded from the study.

## *Geographical Barriers*

### *Pattern of Service Delivery Points*

Eleven hundred and eighteen outlets offered family planning services to consumers in Jamaica. As table 1 demonstrates, the private sector accounted for the largest number of outlets, with private physicians being most numerous. Although the survey did not specifically examine trends, a review of past data suggests that the number of physicians in private practice has been increasing, partly as a result of a reduction of those emigrating (Bailey and Phillips 1990). The public sector, on the other hand, provides the majority of women with services, although it has less than half the number of SDPs as the private sector. Non-governmental organizations, although filling a very important need, comprised less than 10% of the total number of outlets.

**Table 1. SDPs by Facility**

| Facility Type | Number | Percent |
|---|---|---|
| **Private** | | |
| Private Doctors' Offices | 463 | 42 |
| Pharmacies | 229 | 20 |
| Private Hospitals | 7 | 1 |
| **Public** | | |
| MOH Clinics | 324 | 29 |
| MOH Hospitals | 16 | 1 |
| **NGO/Other** | | |
| FAMPLAN | 45 | 4 |
| NFPB | 28 | 3 |
| UWI/CAST | 3 | <1 |
| Other | 3 | <1 |
| **Total** | 1,118 | 100 |

Table 2 shows the distribution of SDPs by area. SDPs were fairly evenly distributed among the three geographic areas - the Kingston Metropolitan Area (KMA), other main towns (OMT) which include parish capitals and towns with a population in excess of 2,500 persons, and rural areas. However, when population distribution is taken into account, it can be seen that urban areas were served by a disproportionately large number of SPDs, while rural areas were correspondingly less well served.

Although not as dramatic as the rural-urban distribution, the contrast among parishes was also interesting. Kingston/St. Andrew was the best served parish with an SDP/population ration of 1:1649 compared to a ration of 1:3105 for St. Elizabeth, a parish with one of the largest rural populations. The ration was also quite low in the parish of St. Catherine (1:2967). This parish has witnessed the most rapid rates of population growth over the past two decades, the result of planned housing development. It would appear that services here have not kept pace with the dramatic growth in population.

**Table 2. Number and Concentration of SDPs**

| SDPs by Number and Concentration | | | |
|---|---|---|---|
| Area | # of SDPs | % of SDPs | % of Pop. |
| Kingston Metropolitan Area | 365 | 33 | 24 |
| Other Main Towns | 412 | 37 | 26 |
| Rural | 341 | 30 | 50 |
| Total | 1,118 | 100 | 100 |

## *The Private Sector*

### *Geographic Distribution*

Spatially, the private sector exhibited a pattern of dense clustering at two levels. Ninety two percent of all private sector SDPs are located in urban areas. Kingston/St. Andrew held a position of extreme dominance with 43% of all SDPs. In addition, within urban areas there was a marked tendency towards centralization of services, since private doctors, hospitals, and pharmacies showed similar locational preferences. In the Kingston Metropolitan Area (KMA), for example, private physician SDPs formed very dense clusters in the commercial nodes of Cross Roads and Half Way Tree.

Several reasons can be determined for the pattern of intra-urban clustering. The location of private doctors in Jamaica, as elsewhere, is influenced by the location of hospitals which offer employment, special services, and hospital beds for their patients (Bailey and Phillips 1990). Cross Roads and Half Way Tree are the main foci of private hospitals in the KMA. As their names suggest, these two areas are the hubs of major roads which enhance accessibility. Very important also, is the change from solo to group and shared practices, which has increased in recent years. Not only is there a trend towards shared practices, but also towards larger shared practices, with some accommodating up to 30 practitioners. This necessitates large physical facilities which favour commercial nodes. These developments have been accompanied by a reduction in overall accessibility.

The distribution of pharmacies was very similar to that of private physicians, amplifying the pattern created by the distribution of physicians. Pharmacies were found mainly in urban areas and within close proximity to the offices of private physicians, giving consumers ready access to their services.

### *FP Services Offered and Fees Charged*

Family planning methods are frequently classified as short-term. Once used, these methods provide protection from unwanted pregnancies for relatively short periods of time. Consistent use of these methods requires a periodic replenishing of supplies, resulting in their referral as supply methods. Short-term or supply methods include the condom, the oral contraceptive pill (OCP), and the injectable contraceptive.

Long-term methods provide longer lasting protection than do short-term methods. IUDs and implants are examples of long-term methods. Surgical sterilizations are permanent methods of contraception in that they provide lifetime protection against unwanted pregnancies. Long-term and permanent methods are also called clinical methods.

Private physicians offered primarily counselling and clinical methods of contraception. Pharmacies were the primary suppliers of short-term methods. Most private hospitals offered permanent methods of contraception only.

No government price controls for commercially provided family planning products and services exist. Prices vary by method, brand, location, and type of professional providing the service. The most popular pharmacy brands sold for approximately three times the corresponding public sector product. Private physicians' fees were, in some instances, as much as ten times the public sector fee.

## *The Public Sector*

### *Geographic Distribution*

The majority of public sector SDPs were MOH clinics whose numbers and spatial distribution are the direct outcome of the Government's health care policy. This policy, enunciated in the 1970s, gave priority to accessible primary health care (PHC) (Ministry of Health 1978). This represented a major shift in focus from the earlier institutionally-oriented health services approach. Clinics were to be accessible and sited with relatively fixed catchment populations. The accessibility criterion tipped the balance in favour of rural areas, for some 50% of the population in rural areas held more than 80% of MOH clinics (Table 3). The catchment basin populations were updated in 1982 when a mapping exercise revealed that only 10% of rural households were more than five miles from a health centre (Ministry of Health 1985).

Health services rationalization in the 1980s led to the closure of five rural hospitals which were reclassified as polyclinics. With the exception of the Percy Junior Hospital in the parish of Manchester, all hospitals are now located in urban areas. Each parish, however, has at least one hospital which is, typically, located in the parish capital.

**Table 3: Public Sector SDPs by Area and Parish**

| SDPs by Area | | | | |
|---|---|---|---|---|
| **Area** | **MOH Hospitals** | **MOH Clinics** | **Total #** | **%** |
| Urban | 15 | 64 | 79 | 23 |
| Rural | 1 | 260 | 261 | 77 |
| Total | 16 | 324 | 340 | 100 |

*FP Services Offered and Fees Charged*

All MOH clinics are supposed to offer family planning counselling as well as short-term methods. The majority of clinics were offering these services at the times of this research (June 1993). There were times, however, when stock or staffing shortages prevented some clinics from providing these methods. Investigations have uncovered the practice of rationing supplies, especially condoms, to ensure that they last .

Only 6% of MOH clinics inserted IUDs. The lack of trained staff appeared to be a main factor explaining the limited access to this and other long-term methods. Some MOH policy makers claimed that a lack of demand for long-term methods prompts them to staff accordingly. Norplant has not yet been made widely available in Jamaica. A pre-introductory study was completed in 1993 by the Population Council in collaboration with the NFPB. As a part of this study, four physicians were trained at three different sites and 300 implants inserted. More wide-spread availability of Norplant is dependent on securing a donor for the public sector. The estimated commercial price of Norplant will be approximately $1,250 USD per person. MOH hospitals offered surgical methods of contraception only.

The MOH has developed a seat of proposed guidelines for the collection of fees for services provided at public sector clinics. The fees were supposed to be implemented island-wide with sufficient flexibility to avoid excluding those who could not meet the new costs. Implementation, however, demands a system of controls and regular reporting. Until this system of accountability was put in place, the MOH did not feel that it was in a position to enforce the fee structure. As a result, the guidelines were unevenly applied and a wide variety of practices was discovered.

### *NGOs*

NGOs and other organizations comprised the smallest sector, with 7% of family planning outlets. A diverse range of organizations fall under this category, including FAMPLAN, the group which pioneered family planning in Jamaica, the University of the West Indies, the College of Arts Science and Technology, Operation Friendship, and the Foundation for International Self Help. The NFPB also operated three clinics and a Mobile Unit which serves industrial complexes.

With the exception of FAMPLAN's rural outreach program which served remote rural areas in the parishes of St. Ann and Trelawny, NGOs serviced urban communities. They mainly offered supply methods under a fee structure that was similar to that of the public sector.

### *Undeserved Areas*

#### *Access to Affordable Providers*

Access to MOH clinics was acceptable and all rural areas were well served. Government services were affordable because they were provided at nominal fees or without charge to those who could not afford to pay. Access to all other types of providers was more difficult for rural groups. The greatest area of disparity between urban and rural groups was in access to private physicians. This is important because physicians are perceived to offer more expert counselling and higher quality care when difficulties arise (Wedderburn 1991).

