# Tant qu'on a la santé

## Les déterminants socio-économiques et culturels de la santé dans les relations sociales entre les femmes et les hommes

Textes réunis par
Yvonne Preiswerk

Commission nationale suisse pour l'Unesco, Berne

DDC, Direction du développement et de la coopération
Département fédéral des affaires étrangères, Berne

IUED, Institut universitaire d'études du développement, Genève

1999

THE GRADUATE INSTITUTE GENEVA

INSTITUT DE HAUTES
ÉTUDES INTERNATIONALES
ET DU DÉVELOPPEMENT
GRADUATE INSTITUTE
OF INTERNATIONAL AND
DEVELOPMENT STUDIES

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**Yvonne Preiswerk et Mary-Josée Burnier (dir.)**

DOI : 10.4000/books.iheid.6048
Éditeur : Graduate Institute Publications
Année d'édition : 1999
Date de mise en ligne : 5 juillet 2016
Collection : Genre et développement. Rencontres
ISBN électronique : 9782940503759

**Édition imprimée**
Nombre de pages : 279

**Référence électronique**
PREISWERK, Yvonne (dir.) ; BURNIER, Mary-Josée (dir.). *Tant qu'on a la santé : Les déterminants socio-économiques et culturels de la santé dans les relations sociales entre les femmes et les hommes.* Nouvelle édition [en ligne]. Genève : Graduate Institute Publications, 1999 (généré le 25 juin 2019). Disponible sur Internet : <http://books.openedition.org/iheid/6048>. ISBN : 9782940503759. DOI : 10.4000/books.iheid.6048.

# Tant qu'on a la santé. Les déterminants socio-économiques et culturels de la santé dans les relations sociales entre les femmes et les hommes

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ANNE ZWAHLEN, CLAUDINE SAUVAIN

# A LA MÉMOIRE D'YVONNE

Yvonne Preiswerk, chargée de cours à l'IUED, a fait largement en sorte que se développe dans cette institution une attention plus aiguë aux relations sociales hommes-femmes comme thème fondamental de la coopération au développement. Trois autres colloques sur le thème du genre ont précédé celui consacré à la santé. Et depuis peu, le genre fait partie de l'enseignement de base à l'IUED.

Yvonne Preiswerk est décédée brusquement en avril dernier et nous aimerions ici la remercier de ce qu'elle a été et continue à être pour tous ceux et celles qui ont eu le privilège de partager un bout de chemin avec elle.

Comme femme, comme chercheuse et comme enseignante, la prise en compte des relations de genre s'est toujours imposée à Yvonne à la fois comme une évidence et comme une exigence. Comment, sans cela, bien comprendre les sociétés dans lesquelles on travaille ? Et comment, sinon, agir de manière équitable?

Mais pendant longtemps, dans le monde de la coopération, on a pensé que cette attention aux relations hommes-femmes était soit superflue – le développement étant censé profiter également à tous les membres d'une maisonnée – soit déplacée car on touchait là au domaine du privé.

Pour faire du genre une préoccupation légitime du développement, il a fallu vaincre des résistances, faire preuve de persévérance, d'humour et de patience. Se rencontrer, échanger, se soutenir dans des réseaux plus ou moins formels fut important.

C'est d'abord dans le réseau romand Femmes et Développement qu'avec Yvonne nous avons élaboré, approfondi, affiné, transformé nos idées et représentations de ce que l'on appelle le genre.

Aussi, nous ne pouvons pas évoquer Yvonne sans rappeler l'empreinte qu'elle a imprimée à ce réseau et aux activités que chacune d'entre nous avons développées avec elle dans cette mouvance.

Depuis les premières réunions de 1986, ce groupe d'une douzaine de femmes aux points de vue différents car d'origines culturelles et professionnelles diverses, s'est *donné le temps de penser en toute liberté* – pour reprendre les mots qu'Yvonne avait utilisés lors d'une présentation au Louverain – et s'est offert le luxe de *penser sans contrainte de rentabilité ou d'objectif opérationnel immédiat*. Pour aborder les questions que soulève le développement, et la situation des femmes, il nous a fallu du temps, des explications, des définitions de mots. Nous nous sommes amusées, passionnées mais aussi querellées parfois.

Nous avons commencé par affiner ensemble ce que nous ne voulions pas, puis ce sur quoi nous pouvions nous mettre d'accord. Ce que nous ne voulions pas, c'est contribuer à créer des ghettos de femmes ou nous laisser piéger par des banalités et des généralisations sur les femmes. Ce que nous voulions, c'est *apprécier concrètement ce que les femmes apportent au développement, dire à quel point elles sont un agent essentiel du changement, certainement le principal au niveau des pratiques quotidiennes, montrer comment elles transmettent les savoirs et par là même la modernité avec toutes ses transformations sociales.* Bref, ce que nous voulions, c'est rendre manifeste le fait – pourtant si banal et évident dans un sens – que finalement le développement ne peut se passer des femmes comme partenaires. A la lumière du rôle des femmes et des relations de genre, nous avons abordé ensemble tous les aspects traditionnels et historiques déterminés par une culture, les aspects cachés et présupposés des rapports Nord-Sud, les liens fondamentaux entre le macro et le micro, entre le monde, la région, le village ou le quartier; nous avons parlé d'exode rural, de relations de pouvoir, d'écologie et d'économie mondiale au sens large; nous nous sommes penchées, riches de nos propres expériences personnelles et professionnelles, sur les problèmes liés à la scolarisation, la santé, l'alimentation, la répartition du travail entre femmes et hommes, la garde des enfants, l'introduction de nouvelles techniques d'élevage, de jardinage, etc.

De ces années de rencontres plus ou moins régulières ont émergé quelques notions phares que l'on retrouve dans les notes écrites par Yvonne lorsqu'elle se chargeait de synthétiser nos rencontres. *La démarche qui divise le monde en opposant les hommes et les femmes comme s'il y avait un développement à deux vitesses est choquante et ne correspond pas à la réalité. Il faut passer d'une dichotomie de genres à la notion de solidarité. Il n'y a pas de normes abstraites de développement; il est nécessaire d'agir sur le quotidien pour rendre la vie plus acceptable. Tout changement se fait en confrontation avec d'autres éléments externes et il faut que chacun en garde la maîtrise ce qui n'est pas le cas de beaucoup d'hommes et de femmes dans le développement. Absente du pouvoir visible et officiel, la femme a pourtant des pouvoirs qu'il s'agirait de mettre sous les projecteurs des planificateurs. Ce faisant il ne s'agit pas d'en faire une affaire de femmes, mais plutôt de ne pas oublier que les femmes sont au centre du fonctionnement des groupes sociaux.*

Ces extraits de la main d'Yvonne expriment bien ce foisonnement d'idées hors de la normalisation banale, cette façon d'aller à l'essentiel sans paraître y toucher, cette utilisation du mot juste qui devient alors véritablement un outil d'action. Les longues discussions sur l'intimité révélée par les tâches domestiques comme la lessive, sur le contenu des pharmacies de ménage, sur les gestes du quotidien nous ont rendues plus lucides sur la réalité du pouvoir des femmes à travers leurs stratégies propres et leur polyvalence et à travers la transmission de leurs savoirs. Par des aller et retour entre l'ailleurs et nos préoccupations de femmes ici et maintenant, le débat a perdu son abstraction ; au-delà des projets pour les autres, la problématique Femmes et Développement est devenue aussi un partage de nos «petits soucis quotidiens», en réalité des faits significatifs révélateurs eux aussi du social.

L'idée de ces rencontres était bien loin de *la "bienfaisance-développement" que l'on fait comme dans le temps où on allait au thé de la paroisse*. Mais, Yvonne n'oubliait pas d'apporter quelques gâteries qui contribuent à la convivialité. Bien loin de cette *culture protestante du scrupule* et de la retenue dans laquelle elle avait été élevée, elle osait concilier plaisir et travail. Le plaisir qui donne envie, le plaisir qui rend créatif.

Ce qui va dorénavant nous manquer, c'est cet élément très personnel qu'Yvonne amenait dans cette approche genre qui, par ailleurs, fait maintenant son chemin.

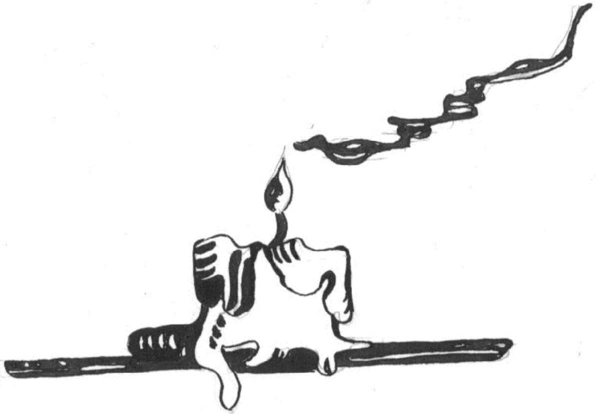
C'est ce côté drôle, pointu et (im)pertinent d'Yvonne qui a, au sens propre, véritablement animé notre groupe qui aurait pu parfois être un peu trop «plat» voire ennuyeux.

Elle nous a bousculées, apostrophées à juste titre car nous nous perdions par moment dans la simple description de situations personnelles ou professionnelles sans en dégager le sel et les aspects significatifs. Cela Yvonne savait le faire avec des mots qui restaient proches du concret et de la spécificité des situations mais qui touchaient également, de manière pointue, au sens social. Elle avait sur tout un regard vif et décapant. Si ce faisant, Yvonne pouvait nous rudoyer, il faut relever que c'était toujours fondamentalement amical. Elle était solidaire et bienveillante mais sans complaisance ou apitoiement. Elle nous a appris à ne pas être des victimes mais des personnes crânes et combattantes, dans toute situation. Dans le réseau, Yvonne eut un rôle fondamentalement tonique.

Pour Yvonne, recherche et action étaient liées. Elle aimait que s'affrontent l'analyse et la pratique, elle aimait le jeu des idées et la rigueur des concepts mais elle en dénonçait aussi très vite la vacuité s'ils ne servaient pas à mettre en évidence des réalités, celles des hommes et des femmes, et s'ils ne nous incitaient pas à nous engager sur des chemins de vie et d'action.

Elle s'est toujours demandée comment partager la vie et le devenir du monde et des gens qu'elle observait. Elle aimait ses «terrains» avec les femmes, les hommes et les animaux qui le peuplaient. Elle en respectait la culture et l'histoire mais elle se refusait à tout passéisme et se tournait résolument vers l'avenir lucidement, sans fausses illusions, mais avec une joyeuse curiosité, une grande générosité et une totale absence de dogmatisme.

C'est ces qualités-là qu'il nous faut maintenant cultiver. Puissent le rayonnement, la chaleur, l'enthousiasme d'Yvonne Preiswerk continuer à nous animer et nous aider dans le chemin encore très épineux sur lequel nous nous sommes engagées. Beaucoup reste à faire, ici en Suisse et ailleurs dans le monde.



MARY-JOSÉE BURNIER

# AVANT-PROPOS

Depuis un certain nombre d'années, les expériences concrètes et les recherches en santé publique démontrent de plus en plus clairement que la santé est le résultat d'interactions avec l'environnement social, culturel, économique, politique et physique dans lequel nous vivons au quotidien. En partant des déterminants sociaux de la santé davantage que des systèmes de soins et des infrastructures, on ouvre une large brèche sur la prétendue neutralité des données sanitaires catégorisées jusqu'ici selon des critères d'âge, de sexe, d'éducation, de catégories socio-économiques, d'appartenance à un pays riche ou pauvre. Cela constitue l'une des nouvelles approches que nous souhaitions explorer dans ce colloque.

A y regarder de plus près, les théories habituelles autour des spécificités de la santé sont liées au sexe biologique et confinent le plus souvent la santé des femmes à leurs conditions reproductives et de fourniture de services, en particulier au foyer (le «dedans»), au contraire de celle des hommes, vue sous l'angle du «dehors»: le monde du travail, l'économique, le politique. Jusqu'ici, les questions de la santé ne se posaient donc pas de la même manière pour les uns et les autres, par la force d'une évidence peu remise en question. Dans son exposé, *J. Price* démontre ainsi que les sciences de la vie, dont la biomédecine, ne sont pas neutres mais orientées selon le genre de ceux qui en ont jeté les bases. Elle s'interroge donc sur l'influence exercée par une telle orientation sur tous les choix faits dans le domaine de la santé et des soins.

L'analyse des rapports sociaux entre hommes et femmes nous semble fondamentale pour approcher l'extrême complexité et la diversité des besoins des hommes et des femmes dans leurs différences biologiques d'abord, mais aussi dans l'expression de leurs différences socialement construites par l'histoire, la culture et les pratiques sociales, entre autres. C'est cette analyse de genre que propose *L. Doyal* en nous présentant un cadre conceptuel incluant le sexe, le genre et leurs liens avec la santé. *A. Deluz*, toutefois, nous incite à nous méfier de nos critères occidentaux de différenciation des hommes et des femmes et de leurs rôles respectifs dans la société à travers une description des chants de femmes sur la vie, la maladie et la mort en Côte d'Ivoire.

Les conditions d'existence et d'organisation que se donne une société s'expriment de manière différente tant au niveau des classes et des statuts sociaux que des rapports sociaux entre hommes et femmes. Elles influencent fondamentalement les conditions de vie de sa population et, par conséquent, son état de santé. On a trop souvent tendance à faire un constat des inégalités sans se souvenir ou vouloir reconnaître qu'elles sont le fruit d'une construction sociale et culturelle qui n'est pas immuable et définitive. *D. Fassin* se fait ainsi l'avocat d'une «lecture sociale du genre», autrement dit une lecture incluant une analyse des inégalités sociales en complément d'une «approche politique de la culture».

Aux inégalités de ressources entre riches et pauvres, qu'ils soient hommes ou femmes, s'ajoutent pour les femmes les inégalités dans les relations de genre. L'exemple des maladies sexuellement transmissibles est particulièrement parlant, car pendant très longtemps l'importance des facteurs sociaux dans ce domaine a été négligée. Par exemple, le fait de centrer les campagnes de prévention sur l'utilisation du préservatif a laissé sous-entendre qu'il ne s'agissait que d'un problème d'information et de connaissance, alors qu'il est question, pour les femmes, de rapports de pouvoir et de négociation avec leurs partenaires ainsi que de leurs droits fondamentaux. *A. Welbourn* montre, à travers le projet «Stepping Stones», comment aborder la prévention du sida d'une manière qui soit à la fois respectueuse des gens, de leur culture et de leurs valeurs, ainsi que des différences entre hommes et femmes et entre groupes d'âge.

Les problèmes de pouvoir et d'enjeux sociaux sont particulièrement aigus dans le cas des mutilations sexuelles analysés par *B. Ras-Work*. De manière plus large, *M. Cordeiro*, riche de son expérience au Centre des femmes de Cabo (Brésil), insiste sur l'importance du travail lié aux droits des femmes en matière de santé reproductive et basé sur une stratégie communautaire mais aussi politique. Ce type de travail est nécessaire puisque, comme le montre *G. Patscheider Graf*, les changements socio-économiques actuels à Cochabamba (Bolivie) augmentent la charge de travail et les responsabilités des femmes, avec des répercussions négatives sur leur santé.

Ces exemples éclairent bien l'importance qu'il y a à tenir compte des conditions dans lesquelles les gens vivent, travaillent, se détendent, s'aiment. C'est dans l'interaction quotidienne entre les personnes et le contexte qu'agissent les facteurs déterminants pour la santé. Chacun, chaque jour, «prend soin de sa vie» et donc de sa santé, en adéquation avec sa culture, ses connaissances et ses moyens. La santé devrait donc être considérée comme une ressource fondamentale de la vie quotidienne. Pourtant, comme l'explique *C. Sanchez* au sujet de la situation alarmante des femmes en République dominicaine, les inégalités et les conditions de vie précaires dues à la pauvreté sont autant d'obstacles à une bonne santé. Elle développe l'exemple de l'augmentation des inégalités sur le plan nutritionnel pour les petites filles, d'emblée défavorisées par rapport aux garçons.

Les expériences faites en santé publique, en prévention et en éducation pour la santé, ainsi que les résultats de récentes études épidémiologiques montrent de manière claire l'influence des conditions sociales sur la santé, et les liens avérés entre pauvreté, oppression, soumission et mauvaise santé. Elles ont abouti ces dernières années à de sérieuses remises en question dans la manière de penser les politiques de santé. Ainsi, la Charte d'Ottawa de l'OMS (Organisation mondiale de la santé) propose une approche novatrice pour le troisième millénaire, intitulée «Promotion de la santé», qui, sans remettre en cause l'utilité des soins, tient néanmoins compte des arguments développés ci-dessus. Elle a pour ambition de créer les conditions qui devront assurer une bonne santé pour tous, là où les gens vivent, pour qu'ils puissent contrôler la qualité de leur vie et donc de leur santé. Cela implique des choix de société qui dépendent autant des individus et des communautés locales que des institutions politiques nationales et supranationales. C'est à ce prix que les décisions utiles pour une meilleure qualité de vie pourront être prises. Mais *M. O'Connor* démontre de manière précise, inspirée par son expérience au Canada, à quel point il est important d'avoir une approche différenciée en matière de genre et d'inégalités dans une politique de promotion de la santé basée sur les déterminants.

Croiser les concepts de «genre» et de «Promotion de la santé» est un choix exigeant car tant l'un que l'autre sont relativement nouveaux dans les réflexions et débats actuels et souvent difficiles à rendre visibles ou à mettre en œuvre, que ce soit dans les activités quotidiennes, dans les programmes de santé ou dans les projets de coopération au développement. A l'heure de la redécouverte, par ces projets, des ressources existantes en termes d'organisation sociale dans les communautés, *E. Papa* et *Y. Coulibaly* analysent une organisation mutualiste de femmes, son fonctionnement, ses problèmes et les moyens nécessaires à son soutien de la part des instances publiques et de la coopération. Les réflexions générales de *E. Burnier* et celles, plus spécifiques, de *P. Dauby* et ses collègues au Bénin sur la demande d'appui par un groupement féminin posent les questions du soutien aux actions émanant d'une communauté, du rôle des hommes et des femmes, et des réponses que la coopération peut apporter.

Deux exemples très différents montrent comment la composante genre peut être intégrée dans l'ensemble des activités d'un projet, et ce dès son élaboration. Dans le projet de développement sanitaire en milieu rural au Népal, présenté par *N. C. Chaulagai* et *A. Bürki*, la politique de «discrimination positive» en faveur des femmes permet à ces dernières d'être plus nombreuses à participer à des formations puis aux activités générales. Dans le projet de santé des femmes en Afrique du Sud, *S. Fonn* démontre avec succès comment procéder pour que l'approche genre fasse partie intégrante des activités en impliquant les personnes concernées, ce qui en outre constitue un moyen d'améliorer la qualité des services.

Les présentations et les débats avaient comme toile de fond les questions fondamentales suivantes:

- ❑ Comment et dans quelles conditions les rapports sociaux entre hommes et femmes influencent-ils la capacité des gens à prendre soin quotidiennement de leur vie et de leur santé et à faire des choix?
- ❑ Comment la prise en compte des rapports sociaux entre hommes et femmes permet-elle une autre lecture des déterminants de la santé?
- ❑ Si on admet que les rapports sociaux entre hommes et femmes transforment les facteurs déterminants de la santé, quels sont les changements à apporter dans nos pratiques et dans celles des intéressés, tant dans la formulation des politiques de santé que dans la mise en œuvre de projets?

Ce sont ces questionnements et les balbutiements de débuts d'expériences que nous désirions partager lors de ce colloque. Nous n'avons pas la prétention d'en finir avec une réflexion qui doit se poursuivre sur tous les fronts du développement social et sanitaire. Nous osons espérer que ce débat, dont nous avons à peine esquissé les contours, sera largement repris et alimenté par vos connaissances, analyses et pratiques de terrain pour que s'amplifient la pertinence et la nécessité de reconsidérer autrement les politiques actuelles de la santé afin de les ouvrir à d'autres perspectives. C'était là notre pari.

LESLEY DOYAL

# SEX, GENDER AND HEALTH: A PRELIMINARY CONCEPTUAL FRAMEWORK

The term "gender" is now widely used in health planning and also in medical research. However its precise meaning and its implications are not always clear. Two particular misapprehensions or confusions need to be addressed if the relationship between gender, health and development is to be properly understood.

First we need to be clear that "gender" is not just a more modern or more politically correct term for "sex". Rather it is a term used to distinguish those differences between men and women that are socially constructed from those that are biologically given. Second, it is important to recognise that gender issues are not only of concern to women. It is increasingly clear that men's health too is affected by gender divisions in both positive and negative ways. These are complex issues and we will be exploring them from a variety of perspectives, beginning with a brief overview of differences in male and female patterns of health and illness around the world.

One of the most obvious differences is that women as a group tend to live longer than men of the same social status as themselves. The extent of their greater longevity varies between countries and in some societies gender discrimination eliminates it altogether. Broadly speaking however, women appear to be biologically the stronger sex, when strength is measured in terms of life expectancy. Yet at the same time, women report more sickness and distress than men do. There are also marked variations in the rates of particular diseases between men and women. Men are more likely to die prematurely from heart disease for example, while women are more likely to suffer from autoimmune diseases or musculoskeletal disorders and also from anxiety and depression. How are we to explain these differences?

In order to understand the impact of "maleness" and "femaleness" on human health, we need to use the expertise available across a number of disciplines. Traditionally, biological or sex differences have been explored within the framework of biomedicine while social or "gender" differences have been the territory of the social scientists. Most researchers have explored either one arena of difference or the other but both are important if we are to develop an integrated explanatory framework which can be applied to tuberculosis specifically but also to a wide range of other health problems.

## UNDERSTANDING SEX DIFFERENCES IN HEALTH AND ILLNESS

Looking first at the biological influences on the health of men and women, the differences in the nature of male and female reproductive systems have dominated both common-sense and also biomedical thinking. The particular nature of their reproductive systems clearly do generate specific health problems for each sex. Only women can get cancer of the cervix for example, while only men need to fear cancer of the prostate. However, women's capacity to become pregnant and give birth means that they have additional needs for care both in sickness and in health. Unless she is able to control her fertility and give birth safely, a woman can determine little else about her life. (Sen et al. 1994) This is only too evident from the continuing high rates of matenal morbidity and mortality borne by the world's poorest women (Koblinsky, 1992).

These differences in reproductive health needs are important but they do not exhaust the biological differences between the sexes.

There is now a growing volume of evidence to suggest that a much wider range of variations may be clinically relevant but as yet these are little understood (La Rosa and Pinn, 1993). It seems likely for example that the differences between male and female hormonal systems affect both the onset and the progression of coronary artery disease but there have been few studies designed to investigate this possibility (Sharp, 1994). Similar concerns have been expressed in relation to HIV/AIDS. (Kurth, 1993). Thus the confinement of "female problems" to the reproductive specialty of obstetrics and gynaecology leaves important sex differences in biological functioning unexplored. Many of these will be relevant to a broad range of both preventive and curative services and our understanding of them needs to be increased.

## THE SOCIAL CONSTRUCTION OF GENDER DIFFERENCES IN WELLBEING

But even if we learn more about these biological variations, this will still give us only a partial picture of the impact of maleness and femaleness on health. Gender or social differences are also important. In daily life men and women are systematically exposed to a range of different factors which can profoundly affect their well-being both positively and negatively. Thus far however, the nature of these influences and their broader relationship to gender divisions have received little attention from those working within the biomedical tradition.

In order to understand the significance of gender divisions we need to start by recognising that all societies are divided in two along a male/female axis. This means that those falling on either side of the divide are seen as fundamentally different types of creatures with different duties and responsibilities. Most importantly, those who are defined as female are usually allocated primary responsibility for household and domestic labour – for the care of others in their family. Conversely males are much more closely identified with the public world – with the activities of waged work and the rights and duties of citizenship.

In most societies there are not just differences but inequalities inherent in these social definitions of maleness and femaleness. Those things defined as "male" are usually valued more highly than those defined as "female" and men and women are rewarded accordingly. The work women do at home for instance, is unpaid and usually of low status compared with waged work. These differences have a significant impact on the health of both men and women but so far it is only their impact on women that has been systematically investigated.

Economic inequalities mean that many women will have difficulty in acquiring the basic necessities for a healthy life. Of course the degree of their deprivation will vary depending on the society in which they live but around the world the "feminisation of poverty" remains a consistent theme. What we can call "cultural devaluation" is more difficult to define but it too is important. Because they belong to a group that is seen to be less worthwhile, women may find it difficult to develop positive mental health. This process begins in childhood with girls in many cultures being less valued than boys and continues into later life as "caring work" is given low status and few rewards. These gender inequalities are maintained and reinforced by women's lack of power and influence which makes change difficult to achieve.

At the same time, the particular nature of female labour may affect health. (Doyal, 1995) Household work can be exhausting and debilitating especially if it is done with inadequate resources and combined with pregnancy and subsistence agriculture. It can involve exposure to toxic substances (Chen et al, 1990) and may also damage mental health when it is given little social recognition and carried out in isolation. (Desjarlais et al., 1995) For some women, domestic life may involve the fear or the reality of violence and the rewards they receive may bear little relation to the intensity of their labours.

But what about men ? What can we say about the impact of gender divisions on male patterns of health and illness? Thus far it is women and their advocates who have explored the impact of gender divisions in greatest detail. This is not, of course surprising since as we have seen it is clear that these inequalities often have damaging (and preventable) effects on their health. However new questions are now being raised about the possible health hazards of being a man and these need to be addressed if we are to take the issue of gender and well-being seriously.

On the face of it, "maleness" can only be an advantage in the context of health, since it is likely to give the individual man greater power, wealth and status than a woman in a similar social situation. However certain disadvantages are also becoming apparent. One of the most obvious of these is to be found in the area of waged work. The emergence of the idea of the male "breadwinner" in the nineteenth century forced many men to work in dangerous conditions. As a result, male rates of industrial accidents and diseases have historically been higher than female rates with deaths from occupational causes more common among men than among women (Waldron, 1995).

During the same period men in many parts of the world have increasingly adopted unhealthy lifestyles – smoking and heavy drinking for example, as well as dangerous driving. All of these have contributed to their higher rates of premature mortality, reinforcing their greater biological vulnerability so that in most societies their life expectancy is lower than that of women in the same social groups as themselves (Waldron, 1995). These patterns are linked in most cultures to ideas about masculinity, with young men in particular often feeling pressure to indulge in "risk taking" behaviour in order to show they are a "real man".

Similar concepts are important in explaining the high rates of male on male violence found in many societies. In the inner cities of the United States for instance young black males are said to be an "endangered species" because their life expectancy is declining as they fight to live up to particular notions of "masculinity" (Gibbs, 1988). In the area of mental health too, some men are now beginning to make a link between their individual problems and the wider gender divisions in society. They are pointing out that gender stereotyping narrows the range of emotions men are allowed to express making it difficult for them to show weakness for example as well as other characteristics thought of as predominantly female (Harrison et al., 1992; Sabo and Gordon, 1995).

We have seen that the health of both men and women is influenced by their biological or "sex" characteristics on the one hand and by the impact of their gender identity on their social, cultural and economic circumstances. Hence "males" and "females" do have certain health needs in common. Moreover, gender differences may also affect the ability of individuals to meet those needs. As we shall see there is growing evidence of unacceptable variations between men and women both in access to medical care and in the quality of care received. Such inequalities are of course preventable and currently operate mostly to the disadvantage of women. We can explore the implications of this in more depth through looking first at the production of medical knowledge and then at aspects of the organisation of health care itself.

## SEX AND GENDER BIAS IN MEDICAL PRACTICE

Gender bias in funding priorities and in the methods of medical research have received a great deal of attention in recent years especially in the United States (US National Institutes of Health, 1992). There have been campaigns for increased funding on topics such as breast cancer which have special relevance for women alongside demands for medical researchers to pay more attention to sex and gender issues in all their areas of work (Auerbach and Figert, 1995).

Most epidemiological studies and clinical research continue to be based on the unstated assumption that men and women are physiologically similar in all respects apart from their reproductive systems

(Mastroianni et al., 1994). Thus men are treated as the norm and women as the "other". As a result some studies leave out women altogether while other do not treat sex and gender as important variables in the analysis.

This bias can limit the effectiveness of both curative and preventive services. In the case of coronary artery disease for example, many of the major epidemiological studies in both Britain and the US were based on all-male samples, reflecting the perception of CHD as a predominantly "male" problem (Sharp, 1994). As a result we know very little about the extent to which the most common prevention strategies in the field are equally applicable to men and women. Doubts have been raised for instance about the relative effectiveness of cholesterol lowering drugs in women.

Turning now to research into infectious diseases, women are rarely excluded from the samples to be investigated but relatively little attention has been paid to either sex or gender issues in analysing the results. If differences between males and females are considered at all, the focus has generally been on women's reproductive lives, assessing the impact of disease on fertility and pregnancy outcomes (Manderson, Jenkins & Tanner, 1993). Yet there is growing evidence that sex-related biological factors can affect both susceptibility and immunity to infectious diseases. (Hudelson, 1995) At the same time it is clear that gender differences in patterns of behaviour and in access to resources will influence both the degree of exposure to infection and the options available to those who become infected (Vlassoff & Bonilla, 1994).

In the case of malaria for instance, men appear to be biologically more vulnerable to the disease than women. However women's greater immunity appears to be somehow compromised during pregnancy, for reasons that are not yet clear. There is also evidence that differences in the daily lives of men and women can affect their exposure to particular disease vectors. Research thus far has concentrated mainly on the higher risk faced by men because of their greater participation in activities outside the home. However the nature of women's labours may also be important.

Those women who remain in seclusion and keep their bodies covered, may well be less exposed to mosquitoes and therefore to malaria. However the greater involvement of so many women in water-related work may pose an alternative threat. In the case of schistosomiasis for instance, the rate in males drops after adolescence when they no longer play in water while that of females peaks at around the age of 15 when they become fully involved in agricultural and domestic tasks (Michelson, 1993). These early findings suggest that further work is urgently needed to clarify both sex and gender influences on a range of infectious diseases including tuberculosis (Hudelson, 1995).

Similar concerns have been raised about gender inequalities in access to medical treatment and about the quality of care received. In the poorest parts of the world in particular, there is massive evidence to show that women are often constrained in their use of health care by inadequate resources, by the lack of culturally appropriate care, by lack of transport, and sometimes by their husband's refusal to give permission (Timyan et al., 1993).

Of course limited public expenditure on health care will affect men as well as women, but we know that in conditions of scarcity it is usually women and young girls who are given lower priority especially if their needs are not directly connected to reproduction (Sen, 1988; UNICEF, 1990). Many women also have to face additional obstacles if their disease is a stigmatising one, either because of its effect on appearance or its assumed relationship to sexuality.

If they do gain access to health care, there is evidence that the quality of care they receive is often inferior to that of men (Mensch 1993). Too many women report that their experiences of health care are distressing and demeaning. Medical knowledge is presented as inevitably superior, giving women little opportunity to speak for themselves or to participate actively in decision making about their own bodies. This is reflected particularly in the context of reproductive health services where providers are often concerned more with the prevention of fertility than with the well-being of individual women. As a result, the treatment women receive can be insensitive and dehumanising and often affects their willingness to use the services (Jacobson, 1991; Timyan et al., 1992; Sen, Germain and Chen, 1994).

Concern about inequalities in health care has traditionally focused mainly on qualitative issues – on the unequal relationships between women and those who have the responsibility to care for them. In recent years however this critique has broadened. In the US and the UK in particular it is now clear that women and men are sometimes offered different levels of treatment for the same clinical conditions. They are less likely to be offered certain diagnostic procedures or treatments for heart disease for instance (Kudenchuk et al., 1996; Petticrew et al., 1993). Similarly women on kidney dialysis are less likely than men of the same age to be offered transplants (Kjellstrand, 1988). Again further research is needed to determine the extent of this discrimination in different parts of the world, and in different medical specialties.

## CONCLUSION:
### PUTTING SEX AND GENDER ON THE AGENDA

We have seen that the concepts of sex and gender need to be a central part of the framework we use for understanding both the determinants of health and illness and also the utilisation and effectiveness of health services. At present, we know most about the impact of gender divisions on women's health and more research is needed to identify both the advantages and disadvantages they offer to men. However we need to end on a note of caution.

This paper has concentrated on the differences between men and women. It has explored the similarities between men and between women and has identified the interests that they have in common. Yet this does not mean that women (or men) can be treated as a homogeneous group. Class, race and age are also major determinants of health and these need to be integrated with sex and gender in any attempt to develop an integrated explanation of the complex reality of changing patterns of health and disease around the world. Insights from a range of both biological and social sciences will be required if an effective strategy is to be developed that respects both the biological reality of the disease itself and also the wider social and economic context in which it is embedded.

This is a slightly amended version of a paper first published in V. Diwan, A. Thorson and A. Winkvist (eds) 1998 *Gender and Tuberculosis*, Göteburg: Nordic School of Public Health.

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SILVIA MARIA CORDEIRO

# SALUD REPRODUCTIVA, CONCEPTO GLOBAL Y GENERO

Agradezco a la Comisión Organizadora del Seminario, en las personas de Mary Josée Burnier e Yvonne Preiswerk del IUED así como Serge Ghinet de Terre des Hommes, la invitación para participar en el Seminario Internacional «Salud: los determinantes sociales y económicos en las relaciones sociales entre mujeres y hombres».

Mi presencia en este Seminario representa un gran desafío y una oportunidad privilegiada de participar y compartir con todos y todas ustedes la experiencia en salud reproductiva del Centro de Mujeres del Cabo, así como reintegrarla sobre las prácticas cotidianas del movimiento de mujeres, sus impactos y dilemas. Esta organización no gubernamental (ONG) se ubica en el nordeste del Brasil, en la Región Metropolitana del Recife, capital del Estado de Pernambuco.

Contrariamente al elevado nivel de los(as) participantes(as), espero contribuir con mi presencia en las discusiones, tanto desde el punto de vista de la profundización teórica como del relacionado con los idiomas adoptados en ese evento. Las cuestiones a reflexionar que se plantean en este seminario son por lo demás pertinentes y actuales, al mismo tiempo, hacen parte de las preocupaciones del movimiento de las mujeres, tanto a nivel de la formulación de las prácticas de salud pública como de nuestras prácticas cotidianas.

El concepto de género, refiriéndose a las relaciones de poder entre las personas, explica los comportamientos entre las mujeres y los hombres en nuestra sociedad y ayuda a comprender las dificultades que las mujeres enfrentan en la familia, el trabajo y la vida política.

Las relaciones sociales entre mujeres y hombres, basadas en las desigualdades de género, repercuten profundamente en la calidad de vida y exigen cambios en sus formulaciones y prácticas en la vida política.

Para las mujeres brasileñas, la apropiación del concepto de salud reproductiva inaugura un nuevo tiempo en el cotidiano, marcado éste por una realidad de subordinación, de doble jornada de trabajo, de desvalorización del espacio doméstico y, de violencia.

La introducción de género en las políticas públicas de salud, coloca en discusión la cuestión de la ciudadanía, de las diferencias y del enfrentamiento de las desigualdades. Otras cuestiones significativas y desafiantes planteadas por las mujeres, son la autonomía del cuerpo y el cuestionamiento del poder médico.

El concepto de derechos reproductivos tiene como principios la autonomía del cuerpo, la libertad reproductiva, la integridad de las acciones de salud y el ejercicio de ciudadanía por las mujeres y los hombres.

Algunos autores consideran que «Los derechos reproductivos pueden ser considerados como una nueva generación de derechos, pero no pueden ser separados de los demás derechos (civiles, políticos y sociales), particularmente cuando se hace referencia a la libertad reproductiva. En efecto, podemos pensar esa libertad tanto desde el punto de vista civil como del político y social. En tanto derecho político, la libertad reproductiva está directamente ligada a las luchas del movimiento de las mujeres, esto es, a la capacidad del individuo para disponer de sí mismo. Finalmente, en tanto derecho social, la libertad reproductiva está asociada a las políticas de la salud publica».

En el Brasil, país de inmensas desigualdades, el movimiento de salud y el movimiento de mujeres han construido estrategias comunes con miras a la inclusión social de la mujer, los negros, los trabajadores, los campesinos, los homosexuales, los portadores de deficiencias, los cero positivos (HIV-SIDA), en fin, los diversos segmentos y estratos sociales que componen la sociedad brasileña. El dialogo entre los actores no siempre se establecieron sobre bases amistosas. Fue necesario un gran esfuerzo para prevalecer las preocupaciones de ambas partes y lograr un consenso de los intereses (específicos, individuales y colectivos) de cada uno de esos segmentos, intereses que no necesariamente son antagónicos, es más, en la mayoría de veces se complementan. De esta manera fue posible comprender que el establecimiento de políticas de salud favorable a determinados segmentos sociales, no será posible sin una amplia alianza con la sociedad, con miras al fortalecimiento del Sistema Único de Salud (SUS).

## EL SISTEMA UNICO DE SALUD (SUS)

El texto Constitucional Brasileño establece que la salud es un derecho de todos y un deber del Estado. Ello atendiendo a las reivindicaciones de la sociedad civil que participó ampliamente de la Reforma Constitucional de 1988. Es en este contexto en el que fue pensado el Sistema Unico de Salud (SUS) y el Programa Integral de Asistencia a la Salud de la Mujer (PAISM), a partir de ahí, se inició un largo proceso de discusión y se establecieron las asociaciones y alianzas necesarias para la instauración de los objetivos.

El SUS, tiene como referencias la universalidad y equidad en la atención de la salud, la democratización de la gestión de los servicios y el control social. De estas referencias, el controle social es el elemento innovador, abriendo el espacio para la participación democrática de la sociedad con la institución de los diferentes niveles de esfera del poder (federal, estatal y municipal).

Los Consejos, instrumentos de control social propuesto por el SUS, son espacios democráticos de proposiciones de políticas, defensa de intereses de los distintos segmentos que lo componen y de ejercicio práctico de la ciudadanía reglamentados por ley federal. Es en este espacio de disputa y negociación en el que las mujeres se encuentran insertas, en calidad de usuarias del sistema de salud.

Para cambiar la forma centralizada de la administración de las políticas públicas, principalmente a nivel local, la estructuración y fortalecimiento de los Consejos dependen directamente de la voluntad política del Estado. Ello implica la democratización del poder y el entendimiento por parte de la sociedad, de la función de los Consejos y del papel de los consejeros(ras).

## EL NEOLIBERALISMO, EFECTOS SOBRE LAS CONDICIONES SOCIALES Y DE SALUD DE LA MUJER

A pesar de los avances alcanzados por el SUS, prevalecen amenazas sobre la sociedad -de desestabilización del sistema- provenientes de sectores sociales vinculados a un carácter esencialmente privatista. Estas amenazas encuentran eco en el neoliberalismo adoptado por el gobierno federal, que en nombre de la eficiencia, la libertad de mercado, el fortalecimento de la moneda y la estabilización de la economía, debilita al Estado y profundiza las desigualdades sociales, de clase, de género y de etnia. Es dentro de esta lógica que se efectuaron los cortes en los presupuestos y las inversiones sociales, con un impacto directo en la salud, educación y asistencia social.

Lo más lamentable es que la tenacidad en defender este modelo económico no produjo los resultados esperados. El País está viviendo la crisis más grande de su historia (desvalorización de la moneda, evasión de divisas), presenta un cuadro de profunda recesión económica que amenaza con el retorno de la inflación y el aumento del desempleo.

En este escenario, el SUS, idealizado para que el Estado cumpla su papel social con la población, corre el peligro de inviabilizarse y, en la practica, convertirse en un sistema para los ciudadanos y ciudadanas de «segunda categoría».

Desde hace algún tiempo, la sociedad brasileña viene presentando avances significativos en el campo de la democracia política, demostrando gran madurez en el proceso de la construcción democrática. No obstante, en el campo de la democracia social, las desigualdades son cada vez más profundas y, en la cadena de los excluidos, la mujer ocupa un lugar bastante desfavorable.

Esta situación refleja por si sola, la deterioración de la calidad de vida de la mayoría de la población, en particular, la diminución de la satisfacción de las necesidades básicas. De acuerdo a los indicadores socioeconómicos, esta situación concierne principalmente a las mujeres, de tal manera que algunos hablan de la «feminización de la pobreza» en el Brasil.

De acuerdo con la demógrafa Elza Berquó, «los indicadores económicos y sociales muestran una pauperización progresiva de los diversos sectores sociales y revelan el empobrecimiento de la población femenina, sea por el aumento crítico de la pobreza en las áreas rurales o por el crecimiento de la economía en los sectores terciarios e informales o, incluso, por la sobrecarga de trabajo debido a la debilidad y a la inadecuación de los programas sociales, de los servicios de salud pública o de la infraestructura educacional. Además de esto, contrariando las previsiones de las políticas neoliberales, la caída de la tasa de fecundidad no fue acompañada por la mejoría de los indicadores de salud de las mujeres.»

En una encuesta realizada en la Región Metropolitana de Recife (RMR), por el SOS CUERPO, Género y Ciudadanía (ONG feminista) con el objetivo de evaluar los servicios de salud ofrecidos a la mujer y medir el nivel de inserción del PAISM (Programa de Asistencia Integral a la Salud de la Mujer) en la red pública, fue constatado que si no fuera por las mujeres, esos servicios no existirían. La mujer es la mayor copartícipe de la demanda de los servicios de salud, lo más inusitado es que ella va al servicio para pedir consultas, en primer lugar para sus hijos, en segundo lugar para los ancianos y, en ultimo lugar, para ellas mismas.

El nivel de la escasa valorización del tiempo de esas mujeres es indignante, para pedir una consulta ambulatoria -que en la mayoría de las veces no consiguen- ellas permanecen en el lugar esperando un promedio de casi diez horas. La encuesta revela aún inmensas distorsiones en la asistencia, éstas van desde las pésimas condiciones de trabajo hasta la desatención y negligencia con la clientela, reforzadas por la descalificación profesional.

Las desiguales relaciones de género al interior de dichos servicios, son emblemáticas. La jerarquía establecida entre los profesionales de la salud, hombres y mujeres, revela esas desigualdades. En la mayoría de casos, las direcciones de los servicios son asumidas por los médicos-hombres y las ejecuciones por las enfermeras, asistentes sociales, auxiliares de enfermería y agentes de salud, éstas dedican mayor tiempo a las actividades pero reciben menores sueldos.

El Movimiento de Mujeres en el Estado de Pernambuco tiene una larga historia de lucha por los derechos, principalmente en el campo de la salud. Dicho movimiento construyó el Forum de Mujeres de Pernambuco, espacio de articulación política y de interlocución con el Estado y la Sociedad. Existe asimismo, una red articulada entre grupos de mujeres que trabajan en áreas de salud reproductiva, son varios los grupos organizados que actúan principalmente en la región Metropolitana del Recife (RMR). Dicha red es la sección regional de la Red Nacional Feminista de Derechos Reproductivos.

## EL CENTRO DE LAS MUJERES DE CABO (CMC)

El Centro de las Mujeres de Cabo, hace parte de la red mencionada en líneas anteriores y se destaca en la región por su trabajo de salud reproductiva y derechos sexuales con las mujeres de la periferia urbana y área rural.

La naturaleza de nuestro público define el perfil de nuestra intervención, en nuestros proyectos, el mayor peso es la inclusión social de la mujer. Por consiguiente, usamos estrategias coyunturales que van desde la prestación directa de servicios, muchas veces sustituyendo el papel del Estado (en su ausencia), hasta la formación y capacitación política, con vistas a la formulación de políticas públicas. De esta forma, el Centro mantiene una relación directa con las mujeres a través de la prestación de servicios (ginecológicos, de prevención del cáncer del cuello uterino y de mama) y del acompañamiento a los grupos de mujeres. Ello con la finalidad de reflexionar sobre los derechos reproductivos, la sexualidad, el embarazo en la adolescencia, el SIDA/MSTS (molestias sexuales transmisibles), el aborto, la maternidad segura y la violencia de género. Estas actividades son matizadas por una discusión sobre la condición femenina, la identidad social de la mujer y las relaciones de género en la vida pública y privada.

Con este trabajo el Centro, a través del servicio de asistencia ginecológica, atiende anualmente a 3500 mujeres, lo que representa el 6 % de la población femenina en edad reprodutiva (10-45 años) del Municipio del Cabo.

Como estrategias para comprometer a la Sociedad local con las cuestiones de las mujeres, el Centro participa activamente en el Consejo Municipal de Salud, actualmente asumen la presidencia del consejo y conduce el Programa de Radio «Palabra de Mujer». Este programa se transmite en dos Radios, uno comunitario situado en el Municipio del Cabo y otra comercial de grande audiencia, ubicada en el Municipio de los Palmares, región de la Matasul, llegando a 21 ayuntamientos. En dicho espacio de comunicación se debaten temas específicos relacionados con la salud reproductiva y los derechos de ciudadanía. Para realizar esas intervenciones el CMC cuenta con el apoyo de la sociedad local, sobre todo de las mujeres y la solidaridad de la cooperación internacional.

La experiencia del Centro de las Mujeres del Cabo, como ejemplo de otras experiencias exitosas en el Brasil, demuestra que es posible poner al alcance de las mujeres y a nivel de su comprensión, las más complejas cuestiones y tesis sobre la condición femenina y género. Intervenir en lo cotidiano es tener la seguridad que existen espacios donde se puede ser oída y respetada, abriendo posibilidades significativas de cambios en las relaciones de género.

A nivel local, las mujeres están obteniendo algunos frutos, un ejemplo es el proceso del establecimiento del Programa de Asistencia Integral de la Salud de la Mujer (PAISM) por la Secretaria Municipal de Salud, dando prioridad a la prevención de cáncer del cuello uterino, la planificación familiar, la laqueadura tubaria y la vasectomía. Asimismo debe destacarse, la introducción en las maternidades municipales del parto humanizado y la instalación del Comité de Mortalidad Materna, el funcionamiento de Centro de Prevención y Tratamiento del SIDA/MSTs (molestias sexuales transmisibles), el Centro de referencia para la Salud de la Mujer y de la Adolescente y, finalmente, el estudio para la adquisición e implantación en la red pública de salud de preservativos (condón femenino).

Todas estas conquistas hacen parte de la plataforma de lucha del Movimiento de Mujeres. Movimiento que contribuyó significativamente en la formulación de esas políticas, ratificadas en la Conferencia Municipal de Salud en marzo de 1998. Incluso considerando que las mujeres hayan avanzado en sus conquistas, los dilemas y cuestiones hoy planteados para el movimiento, van en la dirección de cómo monitorear las políticas y garantizar su continuidad y cómo medir el impacto de esas acciones sobre la vida de las mujeres, teniendo en consideración todos los factores implicados: género, cultura y condición socioeconómica. La relación que el Centro mantiene con las mujeres es de asociación e intercambio de conocimientos en el hacer/aprender.

Para finalizar, espero que en el transcurso de los debates lleguemos a comprender algunas cuestiones y aportar con avances significativos y/u otros cuestionamentos que enriquezcan nuestras practicas así como nuestras luchas cotidianas.

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RELATORIOS ANUAIS DO CENTRO DAS MULHERES DO CABO.

