



LISTENING TO VOICES THAT MATTER: PLACING WOMEN'S CONCERNS AT THE CORE OF HEALTH PROGRAMMES^β

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INTRODUCTION

One of the hallmark achievements in the world today is the increasing recognition that the health of women is central in the development process. Many individuals, governments, non-governmental organizations (NGOs), corporations, policy-makers, and even multinational corporations today talk of increasing women's access to affordable quality health. They pronounce their commitment to ensuring women's full participation in decisions, including the development of health policies and programmes, and empowering women to protect and care for themselves. Their commitments extend to maternal and infant mortality, HIV/AIDS and other infectious diseases. Thus, at least at the level of rhetoric, there is a growing consensus that women have claims to social arrangements that protect them from the worst deprivations and abuses.

The seeming 're-awakening' towards women's interests is against the background of various international concerns that have been expressed in various fora and documents. For example, the International Convention on Economic, Social and Cultural Rights (1966), the Convention on the Elimination of All Forms of Discrimination Against Women (1979), and the African Charter on Human and Peoples' Rights (1981) called for recognition of women's rights. The 1987 Safe Motherhood Conference in Nairobi, in its 'Call to Action', recognized that:

...the causes of poor health among women and their children are deeply rooted in the adverse social, cultural, political, and economic environment of societies characterized by widespread poverty, lack of educational opportunities, and substandard living conditions, among other factors. They are especially rooted in the environment that societies create for women, who are discriminated against in terms of legal status and access to food and proper nutrition, education, employment, financial resources and health care. This discrimination begins at birth and continues through adolescence and adulthood, where women's contributions and roles are ignored and undervalued (Isaac S. et. al. 1987)

More importantly, since the 1994 Cairo Programme of Action, the 1995 Beijing Platform for Action, the WHO's Women's Health and Development Programme (1998), the Commonwealth Plan of Action on Gender and Development (1995), and the International Planned Parenthood Federation's Charter on Sexual and Reproductive Rights (1999) significant gains have been made in women's rights, gender equality and reproductive health issues in most parts of the world. The right of women to live longer and in a less stressful environment and their right of women to survive and enjoy their lives is in the context of enhancing women's capabilities, that is, expanding their choices and opportunities so that they can lead a life of respect and value. No wonder, the agenda for sustainable human development places women's health and access to resources at the centre. However, the rosy picture stops at pronouncements and much remains to be achieved.

WHAT IS AMISS?

Positive developments in working towards recognizing the needs of women apart, we still live in a world in which women are placed at the margins of health programmes. In most regions of the world where both the development crisis and patriarchal structures remain endemic, health care systems are still largely insensitive to women's health needs. The availability of advanced medical technology and the overall increase in life expectancy have not fundamentally reduced the inequalities that women face in health status and treatment.

We live in a world where women still face immense health risks compared with men. Women's ability to avoid being victims of disease and their capacity to access and effectively utilize health services is very much limited by the prevailing power relations. Throughout the 'developing world', in particular, millions of women are vulnerable to chronic respiratory disorders that are closely associated with the smoke they inhale as they prepare meals they hardly have time and energy to enjoy.

Millions of women still lack access to health resources, safe water and adequate sanitation. Imagine a world in which approximately 15 million young women aged 15-19 give birth every year, accounting for more than 10 percent of all births worldwide. In sub-Saharan Africa and South Asia 50 percent of young women have at least one child by the age of 20. In some countries, 1 out of 7 women die from pregnancy related causes; the risk is three times as high for women under 18 than for women aged 20-29 (World Bank 2002).

UNRESPONSIVE HEALTHCARE

In much of Africa, particularly Uganda, health care systems are still insensitive to women's health needs. The voices of a few women who have experienced deprivation and loss as a result of sexual discrimination speak volumes. Perpetua, a sister to Rhoda who died while delivering her third born at a mere age of 18, laments: a mere age of 18, laments:

Rhoda was too young to marry, later on deliver three children in a period of five years. Her health became fragile the more children she produced. But society demanded that she keeps producing. She paid with her dear life only for the husband to replace her with Martha who has since produced two children in less than three and a half years (Perpetua 2003)

Anna, 23, narrates:

One day, I felt dizzy. I went to hospital, was made to line up despite my condition. While lining up, two men came and joined the line ahead of me. The person who was supposed to supervise the line simply told me not to complain because I did not have any money to tip him. By the time I saw the medical officer, I was nearly collapsing. The medical officer prescribed medicine, which I could not afford then because my husband had spent most of the money we had got from the sale of beans looking after her mistress in the trading center (Anna 2003).

Barbara highlights the problem of women's health and marginalization from a different perspective. She says:

When you talk of good health for women, you are dreaming because many of us are poor, we cannot afford even the few health service that are available. Even when there is free medicine at the clinic, how many of us can manage to walk twelve kilometers, or give up attending our gardens and looking after children so as to go to the clinic? I always request my husband to ride to the clinic and collect the medicine. I cannot force him to go. Twice he refused and I used the herbs (Barbara 2003).

The cries contained in these voices show that women continue to suffer inequalities in many forms, including inequalities in health status, access and treatment, despite the daily rhetoric of gender-sensitive programmes. Their suffering is reinforced by available evidence. For example, unintended pregnancies among teens account for at least 2 million unsafe abortions each year; annually an estimated 76,000 women die from unsafe abortions. Half of the 34 million HIV-infected persons worldwide are under 25 years of age, and the majority are women.

Poor reproductive health services

The high incidence of unwanted pregnancies, abortions and STDs among young women seriously affects their lives. Early pregnancy and childbearing are typically associated with less education and lower future income for young mothers. Many of the health problems young people face are preventable through appropriate education and information and access to services. However these are still rare for most women.