Reilly (1980) argued that one means of overcoming the problem of regional underservicing by private physicians was to increase the total supply. There has, however, been an increase in the total supply of physicians in Jamaica. One effect of this has been a movement out of the KMA and into other urban centres. It may be that once market saturation has been achieved in these urban centres, physicians would move into rural areas. There must, however, be an appreciation of the role of government policies in this process. It has been shown that hospitals attract physicians. The closure of rural hospitals has implications for physicians' choice of locations, and for the practice of medicine in rural areas.

The typical private sector client tends to be urban-based and middle class. It is incorrect to assume, however, that rural women cannot afford and do not occasionally seek and desire the advice of private providers. The Jamaica Survey of Living conditions (1991) revealed that 53% of rural residents had visited a private physician during the previous year. Evidence suggest that many are willing to pay for the perceived higher quality care when the situation warranted.

#### *Access to Affordable Methods*

Overall, good access to most short-term methods of family planning did exist. As these methods were principally supplied by MOH clinics, they were affordable. Affordability for supply methods is usually viewed in relation to minimum monthly wage and other consumer products.

Ready access to long-term and permanent methods for the 50% of the population living in rural areas was not good. From a planning perspective, it makes sense to concentrate higher order services, that is, services that are infrequently utilised, in urban areas. Thus, especially in a situation of limited resources, the efficiencies resulting from the centralisation of services can outweigh considerations of equal access. It must be recognised, however, than an efficient location from a managerial point of view can impose severe constraints on rural clients who are dependent on inefficient transportation systems. Studies have confirmed the existence of distance decay effects, that is, a negative correlation between distance and utilization of medical facilities, especially in non-emergency situations. This is not only the consequence of the friction of distance, but also the result of the fact that clients who are farther away are less likely to have a good understanding of or an exposure to the services provided by the facility. Greater familiarity can bring with it higher levels of acceptability.

The issue of affordability of long-term methods offered mainly by the private sector is more complex. Many long-term methods are more cost effective than short-term methods when duration of use is considered. The problem is that the costs come up front in the form of substantial one-time payments. It is this aspect which makes these methods less affordable and more burdensome. Indicators of affordability for long-term methods typically include one or two weeks' salary for semi-skilled workers, or the cost of larger consumer items for which people must save. Interestingly, a recent focus group study showed that middle income women recognized private sector costs for long term methods to be burdensome, but were also quick to reason that they were in line with the cost of other consumer products (Chambers and Branche 1994).

In sum, both accessibility and affordability for long-term methods were not as good as for temporary methods. Long-term methods were provided mainly by the private sector, which showed a preference for urban areas. For the transport-poor in rural areas, maldistribution may be a major deterrent to utilisation.

## *Medical Barriers*

Over the past 30 years,contraceptive methods have been made much safer. The oral contraceptive (OC), for example, has become the most studied family planning method in history (Townsend 1993), and today's formulations offer much lower doses with minimal risk to most women. The second generation intra-uterine device (IUD) has been shown to be safe and effective when inserted by trained personnel in women who are not considered at risk for acquiring sexually transmitted diseases (STDs). After many years of careful testing, the Food and Drug Administration (FDA) has given its approval for the use of Depo Provera as a safe contraceptive. Thus, necessary precautions and prescribing practices three decades ago are now considered unnecessary obstacles to access today.

The Program for International Training in Health (INTRAH), an American group, has revised its guidelines for clinical procedures in family planning (1993) to simplify instructions for the providers of family planning services. INTRAH guidelines were

reviewed by experts in 13 countries and are accompanied by citations to support recommended service practices. International organisations such as WHO are also attempting to standardise eligibility criteria worldwide. INTRAH guidelines were chosen for comparison with the practices of private providers in Jamaica because they are widely considered the most current and comprehensive family planning service delivery guidelines available. Although a comprehensive list of service delivery practices were considered, only three are examined in this paper.

## *Eligibility Criteria*

Doctors were asked about age and parity requirements as well as a number of medical and physical conditions to be considered when recommending various contraceptives.

### *Age Criteria*

Private doctors were asked their age eligibility criteria for the use of various contraceptives. International evidence does not indicate age requirements for contraceptive use, except in the case of OC for women over the age of 35 with any two of the following conditions - high blood pressure, diabetes, and tobacco smoking.

Just 23% of the physicians interviewed followed international guidelines, in that they had no minimum age requirements for prescribing the pill. Doctors had widely differing views as to the appropriate age range, but for 46% the range lay between 16 and 18. In so far as the maximum age was concerned, just 8% specified none and roughly 48% stated 35 years or less.

Prescribing practices tended to vary between urban and rural areas, with doctors in rural areas being more conservative. Rural doctors were slightly more likely than urban doctors to stipulate minimum and maximum age eligibility criteria. Ninety five percent had minimum age requirements for Depo Provera. For IUD, the percentage fell to 91%. This compares with 87% and 73% respectively, for urban areas. Similarly, 95% of rural doctors imposed maximum age requirements compared with 89% for urban doctors. A similar pattern emerged for other contraceptives, with doctors in the Kingston Metropolitan Area (KMA) tending to be less restrictive in their practices than those in other areas. Thus, those rural clients who overcame the geographical barriers to private care were more likely than their urban counterparts to encounter restrictions resulting from provider preferences.

### *Parity Criteria*

The IUD is the only contraceptive for which INTRAH guidelines specify a parity criterion. According to these guidelines, the IUD is best used by women who have had at least one child. There is no parity requirement for Depo Provera, although it is important for young nulliparous women to understand the delay in return to fertility. INTRAH specifies no parity requirement for either male or female sterilization.

The majority of Jamaican doctors had a more cautious attitude than recommended towards prescribing all contraceptives to nulliparous women. They were almost unanimous (93%) in their belief that women especially should not be sterilized before they had children. Over 70% required that women have two or three children. Nine percent required four or more. There was a little less concern that men have children before having a vasectomy but, nevertheless, this was a requirement for the majority of doctors. There were no significant rural/urban differences among the very small minority who had no parity requirements.

### *Medical and Social Criteria*

INTRAH guidelines caution that all health problems should receive appropriate attention. For OCs, international guidelines list as contraindications smoking women over the age of 35 and high blood pressure. Diabetes should be given consideration in prescribing Depo Provera, as should suspicious breast lumps/cancer and pelvic/cervical cancer. Screening criteria listed for the IUD include pelvic/cervical cancer, irregular bleeding, cardiovascular problems, and pelvic inflammatory disease (PID) or STDs.

A high percentage of private doctors did not screen for conditions deemed important by international guidelines. For example, only 59% screened for tobacco smoking in older women when prescribing the OC. Diabetes and breast lumps were given consideration by only 29% of doctors in prescribing Depo Provera. Irregular bleeding was considered a contraindication for the IUD by roughly 41% of doctors. On the other hand, some screened for conditions inappropriate for the method. Many screened out women with sickle cell disease from using the injectable, a method de Ceulaer found to be beneficial to sickle cell patients in Jamaica (1982).

Rural/urban differences were small except in the cases of screening for cardiovascular problems when prescribing the pill and irregular bleeding in the IUD. Rural doctors were far less likely to regard these as contraindications than urban doctors.

## *Conclusion*

Ensuring access to safe and affordable contraceptive services is one means of improving the health and status of consumers, for it allows them to limit and space pregnancies. Resources, policies, and provider practices often limit the reproductive choices of clients and threaten their right to choose.

The study revealed several geographical and medical barriers to family planning care in Jamaica. In so far as geographical barriers are concerned, the most noteworthy was the uneven access to different methods of family planning. Short-term or supply methods were widely available and were affordable. Longer-acting methods were less widely available and were less affordable because of large up-front charges. Rural groups in particular had poor access to long-term methods of contraception. This is important as these methods are often most appropriate for these women (McFarlane et al. 1994).

The NFPB would like the private sector to play a greater role in family planning delivery and in improving access. Private doctors are expanding into other main towns and market centres in rural areas and, it appears, an increase in the supply of doctors on the island has led to a better distribution. Those practising outside of the KMA reported a larger patient volume and higher incomes since several had more than one practice. By widening their catchment in under-served areas, these doctors have overcome the problem of small local markets.

This, however, is unlikely to improve access for women significantly in truly rural areas, for such areas have neither the threshold nor the support services. Women living in rural areas will be disadvantaged in terms of mobility and accessibility for some time to come. If the private sector could provide services for a larger segment of lower middle and middle income communities in urban areas, the public sector would have additional resources to target under-served areas. The public sector must recognize the need to continue to serve rural areas.