## SHARON FONN

# APPLYING THEORY IN PRACTICE, SOME EXPERIENCE IN INCORPORATING GENDER ANALYSIS IN HEALTH PROGRAMMING

Following on the consensus documents from the UN decade conferences on population in Cairo in 1994 and women in Beijing in 1995 attention has been focused on addressing gender inequality and these documents have included recommendations on health services. These consensus documents form a common understanding which underpins much of current debate and can, and has, be taken as a starting point in re-evaluating health service provision. Gender audits of health programmes have indicated that positive steps towards addressing gender inequality have been taken. A report coming out of a 1998 UN expert group meeting[1] found that the "shift towards a gender perspective was an important step forward. However it has not yet delivered the expected results and two main reasons for this can be identified." The report sites a lack of understanding about the concept of gender to be one reason and the second being "a lag in the development and dissemination of appropriate techniques for incorporating gender issues into the

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[1] United Nations Division for the advancement of women, World Health Organisation, United Nations Population Fund, Commonwealth Secretariate, Tunisian Ministry of Women and Family. Women and Health Mainstreaming the Gender Perspective into the Health Sector expert group meeting report 1998.

policy process". A review[2] commissioned by the Swedish International Development Co-operation Agency (Sida) on behalf of the Working Party on Gender Equality of the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development made similar findings. This study reviewed work undertaken or supported by 10 bilateral development agencies[3]. The study found that "though all agencies accept the goal of gender equality and the need for mainstreaming a gender equality perspective in operations, there is often a gap between agency policy and practise" they go on to say that "The language of policy and strategy documents has changed but the content of programmes and projects have remained mostly unchanged". It seems therefore that the challenge is to consolidate an understanding of the relationship between gender inequality and health and to translate this theoretical understanding into everyday practice.

Health programming is about provision of services from policy development to providing the physical infrastructure and resources, both human and material, as well as providing a package of care and the systems which need to be in place to ensure optimal functioning. How as a programmer do you know if, within this mammoth task, you are taking gender inequality into account?

A useful first step is the framework developed by the DAC team in order to evaluate the agencies they reviewed. The framework postulated three areas which are influenced by gender inequalities in society: the health of men and women; access to health services; and the response structure of the health system. Within this framework, for each of these three areas they elaborated how these inequalities can be manifest and thereafter indicate actions that could be taken to promote gender equality in sexual and reproductive rights and health. This framework, presented below, provides a checklist both to review and plan interventions.

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2. Jahan R., Ahmad N., Hunt J., Klugman B., Schalkwyk J. and Silberschmidt M. Gender equality in sexual and reproductive rights and health. OECD/DAC Working Party on Gender Equality. 1998.
3. The agencies reviewed were AusAID, BADC, CIDA, DANIDA, GTZ, Irish Aid, NZODA, Sida, DFID and USAID.

## FRAMEWORK FOR UNDERSTANDING GENDER EQUALITY IN SEXUAL AND REPRODUCTIVE RIGHTS AND HEALTH[2]

| **Gender inequality in society influences** | **Through** | **Therefore, what should be addressed to promote gender equality in sexual and reproductive rights and health is:** |
|---|---|---|
| health of women and men | ❑ differences by gender in autonomy (higher vulnerability of women to violence, STDs*, unwanted pregnancy, mortality from unsafe abortions)<br>❑ higher risk of poverty among women linked to discriminatory legislation on economic rights, discriminatory practices in the economy, education (vulnerability to poor nutrition, maternal mortality)<br>❑ cultural practices (e.g., biases against women and girls in food allocation, female genital mutilation)<br>❑ division of labour (different occupation health hazards for women and men)<br>❑ workload/length of working day of women (stress, mental health, fatigue) | ❑ promotion of women's rights to autonomy in relation to control over sexuality, fertility, rights to decision-making in marriage and sexual practices (human rights approach)<br>❑ linkages to related policies and sectors (e.g., agriculture/food security, nutrition, water and sanitation, media, education and to gender equality policies)<br>❑ overall priority assigned to poverty reduction and improved quality of life (particularly among women)<br>❑ changes in behaviour patterns of men (on fertility decisions, reproductive/sexuality practices, violence) (sexuality and life skills for men to promote increased responsibility for sexual practices, domestic work and child rearing and a decrease in violence against women) |

### FRAMEWORK FOR UNDERSTANDING GENDER EQUALITY IN SEXUAL AND REPRODUCTIVE RIGHTS AND HEALTH[2] (CONTINUE FROM P. 45)

| **Gender inequality in society influences** | **Through** | **Therefore, what should be addressed to promote gender equality in sexual and reproductive rights and health is:** |
|---|---|---|
| access to health services | ☐ lack of willingness of families (including women) to invest in health care for girls and women; lack of independent income of women<br>☐ women's heavier workloads (less time) and women's opportunity costs in using health care services<br>☐ social/cultural attitudes | ☐ lowering the cost for individuals at primary health service level<br>☐ alternative strategies to avoid making women carry an ever-increasing roles as care-givers<br>☐ need to promote financial independence of women<br>☐ promotion amongst women and men of positive-attitudes to women's health and women's confidence to challenge barriers; support women's organisations, NGOs, CBOs *<br>☐ services structured to promote access (longer opening hour/schedules, distance in relation to availability and cost of transport, integrated services, sex of staff) |

| **Gender inequality in society influences** | **Through** | **Therefore, what should be addressed to promote gender equality in sexual and reproductive rights and health is:** |
|---|---|---|
| response structure of the health system | ❑ priority biases toward single-issue vertical services (family planning, STDs, safe motherhood) targeted to specific groups of women<br>❑ biases in resource allocation favouring e.g., tertiary hospitals rather than primary health care<br>❑ biases in staff attitudes about appropriate roles of women and men<br>❑ service provision that does not take account of the gender based needs of women and men<br>❑ unwillingness to recognise the sexuality of young people<br>❑ lack of women in decision-making<br>❑ negative working condition for health workers | ❑ adequate investment in the health system at PHC* level (management, supervision, training drug supply, facilities, infrastructure and transport for emergency case)<br>❑ reorientation of services/staff toward client focus: i) understanding the impact of gender on people (life-cycle approach beyond sexual and reproductive health for women and men, dignity, respect); ii) skills to provide integrated services (e.g., family planning, safe abortions, STDs, infertility, violence, maternal care, TB*, immunisation, diarrhoea, etc.); iii) appropriate working conditions for staff, including non-discrimination by sex<br>❑ organisation of services (privacy, queuing and booking systems, all services from one health worker)<br>❑ services that address people through the life-cycle and recognise diversity among both women and men (i.e., broader range of services)<br>❑ capacity-building of women in the health sector for management (e.g. training, personnel policies etc.)<br>❑ targeting of both women and men for SRH *services (to look after their own health, and health of partners, have confidence in use of health system); also link with the education system (knowledge and confidence)<br>❑ mechanisms for user inputs (both women and men) e.g., stakeholder consultations, partnership with civil society etc. |

* STD = Sexually Transmitted Desease
CBO = Community-based organisations
PHC = Primary Health Care
TB = Tuberculosis
SRH = Sexual and Reproductive Health

Both these documents describe challenges in operationalising a gender perspective in health service delivery. Interventions undertaken by Women's Health Project, a South African NGO, have attempted to address some of these challenges. WHP undertook a project in conjunction with three of the provinces in South Africa – the Transformation of Reproductive Health Services Project (TRHSP) which explicitly and implicitly included a gender component. The TRHSP aimed to: strengthen reproductive health services in the provinces; to collect a body of information to inform health system development through a process which facilitates an openness to change among health service personnel; to identify barriers to quality care and methods to overcome these; to build the confidence and capacity of health providers at all levels of the health system; and to increase understanding on the impact of social inequality, especially gender inequality, on health and health services. The TRHSP has been described in detail elsewhere[4], a table describing the data collection tools that comprised the TRHSP is appended.

In this paper some of the tools and processes of the TRHSP are described to illustrate how a gender sensitive approach can be incorporated into health system development. The point of the paper is to indicate that incorporating a gender perspective in health service planning is possible. Further, that if gender interven-

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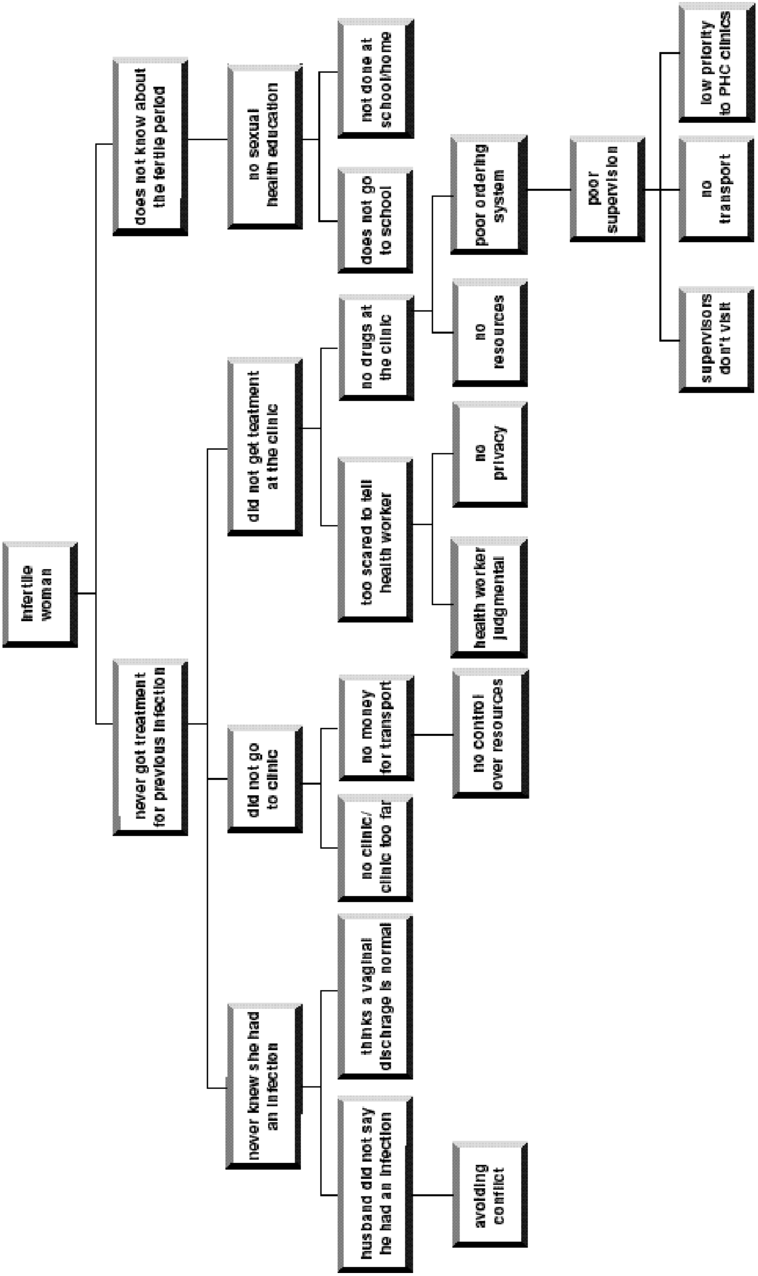
4. This has been described in various publications: S. Fonn, M. Xaba, K. S. Tint, D. Conco, S. Varkey, T. Maluleke, B. Klugman. Reproductive Health Services Transformation Project – an example of mainstreaming gender in health systems development. Innovations 1997; 5: 15-30.
S Fonn. M. Xaba. K Tint. D Conco. S Varkey. Maternal Health Services in South Africa South African Medical Journal 1998; 88: 697-702.
Sharon Fonn, Makhosazana Xaba, Kin San Tint, Daphney Conco, Sanjani Varkey. Reproductive health services from rhetoric to implementation: South African experience. Reproductive Health Matters 1998; 6h22-32.
Fonn S., Xaba M., Tint K S., Conco D., Varkey S. Transforming reproductive health services: results from a multi-faceted research and implementation process in three South African provinces. Forthcoming Women's Health Project.

tions are consistent with health service priorities and complement other developments in the health sector, they will be embraced and their value as a method of health system development will be appreciated.

The UN expert group meeting report sites poor understanding of the meaning of gender as the first reason for non delivery of improvements expected to come from adopting a gender perspective. The need for a greater understanding of the concept of gender was recognised and incorporated in the TRHSP. Thus the TRHSP included various interventions that helped people understand gender relations and their impact on health and health care.

The official start of the TRHSP was a one day orientation workshop that was held for senior staff in the provinces. This intervention was included in the project design in order to build or consolidate political will, identified in the UN expert meeting document as an essential element in mainstreaming gender. This workshop was attended by 26 senior health staff, 18 of whom were male, and also including the Directors General of Health from two of the provinces and the Minister of Health from one of the provinces. It is worth describing in detail at least one aspect of this workshop as it gives a concrete example of how to build an understanding of the impact of gender relations on health and health care. Further this tool is described because it demonstrates how a gender training exercise can be adapted to health system development and people interested in applying it will hopefully be able to do so from the description.

A common tool used by gender trainers is the "bubble – but why" exercise. A statement about a common health problem is written in a circle on the lower left hand side of a large sheet of paper. Participants then ask "but why?" and write the answer in a circle adjacent to the problem. There are usually more than one reason and as the answers relate the preceding statement, so the circles are laid. This exercise was done with these very senior health service personnel. The problem of infertility is common in Africa and represents a challenge to health planners trying to give expression to


infertile woman
does not know about the fertile period
never got treatment for previous infection
no sexual health education
did not get teatment at the clinic
did not go to clinic
never knew she had an infection
not done at school/home
does not go to school
no drugs at the clinic
too scared to tell health worker
no money for transport
no clinic/ clinic too far
thinks a vaginal dischrage is normal
husband did not say he had an infection
poor ordering system
no resources
no privacy
health worker judgmental
no control over resources
avoiding conflict
poor supervision
low priority to PHC clinics
no transport
supervisors don't visit

the sentiments expressed in the Cairo and Beijing documents – to address issues that are important to women; to extend existing services; and in particular move away from the population control orientation that had dominated family planning programmes. Infertility is a difficult issue given the low resource settings in which many health planners work. Thus this problem was chosen. Part of the answer as constructed through the exercise is illustrated below as a demonstration.

In developing the answers to the question "but why" at each stage in the construction of the diagram, gender relations are explored. For example, participants had to discuss why a woman may not know she had an RTI (Reproductive Tract Infection), consequently: women's education; inability for couples to talk openly about sex; the consequences of multiple sex partners; and dual standards for sexual freedom for men and women; all get discussed. Thus the exercise develops people understanding of the impact of gender relations on a health problem.

After the diagram is completed, for each of the points identified, the health planners are asked what, if anything, can the health service do to address this. In this way the complexity of the issue is explored more fully and the health service sees its role as more than just providing health services. For example the need for education about the relationship between reproductive tract infections and infertility is made clear, this may be a role for the health services. The need for sexuality education in relation to conception and the role of schools in this kind of education or the role of NGOs in providing support for home based discussion of such issues become clear as well as the need for the health service to liaise with and support the development of such initiatives in other sectors. Although infertility is often viewed (incorrectly) as a women's problem the educational intervention required, as the problem is fully explored, will clearly need to target both men and women. Men's role in preventing infertility also becomes an obvious component of what is required to prevent infertility.

Taking another aspect of the diagram, health workers' attitudes as a barrier to health care access, often excluded from basic training and as an issue in health care management, can be identified and addressed. This tool itself can be used by trainers in in-service education to sensitise health workers, for example, to the issue of provider client relations. Similarly, patient privacy and confidentiality, highlighting patient's rights, can be identified and addressed.

The health systems issues that this exercise uncovers, such as unavailability of drugs and inadequate supervision, are issues of concern not only in relation to the treatment of RTI's but also for other health problems.

Thus this exercise, in a provoking but playful manner, pushes health care planners to explore a health issue within its broader social context. The response to this is, in our experience, positive. In one instance a regional manager said that given this huge range of things, he would focus only on the health systems aspects, specifically drug availability. If that were the case it would still be a method of meeting women's needs better. However he also added that he now saw things differently and once drug ordering was improved he could imagine going onto another issue. "If this is what gender means I am prepared to take it up."

Gender analysis was recognised as a way of improving quality and assisting managers in their jobs instead of being an extra issue to deal with. In this process the planners could see the relevance of gender to their daily work.

Further health planners can now decide on a rational basis that in their particular circumstance the way in which they could deal with the problem of infertility is to create awareness of the cause of infertility, promote sexual education, including the notion of joint responsibility for sexual health, and to promote prompt and adequate treatment of sexually transmitted diseases. As part of the exercise they had prioritised interventions, like adequate drug management systems or addressing provider client relations, which are a general concern within the health sector anyway and would benefit more than just an STD intervention. In addition this intervention dovetails with interventions aimed at addressing HIV infection. Through this exercise planners also came to understand and see the relevance of components of the Cairo and Beijing documents, like rights or intersectional action and thus no longer feel threatened by the expectation on them to fulfil commitments to these international agreements. They can now indicate in which ways they are in fact taking up some of these issues.

The TRHSP also targeted primary care workers through Health Workers for Change[5] workshops. This is a series of six workshops (tested in two multi-centre studies, one looking at acceptability and one at impact[6]) which explore the interpersonal component of quality of care. The workshops take participants through a process of reflection, to identify the various factors that deter delivering quality treatment and to formulate solutions to bring about change. In addition the Health Workers for Change brings to the fore gender issues. Each workshop has a defined objective and related activity during which health workers reflect on themselves, the situation in which they work and the clients that they serve. Each workshop has a theme: Why I am a health worker; How do our clients see us?; Women's status in society; Unmet needs; Overcoming obstacles at work; and Solutions. This process builds health workers' understanding of the impact of gender relations on health and health seeking behaviour. In exploring these issues both personal and institutional barriers to quality of care come up. The workshops involve analysis and critique of current practise and the development of action plans which primary care workers and managers can use to improve the health service. Health Workers for Change addressees key issues for health systems development while it builds gender consciousness. The external independent evaluation of the TRHSP[7] commented "It is rare to find a training and

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5. Fonn S and Xaba M. Health Workers for Change. WHO/WHP Geneva 1996.
6. The findings of these research projects will be published shortly in Health Policy and Planning.
7. Lund F. Mid term review of the Reproductive Health Transformation Project. Durban May 1997.

management tool which has such impact. The facilitators (members of the provincial health departments trained by WHP to run the workshops) gave glowing reports of what the training had done for them. Health Service managers who were acquainted with the Health Workers for Change felt positively about it, and importantly, saw it is a useful management tool." Health Workers for Change has also been described as "the most innovative management tool around" and as "the first manual to put gender into health workers training" by health service people involved in the TRHSP. What this intervention does is address key issues in the health sector such as management and change management, health systems development (a major issue internationally in the health sector reform process) and it does this through a gender eye. It is the combination of these factors that has made people respond positively to this tool.

Thus the TRHSP had as part of its brief to develop the conceptual understanding of gender relations of health personnel from senior management to primary care workers. This was not done in a theoretical manner, rather gender analysis was applied to current health care problems and health planners saw how it could be used as a tool for health system development. As a male top level manager in one province said "The TRHSP is about empowerment of users and providers. It is not just about sexuality and rape. It is about a whole package of the wider impact of gender on society."[8]

These aspects of the TRHSP are examples of overt attention to gender inequality. What is different about it is that it deals with issues that are already of concern for health planners and compliment, rather than place an additional burden on, their current work.

There are ways of dealing with gender within health programming that are less overt and these too were incorporated in TRHSP. The project addresses many of the issues referred to in the DAC framework presented above. A few of these – adequate investment in the health system at PHC level (management, supervision, training

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[8] See note 5 above.

drug supply, facilities, infrastructure and transport for emergency case; providing integrated services; organisation of services (privacy, queuing and booking systems, all services from one health worker)– and how they were incorporated into ongoing health system development will be described.

Existing activity within the health sector at the time of the TRHSP was to develop and consolidate primary care within a district model. This was a priority in South Africa after the change to a democratic government. The TRHSP engaged in a participatory data collection process to provide information to inform this process. In various ways this data collection process took on gender issues.

Firstly the data was collected from all stakeholders: users; primary care providers; managers; and planners within each province. Data was collected using qualitative, quantitative and change management tools. This data was then presented back for participants to interpret and analyse in a collective workshop process. At the end of the workshop a prioritised plan of action was determined. The dissemination workshop process is described in detail elsewhere[9]. This process in itself was a variation from usual practise. It was the beginning of the reorientation of staff to a new way of working that valued input from all role-players. This is in itself an important contribution in two ways. One, it demonstrates, and values, participatory methods of management and this has been shown to be an important element towards treating patients with respect and providing high quality care[10]. Secondly, service user's opinions were also solicited which gives a practical example of how community participation may be incorporated into planning, values service users and gives real expression to the notion of patients' rights.

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9. Tint, K.S., Varkey, J.-S., Fonn, S., Xaba, M., Conco, D. and Klugman B. Health systems assessment and planning manual: Transforming Reproductive Health Services. Women's Health Project, Department of Community Health, University of the Witwatersrand March 1998.
10. Kay B., Germain A. and Bangser M. The Bangladesh Women's Health Coalition. Quality 3: The Population Council. 1991.

Thus the process itself was an important part of giving expression to the notion of equality.

Various data collection tools were used and a few of these will be described to elucidate the gender component in them. Facility check lists were sent out to all PHC clinics. This tool generated information on adequacy of physical resources like the quality of the building and presence of electricity and water, etc. Data was also gathered on community participation and patient privacy. Including these questions promoted the notion that issues such as privacy, for example, are as important as data on physical infrastructure. This also illustrates how gender issues can be incorporated into normal activities and did not require extra investment.

Included in the questionnaire were questions about the availability of certain drugs. Oxytocin, essential for treating post-partum haemorrhage, was specifically audited because haemorrhage is an important cause of maternal mortality. A significant number of clinics did not have this drug. Highlighting this led to a discussion about the possibility of health service quality being judged on the availability of drugs required to prevent maternal mortality. It could be a useful indicator of health service quality and development, in as much as immunisation rates are currently. Pethidine, the drug of choice for pain relief in labour in South Africa, was also audited. Asking this specifically promotes the notion that women should have a choice about pain relief in labour. The combination of the process (discussing the implications of the findings in a workshop format) and the data itself make these links overt. This required facilitation by people who had previously thought through these issues and could make these links. Clearly the questions included in any circumstance have to be situation specific. However what is clear is that much can be done to promote the notion of meeting women's needs – including those needs which result from the social roles ascribed to women – that threaten their lives and health.

Integrating services is another challenge. To inform this all stakeholders were asked their opinion on how services should be organised. Users wanted a one-stop-shop under one roof and the vast majority of managers were also keen on this option. Providers were less sure that this was feasible. It is important to ascertain if it is in fact feasible to provide a one-stop-shop service and thus clinic based time flow and workload studies were incorporated into the TRHSP. One clinic per province, as a pilot intervention, was chosen for this component of the TRHSP. The studies looked at how staff and patients spent their time in a clinic on a typical day. The data formed the basis for discussion about the efficiency of the clinic and opportunities for improvements. The studies were again conducted in a participatory manner which allowed the people who would have to make changes to decide how to move forward. Data were collected on: the number of staff; number of patients seen per day; number and type of services provided; patient waiting time; time receiving care; time allocation of staff to different activities – productive and unproductive time, direct and indirect patient care etc. How does this technical intervention address gender? The data gathered indicated that the majority of people attending the health service are women. Reasons for this can be discussed when the data is analysed in each clinic. The role of women as care givers, or their reproductive role and thus their use of health services are made overt. The consequences of these roles in terms of women's time can be discussed. In services where women wait a long time for services and the ratio of waiting time to time with a provider (waiting time often being disproportionately long) can be discussed and methods of addressing this can be put forward. For example, in user focus groups, users mentioned that an appointment system may be desirable. Providers, when analysing data and noting that all patients arrive at the same time in the morning and that this increases the average waiting time, may be open to the idea of an appointment system. These kinds of interventions are possible, are free of additional costs, value women's time and take into account the extra burden of the reproductive and caring role that women play in society. These kinds of intervention acknowledges gender inequality. Of course gender equality will have been achieved when community wide change occurs which results in as many fathers as mothers bringing their children for immunisation. However this is beyond the scope of the health sector alone and until that time the health sector needs to recognise and compensate for gender inequality.

The external evaluation of the TRHSP found that it "could deliver on gender". The evaluator also found that "There was good understanding of one major goal of the project, which was to introduce comprehensive integrated services." This particular understanding of the project was particularly gratifying as it indicated the degree to which an intervention which has a strong gender component was also seen as a health system development tool. Another finding in the evaluation was that the "The project was most appreciated by managers for its being an effective tool of the management of change, and as a vehicle for capacity building in the civil service." These change management tools and the process of the TRHSP were overtly addressing gender inequality. Yet they were seen as methods of developing the health sector. We had succeeded in mainstreaming gender.

As a consequence of the evaluation a manual describing the process and the content of the TRHSP has been produced. *The health systems assessment and planning manual: transforming reproductive health services*[11] (with the companion manual *Health Workers for Change*) describes: the methodologies used; what information this method gives; who the target group for each method is; how the information helps in understanding the impact of inequalities between men and women on the health system; how the methodology involves people in the process of change; how managers can use this information; how to implement the methodology; how to analyse the data; and a section on inadequacies so that people can adapt and improve the methods in subsequent applications. These two manuals[12] are available and provide a base for people wishing to incorporate gender into health systems development.

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[11] See note 6 above.

[12] Health Workers for Change is available from TDR/WHO Geneva, and both manuals are available from Women's Health Project P.O. Box 1038 Johannesburg 2000.

As has been emphasised during the paper it is the combination of the data collection and the process of that collection which makes this an intervention which builds understanding and develops individuals and institutions. The role of individuals to facilitate this is important. Incorporating a gender perspective into planning requires a significant level of interest in the issue on the part of planners and health service managers. South Africa was fertile ground for this kind of intervention in that the entire country at every level was focused on inequality as a consequence of the removal of the apartheid government. The impetus of the ICPD (International Conference on Population and Development) document provides a similar, if less forceful, focus internationally. However the relevance of gender to health planning and how it can assist planners do their usual job is required in this case study. WHP was able to facilitate this by capitalising on the political process in South Africa. Building this elsewhere requires an a priory investment. In order to foster this knowledge WHP has undertaken another initiative in conjunction with WHO and the FXB Centre (Fondation François-Xavier Bagnoud) at the Harvard School of Public Health. We have initiated a three week training course in gender and reproductive health with a very strong focus on health systems. In this course senior health managers, aid agency and NGO staff are taken through modules on: gender and health; human rights; policy; using research data; and on health systems development. These all interrelate and through this a cadre of health workers who are able to apply gender analysis to health systems development is graduating. It is hoped that this cadre of people will be able to act on and carry forward the ideas and momentum that can be generated by an intervention such as the one described. This has been a limitation on the impact of the TRHSP in South Africa.

In this paper I have tried to illustrate that incorporating gender into health programming and health system development is possible. Further, that gender analysis can be used as a tool for improving service quality. In addition tools have been described which can be used by institutions or individuals who wish to do so.

### APPENDIX – DATA COLLECTED DURING THE TRANSFORMATION OF REPRODUCTIVE HEALTH SERVICES PROJECT

| Data collection tool | Target | Information collected | Number reached |
|---|---|---|---|
| Key Informant interviews | Senior Health Managers | Opinions on service development | 76 managers |
| Self administered questionnaire | Staff of primary care clinics | Views on reproductive health services and requirements to deliver these | 1481 primary care staff |
| Change management workshops "Health workers for Change" | Primary care staff | Open up discussion on role that providers can play to impact on quality of care | 270 3-day workshops reaching 820 primary care staff |
| Facility check lists | Primary care clinics | Adequacy of infrastructure and supplies | 378 clinics |
| Focus group discussions | Community women | Community opinion of services | 7 groups |
| Time flow and workload studies | Primary care clinics | Assess workload and patient waiting time | 1 pilot clinic per province |
| Self administered questionnaires | Nurse tutors | To assess tutors understanding of reproductive health | 128 tutors |
| Focus group discussions | Nurse tutors | To assess tutors understanding of gender | 7 groups/8 tutors |
| Focus group discussions | Nursing students | To document their opinions on teaching methods | 83 students |
| Interactive questionnaire | Nursing students | Students' understanding of reproductive health and gender | 425 students |
| Observation of classroom teaching | Nursing teaching institutions | Methods of teaching | 20 classes |
| Review nursing curricula | Nursing teaching institutions | Content of curricula | 7 institutions |
| Key informant interviews | Heads of nursing teaching institutions | To document their understanding of how gender could be incorporated into the nursing curriculum | 46 heads of sections |
| Gender and Health workshops | Primary care staff | Expand understanding of gender and health and discuss how this impacts on quality of care and on service provision | 52 2-day workshops reaching 779 primary care staff |

BERHANE RAS-WORK

# VIOLENCE AGAINST WOMEN AS A TRADITIONAL PRACTICE

Violence against women is a universal reality which cuts across cultural, religious, economic and geographical boundaries. Various forms of traditional beliefs are upheld by the human society as social ethics for controlling the sexuality and status of women. As a result, women are subjected to violence across their life cycle.

In Africa, violence begins with gender bias at birth with ceremonies which attach lesser value to girls and continues through feeding practices. If we traced the life of the average African woman from Ethiopia up to Gambia it would read as follows:

- born from a malnourished mother
- lesser value attached to her birth
- fed less than her brother
- assume household chores as early as three years old
- less play time than her brother
- mutilated as of 7 days up to age of marriage
- married early
- marriage as the only social security
- widowed: a threat as a social stigma
- rape, battering, polygamy, threatening her life
- old age and menopause presenting rejection.

The most visible forms of violence recognized as violation of human rights are female genital mutilation (FGM), early marriage and nutritional taboos.

## EARLY CHILDHOOD MARRIAGE

In many African and Asian countries, early childhood marriage exists, whereby young girls as young as 8 years old are given away to husbands and become pregnant at early puberty. So young mothers have not had the time to finish their own physical growth and as a result there is competition in nutrition between the fetus and the young mother, leading to nutritional deficiency for the mother and the baby. According to WHO, over 50% of the first births in many developing countries are from women aged less than 19.[1]

### REASONS FOR EARLY MARRIAGE

#### *Protecting the virginity of the girl for the honour of the family*

In order to ensure that girls are virgins for the first husband, parents prefer to marry their daughters at an early age. Virginity brings higher dowry for the parents and pride to both families.

#### *Family reasons*

If the girl is wooed by her first cousin, usually considered the rightful person, it is difficult to refuse him for fear of causing family division. This is particularly true in Africa among the Peuls or Foulas.

#### *Economic reasons*

In addition to the dowry, families feel that giving a daughter away for marriage reduces the family expenses "one mouth less to feed".

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[1] WHO offset publication no. 90, 1985 *Women, Health and Development.*

### *Enlarging kinship relations*

Peasant families strive to enhance their status by marrying their daughters to families of higher economic and social status. The competition to secure a family higher in status is quite high among families of low income.

### *Early school drop out*

Early school drop-outs are also married away to protect them from excesses and permissiveness.

## CONSEQUENCES OF EARLY MARRIAGE

In many countries in Africa such early marriages are largely followed by divorces because neither the girl nor the boy had been able to choose their spouse. A young girl who is subjected to forced initial sexual relationship may become frigid.

The most serious complications for young mothers is obstructed labour, which occurs when the baby's head is too big for the orifice of the young mother. Obstructed labour provokes vesico-vaginal fistulas leading to incontinence with the ensuing social rejection. The following story of a 13-year-old mother in Ethiopia reveals the sad reality:

"At first, she was keen to confide in us only about her preoccupation during her labour. It was striking that her thoughts were going back to her period of pregnancy. For instance, her initial embarrassment about being in the condition within less than a year of her marriage and how, because she often felt tired, she would cut down on the food she consumed: 'I would not eat because that would have meant grinding more flour and cooking more food I used to feel so tired most of time, therefore we did not have flour in the house. My mother used to encourage me to borrow from neighbours. I did not see how I would repay, so I did not borrow.'

"She took a long time before she finally talked about the uterine ruptures and other damages she had suffered. To address the issue at all, she had to be prompted. She explained: 'My labour went on for three days. Everybody began to say that I should be taken to Qoyya [the closest town with a hospital]; those in Qoyya were not able to get me to release water. They recommended that I should be taken to Bitchena [hospital]. Those in Bitchena told me to put my legs here and there and, bringing something like a bowl, relieved me of three containers of urine… then… I did not see the metal. I am not sure if it was metallic, but they would insert it into me and did whatever. On bringing it out, they would utter… it [the baby] escaped us… and whenever it came up here [pointing to the area of her stomach] they tried in turn. There were two of them. They kept saying it has escaped. And there was the handsome one [male doctor] who kept saying: Courage! The woman with him [assistant], she was very agitated and said: They have given this baby in marriage before her time.

The 13-year-old eventually gave birth to a still-born baby girl."[2]

## PROSTITUTION

In rural areas, young divorced mothers have no other livelihood except to migrate to the urban centers for prostitution or to be employed as domestic servants. This is observed in many Asian and African cities. The status of divorced women is very low because of their lack of economic support from the husband. In many societies in Africa and Asia, women have no right to share the family property in case of divorce. They leave with a few of their personal belongings without any means of social security. The parents consider divorced daughters an added economic burden so most are reduced to destitution or prostitution.

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[2] Inter-African Committee: *Interim Report on a Study on Early Childhood Marriage in Ethiopia*, June 1993, excerpt.

## GENDER DIFFERENCE IN NUTRITION

In families where food is scarce, the most nutritious food is preserved for boys. A WHO report of 1985[3] shows preferential feeding practices and gender bias in nutrition. Food taboos exist in many countries to prevent women from eating essential food items such as meat, fish and eggs, particularly during pregnancy and lactation. The following table, taken from a report of the Inter-African Committee on Traditional Practices, shows the prevailing food taboos to the detriment of the health of. women and girl children.

| FOOD | BELIVED TO CAUSE |
|---|---|
| Eggs, chicken | Frequent stools in babies |
| Fish : Eel | Ptyalism and mucus in babies |
| Electric fish | Tetanus |
| Benni seed | Too much vernix on baby |
| Beans | Cord round the baby |
| Plantain | Retained placenta ;<br>In the male child, a large phallus |
| Intestines of animals | Abnormal skin pigmentation (discoloration) |
| Brain of animals | Purulent otitis media |
| Garden eggs | Pemphigus |

Malnutrition including aneamia among women is a serious health problem, especially among those who have too many pregnancies too closely spaced.

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[3] WHO 1985 offset publication no. 90, *Women, Health and Development*, p.4.

## FEMALE GENITAL MUTILATION

Female genital mutilation (FGM) is a practice which involves the cutting away part or the whole of the female genital organs. The origin of the practice is eclipsed by the passage of time and more in-depth study is needed to define its origin. It is believed to have existed worldwide at one time in history for various reasons, all related to a woman's sexuality.

At present, the practice exists largely in Africa, affecting at least 28 countries, and also in Indonesia, Malaysia, Yemen, United Arab Emirates, Bahrain. With immigrants from these countries reaching Europe, Canada, USA and Australia, the practice can be found in these regions among some immigrant populations.

To date, types of identified and documented genital mutilations are: sunna, clitoridectomy, excision, infibulation, defibulation, re-infibulation, the Gishiri cut and Angurya cut.

The long and short term consequences of these operations have been identified as serious risks to the health and well-being of young girls and mothers. Several documents have presented evidence of these dangers.

## WHAT ARE THE CONSEQUENCES OF FEMALE GENITAL MUTILATION?

### *Immediate complications*

- Haemorrhage: This occurs mainly when the clitoris is completely removed and the blood vessels of the clitoris (the vein and also the dorsal deep artery of the clitoris) rupture: the haemorrhage may lead to serious collapse or death.
- Acute infections: These are related to the operating equipment used (traditional knife, razor blade, a piece of glass, etc.). The two most serious and common infections are tetanus and general septicaemia, and nowadays the risk of AIDS is also present.

- Bleeding of adjacent organs: Sexual mutilations are often performed without anaesthesia. Consequently, the young girl suffers much pain and agitation. This may lead to clumsy operations which may sometimes cause bleeding of the urethral meatus, if not the uterus, with its complications such as urine retention, bleeding of the vagina and even of the posterior perineum.
- Violent pain: The lack of anaesthesia is very often the cause of some atrocious pain, particularly in major excision operations, that may result in very serious shock, especially since the young girl is already in a state of anguish brought on by an atmosphere of ritual celebration.

*Later complications*

- Obstetric complications: They are the most frequent and spectacular, resulting from vicious scars in the clitoral zone after excision. These scares open up during childbirth and cause the anterior perineum to tear, leading to haemorrhage which is often difficult to stop.
- Psychological complications: The ordeal of FGM leaves an indelible mark in the life and mind of the woman who has undergone it. This is sometimes the cause of anxiety, melancholy, a state of depression.
- Psychiatric disturbances: Clinically, psychiatric disturbances associated with FGM have been observed to be either related to the inflicted psychological trauma or as sequel to the physical complications of the operation. It is quite obvious that the mere notion of surgical interference in highly sensitive genital organs constitutes a serious threat to the young girl and the painful operation is a source of major physical as well as psychiatric disturbances depending largely on the child's inner defenses and the prevailing psychological environment.
- AIDS: An alarming situation has come up with the spread of HIV/AIDS and the possible risk FGM could represent for the transmission of this virus.

The age at which female genital mutilation is performed varies from one area to the other, from a few days old in some parts of Ethiopia, to about seven years old in Egypt and the Sudan. In West Africa, it is performed on adolescent girls of 14 to 15 years.

The reasons for the continuation of FGM vary according to the socio-cultural context in the different countries. The major justifications are:

- ☐ moral or religious precepts
- ☐ virginity: bride price and family honour
- ☐ anatomic/aesthetic reasons
- ☐ need for social integration
- ☐ prevent child mortality
- ☐ ensure fertility
- ☐ hygiene.

The following table shows the percentage of women who have undergone FGM in Africa.

Percentage of FGM performed on total female population

| *Country* | *Percentage* | *Country* | *Percentage* |
|---|---|---|---|
| Benin | 30 % | Kenya | 40 % |
| Burkina Faso | 78 % | Liberia | 55 % |
| Cameroon | 15 % | Mali | 80 % |
| Ctrl. Afr. Rep. | 35 % | Mauritania | 55 % |
| Chad | 40 % | Nigeria | 55 % |
| Djibouti | 95 % | Senegal | 20 % |
| Egypt | 55 % | Somalia | 99 % |
| Ethiopia | 85 % | Sierra Leone | 60 % |
| Gambia | 79 % | Sudan | 90 % |
| Ghana | 20 % | Tanzania | 15 % |
| Guinea | 60 % | Togo | 40 % |
| Guinea-Bissau | 45 % | Uganda | 20 % |
| Ivory Coast | 40 % | | |

Information collected from reports of national committees and research findings.

# PROGRESSIVE EFFORTS MADE TO ERADICATE FEMALE GENITAL MUTILATION

## INTERNATIONAL AND REGIONAL LEVELS

### *World Health Organization (WHO)*

The first major step taken to deal with FGM was the 1979 Khartoum Seminar on Traditional Practices, organized by the WHO Regional Office for the Eastern Mediterranean (EMRO). Representatives from 10 countries – Burkina Faso, Djibouti, Egypt, Ethiopia, Kenya, Nigeria, Oman, Somalia, Sudan, South Yemen – attended the meeting.

One of the subjects discussed was FGM as a harmful traditional practice. The complications it causes were noted and recommendations were made for its progressive eradication. In general, the seminar proposed the establishment of a national commission to coordinate activities including legislation, intensification of general education and sensitization of midwives and Traditional Birth Attendants (TBAs). The adoption of a clear cut policy was also recommended.

In 1982, WHO issued a statement on its position regarding FGM (female circumcision). In this statement, female circumcision was recognized as having serious health consequences. The recommendations made at the Khartoum meeting were re-emphasized and WHO expressed its readiness to support national efforts aimed at eradicating the practice. Strong advice was expressed to health workers not to perform FGM under any conditions.

WHO/EMRO adopted a resolution at its thirty-fifth session, stating that women's health must be safeguarded by ensuring the elimination of harmful traditional practices.

In September 1989, the WHO Regional Committee for Africa (AFRO) adopted unanimously a resolution recommending to concerned members to adopt appropriate policies and strategies to eliminate female circumcision. The Director was asked to provide support and to make a report, at the 40th session, on the progress of work in this area.

In May 1992, at the WHO Technical Discussion on Women, Health and Development, the issue of FGM and other traditional practices was raised and a proposal was made stating that more courageous steps must be taken by the national and international communities to eliminate mutilating practices.

At the Safe Motherhood Conference in Niamey, February 1989, organized by the World Bank, UNFPA, WHO and UNICEF, a call for the eradication of harmful traditional practices was included in the final declaration.

WHO initiated and funded a research study on the influence of FGM on the choice of contraceptive methods, which was undertaken by the Inter-African Committee in Djibouti and Sierra Leone.

### *UNICEF*

UNICEF co-sponsored a Regional Seminar on Traditional Practices, held in Dakar in 1984. It provides financial, moral and technical assistance to the Inter-African Committee and its national affiliates. It gave financial support for research on traditional practices undertaken in Burkina Faso, Chad, Ethiopia, Niger and Sudan. It also finances activities such as seminars and workshops in Benin, Ethiopia, Sierra Leone, Uganda, etc.

The UNICEF Executive Board paper E/ICEF/1992/L.5 confirms the UNICEF policy regarding the genital mutilation of girl children.

### *UN and NGO Forum*

The Copenhagen Conference on Women's Decade, held in 1980, brought the subject of female circumcision to the international attention. At the NGO Forum, held parallel to the Conference, concerned Western women discussed and condemned the practice as a barbaric custom. Africans regarded this interference as Western cultural imperialism and reacted to it negatively.

The actual Conference document on the revision and evaluation of progress achieved, document A/CONF.94/9, refers to the subject of female genital mutilation in the sub-heading "Cultural practices affecting women's health".

The Second UN/ECA (Economic Commission for Africa) Regional Conference on the Integration of Women, held at Lusaka (Zambia), 3-7 December 1979, condemned sexual mutilation but called on a cautious approach to the international campaign. It called upon Africans to find suitable solutions to the problem.

### *UN Human Rights and other Conventions. Legislation*

Human rights are based upon the principles of equality and non-discrimination. These rights are articulated in several conventions such the United Nations Charter, the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child. FGM violates basic human rights principles to health, life, freedom from cruel and/or degrading treatment, freedom from slavery and servile status and freedom from discrimination.

The Convention on the Rights of the Child, article 24.3, states that "The States Parties of the present convention shall seek to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children".

### *Female genital mutilation at the UN/Human Rights Centre*

FGM was first introduced by NGOs to the Working Group on Slavery and Slavery Like Practices, in 1981.

On 13 March 1984, the Commission on Human Rights by its resolution 1984/48 recommended the setting up of a special Working Group of experts on traditional practices and ECOSOC endorsed the recommendation by its resolution 1984/34 May 24, 1984. The members of the Working Group assigned as experts were Mrs.

Halima Embarek Warzazi of Morocco and Mrs. Murlidhara Bandari of India. Mrs. Wassyla Tamzali of UNESCO, Mrs. Marjorie Newman-Black of UNICEF and Mr. Robert Cook of WHO were invited to join the Group and provide their expertise.

The NGO Working Group held its first session 18-25 March 1985 in the presence of several NGOs to study the practice of FGM, the preference of the male child and traditional birthing practices. FGM was considered as a priority and it was dealt with from socio-cultural, medical and human rights aspects.

The conclusion reached was that FGM is a complex problem which has an evolutionary aspect. The Group called on governments to adopt policies and legislative measures for its eradication. It also recommended educational measures to be undertaken and requested governments to support local efforts being made by individuals and organizations. It recommended the organization of international, regional and national meetings for exchange of information. The report of the Working Group, document E/CN.4/1986/42, was presented to the UN Commission on Human Rights at its 42nd session.

The Commission by its resolution E/CN.4/1986 requested the relevant specialized agencies of the UN system and interested NGOs to provide assistance to the governments in their efforts to fight harmful traditional practices.

For the purpose of a follow-up, Mrs. Halima Warzazi of Morocco was appointed as a rapporteur to study the situation of traditional practices and report back to the Sub-Commission at its 43rd session in August 1991.

A Regional Seminar on Traditional Practices was organized by the UN Human Rights Centre in Ouagadougou (Burkina Faso) 29 April-3 May 1991. Another Regional Seminar was organized for Asia from 4 to 8 July 1994 in Sri Lanka. The recommendations made at these two seminars formed the basis for a plan of action drawn by the Special Rapporteur to be adopted by the Sub-Commission on Prevention of Discrimination and Protection of Minorities.

## NATIONAL AND REGIONAL INSTRUMENTS

Sudan: In 1946, the British Government then in power in the Sudan legislated against infibulation. But since the move was considered as another colonial imposition, the practice went underground and continued to be performed, thus creating a worse situation since complications such as infections, haemorrhage, etc. resulting from the infibulation could not be reported for fear of legal measures.

Egypt: In 1959, an order by the Ministry of Health was issued prohibiting female circumcision in government hospitals and health centers. In spite of this order, the practice continued both in and outside health centers.

In Europe, France, Great Britain and Sweden have laws prohibiting FGM. The British and Swedish legislations regarding FGM are clear about the prohibition of the practice. The French Penal Code, article 312, stipulates that a person who has committed an act of violence involving mutilation or resulting in death without the intention of doing so is liable to criminal proceedings. As a result of this law, African mothers have been prosecuted for having circumcised their daughters.

Article 18.3 of the African Charter on Human and Peoples' Rights reads: "The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions".

The African Charter on the Rights and Welfare of the Child also protects children from harmful traditional practices.

The Abuja Declaration. The UN Economic Commission for Africa organized a conference in Abuja (Nigeria) in November 1989 to review the "Role of Women in Africa in the 1990s". Among other issues, traditional practices such as early marriage and pregnancy, female circumcision, nutritional taboos, etc. were discussed and proposals for action were made. The proposal calls for research, training, dissemination of information and legislation to eradicate harmful traditional practices. The setting-up of regional and sub-regional structures was also recommended for the follow-up.

## STATEMENTS OF LEADERS AND POLICY MAKERS

President Jomo Kenyatta of Kenya supported the preservation of culture as a defense for one's identity against colonial aggression. In his book "Facing Mount Kenya" he supports the initiation ritual of circumcision. But later, in 1990, his successor President Arap Moi issued a ban on the practice, stating that such customs do not belong to modem times.

President Thomas Sankara of Burkina Faso also denounced the practice of FGM on 20 December 1983, stating: "It also shows an attempt to confer an inferior status on women by branding them with this mark which diminishes them and is a constant reminder to them that they are only women, inferior to men, that they do not even have any rights over their own bodies or to fulfillment, either bodily or personal."[4]

President Abdou Diouf of Senegal stated: "These practices, however, raise a problem today because our societies are in a process of major transformation and are coming up against new sociocultural dynamic forces in which such practices have no place or appear to be relics of the past: What is therefore needed are measures to quicken their demise."[5]

At the UN seminar in 1991, the First Lady of Burkina Faso, Madame Chantal Compaoré, said: "We in Africa still have some backward and unacceptable customs and traditions. One of the objectives of the August Revolution in Burkina Faso was to combat all the social and cultural impediments which are holding the country back. The practice of female circumcision is the most perni-

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4. UN Document E/CN.4/1986/42
5. UN Document E/CN.4/1986/42

cious impediment to the psychological and physical flowering of women and children."[6]

The International Conference on Assistance to African Children, held in November 1992 in Dakar (Senegal), treated the issue of FGM as a threat to African children. The final document adopted as the "Consensus of Dakar", paragraph 28, reads: "Furthermore, we commit ourselves to ensure the protection of the female child from all forms of harmful traditional practices and in particular to the elimination of such practices as female genital mutilation, and early and forced marriages".

Recently, FGM has gained prominence in various international conferences.

The World Conference on Human Rights, held in June 1993 in Vienna, condemned gender based violence and accepted the principle that women's rights are human rights and as such they should be respected fully, regardless of cultural diversity or economic disparity. The indivisibility and non selectivity of the principles of human rights prohibits the violation of human rights on the basis of culture or religion.

The International Conference on Population and Development and its programme of action condemns the practices of FGM and early marriage along with other harmful traditional practices and several measures are proposed to governments and NGOs to work toward their elimination.

The World Summit for Social Development, held in Copenhagen in 1995, reaffirmed the call for the elimination of violence against women, including female genital mutilation.