Sexual and reproductive health is of importance not only in the context of health programmes but for all projects and strategies working with young women in particular. The Action Programme of the International Conference on Population and Development in Cairo in 1994 defines reproductive health as a state of complete physical, mental and social well being in all matters relating to the reproductive system. This implies that women are able to have satisfying and safe sex life; they have the capability to reproduce; they have the freedom to decide if, when and how often to reproduce. They also have the right to be informed, have access to safe, effective, affordable and acceptable methods of family planning of their choice, and the right of access to appropriate health-care services.

Sexual and reproductive rights include information about sexuality, contraception, sexually transmitted diseases (STDs) including HIV/AIDS, pregnancy and delivery, gender roles, domestic violence and abuse, as well as access to contraception including condoms, STD diagnosis and treatment, prenatal and post-delivery care, safe delivery and emergency care, safe abortion and prohibition of female genital mutilation. We must note that legal and social obstacles often prevent young women from gaining access to reproductive health services and information, thereby rendering them victims without choice. Consequently, millions of the women in the world today do not enjoy these opportunities and are denied these rights.

Women generally face discrimination and harassment in access to available health services, neglect in their specific needs, and lack control over time, money and infrastructure. The opportunities and rights of women are also fundamentally undermined by insecurity and violence they are subjected to without appropriate health programmes to address these threats. Add to this the fact that health systems hardly recognize and address the impact of unequal male-female power relations on women's health risks and health-seeking behaviour, the situation becomes daunting. Around the world on average, about one in every three women has experienced violence in an intimate relationship, while thousands are subjected to rape and sexual coercion both in homes and in conflict-ridden areas. Consequently, many suffer serious health problems such as sexually transmitted diseases (STDs), HIV/AIDS, depression and anxiety. Worldwide, more than 1.2 million women and girls under 18 are trafficked for prostitution each year. Very few health programmes tackle the question of women's marginalization, which is the major breeding ground for women's disorders.

The patriarchal culture

Our societies are so predominantly male-oriented and most health programmes are so unfriendly to women that many women find it difficult to gain self-confidence and drive that are necessary in seeking medical help, let alone demand the good health they are entitled to. The under valuation of self partly has its roots in the colonial health system which put emphasis on providing medical care to the colonial staff that was overwhelmingly male. Peripheral health care for the majority of women was only considered urgent in the event of infectious diseases such as plague, sleeping sickness, small pox, malaria and syphilis. Even then, these were often blamed on women.

Like in other sectors, the male-orientation of health programmes received little attention until very recently. The harsh economic realities that have afflicted most African countries since independence have coupled with the patriarchal biases to render women helpless even when their health needs demand attention. Worse still, women are socialized to be submissive; they are denied opportunity in decision-making, and have limited access, if any, to resources and developmental issues. These limitations act as real obstacles in the women's choice of desirable and suitable health resources.

Women are always fully occupied, overworked with household chores, and have competing demands for their time. They are also regarded as social objects and property of men to the extent that their health needs are defined by others. In some places in Uganda, it is quite common to find husbands blaming wives and daughters for the dirt, unsafe water, poor sanitation, and poor nutrition in the household. This is the culture of blaming the slave for the ills prevailing in society.

WHAT IS TO BE DONE?

A fundamental break with the male-dominated thinking and practice in health care needs to be made so that women's concerns are placed at the core of health programmes. Health programmes must take full account of women's biological, social and cultural situation within the overall power structure. They must recognize women's individuality and collectivity, their desire to be treated with dignity and respect and the right to be treated as equal partners in decisions about their own health care.

We must put women's concerns at the centre of health programmes by developing women-friendly policies and increasing the number of women professionals in the health establishments. Both the programmes and staff must care for women's quality of life. We must intensify efforts towards sensitizing communities and leaders on the women's rights, women's specific health needs and women's invaluable contributions to society. This necessitates that the socio-economic and political thinking makes a real 'u-turn' and considers women as equal partners in the ownership of major means of production.

In addition to gaining full access to wealth and household incomes, women need opportunities to influence the formulation of health policies. Women's larger concerns, including access to safe water supply, sanitation and fuel, problems of single women, aged women, commercial sex workers, questions of risk factors and determinants, access to and control over resources such as money, transport and time, must be the focus of research funding, epidemiological studies and clinical trials. We must go beyond the traditional reproductive issues of pregnancy, childbirth and contraception, important as these might still be.

Women-friendly health programmes entail paying serious attention to existing gender differences, issues and inequalities and incorporating them into strategies, actions and services so as to improve women's health. The guiding principle should be: women, individually and collectively, must be treated with dignity and respect; there has to be a conducive atmosphere in which women make informed decisions; women must be facilitated to become equal partners in decisions about their own health care; women must be provided the opportunity to be heard as far their health concerns are concerned. All stakeholders need to realize that women's access to independent resources is vital in enabling them to access and use health services. Women, individually and collectively, must stand up and challenge structures and thinking that keeps them on the margins of society, by advocating for and spearheading the development of women-friendly health care systems.

Finally, we must realize that women's health needs cannot simply be met by erecting health facilities near where they happen to live. Rather, it requires removing barriers that women face as individuals and as a collective. This, in turn, requires a persistent, resolute, and fundamental struggle against the existing hegemony of patriarchal norms and structures that do not allow women to decide on their own priorities, including their own health, sexuality and reproduction. This is a struggle whose objective is to establish a society in which the principles of equality, equity, empowerment and emancipation are pivotal.

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