It is the need for longer-acting methods specifically which must be addressed in rural areas. Each village cannot have ready access to clinical methods, so a need exists to emphasize counselling and referrals by MOH clinic staff and rural outreach workers. Doctors could also be offered incentives - training in new procedures and after-hours access to MOH facilities, for example - to establish part-time practices in rural areas.

If private physicians are to play a greater role in the delivery of family planning services, then an effort must be made to improve their technical competence. The Medical Association of Jamaica is lobbying for compulsory refresher training and periodic registration of doctors (Green 1994). In the meantime, the Association has been attempting to provide continuing education to its members through seminars which address clinical protocols for contraceptive use. There is recognition of the fact that some physicians may not be providing optimum quality care by not screening for important health conditions associated with various contraceptive methods.

Choice of method is also restricted in some practices by provider preference among methods. A need exists to standardize the consistency of care given to clients. Private providers may sincerely desire to provide high quality care and to ensure the safe use of contraceptives. However, the high incidence of hypertension and diabetes in Jamaica must be considered in restricting hormonal methods to some clients and using guidelines more cautiously than international recommendations. These considerations apply to private practice throughout Jamaica. For the criteria examined, rural doctors appear more conservative than urban doctors and their activities limit access even further, thus compounding the problem of multiple deprivation in rural Jamaica.

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## Discussion

Following the presentations, a general discussion took place on the topic of Gender and Human Reproductive Health. The following points were raised.

- Rural communities face particular difficulties in terms of access, availability, and affordability of family planning programs. The question of how to deal with allocation of resources is difficult, as policy makers must strike a balance between urban areas, which have a more concentrated population (and therefore more resources for family planning programs), and rural areas, which are more dispersed, are often poorer, but which are more likely to have larger families because of a lack of programs. The role of funding agencies in influencing resource allocation decisions was mentioned.

- The role of the health care provider in family planning programs was raised. Private practitioners must be made to see the importance of practicing in dispersed rural communities where little infrastructure has been built. With increasing government health budget cutbacks, public health facilities in rural areas will continue to decline and may eventually disappear. Without access to affordable private practitioners, the rural population will be left without any family planning programs. Increased poverty and unemployment, particularly for women, will be likely results.

- Very little work has been done to address issues related to male contraception. We have been socialized to accept that females bear primary responsibility for contraception. The question was raised whether the lack of male focus in family planning research and programs is based more on fear or lack of awareness, or both. The group emphasized the need for family planning education programs for both males and females.

- Contrary to popular belief, women have been expressing dissatisfaction with condom use. At the same time, however, women who want to suggest condom use to their partners are unable to because raising the issue of condom use often condemns the women as being "loose".

- Research and policy on AIDS in the Caribbean focuses heavily on women's dependence on men. While women may realize the risks inherent in their sexual behaviour patterns and/or partners, day to day life takes priority. In many situations, women's financial dependence on men, as well as their unwillingness to disrupt their children's lives, means that they will stay in a relationship even when they are aware that their partner is involved in extra-marital relations.

- It is an extremely complex task to attempt to change culture. What are potential downstream effects? How do women control their own lives? Researchers need to look at how to use culture for policy development.

- The increasing prevalence of HIV infections have presented the medical community with the opportunity to move away from the medical model and into socio-behavioural determinants of risk.

- Policy makers must listen to women to learn what women want/need to know about HIV and AIDS. At present, policy makers appear to be unclear about the messages they want to get across. They need in particular to examine factors impacting on women's ability to manage their own health.

# Impact of Gender Issues on Chronic Diseases

# Chronic Diseases and Women

**Knox E. Hagley**[1]

## *Introduction*

Chronic diseases are either infectious or non-infectious in origin and nature. The chronic non-infectious diseases, often referred to as the non-communicable diseases, are in today's world the leading causes of chronic ill-health and death in both the developed and many of the developing countries.

The impact of chronic diseases on the health of women in particular is wide ranging and, for the most part, severe. These diseases are major contributors to female deaths, to their chronic ill-health, and to their chronic disability. The Caribbean experience provides compelling evidence of this phenomenon (Hagley 1990).

Over the past fifty years, the Caribbean region has been experiencing an epidemiological transition which has involved a shift in the nature and pathogenesis of the leading diseases. This shift, a major one in terms of the extent and rapidity of the process, has led to a replacement of the infectious diseases on centre stage, in the arenas of both morbidity and mortality, by the non-communicable diseases. Heart disease, malignant disorders (mainly cancers), and cerebro-vascular diseases (mainly strokes) are now the leading causes of death in the region.

Despite the fact that these changes have been relatively recent, the impact of the chronic non-communicable diseases on the health of Caribbean citizens has been enormous. This region provides a good study of the processes involved in the transition, as well as the extent to which the pathological processes at work in the chronic non-communicable diseases are undermining community health status.

The eradication from almost all of the Caribbean islands of yellow fever and malaria, conditions which claimed thousands of lives in past centuries, was achieved without the specific aid of drug therapy. It was the effective control of the mosquito vectors which accounted for this success. Much of the control of many other infectious diseases resulted from improved sanitation and the provision of potable water. Improvement in the nutritional status of children led to dramatic falls in infant and childhood mortality rates. The increased

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use of immunization process in later years led to the control and, in some cases eradication, of many childhood diseases. The arrival of chemotherapeutic agents and antibiotics provided a sharp and effective tool for annihilating the infective agents of diseases as they attacked.

Control of the infections led not only to a saving of lives, but also to the prolonging of life. Life expectancy, another index of the health status of a community, moved from an average of 44 years in the fifth decade of this century to an average of 64 years by the decade and is, at present, an average of approximately 70 years (PAHO 1994). Progressive falls in birth rates has resulted in a decrease in the childhood population and a further acceleration in ageing of the population. This phenomenon has been particularly well demonstrated in Barbados, where the dramatic reduction in birth rates, which took place between the seventh and ninth decades, led not only to an effective control on population growth but to an ageing of the population which has been noticeably more rapid than that experienced in the rest of the Commonwealth Caribbean. Persons over age 60 now constitute about 12% of the Barbadian population. In the other Caribbean countries, the elderly constitute only 6-10% of the population (PAHO 1994).

Phenomenon worthy of note is the major contribution of women to the ageing of the population. In relation to both the falls in infant mortality rates and the reduction in fertility rates, women were not merely involved in, but were indeed central to, the processes.

It must be clear therefore, that the gains made in the health status of the Caribbean community over the past decade, although largely the result of broad and effective public health measures, were in tandem with the strides made in the social, economic, and education arenas of the region. This experience is, of course, not peculiar to the Caribbean. Similar relationships were established in relation to the health gains made between the 19th and 20th centuries in both the United Kingdom and the United States of America.

Notable differences in the nature and extent of the impact of the chronic diseases on women's health can be noted in the middle and older age groups.

## *Middle and Older Age Groups*

### *Chronic Infectious Disease*

In general, women in their middle and later years of life suffer more from chronic infections in terms of both mortality and morbidity than do younger women, or men of both age groups. Cases of tertiary syphilis are seen from time to time, while pulmonary tuberculosis continues to provide timely reminders of its presence in the community. The latter disease, of course, is a notable indicator of social status. Small wonder, then, that in the prevailing climate of socio-economic deprivation and the rampant spread of the human immuno-deficiency virus with its large and long tail of immunoincompetence, there is a worrying rise in the number of cases of tuberculosis in various Caribbean communities.

### *The Chronic Non-Communicable Diseases*

The ageing of the population sets the stage for the rise in prominence of chronic non-communicable diseases. In the ordinary course of events, these diseases require a prolonged period of gestation and make their appearances in the middle and older age groups. In this regard, the net effect of the ageing of the population was the presence of a much larger target population for these disorders. But age is merely one factor in the pathogenesis and development of the non- communicable diseases. Styles of living and behaviours constitute another major factor. It has become only too obvious that the leading diseases of today are closely intertwined with lifestyles in relation to dietary and nutrition practices, habits surrounding physical activity -- more succinctly and pointedly phrased as degrees of sedentariness, the use and abuse of substances injurious to health, and a varied assortment of other unhealthy behavioural practices.

Heart diseases, malignant disorders, and cerebro-vascular diseases, previously identified as the leading causes of chronic ill-health and death in Caribbean countries, hold similar positions throughout the developed world and in many of the developing countries. The failure of hypertension and diabetes to attain such high ranking on mortality lists in Caribbean countries should not lead to an underestimation of their yearly contribution to death.