The Fourth World Conference on Women, held in Beijing in September 1995, witnessed the international awareness about violence against women in general and FGM in particular. Several statements by high level officials, including the Secretary-General

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[6] UN Document E/CN.4/Sub.2/1991/48

of the United Nations, and delegates called for the elimination of FGM as a gender based violence.

## CONCRETE ACTIONS TO STOP THE PRACTICE

The anti FGM campaign was initiated by committed and convinced individuals who considered the practice of FGM as a health hazard and violation of the human rights of women.

Gradually, as more and more public awareness developed, organizations were formed with the aim of eradicating FGM. In 1977, the NGO Working Group on Traditional Practices was set up in Geneva with a membership of international organizations enjoying consultative status with the UN Economic and Social Council. The Coordinator of the Group and a representative were assigned to undertake missions to several African countries for studying the extent of the problem and for dialoguing with nationals on the best approach to adopt in handling the problem. The various visits and meetings resulted in building collaborative efforts. The Working Group initiated educational activities in Burkina Faso, Egypt, Kenya, Mali and Sudan and fundraised for such local initiatives.

A vital role of the Group has been lobbying at the various relevant meetings such as the World Health Assembly, the UNICEF Board meetings, the sessions of the Commission on Human Rights, the Commission on the Status of Women, etc. Members of the Group made statements, submitted communiqués and appealed to governments to take action. Briefing sessions with African delegates were held during the WHO Assembly in 1983 and 1984 at the request of members of the Working Group. Members of the Group took an active part during the two sessions of the UN Working Group on Traditional Practices held in 1986. They advocated the appointment of a Special Rapporteur on traditional practices and, at present, they work closely together with this Special Rapporteur, Mrs. Halima Embarek Warzazi.

During the drafting of the Convention on the Rights of the Child, it was the NGOs which lobbied for the inclusion of article 24.3 calling upon the States Parties to protect children from practices prejudicial to their health.

In 1984, the Working Group in collaboration with the Government of Senegal, WHO, UNFPA and UNICEF organized a Regional Seminar in Dakar, to which twenty African countries sent representatives to examine the issues of FGM, early marriage, nutritional taboos and practices related to delivery. A unanimous agreement was reached to eradicate harmful traditional practices and to follow this decision by establishing the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children.

The Working Group continues its campaign against FGM through advocacy and fundraising. WHO and UNICEF participate in its activities with an observer status.

## INTER-AFRICAN COMMITTEE

The Inter-African Committee (IAC) is a regional body set up in 1984 with the following mandate:

- ❑ to reduce the morbidity and mortality rates of women and children through the eradication of harmful traditional practices,
- ❑ to promote traditional practices which are beneficial to the health of women and children,
- ❑ to play an advocacy role, by raising the importance of taking action against harmful traditional practices at international, regional and national levels,
- ❑ to raise funds and support local activities of national committees and other partners.

Since its creation, IAC has set up national committees in the following 26 countries: Benin, Burkina Faso, Cameroon, Chad, Congo, Ivory Coast, Djibouti, Egypt, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo and Uganda.

The main focus of activities are:

❑ Training and Information Campaign (TIC)

TIC training workshops are aimed at providing intensive and meaningful health education with the help of visual aids. The subjects discussed are related to FGM, early childhood marriage, human reproduction, pregnancy, childbirth, breast-feeding and hygiene as well as to nutritional taboos.

The programme consists of 4 sets of training workshops, to be conducted consecutively in 5 months. After each TIC programme, 28 persons will have been trained to be able to conduct sensitization programmes on the harmful effects of FGM and other traditional practices, and a further 136 persons will have attended workshops to spread information regarding these issues.

❑ Training of Traditional Birth Attendants (TBA)

As TBAs can play an important role in the campaign against harmful traditional practices, it is necessary to provide them with an effective training programme and to encourage them to campaign for the abolition of FGM and other such practices.

For IAC, the aim of the TBA training is first to train head trainers for a short period and to ensure that the required information pertaining to the practice is transmitted to other TBAs working in rural areas and mothers in the communities. First, a head trainer gives a one-day training for 5 future trainers. Each will in turn train 50 TBAs in rural areas, thus creating a multiplying effect. When each TBA programme is completed, 50 TBAs will have been trained to play a key role in rural areas in the campaign against FGM and other harmful traditional practices.

- ❑ Alternative Employment Opportunities (AEO)

  Practitioners or circumcisers are largely respectable individuals whose skills are indispensable to the community. Their service is paid for in cash or kind and they enjoy special social status in the community. The campaign against FGM has to include changing the attitudes of practitioners and finding them alternative sources of income for their livelihood.

  IAC runs two AEO projects for circumcisers, one in Ethiopia and another in Sierra Leone. In both projects, a selected number of women have identified income generating activities such as bakers (Ethiopia) and tie and dye (Sierra Leone), and are working in groups running their projects. Members of these groups have abandoned the practice of FGM and other harmful traditional practices. They are used as agents of change within the communities.

Such projects have to be designed and implemented in order to convince practitioners to give up some of their old habits and practices and to provide beneficial services.

- ❑ Research

  IAC conducts research in the area of traditional practices, particularly FGM. Several research papers are produced showing the extent of the problem. These documents are valuable, particularly for designing strategies of intervention.

- ❑ Production of educational materials

  IAC produces and distributes a number of educational materials to be used in the different programmes of education and information.

  - An anatomical model of the lower part of the female body with 7 removable parts showing (1) the normal state of the female genital organs; (2) result of "sunna"; (3) result of excision; (4) result of infibulation. (5) keloid; (6) normal delivery; (7) delivery of an infibulated or severely excised woman.

- Flannelgraphs: A set of 5 folders with schematic designs to be stuck on a piece of flannel for group teaching based on a small manual contained in each folder. The series comprises A. the female genital organs, B. fertilization, C. pregnancy, D. birth, E. complications during childbirth: a consideration of female genital mutilation.
- Simple viewers with a set of slides, to be shown in connection with the flannelgraphs. The slides are made from realistic designs which demonstrate (1) infibulation; (2) keloid; (3) incision at delivery, (4) delivery by pulling out the child; (5) child injured at birth.
- Multi-media training modules and materials are targeted to reach four major groups: a) women in influential positions and those participating in activities of women's organizations; b) secondary school students and youth groups, both male and female; c) teachers, religious and community leaders; d) paramedical staff. The modules include transparencies, slides, cassettes and stories with pictures.
- The IAC video (Beliefs and Misbeliefs) (43 min.) explains the dangers of FGM and shows the activities of IAC in Africa. A French versions is also available.
- The IAC Newsletter is published twice a year in English and French and distributed widely.
- The IAC Information Leaflet is available in English and French.

IAC organizes international and regional conferences to examine the problem, to elaborate new strategies and to work out activity plans. Such a conference was held from 11 to 15 April 1994 for the purpose of evaluating a decade of IAC activities. Representatives of 24 countries participated and the First Ladies of Burkina Faso, Ghana and Guinea graced the conference with their presence. The full report of this conference is available.

## IAC/UNHCR JOINT PROJECT

A joint project between the IAC national committee in Ethiopia (NCTPE) and the UNHCR among refugees and indigenous Somali displaced persons in the Jijiga refugee camp is in progress since 1993.

The Somalis are known for practising the worst form of FGM – infibulation – and the purpose of this project should be seen in the light of one more effort to minimize and ultimately eradicate this harmful traditional practice. In addition, the project foresees the promotion of beneficial traditional practices such as breast-feeding and improved child care.

The strategy used is sensitization of the socially influent target groups by means of short term training and seminars. The beneficiaries of the project are traditional birth attendants and opinion leaders in addition to the refugee/returnee communities in the different camps within the Jijiga area. It is estimated that some 200 opinion leaders in nine of the camps could be reached in this process. In addition, a seminar on the hazards of FGM was held for NGO representatives working in the camps and from which an estimated 14 participants benefited.

## ADVOCACY

The advocacy IAC plays together with other partner NGOs is showing gradual progress.

At the UN level, the appointment of a special rapporteur on traditional practices is an outcome of this lobbying. The fact that IAC has official relationship with the UN, OAU and WHO gives it the possibility to make its voice heard on behalf of African women and children who are the victims of prejudicial treatment.

At national level, the national committees in Djibouti, Ethiopia, Ghana and Nigeria have succeeded in impacting policy changes by including articles which prohibit harmful traditional practices. This is a welcome sign.

The Inter-African Committee and its national committees are making efforts to free women and children from socially sanctioned violence such as female genital mutilation. These efforts alone could not have produced results if it were not for the collaboration of other organizations and concerned individuals.

## PROPOSALS

Despite the widespread violence against women, particularly in relation to culture and misinterpretations of religion, women themselves have to be empowered through information and education to protect their human rights. In this domain, the following proposals are made:

- educate women through various means to valorize themselves and to develop self esteem;
- explain and clarify misconceptions about religion;
- disseminate information about the functions of the female body and project positive images about the reproductive role of women;
- educate the community about the contribution of women towards the development of the community and the nation;
- valorize the image of the girl child through education, including religious teachings;
- adopt legislation which will allow women to inherit property, including land, in order to allow them to be economically self-sufficient;
- adopt measures to abolish practices such as female genital mutilation;
- conduct research to collect gender desegregated date;
- concerned organizations, international, national and government institutions should coordinate their efforts to integrate activities related to abolishing violence against women in their plans and programmes of work.

GLORIA PATSCHEIDER GRAF

# RELACIONES DE GENERO: FACTOR DETERMINANTE EN LA VIDA Y LA SALUD DE LAS MUJERES

## EL CASO DE LOS BARRIOS PERI-URBANOS DE COCHABAMBA (BOLIVIA)

Antes de iniciar con el tema de mi intervención, me parece importante señalar que la institución a la que represento en este encuentro, el IFFI, es una organización no gubernamental que trabaja prioritariamente con las mujeres de los barrios populares de Cochabamba, tercera ciudad en importancia política, socio-económica y demográfica (540000 habitantes) de Bolivia. A través de diferentes líneas de trabajo, el propósito del IFFI es fortalecer la democracia, el ejercicio de la ciudadanía, la equidad de género y el respeto a la diversidad cultural. Uno de los programas de la institución es el de Salud y Seguridad Alimentaria Nutricional, con acento en derechos los sexuales y reproductivos, la calidad de atención en salud, la educación alimentaria nutricional y el apoyo a centros de abastecimiento.

Hemos aceptado con gusto participar en este encuentro porque la reflexión y las experiencias institucionales, desde sus distintos programas, tienen como uno de sus ejes fundamentales los derechos humanos y la equidad de género. Tengo la certidumbre que de este evento saldremos todo(as) enriquecidos(as) por los distintos aportes y que sobre todo, juntos(as) habremos avanzado un paso en la reflexión global respecto a las políticas de salud mundiales, nacionales y locales, que vayan verdaderamente a crear las condiciones que aseguren una buena salud y una mejor calidad de vida para todos(as).

Mi exposición consta de tres partes. En la primera se hace una presentación sucinta de la realidad boliviana y la situación de la mujer, la segunda parte trata sobre los aspectos culturales andinos respecto a la salud y género y finalmente, a manera de conclusión, en la tercera parte se intenta responder a las preguntas formuladas por las organizadoras de este encuentro.

## 1. LA REALIDAD BOLIVIANA, ALGUNOS DATOS[1]

### POBLACIÓN

Según el último censo de 1992, Bolivia cuenta con aproximadamente 7,5 millones de habitantes, de los cuales 50,6% son mujeres. Se trata de una población «joven» pues las personas menores de 18 años representan el 47,7% y las mayores de 65 años sólo el 4%. Bolivia registra la tasa más alta de fecundidad en Latinoamérica con 5 hijos por mujer.

Según un estudio realizado por la Comisión Económica para América Latina y El Caribe (CEPAL) en 1988, Bolivia es la nación con mayor índice de población indígena de Latinoamérica (51%). Este dato es claramente subestimado – lo reconoce el mismo estudio – por varias razones, entre ellas la discriminación, la aculturación y lo difícil que resulta categorizar al indígena como tal. A nivel lingüístico, el Instituto Nacional de Estadística censaba en 1992 un 58% de personas que hablan castellano, 23% de quechua-hablan-

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[1] La mayor parte de los datos presentados provienen de distintas fuentes oficiales nacionales e internacionales que han sido recopilados y analizados por el P. Gregorio Iriarte en su obra *Análisis crítico de la Realidad*.

tes, 16% de personas hablan aymara y 1,6% habla otros idiomas nativos. El resto habla lenguas extranjeras. Según esta fuente, más de la mitad de la población es bilingüe. Sin embargo, es importante señalar que, por una parte, se trata fundamentalmente de un bilingüismo sustractivo, es decir, con claro intento de castellanización y de desaparición paulatina de las lenguas (y) de las culturas indígenas. Por otra parte, grandes porcentajes de la población indígena – sobre todo femenina – que viven en las zonas peri-urbanas y dicen hablar el español, tienen en realidad apenas conocimientos rudimentarios de esa lengua y se comunican perfectamente sólo en su lengua materna indígena.

## LA REALIDAD SOCIAL, ALGUNOS INDICADORES BÁSICOS

A continuación se mencionan algunos datos que también son determinantes fundamentales en la situación de salud de la población boliviana. Casi un 70% de la población vive en condiciones de hacinamiento (3 o más personas por habitación), 77% no cuenta con servicio higiénico, 90% no dispone de ducha ni de tina de baño, 72% no tiene alcantarillado y un 59% no cuenta con agua potable.

A pesar de tener suficientes tierras fértiles para nutrir a sus habitantes, Bolivia, debido a la ausencia de políticas pertinentes, la corrupción imperante, el bajo nivel de los salarios, etc., se sitúa una vez más en el lamentable «último lugar», del país con menor consumo de calorías de América Latina. En relación a las recomendaciones de la FAO respecto al requerimiento diario por persona adulta, 2500 calorías, la disponibilidad calórica diaria por habitante boliviano es de 2088. A nivel de los barrios marginales, donde se sitúa la población peor alimentada, se estima un consumo de 1350 a 1500 calorías diarias.

Según diversas fuentes, la tasa de mortalidad infantil varía entre 75 y 80 por mil nacidos vivos. En el área urbana la tasa es de 58 y en la rural de 94. En base a la información de las madres, el 40% de las causas son aquellas ligadas al estado nutricional y sus complicaciones. Son muy numerosos los casos de muerte por diarreas agudas, vinculados a la malnutrición y, obviamente, a las condiciones de salubridad. La tasa de desnutrición en Bolivia alcanza al 11,67% (indicador peso por edad).

Según datos de la Organización de las Naciones Unidas para la Infancia (UNICEF), la mortalidad materna en Bolivia es la más elevada del hemisferio occidental, estimada entre 480 y 600 decesos maternos por 100000 partos de niños nacidos vivos. Como bien señala Iriarte, «el riesgo de morir para una mujer boliviana durante el embarazo o el parto es aproximadamente 60 veces mayor que para una mujer en Europa o en Estados Unidos».

Veamos las causas de estos decesos. Según datos obtenidos de los hospitales, 55% de las causas de mortalidad materna se deben a abortos inducidos, 26% a hemorragias de diversa etiología, 10% a toxemias y 9% a «otros». De acuerdo con la información que proporcionan las comunidades campesinas, las muertes maternas entre 1975 y 1988 se debieron en un 67% a causas vinculadas al embarazo, 12% al parto y 21% al tiempo del puerperio.

Según estas fuentes, ratificadas en el trabajo de campo, 48 de 10000 madres mueren por abortos inducidos, infecciones y hemorragias, anemias, desnutrición y trabajo físico excesivo durante el embarazo. No existen datos registrados respecto a la desnutrición materna después del parto.

Si bien se han registrado mejorías en los últimos 20 años, es importante señalar que Bolivia ocupa siempre el sitial menos favorable de índices de morbi-mortalidad en América Latina. Según un informe de la UNICEF, la tasa de mortalidad infantil que en 1978 ascendía a 120 por mil niños nacidos vivos, disminuyó a 80 en 1992. La esperanza de vida, calculada en 1990 en 53 años pasó en 1994 a 60 años. A pesar de ello, los ciudadanos bolivianos viven 10 años menos que sus vecinos latinoamericanos y 18 menos que los ciudadanos suizos.

Si la pobreza, según G. Iriarte, se define como «la insuficiencia en el consumo de bienes y servicios de los grupos alimentación, salud y educación», vemos que la pobreza en Bolivia se ha urbanizado.

En 1976, el 34% del total de la población pobre se encontraba en el área urbana. En 1988, el 45% de los pobres vivían en las ciudades, situación que ha ido y sigue en aumento. Ello significa que cerca del 63% de los hogares de las ciudades capitales son pobres y un poco más del 26% son indigentes, es decir que sus ingresos no alcanzan a cubrir los gastos de alimentación. Estos hogares representan fundamentalmente a los migrantes de origen quechua y aymara, mineros que abandonaron las minas a causa de los despidos masivos en la década de los 80 y campesinos del altiplano que abandonaron sus tierras por las sequías. Dichos migrantes se instalaron, legal o ilegalmente, en los alrededores de las ciudades, particularmente de la ciudad de Cochabamba, próxima a la región de mayor producción ilegal de coca del país. Estas son pues las características de las zonas marginales en las que trabaja el IFFI.

## SITUACIÓN DE LA MUJER BOLIVIANA

Del total de la Población Económicamente Activa (PEA), las mujeres constituyen el 36,5%, 10% más que en 1976. Casi la mitad de ellas se ocupa en el sector terciario (comercio minorista, comercialización de productos de contrabando y de ropa usada, servicio doméstico, etc.). El 44,4% realiza una actividad lucrativa en el sector primario y sólo el 16% realiza una actividad económica calificada (profesional o técnica).

El creciente aumento de la pobreza urbana obliga a las mujeres a trabajar en lo que fuere para asegurar la subsistencia de la familia. La combinación de su bajo nivel de instrucción con las responsabilidades domésticas, produce una ampliación irracional de la llamada economía informal. La lucha por obtener mejores ingresos, «conciliada» con la situación personal de la mujer, incluye las más creativas respuestas: pequeña industria, artesanía, actividades que se derivan del narcotráfico y del contrabando, comercialización de todo lo posible e inimaginable, etc. Estrategias que frecuentemente se desarrollan en el ámbito familiar, a veces a cargo exclusivo de las mujeres, sin ningún beneficio ni seguridad social. Las condiciones de esas «ocupaciones laborales» significan para las mujeres la llamada «doble o triple» jornada de trabajo, con las sobrecargas y consecuencias físicas que cabe suponer.

La creciente responsabilidad económica de las mujeres bolivianas se refleja asimismo en la jefatura del hogar, 19 de cada 100 mujeres entre los 15 y 19 años son consideradas jefas de hogar, 57 de cada 100 mujeres entre los 30 y 59 años y 23 de cada 100 mujeres de 60 y más años. A nivel nacional se estima que el 46% de los hogares bolivianos son sostenidos económicamente por mujeres.

Como en muchos otros países pobres vemos pues que las mujeres bolivianas ejercen un triple rol (reproductor, productor y de gestión) y asumen una serie de responsabilidades para la subsistencia de la familia. En efecto, con el objetivo de mejorar los escasos e inestables ingresos familiares – debido al aumento del desempleo y subempleo de los hombres y la dramática reducción de la capacidad adquisitiva – las mujeres hacen uso de diferentes estrategias de sobrevivencia, intensificando y diversificando su participación económica.

A estas alturas del análisis me parece importante resaltar dos aspectos. El primer aspecto – según informes de la Subsecretaría de Asuntos de Género del Gobierno y de la experiencia de terreno – es que a pesar de las terribles condiciones de vida y de trabajo a las que está sometida la mujer, su aporte económico toma una importancia vital tal que le permite renegociar algunos términos en su relación de pareja. De este modo, surge una redefinición del campo y los límites del «respeto» obligado hacia el esposo y, en tanto generadora de ingresos económicos, es ella la que ahora empieza a esperar o exigir el «respeto» que se le debe. El segundo aspecto importante a considerar es la verificación de que las mujeres gastan sus ingresos de manera distinta que los hombres. Ellas invierten prioritariamente en educación, alimentación y salud para la familia, los hombres destinan una parte importante de sus ingresos a la recreación.

Las mujeres se relegan frecuentemente, no reivindican ni toman lo que necesitan mientras el resto de la familia no esté «servida». Un ejemplo ilustrativo es la injusta distribución de los alimentos dentro de los hogares observados: la porción mayor la recibe el esposo «porque trabaja duro», luego vienen los hijos – primero los varones – y finalmente, lo que resta, si resta algo, es para las mujeres. La que distribuye los alimentos en la mesa es la madre-esposa, por consiguiente no resulta extraño que el 30% de las mujeres latinoamericanas embarazadas sean anémicas.

En octubre de 1994, bajo la presión del movimiento de mujeres y gracias a la intervención consecuente y militante de las mujeres parlamentarias, el gobierno boliviano decidió aprobar y ratificar la Convención Interamericana, promulgada por la OEA, para prevenir, sancionar y erradicar la violencia contra la mujer. Es así que en cumplimiento de la Ley contra la Violencia, se crearon a nivel nacional las «Brigadas contra la Violencia», compuestas fundamentalmente por mujeres policías.

Respecto a la violencia, de un total de 5526 denuncias de violencia registradas en un año, 76,3% fueron de violencia física y 12,2% de violación. La agresión física, violación y asesinato tuvieron lugar en el hogar y fueron practicados por los mismos familiares de los cuales 95% fueron varones. Respecto a las causas, la Subsecretaria de Asuntos de Género del Gobierno dice: «…en nuestro país hay una cultura autoritaria que se expresa en relaciones de poder al interior de la familia… es el sistema de valores y jerarquías vigentes en el país el que origina la violencia». Nuestra experiencia en barrios populares observa también que a medida que las mujeres empiezan a reivindicar su derecho a la salud, al margen de su rol reproductivo, y se atreven a aspirar otro destino de vida – por ejemplo pretendiendo planificar el número de hijos para buscar otras formas de realización personal o simplemente para tener tiempos prolongados de recuperación física – ellas se vuelven objeto de «sanciones» o control social, discriminaciones y violencia física y psíquica.

## 2. ESPECIFICIDADES DEL MUNDO ANDINO

Presentada la realidad boliviana, y dentro de ella de manera más específica la situación de la mujer en aspectos que tienen que ver con la salud integral, me parece importante ahondar sobre algunos aspectos de la cosmovisión y la práctica respecto a la salud y a las relaciones de género, de esa gran mayoría de la población boliviana que vive en las dramáticas condiciones de salud descritas. Me refiero a las poblaciones de origen indígena más representadas a nivel nacional y con las que el IFFI trabaja desde hace 18 años: aymaras y quechuas, quienes constituyen, como veíamos antes, más de la mitad de la población boliviana.

La razón de ello es que, como lo señalan las organizadoras de este encuentro, la promoción y el mejoramiento de la salud, al margen de las desigualdades socio-económicas que saltan a la vista de manera dramática en los países del hemisferio sur, no son solamente un asunto de transmisión de información y conocimientos de aquí para allá. La salud es un basto campo donde las relaciones de poder y de negociación, que son «socialmente construidas por la historia, la cultura y las prácticas sociales, juegan un rol fundamental…». Es decir, y es mi profunda convicción, se debe abandonar la actitud «globalizadora» (por no decir etnocéntrica) y entablar un verdadero diálogo con «el otro» y «la otra», en el afán conjunto y sincero de mejorar nuestras y sus condiciones de vida.

A pesar de que sólo intentaré acercarme a algunos aspectos de la cosmovisión andina, la empresa no será fácil debido a que la llamada cultura andina es un mundo inmenso y misterioso para quienes la percibimos desde el exterior. La experiencia de terreno y algunas lecturas de autores(as) que se ocupan del tema son la base de los enunciados subsiguientes.

En primer lugar, me parece importante aclarar que, a pesar de los índices publicados sobre «indigenidad», hoy no se puede hablar en Bolivia de culturas andinas puras, aisladas del conjunto de las otras culturas existentes. No podemos olvidar que, en un afán homogeneizador, durante más de 500 años esas sociedades sufrieron y sufren aún considerables agresiones a su cultura, desde intentos de supresión étnica hasta múltiples esfuerzos de integración a las Sociedades Nacionales. Como no puede ser de otra manera, la aculturación forzada o sutilmente subterránea ha dejado huellas, la yuxtaposición cultural se hace visible y sensible en todos los ámbitos de la vida de los bolivianos y bolivianas. Los procesos de intercambio, préstamos, asimilaciones e imposiciones culturales, modifican las cosmovisiones andinas, sobre todo en el área urbana. A pesar de ello, la cultura andina mantiene su singularidad y peculiaridad respecto a la cultura occidental. De ahí la importancia para referirme a ella en el marco de este encuentro.

## LA VISIÓN ANDINA DE LA SALUD

Como afirman algunos autores, las culturas andinas asumen una actitud integral, global, respecto al cuerpo y alma, persona, sociedad y cosmos. No se puede considerar al ser humano ni a la enfermedad o a la salud separadamente, sin tomar en cuenta todo el entorno (familiar, social, natural, etc.). Por otra parte, existe un principio estructural de dualismo (dos mitades, cielo-tierra, grande-chico, frío-caliente) que debe estar en armonía y equilibrio. La enfermedad es considerada justamente como un desequilibrio entre los contrarios. Consiguientemente, el proceso de curación pasa por el restablecimiento del equilibrio entre influencias opuestas. Algunos ejemplos: el resfrío es generalmente considerado «fresco» y puede ser curado con inhalaciones de eucalipto considerado «cálido», mientras que la fiebre (cálida) se curará con un emplasto fresco. En algunas regiones la inyección es percibida como «cálida», debido a ello muchas veces es rechazada cuando se trata de una enfermedad considerada «cálida». Siguiendo la lógica de los opuestos, no es de extrañarse que frecuentemente se rechacen las sales de rehidratación en casos de diarrea aguda, lo que se necesita es algo que «seque» las heces en vez de introducir al cuerpo un elemento líquido más.

Otro aspecto fundamental de las culturas andinas es el del intercambio y reciprocidad respecto a todos los ámbitos de la vida y de relaciones: entre personas, entre la naturaleza y el ser humano, etc. En este sentido, cuando por una u otra razón el principio de reciprocidad no se cumple, se produce el desequilibrio, la enfermedad, la riña, etc.

Según apreciaciones de algunos autores, confirmadas en nuestra práctica, las rupturas de equilibrio (enfermedades) pueden ser de varios tipos:

- ❑ «Enfermedades de dios». Frecuentemente resentimiento o ira de los Apus (espíritus de las montañas) o de la Pachamama (madre tierra) por que no se les trató bien, es decir, se faltó al principio de reciprocidad.
- ❑ «Enfermedades del blanco». Algunas infecciones.
- ❑ «Enfermedades de la posta». Las que sólo se pueden curar a través de la medicina occidental.
- ❑ «Nuestras enfermedades» o «enfermedades del brujo». Las que sólo se tratan con curanderos y medios tradicionales.

Es así que cuando escuchamos decir «no había sido enfermedad de médico», simplemente significa que el médico no puede curar todas las enfermedades y que hay casos que sólo el yatiri (curandero) puede curar. En el período de la concepción, el embarazo y el parto existen muchos peligros de tener una enfermedad de este tipo, por ello existe una variedad de medidas de protección.

Más allá de lo anecdótico o «exótico» de ésta y otras maneras de concebir la salud-enfermedad en las distintas culturas y latitudes del mundo, lo que se intenta es demostrar que no se puede prescindir del conocimiento de esas otras formas de ver las cosas cuando se trata de impulsar proyectos de cualquier tipo. Es necesario hacer un esfuerzo de lucidez y honestidad en las explicaciones respecto a los pocos o nulos resultados de las políticas de salud, aplicadas indiferentemente en distintas regiones y culturas del mundo.

## LAS RELACIONES DE GÉNERO EN LA CULTURA ANDINA

El enfoque de género nos permite visualizar en qué medida las diferentes sociedades definen y construyen las identidades de las mujeres y varones asignándoles diferentes características y roles. Del mismo modo, permite constatar las discriminaciones y las relaciones de poder que se establecen entre ambos sexos en diferentes espacios: el hogar, la escuela, el trabajo, la organización, los medios de comunicación, las leyes, etc.

Ahora bien, el mundo andino es un mundo de complementariedad, es decir, se basa en relaciones complementarias y de reciprocidad. Mencionábamos anteriormente que en el mundo andino todo es «par» (dos). Así, para ser «persona» se debe tener pareja. Al concepto «par», se contrapone el de «ch'ulla» (impar, sólo). Esta dualidad se expresa a través de la división entre derecho e izquierdo, que siempre son complementarios y se necesitan mutuamente (hombre-mujer, yunta de bueyes, etc.). Para lograr dicha complementariedad la pareja «debe ser» la unión de dos opuestos que juntos componen una simetría en tanto concepto ideal. En el mismo sentido, las «desigualdades complementarias» no necesariamente son dos «iguales» que se unen para formar el par y complementarse, puede haber asimetría y diferencias entre ambos «impares» que justamente hacen que al juntarse se complementen. Cada componente de una relación es alguien incompleto mientras no encuentre su «complemento» para posibilitar la regeneración de la vida.

Esta visión de «imprescindibilidad» de la pareja, fueron observados permanentemente en nuestro trabajo con mujeres de origen quechua y aymara del área urbana: «...sin marido, no hay respeto para la mujer, siempre le falta algo», «...el pobre, hasta ahora no ha podido conseguir mujer». Según un documento del equipo de educadores populares bolivianos (PROCEP), para las mujeres con las que trabajamos existe una jerarquización en el «ser mujer». El primer lugar valorativo ocupa la madre-esposa, el segundo lugar la madre, luego la soltera instruida, seguida por la mujer que aporta económicamente y finalmente, la mujer mayor con experiencia. En este sentido, la identidad más valorada y anhelada de la mujer como ser, pasa por la maternidad y por el hecho de tener marido. Para sentirse «mujer completa», existe una necesidad sentida en las mujeres por obtener y mantener dichos vínculos, en lo posible armónicos. Por otra parte, el sentido de bienestar (salud física y psíquica) de la mujer, a raíz de la concepción de globalidad que tiene, implica también su entorno familiar y social. De este modo, la mujer no puede considerarse como individualidad «fuera de», ella está y se siente bien, en la medida en que su familia también goza del bienestar.

Como institución que se plantea el enfoque de género en tanto relaciones equitativas entre varones y mujeres, el IFFI tiene como meta lograr las condiciones que permitan a todos y todas un acceso a bienes y oportunidades según los requerimientos y particularidades de las personas. En este sentido, los siguientes son los criterios trabajados en el proyecto de salud: la igualdad de derechos y responsabilidades en el cuidado de los hijos, la alimentación y salud de la familia, el trato equitativo a embarazadas, niños y niñas, la distribución equitativa de alimentos al interior de la familia, etc.

Muchas veces nos encontramos con que las mujeres mismas rechazan estos criterios «...el hombre trabaja mucho, él trae el dinero y yo como mujer tengo que cuidar a las guaguas», nos dicen. Como en tantos otros lugares del mundo, el trabajo doméstico no es valorado, es un quehacer cotidiano que debe ser asumido exclusivamente por la mujer aunque tanto ella como el hombre tengan que salir a trabajar fuera del hogar.

Como se mencionó precedentemente, la urbanización de lo indígena, el «roce» cotidiano con el mundo citadino occidentalizado y la nueva realidad socio-económica (creciente pauperización de los hogares de origen quechua o aymara que viven en los barrios marginales de las ciudades), son los factores que han modificado significativamente la vida de la gente andina y dentro de ella las relaciones entre mujeres y hombres. Los roles han cambiado, las mujeres tienen nuevas responsabilidades y mayor sobrecarga física y psíquica, los hombres no acaban de ubicarse ante tanta transformación de la vida de sus esposas. Creemos que estas modificaciones en las relaciones de género, como determinante importante en las condiciones de salud en general, influyen negativamente en la realidad de la salud de las mujeres. Por una parte, hombres y mujeres ven con naturalidad el aumento de las responsabilidades de la mujer, sin cuestionar el reparto de tareas dentro del hogar. Por otra parte, el desequilibrio que se presenta, ante esa aparente «superioridad» femenina que empieza a «exigir respeto» y la inestable situación laboral de los varones, provoca en ellos una profunda inseguridad, desconcierto y frustración que se expresa de diversas maneras: alto índice de alcoholismo masculino (frecuentemente vinculado a la violencia física y psíquica de la mujer), actitud posesiva y patriarcal (que impide a las mujeres regular su fertilidad), «aborto masculino» (el abandono de la familia), etc.

Referente a la Planificación familiar, tema «privilegiado» cuando se habla de relaciones de género vinculadas a la salud de las mujeres, no voy a extenderme mucho, sólo voy a confirmar que también es una necesidad muy sentida por las mujeres quechuas y aymaras «urbanizadas». Ellas se sienten sobrecargadas económica y físicamente, «los hijos cuestan, siempre es una boca más», «estoy gastada, cansada», «quisiera morirme», nos dicen. El alto índice de mortalidad materna a causa de abortos inducidos es dramáticamente ilustrativo. El sentimiento de las mujeres no siempre es compartido por los varones que, como veíamos anteriormente, ven en los continuos embarazos una forma de controlar la fidelidad de la esposa, de mantenerla «ocupada» para que no tenga tiempo de «andar mal». Son ellos los que muestran mayor resistencia a los métodos anticonceptivos, y el hecho de no trabajar el tema desde la perspectiva de las relaciones de pareja, pone a la mujer en una situación de conflicto suplementario. Quizás éstas sean parte de las razones por las que a pesar de la infinidad de programas y proyectos de Planificación familiar, la gran mayoría de las mujeres no emprende ninguna medida y sigue embarazándose.

## 3. CONCLUSIÓN

La reflexión sobre la realidad boliviana y la situación de la mujer andina que acabamos de exponer, no se agota ahí ni mucho menos, el tema es sin duda de mayor amplitud y complejidad. Sin embargo, a partir de los elementos vertidos hasta aquí, podemos formular algunas conclusiones en relación a las interrogantes de este encuentro.

A la pregunta de cómo y en qué condiciones influyen las relaciones de género sobre la capacidad de las personas para cuidar su vida y su salud y en su capacidad de optar, trataremos entender y responder esa influencia para el caso de las relaciones entre hombres y mujeres del mundo andino que viven en los barrios marginales de las ciudades de Bolivia.

Si consideramos, no sin cierto atrevimiento, dichas relaciones de género dentro de la cultura andina separada del entorno social y natural, vemos que esas relaciones en el contexto urbano ubican a la mujer en franca desventaja. Surgen una serie de contradicciones, sobre todo en la mentalidad y en la práctica de las mujeres, que son de cierta manera reforzadas por la sociedad y que provocan, justamente, el desequilibrio: enfermedad, infelicidad.

Por una parte, en un intento profundo y sincero de mantener el principio de complementariedad, las mujeres no se atreven salir de ciertas categorías, como la de la sobrevaloración de su rol principal: la procreación y el bienestar de sus hijos. Vimos que en la jerarquización del «ser mujer», el primer lugar valorativo está ocupado por la madre-esposa, ella sola no importa, por eso no acude a los centros de salud ni al curandero cuando está enferma, pero sí concurre cuando sus niños o el marido necesitan atención médica. Por otra parte, debido a la necesidad material de buscar medios de sobrevivencia para la familia, la mujer deja de tener ese único o principal rol y asume también el de producción, realizando jornadas de 16 horas y más, sintiéndose única responsable del bienestar de su entorno, sin darse cuenta de que también ella hace parte de ese entorno.

Como si fuera poco, vimos que en muchos casos el equilibrio del mundo de la mujer se rompe también cuando -por diversas razones- ella sola asume la Jefatura del hogar (quedar impar, ruptura de la estructura dual). Este es el caso de las familias de ex-mineros a causa de la morbi-mortalidad masculina (consecuencias nefastas de las pésimas condiciones de trabajo que tuvieron en las minas), de las familias donde los esposos se ven obligados a trabajar en otros lugares y que sólo pasan algunas temporadas del año con sus familias, de las innumerables familias que fueron abandonadas por los hombres («aborto masculino») o de aquellas en donde éstos no asumieron las consecuencias de sus actos (caso de las madres solteras), etc. Es decir, que además de vivir sobrecargadas física y psíquicamente, gran cantidad de mujeres son discriminadas socialmente a causa de su situación de «impar».

La no importancia de la mujer como persona obtiene un tinte «oficial» en la sociedad donde dominan estas relaciones de género, que no puede menos que estremecernos. Lo ilustraremos con un ejemplo. En la primera parte de esta exposición decíamos que en los Centros de Salud sólo existen datos del progreso y estado nutricional de los niños menores de un año, no así sobre índices de desnutrición materna después del parto. Una vez nacido(a) el niño(a) el estado nutricional y de salud en general de la mujer, no se controla. Cuando se le habla de mejorar su alimentación es siempre con el argumento de la producción de leche «para que su hijo esté sano y gordo». Lo que suceda con ella, con su cuerpo, con su salud, no interesa a nadie sino en función de su rol de madre proveedora.

Otra contradicción y campo de desequilibrio provocado por las relaciones de género se observa en la actividad de la recreación, la que consideramos parte integrante de la salud de las personas. Los varones invierten una parte importante de sus ingresos (y tiempo libre) en actividades deportivas, encuentros con los amigos en las chicherías[2], etc. Contrariamente, las mujeres, los domingos lavan lo no terminado en la semana, van a vender (bebidas, salados, sand-

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[2] Lugares donde se consume chicha,especie de «cerveza» andina producida del maíz.

wichs) a las canchas de fútbol, etc. Ella se permite y «se» le permite «salir» sólo si lo hace con el fin último de proveer una vez más a la familia. Es más, si la mujer sale a vender algo y no vuelve al hogar con el dinero de la venta, es agredida verbal y físicamente por el esposo.

El rol de la madre procreadora y proveedora, tradicionalmente sostenido y asumido, ha sido reforzado en contacto con la cultura judeo-cristiana occidental de los blancos y mestizos de las ciudades. Nos referimos a la identificación de la imagen de la madre con valores absolutos y sublimes de autoentrega, sacrificio y renuncia personal por el bien de su familia. Por esta razón, si a través del contacto con otros valores y modelos[3] las mujeres de origen indígena llegaran a aspirar a una realización de carácter personal diferente, se ven sometidas a presiones sociales y culturales tan fuertes que finalmente – en la mayoría de los casos – prefieren darse por satisfechas con su realización a través de los demás.

Nuestra reflexión sobre cuáles podrían ser los cambios de nuestras prácticas y las de las interesadas, tanto en la formulación de políticas de salud como en la ejecución de proyectos, surge igualmente de lo que antecede.

Una primera evidencia es que no es tan simple, menos aún a través de nuestra sola intervención, modificar las relaciones de género que influyen negativamente en la salud de las mujeres. De un lado, pensamos que no se puede tratar el tema de la equidad sólo en términos de reivindicación y confrontación, de otro lado, es necesario considerar, en este como en todos de temas, que el mundo andino es también un mundo de conversación. En efecto, para establecer reciprocidades y complementariedades, la comunidad andina necesita conversar[4], por lo tanto existe la necesidad, entre otras, de conversar con las mujeres sobre las relaciones de pareja y los significados que ellas y nosotras le damos. Charlando con ellas sobre sus

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[3] Valores y modelos de vida en la ciudad y la poderosa influencia de los medios de comunicación, sobretodo la televisión,que no falta ni en los hogares más pobres.

[4] Por ejemplo, el campesino charla con el viento, con las plantas, la tierra, etc., para saber dónde y cuando sembrar mejor.

sentimientos y aspiraciones para mejorar o modificar los efectos que se desprenden de esas relaciones, podemos imaginar juntas cambios «de a poquito», en términos de seguir sintiéndose complementada(o) así como de negociación dentro de las condiciones peri-urbanas. Estas condiciones, al haberse añadido el rol productivo al reproductivo, han significado para la mayoría de las mujeres un desequilibrio en la repartición de roles y de poder dentro de la pareja.

Creo que el tema del poder debe tratarse cuando las mujeres lo mencionan, cuando en la charla surgen elementos que ellas viven y sienten como conflicto o problema. Nuestra experiencia muestra que cuando se conversa verdaderamente en un plano de intercambio horizontal, ellas mencionan el tema cuestionando prácticas y actitudes. Este no es el caso cuando se llega con posturas predeterminadas y generalizadoras, cada realidad, cada caso, son únicos.

En cuanto al tema crucial de Planificación familiar, creemos que la razón fundamental de la no utilización de métodos anticonceptivos, más allá del temor a los efectos secundarios – algunos imaginarios, relacionados con su cosmovisión –, es el temor a romper la armonía de la pareja. Temor que tiene como base lo que tanto hombres como mujeres dicen y repiten: «…las mujeres que se hacen poner la T de cobre andan con otros hombres», en ese caso consideran que sus esposos tienen razón y derecho a oponerse. Además de información técnica y de insistir sobre aspectos vinculados a los derechos de la mujer como ser humano que hace parte del entorno y que tiene que «estar bien», parecería necesario abocarse al desafío de trabajar con ellas y sus parejas. Trabajo relativo a las significaciones sobre pareja desde su cosmovisión, la situación de la mujer dentro de ésta, las dependencias y relaciones así como las implicaciones en la salud de la mujer y de los niños que supone la presencia o ausencia de la planificación familiar.

El tema sobre el derecho de la mujer a la libre elección de la maternidad, en el caso de las mujeres andinas, no se puede descontextualizar de su realidad y sobre todo de su pareja. Como veíamos anteriormente, ella no puede verse «fuera de», al parecer, la solución al problema pasa por una solución desde el entorno. En este sentido, más que reivindicar el derecho de la mujer a decidir sobre su cuerpo, habría que hablar del derecho al bienestar de su entorno social, que implica necesariamente el bienestar y la buena salud de la mujer.

El tema de la fecundidad pone en evidente desventaja a las mujeres de los barrios populares. Por ello, las relaciones de poder y de dependencia dentro de la pareja, debería tratarse en un ambiente de negociación, complementación y reconstrucción de la pareja. Ello implica la «auto-re-valoración» de la mujer así como su valoración desde su entorno, reconociendo su derecho a «estar bien» y sabiendo que hay instancias que la protegen. Paralelamente, surge el desafío de empezar a considerar el tema de la «auto-re-valoración» de los varones dentro de su realidad y en relación al enfoque de género.

Quedan seguramente muchos aspectos a seguir reflexionando en este tema, muchas dudas e interrogantes a seguir trabajando dentro un proceso que no termina aquí ni ahora y que nos invita a ir(nos) re-creando permanentemente. El desafío es grande, pero creemos que vale la pena asumirlo, sobre todo, sabiendo que somos muchos(as) los que nos acompañamos en este camino.

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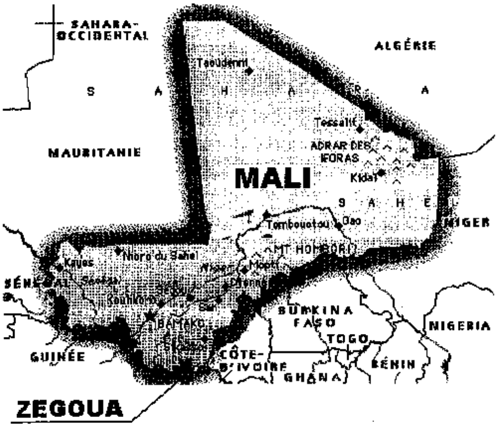
Ernesto R. PAPA, Yaya COULIBALY,
Sodjougou TEME, Marceline PAPA

# L'ORGANISATION MUTUALISTE DES FEMMES EN ZONE RURALE ET SON IMPACT DANS L'UTILISATION DES SERVICES DE SANTÉ

## LE CAS DES FEMMES DE L'AIRE DE SANTÉ DE ZÉGOUA (RÉPUBLIQUE DU MALI)

L'aire de santé de Zégoua (Cercle de Kadiolo, Région de Sikasso au sud du Mali), est constituée de huit villages et d'une ville frontalière. Elle couvre une population de 19872 habitants (chiffres pour l'année 1998) et est composée principalement des ethnies Sénoufos, Dioulas et Peulhs. Sa superficie est d'environ 750 km$^2$.



Les activités économiques prédominantes sont l'agriculture, l'élevage et le commerce.

Le Centre de Santé Communautaire (CSCOM) de Zégoua constitue le premier niveau de soins pour les habitants de l'aire. Il délivre un paquet minimum des activités (PMA) selon les normes de la politique sectorielle de la santé au Mali. et il est situé à 13 km de l'hôpital du district (première référence) de Kadiolo.

Depuis plusieurs années, l'équipe de santé du CSCOM de Zégoua avait constaté dans les huit villages périphériques de l'aire les problèmes suivants:

- Une faible utilisation des services préventifs : consultation prénatale et postnatale, accouchements assistés, vaccination des femmes et des enfants…
- Une exclusion financière temporaire (saisonnière) des femmes.
- Une présence des associations féminines traditionnelles se limitant à l'organisation des fêtes populaires.

Face à cette problématique, l'équipe de santé du CSCOM de Zégoua, avec l'infirmier chef de poste comme élément pivot et l'appui technique de l'équipe cadre du district de Kadiolo, a mis en place une stratégie visant à redynamiser les associations féminines traditionnelles, et à les organiser en mutuelles villageoises.

Le présent exposé est un récit de cette expérience qui a commencé au début de l'année 1997.

## 1. LES ASSOCIATIONS FÉMININES TRADITIONNNELLES

Les associations féminines ont toujours existé en milieu Sénoufo. Certaines datent de plus de cinquante ans. D'une manière générale, toutes les femmes mariées d'un village se regroupaient en une grande association. Elles travaillaient dans un champ communautaire leur appartenant pour en tirer profit. Parfois, elles offrent leurs services en cultivant des champs chez des privés à la demande, moyennant des rétributions symboliques en espèce ou en nature (exemple : un panier de céréales, une chèvre…). C'était une manifestation de solidarité, car les femmes de l'association rendaient des services à des familles, individus ou membres de l'association en difficulté en cultivant gratuitement leurs champs. Elles faisaient aussi un tour dans les champs de chaque membre.

### 1.1. BUREAU DE L'ASSOCIATION FÉMININE TRADITIONNELLE

Chaque association était dirigée par un bureau traditionnel. Il y avait souvent une petite modification dans la composition du bureau selon les villages. Ce bureau était généralement composé:

- ❑ d'une présidente très écoutée et qui avait tous les honneurs. Elle jouait très souvent le rôle de trésorière.
- ❑ de deux policières chargées de la surveillance générale, du conrôle de la présence, du respect des horaires aux moments des travaux, de l'identification des personnes en porte à faux par rapport aux règlements de l'association.
- ❑ d'une griotte faisait passer l'information et jouait le rôle de médiatrice en cas de conflits.
- ❑ de deux organisatrices chargées de la programmation des activités communautaires, des commissions diverses, du partage des repas pendant les fêtes et dans les champs.
- ❑ du parrain de l'association qui était un vieux notable, très respecté aussi appelé *Tonfa*, père de l'association.

### 1.2. ÉVOLUTION DES ASSOCIATIONS FÉMININES TRADITIONNELLES

Avec l'accroissement rapide de la population des villages, des quartiers se sont créés. Les chemins à parcourir entre le village et les champs devenaient longs, la gestion du temps difficile. Ce qui a nécessité l'éclatement des grandes associations en associations plus petites au niveau des quartiers. Dans un village de cinq quartiers, on peut recenser cinq associations de femmes. Ainsi au niveau des huit villages de l'aire de santé, on dénombre une trentaine d'associations organisées de façon identique et visant presque les mêmes objectifs: solidarité, appui, entraide dans les champs, organisation des fêtes.

Les produits issus de la culture des champs privés, les recettes des ventes des produits des récoltes des champs collectifs et les chèvres étaient destinées à organiser les fêtes d'après hivernage. Ces fêtes pouvaient durer de deux à trois jours en fonction du gain, si bien que les caisses étaient complètement vides après ces fêtes et les femmes ne pouvaient plus faire face à aucun problème financier.