Hypertension and diabetes mellitus are common conditions in many communities, and the Caribbean experience bears this out. Population-based studies carried out in the English-speaking Caribbean over the years have shown that, in the age-groups 35 years and over, hypertension is present in at least 30 and diabetes in 10 out of every 100 persons (Hagley 1987). An alarming finding from these studies, is that prevalence rate of diabetes has increased some 300-400% over the past forty years (Hagley 1990). The contributions of both these conditions to mortality in the Caribbean region are great. Pathological data obtained from 10 English-speaking Caribbean countries as far back as the late seventies had shown that they were responsible for as much as 40% of total mortality in these countries (McGlashan 1982). A matter of added concern is that a comparison between countries in the region and North America reveal that mortality rates experienced in the Caribbean are excessive. For instance, it has been shown that mortality rates in the diabetic populations in Caribbean countries are at least three times those experienced in diabetic populations in North America. Mortality rates from hypertensive diseases in the region have also been shown also to be excessive.

The gender perspective in relation to both hypertension and diabetes provides further cause for concern. There is a preponderance of women among persons with these disorders. In relation to hypertension, although an excess of males is seen among persons below the mid-forties, females not only exceed males in later years but this disparity increases as age increases. In relation to diabetes, there is generally an absence of male preponderance in the early years and, again, females appear with increasing frequency in the older age-groups.

Analysis of the mortality data provides reason for even greater concern. The Trinidad experience related in the St. James Cardio-vascular Survey is that mortality from cerebro-vascular disease was greater among women than among men in the same age-groups (Beckles 1988). Indeed as far back as the seventies it was shown that mortality from this disease among Trinidad women was greater than that experienced by women in other countries of this hemisphere (PAHO 1976). In that same period, age-adjusted death rates for diabetes in the English-speaking Caribbean countries were also shown to be much higher than those experienced in North America and many of the Latin American countries.

Another surprising finding from the St. James study was that mortality experienced by women from coronary artery disease was notably greater than that experienced by North American women with the same disease. For instance, the male: female ratio in Trinidad was 2:1, whereas in North America it was 4:1. Coronary Artery Disease, a much more common disorder among males, was infrequently seen in Caribbean countries prior to the 1970s. Its rapid rise to prominence in the region has been a subject of much comment, as has the relatively greater toll it appears to be taking on the lives of Caribbean women.

Why women are bearing a disproportionate share of the disorder of these diseases is not clear. Time does not permit a detailed analysis of possible and likely factors which are responsible for the phenomenon. We dare not, however, overlook the recognized role and contribution of excess body weight to both the development and progress of diabetes, hypertension, and heart disease. It is of interest, and must also be of significance, that the years which saw the marked rise in prevalence of diabetes in the region also saw marked increases in the average body weight of Caribbean women. This phenomenon seemed to have crept up almost imperceptibly before it became sizeable and so glaringly obvious at both the individual level and its wide prevalence in virtually every country in the Region. Indeed obesity, the term applied to body weight in excess of 120% of ideal body weight, is not only endemic but has reached epidemic proportions. Nutritional studies carried out in various English-speaking Caribbean countries with the assistance of the Caribbean Food and Nutrition Institute have revealed that, on average, one out of every two women aged 40 years and over is now obese. What is of added concern is that the prevalence of obesity is continuing to increase (Sinha 1984). Let me add from the gender perspective that excess body weight among men in the region is also a growing phenomenon though still relatively small.

Reasons for the widespread prevalence of excess body weight are not altogether clear. Conventional wisdom is that the problem is basically one of a failure to balance intake and output of calories; but, as many would attest, control of the problem is clearly not as simple as suggested in that statement. It is of interest to note that this creep of obesity on Caribbean women occurred at the same time that the region was focusing on another nutrition-related problem - that of malnutrition among children. A relationship is not implied but is one worthy of note. What is well recognized, however, is that many, if not most, women relate

the onset of weight gain to pregnancy and the child-bearing period in their lives. Such a relationship can be rationalized, but not condoned, and brings into focus the rather complex phenomenon of attitudes and behaviours.

The malignant disorders, previously identified as one of the leading causes of mortality, are a mixed group of diseases but are comprised primarily of cancers. Cancers have their origin in various tissues, are of various types, even though they may arise in the same organ, and both the pathogenesis and behaviour of these disorders are usually the results of an interplay of a number of factors. The second half of this century has seen not only a marked increase in the number of persons affected, but also changes in the patterns of malignancies. These changes have been seen among both sexes. For instance, cancer of the stomach, the leading cancer among both males and females in the region in the early part of the second half of the century, has shown a steady fall in incidence and now occupies third place among the leading cancers of both males and females. On the other hand, and at the other end of the gastro-intestinal tract, cancers of the colon and rectum have been increasing. Among women in the region, cancer of the cervix holds first place and remains one of the most common cancers seen. Marked increases of the incidence of breast cancer however, have made this malignancy a rival for first place. Cancer of the lungs, which was almost never seen among women in the fifties, is now increasingly seen and, although not yet listed as a major cause of death among females (it is, however, a close second to prostate cancer among males), it was identified as far back as the 1970s as the cancer with the most rapidly rising rates among females. Overall mortality from cancers in the English-speaking countries was shown by Persaud (1976) to be greater among women.

In the quest for reasons for the dominance of the chronic noncommunicable diseases, the point was previously made that demographic changes had thrown up a target population for the diseases, but the gallop of the non-communicable diseases in Caribbean countries has been undoubtedly generated, fuelled, and maintained by present day lifestyles and behaviours.

Cardio-vascular diseases and cancers are among the most common causes of premature deaths. Each year large numbers of middle-aged women succumb to these diseases. The older women who survive the onslaught of these diseases in their earlier years are inflicted with disabilities of various types and severity prior to experiencing the same fate of their younger colleagues. Disability is common among the elderly, whether the problem is viewed as one of blindness, strokes, amputation, or cardiac disability. Then there is the less drastic but nevertheless incapacitating disability resulting from osteo-arthritis -- that ageing process in the joints which so limits the activities of so many of the ageing and overweight women. There is yet another major tragedy inflicted by the chronic diseases in older women, and that is the loss of companionship brought about by the demise of her life's partner who had succumbed to one or the other of the non-communicable diseases. Indeed, females make up increasingly larger proportions of the population in the elderly group and many have some form of chronic disability.

## *Adolescents and Young Adults*

The chronic non-communicable diseases do make their appearance in females in the younger age-groups, but the numbers afflicted are relatively small. Diabetes Mellitus is relatively uncommon in persons under 20 years, but the type most frequently seen runs a more aggressive and unpredictable course. Hypertension makes an infrequent appearance in this age-group, but is a major contributor to maternal mortality in the Region. Cancers do make their appearance in persons under thirty and when they do, female cancers are more likely to be seen. Cervical and breast cancers have been taking their toll on women in their 30s. The past twenty years have witnessed an increasing number of breast cancers in young women.

The chronic, infectious diseases, on the other hand, are making a sizable and growing contribution to both death and chronic ill health in the young age groups. To a very large extent, this has resulted from the rapidly-spreading HIV infection. The human T cell lymphotropic virus (HTLVI) which, among other things, can give rise to either a form of leukemia or a crippling neurological disorder, is endemic to the Caribbean and is seen in greater numbers among females (Hanchard et al. 1988). Then there is the added tragedy that each year a number of young women give birth to infants with congenital syphilis.

It has become traditional to include the accident-related disorders in a review of the non-communicable disorders and I crave indulgence to do so in order to make the point that women are increasingly a part of this widening scenario of accidents and violence. This is as true of motor vehicle accidents as it is of domestic violence. Deaths among the young from accidents and violence carry yet another implication for the young women. Male deaths continue to exceed females by a ratio of 2-3:1 and the numbers are growing. Indeed, deaths from accident-related disorders occupy a position among the first five leading causes of death in most countries of the region, and in other parts of the world. This slaughter of young males by accidental death must hold serious social implications for young females.

There is, however, yet another, and possibly greater, reason to focus the beam on the young, particularly the children and adolescents. This is in relation to the chronic diseases. The point has been previously made that the major health issues of the day, to a very large extent, are resulting from lifestyles and behaviours. It is in early life that those habits, those practices, those styles of living, are introduced and inculcated. Indeed, unsatisfactory dietary and physical practices are accounting for an already high and growing level of obesity among adolescent females in the Caribbean.

It is clear that there is an interplay of a variety of factors in the development of the chronic diseases in relation to the burden they inflict on populations. This is true whether the burden is viewed from the perspective of chronic ill-health, disability, or death. The fact that women are bearing a greater share of the burden undoubtedly is in itself a multifactorial phenomenon. What is also clear is that much of the burden of the diseases can be attributed to excess body weight. Indeed, in striving for the control of these diseases in the community, there is no more effective measure which can be taken by women for themselves than the

control of body weight. It follows, therefore, that females in our communities can do much to reduce the very heavy yearly toll taken on their lives by the chronic diseases. The need for them to do so is a particularly pressing one.

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# Impact of Gender Issues on Chronic Diseases

**Henry S. Fraser**[1]

Caribbean countries have experienced a dramatic transition in morbidity and mortality from communicable diseases, to that from chronic, nutrition-related, non-communicable diseases. Knox Hagley and others have estimated that about 40% of adult mortality can be attributed to cardiovascular diseases and diabetes, and that hypertension and diabetes account for at least 20% of primary health care visits (Hagley 1990; Beckles 1988; McGlashan 1982; PAHO 1982). Hagley has also drawn attention to the greater prevalence of hypertension, diabetes, and obesity among women.

The predominance of female hypertension has been well documented (McGlashan 1982; PAHO 1982; Hagley 1990; Beckles 1988). The most recently published survey of hypertension, diabetes, and obesity in Barbados (Foster et al. 1993) showed a marked predominance of female/male obesity (30% : 10%), using a body mass index (BMI) of 30 $kg/m^2$. A larger study carried out as part of the International Comparative Study of Hypertension in Blacks (The ICSHIB Study) has recently been completed. This representative population-based study of subjects aged 25-74 in urban, suburban, and rural Barbados found a similar prevalence of hypertension among men and women, but a much higher prevalence of overweight women. Fifty-nine percent had a BMI of 28, compared to 37% of men. Overweight was shown to be the major predictor of hypertension. Hypertension was almost twice as common in overweight men as in non-overweight men, and more than twice as common in overweight women. Although these data are not directly comparable with the early national nutrition surveys, taken together they suggest a continuing increase in the prevalence of obesity.

Obesity in Caribbean women has traditionally been regarded as a sign of both beauty and good health. In a study on women's attitudes to obesity, it was discovered that while the majority believed they were only a little overweight (compared to actual overweight of 40% greater than ideal body weight), 82% said their partner *would* like them to lose weight. This possible change in attitude might provide the basis of programs designed to encourage lifestyle and behavioural changes among obese women (and men).

The reasons for the predominance of female obesity have not been formally evaluated, although it is expected that the ICSHIB Study will answer many of these questions. It is reasonable to postulate that the Caribbean women's traditional role in the home, where she chooses the menu, cooks the meals, and is generally much less physically active than her

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economically active partner, predisposes her to a calorie intake in excess of energy expenditure. Although relatively more women have entered the labour force over the past thirty years, these jobs have largely been sedentary or related to immobile factor work. Increased earnings and food consumption may compound the problem of obesity.

A strong clinical impression exists, supported by pilot studies, that excessive weight is gained during pregnancy and breastfeeding, and accumulates with each pregnancy. Dr. Anselm Hennnis is currently studying this problem in Barbados, and is investigating the metabolic implications of excess weight gain.

A strong view exists that health promotion strategies are central to the efforts needed to prevent these chronic diseases, to treat them when they are identified, and to prevent their complications. Health education strategies have long been regarded as a priority for the Caribbean (Fraser 1978; Hagley 1990), but have continued to receive minimal political and financial support.

A major task will be to research and evaluate the most cost effective strategies for changing lifestyles in ways that will achieve the goals of primary, secondary, and tertiary prevention. Strategies which have been successful in California or New York will not necessarily be appropriate or effective in the Caribbean. Cultural attitudes, literacy, and media access are all relevant, and health promotion approaches must be sensitive to these issues.

Women are both the major victims and the major agents in tackling the problem of obesity. They remain pivotal in the family structure of the 1990s across society as a whole, as mother, caregiver, and educator. Their role as health educator must therefore be acknowledged and addressed. Strategies which bring health professionals and communities together in cooperation must be developed and tested. Because of the realities of Caribbean society, women have a major role and constitute a major resource in promoting both women's health and the health of the entire population.

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# Discussion

Following the presentations, a general discussion took place on the topic of the Impact of Gender on Chronic Diseases. The following points were raised.

- The attitudes and beliefs people hold about their lives play an important role in perpetuating the incidence and prevalence of some chronic diseases. For example, the presenters pointed out that many women in the Caribbean expect to be ill after the age of 45. They see illness as a natural part of aging, and that suffering from chronic disease and/or disability is the price they must pay for bearing children. The question which arises, is how to motivate these women to expect a healthy life. Women need to be empowered to manage and to take responsibility for their own life and health. Too much dependence on doctors and on medicine has made many people ambivalent about taking care of themselves.

- Lifestyle and behaviour are key indicators for chronic diseases such as hypertension, heart disease, diabetes, and arthritis. Lack of physical activity is one such behaviour. Women may also nibble frequently while preparing meals. There is a clear link between socio-economic status and obesity, which is itself often a predetermining factor for these chronic diseases. Why are there pronounced gender differences in disease prevalence? What predisposes women to obesity more than men? How can we move from knowledge to behaviour change?

- Women are seen as change agents, as being responsible for family health status and health promotion. However, the group agreed that women should not be expected to bear the burden of ensuring family health alone. What strategies can be developed to encourage men to take on some of the responsibility?

- How do women manage health in relation to chronic diseases? Health promotion activities are most often seen in terms of the prevention of communicable infections. What strategies can be developed for health promotion to reduce the incidence of noncommunicable disease?

- Doctors often do not recognize that the symptoms of chronic diseases may be different for women and men. This has contributed to follow-up failures, to inadequate or inappropriate treatment, and sometimes to poor relationships between women and health care workers. Women who do not use PHC services prior to emergency situations face a much increased risk of death. Health care workers must

be trained to recognize the symptoms of chronic diseases in women. The question was raised, how much of the research findings on chronic diseases in women have been transferred to health care workers to sensitize them?

- Ministries of health have failed to translate research data on chronic disease in women to intervention actions and models.

# Working Group Discussions

## Discussion: Cross-Cutting Issues

Discussions held throughout the workshop brought forth a number of issues which cut across disciplinary lines. These issues are outlined below.

- The question was raised, why we are focusing on gender as a classification when other factors such as class and ethnicity also play important determining roles in health status. It was pointed out that while the others are major variables, gender as a determining factor has been ignored until recently. When controlling for class and ethnicity , it can be seen that significant differences still exist between the health statuses of men and women. By using the gender approach, information can be teased out even if a gender-based study had not been the initial intention.

- There are some cases where a woman-specific intervention is appropriate, although this is not always the case. The point was raised that some researchers see "gender" as a buzzword designed to detract attention from women. However, although the participants acknowledged that they need a systematic understanding of the gender perspective, they understood that isolating women out of their social gender context will not work.

- While health is a human right, it has been virtually impossible to get health on the development agenda. Health is one of the major facets of development: economics, housing, education, voting, and so on are all part of health. Development must serve people, not the economic machine. We need to move away from the goal of using people to fuel economic growth alone.

- In part because of structural adjustment, public sector funds, including those for health, have been steadily decreasing. The Caribbean in particular is seen to have serious economic problems; with the pie so small, priorities must be set. How do we make the case for health? Has it been done properly? Do we know how to do it? Who determines if health is a priority issue?

- Policy makers have little sensitivity for or understanding of women's pains and struggles for health. Women must be empowered to take action on their own behalf, especially since it has been found that women are systematically at the bottom of the poverty line, and are not represented in decision-making bodies.

- There is a constant tension between the dominant paradigm and attempts to change. Education/knowledge does not necessarily change behaviour, as there is a whole complex of factors (including gender) which influence behaviour modification. For

example, if a particular society holds that obesity is desirable, then women in that society will be fat. As well, we must recognize that definitions of personal traits vary across cultures; thus, the definition of manhood is different in the Caribbean than it might be in Canada. Researchers therefore need to look at societal norms and behaviours in order to better understand behaviour, while training approaches need to be adjusted to better address the issues. Policy must acknowledge the fundamental role of gender in influencing behaviour, and policy makers and researchers must be willing to practice what they promote. Unfortunately, there is still a large gap between what people know and what they do. How do we change? How do we encourage others to change? Do they want to change? Should we persist (that is, take the top-down approach) if society is not willing to change?