En effet, il n'était pas rare de voir certaines femmes complètement démunies, ne pouvant faire face à aucune dépense si minime soit-elle. Le chef de poste médical assistait impuissant et désemparé à certaines scènes pendant ses séances de stratégie avancée. C'est là qu'est venue l'idée de redynamiser et d'étendre les champs d'action de ces associations féminines, en l'occurrence dans le domaine de la prise en charge de certaines activités sanitaires: les mutuelles villageoises.

### 1.3. TENDANCE ACTUELLE DES ASSOCIATIONS DE FEMMES

Après des séances de sensibilisation effectuées par des animatrices, les femmes ont mieux compris les avantages des activités préventives telles que la vaccination, la consultation prénatale (CPN), la consultation postnatale, la surveillance préventive des enfants (SPE), l'accouchement assisté par un personnel qualifié; activités pour lesquelles elles sont confrontées au paiement des frais. L'expérience montre que très peu d'hommes en milieu rural se soucient de la prise en charge de ces activités. Ainsi, la nécessité d'une prise en charge par les femmes elles-mêmes s'avérait plus qu'urgente.

Pour la redynamisation, plusieurs rencontres de l'infirmier chef du poste médical avec les responsables des associations existantes et les chefs de familles ont permis d'expliquer cette idée. Après leur avis favorable, une assemblée générale a obtenu l'adhésion de tous. C'est ainsi que de nouvelles associations ont vu le jour pour solutionner l'épineux problème de la prise en charge des activités préventives.

Il est important de préciser que la mise en place de cette expérience n'a pas nécessité la mobilisation des moyens financiers supplémentaires. En effet, l'infirmier responsable mène l'expérience dans le cadre de ses activités de routine.

## 1.4. BUTS DES MUTUELLES DES ASSOCIATIONS FÉMININES

Les principaux buts des mutuelles des associations féminines sont:

- l'amélioration des conditions de vie et de travail des femmes;
- une large information des femmes sur les problèmes de santé;
- le financement des activités préventives (CPN, vaccination, post-natale, SPE, accouchement, carnet de santé, chloroquinisation, fer, planning familial);
- le renforcement de la solidarité entre les femmes.

## 1.5. SOURCES ET REVENUS DES MUTUELLES DES ASSOCIATIONS FÉMININES

Les sources de revenu des mutuelles des associations féminines sont constituées, entre autres, par:

- les frais d'adhésion. Pour commencer avec la nouvelle tendance, il a été demandé à chaque femme de payer les frais d'adhésion qui s'élèvent à 500 francs CFA (1,25 franc suisse).
- les autres sources de revenus: chaque association est libre de définir d'autres sources de revenu. Par exemple la culture de champs collectifs (coton, maïs, riz, arachide, etc); ou l'organisation des journées de culture chez des particuliers à la demande de ces derniers et moyennant un paiement; ou l'institution d'une cotisation mensuelle ou annuelle par membre.
- la mise en place de jardins communautaires, de moulins, avec l'appui des partenaires. C'est le cas du Programme Santé Mali-Suisse (P.S.M.S.).

## 1.6. FONCTIONNEMENT

### *1.6.1. Statut et règlement*

Chaque femme membre d'une association a des obligations vis-à-vis de celle-ci:

- s'acquitter de ses cotisations annuelles ou mensuelles;
- se faire vacciner si on appartient à une population cible donnée;
- amener les enfants à la SPE;

- suivre soit la CPN, soit la postnatale selon les cas;
- accoucher dans une structure sanitaire.

Toute femme membre ne respectant pas le règlement est punissable d'une amende.

### *1.6.2. Bureau*

Il en existe en deux types: un bureau par association féminine et un bureau de coordination s'il y a plus d'une association féminine dans le village. Le bureau d'une association féminine est composé:

- d'une présidente;
- d'une vice-présidente;
- d'une trésorière;
- de deux commissaires aux comptes;
- de deux organisatrices;
- d'une ou de deux secrétaires. Chaque association prend un vieux notable du village, comme parrain appelé *Tonfa*, qui est membre de droit et membre d'honneur.

Le bureau a pour rôle de recenser les membres, de proposer les sources de revenu, de fixer les dates des rencontres, d'assurer la mobilisation de ses membres et d'encaisser les fonds de l'association. La secrétaire et la présidente sont membres de droit du Comité de santé du village.

Le bureau de coordination est composé de la même manière que le précédent. Chaque association a une représentante dans ce bureau. Il a pour rôle d'encaisser les fonds recouvrés par les bureaux des différentes associations, d'assurer l'ouverture d'un compte commun, «la caisse maladie» dans laquelle il verse les fonds et fait les retraits d'argent suivant les besoins de payement au CSCOM de Zégoua. La banque locale de dépôt est le *Kafo Jiguina* de Zégoua. En plus, il fait le point de la gestion par association et en rend compte. Il fixe la date des rencontres de l'ensemble des bureaux.

A ce niveau, la présidente et la secrétaire qui sont membres de droit de l'ASACO (Association de Santé Communautaire, véritable propriétaire du CSCOM), participent aux différentes assemblées de l'ASACO et aux rencontres semestrielles de l'ensemble des animateurs de l'aire de santé.

### *1.6.3. Supports de gestion*

- ☐ Cahier de caisse. Dans ce cahier, sont enregistrées toutes les recettes de l'association, quelle que soit la source. A ce niveau, la trésorière de chaque association fait le versement à la trésorière du bureau de coordination, chaque fois que le montant encaissé atteint 5000 francs CFA. La trésorière générale l'enregistre dans son cahier de caisse et verse le montant à la banque dès qu'il atteint 25000 francs CFA.
- ☐ Cahier de banque. Il est détenu par la trésorière générale. Dans ce cahier sont mentionnées toutes les opérations de versements et de retraits au niveau du *Kafo Jiguina*. Ce document est le cahier de banque du bureau de coordination. Il est à signaler que chaque association a aussi son cahier de banque qui lui permet de connaître sa situation financière à tout moment.
- ☐ Cahier d'activités. L'infirmier, au cours de ses activités de stratégie avancée, inscrit les noms des femmes ou des enfants qui en ont bénéficié, en précisant le montant à payer et en tenant compte de leur appartenance à telle ou telle association. La femme ne paye pas un franc sur le moment. A la fin du mois, le compte de ce cahier est arrêté par les membres du comité de village, en collaboration avec le bureau de coordination de l'association. Ce bureau, à son tour, fait le retrait à la banque et verse le montant au trésorier de l'ASACO de Zégoua qui délivre un reçu.
- ☐ Cahier de fonctionnement. Après retrait, les motifs sont mentionnés dans le cahier de fonctionnement de chaque association pour des contrôles éventuels.

## 1.7. RESPONSABILITÉS DES HOMMES

Les hommes travaillent aux constructions importantes du village: école, barrage de retenue d'eau, forage, centres ou cases de santé.

Certaines dépenses de fonctionnement du village sont aussi prises en charge par les hommes : salaire des enseignants (cas des écoles de base), récompenses et/ou indemnités des agents de développement du village, ainsi que les dépenses de la famille : payement des impôts ou autres taxes, traitement des membres de la famille en cas de maladie.

#### *1.7.1. Appui des hommes aux associations féminines*

Les hommes de certains quartiers ont participé à la réalisation des champs ou des jardins collectifs (défrichage, labour). Des chefs de famille payent les cotisations de leurs femmes. Dans plusieurs localités, les jours de culture sont partagés entre les hommes et les femmes. Il est à signaler que beaucoup d'hommes ont accepté d'accorder des jours supplémentaires aux femmes pour qu'elles travaillent dans leur champ collectif.

### 1.8. APPUI EXTÉRIEUR

En 1998, les associations féminines de trois villages (Fanidiama, Ziangolodougou et Katélé) ont reçu l'appui du Programme Santé Mali-Suisse pour le financement partiel d'un jardin communautaire à Ziangolodougou et de moulins à Fanidiama et Katélé.

Ces appuis nous permettront d'expérimenter l'introduction de la prise en charge d'autres activités en 1999 : achat de chloroquine et de fer pour les femmes enceintes et de contraceptifs pour celles qui le souhaitent.

## 2. L'IMPACT DE L'ORGANISATION MUTUALISTE DES FEMMES

### 2.1. RÉSULTATS OBTENUS DANS L'UTILISATION DES SERVICES PRÉVENTIFS

Les résultats obtenus dans l'utilisation des services préventifs pour les années 1997 et 1998 sont présentés dans les tableaux 1 et 2. Ces résultats démontrent une nette amélioration dans l'utilisation des services. En effet (tableau 3, figures 1 et 2), les chiffres obtenus en 1997 pour l'ensemble des villages de l'aire de santé de Zégoua sont significativement supérieurs à ceux de l'année 1996 et ceux de 1998 ont connu une amélioration importante par rapport à 1997. Des activités comme la SPE, la consultation postnatale, qui n'étaient pas menées auparavant, ont pu démarrer en 1997 grâce à la mise en place de l'organisation mutualiste dans les villages concernés.

Il est à souligner que durant les années 1997-1998, il n'y a pas eu d'autres facteurs pouvant influencer la fréquentation des services préventifs.

Ces bons résultats vont certainement encourager les différents partenaires de cette expérience à élargir la gamme des activités prises en charge par ces mutuelles issues des associations féminines.

C'est ainsi qu'il est envisagé pour l'année 2000 l'introduction progressive des certains actes curatifs comme les sutures et les pansements effectués par des agents qualifiés.

TABLEAU 1 : UTILISATION DES SERVICES PRÉVENTIFS
POUR L'ENSEMBLE DES VILLAGES DE L'AIRE DE SANTÉ DE ZÉGOUA – ANNÉE 1997

| Villages | Pop. | CPN | | Accouch. | | Postnatale | | SPE | | BCG | | DTCP 1 | | DTCP 3 | | VAR | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Nb | % | Nb | % | Nb | % | Nb | % | Nb | % | Nb | % | Nb | % | Nb | |
| Fandiama | 2959 | 182 | 123 | 131 | 89 | 102 | 69 | 131 | 26 | 38 | 80 | 130 | 119 | 98 | 89 | 107 | 98 |
| Ziangolodougou | 1475 | 89 | 121 | 58 | 79 | 20 | 27 | 30 | 12 | 56 | 103 | 50 | 92 | 31 | 57 | 43 | 64 |
| Katele | 1512 | 41 | 54 | 40 | 53 | 3 | 4 | 73 | 28 | 67 | 121 | 59 | 107 | 38 | 69 | 44 | 80 |
| Nassoulou | 570 | 26 | 92 | 19 | 67 | 8 | 28 | 20 | 21 | 19 | 90 | 23 | 109 | 16 | 76 | 25 | 119 |
| Dialakorosso | 716 | 16 | 45 | 4 | 11 | 0 | 0 | 0 | 0 | 22 | 84 | 27 | 103 | 9 | 34 | 13 | 50 |
| Katiolini | 476 | 11 | 47 | 6 | 26 | 0 | 0 | 3 | 3 | 15 | 88 | 15 | 88 | 11 | 64 | 12 | 70 |
| Zampedougou | 450 | 16 | 77 | 19 | 86 | 12 | 54 | 19 | 25 | 22 | 137 | 27 | 168 | 6 | 37 | 10 | 62 |
| Kalibene | 416 | 7 | 72 | 5 | 25 | 0 | 0 | 42 | 60 | 17 | 113 | 12 | 30 | 12 | 80 | 11 | 73 |
| Total | 8574 | 388 | 90 | 282 | 65 | 145 | 33 | 318 | 22 | 306 | 96 | 343 | 108 | 221 | 69 | 257 | 81 |

N.B. : Les % ont été calculés par rapport à la population cible de chaque activité.
Les % supérieurs à 100% s'expliquent par le fait que la population réelle de l'aire de santé de Zégoua dépasse la population cible théorique attendue (motifs : défaillances du recensement, immigration interne, population frontalière…).

TABLEAU 2: UTILISATION DES SERVICES PRÉVENTIFS
POUR L'ENSEMBLE DES VILLAGES DE L'AIRE DE SANTÉ DE ZÉGOUA – ANNÉE 1998

| Villages | Pop. | CPN | | Accouch. | | Postnatale | | SPE | | BCG | | DTCP 1 | | DTCP 3 | | VAR | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Nb | % | Nb | % | Nb | % | Nb | % | Nb | % | Nb | % | Nb | % | Nb | |
| Fandiama | 3012 | 154 | 102 | 159 | 106 | 131 | 87 | 166 | 33 | 110 | 99 | 119 | 107 | 122 | 109 | 100 | 90 |
| Ziangolodougou | 1501 | 67 | 89 | 62 | 82 | 56 | 74 | 64 | 25 | 61 | 110 | 67 | 121 | 43 | 78 | 43 | 78 |
| Katele | 1539 | 68 | 89 | 50 | 65 | 62 | 81 | 83 | 32 | 43 | 76 | 53 | 94 | 54 | 96 | 54 | 96 |
| Nassoulou | 580 | 33 | 113 | 26 | 89 | 19 | 65 | 26 | 27 | 44 | 209 | 55 | 261 | 33 | 157 | 40 | 190 |
| Dialakorosso | 729 | 23 | 63 | 21 | 58 | 21 | 58 | 72 | 59 | 40 | 153 | 43 | 165 | 43 | 165 | 23 | 88 |
| Katiolini | 484 | 18 | 75 | 14 | 58 | 2 | 8 | 14 | 17 | 8 | 47 | 16 | 94 | 8 | 47 | 14 | 82 |
| Zampedougou | 459 | 17 | 77 | 19 | 86 | 19 | 86 | 29 | 38 | 20 | 125 | 22 | 137 | 14 | 87 | 12 | 75 |
| Kalibene | 423 | 24 | 114 | 20 | 95 | 23 | 109 | 47 | 66 | 30 | 200 | 27 | 180 | 29 | 193 | 15 | 100 |
| Total | 8727 | 404 | 92 | 371 | 85 | 145 | 76 | 501 | 34 | 356 | 110 | 402 | 124 | 346 | 107 | 301 | 93 |

N.B.: Les % ont été calculés par rapport à la population cible de chaque activité.
Les % supérieurs à 100% s'expliquent par le fait que la population réelle de l'aire de santé de Zégoua dépasse la population cible théorique attendue (motifs: défaillances du recensement, immigration interne, population frontalière…).

Tableau 3 : Utilisation des services préventifs pour l’ensemble des villages de l’aire de santé de Zégoua – Année 1996-1997-1998

| Année | Pop. tot. | CPN | | Accouch. | | Postnatale | | SPE | | BCG | | DTCP 1 | | DTCP 3 | | VAR | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Nb | % | Nb | % | Nb | % | Nb | % | Nb | % | Nb | % | Nb | % | Nb | % |
| 1996 | 8418 | 247 | 58 | 218 | 51 | 0 | 0 | 0 | 0 | 195 | 62 | 220 | 70 | 123 | 39 | 168 | 54 |
| 1997 | 8574 | 388 | 90 | 282 | 65 | 145 | 33 | 318 | 22 | 306 | 96 | 343 | 108 | 221 | 69 | 257 | 81 |
| 1998 | 8727 | 404 | 92 | 371 | 85 | 333 | 76 | 501 | 34 | 356 | 110 | 402 | 124 | 346 | 107 | 301 | 93 |

N.B. Les % ont été calculés par rapport à la population cible de chaque activité.
Les % supérieures au 100 % s’expliquent par le fait que la population réelle de l’aire de santé de Zégoua dépasse la population cible théorique attendue (motifs : défaillances du recensement, immigration interne, population frontalière…).

## 2.2. RÉSULTATS FINANCIERS

Dans le tableau 4, nous présentons la situation du recouvrement des cotisations et des soldes des associations féminines (par village) au 31 décembre 1998.

Toutes les associations présentent un solde excédentaire après avoir payé au CSCOM de Zégoua l'ensemble des activités préventives prises en charge.

Afin de préserver une bonne santé financière de ces mutuelles villageoises «débutantes», il est très important que l'introduction des nouvelles activités de santé à prendre en charge se fasse de manière progressive et en tenant compte des capacités financières réelles des associations féminines.

TABLEAU 4:
SITUATION DU RECOUVREMENT DES COTISATIONS ET DES SOLDES DES ASSOCIATIONS FÉMININES PAR VILLAGE AU 31.12.1998.

| **Villages** | **Date ouverture compte** | **Montant versé* (1997-1998)** | **Solde au 31.12.98** |
|---|---|---|---|
| Fanidiama | 03.04.1997 | 867 085 | 433 785 |
| Ziangolodougou | 03.05.1997 | 235 425 | 69 625 |
| Nassoulou | 26.04.1997 | 266 195 | 159 045 |
| Dialakorosso | 17.04.1997 | 210 000 | 50 500 |
| Katele | 26.04.1997 | 258 600 | 139 000 |
| Zampedougou | 18.09.1997 | 58 365 | 10 620 |
| Katioloni | 10.05.1997 | 34 000 | 12 180 |
| Kalibene | 20.07.1997 | 132 900 | 80 400 |
| Total | | **2 062 570** | **955 155** |

* Monnaie: franc CFA.

### 2.3. AUTRES IMPACTS DE L'ORGANISATION MUTUALISTE DES FEMMES

- ❑ Prise de conscience et responsabilisation des hommes face aux problèmes de santé des femmes (les hommes appuient les femmes pour la bonne marche de l'initiative).
- ❑ Renforcement des idées associatives de sorte que chaque femme, par solidarité, fasse partie d'une association.
- ❑ Prise de conscience des femmes face à leurs problèmes de santé : meilleure fréquentation des services préventifs, auto-contrôle par les membres de l'association (statut et règlements). Place de choix accordée à la prévention.
- ❑ Renforcement du système de gestion (ouverture de comptes bancaires, supports de gestion qui garantissent les fonds recouvrés et rassurent ainsi les adhérantes).
- ❑ Développement d'un sens de responsabilité, gage d'une bonne gestion de l'argent. S'unir pour le progrès. Organisation de fêtes traditionnelles plus symboliques, moins coûteuses.
- ❑ Large sensibilisation des femmes sur les problèmes de santé de la mère et de l'enfant (les animatrices du CSCOM sont appuyées par les membres du bureau des femmes pendant les séances d'éducation pour la santé).
- ❑ Développement de l'esprit de compétition entre les femmes et entre les associations.

## 3. CONCLUSION

Cette expérience basée sur la solidarité entre les femmes en milieu rural a permis de constater que les femmes organisées en association, motivées et correctement accompagnées par du personnel compétent, peuvent prendre en charge leur propre développement. Le cas de Zégoua est encourageant ; cependant, il faudrait observer plus de recul pour mieux apprécier ses forces et faiblesses avant de le reproduire ailleurs.

Une gestion rigoureuse est fondamentale pour assurer la viabilité des mutuelles des associations féminines. Un suivi régulier et un appui souple et intelligent de l'équipe de santé du CSCOM de Zégoua seront des éléments clés pour garantir la réussite de ces mutuelles et son ancrage.

Enfin, l'expérience de Zégoua, bien que récente, prouve que la mise en place des mutuelles villageoises est possible avec les moyens locaux et un personnel motivé.

### DIDIER FASSIN

# INÉGALITÉ, GENRE ET SANTÉ, ENTRE L'UNIVERSEL ET LE CULTUREL

Dans un ouvrage paru en 1936, et devenu depuis un classique de l'anthropologie, *We the Tikopia*, Raymond Firth, alors jeune ethnologue venant de passer deux années parmi ces habitants de l'une des Iles Salomon qui sont parmi, nous dit-il, «les plus primitifs des Polynésiens», s'émerveille de leur «physique magnifique»: «Quand on songe à la bonne constitution des sauvages, au moins de ceux que nous n'avons pas perdus avec nos liqueurs fortes, quand on sait qu'ils ne connaissent presque d'autres maladies que les blessures et la vieillesse, on est porté à croire que l'on ferait aisément l'histoire des maladies humaines en suivant celle des sociétés civiles». Sociétés heureuses jusque dans leur corps épanoui où se réalise le grand rêve rousseauiste de l'harmonie entre l'homme et la nature!

Deux éléments peuvent pourtant intriguer le lecteur qui découvre le recensement de la population que l'auteur a effectué pendant son séjour. En effet, d'une part, il constate, parmi les enfants, un effectif de 338 garçons pour 249 filles, ce qui représente un ratio de 1,35, tout à fait inhabituel, puisqu'au contraire, en bas âge, la survie des filles est normalement supérieure à celle des garçons. Evoquant l'hypothèse, somme toute raisonnable, d'un infanticide sélectif, l'auteur la récuse pourtant facilement, sur le simple argument que ses informateurs – des hommes – s'en défendent. Mais d'autre part, on trouve à l'âge adulte un retour à l'équilibre parfait entre les deux sexes, avec maintenant un ratio de 1, ce qui est, là encore, assez remarquable. Le fait, cependant, n'étonne pas d'avantage l'auteur qui se contente de noter que la mortalité supérieure des hommes dans cette période de leur vie est probablement liée à des accidents de chasse, des noyades, des chutes d'arbres et des rixes au sein du groupe. Au fond, ces données démographiques sont d'autant plus facilement naturalisées qu'elles débouchent sur un bilan mathématiquement nul, puisqu'au bout du compte, on a bien le même nombre d'hommes et de femmes pour assurer la bonne reproduction du groupe.

De cette brève évocation ethnographique, on peut tirer au moins trois enseignements. En premier lieu, l'anthropologue ne porte jamais, on le sait, un regard objectif sur ses objets et terrains d'enquêtes : il ne voit que ce qu'il est prêt à voir et, bien souvent, les hommes anthropologues ont eu tendance à travailler avec des lunettes masculines. En second lieu, l'inscription de l'inégalité de genre dans les corps existe, même si elle y prend une forme particulière, dans des sociétés très éloignées de la nôtre, y compris celles que nous considérons comme les plus traditionnelles. En troisième lieu enfin, toutes les morts et toutes les souffrances ne s'équivalent pas : le bilan à somme nulle de cette population polynésienne où les hommes sont aussi nombreux que les femmes, masque deux causes de décès sexuellement différenciées, infanticide des petites filles et mort accidentelle des hommes, qui même si elles sont identiques en quantité, n'ont pas la même signification sociale, traduisant précisément, pour autant qu'on y prête attention, des disparités profondes de statut.

Prolongeant ces remarques, j'aimerais, dans ce texte, esquisser une réflexion sur les inégalités sociales de genre et sur leur inscription dans les corps, en m'efforçant plus particulièrement de relier les deux fils de l'anthropologie que sont la recherche de l'universel et l'appréhension du culturel, ou encore, pour paraphraser Leach, l'unité des relations entre les sexes et la diversité de leurs configurations. Dans un premier temps, il sera question de ces disparités incorporées entre hommes et femmes dans des sociétés différentes :

plutôt qu'un panorama exhaustif, l'ambition est de saisir la permanence d'une inégalité et des variations historiques dans ses manifestations. Dans un second temps, il s'agira de partir du paradoxe bien connu de la sous-mortalité et de la surmorbidité des femmes par rapport aux hommes afin de discuter de la contribution de l'anthropologie à une critique du raisonnement statistique faisant de tous les faits sanitaires des réalités équivalentes. Dans un troisième temps, on mettra en cause le recours habituel à l'anthropologie dans l'étude des disparités de genre: le traitement culturaliste de l'inégalité sert en effet souvent à en occulter les déterminations socio-économiques ordinaires et à priver les dominés de leur droit à un universel au prétexte de leur différence. L'analyse ne sera toutefois qu'ébauchée dans les pages qui suivent et l'on pourra, pour une discussion substantielle des différents points traités ici, se reporter à des travaux antérieurs (1987, 1992a, 1992b, 1996, 1999a, 1999b).

## L'UNIVERSALITÉ DIVERSE

Les anthropologues qui ont étudié l'inégalité dans les sociétés traditionnelles ont fréquemment négligé la part revenant aux relations de genre. Ainsi, Alain Testard (1982) dans sa recherche sur l'origine des inégalités, qu'il fait remonter au passage à la sédentarisation avec les possibilités d'accumulation qu'elle permet, traite d'un homme préhistorique asexué, négligeant la division du travail et des ressources à l'intérieur des familles. A l'inverse Marshall Sahlins (1976) qui, lui, s'intéresse précisément au mode de production domestique, ne descend pourtant pas au-dessous du niveau de l'unité familiale pour dévoiler les rapports de domination et d'exploitation existant en son sein et réduit la famille à un adulte mâle et un adulte femelle. Indifférenciation sexuelle dans un cas, naturalisation du genre dans l'autre, il n'y a pas ici de place pour l'inégalité entre hommes et femmes.

Pourtant si l'on suit Françoise Héritier (1996), aucune société n'a été exempte de rapports de domination masculine, contrairement à une certaine vulgate anthropologique confondant probablement matrilignage et matriarcat. La manière, pourtant, dont ces disparités s'inscrivent dans les corps est mal connue et en tout état de cause complexe. Dans l'étude qu'il a consacrée aux Baruya de Nouvelle-Guinée, Maurice Godelier (1982) note que, dans ce groupe qui, jusque dans les années cinquante, n'avait jamais été en contact avec le monde blanc, «les hommes régissaient la société non pas sans les femmes mais contre elles». Ce sont eux qui possèdent la terre, fabriquent les armes et les outils, assurent la production et le commerce du sel, pratiquent la chasse et les travaux agricoles les plus durs, enfin distribuent la nourriture carnée en s'attribuant les meilleurs morceaux. L'incorporation de la différence de genre et de la supériorité des hommes se fait tout au long de la vie, notamment lors des périodes d'initiation. Les éventuelles révoltes contre cet ordre des choses sont sévèrement punies, entraînant parfois la mort de la contrevenante. Cette domination trouve sa justification idéologique dans des représentations du corps et de ses substances, puisque le sexe masculin exprime la force alors que le sexe féminin est symbole d'impureté, et que le sperme confère la vie quand le sang menstruel est associé au danger. Autrement dit, le corps n'est pas seulement le lieu où se manifeste l'inégalité il est aussi celui où elle se légitime : c'est donc parce qu'elle est l'inégalité la plus naturelle que la différence entre les hommes et les femmes est aussi la plus universelle. Et il suffit que les anthropologues s'intéressent à cette réalité pour que les exemples l'attestant se multiplient.

Dans mes propres recherches au sud du Sénégal, j'ai montré la manière dont, chez les Diola de Casamance, la stérilité d'un couple et même la mort d'enfants en bas âge étaient imputées à la seule femme, conduisant à des rituels expiatoires extrêmement douloureux et humiliants durant plusieurs années. Au cours de cette longue période du *kañaalen* pendant laquelle la jeune femme, exilée volontaire, se trouve réduite à un statut proche de l'animalité dans son village d'adoption, toutes sortes de violences physiques et morales sont perpétrées contre elle pour obtenir à la fois sa rédemption et la protection de sa progéniture. La responsabilité de la mère dans les malheurs qui accablent sa descendance, qu'elle en soit consciente si on la considère comme une sorcière ou inconsciente si on la pense possédée par un génie, appelle de toute façon ce traitement spectaculaire qui la conduit à prendre le rôle de bouffonne rituelle et de travailleuse forcenée pour le groupe. Signe, au demeurant classique, de l'assimilation collective de cette représentation des relations de genre dans la procréation, ce sont les femmes âgées, dont beaucoup ont elles-mêmes subi cette épreuve, qui sont les premières à l'imposer aux plus jeunes. Le rituel apparaît ainsi à la fois comme la propriété la plus secrète de l'univers symbolique des femmes et en même temps comme l'espace de la plus grande violence sociale à leur égard. Là encore, la traduction physique des rapports de pouvoir entre les hommes et les femmes relève d'une logique sociale subtile qui fait plier le corps des femmes sous les coups, les rires ou les rites du groupe et qui leur fait reconnaître leur souffrance comme naturelle, puisque c'est par elle que l'ordre de la reproduction biologique peut reprendre ses droits.

L'inégalité de genre, quelle que soit la société que l'on considère, et pour autant que l'on veuille la mettre en évidence, apparaît comme un fait universel, dont les justifications tout comme les manifestations sont toutefois éminemment variables. Son inscription dans les corps revêt de la même manière des formes extrêmement différentes, qui s'expriment, selon les cas, par des disparités devant la mort, par des malnutritions plus fréquentes, par des violences sexuelles, voire par des attitudes de soumission inculquée. C'est dire l'importance d'une anthropologie de l'inégalité qui dépasse le cadre strict de la mortalité et de la morbidité telle que le dessine l'épidémiologie.

## UN PARADOXE HEURISTIQUE

A cet égard, on connaît le paradoxe bien connu. D'une part, il existe, à peu près partout dans le monde, sauf dans la péninsule indienne, une sous-mortalité féminine qui se manifeste par des taux de décès moindres à tous les âges jusqu'à soixante ans et par une espérance de vie supérieure de plusieurs années. Ainsi, en France, les femmes meurent trois fois moins que les hommes entre trente-cinq et soixante ans et même, les femmes des catégories les plus défavorisées socialement – personnels de service, ouvrières spécialisées – ont une espérance de vie à trente-cinq ans supérieure à celle des hommes des classes les plus aisées – ingénieurs, professeurs (Desplanques 1993). Mais d'autre part, on constate, de manière également très répandue sur la planète, que les femmes ont une surmorbidité, c'est-à-dire qu'elles signalent plus de symptômes et de maladies lorsqu'on les interroge sur leur état de santé, avec là encore des écarts généralement importants par rapport aux hommes. Toujours en France, les femmes déclarent ainsi vingt à trente-cinq pour cent de troubles de plus que les hommes, l'excès étant particulièrement marqué pour les problèmes psychologiques (Aïach 1989). Cette situation paradoxale de femmes se disant plus malades mais mourant moins que les hommes a conduit à des explications selon lesquelles les premières auraient, bien plus que les seconds, intériorisé dès la petite enfance un rapport plus attentif au corps et une légitimité sociale à se plaindre. Ces questions sont cependant complexes et appellent des analyses différenciées en fonction des contextes (McIntyre et al. 1996). Deux points méritent en particulier d'être relevés.

Premièrement, la sous-mortalité féminine est beaucoup moins étonnante qu'il n'y paraît de prime abord. Que les femmes soient dominées et souvent exploitées n'est pas en soi contradictoire avec le fait qu'elles vivent plus longtemps. Les modalités d'exercice du pouvoir passent, dans la plupart des sociétés, par des préservations des risques vitaux, lesquels sont socialement valorisés et donc inégalement répartis : les Tikopia meurent plus que leurs femmes dans des accidents de pêche ou de guerre, tout comme les Français meurent plus que leurs épouses de complications du tabac ou d'alcoolisme, d'accidents de la route ou d'homicides. Dans une certaine mesure, les hommes sont plus touchés par ce qui les distingue positivement des femmes, la prise de risque étant en soi une valeur et une réalité associées à la virilité. Probablement faut-il alors s'interroger sur ce que sont des inégalités sociales qui s'inversent du point de vue de l'inscription dans les corps : étranges disparités en effet que celles qui ont pour effet de faire périr les dominants en quelque sorte par là où ils exercent leur domination, au moins symbolique. Mais certainement faut-il aussi considérer que, dans une perspective anthropologique qui vise à appréhender les phénomènes d'inégalité, toutes les morts ne s'équivalent pas, même si le démographe les comptabilise indifféremment : mourir en bas âge d'une rougeole ou d'une pneumonie n'est pas la même chose que mourir victime d'un infanticide parce que l'on est une fille et donc moins désirée qu'un garçon.

Deuxièmement, la surmorbidité des femmes et son interprétation posent un double problème. D'une part, il faut toujours se méfier des explications qui ne renvoient qu'à la subjectivation d'une nature féminine : le rapport au corps et la relation à la souffrance, même s'ils sont culturellement déterminés et si la différence des sexes intervient à l'évidence dans cette détermination, fournissent une clé trop substantialiste qui fait obstacle non seulement à toute autre analyse, mais également à la reconnaissance de données contraires, dont certaines font apparaître des résultats non concordants. D'autre part, il existe des expressions d'inégalités incorporées que les enquêtes sont mal en mesure de prendre en compte : ces formes spécifiques de disparités, et parfois même de discrimination, liées au genre, donnent lieu à des manifestations psychiques ou physiques que l'épidémiologie ne peut guère mesurer en tant que telle. Dans certains cas, et c'est ce que l'on observe en Afrique australe, l'égalité des conditions de morbidité, en l'occurrence de séroprévalence entre hommes et femmes, dissimule le fait que les filles ont bien moins que les garçons les moyens d'empêcher la contamination, compte tenu de la violence dont elles sont souvent les victimes dans les rapports sexuels. Là encore, toutes les séropositivités ne s'équivalent pas.

## LE CULTURALISME MAL TEMPÉRÉ

Ce n'est pourtant pas sur ce terrain que l'anthropologue est le plus souvent convoqué lorsqu'il s'agit de comprendre des disparités. Car supposé être spécialiste de la culture, c'est sur le terrain de la culture qu'il est interrogé (Olivier de Sardan 1995). On lui demande en somme de dire comment des inégalités sociales peuvent être expliquées par des différences culturelles. Autrement dit, c'est dans des termes culturalistes qu'on lui pose la question et qu'on attend sa réponse. Par culturalisme, il faut ici entendre non pas le courant théorique de l'anthropologie nord-américaine formé autour de l'enseignement de Franz Boas et rassemblé sous l'intitulé «Culture et personnalité» dans les années trente (Taylor 1988), mais bien une forme de raisonnement ordinaire que l'on peut caractériser par une double opération intellectuelle: d'une part, l'essentialisation de la culture, qui en fait une réalité en soi, indépendante des autres réalités sociales et susceptibles donc d'être décrite séparément d'elles; d'autre part, la surdétermination par la culture, qui amène à rechercher une explication culturelle en dernière instance; ces deux traits se retrouvent dans le langage de la santé publique ou du développement économique lorsque l'on parle de «facteurs culturels» ou de «résistances culturelles» pour rendre compte de faits sociaux tels que les difficultés rencontrées dans la réalisation d'un programme de santé ou d'un projet de développement. Or, ce raisonnement procède d'une double occultation – de l'inégalité elle-même et de l'universalité des conditions. C'est ce que l'on va voir à travers deux brefs exemples.

Le premier concerne les programmes de réduction de la mortalité maternelle en Equateur. A la fin des années quatre-vingt, dans les suites de la Conférence de Nairobi, le constat de niveaux particulièrement élevés de mortalité parmi les femmes indiennes des Andes a conduit à la mise en œuvre de programmes de prévention, mais également d'opérations de recherche en sciences sociales. Dans la mesure où existait une superposition entre les zones de forte mortalité maternelle et les zones de faible taux d'accouchement sous surveillance médicale, l'intervention envisagée portait à la fois sur le renforcement du réseau de maternités et sur une éducation des femmes. L'hypothèse, avancée du reste par les anthropologues eux-mêmes, était en effet que les paysannes indiennes, prisonnières de conceptions archaïques, tendaient à rejeter la modernité et à se replier sur des traditions, ce qui les conduisait à se méfier des structures sanitaires pour leur préférer les rituels communautaires. L'enquête ethnologique entreprise dans deux régions rurales fait cependant apparaître une tout autre réalité. Loin d'être par essence culturelle, la détermination apparaît en effet de trois ordres. Economique, tout d'abord, et c'est en tant que paysanne exploitée qu'elle est reléguée dans des zones d'accès difficile et de production agricole incertaine d'où il faut parfois une journée pour se rendre à la ville la plus proche et au prix de l'équivalent de près d'un mois de salaire d'un journalier. Ethnique, ensuite, et c'est en tant qu'Indienne discriminée sur une base raciale qu'elle se heurte au mépris des agents de santé, à leur tutoiement, à leur mauvais traitement. Sexuelle, enfin, et c'est en tant que femme dominée qu'elle voit son corps traité en objet par les sages-femmes et les obstétriciens, l'accouchement en milieu hospitalier se terminant dans quatre cas sur dix par une césarienne, pour des raisons de confort du personnel, alors même que, de retour dans sa famille, la femme se verra considérée comme handicapée à cause de son opération et, dans certains cas, sera répudiée par son mari. On voit donc comment la culturalisation de l'explication conduit à escamoter la triple inégalité sociale d'origine économique, ethnique et sexuelle. Ce faisant, les développeurs éludent les responsabilités politiques collectives d'une société et d'un système de soins inégaux en faisant porter la responsabilité de la situation sanitaire très défavorable aux femmes indiennes elles-mêmes. Mais dans ce travail de justification, on voit comment l'anthropologue peut devenir un complice de l'ordre établi et de son occultation en se contentant de recueillir des croyances traditionnelles et des pratiques rituelles.

La seconde illustration porte sur le sida parmi les femmes immigrées d'origine africaine vivant en France. Partout, l'immigré est porteur, pour la société dite d'accueil, des représentations de la différence et ce d'autant plus que sa provenance d'un pays lointain et d'une culture éloignée suscite la curiosité exotique. De ce point de vue, les étrangers d'origine africaine personnifient de manière exemplaire l'altérité du monde occidental. Ces représentations volontiers culturalistes ont été réactivées dans le contexte de l'épidémie de sida, aussi bien lorsqu'il s'est agi de parler de la transmission sur le continent africain que lorsqu'il a fallu rendre compte des développements de la maladie parmi les immigrés d'origine africaine. A cet égard, les femmes posent un problème spécifique, puisque la question de la transmission verticale les met dans la situation de sujet potentiel de la contamination du nouveau-né, alors même que les relations tissées dans l'espace symbolique entre infection, impureté et faute tendent à faire des enfants des victimes particulièrement innocentes et, par voie de conséquence, à confronter les mères à une réprobation forte. On ne s'étonnera pas que, dans ces conditions, les femmes africaines enceintes, qui représentent en France près de la moitié des cas de femmes enceintes infectées par le virus du sida, soient l'objet d'un jugement moral en même temps que d'un regard culturaliste. Que l'on essaie de les justifier ou de les condamner, on invoquera des spécificités originelles pour rendre compte de leur désir inconditionnel de maternité, de l'irrationalité de leur comportement surtout lorsque plusieurs naissances se succèdent, de leur incapacité à suivre les traitements antirétroviraux proposés pour réduire le risque chez l'enfant, enfin de leur refus prévisible de césarienne préventive. Or, là encore, l'enquête menée dans la région parisienne montre que ces spécificités sont tout autres que celles invoquées. D'une part, les femmes africaines diffèrent beaucoup moins qu'on ne le dit des femmes françaises : certaines décident de ne pas avoir d'enfants, révélant la fausseté des généralisations sur l'indépassable désir de grossesse ; d'autres en font le projet, mais avec des arguments parfaitement rationnels tenant compte des statistiques connues sur le risque de transmission ; la plupart acceptent, malgré leurs réticences et malgré les effets secondaires, les traitements principalement bénéfiques pour leur enfant, de même qu'elles subissent le plus souvent une césarienne à propos de laquelle les médecins eux-mêmes n'ont toutefois pas encore dégagé un consensus. D'autre part, et s'il s'agit de mettre en avant des différences, c'est peut-être moins sur le terrain de la culture qu'il faut les chercher que sur le plan social, compte tenu des formes de discrimination multiples qui favorisent un retard diagnostique deux fois et demi plus fréquent que chez les femmes françaises, sur le plan économique, si l'on considère qu'elles appartiennent presque toujours aux catégories les plus défavorisées, sur le plan juridique, pour examiner les effets sur leur vie quotidienne de l'absence ou de la précarité du titre de séjour de beaucoup d'entre elles. Là encore, on voit comment l'invocation du culturel, en faisant écran à l'universel, dégage aussi la société dite d'accueil de ses propres responsabilités dans les situations dénoncées.

Entre rapports de genre et inégalité sociale, entre universel et culturel, l'anthropologue se trouve ainsi sur une ligne de crête. D'un côté, faisant fi du culturalisme, il doit tenir une approche délibérément politique des faits culturels, au sens où elle s'intéresse à la fois aux conditions structurelles de production du culturel et aux configurations sociales dans lesquels trouvent leur place les producteurs de normes et de valeurs. De l'autre, il doit procéder à une lecture des questions de genre sans renoncer à leur inscription dans l'ensemble plus large qui leur donne sens de manière différenciée, les disparités liées au sexe étant l'un des éléments constitutifs de l'inégalité sociale. Approche politique de la culture, lecture sociale du genre: telles sont les deux exigences que l'anthropologie doit se donner, revendiquer, mais aussi mettre en en commun avec les professionnels de la santé et les agents du développement sur les terrains où ils sont conduits à collaborer.

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MARY O'CONNOR

# GENDER AND THE DETERMINANTS OF HEALTH: IMPLICATIONS FOR HEALTH PROMOTION POLICIES

The following paper brings together discussions of gender, health promotion and the determinants of health. It refers broadly to gender as a determinant of health using examples and statistics from Canada. Despite the importance of attending to the social determinants of health, it is argued there are dangers, if not only shortcomings, to a certain broad determinants approach which ignores the differences of the everyday context and lived realities of peoples' lives. Since gender relations have produced inequalities in health, health promotion policies need to employ strategies both at the state level and at the local level to address these inequalities. The health promotion strategies of enabling and empowerment can enhance equity building local practices.

This study generates from the research conducted at the McMaster Research Centre for the Promotion of Women's Health [MRCPOWH] at McMaster University in Hamilton, Canada. Funded by the Canadian federal research agencies for health (NHRDP) and the social sciences and humanities (SSHRC), the Centre's mandate has been to research community based strategies for health promotion with women in the community. Using participatory action research, the researchers have worked primarily on the determinants of healthy work places, social supports, and enhancing coping skills.[1]

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1. The research will appear in 1999 as *Women's Voices in Health Promotion* (Toronto: Canadian Scholars Press).

## THE DETERMINANTS OF HEALTH MODEL

It has become apparent that medical health services can contribute to a population's health only to a certain extent; medical help is only one among many determinants that affect the health of a population. Building on the principles accepted at the 1977 World Health Assembly at Alma Ata, the World Health Organization committed itself to action on the broader determinants of health. Certain fundamental conditions are prerequisites for health: peace and freedom from the fear of war; equal opportunity for all and social justice; satisfaction of basic needs; political commitment and public support (World Health Organization, 1985). Large epidemiological studies, particularly beginning with the Black Report or Whitehall study in England (Marmot, 1986; Marmot, Kogevinas, and Elston, 1987) have pointed to determinants of health other than medical health services. The Whitehall research indicated a relation between the social gradient and health status of government workers (from clerks to management). These and other studies have pointed to various correlations with health status, notably that of social support (House, Landis & Umberson, 1988); a supportive early childhood (Werner & Smith, 1982; Werner, 1989; Martin, Ramey & Ramey, 1990; Grantham-McGregor, Powell, Walker & Himes, 1991; Suomi, 1991); a good working environment (Karasek & Theorell, 1990; Johnson & Johansson, 1991); personal health practices and coping skills; physical environment; biology and genetics; as well as health services.

In Canada, the determinants of health model has been promoted with the leadership of the Institute for Advanced Research (CIAR), under the term "population health" (Evans, Barer & Marmor, 1994). A broad definition of population health is "an approach that addresses the entire range of factors that determine health and, by so doing, affects the health of the entire population" (Hayes & Dunn, 1998). Evans and Stoddart proposed a framework that includes prosperity as one of the contributing boxes (1994). Some proponents of population health have recommended a transfer of investment from the health care sector to the economic sector in order to increase the prosperity of the nation, which in theory would increase the population's health status; others, like Wilkinson in England, have argued that the evidence shows that population health depends on the equality of income distribution, rather than the average income in which some might have a great deal and many a little (Wilkinson, 1996; Poland, Coburn, Robertson & Eakin, 1998).

Population Health, as a framework for understanding health, has been adopted by the Canadian federal and provincial governments, even to the extent of reorganizing and renaming government departments from "health promotion" to "population health". The Federal/Provincial/Territorial Ministers of Health approved the document *Strategies for Population Health* (Minister of Supply and Services Canada, 1994) which identified nine health determinants. They indicated a commitment to act on these determinants. Yet, it would seem that at first the governments were more interested in adopting the framework for its "proof" that health services was not the key determinant of health and therefore did not warrant the kind of expenditures it was receiving. In other words the research model fit neatly into their agendas of debt reduction. At the same time other governmental cost-cutting measures ensued: in some provinces, welfare payments were reduced and women's programs were eliminated; and a national housing program was disbanded. Policy action on the determinants entailed a cut to health care and a neo-conservative emphasis on the GNP as a solution to social and health problems.

The study of the social determinants of health fits with health promotion and feminist work on the structural context of health. However, the population health project, particularly with its emphasis on national economic growth and prosperity as a solution to health inequities, has been criticized for fitting too easily into a neo-conservative fiscal agenda of cutting government funding and weakening the welfare state. Critics have pointed out that within population health analyses there has been no analysis of the relation between specific fiscal policies or economic systems (e.g. capitalism) and health. (Labonte, 1995; Poland et al., 1998).

Feminist critiques have focused particularly on the lack of attention to gender in population health models, notably the role and place of women in the formal health care system and the gendered implications of moving health care into the community (Kaufert, 1996; Love, Jackson, Edwards & Pederson, 1997). Love et al. and others point out that the reduction of health care spending affects primarily the large female-dominated work force in the health care sector within and outside of hospitals. They suggest that the high population health status of countries such as Japan and Sweden may depend not so much on the average income of the country as on the hidden labour of women or the state welfare system that provides such services as day care and parental leave (Lock, 1993; Love et al. 1997). Kaufert (1996) complains that little attention is paid to extreme conditions, such as the impact on health of homelessness, long term unemployment or malnourishment; the relationship between health, poverty and race/ethnicity; and the relationship between health and gender. She re-examines three of the determinants of health listed by CIAR – satisfying employment, a secure and supportive social environment, and the equitable distribution of income – from a gender perspective: "all the indications are that the determinants of health are broadly similar for women and men, but this conclusion has little practical meaning unless related to the position of women within the occupational and general social structure … women are over-represented at the bottom and under-represented in the upper reaches along most of the gradients considered important to CIAR" (Kaufert, 1996, p. 6). Population health has relied heavily on epidemiological research and as such has been criticized for losing the contextual details of differently lived lives (Hayes, 1996; Labonte, 1995). It can also lack a theory of agency (Poland et al., 1998).[2]

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[2] Some work has been done to enlarge our understanding of gender and cultural differences (Corin 1994; King & Williams, 1995; Walsh, Sorensen & Leonard, 1995). Some are working on a hermeneutics or semiotics of health, thus enlarging our understanding of the social determinants of health (Corin, 1995). Others are working on a model of gender as a modifiable health determinant (Davidson, Holderby, Stewart, van Roosmalen, Poirier, Bentley & Kirkland, 1997).

The evidence of structural sources of ill-health is mounting. Doyal has pointed to poverty, women's labour, violence, lack of social support and medical intervention as the causes of women's ill-health (Doyal, 1995), yet health promotion policies have traditionally focused on smoking, eating, drinking, exercise, etc. (Daykin & Naidoo, 1995; Nettleton, 1996). This discrepancy points to the bias that has gone into the conceptualizing of health promotion for women. Denton and Walters (1997) in their analysis of the 1994 Canadian National Population Health Survey found that: "the structures of social inequality are the most important determinants of health acting both independently and through their influence on the behavioural determinants of health."

## WHAT IS THE HEALTH STATUS OF WOMEN IN CANADA?

In Canada, women born in 1995 have a life expectancy of 81.3 years as compared to 75.4 years for men born that same year (Statistics Canada, 1996). Although women live longer than men in Canada, they experience more illnesses and spend a larger proportion of their lives in poor health. The major causes of women's death in Canada are: cancer, ischemic heart disease and stroke (Stein, 1997), with a sharp rise in women's death rate from lung cancer since 1979 (Nault, 1997; National Cancer Institute of Canada, 1997). Between 1979 and 1995 the life expectancy of men has increased at a greater rate than that of women (Nault, 1997). Women are also greater consumers of health care services than are men. They report more stress and mental health problems than men. They are also the main health care providers; they comprise the majority of workers in the health care system; and they are usually responsible for care within the family and community.