- It was agreed that beneficiaries should be part of any research team, as they can help the team get its message across and better determine what is needed.

- In order to better promote health as a development issue, we need research and hard data. The question was raised, how can we be more effective at moving our interests to the policy level? Researchers need to relate their data to a $ sign, by lowering costs or bringing in more. Researchers have not been able to move to that level, that is, make their research sexy for policy makers.

- Women researchers must do a better job of communicating among themselves, and with policy makers. They should lobby, put pressure on politicians, and raise the awareness of both the public and the politicians.

## An Overview of Conceptual and Methodological Issues in Policy and Research: Working Group Exercises

Following a presentation by Dr. Rosina Wiltshire on the conceptual and methodological issues of gender analysis in policy and research, the participants were divided into two working groups. The task assigned to them was to design a research project to study and enhance the nutritional status of children in a given community. As background to the project, it was stated that a teacher at a particular school believes that the children attending that school are under/malnourished. Visible evidence of malnutrition included fainting, lethargic work habits, and lack of concentration.

## Feedback: Working Group 1

The first working group started by making certain assumptions about the school in which this malnutrition was apparently evident. It assumed that the school was mixed, with both male and female students attending, and that it served the primary grade levels. The first question the group asked itself, was whether both boys and girls were demonstrating the same symptoms. Answering this question would involve first-level contact with the teacher who reported the malnutrition, questioning her about her observations, and making personal observations of the children. The working group agreed that if the research team could verify the teacher's observations, a clear definition of (mal)nutrition was needed, in both a technical and clinical sense.

The next step was to check the children for clinical evidence of malnutrition, likely through blood tests. Once the malnourished children were identified, they would be matched by age and sex with adequately nourished children (who would act as a control), to measure household levels of malnutrition.

The group agreed that it would be useful to plot households containing malnourished children onto a map, to determine if there was any geographic significance to malnutrition in the region. If all the malnourished children were coming to school from the same geographic area, it was felt that the research team might be better able to focus on a particular cause.

In order to examine malnutrition at the household level, the group prepared a list of factors which it felt should be studied. Where appropriate, the data is to be disaggregated by sex.

- income available for food
  - who decides what money is to be spent on food
  - who decides what food is bought
  - what types of food are bought

- who cooks and what is cooked
  - what is health status of cook
  - where are, and what is status of, cooking facilities
  - is there access to water and fuel
  - are sanitation facilities available

- knowledge, attitudes, and behaviours regarding eating patterns
  - who gets what portions
  - what are cultural and religious norms concerning what foods may be eaten

- household characteristics (ie. single parent; child living with grandparents; number of children in family; age order of children by sex)
  - what are the roles of individual family members
  - what is the education level of each family member
  - how severe are parasite levels in each family member
  - other factors such as transportation, influence of media

Finally, the group agreed that two important factors need to be considered to ensure that the research team gathers the best possible information. The first concerns the composition of the research team. Not only is it important to assure that the team is interdisciplinary (that is, includes sociologists, anthropologists, nutritionists, medical staff, and so on), but perhaps more importantly, that both male and female researchers take part in the study. The group felt that some family members might be unwilling to answer the questions of researchers if they are of the opposite sex. There might be cultural taboos against male researchers speaking with female family members. The involvement of both male and female researchers might help to ease some of the traditional problems faced by male researchers alone.

The second point raised by the group was the possibility that family members responding to the questions might provide the answers that they believe the researchers are looking for, rather than the truth. The group was unsure how to resolve this potential problem.

Interventions suggested by the group focused on school feeding programs and long term community-wide education on adequate nutrition intake.

## Feedback: Working Group 2

The second working group followed a process similar to that carried out by the first group. The first step identified by the group was to diagnostically confirm the observations of the teacher. Who in the school appeared to be affected by malnutrition (that is, boys or girls)? What symptoms did they exhibit? Clinical tests would be carried out on the children, and discussions would be held with community members to confirm general nutritional status within the community as a whole. Does malnutrition appear to be a chronic problem, or is it an anomaly? A general village profile would be created, then disaggregated into a more detailed profile at the household level.

At the household level, the group agreed that several indicators needed to be examined in a participatory, consultative manner.

- economic status of the family
    - how much money is available for food
    - who is the head of the family

- health status of family
    - what is mother's perception of child's nutritional status
    - who are the caretakers at home
    - who makes decisions about what to eat

- do the children show a pattern of absenteeism from school and/or lateness
    - how far do children have to walk to school
    - do the children have shoes
    - do they take their lunch with them, buy it, or do without
    - what other chores are the children responsible for

As in the first working group, this group agreed that the research team must be interdisciplinary in nature, including such professions as social anthropologist, medical doctors, psychologists, and nutritionists. The group raised the issue whether a separate dietary research questionnaire needed to be produced and applied.

While the group did not suggest an appropriate intervention, its members did raise a number of issues for consideration in devising intervention strategies:

- a participatory, consultative approach is necessary to give the community a sense of ownership of process
- the research team should investigate sources of funding before it proceeds with the study, to ensure that it will not have to abort the process before it is completed
- both short- and long-term interventions are needed

# Identification of Research Gaps: Removing the Policy Barriers

Following the plenary presentations and discussions, which had been organized along disciplinary lines, the workshop participants were asked to take part in a three part process to identify the research gaps as they pertain to gender analysis in the Caribbean.

The first part of this process involved a general discussion of research gaps and policy impediments to research. The participants were then divided into two groups, each of which was asked to take the generic lists and adapt them to their own areas of research. That is, the groups were asked to make the general lists more specific so that research and policy issues could be drawn from them.

Finally, a small group of workshop participants was asked to take the findings from the two groups, and to prepare a research agenda for the Caribbean which could be presented to CARICOM, regional governments, universities, and/or donor agencies.[1] This agenda was then brought back to the group, where it was discussed and refined.

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[1] The initial draft of this paper was prepared by Asha Kambon, Merle Lewis, Candia Richards, Beverly Barnett, Winsome Segree, Wynante Patterson, and Monica Davis.

## Identification of Research Gaps

The participants identified the following issues as gaps in research relating to gender analysis in the Caribbean.

- multidisciplinary teams are not regularly being used for research
- women-centred approaches to research which address system issues such as access and continuation of care are not being utilized
- data which reflects demographic reality (such as the growth of the elderly population) is not being systematically collected
- methodologies for measuring the gender biases to, and implications of, access to and availability of health care services are not regularly being employed
- data to reflect the conditions and health status of those working in the unpaid/informal sectors is not being collected on a systematic basis
- better management and understanding of morbidity and disability data reflecting unpaid work is needed
- knowledge about sector-specific health problems is being increased only slowly
- research on the utilization of resources by the elderly needs to be expanded
- research to better understand, measure, and evaluate the impact of health care workers on the status of community health is lacking
- research to validate, integrate, and evaluate the benefits and/or disadvantages of traditional food production and cooking practices is needed
- knowledge on the benefits and/or disadvantages of public versus private health care services (in terms of access, quality of care, and effectiveness) is generally lacking
- information on the impact of NGOs on the lives of the elderly is lacking
- knowledge about the impacts of levels of access to contraception by rural and urban populations needs to be increased

## Policy Barriers

The participants identified the following barriers to linking research to policy in the Caribbean.

- research is often not policy-oriented or relevant to policy makers
- women have historically played only a minor role in policy formulation
- research results have traditionally not been well marketed (that is, they are not "sexy")
- researchers have not done a good job of gaining the support of NGOs for research results
- the reporting style of labour force data is not conducive to research on the informal and unpaid sectors, which in turn makes it difficult for researchers to convince policy makers of their findings
- links are not being established between poverty, the environment, and health policy
- the notion of development has not been integrated into program delivery at the policy level

# Feedback: Working Group I

The first working group began by attempting to understand what is meant by "research gap". It was agreed that the term refers to something that is missing or lacking in both research processes and priorities. The group then went on to identify what it felt were the most important research gaps, and categorized them by type of gap.

## *Data Collection*

- lack of extensive data analysis
- omission of multiple variables in data collection, including age, sex, and occupation
- lack of indicators which are responsive to the roles of men and women

## *Research Design*

- lack of an intersectoral/multidisciplinary approach
- lack of studies undertaking a multi-country approach in order to complement and strengthen national capacities
- lack of complementary incorporation of qualitative and quantitative approaches, such as ethnographic surveys
- lack of incorporation of policy implications and intervention planning into research proposal designs
- lack of long-term visioning in research design

## *Research Issues*

Demographic transition analysis is needed for a better understanding of population structures and their implications for health care, retirement, and allocation of resources. Three areas were highlighted as deserving special research attention: adolescent health care, young adult health care, and health care for the elderly. In addition, the group pointed out that research and publication of results is needed on what works.

### *Adolescent Health*

- analysis of risk factors associated with behaviour and lifestyle, including sexuality
- analysis of education and information processes which shape attitudes and behaviours
- analysis of health and nutrition needs, particularly as they relate to the transition to adulthood and to obesity

*Young Adult*

- analysis of reproductive health issues
- analysis of occupational health issues
- analysis of social health issues, including lifestyle and weight control

*Elderly*

- analysis of disability and decreased mobility
- analysis of mental health as it relates to the elderly
- analysis of the transition of care taking roles
- analysis of the aging process and related disorders, disaggregated by gender
- analysis of the elderly as a resource

## *Policy Implications*

- gender health-related issues must be included in census activities
- effective strategies should be developed for social marketing of research results, to translate findings into policy formulation
- networking should be encouraged between researchers, policy makers, health officials, and practitioners
- a better understanding of the policy making process is necessary
- lifestyle concepts should be infused into the formal education system, for example, by including sexuality in biology classes, and weight and nutrition in mathematics classes
- greater use should be made of the electronic and print media and of non-formal street theatre for social communication
- existing informational material for public health education should be compiled and evaluated
- the strategies outlined in the Caribbean Charter should be incorporated at all levels
- ministries of health should make presentations and endorsements of research results

## Feedback: Working Group II

The second group began by stating that research must be based on sound epidemiological principles and include social, behavioural, and economic analyses and approaches. It must be multidisciplinary, participatory, gender sensitive, and result in user friendly outputs. The outputs should be shared widely to guide further research and result in actions which will ensure equity and benefit the health of all.

The group then went on to identify a number of research gaps, impediments to research, and policy blocks.

### *Research Gaps*

- work-related health issues in both the formal and informal work sectors
- gender sensitive analysis of violence and injury
- situational analyses of existing data on non-communicable diseases with a view to determining causes of any differentials identified and future directions for research
- appropriateness and quality of health care, particularly with regard to indigenous peoples
- role of traditional medicine, as different from western medicine
- factors affecting compliance and utilization of services
- concepts, indicators, and perceptions of wellness

### *Impediments to Research*

- lack of resources (human, financial, and infrastructure)
- inadequate databases
- lack of information with regards to where and how data can be accessed
- lack of standardization of data and data collection
- variance of agenda and priorities among politicians, policy makers, and researchers
- lack of national policy statements on a particular area

### *Policy Blocks*

- lack of political will
- political disorder, turf wars
- lack of information transfer to inform policy
- influence of extra-regional decisions on local policy

- ineffective use of the collective political power of the people
- weakness of leadership and advisors
- recommended actions may be inappropriate or not feasible
- lack of understanding or acceptance of paradigm shift from the disease model to the health and wellness model

# Caribbean Research Agenda

## *Background*

The Pan American Health Organization and the International Development Research Centre convened a workshop on Gender, Health, and Sustainable Development in Barbados on 6-9 December 1994. This workshop recognized as its framework the priorities identified in the Caribbean Cooperation in Health (CCH) Initiative, and focused on health-related issues related to those in the Caribbean Charter for Health Promotion, which was mandated by the Ministers of Health at their Conference in 1992 and further developed in 1993. These issues included human reproductive health, chronic diseases, food and nutrition, environmental and occupational health, strengthening health systems, and STDs/HIV/AIDS. The workshop also noted the important strategies enunciated in the charter as they relate to gender, health, and sustainable development. These strategies are

- formulating healthy public policy;
- reorienting health services;
- empowering communities to achieve well-being;
- creating supportive environments;
- developing/increasing personal health skills; and
- building alliances, with special emphasis on the media.

The gender concept as suggested by the Economic Commission for Latin America and the Caribbean and the Caribbean Development and Cooperation Committee (September 1994) makes it possible to distinguish biologically-defined sexual differences between women and men, from the culturally-determined differences between the roles given to or undertaken by women and men in a given society. This concept focuses then on relations which are socially constructed and not biologically defined.

Recognizing the dynamics of regional development and the growing impoverishment of the population, the workshop concluded that:

> ...research in support of these issues must be based on sound epidemiological principles, and include social, behavioural, and economic analyses and approaches; it must be multivariate, multidisciplinary and participatory; it must reflect life experiences, be gender responsive and use gender sensitive indicators; its analysis, both quantitative and qualitative, must point to the differentials between men and women, across racial, ethnic, class, and religious strata; and it must result in outputs which will facilitate decision-making, ensure equity, and benefit the well-being of all.

The task of the workshop involved the identification of deficiencies in research for gender, health, and sustainable development. As a result, a Caribbean research agenda was formulated for your urgent consideration and implementation which prioritizes research issues to be examined, outlines key policy issues, and presents recommendations for action.

## *Priority Areas for Research*

Although each of these areas has been presented separately for clarity, they are in fact strongly integrated.

### *Poverty*

- differential impact of disparities in income of women and men on family health, life, and identification of intervention strategies
- gender implications of the link between environmental health risks and poverty

### *Reproductive Health*

- socio-cultural determinants of reproductive health

### *Violence and Injury*

- causes, impacts, and gender implications of the culture of violence prevalent in Caribbean societies, with special reference to households, work places, and schools

### *Nutrition*

- causes of gender differentials in the incidence/prevalence of obesity in the middle-aged population
- gender implications of acquiring food security in the Caribbean
- nutritional requirements and the impediments to meeting the needs of different age groups

*Chronic Non-Communicable Diseases*

- situational analysis of existing data to determine the causes of any gender differentials identified and to recommend possible directions for future research

*Work Related Health Issues in the Formal and Informal Sectors*

- examination of health-related factors affecting and resulting from increasing/ decreasing participation in the labour force

- analysis of support services, from a gender perspective, available within a work environment such as: daycare, breast-feeding facilities, food choices, and recreational facilities

*Appropriateness and Quality of Health Care*

- special emphasis on marginalised, displaced groups and indigenous people

*Role of Traditional Medicine*

- extent and efficacy of practice in the Caribbean region

- conduct of a knowledge, attitude, practices, and beliefs (KAPB) study on traditional medicine

*Gender Factors Affecting Compliance and Utilization of Services*

- gender-based impact of changing health care financing mechanisms

- knowledge, attitudes, beliefs, and practices (KAPB) related to gender in the provider-client relationship

*Existing Perceptions and Indicators of Wellness*

- perceptions, definitions, and indicators of wellness within the population

*Changing Population Structure and Distribution*

- socioeconomic impact of the demographic transition, and its implications for health, such as the changing dependency ratio, decreasing fertility, and the role of the elderly as care givers and providers

- capacity of the population at individual and institutional levels to achieve and sustain health

## *Key Policy Issues*

- increasing information exchange among researchers, policy makers, health officials, practitioners, and the community

- understanding and accepting the paradigm shift from the disease model to the health/wellness model

- collecting adequate aggregate data for formulating policy and facilitating research on gender, health, and development issues at national and regional levels

- improving the utilization of existing data sets (including census data) to inform policy vis a vis gender, health, and development issues, both at the national and regional levels

- creating political commitment to strengthen the intersectoral and multidisciplinary approaches required for the development of sustainable policies

- ensuring that the formal and informal health and family life education programs present and discuss lifestyle issues from a gender perspective

- infusing lifestyle concepts and the importance of supportive systems within the formal and non-formal education systems

- routinely utilizing gender analysis in the formulation of policy and programs, and using gender sensitive social communication and marketing approaches in their execution

- collaborating with the electronic and print media to enhance the dissemination of messages which impact positively on gender, health, and development

- involving non-governmental organizations (NGOs) in the collaborative process, and in the design, implementation, and evaluation of programs

## *Recommendations for Action*

The recommendations listed below are addressed to the following key executing agencies which need to address both their internal and external environments:

- **Governments and their Ministries**
- **Caribbean Development Cooperation Committee**
- **Caribbean Community Secretariat**
- **Commonwealth Caribbean Medical Research Council**
- **Organisation of Eastern Caribbean States Secretariat**
- **Pan American Health Organization/World Health Organization**
- **International Development Research Centre**
- **The University of the West Indies**

### *Internal Environment*

- Training should be provided to foster a better understanding of
    - the paradigm shift from the disease model to the health/wellness model;
    - the mechanisms for using an integrative approach, including the involvement of NGOs and the media, and noting the importance of negotiating and conciliatory skills;
    - the dynamics of the current development environment;
    - the necessary communication skills; and
    - the means of presenting information to influence change.