### MENTAL HEALTH

Health promotion has focused less on mental health than physical diseases. Women are more likely than men to suffer from symptoms of stress, anxiety and depression. The Canadian National Population Health Survey shows that the prevalence of depression in women is double that in men. In a Canadian study of women's perceptions and priorities of their health, stress and other mental health problems were persistent themes in interviews with women (Walters, 1992). Stress was identified as the most frequently mentioned health problem followed by anxiety and depression. Furthermore, poor women seeking help for mental health concerns are more likely to receive intrusive physical treatments (Canadian Mental Health Association, 1989). Recent immigrants to Canada with diverse ethno-cultural backgrounds experience mental health problems that have been overlooked in health promotion (Canadian Task Force on Mental Health Issues, 1988).

## VIOLENCE

Violence has a major impact on health in our society and women are the primary victims of violence at home. A recent report by the Federal Department of the Secretary of State indicates that one million Canadian women are abused by their husbands or live-in partners annually. As well, one in four Canadian women can expect to be sexually assaulted at some time in their lives. 80% of women with a disability will experience sexual assault in their lifetime (Stimpson and Best, 1991). Women who face multiple barriers in our society, such as Aboriginal women, immigrant and visible minority women, lesbian women, young and third-age women, are at a higher risk of experiencing violence than other Canadian women (Kinnon and Hanvey, 1996). Assault has been estimated to be the cause of trauma injuries in 6% of women who visit emergency rooms. In addition to the physical injuries caused by violence against women, women often suffer psychological complications (Canadian Panel on Violence Against Women, 1993).

## POVERTY

In 1993, 60% of female lone-parents lived in low-income situations, 28% of visible minority women and 33% of Aboriginal women

(Status of Women Canada, 1998). In the same year 56% of unattached senior women (65+) had low incomes. Women working full-time earned on average 70% of what their male counterparts earned. In 1994, 69% of all part-time workers in Canada were women. 34% of these workers indicated they would prefer full-time work (Status of Women Canada, 1998). Canada has the world's second highest rate of child poverty among industrialized countries, second only to the United States. In 1995, one in five children under 18 years – 1.4 million – lived in poverty. 40% of today's welfare recipients are children. Canada has no national child care system with set standards for fees and quality of services ; it has abolished its national housing program (Canadian Council on Social Development, 1996).

### ABORIGINAL WOMEN

In 1986, the life expectancy at birth for Aboriginal women was 71 years, compared to 81 for non-Aboriginal women. The infant mortality rate, although decreased from 1979 to 1993, was still 1.7 times the national average in 1993. (First Nations and Inuit Health Programs, 1993). The suicide rate for Aboriginal adolescent girls is eight times the national average. The top four causes of death for First Nations people have remained the same since 1979 : injury and poisoning, diseases of the circulatory system, neoplasms (cancers), and diseases of the respiratory system (First Nations and Inuit Health Programs, 1993). The diabetes rate among Aboriginal peoples is 10 times the Canadian rate and is generally higher for females. Rates of cardiovascular and respiratory diseases, eye and ear infections and dental and gastrointestinal problems are all much higher among Aboriginal women than in the female population in general. Aboriginal women suffer higher rates of cervical cancer, sexually transmitted disease and cirrhosis of the liver than their non-Aboriginal counterparts. (National Forum on Health, 1997). In many Aboriginal communities, economic changes, cultural losses and male domination of political life have compromised the traditional social structure. Historical abuse in church, schools and high levels of alcohol abuse exacerbate the problem. Among Aboriginal women, the rate of abuse may be as high as 80% and in some communities all women have a history of abuse (Ontario Native Women's Association, 1989; National Forum on Health, 1997).

Given the shocking discrepancy between Aboriginal health and non-Aboriginal health we need to introduce a notion of race, the historical context of this ill-health, and the fact that women with multiple barriers are at significant risk. Any generalized population health intervention will obviously be inadequate to deal with the special conditions of, for instance, Aboriginal women or women with disabilities. More generally, if we turn to the question of why for instance women are on average poorer than men we have to postulate a key determinant prior to such determinants as level of education or having a satisfying job, or level of income. Why are women poorer, why do they not get jobs with high control? – because they are socialized in specific ways and the conditions of their lives do not permit them to advance, because the current ideology of what a woman should be and what she should do, circulating both generally in the population and internalized in women, determines whether women are able to advance towards, successfully obtain and retain high control jobs, in other words because of gender.

## GENDER

We understand gender to be the social construction of what it means to be a woman or man in a given society. e.g. women should be passive, men active; women should be care-givers, men bread-winners; women should be dependent, men independent; women should not be scientists or engineers, etc. In all these cases, we have cultural constructions of what a woman or man should be and institutional structures and practices that establish and maintain these ideologies. The family and the workforce reflect these constructions.

So when we turn to working on a determinant of health, for instance, low income, we must analyze the particular ideological scaffolding and the institutional structures on which such a "determinant" depends, such as :

- psychological shaping of masculine and feminine ;
- family, teacher and society career expectations for boys and girls ;
- media representations of boys and girls, men and women ;
- abuse, violence and harassment towards girls and women ;
- employment equity standards and practices (equal pay; equal opportunity to work) ;
- reproductive rights : over their bodies, sexual education and contraception, power to say no and to be listened to ;
- the presence or absence of adequate and subsidized child care, elder care and care for the sick;
- adequate old age benefits or pension funds for widows or single women.

It is not just some abstract notion of poverty that determines a woman's ill-health. Women's poverty and their health are experienced in the context of their everyday lives. On axes of place or time or social relations or labour/activity, women's gendered lives are played out or determined by the structures that precede them and by the strategies they create to manage and endure. Gender (and race and class) is active in social relations ; the division of labour ; status ; violence ; ownership of the means of production ; power over discourses, over political change, reproduction, resources ; access to food, to health services, employment, and education. It is the knowledge of this experience that offers us clues to those structures – how the body, the quotidian is "the very site of material inscription of the ideological" (de Lauretis, 1987).

Nevertheless, to speak only of the determining forces that affect women's everyday life is to tell only part of the story. At the same time, there exists a rich diversity of creative ways of inventing and making health as there are strategic ways of resisting controlling and detrimental structures. The everyday is a location of possible change and resistance ; so Scholle can speak of both "the liberating and dominating relations that organize various aspects of everyday life" finding "possibilities for an emancipatory … politics … already present in … the subjugated knowledges, local narratives, resistances and traditions of specific and diverse struggles over everyday life." (Scholle, 1992 : 281, 283). The local and the everyday are the sites of both inequalities and potential policy change. The local is a place of ill health and oppression on the one hand and a place for social action on the other.

## HEALTH PROMOTION POLICY IMPLICATIONS

The originality and enduring significance of the Ottawa Charter is not only that it directed our attention to the relation between larger determinants and health but also that it pointed to the priority of enabling people to take control of their health. Feminists have argued that community development with empowerment is the approach that most closely meets women's needs (Aird, 1986; Daykin & Naidoo, 1995; Roberts, Smith & Lloyd, 1992; Rodmell & Watt, 1986). Many are writing about a "new health promotion movement" in which empowering political strategies, such as community participation and coalition building, are used to address the social inequities of health" (Ward-Griffin & Ploeg, 1997, p. 282; Labonte, 1992; Raeburn & Rootman, 1998; Robertson & Minkler, 1994).

Nevertheless, that call for empowerment has been translated in many instances into a call for individuals to take responsibilty for their health without any consideration about their power (or lack of power) to take control. In other words, the language of individualism, even consumerism, has privatized health at the very point where the Charter was asking for a collective response to health needs (Nettleton, 1996).

The implications for health promotion policy of the determinants approach would be to work both at the larger state level of intervention – on employment or food security measures, for instance – *and* at the local level. It is this local level that risks being lost in a determinants approach. The local is a place of knowledge – diverse and productive. The local is a place of agency, action and change. What are we to do with locally identified issues that do not appear in a broader determinants model? If longitudinal studies offer broad categories that influence the health of populations, it is still at the local level that health or ill-health is experienced and understood. Health promotion should facilitate or enhance local practices that work for the community.

As health promotion researchers, we too must program our own involvement into the equation. How does our research mediate/promote/displace "health care"? How do our recommendations fit with a government program for managing and encouraging the health of a country; how on the other hand do I, as a feminist researcher committed to the diversity of women's everyday practices and knowledge, support these with the policy I endorse or the health promotion I practise? The institutional funding structures for health traditionally support medical health services with support from public health. The determinants of health paradigm has demanded large epidemiological studies. At the local level, academic community research has faciltated some policy related and academic knowledge production, but:

❑ it is rarely a large investment (in comparison to, for instance, large biomedical research); and
❑ it still means that the communities involved must respond to researchers' needs and specifications. There is no easy funding mechanism for community groups.

The policy implications of a new health promotion that attends to a gender determinants model are that interventions must be made on many levels. If gender relations have produced inequalities in power and access to the general good, all of which determine health status, then health promotion policy must attend to these inequalities and the structures that perpetuate them. To enable women to take control of their health entails programming on a continuum from broad state policy to community provision of programs applicable to individuals; it entails providing the physical and social environment in which women's capacities may flourish.

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JANET PRICE

# BIOMEDICINE BYPASSED?

# THE POLITICS OF ENGENDERING HEALTH

## INTRODUCTION

During the last couple of years, a group at the Liverpool School of Tropical Medicine (LSTM) have been working together to develop a set of guidelines to assist in Gender Analysis in Health[1]. Members of the gender group come from a range of disciplinary backgrounds, covering the biomedical and the social, and our highly fruitful interdisciplinary work has brought into focus what I see to be crucial issues regarding directions for gender and health – namely, the ways in which gender analysis concentrates largely upon socio-economic aspects of health, and leaves to one side the effects of the ways in which the foundational disciplines of the life sciences and biomedicine are themselves gendered. Yet these are the effects that touch directly upon the work of institutions such as the LSTM – and more broadly, upon international approaches to health and to "disease control".

The LSTM works, on the whole, from within the paradigms of bioscience and biomedicine, staffed predominantly by parasitologists, entomologists, molecular biologists and clinicians.

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1. Guidelines for the Analysis of Gender and Health (Jan 1999) are available from Rachel Tolhurst, IHD, Liverpool School of Tropical Medicine, Pembroke Place, Liverpool L3 5QA, England; e-mail: r.j.tolhurst@ liverpool.ac.uk.

Traditionally it has had a focus on disease rather than on health, and on individuals rather than on the social conditions leading to health and illness, operating within what the School historian, Helen Power, has termed "the false geography of colonial science" (1999:239), a geography bound up with the colonial history of Britain. As with similar Tropical Institutes/Schools of Medicine scattered across the cities of Europe in countries that were previously colonial powers, its origins lie in the extension of colonial rule across the countries of Africa, Asia and Latin America. Colonialism, particularly in the early days, was primarily a masculine endeavour – a field in which soldiers, adventurers and civil servants held pre-eminent sway. And where men ventured forth to conquer, govern and administer, male medics and scientists followed in their wake. They went not only to care for the health of their fellow colonists but also to investigate the wide range of new scientific phenomena and diseases opened up to them by these "new" worlds.[2] These countries came to be encompassed in the phrase *the Tropics*, a term that, whilst referring to a geographical area, became redolent of jungles, heat, swamps and fever, of uncharted land to be discovered and mapped (Anderson 1992). Whilst attempting to move forward from this masculine dominated and exotically constituted colonial history, the discipline of tropical medicine continues, to some extent, to treat diseases as though a primary characteristic is their location in particular geographical or climactic situations, to the detriment of any politico-economic understanding of their distribution, transmission and impact.

The growing focus in international health on the influence of power inequities and poverty has, however, stimulated the integra-

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2. In contrast, many of the initiatives in health and medical care for local populations were undertaken by women. Whilst the colonial state generally neglected the health needs of the population (Arnold 1988), women physicians took up their concerns, and particularly those of women and children, with apparent enthusiasm. Further, for women physicians, countries such as India offered a working experience unavailable in Europe, where male physicians attempted to exclude women from practice.

tion of a strand of thinking, a counter discourse, that is focused not upon disease entities *per se* but upon the socio-economic conditions of health, illness and health care. This is an approach that is more in tune with Gender Analysis in Health as it is widely understood. But the integration of the social with the medical is taking place in such a way that, whilst the cultural, political and economic conditions of health and disease are opened up to gender analysis, the theories and even some of the practices of the disciplines of biomedicine and of the life sciences continue to be seen as the arbiters of an objective truth, untroubled by the effects of gender.

## ORIGINS OF BIOMEDICINE

It is this notion that biomedicine can provide us with an objective truth about health and illness that I want to question, drawing upon examples of how gender impacts upon thinking about so-called "tropical diseases", and upon how gender interweaves with questions of race and class to construct particular ways of looking at bodies and diseases. To do so, I want first to make a digression into the past, to look at the histories of our current models of bio-science, for I believe these histories speak powerfully to how we think and act in the present. The development of western bio-medicine as we know it today dates back to the European Enlightenment era (16/17th century) when notions of objective empirical science began to replace superstition and religion as ways of explaining both the natural world and the social order. Science, and bio-medicine in particular, were characterised as masculine undertakings, a part of the process of advancing culture through developing a clearer understanding of the workings of the "natural world". Scientific prowess was itself viewed as a male gift and the subject of investigation, Nature, was held to be related to the feminine, often identified as woman, to be unveiled, unclothed and penetrated by masculine science (Jordanova, 1980). Such Western gendered notions of nature and culture were integral to the practice of science and medicine, always already present in its foundational ideas[3]. Despite its adherence to rationality and objectivity, and its belief in the possibility of "pure knowledge", untouched by the means of its production, science was, from its modern inception, constructed in its beliefs and practices through gendered processes.

## GENDERING BIOLOGY?

### THE FIXITY OF BIOLOGY

The life sciences and medicine developed during the European enlightenment era, through empirical studies of the body. Biology was (and continues to be) seen as a natural given, something that just *is*, whose workings can be revealed to us by science. In these terms, sex, the biological distinction between male and female, is simply a natural, taken for granted fact, a pre-given category, not open to question or interpretation. We are all familiar, for example, with the oft repeated claim that women have a longer life expectancy because of their "natural" biological advantage over men. And as Krieger and Fee suggest, "It seems so routine, so normal, to view the health of women and men as fundamentally different, to consider the root of this difference to be biological sex" (1994:266).

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3. My aim here is not to set up simple binaries – of culture, the rational mind and masculinity as positive notions to be set in opposition to nature, the instinctual body and femininity. For these oppositions were never simple, and there was never a universal gendering of minds and bodies, of science and nature as respectively masculine and feminine. The point rather is that these ideas influence and are influenced by the structuring of the socio-cultural world, and that while there may appear to be dominant discourses – as bio-medicine has been dominant within European approaches to health – there are always alternative and resistant ways of seeing, of representation, of acting, both within and outside such dominant models. Counterdiscourses offer us competing constructions of materiality, of health and illness, of our bodies and minds and their relationship to each other – and they have material effects.

Gender is seen as overlaying this biological base, as involving culture and society, not foundational biology. Thus for a gendered analysis of different experiences of health and illness we might, for example, look at inequities in access to services, or at unequal life chances which means young girls receive less education, less food, less care than young boys. Yet the notion that our ways of living and being and understanding are formed by the societies within which we live stops at the body's surface. What lies outside the body is socio-cultural and open to interpretation and change – but what lies hidden within the body is taken as a universal truth. The body is the pure, uncontaminated ground upon which scientists and medics can operate, fixed and unchanging through time and space.

Most of the gender and health analyses found in the literature unquestioningly reproduce this standard division between sex and gender that separates the biological from the socio-economic.[4] At times, gender analysts appear to maintain the fixity of biology far more vehemently than many current day bioscientists would be prepared to do. Working as they are, with a direct awareness of the mutability and variation in the bodies with which they deal, many bioscientists, whilst recognising bodily limits and boundaries, would themselves be wary of ideas of fixity.

## BIOLOGY AS TRANSFORMABLE

A more nuanced view of biology maintains that, in contrast to this fixed relationship between sex and gender, our lived, sexed bodies are transformable, that they are shaped by and contingent upon both material and social forces, of which gender is clearly one dimension. The way my body is marked as female, living as I do within the socio-cultural context of Liverpool, England, with access to a car, and running water, and health services is very different from the way in which, say, a north Indian woman's body

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[4] In producing the Gender and Health Analysis Guidelines, we conducted a wide literature review, drawing on both published and grey literature in gender and health. Without exception, they all adopted a clear sex/gender split.

may bear the marks of her sex, if she headloads 20 kilos of wood daily, cooks within a smoky hut and has limited access to health care. We both carry the physical and material signs of our being female, of our sex – but the gender/class relations of our contexts mark our bodies in very different ways.

Whilst this approach recognises the body as a dynamic object, changing through different social and environmental pressures, it continues to define it as essentially predetermined, existing prior to and separately from the social sphere. Within gender analysis, we see this separation in diagrams such as that offered by Rathgeber and Vlassoff (1993), which provides a detailed and useful breakdown of socio-economic influences on gender and tropical diseases. Composed of a number of interlocking circles, the largest right hand circle is headed Gender Variables and lists factors that fall into the categories of Economic/productive activities, Social/reproductive activities and Personal factors. This detailed circle is interlinked with two circles containing the terms Prevention, and Nature of Treatment, and these are in turn linked to an otherwise empty cross hatched circle labelled Disease. The circles for disease and for the practices of biomedicine, prevention and treatment, are empty of detail, connected in an undetermined way to social processes. What we see in this socio-economic model is a reversal of the usual biomedical web of disease causation in which the role of genetics, hormones and infective agents are stressed at the expense of the social.

Whilst a small number of models more expressly include biology as the dynamic ground upon which other social forces act, the dynamic assumed is usually that of the inter-relation of a limited and closed system, the body, with an infinitely diverse social environment. These linkages between broad social processes and biology have been a consistently underdeveloped feature of social models of health, and an understanding of how the one affects the other is only just beginning to be teased out. Nancy Krieger suggests that epidemiology still lacks a theoretical framework that truly integrates social and biological understandings of health, disease and well-being, what she would call an "ecosocial" epidemiological theory. She advocates the development of a theory that "embraces population-level thinking and rejects the underlying assumptions of biomedical individualism without discarding biology" (1994:896).

Further, biology usually serves as the ground upon which other explanations are laid, diagrammatically represented as a layer that exists before numbering starts. It is thus pre-social, the first cause answer.

I would like to emphasise that the approaches to gender analysis I have mentioned above have provided us with valuable insights into the complex interaction of socio-economic factors that influence health. But whilst holding onto biology, as Krieger suggests, may push us to start to explore how the body's biology is capable of affecting the way a disease manifests and the frequency and severity of its consequences, the questions of how we investigate these relationships and how we describe these processes are often left unchallenged. Within medical research for example double blind placebo controlled trials continue to be taken as the gold standard for producing "valid" research findings and such results are held up as descriptions of material, objective and scientifically verified truths. Biological investigations of disease-causing organisms, their life-cycles and their development within the human body follow a similar pattern, searching for isolatable factors that can be assigned particular roles or effects. There is no questioning of what is focused on, what is silenced, what is recorded, what is ignored within this complex interplay of the embodied subject and her environment.

Whilst it has long been argued that some of the practices of science and medicine can be understood as gendered activities (seen, most simply, in the gendered divisions of doctors and nurses roles and power relations), other practices, in particular laboratory based experiments continue to be defended as objective and value-free, as though they can be conceived and conducted in a manner totally untouched by the disruptive influences of gender. A growing literature critiques such reductionist approaches in biomedical and life sciences research, whereby the biological body is isolated and separated from its socio-economic environment. As I have said, there is thus a whole area – the most fundamental part of biomedical practice, that involved with understanding and explaining the internal processes of bodies and of biology – that is held to operate to a series of neutral rules that are applicable universally, independent of the social context.

## BIOLOGY AS GENDERED

However, my concern here is not so much with the specifics of experimental and research practices, but rather with the ways in which the theories and language of the disciplines of science and medicine are held to exist outside the social, untouched by and shielded from relations of power: neutral, objective, they are arbiters of "the truth" about the body and about disease. This view of biology and medical theory as outside of relations of power, of their conceptual underpinnings and knowledge claims as value-free, presents a fundamental problem for integrating gender into health in any just or ethical way, obscuring questions of agency and denying history. It has major consequences both for how we understand biology, physiology and the bodily processes of health and illness, and for how we understand the ethical relationships between health workers and clients, and between people and their environments.

In contrast, I would want to argue that the idea of "pure objectivity" which grounds scientific thinking and practice is already compromised, not in that it is contaminated by controllable external effects but rather in that our ways of seeing, believing and understanding can never stand separately, outside of culture. In arguing that biology is gendered, I am not trying to deny the existence of a material flesh and blood body that can be empirically measured and assessed, diagnosed as having, for example, malaria or HIV or malnutrition. The point rather is that bodies and diseases are understood, explained and classified through language – and that language itself is a cultural form with a past, a history, a social context. What appear to be objectively observable facts are both the objects and the effects of particular socio-political contexts. From this perspective, sex cannot exist prior to gender. Rather, sex emerges as a category of analysis through the ways in which gender operates.

For concrete examples of this we could look at the ways in which notions of race and sex became concretised as biological "truths" over the last 400 years. In Renaissance anatomy texts of the 16th century, we are offered representations of the human body such as the penile vagina – at first glance male, but in actual fact, a representation of the female sexual anatomy (see Laqueur 1990). The Renaissance anatomists worked within a discourse that held there were two genders, masculine and feminine, who fulfilled different social roles, but only one sex. This sex developed male or female characteristics through the presence or absence of heat in the body (Laqueur 1990). It was not that the Renaissance scholars were bad anatomists or unobservant. Rather, what they saw, how and where their attention was directed led to anatomical drawings that represented the truth of their age – two genders, one sex.

By the 18th century, biology and gender had come more clearly into line with each other, and increasingly, the body's organs and structures were held to determine our social ways of being. Londa Schiebinger, in her book "Nature's Body" (1993) offers us a detailed historical description of how categories of sex – and race – came to be fixed in a biological hierarchy during the 18th century, through a detailed examination, for race characteristics, of *male* bodies, those of European, African and Asian men and of male orangutans, and for sex characteristics, of *European* bodies, male and female. She suggests that whilst part of the explanation for *which* bodies scientists chose to examine lay within the politics of their own scientific communities, there were other, deeper factors which focused their gaze in particular directions. These were the questions of slavery, colonialism and women's rights.

The 18th century was a time of major political upheaval with, for example, the French Revolution offering abstract promises to its citizens of freedom and equality. But such promises were part of a public struggle for power and representation which concerned primarily men and European women, free peoples of colour and slaves struggled to challenge the limitations put on these questions of rights and equality. Contemporary anatomists of the day analysed sexual and racial characteristics according to a hierarchy of being which placed white European men at the apex. Schiebinger argues that, "increasingly, questions of ethics (particularly those regarding equality) were taken to stand or fall on the findings of anatomists" (1993:172). Soemerring, one of the great anatomists of the late 18th century "expressed a belief that anatomists did not have to take a moral or political stand because *the body spoke for itself*" (Schiebinger 1993:173 – my italics). Again, what they saw reflected the political and cultural truths of their age.

More recently, in the 19th and early 20th centuries, the developing field of "tropical medicine" had a major impact upon ways in which health in the countries of Africa, Asia and Latin America was understood – and in how they were marked by gender and race. Whilst I don't have space to go into the effects of this in detail here, it is clear that much of the early research was conducted only on men looking, for example, at how white men survived under "tropical conditions", in comparison to men indigenous to these countries. Uunusually, a study in the Philippines did include ten nuns. Perhaps, as sisters of charity they somehow didn't count as real women! Much of the research was based upon a desire to demonstrate the superiority of the Caucasian temperament and physiology, whether evinced as greater resistance or increased sensitivity to particular climactic conditions (Anderson 1992). In such studies, as in the examples given by Schiebinger above, men were both the *norm*, the yardstick against which others were measured, and, in the case of white men, the *ideal* to be struggled for. Women's bodies would simply have confused the purity of the research results.

Now these debates about the gendering of biology may be interesting in theory and in a historical sense – but what implications do they have in the here and now, and in our daily practice? What I'd like to do now is pick up on a series of issues, looking at current examples of and implications for the gendering of biology and biomedical theory.

## WHAT DO WE SEE ?

I want to start at the very simplest level – by looking at the ways we describe what we see down our microscopes, the place from which much biological knowledge is held to originate, using two examples from the field of malaria studies. Malaria is caused by a protozoa, a Plasmodium, which reproduces by what have been termed "sexual" and "asexual" means, following a life cycle that was first mapped out at the end of the nineteenth century in the days of light microscopy. Contemporary descriptions of the sexual stage offer us a story of romance and sexual conquest, based upon the meeting of the female and male gametes. As the story opens in the mosquito's stomach, one text tells us, "the female … now a mature gamete, awaits the arrival of a male" (Kreier and Baker 1987:165). Whilst she quietly anticipates the arrival of her suitor, another text takes up the tale of "the development of the liberated male gamete". He "becomes very active" (K&B), and produces flagellae (string-like structures) which "lash about and then break free" (Strickland 1984:523), to "seek out", "penetrate and fertilize" the female gamete (K&B). This description of an active all-conquering super-hero male gamete tallies very closely with that analysed by Emily Martin in her discussion of scientific accounts of human biology. She describes how "the picture of egg and sperm drawn in popular as well as scientific accounts of reproductive biology relies on stereotypes central to our cultural definitions of male and female" (1991:1-2).

But this gendering process does not only apply to mechanisms identified in the days of light microscopy. A recent text on the genetics of malaria provides us with a picture of one of the crucial segments of a chromosome. At either side are areas identified as being the "transcriptionally active antigen-encoding domain" whilst in the centre is an undifferentiated mass of "housekeeping genes", whose purpose is to do with maintaining the interior environment of the cell – the genetic equivalent of organising the dusting, ironing and vacuuming Feagin & Lanzer 1996).

I'd like to highlight just two implications of this gendering of biological descriptions. Firstly, in how it influences where we direct our attention and what we value. Bonnie Spanier argues that there is a hierarchy in how genes are described and analysed, with a higher value conferred on those genes that exert control over the development and expression of other genes as compared to those genes that code for enzymes running the cell's metabolism, the "housekeeping genes". These latter mirror a female domestic workforce that tidies up but whose precise role is not described, counted or valued. They are regarded as "a routinized and less significant kind of gene" (Spanier 1995: 87). Whilst this may not seem to be enormously significant in itself, a gaze directed at one set of genes may miss crucial roles or linkages in other aspects of genetic biology that could have a major impact on research developments.[5]

Secondly and more broadly, what gendered language in biology implicitly reinforces is stereotypical views of women's and men's relations. The female gametes and genes are described as less active, less involved, less influential. Such gendered hierarchies of description of biological processes have a wider significance in relation to the development of disciplines. For example, in some aspects of molecular biology the focus on control genes is part of a move to find a genetic explanation for "life" itself (Spanier 1995). Regular news reports inform us of the latest gene "discovery" – for alcoholism, violence, homosexuality, feminine behaviour. This sociobiological perspective runs counter to recent moves against a reductionist view of biological organisms, and itself reinforces sexist notions of predetermined biological roles, of male control and female caring. As Emily Martin says, "the stereotypes imply not only that female biological processes are less worthy than their male counterparts but also that women are less worthy than men" (1991:483-4).

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5. See Spanier (1995) for a detailed discussion of the impact of gender ideology on molecular biology.

We can see some of these patterns of gendered understanding played out in practical terms in relation to research into HIV/AIDS. Whilst the situation in relation to the development of knowledge about HIV/AIDS is complicated, with differing epidemiological patterns in the USA/Europe and in Africa for example, what is clear is that much of the early knowledge of illness was based upon the effects of infection upon men. Clinical definitions were drawn up in relation to the symptoms men experienced, thus excluding a wide range of symptoms, gynaecological and other, unique to women. Women were diagnosed later because their symptoms were not recognised, there was little knowledge about how disease progressed in women, and drug trials excluded women on the basis of pregnancy (Gilks et al 1998). The cumulative effects of such developments and gaps in knowledge is to reinforce the perspective that the normative forms of health/disease are always already men's, whilst women's health is Other, and has to be labelled specifically as such. Such othering goes hand in hand with a lack of attention to diversity, resulting in delays in mapping the differing patterns of illness and sets of symptoms not only between women and men but, in this case, between HIV/AIDS in USA/Europe and in Africa, a crucial omission, intercut as the experiences of HIV are by questions of race and sexuality and economic situation.

## WHAT DO WE SAY?

What the above analysis has explored is how gender in health, illness and biology works at the levels both of what we learn to see, and of how we describe things. Whilst there have been some recent moves towards more inclusive language in medical writing, our libraries are still full of books and journals in which the female is always marked as the other, not the norm[6] and in which usage of the term "man" is indicative of both the male sex and of all humankind, producing a confusing minefield for the gender sensitive reader.

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6. See, for example, Moore & Clarke 1995 on depictions of male and female bodies in contemporary anatomy texts

For example, on onchocerciasis, the Short Textbook of Preventive Medicine in the Tropics informs us "in most endemic areas, infection is maintained by man-to-man transmission", and "man is the only reservoir of infection". But, confusingly, "males are infected more frequently than females" (Lucas and Gilles 1980:204). To undo the specific use of "male" from the normative and universalising use of "man", to work out that there are not some helminth infections that have a particular predilection for testosterone and homoerotic bonding, whilst turning tail at the slightest whisper of an oestrogen molecule, requires the alert reader to challenge the privileged and unmarked use of masculine terms in biomedical description. The failure here is not simply that of viewing man as the norm. More, it is the failure to recognise the diversity of what "becoming" a woman or a man may entail, within the embodied and multiple dynamics of race, class, disability, age and other power structures that influence health.

Now one response to the gendered gaze and to naming processes would be to attempt to use gender neutral language. Although it might be nice to feel we could get rid of some of the most stereotyped representations, it seems to me that this is an approach that misunderstands the nature of language and of power. It fails to acknowledge that we describe our material world in language whose purpose is to *represent*. Language is not the thing itself, but a cultural form for transferring meaning – and meanings carry the weight of context, of history, of power. They serve a purpose. They constitute our understanding of our worlds. And further, these meanings are not fixed – a point which probably became extremely obvious in a conference such as "Tant qu'on a la santé?", where this paper was first presented. We were working in at least three languages, people were translating for their colleagues – and I know that what I said had differing meanings for many persons to those which I intended. My response to this problem of translation is not to attempt to control meaning, to constrain and limit it, for meaning cannot be fixed and held down in this way.[7]

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[7] I came across such an approach in a gender and health workshop when we were discussing the problems posed by the differing political understandings

It seems to me the challenge of meaning is to interrogate it, to work to continually uncover more of its connections and relations, its dynamics of power, to understand how it helps to practically and materially shape our worlds – and to work out how we can intervene in this process to support knowledges and practices that enhance agency and equity. If as Donna Haraway has said, one of the tasks for a feminist analysis of science is "to construct the analytical languages … for representing and intervening in our … worlds" (1997:62), it is vital that we recognise that *naming is a political act*, and that our words, however scientific and rational they may aim to be, are never innocent.

Whilst the analysis I have presented argues that there are no universal truths, no ultimate solutions, no clear and universally agreed goals at the end of "scientific progress", it does not remove our responsibility to act, albeit within the context of partial and situated knowledges. There is no escape from power within the health field, and the processes of gendering are part of this operation of power. We are engaged with this power – and our actions can demonstrate solidarity with those who face inequality and oppression – or serve to reinforce unequal operations of power. Biomedicine is a highly gendered force-field whose operations and concepts we ignore to our peril.

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7. applied to the term gender. One major international organisation had developed a definition – and I was told that when they talk about gender in the organisation, this definition is the one they all use – implicitly, that they all have the same understanding of gender. Clearly, they don't and they can't.

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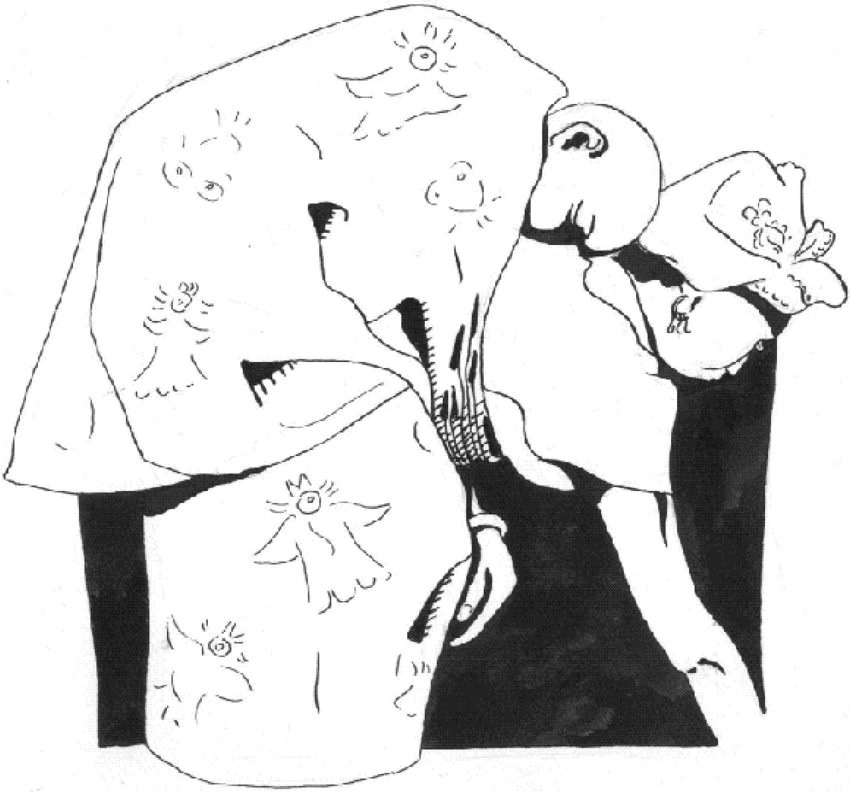

CRISTINA SANCHEZ

# FACTORES QUE INCIDEN EN LA DIFERENCIACIÓN DE LA SALUD SEGÚN GÉNERO: UNA EXPERIENCIA DE TRABAJO

## SALUDOS Y AGRADECIMIENTOS

Al Instituto de Estudios del Desarrollo (IUED), por haber organizado este evento centrado en la búsqueda de propuestas de cambios a realizar en las prácticas y en el diseño de las políticas, para transformar las actuales relaciones sociales de género que afectan la salud de las mujeres y su capacidad de elección.

A Yvonne Preiswerk y Mary-Josée Burnier, quienes han hecho un esfuerzo sistemático en la organización del evento y han hecho posible que estemos aquí.

A Enfants du Monde, quienes con sus lineamientos de trabajo han apoyado financieramente la experiencia que hoy exponemos.

## INTRODUCCIÓN

La diferenciación de la salud según el género está condicionada principalmente por factores socio-económicos y culturales. A partir de la experiencia de trabajo que hoy exponemos, podemos deducir que, de un lado, la capacidad de acceso a bienes y recursos resulta de primera importancia y, de otro lado, el tipo de respuesta a la salud estará mediado por el hecho de ser mujer u hombre.

## UBICACIÓN DE LA EXPERIENCIA

La población implicada se encuentra situada en la zona oriental de la ciudad de Santo Domingo, ciudad que concentra el 30% de la población de República Dominicana, estimada a la fecha en 8 millones. El 70% de los habitantes de Santo Domingo viven en barrios marginales en condiciones de extrema pobreza. En este contexto, las mujeres son las más pobres y muchos de los hogares que ellas lideran caen en la clasificación de indigentes, es precisamente con estas mujeres con quienes trabajamos en primer lugar.

La zona norte de Los Mina, que es el lugar específico donde participa TU, MUJER apoyando programas de desarrollo, tiene una población de alrededor de 63,000 habitantes. Ubicadas en familias diferentes, esta experiencia tiene una cobertura directa de más de cinco mil personas y una cobertura indirecta que abarca el 45% de los y las habitantes de la Zona.

## CONDICIONES DE SUBSISTENCIA

La forma de sobrevivencia usual de la población involucrada depende de su participación en la economía informal, la mayoría de la población masculina que trabaja lo hace como vendedor ambulante, tanto de productos como de servicios. La tendencia de las mujeres que trabajan fuera del hogar es a la realización de diversos servicios personales. Asimismo, en los últimos años han habido algunas oportunidades de empleo en las zonas francas industriales, sin embargo sólo pueden acceder aquellos quienes tienen el nivel de escolaridad (8° curso aprobado) y la formación técnica requerida.

Las mujeres involucradas en el Programa de Salud, madres solteras en un 40% aproximadamente, se valen de un conjunto de estrategias para generar ingresos y salir adelante con la crianza de sus hijos. Actividades que van desde la venta de loterías (rifas), alimentos semi-terminados o terminados (habichuelas, dulces) hasta el envío de los hijos a la calle para realizar servicios marginales y en muchos casos, el trabajo de ellas mismas como trabajadoras sexuales.

## EL PROGRAMA DE SALUD IMPLEMENTADO POR TÚ, MUJER

Desde hace 10 años la Asociación TU, MUJER viene realizando un programa de desarrollo integral que incluye servicios y formación (educación y formación técnica vocacional). Los ejes temáticos bajo los cuales se realizan estos servicios y formación son, salud, alfabetización, relaciones sociales de género, políticas públicas, organización comunitaria, crédito a micro y pequeñas empresas, orientación legal y educación ciudadana.

El Programa «Salud Comunitaria, Salud de la Mujer y Materno Infantil», con énfasis en la población femenina e infantil, forma a las mujeres y a la comunidad en general en salud preventiva, tratamiento de enfermedades comunes y género y salud.

El Programa se realiza en un marco de desarrollo comunitario donde la formación a líderes es un elemento primordial, ya que éstos se convierte en efecto multiplicador, casa por casa, de los conocimientos adquiridos. Los ejes temáticos conducen al conocimiento, a la acción directa en la comunidad, a la organización y a la búsqueda de intereses estratégicos. En síntesis, se busca que la condición y la posición social de las mujeres y la comunidad sean comprendidas por los(las) líderes que hacen el trabajo de multiplicadores(as), y que ello sea transmitido a cada mujer y familia involucrada de forma directa en el programa.

Desde 1994, TU, MUJER viene aplicando una encuesta semestral para estudiar el comportamiento de las variables relacionadas con la salud de la mujer y el niño. El análisis comparativo de los resultados de dichas encuestas, explica no sólo el impacto positivo que se ha logrado en parte de los propósitos generales sino también las situaciones perjudiciales a las mujeres adultas y niñas que se mantienen sin cambiar. Esto último debido a que dichas situaciones fueron ocasionadas por actitudes y comportamientos muy arraigados y profundos que se reproducen culturalmente.

## LOS FACTORES QUE INCIDEN EN LA RESPUESTA DE LA SALUD

Diferente factores socio-económicos y culturales influyen en la diferencia de la respuesta de la salud cuando se es hombre o cuando se es mujer: desempleo y pobreza, educación, tipo de vivienda en la que se vive, acceso a servicios, socialización y construcción social del género, violencia, exclusión del poder, etc. En la experiencia de trabajo que abordamos se ha encontrado diversos factores determinantes que se inscriben en dichas categorías.

### POBREZA Y DESEMPLEO

Atendiendo a las estimaciones oficiales de 1996, el 56% de los hogares dominicanos estarían viviendo en condiciones de pobreza y el 19% de ellos en pobreza extrema[1]. Otro análisis señala que para 1989, el «porcentaje de hogares bajo la línea de pobreza» *era de 49% para la zona urbana y 58.6% para la zona rural*[2]. Cifras que involucran a más de la mitad de la población del país.

Entre los condicionantes de la pobreza en el país, algunas investigaciones[3] indican los siguientes: bajos ingresos de la población ocupada, elevada proporción de hogares con necesidades básicas insa-

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[1] ONAPLAN. 1997. Informe de Población. Pág. 4.

[2] Alemán, José Luis. 1997. *¿Desarrollo con Pobreza?*

[3] IEPD-1996. Condicionantes de Salud de la Población Dominicana, y Factores Demográficos y Socioeconómicos relacionados. Pág. 84 y 85.

tisfechas, deterioro de la distribución del ingreso, tendencia a largo plazo de la reducción del salario real y salario indirecto.

El desempleo es señalado como el principal factor de la pobreza, y ésta como el principal condicionante de la salud en el País. Según los censos y encuestas aplicada en las últimas dos décadas, más del 25% de la PEA[4] se encuentra desempleada.

La población que participa en el Programa de Salud, es parte de las grandes masas de desempleados(as), sub-empleados(as) y de fuerza de trabajo que caracteriza al 1.5 millones de personas que viven en los barrios marginales de la ciudad de Santo Domingo. Ciudad con una tasa crecimiento anual de 10% sin planificación urbana y carente de servicios básicos estables (agua, electricidad, saneamiento ambiental). La mayoría de las familias involucradas viven en los márgenes de los ríos y cañadas que arrastran aguas contaminadas. La amenaza de enfermedades y tragedias debido a la insalubridad y arrastre de las corrientes de agua en épocas de lluvia es constante, tornándose en dificultares mayores como en 1998 cuando, por esta causa cientos de familias perdieron su vivienda.

Tanto en la situación de viviendas inadecuadas como en la de desastres, donde se vulnera aún más o se pierde la vivienda, las mujeres, niños y ancianos son los más afectados ya que permanecen más tiempo en la vivienda. Tal y como revelan las consultas psicológicas abiertas en el Programa de Salud, el mal estado de las viviendas trastorna la salud física y mental de las mujeres y las conduce a un estado de desesperanza y de crisis emocional.

Es de conocimiento general que las mujeres representan el grupo más pobres entre los pobres[5]. Ellas son quienes trabajan más y quienes cargan con los efectos de las sucesivas crisis económicas. En República Dominicana la tasa de desempleo femenino (58%) es tres veces más que la masculina (19%). Estas informaciones impulsan a la reflexión sobre los aspectos culturales que obstaculizan a la

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[4] Población económicamente activa.

[5] PNUD. 1995. Informe de desarrollo Humano. Pág. 43.

mujer el acceso al empleo, teniendo en cuenta que a partir de 1996 la tasa de actividad económica femenina (73%) se acercaba a la masculina (83%).

## JEFATURA FEMENINA DEL HOGAR

La mujer dominicana asume el 31.2% de la jefatura de hogar en la zona urbana[6], situación que alcanza mayores porcentajes entre las mujeres de la población atendida en el Programa de Salud.

En los sectores pobres de República Dominicana, la jefatura de hogar femenina es un fenómeno en crecimiento. Al respecto, un estudio[7] muestra que «en 197 alrededor del 20% de los hogares reconoció a una mujer como autoridad principal, en 1991 este porcentaje se había elevado a un 29.5%. Esta situación es más acentuada en la zona urbana, abarcando a una tercera parte de los hogares». La Encuesta demográfica y de salud, 1996 (ENDESA-96) señala que «en el 27% de los hogares dominicanos es una mujer la que sume la jefatura del hogar» y que «aproximadamente uno de cada tres hogares en la zona urbana tiene una jefa de hogar»[8].

La salud de las mujeres con agudos problemas económicos, y con mayor énfasis de las jefas de hogar, se deteriora a nivel físico, emocional y psíquico. En la mayoría de casos sin compañía de un conjugue, ellas deben asumir el hogar en todas sus dimensiones. Hecho que contribuye considerablemente a que los hogares liderados por mujeres se encuentre dentro de los más pobres.

## NUTRICIÓN

La ENDESA-96, produce informaciones sobre el nivel de nutrición de las madres, en base a medidas antropométricas que incluyen la estatura, el peso y la masa corporal. Se ha encontrado que sólo el

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6. CESDEN, PROFAMILIA, ONAPLAN, DHS.1997. Encuesta Demográfica y de Salud 1996. (ENDESA-96). Pág. 15
7. Duarte, Isis y Tejeda, Hoguín. 1995. Los hogares dominicanos. Pág. 46.
8. CESDEN et al. 1997. Encuesta Demográfica y de Salud. Pág. 15.

2% de las mujeres entrevistadas estaban por debajo del valor crítico de 145 cm y únicamente el 6% tenía una masa corporal deficiente[9]. Sin embargo, los diagnósticos médicos aplicados a las madres atendidas en el Programa de Salud, muestran que gran parte de ellas adolecen de serios problemas de salud, los que podrían prevenirse con una adecuada alimentación.

En el grupo de referencia del Programa de Salud, el limitado poder adquisitivo generado por la pobreza condiciona una nutrición precaria. Los cuadros de anemia y otras complicaciones a causa de una alimentación insuficiente y no equilibrada se presentan con frecuencia. Esto alcanza niveles críticos para las mujeres embarazadas y lactantes quienes con frecuencia, al tornarse de «alto riesgo», ven amenazados sus embarazos así como su vida misma. Una ingestión inadecuada de alimentos durante el proceso de gestación y de lactancia es pues la causa de nacimientos de niños y niñas con bajo peso así como otras complicaciones vinculadas a la descalcificación y falta de energía.

Esta situación repercute sobre la población infantil, provocando altos índices de desnutrición para la población que se encuentra por debajo de la línea de pobreza. A nivel nacional, la ENDESA-96[10] señala que el 11% de los niños y niñas sufren de retardo en el crecimiento o desnutrición crónica, el 1% padece de desnutrición aguda o emaciación (que se refleja en el adelgazamiento exagerado en relación a la estatura) y el 6% sufre de desnutrición global o bajo peso respecto al peso esperado por edad y sexo. Se destaca además que los niños son más afectados que las niñas.

En el Programa de Salud, tanto a nivel de índices generales como por género, la situación es muy diferente para las niñas y niños que atendemos, en general, las niñas son más severamente afectadas que los niños.

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[9] CESDEN et al. 1997. Encuesta Demográfica y de Salud. Pág. 161 y 163.

[10] CESDEN et al. 1997. Encuesta Demográfica y de Salud. Pág. 156.

## POBREZA, DESNUTRICIÓN Y GÉNERO, RESULTADOS DE LA ENCUESTA SEMESTRAL

La Encuesta Semestral que aplica TU, MUJER nos muestra que el grado de pobreza incide directamente sobre la salud infantil y la desnutrición, en la mayoría de los casos son una consecuencia de ello. En junio de 1994[11] se obtuvo que el 30.62% de una población de 2,243 niños(as) menores de 5 años mostraban grados I, II o III de desnutrición[12]. En mayo de 1998, tras la intervención del Programa de Salud en una población de 2,238 niños(as) en la misma zona, se había logrado reducir dicho porcentaje a 16.04%. Según la encuesta de diciembre de 1998[13], en una muestra de 1,721 menores de 5 años, los efectos del huracán George se manifestaron elevando el índice infantil de desnutrición a 18.95%.

El Cuadro N° 1 muestra que a partir de la intervención del Programa de Salud, se ha logrado mejorar los niveles nutricionales de la población menor de 5 años, elevándose en un 14.58% entre 1994 y 1998 (se pasó del 69.38% al 83.96% respectivamente).

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[11] TU, MUJER INC. 1994. Encuesta Semestral de Salud Materno-Infantil.

[12] Esta clasificación se extrae de la curva de crecimiento aplicada por la Secretaría de Estado de Salud Pública, donde influyen las variables de edad, peso y tamaño. La misma es usada en el Programa de Salud para las anotaciones de las pesadas mensuales que se hacen a la población infantil menor de 5 años.

[13] TU, MUJER INC. 1998. Encuesta Semestral de Salud Materno-infantil.