### *External Environment*

- Strategies should be generated to ensure the integration of health and wellness into sustainable development.

- Existing regional policy research-oriented institutions, such as CCMRC and ISER, and the Women and Health Focal Points should be strengthened to promote and support gender-sensitive analysis in preparation for the 1996 Conference of the Ministers of Health.

- All health training programs should be reoriented to ensure greater sensitivity to the social and gender aspects of health, including the training/retraining of health care providers.

- Closer collaboration among researchers, Government, and NGOs should be encouraged to improve monitoring capabilities.

- Gender-specific health items should be institutionalized in the census instruments that will be administered from the year 2000.

- Significant problems/issues common to the region should be identified in order to galvanize intersectoral linkages. Examples of such issues are:

    - poverty alleviation
    - violence and health
    - chronic non-communicable diseases
    - food security
    - alternative health care financing mechanisms

# Appendicies

# Overview of PAHO's Women, Health, and Development Project in the Caribbean

**Hazel Cheltenham**[1]

## *Introduction*

The Women, Health, and Development (WHD) project, funded by the Carnegie Corporation, is designed to increase the gender sensitivity of health policies, programs, and projects in the Commonwealth Caribbean. This project represents only part of a wider project formulated at a regional meeting held in Trinidad in 1992. Each of the countries represented identified the need to strengthen the capacity of national women, health, and development focal points to ensure that women's issues are considered in the process of gender analysis and planning.

The topic "women, health, and development" has occupied the attention of the Pan American Health Organization (PAHO) for many years. However, the subject is assuming increased importance as several resolutions now address the issue. In 1981, a special subcommittee of the PAHO executive committee was created to deal with issues related to WHD. At the 34th meeting of the Directing Council, PAHO adopted a resolution specifically requesting the member governments to strengthen and support the national focal group for the WHD program, and to facilitate the necessary resources to more adequately and effectively implement the program's regional strategies.

Concomitant with PAHO's thrust, the Ministers of Health in the Caribbean have specifically addressed the WHD relationship. At the 12th Health Ministers Meeting in Barbados in 1990, the Health Ministers approved the Caribbean WHD Plan of Action 1990-1994.

## *What are the Goals of the Plan of Action?*

- to strengthen the capacity of countries in the development of gender sensitive health policies and programs;
- to improve the identification of principal health problems affecting Caribbean women, and the development of gender specific indicators;
- to ensure the availability and accessibility of health services appropriate to the needs of Caribbean women;

[1] PAHO/WHD, Bridgetown, Barbados.

- to facilitate the ability of women to make informed decisions and take appropriate action regarding their own health; and

- to promote good mental health as an essential element for total well-being, with particular emphasis on its significance for women.

In addition, the project will have two main outputs.

- Gender training programs aimed at imparting information and techniques to assist national focal points to:

    - encourage governments to introduce gender analysis routinely in the evaluation of policies, programs, and projects;
    - develop strategies for advocacy, collaboration, and outreach; and
    - identify gender-related factors affecting health and their links to development.

- The production of audio-visual materials which will strengthen the capacity of the WHDFP to disseminate documentation on WHD issues.

To date, PAHO has focused on providing gender training to senior health planners, national focal points, representatives of the Women's Bureau/Desk, and officers of the governments' Central Planning Units, where the latter exist. PAHO has also embarked on the development of a gender training manual which, when completed, will provide the basic tool used for gender training in Caribbean countries. The manual has been reviewed and updated by a number of groups and organizations involved with WHD. To ensure that the document responds to the needs of the Caribbean both in its content and methodological approach to training, PAHO engaged three counties in a pilot workshop in July 1994, and conducted a regional Trainer of Trainers Workshop in November.

It is necessary to recognize the need both to clarify the many concepts relating to gender, health, and development, and to provide participants with skills in gender analysis and planning. A specific methodology is being used as the tool of analysis. To date, participant evaluation has been positive.

The need for such a project has been well articulated by the participants, as it is geared primarily to policy change. One significant feature of this project relates to its development by countries based on their own needs. It is expected that at the national level the recipients of the WHD gender training will be equipped to:

- undertake gender analysis of health programs and projects;

- discuss with some degree of confidence the relevance of gender in health with special reference to the Caribbean; and

- formulate, monitor, and evaluate gender responsive health policies, programs, and projects.

Many organizations and agencies are currently involved in the execution of women and development projets. PAHO's aim is not to duplicate the effort. In the context of the present Caribbean economics, the undesirability of this is self-evident. As we face the challenge of improving the health and status of women in the region, we must continue to collaborate and maximize our resources as we strive to alleviate gender inequalities in the Caribbean.

## GENDER, HEALTH AND SUSTAINABLE DEVELOPMENT WORKSHOP

**Bridgetown, Barbados**
**December 6-9, 1994**

# AGENDA

Tuesday December 6

| | |
|---|---|
| 8:00-8:45 | Registration |
| 9:00-10:30 | *Welcome and Opening Address*<br>**Hon. Elizabeth Thompson**, Barbados<br>**Karen Sealey**, Barbados |
| 10:45-12:00 | *Participant Introduction*<br>**Hazel Cheltenham** |
| 12:00-13:30 | *Global Commission - IDRC Perspective*<br>**Janet Hatcher Roberts** |
| 12:30-14:00 | Lunch |
| 14:00-15:00 | Plenary 1 - *An Overview of Conceptual and Methodological Issues in Policy and Research for Gender and Health*<br>**Rosina Wiltshire**<br>Discussion |
| 15:00-15:15 | Coffee break |
| 15:15-16:30 | Plenary 2 - *Panel Discussion*<br>*Gender and Health Programs and Concepts - Case Studies*<br>**Rosina Wiltshire** |

Wednesday December 7

| | |
|---|---|
| 8:30-9:15 | Plenary 3 - *Gender Issues in Caribbean Health Systems*<br>• **Dr. Pat Rodney**, Canada<br>• **Nan Peacock**, Jamaica<br>Discussion |

| | |
|---|---|
| 10:15-10:30 | Coffee break |
| 10:30-10:45 | Discussion continued |
| 1045-11:30 | Plenary 5 - *Focus Presentations*<br>*Gender, and Environmental and Occupational Health*<br>Chairperson: **Christine Barrow**<br>• **Monica Davis**, Trinidad<br>• **Winsome Segree**, Jamaica<br>• **Kamala Dickson**, Jamaica<br>Discussion |
| 12:30-13:30 | Lunch |
| 13:30-14:00 | Plenary 6 - *Focus Presentation*<br>*Gender and Human Reproductive Health*<br>• Asha Kambon, Trinidad<br>• Wilma Bailey, Jamaica<br>Discussion |
| 14:45-15:00 | Coffee break |
| 15:00-16:15 | Plenary 7 - *Focus Presentation*<br>*Impact of Gender Issues on Chronic Diseases*<br>Chairperson: **Barbara Bailey**<br>• **Knox Hagley**, Jamaica<br>• **Henry Fraser**, Barbados<br>Discussion |
| 16:15-16:30 | *CARICOM's Role and its Initiatives*<br>**Cynthia Ellis** |
| 16:30-16:45 | *Overview of Activities of Day Two and Introduction of Format for Day Three*<br>**Janet Hatcher Roberts** |

Thursday December 7

| | |
|---|---|
| 8:30-10:30 | *Identification of Resesarch Gaps - Removing the Policy Barriers*<br>Chairperson: **Janet Hatcher Roberts** |
| 10:30-10:45 | Coffee break |

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|---|---|
| 10:45-12:00 | *Working Groups continued* |
| 12:00-13:30 | Lunch |
| 13:30-14:45 | *Working Groups continued* |
| 14:45-15:00 | Coffee break |
| 15:00-16:15 | *Plenary Feedback*<br>Chairperson: **Hazel Cheltenham** |

Friday December 9

| | |
|---|---|
| 8:30-10:30 | Plenary 8 - *Working Groups - Feedback and Discussion*<br>Chairperson: **Hazel Cheltenham** |
| 10:30-10:45 | Coffee break |
| 10:45-12:00 | Plenary 9 - *Wrap-Up, Conclusion, and Follow-Up*<br>• **Silvio Gomez**, IDRC<br>• **Karen Sealey**, PAHO |

## GENDER, HEALTH AND SUSTAINABLE DEVELOPMENT WORKSHOP

**Bridgetown, Barbados**
**December 6-9, 1994**

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