### CUADRO N° 1

CAMBIOS EN LOS NIVELES NUTRICIONALES POR GRADO DE DESNUTRICIÓN DE NIÑOS(AS) MENORES DE CINCO AÑOS, 1994-1998

| GRADO | PESADA SEMESTRAL JUNIO 1994 | | PESADA SEMESTRAL MAYO 1998 | |
|---|---|---|---|---|
| | Absolutos | % | Absolutos | % |
| **Normales** | **1546** | **69.37** | **1879** | **83.95** |
| Grado I | 498 | **22.20** | 276 | **12.34** |
| Grado II | 136 | **6.06** | 74 | **3.31** |
| Grado III | 53 | **2.36** | 9 | **0.40** |
| **TOTAL** | **2243** | **100.00** | **2236** | **100.00** |

Fuente: TU, MUJER, Encuesta Semestral, 1994-1998.

Aunque el Cuadro N° 2 indica que el promedio de niñas atendidas (50.2%) es ligeramente superior al de los niños (49.8%), el análisis de la información del Cuadro N° 3 pone en evidencia la expresión numérica de un problema cultural de discriminación de género en la práctica misma de la nutrición, generalmente a cargo de las mujeres.

### CUADRO N° 2

PORCENTAJE DE NIÑOS(AS) ENCUESTADOS MENORES DE CINCO AÑOS, POR SEXO Y POR SEMESTRE, 1995-1998

| **Aplicación de la Encuesta Semestre** | **Niñas %** | **Niños %** |
|---|---|---|
| 1ro. 1995 | 50.21 | 49.79 |
| 2do. 1995 | 48.29 | 51.71 |
| 1ro. 1996 | 49.39 | 50.61 |
| 1ro. 1997 | 51.84 | 48.16 |
| 2do. 1997 | 50.03 | 49.97 |
| 1ro. 1998 | 50.59 | 49.41 |
| 2do. 1998 | 51.5 | 48.5 |
| **Promedios** | **50.2** | **49.8** |

Fuente: TU, MUJER, 7 Encuestas Semestrales.

### CUADRO N° 3

DESNUTRICIÓN DE NIÑOS(AS) MENORES DE 5 AÑOS,
POR SEXO Y POR SEMESTRE, 1995-1998

| Semestre | Totales | Niñas | % | Niños | % |
|---|---|---|---|---|---|
| 1ro. 1995 | 550 | 307 | **55.81** | 2243 | **44.19** |
| 2do. 1995 | 423 | 243 | **57.44** | 180 | **42.56** |
| 1ro. 1996 | 451 | 268 | **59.43** | 183 | **40.57** |
| 1ro. 1997 | 296 | 174 | **58.58** | 122 | **41.42** |
| 2do. 1997 | 380 | 234 | **61.58** | 1486 | **38.42** |
| 1ro. 1998 | 359 | 219 | **61.00** | 140 | **39.00** |
| **Promedios** | **410** | **240.83** | 58.77 | **169** | **41.23** |

Fuente: TU, MUJER, Encuesta Semestrale.

De este modo, se encuentra que la mejoría nutricional lograda en el Programa de Salud ha favorecido sólo a los varones. En 1995, del total de desnutridos, las niñas constituyen el 56.63% mientras que sólo el 43.37% eran niños. Tres años más tarde, en 1998, el porcentaje de niñas desnutridas aumentó a 60.55% mientras que el de los niños disminuyó a 39.45%. Ello revela que, igualmente, en el acceso a los alimentos influyen actitudes fundadas en la valoración de género, que perjudican profundamente, tanto en el ejercicio mismo del rol que juega ante la nutrición infantil y familiar como en los efectos que provoca.

## LA EDUCACIÓN

La educación formal es otro factor que incide en la respuesta de la salud y la participación en el desarrollo. En la ENDESA-96 se destaca la relación existente entre el bajo nivel de escolaridad de la madre y la desnutrición infantil crónica. La Encuesta Semestral señala que más del 50% de las mujeres incluidas en el programa de salud son analfabetas y, precisamente, en la gran mayoría de casos son los niños y las niñas de éstas mujeres los que presentan problemas más acentuados de desnutrición.

## FORMACIÓN DE GÉNERO Y SALUD

Hoy en día es de conocimiento general que la educación diferenciada para niños y niñas forma a éstos para ejercer roles sociales distintos. El género es una construcción sociocultural con raíces patriarcales, afianzado en la psiquis humana y capaz de reproducirse automáticamente. Sabemos que las relaciones sociales entre hombres y mujeres, ubican a las mujeres en condición y posición de desventajas con relación a los hombres, en todas las instancias socio-culturales y económicas.

La encuesta semestral de Salud Materno-Infantil confirma que las mujeres estamos relegadas a un segundo lugar, lo que para millones de mujeres en el mundo significa todavía ser apenas una sombra. Junto a la capacidad natural de dar y conservar la vida, se nos ha impuesto el rol social de reproducir una cultura cuyos fundamentos se sustentan en la exclusión y maltrato de la mujer. Hoy en día, diferentes indicadores sociales económicos y culturales nos muestran las dimensiones de esta exclusión.

Durante el período que abarca la Encuesta Semestral, el programa de educación en género y salud ha estado vigente. Mediante este programa, las mujeres participan en espacios de formación donde se sugiere un trato equilibrado entre niñas y niños, en todos los aspectos de la crianza. Aunque las informaciones de la Encuesta nos hablan de cambios de actitud en diversas prácticas y comportamientos relacionados con la salud familiar y ambiental, llama la atención que la nutrición siga reportando dificultades para las niñas, incluso en mayores proporciones que al inicio (hace 5 años) de la aplicación de la encuesta.

Los niveles nutricionales de la población atendida menor de 5 años se han elevado en un 14.58% (pasando de 69.38% en 1994 a 83.96% en 1998). La proporción de niñas y niños guarda un equilibrio, 50.2% y 49.8% respectivamente. Al aplicar en la información un análisis de género, encontramos que la mejoría ha favorecido sólo a los niños. En 1995, el porcentaje promedio de niñas desnutridas era de 56.63%, mientras que sólo el 43.37% era niños. Tres años más tarde, en 1998, el porcentaje de niñas desnutridas aumentó a 60.55%, mientras que en los niños disminuyó a 39.45%.

Tal y como lo evidencian los resultados comparados de las encuestas semestrales aplicadas en el Programa de Salud, la tradición de valorar más al varón se expresa de manera consciente o inconsciente, en hechos concretos que perjudican y amenazan la existencia misma de las mujeres.

Desde el nacimiento, a las niñas se les impide tener las mismas oportunidades de sobrevivencia. En este sector de población, que se encuentra por debajo de la línea de pobreza y donde los alimentos accesibles son insuficientes para mantener los requerimientos nutricionales, se trata de preservar al varón. La mayor cuota de alimentos, de tiempo de lactancia y de afectos, recaen sobre los niños. Se trata de un factor cultural que incide directamente en la salud por género y en la capacidad misma de participar en condiciones de igualdad social en el desarrollo.

## CONTROL REPRODUCTIVO

La respuesta a esta necesidad es altamente impuesta a las mujeres, tanto por su pareja como por la oferta del servicio. Según ENDESA-96[14], a nivel de República Dominicana el uso de anticonceptivos alcanza al 63.7% de las mujeres con pareja. Siendo el de la esterilización femenina el de mayor alcance de los casos (40.9%) seguido de la píldora (12.9%). El impacto de estos métodos se efectúa sobre el cuerpo de la mujer, afectando con frecuencia su salud. Sólo el 9.8% de los hombres sexualmente activos declaró que usaba condón, que a diferencia de la esterilización y la píldora, no representa riesgos para el usuario.

[14] ENDESA 96, Págs. 54 y 76.

La Encuesta Semestral aplicada en el Programa de Salud de TU, MUJER, muestra que entre 1995 y 1998 el porcentaje promedio del uso de esterilización femenina alcanza el 37.44%, el de uso de píldoras el 35.77% y el uso del dispositivo intrauterino (DIU) 8.62%. Inversamente, la proporción de responsabilidad masculina en el control reproductivo (condón) es de 1.77%.

Entre la población atendida en el Programa de Salud sobre la responsabilidad del control reproductivo, son las mujeres, en promedio nacional, las que se ven obligadas a llevar la carga más pesada (ver Cuadro N° 4). Sus compañeros se niegan a usar preservativos, lo que en este momento podría servir no sólo para evitar embarazos no deseados sino también para la prevención de enfermedades mortales como el virus de immunodeficiencia humana (VIH).

### CUADRO N° 4

### CONTROL REPRODUCTIVO
SEGÚN SEXO Y MÉTODO EMPLEADO, 1995-1998

| | | Participación masculina | Participación femenina | | |
|---|---|---|---|---|---|
| Semestre | Mujeres entrevistadas | Condón % | Esterilización % | Píldora % | DIU % |
| 1ro. 1995 | 1805 | 2.9 | 21.0 | 16.6 | 4.9 |
| 2do. 1995 | 1818 | 1.9 | 37.5 | 39.9 | 9.2 |
| 1ro. 1996 | 927 | 2.4 | 40.0 | 40.3 | 9.2 |
| 1ro. 1997 | 1489 | 1.02 | 43.57 | 37.55 | 8.57 |
| 2do. 1997 | 1391 | 1.40 | 42.10 | 36.90 | 10.50 |
| 2do. 1998 | 1002 | 1.00 | 40.52 | 43.41 | 9.38 |
| **Promedio** | **1405** | **1.77** | **37.44** | **35.77** | **8.62** |

Fuente: TU, MUJER, Encuesta Semestrale.

Dadas las condiciones de existencia y de calidad de vida tan distintas para mujeres y hombres de un mismo segmento social, las respuesta a la salud resulta también diferente según el género al que se pertenezca. Así, las mujeres pasan a ser las principales demandantes de los servicios de salud.

## LACTANCIA MATERNA

El Programa de Salud trabaja asimismo promoviendo la lactancia materna, actividad en la que se ha superado las metas propuestas. En la última encuesta semestral encontramos que de un total de 58 niños(as) entre 4 y seis meses, 12 (20.69%) estaban recibiendo lactancia exclusiva como alimentación. De 90 niños(as) de 4 meses, 46 (51.11%) recibían lactancia exclusiva. En ambas categorías se ha logrado un porcentaje superior al nacional reportado por la ENDESA-96, que es de 5% y 25% respectivamente.

La lactancia es uno de los factores que ha ayudado a mejorar los niveles nutricionales en la población infantil atendida en el Programa. Sin embargo, ello tiene efectos negativos sobre las madres, que con frecuencia se ven afectadas por anemia y descalcificación de los dientes, dado el difícil acceso a una alimentación adecuada en este segmento de la población.

En los últimos años el Ministerio de Salud y las instituciones, como la nuestra, que trabajan con salud materno-infantil han promovido la lactancia materna exclusiva hasta los seis meses. Este hecho ha profundizado los problemas de salud de las mujeres lactantes cuyos cónyuges son los suministradores de la alimentación familiar, actitudes culturales inducen a éstos hombre a no proporcionar el alimento imprescindible para que las madres lacten sin consecuencias sobre su salud. Cuando al niño(a) se le alimenta con leche enlatada, el padre está dispuesto a proporcionar los recursos para su adquisición pero cuando la madre lacta 100% al bebé esos recursos no son proporcionados a las madres, de ahí que algunas prefieren la alimentación mixta antes de los primeros seis meses.

## VIOLENCIA DE GÉNERO

La violencia contra las mujeres es un hecho generalizado en la cultura dominicana. La violencia está presente en sus vidas y se manifiesta de las más diversas formas afectando su salud física y mental. Ello conlleva a una baja auto-estima que vulnera la voluntad y la identidad de la mujere.

La verdadera magnitud de la violencia contra la mujer aún no ha sido medida en República Dominicana, los sub-registros probablemente se deban al temor de agresiones o por considerarse aún un tema tabú. No obstante, estadísticas parciales nos indican una violación sexual cada seis horas[15]. El homicidio es la sexta causa de muerte de las mujeres dominicanas entre 25 y 44 años de edad[16]. Según los reportes policiales de 1995, más de la mitad (50.9%) de los homicidios de mujeres ocurrieron por razones pasionales. Se estima que a lo largo de la vida, 1 de cada 6 mujeres dominicanas es o será víctima de violencia física[17]. Según un estudio sobre la violencia doméstica en Santo Domingo (1994), el 27% de las mujeres encuestadas sufrió agresión física, el 94% agresión psicológica (amenaza, ofensas) y el 69% agresión social (por ejemplo la prohibición de amistades)[18]. Ello es una muestra objetiva de la escasa valoración de las mujeres y del rol encomendado como reproductora de la sociedad.

La población atendida en el Programa de Salud es víctima de la violencia en general, la violencia intra-familiar y la violencia de género, pero en todos los sentidos la mujer es la principal víctima de la violencia. Por ello, la violencia es otro condicionante de primera importancia de la respuesta a la salud según el género.

15. Dirección General de Promoción de la Mujer (DGPM). 1997. Cuarto informe periódico referido a la Convención Contra todos las Formas de Discriminación Contra la Mujer. Mimeografiado. Santo Domingo.
16. Mujeres Latinoamericanas en cifras – República Dominicana, 1993. Instituto de la Mujer, Ministerio de Asuntos Sociales de España y Facultad Latinoamericana de Ciencias Sociales.
17. DGPM. 1997. Obra citada.
18. Colectivo Mujer y Salud. 1998. «Situación de Salud de la Mujer Dominicana». Mimeografiado. Santo Domingo.

## REFLEXIONES FINALES

Aspiramos a una cultura más equilibrada donde el desarrollo sea sostenible, aspiramos a la paz y al bienestar generalizado con derechos humanos al alcance de todos. No obstante, la estructura y paradigma patriarcal sobre el cual se sustenta la sociedad actual, hace que tales aspiraciones no trasciendan los enunciados de la filosofía del desarrollo.

La desigualdad de género aún se encuentra encubierta en la planificación e implementación del desarrollo. La lucha contra la desigualdad de género conlleva la implementación de procesos de educación y reflexión y acciones dirigidas al cambio de paradigmas y de actitudes.

La construcción cultural del género, responsable de tanta exclusión para las mujeres, ha sentado bases en las estructuras mentales de la sociedad humana. Ello permite la reproducción del sistema mediante el cumplimiento de roles de género que se hacen difícil de cuestionar mediante simple observación.

El género atraviesa todas las instancias sociales, y la salud no está exenta. Desde cualquier perspectiva que analicemos la salud, el género condicionará respuestas diferenciadas para mujeres y hombres. Ser hombre o ser mujer implica un conjunto de experiencias sociales diferenciadas sobre cualquier aspecto de la vida, aún cuando se participe del mismo sector social.

Un elemento clave para la transformación de las actuales relaciones entre los géneros, es el acceso de la mujer al poder así como la inclusión de la perspectiva de las mujeres en las políticas públicas.

La participación en los cargos en donde se toman las decisiones de políticas sociales así como en el poder en todas sus dimensiones, en la familia y en la sociedad, permitirá profundizar el proceso de destrucción de los paradigmas que excluyen a la mujer y la visión como referente social con igual validez que el hombre.

### ARIANE DELUZ

# CHANTS DE FEMMES SUR LA VIE, LA MALADIE ET LA MORT

Ce texte parle des femmes rurales, lesquelles sont les grandes oubliées de l'Afrique, bien qu'on y évoque fréquemment «la femme africaine», mais souvent en des termes très généraux et sans tenir compte des diversités et des spécificités qui en font des «personnes» vivantes et pleines d'ambivalences passionnantes. Je travaille de façon essentiellement qualitative dans une zone rurale habitée par les Gouro, et je parlerai ici de ce qui se passe dans une région précise de la Côte-d'Ivoire, pays dont le système de santé est à plusieurs vitesses : à Abidjan, pour gens fortunés, tous les soins de santé sont accessibles. A Abidjan aussi, et dans les villes de province, il existe des centres de santé publics dont on peut dire qu'à part les PMI (centre de protection maternelle et infantile) leur qualité est allée en se dégradant. Dans les villages enfin, les habitants survivent avec des médicaments traditionnels plus ou moins bien gérés, ou grâce à des soins payants pour lesquels ils doivent mendier auprès de leurs parents plus aisés qu'eux, avec une forte proportion d'auto-prescription de médicaments divers, ou alors l'utilisation d'ordonnances fournies contre paiement par des membres du personnel de santé (infirmiers, aide-infirmiers, sages-femmes, balayeurs). Il est d'ailleurs frappant d'observer le contraste entre les difficultés financières que rencontrent les villageois quand il s'agit d'accéder aux soins les plus élémentaires et les flux monétaires importants qui circulent lors des rituels de deuil.

J'ai enquêté chez les Gouro dès 1958, ai fait dans leurs villages de nombreux séjours de plusieurs mois et même d'années, et ma dernière visite date de janvier 1999. Pour l'intelligence de ce qui suivra je résume quelques données ethnologiques les concernant, en centrant ma présentation sur les statuts des femmes.

Les Gouro, au nombre de 160000 environ en 1958, et qui seraient 450000 maintenant – y compris beaucoup de migrants d'autres parties du pays et du Burkina – vivent dans le centre de la Côte-d'Ivoire. Ils sont d'origine mandé, très anciennement installés dans la région. Autrefois guerriers, agriculteurs, chasseurs, tisserands et commerçants, ils sont aujourd'hui agriculteurs. Leur filiation est patrilinéaire, c'est-à-dire qu'un individu appartient à la famille de son père. Les filles gouro quittent leur famille quand elles se marient et vont résider dans la famille – je dirai le lignage – de leur mari, lequel comporte plusieurs familles restreintes dont tous les hommes adultes sont apparentés en ligne paternelle.

En principe, une jeune fille sait que son mariage à elle est la condition de celui de ses frères cadets. En effet, les biens versés par la famille de son futur époux à sa famille, ou plutôt à son lignage à elle lors de son mariage, sont en effet réutilisés pour procurer une épouse à son frère (ou à un cousin fils de frère de son père). Une fille du lignage a donc une position sociale dominante par rapport à une épouse du lignage. L'une est «fille» (*bnê*) l'autre est «épouse» (gcn*enã*). Au village tous les conflits entre femmes se règlent entre le groupe homogène des «filles» nées et élevées au village, mais en principe absentes ou seulement en visite, et le groupe hétéroclite des «épouses» venues d'autres villages. Toute femme est donc «fille» dans un village, «épouse» dans l'autre. Ce balancement que vit toute femme, clivée entre son rôle social de fille et celui d'épouse, correspond à l'incertitude qui subsiste quant à l'appartenance des femmes soit au lignage où elles sont nées, soit à celui où elles sont mariées. Sur le plan social, cette question est réglée au coup par coup par les hommes, pendant sa vie conjugale et au-delà : par des dons répétés lors de décès dans son lignage à elle, puis à sa propre mort, et enfin à la mort de ses fils.

Durant toute sa vie conjugale, la femme est écartelée entre son attachement et ses loyautés à son lignage d'origine et à celui de son mari. Chez elle, elle est honorée, respectée, mais elle réside ailleurs; et des visites trop fréquentes chez ses frères risquent de perturber l'harmonie du ménage de ceux-ci. Lors de chaque décès dans son lignage à elle, elle accourt pour effectuer les rituels de deuil et son mari offre de nouvelles prestations à ses beaux-frères donneurs, hommes avec lesquels il a une relation respectueuse et tendue. Il augmente ainsi la valeur de la compensation matrimoniale de son épouse et affirme ses droits sur ses propres enfants. Chez son mari, la femme est aussi respectée et estimée si elle est travailleuse, et surtout féconde. Mais tout écart de conduite de sa part, tout adultère, est une atteinte à l'intégrité de la «terre», laquelle représente les membres décédés, ancêtres du lignage de son mari. En cas d'adultère de l'épouse, réparation doit être faite par l'entremise des fils de sœurs du mari, intercesseurs du lignage, lesquels offrent un sacrifice expiatoire après avoir tancé, insulté, et même battu la coupable. Ceci pour le plan social. Venons en maintenant aux niveaux physiologique et psychologique:

L'organe vital de l'humain est le foie (*bli*); il serait formé du sang des règles. La réserve des éléments vitaux se trouve dans l'intestin grêle (*buã*). Femmes et hommes possèdent chacun un liquide sexuel (*yi*, eau). Lors des rapports sexuels, le liquide sexuel de l'homme est recueilli dans l'utérus (*nepawolo),* le sac où est l'enfant et les deux liquides féminins et masculins rencontrent le sang des règles (*zuru*). Ces trois éléments s'unissent pour donner naissance à l'être humain. L'absence de règles implique le dessèchement, le vieillissement; on dit d'un mort qu'il est sec (*ga*). Après une aménorrhée de quelques mois, si le sperme de l'homme continue à rencontrer le liquide de la femme sans qu'un bébé se forme ou que le sang des règles les évacue, il se forme une boule dans le bas-ventre de la femme. Si les règles ne surviennent pas ou plus, et que les relations sexuelles se poursuivent cette boule grossit dans le bas-ventre de la femme et la femme meurt, d'un «affaiblissement général», de la maladie *zruk niamã*, mot que je traduis par ménopause («règles coupées sur elle»). Toute aménorrhée, tout début de grossesse même, sont donc dangereux pour les femmes gouro. Traditionnellement, l'arrêt des règles devait donc se traduire par l'interruption des rapports sexuels, et la ménopause fait partie du registre des maladies honteuses – et importées – disent mes informatrices. Ici intervient la science traditionnelle des femmes dont la société d'initiation des filles *k ne* est la principale dépositaire, mais non la seule. Les femmes avaient autrefois, et certaines ont encore, à leur disposition des médicaments nombreux, divers et non encore identifiés, sous formes de pâtes de feuilles qu'elles prennent en lavements emménagogues ou sous forme de bois qu'elles mâchent, ou «cure-dents»; leurs menstrues surviennent alors, qu'elles aient été enceintes ou pas. Ces médicaments sont donc des inducteurs de règles et ont une valeur à la fois antiaménorrhéique, contraceptive et abortive. Les femmes les utilisent indifféremment pour empêcher ou faire cesser une grossesse indésirable (en cas de rupture des interdits postnataux), et pour prolonger leur vie sexuelle si elles en ont le désir.

Les femmes mettent l'accent sur l'intestin grêle comme le lieu de la constitution du sang. Ce même intestin grêle (*buã*) se continue par le cordon ombilical (*nek wene,* c'est-à-dire «enfant du nombril») et le nombril (*nek we* = maison de l'enfant).

Le secret que les femmes cachent aux hommes est celui de la naissance; tout homme est relié à sa mère qui l'a détaché, mais l'a «marqué» en nouant le cordon ombilical, un des constituants du *k ne,* le masque sacré des femmes, et qui est enterré avec le placenta, ou qu'on introduit dans les médicaments du masque. Aucun homme n'est admis à assister à une naissance, il doit en effet toujours se poser la question «d'où viennent les enfants?» ce qui peut aussi s'entendre: ne jamais voir le sexe d'une mère. De nos jours encore, la vue d'une naissance reste interdite aux hommes (sauf aux membres des services de santé). Comme me disait un homme, voir une naissance, c'est comme pour une femme voir le masque *je* des hommes, ça tue.

De ce que j'ai rappelé en introduction, semble ressortir une tension entre les éléments masculins et féminins de la société. En fait, elle est plus apparente, revendiquée et publique que réelle; la vérité serait plutôt une très forte complémentarité entre les sexes et une collaboration effective et discrète entre hommes et femmes. Les antagonismes forts sont ceux existant entre des groupes sociaux féminins: «filles» d'une part et «épouses» d'autre part. De plus, ces tensions sont psychologiquement intérieures à chaque femme. On dit ainsi que, nonobstant l'affection apparente qui semble de mise entre mère et fille, une mère est capable d'ensorceler sa fille (la manger en sorcellerie). Effectivement, la mère est «épouse» ou sa fille est «fille», et la relation fantasmatique de sorcellerie double les affrontements sociaux entre «épouses» et «filles» à l'intérieur de chaque village.

Ces oppositions sont ressenties et vécues au quotidien et sont exprimées de façon très forte au cours des cérémonies de deuil. Entre la mort d'un individu et son enterrement, une période assez longue peut s'écouler, car il s'agit de réunir les sommes nécessaires à l'accomplissement des rituels et convoquer les neveux fils de sœurs ou *yuru* lesquels résident parfois assez loin et sont les fossoyeurs obligés de tout enterrement. Mais ils se font prier durant plusieurs jours et ils monnaient ensuite symboliquement leur travail. Après l'enterrement, celles qu'on appelle les «deuilleuses» restent sur place – de nos jours pendant une semaine – car leurs chants apprivoisent le double *lei* du ou de la défunt-e qui rôde encore aux alentours. Parallèlement à d'autres rituels masculins mais aussi féminins dont je ne parlerai pas ici, tout au long de ces semaines, les femmes chantent, réparties entre plusieurs groupes. D'un côté les femmes mariées au village où ont lieu les rituels, et de l'autre, les «filles», venues d'ailleurs à cette occasion. La mort et la «désocialisation» ou «naturalisation» qu'elle implique, autorise la plus grande liberté de parole. Toutes les accusations toutes les insultes peuvent se dire sans restriction et sans que quiconque puisse faire taire les chanteuses. Liberté et ambivalence, car tout chant est à double sens: il signifie ce qu'il affirme, et aussi son contraire.

Au cours des ans, j'ai réuni un important corpus de ces chants, et je les ai utilisés dans plusieurs publications. Il s'agit de textes très divers: certains ont une forme et un contenu plus ou moins figé, à force d'avoir été chantés et répétés par des femmes de tribus (groupes économiques et sociaux bien déterminés) voisines. Ces mêmes chants sont aussi fréquemment empruntés; ils passent alors dans le répertoire d'autres régions du pays gouro, et sont parfois repris dans des tonalités différentes; d'autres sont spontanés, composés à l'occasion d'événements précis, connus, et rejoignent à l'occasion le répertoire d'un groupe de chanteuses. Tous sont susceptibles d'être chantés dans des contextes nouveaux ou distincts, et leur sens se modifie alors au gré de ces contextes, ou même de l'humeur des chanteuses. Le tragique peut faire place à l'ironique, la flatterie à l'insulte, et ainsi de suite. J'ai choisi de présenter quelques chants recueillis dans des villages où j'ai longtemps résidé et où je connais les circonstances entourant la mort du ou de la défunt-e et un certain nombre de traits caractérisant la personnalité des chanteuses. Ces chants se rapportent plus ou moins directement aux thèmes de la maladie, des causes de la mort et des circonstances l'ayant entourée.

Ces chants sont interprétés pendant la nuit, de neuf heures du soir environ jusqu'à l'aube. Une soliste (il peut y en avoir plusieurs dans chaque groupe) entonne un chant qui se compose en général d'une phrase ou deux. Ce thème est repris par une accompagnatrice, plus rarement par plusieurs chanteuses. Au chant proprement dit, répond un chœur qui en reprend un ou deux termes ou qui en propose un autre, souvent en le modulant. La ou les chanteuse-s reprennent plusieurs fois le chant avec de légères variantes, toujours avec réponse du chœur. Ces variantes parfois infimes éclairent souvent le sens du chant. La performance d'un chant peut durer de quelques minutes à une demi-heure et il est parfois repris plus tard dans la nuit. Les chanteuses sont souvent divisées en deux groupes antagonistes «filles» et «épouses» qui chantent tour à tour et se répondent en s'insultant. Parfois aussi une session comporte un seul groupe «filles» ou «épouses» et le groupe adverse se produit la nuit suivante.

Sans entrer dans le détail, évoquons ce qu'il en est de la rétribution des chanteuses. Les gens responsables du deuil qui les ont invitées leur offrent des plats de nourriture en fin de journée et leur donnent ensuite des casiers de boisson («sucreries» c'est-à-dire sodas, ou vin) qu'elles se répartissent et boivent dans les heures qui suivent. Ils leur remettent ensuite des sommes d'argent plus ou moins importantes tout au long de la nuit pour les remercier et les encourager dans leurs chants. Tous ceux qui assistent à la cérémonie leur versent aussi régulièrement des cadeaux en argent qui varient selon leur propre statut et leur implication. Les chanteuses elles-mêmes ne se font pas faute de réclamer de l'argent avec insistance en des termes parfois agressifs ou ironiques. J'ai moi-même généralement donné une somme convenable en début de nuit, puis régulièrement de plus petits cadeaux.

Des quinze textes que je présente ici, les cinq premiers ont été chantés en 1976 à Boifla, un village du nord du pays gouro où je vivais alors, à l'occasion du décès de la mère de Zan, un fonctionnaire très intelligent et alcoolique, qui avait promis de se montrer fastueux à cette occasion. En fait il eut un comportement délirant pendant plusieurs semaines. Le premier chant est chanté par les filles du village, et en particulier par celles non parentes de la morte ou de son fils, mais mariées à Kohoufla, village où l'épouse de Zan est fille:

### CHANT 1.

*Pour les femmes gouro, il est préférable*
*de mettre au monde des enfants garçons / des enfants garçons*

Ici, les «filles» pensent à Zan. Il est un homme supposé avoir des moyens financiers, et elles l'encouragent à se montrer généreux comme tout «bon fils» doit le faire. Cet espoir est déjà infirmé par la réalité et le chant a une tonalité ironique.

Le deuxième chant est interprété par les «épouses» de Boifla soutenues par les «épouses» de Kohoufla:

CHANT 2

*La vieille femme est comme de l'huile de palme renversée,*
*le chien se jette sur cette huile / sur cette huile*

L'huile de palme est chose précieuse; renversée, elle représente la morte; tous ses enfants (sous-entendu: fils et filles du village) se contentent de bavarder autours du corps, comme des chiens buvant de l'huile renversée. Ce disant, les épouses insultent les filles.

Le chant 3 est aussi dit par les épouses:

CHANT 3

*La maladie ne mange pas l'igname médiocre dans leur village,*
*elle ne mange que la bonne igname / la bonne igname*

«Leur village» est un terme dépréciatif pour Boifla, où elles souffrent de leur condition d'épouses, et où la maladie, donc la mort, attaque les meilleures.

Les deux textes suivants ont été enregistrés sept jours après l'enterrement, lors de la cérémonie dite de levée de lit: les femmes chantent toute la nuit autour du lit vide où on avait exposé le cadavre, lit qui était resté sur place après l'enterrement. A la fin de la nuit, un dernier poulet est sacrifié pour congédier le *lei* de la morte et le lit est enlevé. Cette cérémonie, probablement d'origine akan a été instituée dans les années 70 afin de permettre aux parents fonctionnaires en ville de venir participer aux rituels de deuil. Elle semble avoir tendance à se perdre.

Cette nuit-là, les chanteuses sont des filles et des épouses de Boifla:

CHANT 4

*La semoule de maïs que j'ai faite, je l'ai secouée sur l'herbe / sur l'herbe*

ce qui signifie «l'enfant que j'ai mis au monde, il est perdu, je n'ai plus rien».

Ceci renvoie à l'histoire d'une femme qui n'avait qu'un seul enfant, lequel est mort; les «filles» déclarent que les «épouses» se sont essuyé les mains sur elle, comme elles l'auraient fait sur l'herbe après avoir déféqué. Ce chant circonstanciel est souvent repris à la mort d'une femme n'ayant eu qu'un seul enfant. Ce n'est pas le cas ici, les filles sous-entendent «vous les épouses l'avez méprisée».

### CHANT 5

*Toi (sous-entendu la mort) tu as tué la petite femme.*
*Ne déposez pas brutalement son cadavre sur la civière / sur la civière*

On a ici la reprise d'un chant ancien d'une «fille» à la veillée funèbre d'une co-épouse cadette de sa propre mère. Cette jeune femme est en quelque sorte une sœur pour elle, car sa mère considérait et traitait cette jeune co-épouse comme une fille. Ici ce sont les «épouses» qui chantent.

Les six chants suivants ont été enregistrés en novembre 1975, dans ce même village Boifla lors des cérémonies autour de la mort d'une femme âgée, originaire de Maminigui et mariée à un «féticheur «pauvre et sans renommée. Là aussi les groupes vont se faire et se défaire: la fille de la morte «fille à Boifla» contre les épouses de Boifla, (chant 6) puis les filles de Maminigui contre les filles + épouses de Boifla (chant 7, 8 et 9), et enfin les épouses de Maminigui et Boifla contre les filles de Maminigui (10 et 11).

### CHANT 6

*Les hommes de Basse Côte ont fermé la porte sur le revenant (le cadavre juste après sa mort), c'est pourquoi le bonheur s'est retiré de moi / de moi*

La fille de la morte s'explique: elle était à Abidjan, en Basse Côte quand sa mère est tombée malade. Elle n'a rien pu faire pour la sauver. Le malheur qui lui est tombé dessus est dû à cette malchance.

### CHANT 7

*Je n'ai pas pu être dans la sauce des étrangers,*
*la tête du coq est dans la sauce / dans la sauce*

Quand on tue un poulet pour honorer un étranger, on ne met jamais la tête dans la sauce, ce serait une honte ; on la donne au plus jeune de la famille. La défunte est «épouse» à Goabohifla, elle est venue chez des étrangers, on la compare à la tête d'un coq qu'on aurait mise dans leur sauce. Bref, on ne l'a pas considérée.

### CHANT 8

*Vous dites toujours que le brouillard fait pousser le maïs,*
*cette fois-ci le brouillard n'a pas fait pousser le maïs / le maïs*

Zohuli le veuf se déclare féticheur/guérisseur, mais il n'a pas pu guérir sa femme. Ses médicaments sont le *dibi* et un philtre d'amour. Lui-même aurait guéri des fous légers, ceux qu'on appelle des toqués. En une certaine occasion, il aurait guéri sa femme devenue légèrement folle. Il a emprunté l'argent nécessaire aux cérémonies de deuil à l'un de ses anciens malades.

### CHANT 9

*Nous autres femmes actuelles, nous sommes comme une souris morte à la guerre. On la mange avec ses poils / nous sommes des gens morts à la guerre*

On la mange avec ses poils, c'est-à-dire on l'enterre avec sa honte.

Si une femme s'est promenée de gauche et de droite avant de mourir, elle est considérée comme morte à la guerre. Dans ce cas, on ne paie pas son corps, dernière prestation aux neveux fils de sœurs de son mari, et selon les anciens Gouro, le cadavre a alors honte.

### CHANT 10

*Mon enfant va à gauche à droite, c'est la mort qui l'y a incitée / c'est la mort*

Peu avant sa maladie, la défunte avait pris l'habitude d'aller à gauche et à droite, c'est-à-dire elle avait des relations sexuelles avec plusieurs hommes / c'est la mort qui l'y avait incitée. Ses vagabondages ont duré deux mois environ. Auparavant, elle était sage.

### CHANT 11

*Autrefois on ne m'insultait pas.*
*La mort décrète que tous m'insulteront désormais / m'insulteront*

Les chanteuses s'adressent au veuf en parlant en son nom. Quand il avait une épouse, il était respecté ; dès qu'il est veuf, on va l'insulter. S'il lui arrive en rentrant des champs, de demander un service ou de la nourriture à une femme du village, elle peut lui répondre «eh ce n'est pas moi qui ai tué ta femme», sous-entendu «je ne vais pas prendre sa place».

Le chant 12 a été enregistré en septembre 1983 à Bokouaifla où j'étais en visite chez Bolia, le plus grand chanteur homme gouro. Les épouses du village chantèrent durant une longue nuit autour du corps de l'une d'elles qu'on allait enterrer le lendemain.

### CHANT 12

*Moi, j'ai donné une grosse poule au yu*
*J'ai donné un gros cabri au yu, le yu n'a pas accepté / le yu a menti*

Le *yu* désigne un esprit incarné dans un végétal ou un animal, une force spirituelle, un culte, un masque. Si un malade cherche un médicament, il ne faut pas se contenter de donner des poulets et des cabris à son *yu*. C'est un chant moderne, depuis qu'on connaît l'importance de la médecine. Les épouses reprochent au mari de la morte de ne pas avoir pas emmené leur amie à l'hôpital.

Les chants 13, 14, 15 ont été enregistrés en 1992 à la mort d'un vieux du village où je résidais, proche de la préfecture de Bouaflé. 13 et 14 sont chantés par une «fille» du village et 15 par une épouse. Les deux femmes s'entendent fort bien au quotidien, mais se livrent à des compétitions farouches lors des funérailles.

### CHANT 13

*Le manche du seau de ma camarade est cassé / le seau est percé*

La chanteuse est déjà âgée et elle n'a pas d'enfants. Ses camarades ont des enfants personnalisés par des seaux – le terme français est utilisé. Même si ces enfants de valent rien ce sont des seaux sans manche mais quand même des seaux. Son seau à elle est percé, il ne retient rien, elle n'a pas d'enfant. Ici le seau représente l'appareil génital. Le motif de la femme percée est fréquent dans les chants.

### CHANT 14

*Le piment est sorti de sa tombe*
*le piment est sorti de la tombe du méchant / du méchant*

Le piment évoque la méchanceté. Les chanteuses affirment qu'une personne méchante n'a jamais des bons descendants.

### CHANT 15

*Dans le palmier Glinè est morte et le palmier s'est fait ami de Samni*
*C'est ainsi qu'on parle: Glinè est morte dans le palmier / dans le palmier*

Les chanteuses se réfèrent à un événement authentique : Glinè, une vieille femme, est allée toute seule couper son régime de graines de palmes. Pour ce faire, elle est montée dans le palmier, elle n'a pas pu en descendre et elle y est morte. L'allusion à Samni reste obscure

Que nous apprend ce bref aperçu d'une production orale aussi riche que dense à la fois dans son contenu et dans sa forme?

Quelques grands thèmes sont évoqués et mis en rapport direct les uns avec les autres ou avec la mort qui est le motif nodal de cette littérature.

La nourriture d'abord, tantôt bonne, tantôt mauvaise : igname, semoule de maïs, maïs, poulet, palmier, huile de palme, piment. Ainsi l'huile de palme est ici nourriture de la mort et des chiens, lesquels sont des intermédiaires entre l'animalité et l'humanité, avec une valence inverse de celle qu'a cette huile de palme dans la société gouro, où elle est la «sauce» obligée des offrandes des vivants aux ancêtres.

L'animalité : chiens, souris rappellent la mort ; poulet ou cabri sont vainement sacrifiés pour la conjurer.

La sexualité, implicitement liée à la nourriture – le terme «manger» se traduit aussi par «avoir des rapports sexuels » – est ici franchement mise en rapport avec la mort. Il s'agit en effet des relations hors mariage d'une femme âgée et ménopausée, donc d'une sexualité désocialisée, comme les relations furtives et nocturnes que peuvent avoir les jeunes gens et jeunes filles accourus aux funérailles, relations que le groupe social traite comme non avenues.

Les sentiments exprimés sont variés et chargés d'ambivalence : agressivité, ironie, douleur, tristesse, compassion, solitude.

Dans cet univers féminin, les chanteuses n'attaquent pas les hommes, elles les dévalorisent. La virilité de Zan est reconnue, à condition qu'il se montre généreux. Zohuli, le veuf, est un guérisseur minable, incapable de procurer des soins décents à son épouse. Sa femme disparue, il n'est plus qu'un zéro social. Liberté de paroles, liberté de ton, les femmes se posent en actrices de leur propre destin.

Au clivage des hommes, entre donneurs de femmes et preneurs de femmes, tout homme étant simultanément dans les deux positions vis-à-vis de groupes distincts, correspond le clivage des femmes entre filles et épouses, où toute femme est à la fois l'une et l'autre, et aussi vis-à-vis de groupes différents. De sorte que l'on pourrait avancer que si dans le temps de la vie les hommes «échangent » entre eux symboliquement des femmes en restant dans un lieu fixe, dans le temps de la mort, les femmes échangent entre elles dans une joute symbolique, les savoirs, ignorances, valeurs et contre-valeurs de la société, en se déplaçant d'un lieu à l'autre. Le pouvoir appartiendrait aux hommes pendant la vie, aux femmes à la naissance et à la mort.

En conclusion, je dirai quelques mots rapides des implications, dans le monde moderne, de ce que j'ai tenté de décrire. A propos de tout projet de développement en Afrique, on déclare classiquement : «réunissez les femmes, parlez avec elles, recensez leurs attentes et leurs besoins, etc. » Certes, mais à condition de ne pas traiter les femmes comme un ensemble monolithique ou en leur appliquant les seuls critères de différentiation de type occidental : âge, niveau d'éducation ou de scolarisation, statut matrimonial, etc. Comme je l'ai montré, les femmes forment des entités à la fois changeantes et complexes, qu'il est indispensable de connaître et de prendre en compte.

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ALICE WELBOURN

# GENDER, SEX AND HIV: HOW TO ADDRESS ISSUES THAT NO-ONE WANTS TO HEAR ABOUT

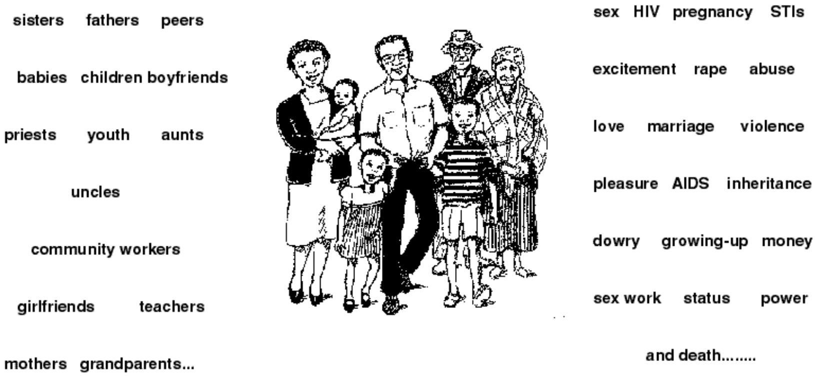
Abstract: This paper discusses the limitations of conventional Information, Education and Communication (IEC) approaches to HIV prevention and describes Stepping Stones, one approach which 1) is more holistic in recognising the location of HIV in a broader sexual and reproductive health (SRH) context; 2) emphasises the importance of a gendered perspective throughout; and 3) works on the basis that, with good facilitation, ordinary community members are those most able to develop the best solutions for their own sexual health needs.

## INTRODUCTION

We are all members of the human race and, one way or another, have relationships through family, through community and/or through professional ties with one another. For all of us there are issues and choices which, at stage in our lives we are likely to need to face, relating to sex. Without our parents having had sexual intercourse, none of us would be here. So sex is in fact a basic ingredient to all our lives. We all of us are aware of our sexual identity. Whether we view ourselves as male or as female – or as something else – is critical to all of us. It influences how we are viewed by others and how we ourselves view the world. Yet most of us find sex and issues related to sex extremely difficult to talk about.

Death too is an issue around which there is perhaps even more taboo than sex. Although we are surrounded by both subjects in the news and in the popular press, and although we will all one day die, most of us find it a huge challenge to talk either about our own sex lives or our own deaths (see Table 1).

**Table 1 - Who we are - and how we relate**



Thirdly, gender issues raise the tempers of many people. Whilst gender inequalities around the world are huge[1], many consider that it is the natural place of women to have inferior status to men and inferior access to and control of goods and produce, as well as inferior access to their children. Those who attempt to challenge these views are often accused of imposing Western views in an inappropriate way, and of interfering with traditional values. The recent Supreme Court vote in Zimbabwe, which found 5-0 in favour of withdrawing women's rights to equal inheritance with men (a right which was gained 19 years ago at Independence) is just one example of how entrenched such views still are.

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1. See for instance PANOS briefing 1998

Yet unfortunately, with the growing rates of global HIV infection, all three of these are subjects which are increasingly in need of discussion and attention[2]. Because of our difficulties in addressing them, the HIV epidemic has been able to grow and flourish. Latest UNAIDS figures indicate that 33[3] million people worldwide are infected with the HIV virus. A quarter of all adults in Botswana and Zimbabwe are HIV positive. 10 million people in India alone are now HIV positive. Most of those infected are in the 15-49 years age group, which is the group which is most economically productive in society. Whilst only 43% of women are infected, compared to 57% of men, the vast majority of the burden of caring for the sick and dying falls on women, thereby forcing them to give up many other activities to support their beloved ones. There are also now increasingly large numbers of orphans who are either being looked after by ageing grandmothers, or who are having to fend for themselves. HIV is not a problem which will go away by itself.

The two personal case studies below, from West and East Africa respectively, give some idea of the range of challenges facing individuals with HIV.

***Albert, Côte d'Ivoire[4]:***

*"I haven't told any members of my family that I'm HIV-positive," says 32 year-old Albert, "but I've done a will, explaining everything about my situation. I can't tell them I've got HIV*

***Consolata, Kenya[5]:***

*"I'm 30 years old and I was born and brought up in Kisumu. I had my first sexual encounter when I was only 14. This was quite normal in my neighbourhood. I was in the*

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[2] This article deals primarily with heterosexual transmission of HIV. Other transmission routes, such as mother-to-child transmission, injecting drug use, same-sex transmission and transmission through unsterile implements are also important issues, but are not addressed here. One good source of information about same-sex transmission in Asia is the Naz Project.

[3] For the latest update on figures worldwide, see www.unaids.org

[4] From Williams et al 1995

[5] From Williams et al 1997

*because I'm the eldest and the best educated in the family, and it would be like admitting that I can't do anything for them. They would feel betrayed.*

*"I used to be a school teacher in Mauritania, but I lost all my money and possessions when I was expelled in 1989, because of the war with Senegal. I was living with a Senegalese woman, and we had a baby girl, but I had to leave them behind in Dakar. I'm worried about them of course. How are they managing without me? And they might have HIV too.*

*"I went for a blood test because I'd heard about CIPS (Centre pour Information et Prevention du SIDA) on the radio. The counselling they gave me before the test was really good. In fact if it hadn't been for that, I'd never have had the courage to go back for the result. I suspected I could have HIV because my penis was swollen and covered in lumps at the time, and also because I'd had shingles in Mauritania.*

*"But when CIPS sent me to a hospital for treatment, things were not so good. The first doctor I saw was very nice, but she sent me to another department for treatment. I had to expose myself to some trainee doctors, and afterwards I overheard them talking about me. One was saying 'Hey, did you see that guy with AIDS, with all the lumps on his penis?' It was final year of primary school, and it was the 'in thing' for girls to engage in sex. No-one knew the dangers of sex then. We just did it.*

*"I then went on to high school. I had a steady boyfriend and sex was part of our relationship. I remember how once I missed my period and got into a big panic. I took twelve malaria tablets because I'd heard they induce abortions. Nothing happened but my periods came later anyway.*

*"Four years later I got married. I was 18 years old. My husband worked as a mechanic in Nairobi, and I lived in Siaya in Western Kenya. After five years of marriage we still had no children and we had a big disagreement because my husband said I was barren, so I left him and went back to my mother's house. Three months later I discovered I was pregnant but I didn't tell my husband. In November 1990 I delivered two beautiful twin girls.*

*"After the delivery I began getting sick, and this went on for more than a year. I got better but one of the twins began getting diarrhoea, vomiting and having oral thrush. She was tested for HIV and found to be positive. Four months later she became very sick and died. I felt very guilty. I kept blaming myself for her illness. I took a test myself*

*really humiliating for me, and I complained to the doctor about it.*

*"Because I couldn't pay for the medicines they prescribed, they sent me to CASM (Centre pour Assistance Socio-Medicale), where I was received very warmly. They gave me coffee and bread, the doctor examined me, and I was given the medicines I needed. When the Friends' Club started I got involved, and now I'm in charge of the small projects to help our members earn some money.*

*"I also started going to church, and that's helped me a lot. I used to feel very bitter and wanted to revenge myself on society, but that's all gone now.*

*"But I still have quite a few problems. I stay with a cousin and his family, but they don't know my HIV status. I'm afraid they'd reject me if they knew. My cousin is already suspicious. He says if I've got AIDS I should tell him.*

*"I'm desperate for a job too. When you don't work, you think of suicide all the time. But I'm afraid of my HIV status becoming known because employers sometimes test their staff for HIV without telling them."*

*and it was positive, but my health was very good.*

*"In 1994 I got news that my husband had died. I buried him but refused to be inherited (by my husband's brother, which is the tradition here). I told my family I was HIV-positive but they said I was just looking for an excuse not to be inherited. I went to Nairobi, and I met with TAPWAK (The Association for People with AIDS in Kenya), where I met a lot of people who helped me to live positively with HIV. I did some courses and started counselling people. Then I came back to Kisumu, where I work for TAPWAK as a counsellor. We have young people here in their teens and early twenties living with HIV. We all know we have limited time so we try to make the best possible use of it.*

*"I feel very strongly about the abuse of married women by their husbands. They are afraid of speaking out even when they know their husbands are unfaithful. They stay in marriages because of the children and the need for security. I knew my husband was having women left, right and centre but I was afraid to leave him. When I finally did leave him, it was too late. He had already infected me.*

*"From my own experience I would say that the youth should receive sex*

> *education from as early as ten years of age. When I started having sex I knew nothing about the real dangers. I only knew it was forbidden. Ignorance is still a problem today. Just recently I learned that my 11 year-old niece was being treated for an STD. What is our society coming to?"*

This presentation charts the responses to this epidemic, explains briefly their drawbacks and describes a training package, called Stepping Stones which is designed to help people to address and overcome their fears, and to face these important issues for themselves.

## WHOM SHALL WE BLAME ?

Initial responses to the epidemic focused the blame on others (see Table 2). For instance, in different parts of the world, foreigners, sex workers, gay men, and women have all been blamed. In Africa, AIDS is often known as "**A**merican **I**nitiative to **D**iscourage **S**ex", an allusion to Western ideas about family planning and population levels. Injecting drug users, uneducated people, rich men, sinners… all in turn have been blamed.

Measures have been introduced in various countries to exclude foreigners with HIV, to test sex workers and, for instance most recently in South Africa, to make HIV a notifiable disease (so that anyone who tests HIV positive is named to public health officials, in order to try to trace their sexual contacts). In most countries, however it soon became clear that such measures were both unethical and unworkable. (In South Africa again, UNAIDS recently reported the death of Gugu Dlamini, a 36-year-old mother of a son. She died last December as a result of the beating she received by neighbours in her own home. They had accused her of having brought shame to their community, Kwamashu, in the outskirts of

Durban, after she openly revealed on December 1 – World AIDS Day – that she was HIV positive[6]. HIV rate in this neighbourhood stands at about 30% of the adult population. Yet few people in South Africa are now likely to dare to be tested, for fear of a similar fate. HIV has no preference for gender, nationality, sexual orientation, occupation, skin colour, religion or age. HIV has to do with the risks that each of us take as individuals, and our personal abilities to make choices about those risks. And some of us have far more choice than others. A recent study of married monogamous women in India[7], for instance, found that HIV infection amongst them is increasing and that the most likely means of infection is through unprotected sex with their husbands.

**Table 2 - Whom shall we blame?**

!men!
!sex workers! !foreigners!
!women!
!youth! !rich people!
!uneducated people!
!gay people!
!Americans!
!drug users! !sinners!
!you!
***?me??***

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6. See www.unaids.org press release of 5th January 1999
7. Gangakhedkar et al 1997. The study group consisted of 916 women, including 525 female sex workers (FSWs). The rate of infection in FSWs was nearly 50%, versus about 14% among those who were not sex workers. The researchers note that the infection rate among non-sex workers was "disturbingly high", considering their relatively low-risk behavioural profile. However, they say the rate may be explained by the discovery that non-sex workers had a higher incidence of STIs than FSWs and that some women were referred to STI clinics by husbands recently diagnosed with an STI. Source: Gender-AIDS: Gender-related articles, December 1997. E-mail: gender-aids@ bizet.inet.co.th

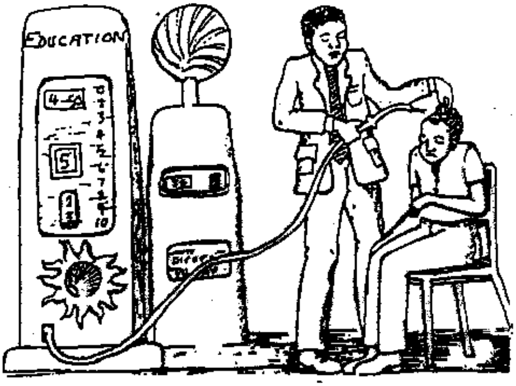
It has thankfully become increasingly clear, therefore, in most countries of the world, that blaming others only serves to increase fears, to reduce openness to each other and therefore to increase the chances of HIV gaining ground.

## THE IEC APPROACH

Those who were able to look beyond blame to a less biased and more measured approach began to develop public awareness campaigns, based on a public health "Information, Education and Communication" (IEC) model. These campaigns were based on the principle that if the public were given enough information about the issues, then they would surely halt their risk-taking activities, thereby stopping the chances of HIV spreading. Unfortunately, however well-intentioned, a lot of the campaigns (such as the one in UK in the mid-1980s, which presented HIV as an iceberg floating towards the TV viewer) were too negative, sombre and frightening for most viewers, who responded by laughing at the threat, or ignoring it, turning their heads away from the adverts.

Anti-HIV campaigns, like anti-smoking or health food campaigns, can rarely succeed through information alone. Recipients of the messages (see Table 3) are not empty vessels and already have their own ideas and experiences which influence their views. For instance many AIDS campaigns have ignored the facts that sex can also be enjoyable and creative. So by only focusing on the negative issues, and by only linking sex with death and not with life too, the messages have often been over-simplified and have just switched people off from wanting to hear any more.

**Table 3 - Pouring information into an empty head?**



***A**bstain!*
***B**e faithful!*
*or use **C**ondoms!*

As well as basing such campaigns on our great fears around sex and death, the campaigns presented the idea of a simple solution to our fears: namely the "ABC" approach to safer sex. This stands for "**A**bstain, **B**e faithful, or use **C**ondoms". Unfortunately, the presentation of simple solutions in public health campaigns often implies that if we find them difficult to follow, we must be stupid or failures. This has also been the case of such anti-HIV campaigns, especially because the "ABC" approach is extraordinarily difficult for most people to follow.

Although in an ideal world there might be nothing wrong with the "ABC" approach, it is a highly gender-insensitive message, which just does not meet the needs of most of its intended audience, men or women. For the vast majority of women in the world who are economically dependent on their husbands, and who are in danger of losing their children if they leave the marital home, the idea of telling their husbands that they want to abstain from sex, or use a condom for sex is impossible. Without her husband's permission, such a woman has no choice over her sex life and these messages, which imply that she does, have only served to undermine her self-esteem. Even women who are without husbands, especially poor women, often need to sell sex for money or goods. If their only choice is between receiving some support to feed their children, or insisting on sex with a condom, they rarely have any option but to choose unsafe sex.

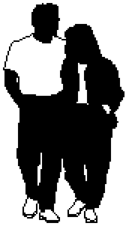
Next, the "ABC" message has not adequately reflected the role that parenthood has in many countries of the world. Motherhood and fatherhood are central to adulthood in so many societies that, once more, abstaining from sex or using condoms is not an option which people are prepared to consider, since they do not meet people's more immediately felt needs.

Thirdly, being faithful also presents a conundrum. No matter how much an individual is faithful to his/her partner, if the latter is having unprotected sex with others, that individual is at risk. For many women – as in the case of the Indian wives cited earlier – this has proved to be a huge challenge, since in many societies it is culturally acceptable for men to have sex with multiple partners without their wives' knowledge or consent; and culturally *un*acceptable for women to discuss such matters with their husbands. Once more, therefore, this message is beyond the choice of women, who have no power to determine their husbands' actions.

This is not meant to be an anti-men treatise. There are huge problems for many men too, as Albert's story from Côte d'Ivoire shows us. He had to hide his status from his family. Others dare not tell their wives. For instance, if a man has had unsafe sex in the past and fears that he may be infected, he may wish to use condoms in future with his wife. But if she wants to have children and also associates condoms with the sex trade, how can he start using them to protect her? There are huge dilemmas here both for women and for men and their relationships with one another (see Table 4). The simple "ABC" message fails to address any of them and provides very few members of the public with acceptable solutions.

In conclusion, although the IEC approach to behaviour change in general may bring greater *public* attention to an issue, such as HIV, it has had very little effect on people's actions in their *private* lives.

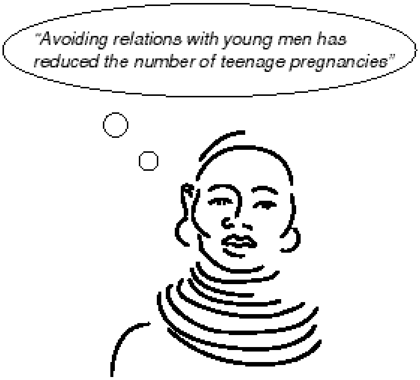
## Table 4 – The "ABC" message is too simplistic[8]



*"Yes, we can stop sex for money, but what are we going to do to have our needs fulfilled, such as clothes? The problem is lack of employment"*
(Young women, Malawi)

*"Many young men came home sick from towns after spending a long time there. Thus I became concerned + involved in the AIDS programme"*
(Old man, Zimbabwe)

*"I got involved after the death of my only two children, who left behind 5 orphans"*
(Old woman, Zimbabwe)



*"How do we reconcile the two groups and share on their dreams? A challenge for us all!"*
(Tanzanian project workers)

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8. Quotes and illustrations taken from CAFOD 1998

There has been raised awareness, therefore, but with no acknowledgement of the complexity of the gender dimension to the issue, virtually no behaviour change has taken place. People have felt that the issues are too complicated for them to solve by themselves, they have then felt helpless and have decided that the best thing to do is nothing and to try to stop worrying about it, in the hope that the problem won't affect them and will go away by itself. Of course, it does affect them and it won't go away. So what next?

## THREE LESSONS LEARNT FOR MORE RECENT RESPONSES

More recent responses have been based on three growing realisations. Firstly, we have learnt that people learn to find strategies to change their behaviour far more easily through discussions with their peers of *their own* needs and situations, than they do through being fed messages from others. Secondly, we have seen that HIV can often be more readily addressed by people as yet another branch of those sexual and reproductive health problems which have faced people for many years, such as unwanted pregnancy, sexually transmitted infections (STIs), infertility and so on, rather than as a totally new problem. Thirdly, we have learnt that HIV and these related issues are greatly influenced by gender inequalities, which need to be recognised and addressed if the challenges are to be overcome. These three significant realisations have shaped current thinking on HIV community work.

Lesson number one: *local* group discussions and analysis for action. The general development world has changed much over the past ten years. Moving away from externally generated, large-scale, technological interventions, with scarcely any local consultation, the PLA movement[9] has recognised the importance of involving community members as central players in needs assessment, planning,

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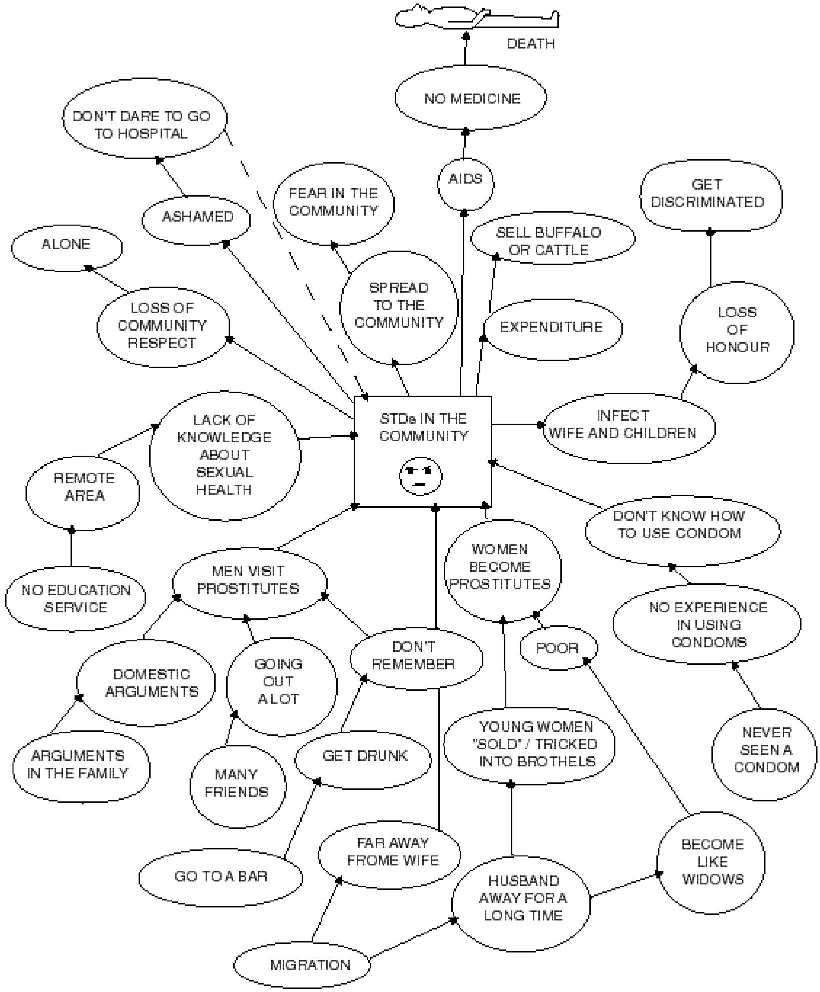
9. See for instance RRA Notes, subsequently renamed PLA Notes, 1989-present, Chambers 1992, Pretty et al 1995

implementation and on-going monitoring of development work. Projects have often become more small-scale, more tailored to local contexts, more socially and environmental aware with more emphasis on local capacity building, on locally generated resources and on training. The concept of "handing over the stick" to local people, thereby recognising their own skills, experience and expertise in living their own lives and understanding their own context, has grown into a central tenet of this approach to development. Methods have been developed which need no formal educational background for community members to take part. With a range of participatory techniques, including drawing of maps, charts (see table 5), seasonal diagrams; role-playing and "rehearsing for reality"; and so on, local community members have been able to articulate *their own* felt needs, concerns and aspirations and then to develop *their own* ideas for achieving change, rather than just having a project dumped on them from outside.

Although there is still much room for improvement, this has greatly changed the face of general development work and has also, more recently, influenced the way in which HIV workers approach their challenges.

Lesson number two: beginning where people's *own* concerns lie. This second lesson has also built on the experience of the PLA movement which has learnt, for instance, that it is unwise to go rushing in with an EPI (childhood vaccination) programme, when people's main concerns are about diarrhoeal disease and malaria control. The point is that although EPI may also be important and valuable to a community, they will not view it as such unless and until their more directly felt needs are addressed first. In the same way, therefore, it makes little sense for us to rush into a community in W. Africa or in UK waving our banners about HIV, when people there have little or no direct knowledge of or concern about the

## Table 5 – Exploring the causes and effects of STDs experienced by community members in Cambodia[10]



CAUSAL FLOWCHART EXPLORING CAUSES AND EFFECTS OF A MAJOR SEXUAL HEALTH PROBLEM OR NEED IN A LOCAL COMMUNITY. HUM TOUCH AND SOK MAYONG, BFA, BANTEAY MEANCHEY, CAMBODIA. NOVEMBER 1996.

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[10] From International HIV/AIDS Alliance report 1996

matter. However, if we were to address people's *more immediate concerns* in these places, such as unwanted teenage pregnancies[11], or infertility (often caused by STIs) or impotence, we would be gaining the trust of a community far more effectively. Moreover, in helping to address these problems, we would often be going a long way to reduce HIV transmission risks in any case.

Lesson number three : the role of gender. We have also learnt how the most effective way of working with groups on these issues is by asking community members to divide themselves into smaller groups based on gender – and also often on age. Thus most community groups divide themselves easily into groups of older women, older men, younger men and younger women. (Sometimes even younger groups are formed of, say 9-13 year olds, depending on the community wishes.) Some communities use marriage as a dividing line between younger and older groups ; others use parenthood – the important thing is for them to choose the criteria for themselves – so that they feel most at ease with others in their own group, with whom they can identify and address commonly experienced issues. In this way, there is far more chance of more community members being involved, through membership of separate groups more relevant to their own needs. The groups of less powerful, more marginalised people in a community begin to find a voice, instead of the discussions only taking place amongst the male leaders. Each group has a chance to have safe private time and space to explore concerns particular to its members. Every so often, these groups are then brought together to present their hopes and fears to the other groups in the community. This "fission and fusion" approach then allows the separate groups to exchange and share these ideas and build on them to create new plans for the future[12].

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11. See for example Kambou et al 1998, Mbowa R 1997
12. See Guijt et al 1999 for further discussion of this.

## THE STEPPING STONES PROJECT – ONE RESPONSE BASED ON THESE LESSONS

The Stepping Stones training package is one such recent response, which is based on the three lessons described above. Originally published in 1995 for use in sub-Saharan Africa[13], it has now been distributed to over 1500 organisations in 103 countries worldwide. Local groups have translated and adapted it for their own use in many different countries, including Sri Lanka (singhala), Cambodia (khmer), Russia, urban South Africa, Tanzania (ki-swahili), Argentina (spanish) and Mozambique (portuguese). These translations and local adaptations are exciting because they keep the package alive and useful to new communities, rather than letting it gather dust on a shelf or being used to keep a cupboard door open. For instance, the South African version has added new sessions on fertility, on STIs, on gender violence and on grief and bereavement[14]. The package is supported by the Stepping Stones Training and Adaptation Project (SSTAP), which is currently setting up local regional advisers around Africa, Asia and L. America, who will be able to provide advice, support and training to organisations wanting to develop participatory approaches to sexual and reproductive health issues in general, including HIV.

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[13] See www.stratshope.org

[14] Information, advice and guidelines about these and other adaptations and about training are available from knewman@ actionaid.org.uk

### Table 6 - The Principles and Approach of Stepping Stones

Principles:

- that the best prevention strategies are those developed by community members themselves
- that peer groups need their own time and space to identify and explore their own needs
- that behaviour change will be more effective and sustained when all members of the community are involved

Approach:

- working with groups, usually based on gender and age, for example:
  older women     older men     younger women     younger men
- all the work is based on people's own experiences
- role-play, drawing, song and dance mean that everyone can take part, without formal education

## THE WORKSHOP SESSIONS

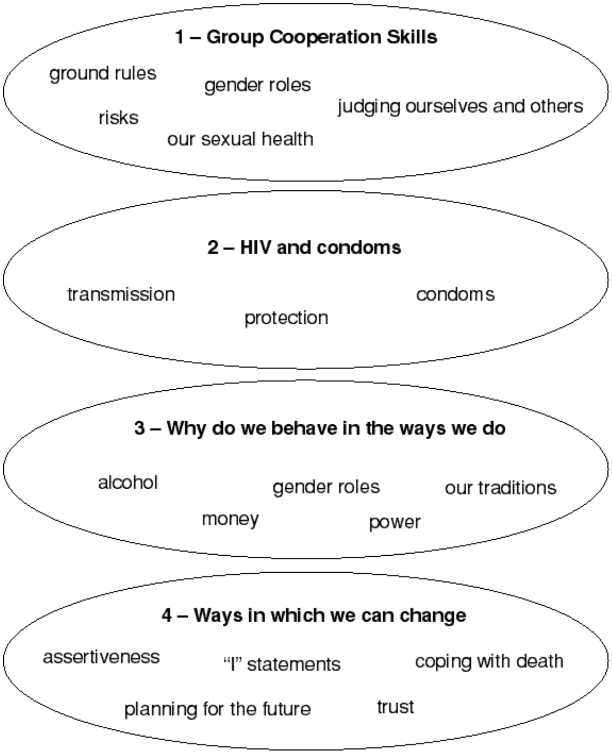
The original Stepping Stones package suggested that a total of 18 separate workshop sessions be held over a period of 9-12 weeks in a community. Spreading the sessions over several weeks like this enables community members who want to join the workshop to put what they have learnt into practice between sessions, turning rehearsal into reality. All the sessions are based on exercises using creative skills such as drawing, acting, song and dance, none of which need any formal education background for participants to take part. The role-play work, all of which is based on participants' own experience, is based on the ideas of Augusto Boal. The drawing work is based on the PRA (Parcipatory Rural Appraisal) ideas of general development workers (see above).

There are four themes for the whole training process (see Table 7). The first theme, covering the first few sessions, establishes the identity of each group which has been formed and enables them to develop group cooperation skills. It helps participants to explore the risks that we take in our lives, helps them to think about how we judge ourselves and others, starts to look at the gender roles which we have in our lives and addresses the good feelings and concerns that we have about our sexual health.

The second theme covers HIV: its transmission, protection and condoms. Workshop participants are given information about different possible options presently available for them to practise safer sex. Each and every workshop participant has the individual opportunity, if they want to, to touch and feel a condom and learn how to use one effectively. (This is in sharp contrast to more conventional campaigns, where one "educator" has stood up in front of a large group of onlookers, whilst placing a condom on a dildo.) However, no workshop member is told that they must do one thing or another. Instead they are having the opportunity to ask questions of their workshop facilitator (who is of similar gender and age to themselves), to share their thoughts and experiences, and to work out for themselves what is best for them.

The rest of the workshop sessions deal with theme three: "why we behave in the ways we do" and theme four: "ways in which we can change". This is where there is the big departure from more conventional health education approaches and where workshop participants really begin to start exploring for themselves the complexities of our lives. One session looks, for instance, at the role of alcohol in our lives – its pleasures, it dangers and how we might learn to control it rather than it control us (unsafe sex often takes place under the influence of alcohol or other drugs). Other sessions address household expenditure – who takes responsibility for paying what, and who takes decisions for expenditure within the household. (Often, men spend their earnings on themselves and women have to find money for their children's health care or clothing by other means, such as sex with other men.) The sessions

**Table 7 – The workshop themes**



On-going meetings… the hard work for sustained change begins

explore the fairness of existing systems. Another session looks at traditional practices. All societies have time-honoured practices, some of which may be good, others of which may have problems now attached to them. For instance, in much of southern Africa, a widow would be re-married to her dead husband's brother. This might traditionally have ensured that she and her children were cared for by the husband's extended family. But nowadays, if her husband or she were infected with HIV, this may not be a wise option. Moreover, she may prefer anyway to remain single and establish her own household without a man, as we saw in the case of Consolata from Kenya, earlier on. Such traditions are aired and new, alternative options are explored.

The final sessions of the training workshop address "ways in which we can change" and explore assertiveness skills, "I" statements, trust, coping with death and planning for the future. These are difficult and challenging sessions and it is especially important that these sessions are only covered once the groundwork of the preceding sessions has been firmly laid.

Of course, people cannot be expected to change their approach to life on the basis of nine weeks' work. This workshop can only be seen as the starting point for changes within a community. So workshop participants are encouraged to continue meeting by themselves after the last session is completed. We consider that these continued meetings enable participants to sustain the changes that they have decided to make in their lives and act as a support group, enabling people to compare and share their successes and failures and to renew their determination to do things differently in future – a tall order, but one made easier by sharing the experience with a group of similarly committed people.

## "FISSION AND FUSION" OF WORKSHOP GROUPS

It was explained earlier how groups are encouraged to meet alone and then to come together for large group exchanges (see Table 8). This principle of "fission and fusion" allows two important things. It creates the private time and space for discussion of personal issues, which many individuals might find far too embarrassing or painful for wider group discussion. It also creates the public space where the less powerful groups in a community have an equal platform with the more powerful groups[16]. Each group in turn presents a role-play or tableau (a frozen scene) to the other groups and the

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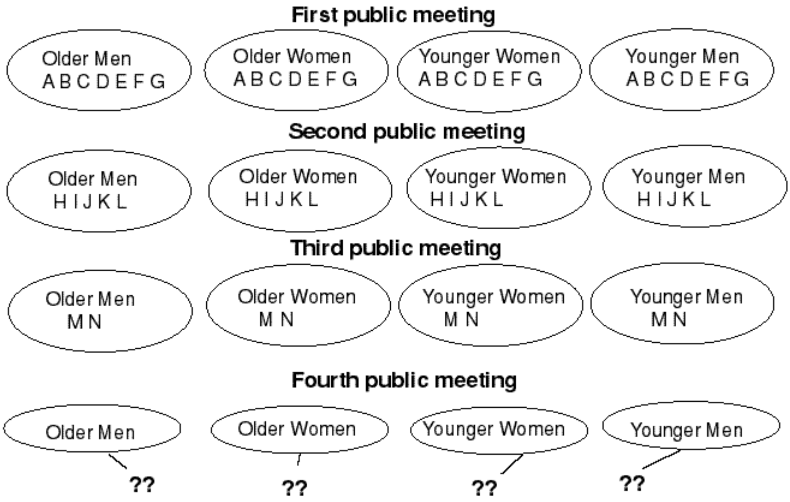
[16] Adaptations of the original SS package have called for more public meetings of workshop participants than the original manual suggested

**Table 8 – Workshop fission and fusion structure**



issues raised can then be discussed by everyone present. The intimate details of the small group discussions can get ironed out of this public presentation, but it enables the young women, for instance, to present the dilemmas which they face with "sugar daddies" who pursue them for sexual favours in return for school fees; or for older men to present the loss of self-esteem that turns them to drinking when they are made redundant. These sharings between groups enable everyone in the community to develop more awareness of the needs and difficulties of others around them, as well as increasing their own self-esteem and self-respect through having their own needs appreciated more clearly. This reciprocal experience of growth in self-knowledge and growth in awareness of others has a powerful and positive effect on community cohesion. Such meetings produce many comments such as "I never realised that…" and "now I understand why…" As the community members begin to understand themselves and one another more, simultaneously at the individual level, with peer level support and also with wider community understanding, so the foundation stones for change are laid.

## WHAT CHANGES CAN HAPPEN AFTER USING STEPPING STONES?

As an integral part of the SSTAP we are supporting organisations to develop their own participatory approaches to monitoring and evaluation with communities with whom they work. We believe that people's own involvement in charting the progress of the work forms an integral part of its sustainability. Inevitably there are both good and bad changes to report!

To start with the positive changes first, table 9 illustrates changes reported by a community in Uganda, 16 months after a Stepping Stones workshop had been conducted there.

Each of the four separate groups involved in this workshop were interviewed separately about their perceived changes in the community. It was a useful cross-reference to see that each reported change was mentioned by at least two separate groups. It was particularly encouraging to see that young men and young women felt that they now had a better sense of trust between them. Previously, each had been blaming the other group for spreading AIDS – now however members of both groups were describing how they had realised that they had to work together to overcome the challenge.

It was also exciting to see how community members were beginning to write wills and that these wills were being respected by community leaders – this had not previously been the case and reflected a huge shift in people's courage and capacity to prepare for and cope with death.

Thirdly it was very encouraging to see the young men reporting that they were now starting to visit and help people with HIV and their carers in the community. Whilst older women had been doing this anyway, the young men had said that they had previously just ignored or even ridiculed such people. Now, however, they reported that they had decided to do something to help them. This reported change was particularly heartening, since it had not been something which had been addressed explicitly in the workshop sessions. So this unexpected response was especially welcome. This change will be considered further later.

### Table 9 – Changes in Buwenda, Uganda recorded 16 months after Stepping Stones workshop, December 1995

(OM: older men; OW: older women; YM: younger men; YW: younger women)

| **Changes: mentioned by** | **OM** | **OW** | **YW** | **YM** |
|---|---|---|---|---|
| less quarrelling between couples and more sharing of household costs | √ | √ | √ | — |
| less wife-beating | √ | √ | — | — |
| a respect for the wills of those who have died, regarding the rights of spouses and children | √ | √ | — | — |
| greater sense of well-being and respect for others | √ | √ | √ | √ |
| greater mutual respect between young men and young women | — | — | √ | √ |
| greater ability of women to discuss sexual matters with their children | — | √ | √ | — |
| greater self-esteem among young women | √ | — | √ | — |
| a reduction in alcohol consumption, by older men especially | √ | √ | — | — |
| a sustained increase in condom use by participants from all peer groups and others | √ | √ | √ | √ |
| continued peer group meetings | — | √ | √ | √ |
| wish to become economically self-sufficient | — | — | √ | √ |
| improved relations amongst other persons in the community who had learnt about the workshop from participants | √ | √ | √ | √ |
| development of care and support for HIV positive people and their carers within the community | — | √ | — | √ |
| enquiries from other communities about the workshop process | — | √ | — | √ |

Finally, it was encouraging to see that most of the groups (which had not existed prior to the workshop) had continued to meet regularly over the ensuing months. This would appear to be another key ingredient to sustained change. The one group which did not continue to meet was the older men's group. This leads us on to the reported problems which have resulted.

A number of negative changes were reported during a participatory review of the use of Stepping Stones, which took place in two other communities in Uganda in 1998. There has also been information from Tanzania, where a less detailed review also took place in 1998, and from informal feedback from trainers and facilitators in Zimbabwe.

Key issues which were mentioned included: condoms, exclusion of non-attendants, insufficient husbands attendance, facilitators' problems with running later sessions, organisations' own discomfort with the radical approach which Stepping Stones takes, and lack of training support and/or follow-up.

*Condoms.* Some feared that use of condoms would lead to an increase in sexual activity and multiple partners. Others reported problems with condom disposal. Clearly, more work is needed here. Condoms are a huge challenge to use and, whilst they can be successfully adopted by those who are determined to use them, there are still many fears and moral judgements made about their use.

*Exclusion of non-attendants.* It was reported that those who were attending the SS workshops became rather cliquey and excluded those who had not. (The difficulty here is partly that after the first session or two, newcomers are discouraged to join in, because the existing participants have learnt so much already that they feel held back by those who haven't been there previously. Yet later on, more want to join up, because they have seen and heard the participants' interest in the sessions.) In Tanzania, people who hadn't attended the SS workshops accused those who had of being "saved". This has religious connotations which is sad because Stepping Stones has no formal religious stance. However, in Uganda it was suggested that one way round this exclusivity would be for each workshop participant between each session to share something about what they had learnt with a friend who was not attending, so that the workshops could be seen to be helpful to a wider group of people. It would be important elsewhere also to develop this basis of sharing and openness with others about what participants had been discussing and learning in the sessions, so as not to turn it into an exclusive club.

*Absent husbands.* It was reported that where both husbands and wives attended Stepping Stones workshops together, there was far greater chance of mutual progress in the relationship than if the wives alone attended (which was the usual case). This too is an expected drawback. It has always been difficult to get men involved in such workshops. Moreover, many men are absent from their communities in any case, because of migrant labour. This highlights the importance of increasing the number of good male facilitators who have the right kind of approach to encourage men to come forward and join in. It also highlights the need to explore the possibilities of running training workshops during periods of male workers' home leave from work.

*Facilitators' problems.* This became clear in Zimbabwe, when facilitators seemed to have few problems with running the sessions covered by the first two themes. But they seemed to stop their activities at page 100, which is where the first session of the third theme begins. This theme, "why do we behave in the way we do" and the fourth theme, "ways in which we can change", cover radically different issues from those with which facilitators have been familiar in the past. Whilst the first two themes are only going over issues with which facilitators on the whole are comfortable, page 100 onwards moves into hugely challenging issues to do with gender relations, with assertiveness skills and with death – issues which very few facilitators have previously addressed in their own lives – let alone helped others to address for themselves. So we were expecting too much of facilitators to assume that they could just run these sessions with community members. This realisation has led the organisations involved in facilitator training in Zimbabwe to restructure their training. Facilitators are now given the time and space to experience Stepping Stones first for themselves as participants, before they go on to learn about how to facilitate the sessions for others. Sessions on gender issues are included in the facilitator training also. In this way facilitators have felt more confident in moving further through the manual and to help others to face these issues for themselves.

*Organisations' discomfort with Stepping Stones.* We have also realised that the approach taken by Stepping Stones – and other radical approaches to development work, such as the Reflect Freirian literacy project[17] – are quite daunting for many development agencies, whose style of working has been much more agency – led than the Stepping Stones approach advocates. The gender issues, the frank talk about sex and facing up to death are also all hugely different from the work content of most NGO (Non-Governmental Organisations) and CBOs (Community-Based Organisations). Furthermore, the facilitation process, where the facilitator sits as one with a group, instead of standing up in front of them like the teacher or the health professional, is still hugely challenging to many agencies' views on appropriate learning methods, especially where the agencies' main work is in health service delivery and health education. So when people take on Stepping Stones, it is possible that they have taken on not just another training package, but another way of thinking about development – and one with which they may feel distinctly uncomfortable.

*Lack of training support and/or follow-up.* The final problem to be discussed here addresses the importance of local support and advice on how this – and indeed any – training package may best be adapted to suit the needs of local organisations in an area. While in Uganda and many other countries there have been local training workshops held for facilitators from different organisations, in Tanzania there has been virtually no such activity. This absence of

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[17] David Archer, pers. comm

training has been reflected in the predominantly poor up-take of the package compared to that seen in other countries. Organisations in Tanzania have reported that they already have their own training worked out and that Stepping Stones looks too long and cumbersome for them to make use of. They could not see how the package could be adapted for use in their own areas of concern. Yet the author of the report felt that there was a distinct use for the material in Tanzania provided that appropriate training and follow-up support could be given to agencies, so that they could adapt it and incorporate its approach into their existing work. These findings from the Tanzania review have been incorporated into our plans to develop local regional SSTAP advisers, who will be able to provide precisely this kind of back-up on a local basis.

There are clearly some challenges for us to address here. Overall, however, there has been an overwhelmingly positive response to the package which, we believe, is reflected partly in the time and effort invested independently by others in translating and adapting the package for local use. In 1997 a postal questionnaire of Stepping Stones recipients was conducted. In the words of one respondent:

*"When I started on the programme I used to feel ashamed of some issues, but after I started to use the manual I became more confident… it has guided me on a daily basis. I have also maybe changed my attitudes and approach to the community and my family. I love it.*

(Steve Paradzai Mushambi, Dananai Home Based Care Programme, Zimbabwe)

The questionnaire findings concluded that:

*"It is clear that Stepping Stones materials have been enthusiastically received and put to good use… Feedback has been overwhelmingly positive. Real change has been reported, particularly in the kinds of areas in which conventional HIV/AIDS prevention strategies have been notoriously weak… The changes noted by respondents indicate that SS serves a more profound function in promoting behaviour change: addressing the less tangible and deeper aspects of interpersonal communication."*

(Dr Andrea Cornwall, Stepping Stones users' questionnaire report[18])

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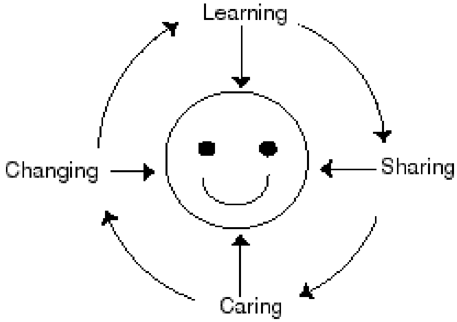
[18] Cornwall 1997

## BUT WHAT DOES "BEHAVIOUR CHANGE" MEAN?

The questionnaire described above gave us some insight into what various users of Stepping Stones on HIV prevention and support projects actually meant when they said that "behaviour change" had taken place in the communities where they work. What was clear was that the phrase "behaviour change" means different things to different people. We realised that their comments could be sorted into four different types or stages of behaviour change, namely "learning, sharing, caring and changing". By "learning", we mean knowing the basic facts about SRH and HIV. By "sharing", we mean beginning to talk about issues of concern to us with our friends, our parents, our children, our partners. By "caring" we mean that we begin to care for others in our community who are infected with or affected directly by HIV, instead of ignoring or shunning them. By "changing" we mean that we are empowered through our own individual will, combined with the mutual support of our peers and wider communities, to change our actions. We decided to draw a diagram which we called the "wheel of change" which would include these different forms of "behaviour change" which we had received and which might help us to understand "behaviour change" more clearly as an on-going process.

**Table 10 - The Wheel of Change**



KEY: The smiling face in the centre of the wheel stands for "sustained behaviour change"

We can think of this wheel as one on a bicycle moving along a long and bumpy road, where each of the forms of change is a spoke of the wheel. As the wheel turns, so we can move along. If we can make the wheel move forward, we can create the force and momentum of "sustained behaviour change", represented in the diagram by the smiling face at the hub of this wheel.

In Table 11 a number of the responses to the questionnaire survey are shown according to the categories into which we then sorted them for our model of behaviour change.

### Table 11 – Some examples of different stages of reported behaviour change

**• (Men)**

**Learning**

- 'Many people have realised that AIDS is really here…'
- 'There is more awareness of AIDS, and acceptance of the AIDS situation in the area.'
- 'People are eager to learn more.'

**Changing Behaviour**

- 'The use of condoms which was strongly rejected especially by the older peers is now accepted as a good alternative to fight the disease/infection.'
- 'Higher demands for condoms.'
- '…less wife beating.'
- '…culture beliefs are being discarded such as wife inheritance which was very rampant before.'
- 'Most people who are dying are leaving wills.'
- '…girls no longer worry about the accessibility of money from boys.'
- 'Less unwanted pregnancies.'
- 'The peer groups are still working together…'

**Sharing**

- 'The peer groups became more open to discuss sexuality, a topic which the older regarded as taboo…'
- 'The people that participated in Stepping Stones continue to talk and discuss it with their community.'
- 'Straight talk to youth by parents.'
- 'Girls talking with boys on condom use.'
- 'Less boasting by boys.'

**Caring**

- 'People never wished to hold anybody suffering from AIDS… but these days they take care of them…'
- 'There is sympathy for AIDS patients'

**(Women)**

However, since we first developed this model of the "wheel of change", we have since realised that this too is an ungendered model, in the sense that it assumes that everyone has an equal opportunity to move from one stage to the next. In reality, as this paper has already explained, this is clearly not the case. The truth of the matter is that in most conventional IEC approaches to this work, many women are stuck on the wheel, between "caring" and "changing" (see table 11). Many of them are already involved in the care of others who are infected with HIV. Many women also *want* to reduce their vulnerability to HIV and other infections. But few women have the power by themselves to change their own behaviour. Meanwhile, men are also stuck on this wheel and they too need to be helped to move along it. But the position for most men is between "learning" and "sharing" (see table 11 again). Although many men may have *heard* about HIV, most men find it very difficult to begin to *talk* about it seriously amongst their peers and particularly with their sexual partners. And yet, from what we have seen, those men who have begun to *share* their thoughts with others, and especially those who have actually started to *care* for others, have really then been able to *change* their own behaviour and thereby support and enable the women around them to change theirs also. It has been especially exciting for us, therefore, after Stepping Stones workshops, when we have heard young men reporting that they have begun to visit the sick and their carers in their own communities, instead of shunning them or laughing at them as they had done previously. At that point we know – and they know too – that a critical breakthrough is beginning, not just for a few individuals, but across their community. From this point, *real* behaviour change, both for men and for the women who depend on them, can begin to flow.

## CONCLUSIONS

Through working on all these issues we have learnt how conventional IEC approaches may help people to *learn* about issues, in some external, impersonal form. But learning about something alone, especially something as frightening as HIV, rarely influences people sufficiently to change their actions in a sustainable manner. If we are all really to find this holy grail of *sustained* behaviour change, we really need to adopt a far more radical approach to our working practices, so that we *dare* to address the unmentionable and so that "sharing, caring and changing" can then begin to take place also, both for men and for women. In so doing, there are now possibilities of enabling women and men of all ages and backgrounds – ourselves included – to feel safe about exploring – and learn to take more control of – the most personal details of our lives.

What is so encouraging about these approaches is that people *do* feel able to begin to address these issues, about which they have immediately felt concerns, for themselves. In so doing, they are also helping to challenge conventional attitudes about women's rights, about traditional gender roles and about their own behaviour, as well as starting to meet their own sexual and reproductive health needs. Through such routes as these, we believe, sex, death and gender *can* begin to become subjects surrounded with less taboo and therefore less fear. By such means, there *is* a way ahead in the fight against the causes and consequences of gender conflict.

Work in such areas will also alleviate vulnerability to HIV transmission of course, and enables it then to be addressed as an *extension* of these other issues, rather than as an isolated and insurmountable problem, which bears no relation to the rest of our lives.

One final thing which is also clear is that problems related to sex and gender are global issues and not just problems of poorer countries. In UK too, for instance, there are huge challenges. UK currently has the highest rate of teenage pregnancies in Europe. Chlamydia – which has few noticeable symptoms and can cause infertility in both men and women – is also on the increase in Britain at a disturbing rate. We have a great deal to learn about "behaviour change" in the North from the pioneering work of individuals and communities in the South, who are daring to address these challenges. An extra challenge for us then is to get better at listening.

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CHET NATH CHAULAGAI, ALBERT BURKI

# GENDER AS A TRANSVERSAL COMPONENT IN A RURAL HEALTH DEVELOPMENT PROJECT IN NEPAL

## GENDER IN NEPAL

Nepalese people are deeply conservative with socially, traditionally, ethnically-constructed and assigned roles for men and women. There is social pressure to follow traditions and there is criticism and blame if someone dares to share or inter-change their expected role. Certain activities are traditionally carried out only by men and others only by women.

Cooking, serving food and cleaning dishes, washing clothes, rearing of and caring for infants and children, grinding grains, cleaning and sweeping the house, planting paddy and millet, working as a nurse, weaving of mats and clothes is considered only women's work. The reasons given for such assignments is that they demand less physical strength and that women being considered physically weaker than men should do the easier work.

Ploughing, driving, boating, masonry work, wood-cutting, working in the police and army, preparing fields for the planting of crops, and slaughtering of animals is considered to be men's work. The reasons given for such assignments is that these types of work need more physical strength, so men being considered physically stronger than women should do the "difficult" work.

These divisions are well and good and should not be disturbed as long as it does not hurt either the men or women of any particular society. However, the general situation in Nepal and the situation revealed from a baseline survey carried out in Ramechhap and Dolakha districts show the people in these areas are definitely hurting: a high maternal mortality rate of 875/100'000 among women of reproductive age (15-49 y) as a consequence of the low level of accessibility to antenatal, natal and postnatal services, and a high infant and child mortality rate which is higher in females as a reflection of the economic, social, cultural, political and educational differences and inequities between men and women. Enrolment in school is significantly lower in girls than in boys. A similar gap exists between female and male literacy rates. This is of particular importance since many health parameters have shown to be distinctly worse for the illiterate. Awareness of family planning methods is significantly lower in illiterate people. Despite this, women are more aware of methods like male or female sterilisation and Norplant. Only 1/3 of the adult population is aware of AIDS with a highly significant difference in awareness between men and women (44%/25%). There is also a difference in the awareness of the consequences of being infected by the HIV virus and of how to prevent infection. Women think that maintaining a single partner is the best way of avoiding AIDS, whereas men consider safer sex and the use of condoms as the best methods. This also points out to gender differences in sexual behaviour. Other health factors such as immunisation status for all vaccinations is higher in male children. Awareness of micro-nutrients, Vitamin-A and iodised salt is lower in women, who are solely responsible for preparing food.

The standard of living and health status is very low in Nepal and it is even lower among women. Modern services are out of reach for many people due to the topographical difficulties. People have to work hard in order to earn little and have therefore only little time and money to spend on distant health services. Therefore people often do not get proper care. These shortcomings affect women and children more than men.

## BACKGROUND OF THE RURAL HEALTH DEVELOPMENT PROJECT (RHDP)

This RHDP is the second phase continuation of the Primary Health Care, Mother-Child Health and Family Planning project (PHC-MCH/FP) of His Majesty's Government of Nepal (HMG/N) and of the Swiss Agency for Development and Cooperation (SDC) which emerged in 1991 as an offspring of the Integrated Hill Development Project (IHDP, 1975-1990). Three projects started at that time as the hard core of SDC's Rural Development Sector in Nepal: one covering the field of community forestry, another building upon experiences with leading farmers and the third, addressing community development and health in the districts of Ramechhap and Dolakha.

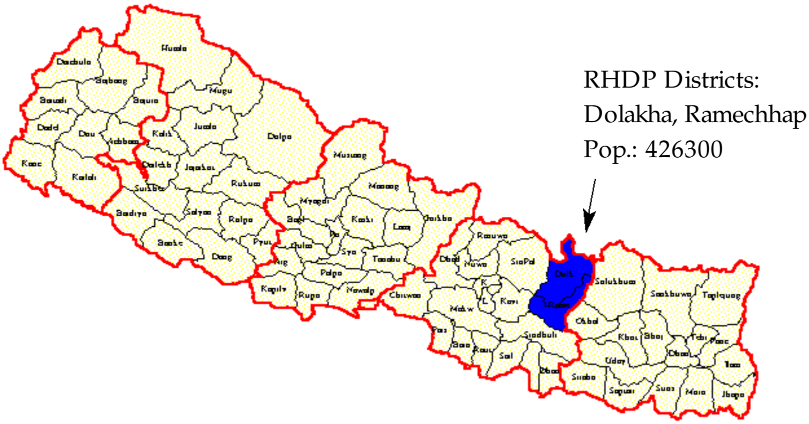
Certain crucial experiences of IHDP strongly influenced the design of the project and the implementation of the first phase (1991-1996). Some of the recommendations applied were:

- use a process approach and create programs for "direct community development" and not just have a stand alone project approach
- for community formation, a motivator/facilitator is needed
- work with user groups – do not use contractors
- develop activities to empower the people, especially the women
- allow time for the process and for mutual learning
- handing over to the people is only possible with real decentralisation of power for making decisions
- big inputs of money and infrastructure during implementation make a smooth handover very difficult
- let villagers ideas prevail.

These recommendations and their impact on design and implementation remain valid during the second phase (1997-2001) of the project. They are considered the strategic link with the first phase and the basis of continuity.

## RHDP AREA

The project area is situated within the Central Region of Nepal, north east of Kathmandu, in the Districts of Dolakha and Ramechhap. Both are remote districts in the hills of Nepal. Dolakha District is accessible by road, although most parts can only be reached by foot. Two days walking is needed to reach the northern parts. Swiss involvement in Dolakha district goes back 40 years, with 30 years of experience in the health sector. Ramechhap district, which lies to the south and east of Dolakha, remains the only district within the Central Region not to have road access. During 1999, the road has reached the district headquarters.



RHDP Districts:
Dolakha, Ramechhap
Pop.: 426300

Approximately 426′300 people live in the project area, 204′900 in Dolakha and 221′400 in Ramechhap. The population is concentrated in the central and southern parts of the districts, where the main groups are Brahmins and Chetris, with Magars and Sunuwars in smaller numbers. In the northern areas where the population is smaller, the dominant ethnic group is Sherpa. Within both districts, there is a sizeable Newari community. Tamangs are scattered throughout the area. The main socially deprived groups are the Thamis and the Jirels in Dolakha, and the Majhis, Hayus and Thamis in Ramechhap. Most residents are subsistence farmers living in small, scattered settlements. Seasonal migration of mainly male family members plays a considerable role in the economy of the area. Trafficking in girls for the sex trade occurs traditionally in specific locations, mainly in Dolakha district.

## ORIENTATION OF THE RHDP

The RHDP aims at "contributing to a sustainable improvement of the local health system with emphasis on health at the periphery." For this, the collaboration of the Community Health Coordinators is sought. Their main task is to support the promotive, preventive and curative health activities of the community organisations in both districts especially those concerning mother and child health.

The project invests more in capitalisation of experience at both districts and national level. A proactive and selective participation in policy/donor dialogue is linked to the project's objective. A monitoring and evaluation strategy with clear indicators and means of verification is implemented. Alliance building between the organisations in the rural communities is strengthened and promoted. Activities are co-ordinated with the Village Development Committee (VDC) and their health committees and where useful, with the District Development Committee (DDC) in a constant effort to build up linkages.

A greater potential to build up links for better resource mobilisation and utilisation for the local level is arising as the "Decentralisation Act" is coming into effect. This is the legal background that supports an improvement in the local decision making process as well as in networking and co-operation between different line agencies, non-governmental organisations (NGOs), local political bodies and community organisations (COs). As decentralisation becomes a reality, strategies are oriented towards strengthening local capacities to make use of new resources and decision-making powers.

The project looks for opportunities to channel its support to COs, to the capacity-building of health workers and to increase collaboration with those local NGOs that have similar objectives. They are supported to implement community initiatives in focus areas provided that they are ready to work within the guidelines and policy practices of the project.

## RHDP PLANNING PROCESS

The foundation for the planning process of this phase was laid in June 1996 in a one-day workshop in which different donors involved in community health, SDC's Co-ordination Office and a few representatives of the project participated. The experiences of the donors in community involvement and health were discussed and messages to SDC were formulated.

After intensive, facilitated discussions between SDC and the project, an external review planning mission was called for. Its task was to analyse the field realities in Dolakha and to review the achievements and experiences of the first phase of the project in order to assess its potential and to develop a framework for the future involvement of SDC in the field of health.

SDC headquarters in collaboration with the Co-ordination Office in Nepal, decided towards the end of 1996 to continue with the direct implementation of the project as part of SDC's programme. This decision was based on the findings of the above-mentioned mission, on SDC's sector policy for health and on a small proposal for the next phase drafted by the project. The desire to "remain in touch with the people's reality", expressed as an immediate field-based experience and SDC's own interest in capitalisation and intra-programme synergy, were two major decisive arguments for this. The main modifications to be undertaken in the second phase were identified as: a system orientation, more health at the periphery, capitalisation of experience, greater care for cost-effectiveness, shift of the management to the field and participation of the project in a policy/donor dialogue.

The concrete planning process was carried out in a participatory manner in four planning workshops facilitated by a private local consultancy firm. The first one involved representatives of HMG/N, SDC and different NGOs who identified at a policy level the broad areas the project should direct its support to in this phase. Representatives of a number of COs and traditional healers then gathered in each district, in a community level workshop, to set their vision and analyse the health situation before the project's intervention: how it had evolved, how they viewed the future and what their hopes were. The major factors hindering them in reaching their vision in the area of health were assessed and possible solutions identified. Furthermore, linkages were examined between the different actors and the roles they play in the communities' development.

The final district level workshop involved the DDC chairmen of both districts, the District Health Officers and Public Health Officers, the heads of different line agencies of Ramechhap district (Local Development Office, Women's Development Office, Drinking Water Supply Office, District Education Office) and representatives of the main NGOs working in the two districts as well as of the two projects involved in SDC's rural development sector. A log-frame methodology for planning was used to define the goals, purposes, outputs, major activity areas and the guiding principles for the project. A more suitable project name was suggested as Rural Health Development Project and the roles of different partners were defined.

### RELATIONSHIP WITH REVISED COUNTRY PROGRAMME NEPAL 1998-2004

The elaboration of the RHDP was done in parallel with the revision of the Country Programme of SDC for Nepal. The revised Country Programme (CP) 1998-2004 defines the priorities and strategies for SDC in Nepal. While "Health" is not considered a priority sector, it states that the positive results of this project warrant it to be continued under the category of projects belonging to the "consolidation project". The CP defines two strategic thrusts: "functional division of tasks of various actors in the society" and "striving for a more equitable society"; both these thrusts are well represented in RHDP, a) by working with a multiplicity of partners who should be enabled to fulfil appropriate roles and b) by focusing on equity aspects; the significance of the latter is reflected in the two transversal issues of the CP: gender-balanced development and poverty-focus; both themes are of equally high importance in the RHDP. Another guideline contained in the CP is the gradual shift of SDC's attention from Dolakha to other, more needy, districts. The project plans its withdrawal from Dolakha within this phase. The RHDP is the first attempt to translate many of the strategic guidelines of the CP into operational reality.

## GENDER CONSIDERATION IN DESIGNING THE RHDP

The RHDP is designed in such a way that gender is considered to the maximum possible extent. The main mission of the gender consideration is to empower women and men to enhance their self-respect, to realise personal rights and to understand each other. In this regard, the project has defined the specific health needs of women, girls, boys and men as personal rights and explicitly mentions this in its goals and objectives.

## RHDP'S GOALS AND OBJECTIVES

The goal of the project is "to contribute to improve the health status of women, girls, boys and men through participatory development of a locally adapted and affordable health system", whereas the objective of the project is "Women, girls, boys and men are empowered to enhance their health conditions and they have access to improved comprehensive health services at local level".

## GUIDING VALUES AND PRINCIPLES

The following guiding values and principles describe the fundamental concepts that determine and underpin the strategic choices and selection criteria of the project:

### *Sustainability and affordability*

Developing the capacity of women, girls, boys and men to manage their community actions for health is an essential contribution to sustainability as well as promoting local ownership, building on existing resources, developing resource mobilisation capacities and supporting local initiatives. Efforts are concentrated on developing accountability and the linkages between community-based organisations, locally-developed health services, VDCs, DDCs and the concerned district line agencies (particularly DHO, DEO, WDO, DWSO, LDO). As a key contribution to sustainable changes, the main focus of the support has been rooted in the value systems of women, girls, boys and men at community and family level, particularly where health is concerned. All project inputs with foreseeable adverse effects, primarily in terms of sustainability, are avoided. Special attention has been given to ensure that any development of the local health system is affordable.

### *Social equity*

To incorporate this principle, the specific problems of marginalised and deprived groups of women, girls, boys and men are identified and addressed with each CO. Particular attention is given to the issues of inequity and inequitable situations as the project aims to empower disadvantaged groups of society.

### *Gender equity*

As gender imbalances have serious repercussions on women's health, the RHDP concentrates its efforts on fostering awareness on gender equity. Women and men have been involved in all steps of programming this project and also fully participate in its implementation and evaluation. Special arrangements such as child care facilities have been provided to enable women to participate in project events, training, etc.

### *Empowerment and participation*

The project's major thrust continues to be orientated towards women, girls, boys and men at the local (peripheral, grass root) level enabling them to be involved in decision-making concerning their own development related to their health. They are encouraged to make choices and to take an active role at all stages of developing locally appropriate approaches to health and health-related matters. Working with women, girls, boys and men on health awareness, building up their knowledge about health related issues and facilitating their access to information helps to increase their sense of responsibility for their own development. The project also facilitates the promotion of knowledge about their basic rights, especially those related to health.

### *Respect for local standards, culture and sensitivity*

An essential principle when supporting and sustaining the development efforts of women and men is to respect their social and cultural norms and values. Perception of development and of health, illness and death varies greatly according to culture. To respect these differences is one of the basic conditions for sustainability. The acceptability of a particular measure to prevent or treat a disease or of a health service is often neglected. At the same time it is important to realise that diseases are neither the outcome of need assessments nor do they evolve out of a free choice made by a woman or a man. A disease is something "imposed" on a person or on a community, as in the case of an epidemic (for example AIDS). The free choice of a person occurs when it comes to preventing the disease, to treating it, and also to explaining its underlying cause. Here, traditional medicine predominates in people's value system as it gives a "sense" to the illness. A choice is only free if it is an informed choice, leaving the person the freedom – and the resources – to opt for different solutions. Accordingly, awareness is raised among health workers and among women, girls, boys and men about the advantages and disadvantages of traditional and "modern" values as part of an empowerment process. At the same time, intercultural understanding and social know-how has been developed among project support staff.

### *Holistic health understanding*

At all levels, the project promotes a holistic understanding of health, linking it with SDC's health development policy. It emphasises the multidimensional nature of health. Firstly, its human dimension which postulates that a favourable environment to health is crucial to ensure that health development interventions are effective and the initiated changes sustainable. Secondly, its intersectoral dimension which recognises the importance of knowledge, skills and technology of all sectors for health improvements and therefore the necessity for collaboration between the sectors. Thirdly, the sectoral dimension which encompasses the public health care system in its entirety with a popular, a folk and a professionally organised element. The holistic approach enables greater empowerment in several respects: it deals with health as a fundamental human right; there is considerable potential for developing self-reliance in terms of self-care and prevention of disease; quite a number of non-health factors (e.g. basic education) have an acknowledged influence on the health status of women, girls, boys and men and contribute at the same time to their empowerment.

### *System orientation*

This means working with existing organisations through strengthening their capacity rather than creating new and parallel systems. System orientation includes intersectoral co-operation between the health sector and other key development sectors. Regular synergy meetings are organised among project support staff of SDC projects working in the same districts to develop and share in interdisciplinary dialogue. At a local level, multi-sectoral programmes involving a variety of actors and affecting the health conditions and health status of the population are encouraged.

## CHOICE OF PARTNERS

The main partners of the RHDP at ward, VDC and district level are defined in the project document. The term "community organisation" (CO) is used for any kind of existing organisation of the rural community: including groups, associations, committees, elected bodies, etc. The traditional forms of community organisations receive greatest attention. The selection criteria for phasing in to support any CO is summarised in the following table:

| Partners | Selection process and criteria | Work style / remarks |
|---|---|---|
| **Organisations of the rural communities** (CBOs, self-help groups, user groups, mother groups, interest associations), existing committees (e.g. management committees of SHPs), elected local government organisations (especially VDCs).<br>**Main partner**. All other partners are supported in as much as they serve these organisations in improving the health situation at the local level. | ❑ Open and competitive selection procedures<br>❑ Selection based on<br>– interest in "offer" of the project (cf. Action lines)<br>– readiness to contribute<br>– internal functioning of the group (especially participation of women / marginalised in decision making) | ❑ Working with "support agreements" spelling out extent of support, responsibility/ contribution of group, etc.<br>❑ Working with existing groups, not creating new ones.<br>❑ Direct support only to the extent needed to empower "others" to perform the job. |
| **Health practitioners**<br>Traditional healers, volunteers, health workers in public system, etc. | ❑ Priority to those who are closer to the villagers<br>❑ Gender criteria<br>❑ Personal motivation<br>❑ "likelihood to stay" | ❑ Support to build up linkages between the practitioners<br>❑ Related to identified needs of community people<br>❑ Treating them as members of the community |

| Partners | Selection process and criteria | Work style / remarks |
|---|---|---|
| **Local intermediaries**<br>NGOs/consultancy firms | ❑ Locally based<br>❑ Experienced in working with community people<br>❑ Existing expertise in specific field<br>❑ No political, religious or ethnical bias | ❑ Increasing role/handing-over of implementation tasks to them. Are main implementers for certain programmes (e.g. literacy) from beginning.<br>❑ Important beneficiaries of experience sharing exercises.<br>❑ Receive support from project for task based ID (including capacity to co-operate) |
| **District health services**<br>Ministry of Health is the implementing agency on the part of HMG/N. DHO with its district wide services is therefore the governmental partner of the project at peripheral level. | ❑ Activities contributing to strengthen the links between the villages and the district in health matters. | ❑ **Selective interaction** : involved in planning and steering of village based activities ; monitoring and experience sharing, limited amount of direct financial support for district-wide activities<br>❑ Maintain good working climate |

The involvement of different actors and partners calls for a co-operative and complementary attitude. This requires that roles and responsibilities are well defined. One of the project's roles is to facilitate this process of collaboration and to find opportunities to reinforce this approach of interaction.

## GENDER CONSIDERATIONS IN THE IMPLEMENTATION OF RHDP ACTIVITIES

RHDP has been trying in every effort to promote gender balance in all RHDP activities. Some of them are briefly highlighted:

### REVIEW OF THE PROJECT FROM A GENDER PERSPECTIVE

At the start of implementation of the RHDP, a gender workshop was organised for the RHDP staff with the objective of fostering a better understanding of the differences between men and women, of inherent injustices and imbalances, and of reviewing all defined RHDP inputs from gender perspective.

The workshop helped participants to define gender and to realise the extent of the problem in Nepal in general and in the project area in particular. Project staff were oriented on the latest concepts and approaches of "gender". Essential elements of this workshop were discovering and analysing one's perceptions and attitudes about gender relationships and realising one's own role in both the private and in the project environment. It led to an improved understanding of gender and to changes in attitudes and behaviour of the RHDP staff. As an outcome of the workshop, all possible actions as explained in the table below were identified to integrate gender into the project activities:

| Action line | How to integrate Gender |
|---|---|
| Promotive Health Activities: Awareness building and health education | ☐ Develop and distribute gender sensitive Information Education Communication materials.<br>☐ Accomplish orientation of health workers on gender issues in health through regular programmes.<br>☐ Inclusion of gender agenda in all health education and awareness programmes. |
| School health programmes | ☐ Sensitise the schoolteachers and students on gender issues in health during training. |
| Community initiatives: Strengthening management competencies of Community Organisations, VDCs, health committees and facilitators in community action for health. | ☐ Increase the number of both men and women in the committee to plan, implement and evaluate the programme.<br>☐ Sensitise the committees on the different health needs of men and women.<br>☐ Give priority to those committees which have females in key positions and which work for both men and women. |
| Support to community clinics | ☐ Encourage both women and men to establish community clinics.<br>☐ Facilitate men and women to be involved in the management of the established clinics. |
| Adult education programmes | ☐ Support to men for the internalisation of adult literacy programmes to increase female participation. |

| Action line | How to integrate Gender |
|---|---|
| Support to Health Post / Sub Health Post construction | ☐ Encourage both men and women to become involved in the committees and in the management and maintenance of HP and SHP.<br>☐ Establish provision of a maternity room as a criteria for roofing materials support. |
| Promotion and integration of traditional medicine | ☐ Facilitate the understanding of the health workers about the perception of women and men relating to traditional medicine.<br>☐ Expose traditional healers to gender issues by incorporating a gender component in the regular programmes. |
| Strengthening Outreach Clinic and Sub Health Post services | ☐ Improve reproductive health services by participating in RHS training and design.<br>☐ Involve male and female committee members in managing their local health services.<br>☐ Facilitate the understanding of health workers and volunteers for male and female health needs through workshops.<br>☐ Improve reproductive health services by participatingDevelop gender sensitive communication and counselling skills among service providers. |

| Action line | How to integrate Gender |
|---|---|
| Planning, monitoring, supervision of health system | ☐ Incorporate Gender related information in monitoring tools.<br>☐ Male and female gender related issues to be included in review and planning. |
| Management of epidemics | ☐ Sensitisation of male and female community members on prevention of local epidemics. |
| Promotion of drug schemes | ☐ Involve men and women throughout the process as a guiding principle.<br>☐ Explore the possibility of including illiterate people of both genders on the committee. |
| Skill development of health workers | ☐ Incorporate gender related issues in workshop and training.<br>☐ Select training/study tours that can address gender sensitive issues. |
| Support to DHO for durable equipment and infrastructure | ☐ Provide and facilitate the use of obstetric equipment.<br>☐ Provision of maternity/counselling room in HP construction. |
| Strengthening the local health system | ☐ Sensitise men and women on the critical health issues faced by women. |
| Co-ordination and alliance building among stakeholders at village and district level | ☐ Inclusion of a gender agenda in workshops and in all other activities. |

| **Action line** | | **How to integrate Gender** |
|---|---|---|
| Study tours in project areas | ☐ | Inclusion of a gender-specific check list, including orientation. |
| Capitalisation of experiences at district and central level | ☐ | Encouraging experiences of all action lines and activities that will be properly recorded and shared with partners through W/S, seminars and media at all levels. e.g. national, district and community. |
| Project management support<br>Overall management and co-ordination | ☐ | Orientation / re-orientation and sharing regarding gender issues for project staff (e.g. communication, female to female, male to female, male to male relationships, working styles). |

## EMPOWERMENT OF WOMEN

Women are disadvantaged when compared to men in many regards. The significantly higher number of illiterate women is probably one of the most striking examples of gender inequities, because its consequences on the health status of the mother and of the family is well proven to be negative. Gender imbalances are known to be further exacerbated with illiterate women. The use of antenatal services illustrates this in a dramatic way. Antenatal and natal care is strongly under-used in many places of Nepal including in the project's districts. Out of 809 women who were pregnant in the last five years, only 29% received any kind of antenatal services during their latest pregnancy. Fifty-five percent of the literate were the recipients of these services whereas only 25 % of the illiterate went to seek the services. The illiterate, socially and economically weak are at a significantly greater risk of not using the services with all the negative consequences this might have on maternal morbidity and mortality. Children of illiterate mothers have a significantly higher incidence of diarrhoea and of acute respiratory infections (ARI). The use of family planning methods is also much lower in the illiterate compared to the literate.

## TOWARDS MORE GENDER BALANCE

The above-mentionned situation compels the RHDP to make choices in terms of balancing male and female participation in workshops, trainings, study tours and scholarships as illustrated in the following table.

| **Type of training / workshop** | **Male** | **Female** | **Total** |
|---|---|---|---|
| VDC and community level training | 560<br>(32%) | 1207<br>(68%) | 1767 |
| PRA[1] & management training to mother groups | 1056<br>(20%) | 4225<br>(80%) | 5281 |
| Scholarships | 4<br>(25%) | 12<br>(75%) | 16 |
| Teachers' training | 139<br>(90%) | 16<br>(10%) | 155 |
| Training to community clinic operators | 42<br>(88%) | 6<br>(12%) | 48 |
| Training/workshops to RHDP staff | 65<br>(66%) | 33<br>(34%) | 98 |
| Various training to health workers and volunteers | 358<br>(49%) | 371<br>(51%) | 729 |
| Study tours | 63<br>(55%) | 52<br>(45%) | 115 |
| Total participants in 21 months: | 2287<br>(28%) | 5922<br>(72%) | 8209 |

Balancing between male and female has different meanings. It should always be in favour of the deprived. When it comes to empowerment, it means giving more emphasis to a female participation in decision making of public affairs. Therefore, training at VDC and community level include a substantially higher amount of women and so do PRA[1] exercises and management training that are oriented to mother groups. The quantitative male dominance of training to teachers or to clinic operators simply reflects the reality of these occupations which are mainly filled by men. In Nepal, only one out of ten teachers is a women.

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[1] PRA: Parcipatory Rural Appraisal

## SCHOLARSHIPS TO WOMEN TO PROMOTE GENDER EQUITY

There are ongoing adult literacy classes (ALC) in the villages provided by the adult literacy programmes of HMG. These ALCs are not sufficient in number to address the problems of female illiteracy. To remedy this situation the RHDP provides additional quotas for female adult literacy classes through the district education system to allow a bigger number of women to have the opportunity to become literate.

To address the lower schooling level of women and the higher illiteracy rate amongst them, the RHDP is providing a number of scholarships for girls to be able to stay in school. This is intended for girls who drop out of school for financial reasons and because they have to participate in housework.

The RHDP has realised that to increase the opportunities for girls to finish their regular schooling is a long term effort which can only succeed when the different decision makers at family and household level including the women themselves are repeatedly sensitised and constantly reminded of the importance of female education.

In order to bring more women to the professional field the RHDP is providing a substantial number of scholarships to study different courses in the health professions.

## WORKING WITH WOMEN'S GROUPS

Acknowledging women's importance in care-taking care, prevention and promotion of health, His Majesty's Government has institutionalised the formation of mother groups nation-wide. For each 250 members of the population living in the hill districts, a "mother group" is formed consisting of all women of reproductive age. Each mother group selects a Female Community Health Volunteer (FCHV) from amongst their members. The FCHV is trained, then given the responsibility to activate the mother group, to plan with them for health related activities and to provide health education.

In order to empower rural women with the basic knowledge of Primary Health Care (PHC), to promote community participation and to increase awareness of public health issues the FCHV have been trained nation-wide in recognising and treating minor ailments, prevention of communicable diseases, immunisation, nutrition, family planning, sanitation and personal hygiene. After the training, each FCHV is provided with a first-aid kit containing a few basic medicines.

Most of the time, neither the mother group nor the FCHV is functional. The necessary skills to lead and facilitate a group are usually missing. The RHDP therefore empowers both the mother group and the FCHV to manage the group in the following ways.

Starting from the women's own assessment of their needs, a planing exercise is carried out, where they define the activities they want to carry out to address these needs. During this exercise, they learn to identify the resources needed to carry out the planned activities and how to mobilise as much as possible locally available resources. Where a clear plan exists, RHDP supports the elaboration of a "community health initiative" with a contract between the group and the workforces involved. Action plans formulated by mother groups are related to literacy classes, building of smokeless stoves and toilets, repairing and maintaining drinking water schemes, health education campaigns to mention just a few examples. Such actions carried out together strengthen the management skills of the group.

The mother groups are given "management training" aimed at enhancing their capacity to make decisions and mobilise local resources. FCHVs are also given additional training focusing on group dynamics, management and facilitation. As they participate in needs-identification, planning and formulating of an action plan they gradually acquire skills on how to facilitate the mother groups. In some groups where the FCHV was found by the mother group to be unmotivated and inactive, another FCHV has been selected.

A number of mother groups have included some men in the group to give support for certain activities. This is seen as an improvement in the relationship between men and women which goes along with the empowerment of women.

Wherever possible, the health workers (Village Health Worker and Mother Child Health Worker) of the nearby health post or sub health post have been included in the planning exercise. The aim is to motivate them to work with the community, to recognise women's needs and to equip them with the tools to work with community people thus diminishing the gap between users and service providers. In many instances, the VHW and MCHW therefore participate in planning for community actions for health.

In addition to the FCHVs, management training is given separately to traditional birth attendants (TBA) and faith healers who are important health care providers in the local health system. These training courses focus on developing management and facilitating skills. School teachers are also trained in rural health problems and on how to mobilise the students to identify and address health problems in their respective communities and households. Health workers and notably the ones working at the community level (VHWs, MCHWs) receive additional training with a strong emphasis on facilitating skills on how to deal with community groups.

## OUTLOOK

It is extremely difficult to achieve equity in terms of gender. There is not one single way nor one best way to act towards more gender equity. It can only be achieved by moving through a process rather than with dramatic changes in practice because any dramatic change may not help or may even have negative consequences on gender balance.

The efforts to hire female staff for the project have remained futile as only a limited number of women are available in the job market. However, with the provision of reserved places for females, the RHDP will have a more balanced situation in future compared to the past.

As there are only a few female teachers in the schools, the promotion of health awareness through teaching will remain essentially a male activity until more women are educated to become school teachers. ALC and scholarship programmes will contribute to the increase of the proportion of literate and educated women in the project area. By the end of the next phase of the project, a number of women, who will have successfully completed high-school, are expected to be trained to take more public positions including those of teachers and health workers.

RHDP also has a number of shortcomings in ensuring gender equity in all its inputs. When using female community members who are already overburdened when compared to their male "counterparts" as volunteers to empower other women, we have to ask whether or not we are on the right track. Do we contribute to a greater "exploitation" of these women? Of course, we try to improve their capacity to deal with existing problems, to recognise needs, to make use of local resources and to mobilise them, to facilitate and develop all the skills among a group of women to make decisions. But are we really empowering them? Or are we simply putting a greater burden on these women?

An increased number of local women trained as health workers will have a direct impact on the employment scenario of the local health system. Trained people who will not be able to obtain jobs in the public sector will start to run their own private businesses. With the increase of female providers, utilisation of services by females is also expected to increase.

Formation of VDC Health Coordination Committees with the involvement of Mother Groups, FCHV and TBA will ensure women's concerns will be reflected in the VDC Health Coordination Committee's decisions. At the same time women and men will learn to work together in the local health system to mutually address each other's problems.

As a result of these multi-dimensional approaches, the degree of gender discrepancies is expected to decrease progressively.

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PATRICK DAUBY
LAURENT ASSOGBA, FOUAD KAHIA-TANI

# RÉFLEXION CRITIQUE SUR UNE DÉMARCHE DE RECHERCHE-ACTION AVEC DES GROUPEMENTS FÉMININS AU BÉNIN

## LECTURE GENRE DE PROGRAMMES DE COOPÉRATION EN SANTÉ

## INTRODUCTION

Au Bénin, divers groupements de femmes ont sollicité la construction d'un centre de santé dans leur village. A partir de cette problématique somme toute assez banale s'est organisée toute une réflexion autour de l'approche genre. En effet, la solution s'impose assez naturellement à partir des orientations de la politique sanitaire, elle doit, pour pouvoir se réaliser, être d'abord *reconstruite*, selon une démarche qui prend en compte les questions des groupements et des relations hommes-femmes ; du passage des soins à la santé ; du capital social des groupements ; et enfin du partenariat genre et santé. Un tel cadre théorique d'intervention constitue une condition essentielle à la mise en œuvre de programmes de coopération en santé dignes de ce nom afin, comme dit Corin (1994), «qu'une compréhension plus globale des déterminants sociaux de la santé et des caractéristiques de la vie collective qui aggravent ou atténuent leur influence [puisse] fonder des interventions mieux ciblées et interactives au sens où elles considéreraient les divers groupes et communautés comme de véritables partenaires».

Suivant les objectifs de ce colloque, nous nous intéresserons aux questions fondamentales suivantes:

- ❑ Comment et dans quelles conditions les rapports sociaux entre hommes et femmes influencent-ils la capacité des gens à prendre soin quotidiennement de leur vie et à faire des choix par rapport à leur santé?
- ❑ Comment la prise en compte des rapports sociaux entre hommes et femmes permet-elle une autre lecture des déterminants de la santé?
- ❑ Si on admet que les rapports sociaux entre hommes et femmes transforment les facteurs déterminants de la santé, quels sont alors les changements à apporter dans nos pratiques et dans celles des intéressés, tant dans la formulation des politiques que dans la mise en œuvre de projets?

## CONTEXTE GÉNÉRAL: LES PROGRAMMES DE COOPÉRATION EN SANTÉ

Nous débattrons de ces questions dans le cadre des programmes classiques de coopération en santé. Ces programmes sont dits «classiques» car cela fait déjà quelques années qu'ils s'inscrivent dans une démarche d'appui aux services de santé. Ils sont caractérisés

- ❑ par un positionnement institutionnel en appui aux Ministères de la santé publique (MSP) et aux politiques et stratégies nationales de santé;
- ❑ par une approche par services de santé sur le plan opérationnel, mais également sur le plan institutionnel, à travers le renforcement des différents niveaux du système de santé;
- ❑ par un haut niveau de conceptualisation et d'implantation géographique;

- par une volonté de participation des populations à la gestion de la santé à travers la mise en place de comités de santé ou de gestion des services de santé.

Au Bénin, ces programmes classiques, dont nous faisons partie, représentent pas moins de quatre agences de coopération bilatérale et trois agences de coopération multilatérale, couvrant quasiment l'ensemble du territoire. C'est dire si l'influence qu'ils exercent sur les politiques sanitaires et sur les pratiques d'intervention est grande, influence qui se manifeste dans les diverses conditionnalités, procédures et modalités d'appui aux services, aux ONG (organisations non gouvernementales) et aux associations concernées, qui à leur tour influent considérablement sur les réalisations et les types d'activités entreprises. C'est pourquoi il n'est pas inintéressant de réfléchir à la manière dont la problématique genre est intégrée dans ces différents programmes. Un rapide sondage montre qu'ils approchent cette problématique selon trois niveaux de réflexion:

1) La dimension genre n'est pas prise en compte dans les activités de santé.

2) Les programmes appuient des groupements féminins par une aide surtout économique et participent peu aux choix des interventions; les groupes sont identifiés suivant un certain nombres de critères (économiques, participation à des programmes, etc.) qui sont déterminés *ex ante* par les organismes d'appui. Les extraits suivants d'un programme de santé sont très illustratifs à ce sujet:

   «Le questionnement fondamental est d'identifier, au niveau des groupements féminins, les besoins de formation et de renforcement institutionnel dans les domaines de l'entrepreneuriat, de l'identification, de la gestion et du financement d'activités génératrices de revenus. Bien que féminins, les groupements comptent dans leurs rangs un ou deux hommes lettrés ou déscolarisés qui en sont les principaux animateurs et gestionnaires.»

   «Ni l'esprit d'innovation, ni le goût du risque calculé ne leur sont familiers. Beaucoup de femmes interrogées ont avoué être incapables de tenir une simple comptabilité analytique sur chaque produit si le nombre total des différents produits qu'elles commercialisent dépasse quatre.»

«Pour corriger les insuffisances institutionnelles, il est proposé un programme de formation et d'appui. Le but est de contribuer à l'amélioration substantielle de la demande et de l'offre en matière de santé reproductive.»

3) L'approche privilégie la prise en compte des problèmes de santé des femmes à partir d'une double conception: les femmes sont un groupe vulnérable, et elles sont un véhicule majeur pour la réussite des programmes de soins de santé primaire (SSP). L'extrait suivant est éloquent à cet égard: «Il ressort que les femmes jouent un rôle capital dans les programmes de soins de santé primaire. Elles assurent le transport et la surveillance des enfants dans les programmes de vaccination. Elles participent aux séances de causeries-débats, de démonstration nutritionnelle [...].»

Cependant, on constate que l'introduction du concept genre ne renouvelle pas les approches concernant les soins de santé primaire et les manières de faire. Non seulement le rapport entre déterminants sociaux et santé n'est pas pris en compte, mais il apparaît que la notion même de ce rapport n'est pas très claire au niveau de la conception des programmes. Toutefois, une constante plus positive est également manifeste: plusieurs acteurs de ces programmes mènent une réflexion au sujet de leur propre organisation et de leur mode de fonctionnement par rapport à la problématique genre. Si la possibilité de recruter des femmes au sein des programmes est souvent évoquée, mais sans être finalement perçue comme essentielle, en revanche le mode de fonctionnement au sein des programmes ainsi que les relations hiérarchiques de travail retiennent plus fortement l'attention. On n'est dès lors pas loin d'un regard critique sur les déterminants sociaux de la santé à travers la réflexion sur les pratiques et modes d'organisation au sein des programmes.

## LE PROGRAMME D'APPUI AU DÉVELOPPEMENT DE LA SANTÉ (PADS)

A l'égard de l'approche genre, le PADS se trouve dans la même situation que les autres programmes de coopération en santé. Même si les responsables du programme ont pu bénéficier d'une formation complémentaire sur l'aspect genre et développement, force est de reconnaître que peu d'idées concrètes de mise en œuvre ont émergé dans les consciences. Après avoir écrit que cet aspect serait une des préoccupations du programme, il ne manquait finalement, pour confronter cette intention à la réalité, que l'épreuve du feu, laquelle est apparue lorsque le programme a été contacté par un groupement féminin qui demandait la construction d'un centre de santé à Kpakpa, un village du centre du pays qui ne possède à ce jour qu'une modeste unité villageoise de santé (UVS).

## DEUX DÉMARCHES POSSIBLES

Ce genre de demande est assez habituel et conforme à notre vocation. Une réponse assez classique semblait donc s'imposer d'emblée : la construction de centres de santé s'inscrit dans un plan de développement sanitaire et doit répondre à un certain nombre de critères, telles la taille de la population, l'accessibilité et la dynamique communautaire; l'ensemble de ces critères sert alors à définir une grille de priorité. Il y a quelques années, Kpakpa, avec une population cumulée de près de 4000 habitants et un nombre d'accouchements avoisinant les 180 par année (quand il y avait un infirmier au poste de santé), méritait assurément qu'on s'y intéresse et l'affaire semblait entendue, pour autant qu'elle fût reprise dans la programmation du Ministère de la santé publique (MSP).

Toutefois, une deuxième réponse à cette demande était également possible. Il faut savoir qu'au Bénin, grâce à l'Initiative de Bamako qui permet aux centres de santé de s'autofinancer à travers le recouvrement des coûts, une forte dynamique communautaire est engagée autour de ces centres. Ils sont ainsi cogérés entre les agents de santé et la population à travers des comités de gestion élus. Ces comités de gestion ont un poids indiscutable, tant sur le plan gestionnaire lui-même (le recouvrement des coûts permet, outre le rachat des médicaments, la prise en charge des frais récurrents et le financement des salaires pour la moitié des agents des santé des centres périphériques) que sur le plan politique : ils se constituent en réseau et interviennent de plus en plus dans le débat sur la politique de santé[1]. Dans cette situation, un appui à la constitution d'un comité de gestion constituait une façon de répondre à la demande du groupement féminin en restant dans la mouvance générale.

Ces deux approches souffrent cependant du biais suivant : le service de santé s'impose par lui même ; il va délimiter *a priori* les besoins légitimes dans le domaine de la santé selon les activités qu'il est en mesure d'offrir. Beaucoup de bonnes paroles accompagneront la remise d'un centre de santé «joyau» à la population, dont la responsabilité sera de le gérer, à la place et au service de l'Etat. La formation des comités de gestion et l'animation santé suivront. On développera une écoute éducative et, pour reprendre les propos d'Isabelle Stengers (1994), «on accepte, à la limite, d'apprendre d'eux, mais c'est pour les ramener dans le droit chemin et non pas parce qu'il s'agirait de réinventer avec eux à la fois ce qu'est un médicament et ce qu'est un malade».

## TROISIÈME DÉMARCHE : UNE LECTURE GENRE

Comme alternative aux deux démarches ci-dessus, nous avons tenté de développer une lecture genre de l'approche, ce d'autant plus que la demande émanait d'un groupement de femmes. Dans un premier temps, il nous fallait clarifier la réalité des groupements féminins et

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[1] Les différentes études et recherches montrent cependant que les comités de gestion sont faiblement représentatifs de l'ensemble de la population. Cela est assez classique et a déjà été largement décrit pour d'autres pays.

considérer les rapports entre groupements féminins et communauté. Après avoir discuté une journée avec des membres de ces groupements, nous avons proposé à un sociologue de passer une semaine dans les villages et d'essayer, en dépit de la brièveté de son séjour, de rédiger une monographie concernant ces groupements qui répondrait à certaines questions élaborées à partir de l'interrogation suivante: au-delà des réalités sociosanitaires rapportées, y a-t-il, oui ou non, une «conscience-genre» pouvant orienter l'intervention du PADS dans le sens du dépassement d'une simple offre d'appui sanitaire, et vers le renforcement et l'amélioration des rapports sociaux dont participe le statut social des femmes? Les diverses questions accompagnant cette hypothèse étaient les suivantes:

- ❑ Ces groupements ont-ils une influence sociale ou aimeraient-ils en avoir une, et dans quel sens?
- ❑ Comment s'opère leur démarche concernant les préoccupations et les demandes en santé?
- ❑ L'existence de ces groupements a-t-elle des répercussions sur les rapports hommes-femmes dans la localité? Modifie-t-elle dans chaque ménage, famille, village, etc., les relations individuelles hommes-femmes?
- ❑ Les groupements féminins exercent-ils une influence sur la santé des femmes en tant qu'individus et en tant qu'éléments du corps social?
- ❑ Existe-t-il au sein de ces groupements une réflexion sur la santé? Et sur d'autres besoins?
- ❑ L'existence de ces groupements améliore-t-elle la santé dans la localité?
- ❑ Peut-on, à partir des réponses aux questions précédentes, *reconstruire* une demande de soins qui s'oriente vers les autres axes de la santé, ou *comment passer des soins à la santé?*
- ❑ Eu égard à l'état des rapports sociaux de genre, peut-on approfondir les discussions sur d'autres thématiques de santé, relatives aux problèmes des maladies sexuellement transmissibles (MST),

du sida, de la nutrition, de l'approvisionnement en eau potable, etc.?

- ❑ Y a-t-il intérêt à renforcer les trois groupements féminins de Kapka sur le plan institutionnel? Une telle institutionnalisation comporterait-elle des risques?
- ❑ Quelles sont les perspectives d'avenir pour ces groupements féminins dans tous les domaines (santé, éducation, développement rural, etc.) ?
- ❑ Quels sont les avantages en termes de rapports sociaux liés à la présence d'hommes dans les groupements féminins?
- ❑ Quelle différence peut-on établir entre groupements féminins et communauté?

Nous donnons ci-dessous une synthèse des éléments contenus dans le rapport de l'enquête à Kpakpa.

Les deux villages de Kpakpa Agbagoulè ont une population d'environ 4000 habitants, qui sont frères de par leur origine idatcha, leur langue idatcha et leur religion. La population locale est formée à 99% de chrétiens protestants, les musulmans et les animistes se partageant le 1% restant. Les populations des deux villages se livrent presque exclusivement à la production agricole. A côté de la production vivrière, on note surtout celle du coton qui prend une ampleur inquiétante, causant une surcharge de travail pour les paysans et un manque de temps pour «s'occuper des enfants et les protéger contre le froid matinal» qui ont eu comme conséquences fâcheuses que, «il y a trois années de cela, 13 enfants sont morts d'anémie», ainsi que le rapporte le secouriste de l'unité villageoise de santé (UVS).

Deux puits à pompe ont été forés grâce aux cotisations de la population locale et à l'appui de l'UNICEF : «Les femmes cotisent 500 francs CFA et les hommes 1000 francs CFA jusqu'à atteindre 60'000 francs CFA par puits.» Une école primaire publique de six classes, avec un effectif total qui est passé de 201 élèves en 1976 à 266 élèves aujourd'hui, a été créée en 1969, et une UVS en 1991.

## LA RÉALITÉ DES GROUPEMENTS FÉMININS

Dans la localité, on dénombre environ 85 femmes qui appartiennent aux trois groupements féminins existants, dont l'effectif global avoisine 95 personnes avec la présence de neuf hommes. Tous sont membres de l'Association pour la promotion féminine et infantile en milieu rural (APROFIMIR), appuyée par le Programme allemand groupement féminin (PAGF) et le Centre de promotion sociale (CPS) pour les activités génératrices de revenus et l'information relative au planning familial, aux droits de la femme, etc. Chacun des groupements féminins a un compte d'épargne, grâce à la commercialisation de ses productions.

Les trois citations suivantes sont des extraits d'entretiens:

«Il y a environ neuf ans que le premier groupement est né sur la base d'imitation de ce qui se fait dans d'autres localités avoisinantes à Kpakpa Agbagoulè et aussi sur la base des émissions de la radio nationale qui conseillent aux gens de se mettre en associations de développement, en groupements féminins, en organisations non gouvernementales, etc., pour pouvoir obtenir, des bailleurs de fonds, un appui au développement sectoriel. Deux ans après la naissance du groupement, l'effectif s'est accru si bien qu'on a dû scinder le groupement initial en trois, avec les mêmes objectifs de développement.»

«La femme est faible par rapport à l'homme et ne retrouve de nos jours un peu de force que dans un groupement féminin. S'il y a trois hommes dans chacun de nos groupements, c'est pour qu'ils comblent notre faiblesse physique et apportent leur intelligence masculine en renfort à notre intelligence féminine.»

«Ainsi, nos groupements sont en train de devenir des porte-parole mandatés de toute la communauté.»

## COMMENTAIRE

Les groupements des femmes de Kpakpa ont une histoire. Créés par des femmes et des hommes en 1991 plus par effet de mode, dans le courant de la démocratisation, que par prise de conscience sociale, ils ont évolué et s'inscrivent maintenant dans la vie sociale des villages, à tel point qu'ils deviennent des porte-parole efficaces et écoutés par la communauté. Même si le nombre des membres n'est pas énorme, ces groupements participent à la vie quotidienne des ménages ; en effet, faire partie d'un groupement implique des obligations en participation et en travail (aux champs, transformations) ainsi que des bénéfices, financiers (en fonction des excédents), en nature et sociaux (en termes de promotion sociale) ; mais ne pas en faire partie implique aussi un choix (libre, mais le plus souvent imposé ou par défaut) pour des femmes qui ont été interpellées dans cette communauté et qui ont dû en discuter dans le cadre de leur ménage.

Les femmes se réunissent une fois par semaine autour d'activités de production et trois hommes au moins participent à chaque réunion. Ce choix s'est imposé pour faire bénéficier les groupements de la «force» des hommes, mais aussi pour en assurer la légitimité suite à l'inquiétude, et parfois à l'opposition, des hommes de voir leurs femmes se regrouper. Cette situation semble vécue de manière positive, non comme une fatalité, mais comme un compromis négocié. Ces hommes sont chargés de «surveiller», comme le dit une responsable, mais ils sont aussi les premiers messagers de la vie des groupes auprès des hommes.

Cela change-t-il la vie au village et les rapports sociaux? Il semble que oui, notamment en ce qui concerne la solidarité entre les membres, le recours aux vieux quand une femme malade est battue par son mari, la volonté et les efforts collectifs menés pour détendre certaines des participantes plus timides afin de leur permettre de prendre de l'assurance et, apparemment, de bien rire et s'amuser.

Travailler et encore travailler! La participation au groupement ne semble pas permettre un allégement du travail quotidien. Peut-être faut-il y voir une raison du faible nombre de membres. Alors, pourquoi continuer? Pour l'avenir, répond une responsable, quand le groupement aura un peu plus de moyens ; mais pour l'immédiat aussi, peut-être, avec les quelques bénéfices retirés de l'exploitation ; mais surtout, pour les hommes : pour la fierté d'être reconnues et de diminuer sa dépendance.

## LA DÉMARCHE VERS LA SANTÉ

La démarche vers la santé s'opère sur plusieurs plans, qu'il est important d'identifier tout d'abord :

- ❑ *L'identification de l'offre institutionnelle :* le Ministère de la santé publique (MSP) n'est pas identifié et l'interpellation n'est pas directe. C'est le Programme qui est identifié et interpellé via une ONG servant de médiateur.
- ❑ *La demande s'oriente vers les soins*, mais reste limitée : en effet, dans un premier temps elle visait un appui en médicaments et la consommation de soins, puis elle s'est élargie avec l'objectif de la construction d'un centre de santé.
- ❑ Les *bénéfices directs* – les soins et l'accouchement – sont présentés comme la seule justification de la demande et semblent être les seuls exprimés. En effet, à la question du pourquoi d'un centre de santé, la première réponse est : pour les soins et l'accouchement, car «nos mères ont trop souffert». Quant aux bénéfices indirects – gain de temps, affirmation des groupements –, ils ne sont pas exprimés d'emblée, comme s'ils ne pouvaient être l'affaire de professionnels.

Mais des investigations plus poussées apportent un autre éclairage :

- ❑ *Par rapport à la communauté :* des raisons de rivalités et de prestige poussent la communauté à revendiquer un centre de santé. Les groupements féminins étant perçus comme ayant plus l'oreille des bailleurs de fonds, c'est eux que la communauté va mandater pour faire la démarche de demande d'un tel centre. Cela explique peut-être pourquoi le MSP n'est pas identifié en premier lieu comme interlocuteur, parce que, bien évidemment, il se montre moins sensible à la composante féminine.

- *Par rapport à l'organisme d'appui:* de plus, il apparaît que l'identification de la disponibilité de l'institution d'appui a conditionné la demande. Il ne semblait pas pertinent au groupement féminin de nous demander autre chose qu'un centre de santé: image en miroir de nos interventions plus que de nos intentions…
- *Par rapport à la santé:* les groupements féminins prennent déjà en charge des activités de santé en marge des activités de soins. Ainsi, ils organisent des séances de pesée ou de vaccination qui semblent aussi destinées à aborder des thèmes liés au planning familial, aux maladies sexuellement transmissibles (MST), etc.
- *Par rapport aux bénéfices:* la nécessité d'avoir un centre de santé paraît aussi liée à la disponibilité diminuée des personnes due à l'extension de la culture du coton; l'installation d'un centre de santé au village permet en effet un énorme gain de temps.

L'élargissement de l'analyse de la demande suivant la sensibilité genre ouvre ainsi la porte à beaucoup de questions et esquisse les contours flous et complexes d'une situation en apparence simple.

## UN CADRE CONCEPTUEL POUR L'ACTION

Il est évident que ces éléments d'analyse restent fragmentaires même s'ils permettent des hypothèses de travail; en aucun cas nous n'aurions la prétention de croire qu'ils épuisent le sujet. Mais l'intervention doit se réaliser de toute façon, même si les résultats sont incertains. En effet, dans la situation de Kpakpa, la production de soins reste une préoccupation majeure, et c'est dans ce domaine qu'il faut d'abord aider à trouver des réponses. La construction de la demande autour de la santé suppose que des garanties soient données quant à la production de soins; sans cela, la démarche sera dénuée de toute crédibilité.

Dans toutes les évaluations de groupement féminins, on trouve des éléments sur leur organisation, leurs productions et leurs avoirs bancaires. Dans la situation présente toutefois, nous sommes finalement moins intéressés par cet aspect que par la dynamique sociale autour et à partir des groupements. Nous voudrions utiliser ici la notion de *capital social*, concept fréquemment utilisé dans le cadre de la décentralisation. Bourdieu le définit ainsi : «Le capital social est l'ensemble des ressources actuelles ou potentielles qui sont liées à la possession d'un réseau durable de relations plus ou moins institutionnalisées d'inter-connaissance et d'inter-reconnaissance ; ou en d'autres termes l'appartenance à un groupe [...]. »

Présenté comme tel, il fait référence à un réseau, mais il a aussi trait à d'autres dimensions comme l'attente en matière d'équité, le volontarisme (perçu comme la volonté de se mettre ensemble pour résoudre des problèmes de la communauté), l'échange d'information, l'optimisme, la confiance (Widner and Mundt 1998). Bien que nous n'ayons évidemment pas la compétence requise pour approfondir ce concept et en discuter les limites, nous pensons que cette perspective, si elle est une offre aux anthropologues de collaborer avec nous, nous permet aussi de déplacer le champ de l'intervention.

Au niveau de Kpakpa, le capital social des groupements féminins est réel : médiateur, porte-parole de la communauté, espace d'entraide et de discussions… Plus qu'une réponse à un problème de soins ou à une demande, il semble que le renforcement du capital social des groupements, en engageant avec eux un partenariat genre et santé, permettra de reconstruire la demande en santé avec les femmes, de renforcer le rôle et l'insertion sociale des groupements et d'influer positivement sur les relations hommes-femmes. Cette hypothèse d'action doit bien sûr être concrétisée en interventions, dont quelques orientations sont en discussion:

- reconstruire avec les groupements une demande en santé qui dépasse le cadre des soins;
- mettre en œuvre un centre de santé communautaire dont les services et le contenu des activités sont discutés avec les groupements;
- favoriser la participation communautaire à travers les groupements;

- ❑ faciliter l'intégration des groupements au niveau des réseaux des comités de gestion de la santé;
- ❑ favoriser la rencontre et les échanges entre les groupements et l'offre institutionnelle de soins (le Ministère de la santé publique).

## CONCLUSION

Plutôt que de trouver une solution à un problème de santé publique, notre démarche a enclenché un processus de recherche de solution dans une perspective genre. Même si les groupements de femmes restent minoritaires, il nous paraît important de participer à l'affirmation de leur identité et d'en respecter les exigences dans un esprit de partenariat.

La lecture genre a permis de tracer un nouveau cadre conceptuel pour l'intervention. Ce cadre s'articule autour de questions qui sont autant d'hypothèses de travail, dont la mise en pratique constituera d'ailleurs aussi un long questionnement.

Dans ce processus de recherche-action, il est important de souligner qu'une approche genre ne se décrète pas au sein des programmes. Nous redoutons que sous la pression de bailleurs de fonds ou par effet de mode, l'approche par les déterminants sociaux ne devienne une composante universelle des programmes de santé, confortée par des théories scientifiques bien étayées, allant jusqu'à la mise en place de «programmes nationaux genre», après avoir été laissée de côté par les «développeurs» au profit des anthropologues. Nous pensons que pour ce qui concerne le domaine de la santé, ces approches doivent se construire au centre même de l'action.

Il n'y a pas de recettes miracles, mais la redéfinition du cadre conceptuel de l'action dans le domaine genre et la mise en œuvre des réponses sous forme d'hypothèses critiques de travail ne peuvent aller sans une adaptation des cadres et des procédures d'intervention. Le cadre conceptuel définit un nouveau paradigme d'intervention et le cadre opérationnel de nouveaux instruments et procédures d'évaluation. Mais nous ne sommes pas loin ici de ce que d'aucuns appelleraient «planification à rebours».

**Le Programme d'appui au développement de la santé (PADS, ex-PMSBS)**

Le PADS est un programme financé par la Coopération suisse et mis en œuvre en régie par l'IUED. Sa finalité est l'amélioration de l'accessibilité et de l'équité des services de santé, la promotion de la santé au niveau des populations et la réforme sectorielle globale du système de santé. Le cadre opérationnel du programme est la zone (district) sanitaire, considérée comme l'unité la plus décentralisée de la pyramide sanitaire dotée d'une autonomie de gestion. L'intervention se concentre sur trois zones sanitaires sur le plan opérationnel et sur les différents niveaux de la pyramide sanitaire sur le plan institutionnel.

Les stratégies s'orientent autour de l'appui institutionnel vers les secteurs privé et public et la recherche-action dans les domaines de l'accessibilité socioculturelle et de la qualité des soins, des relations de genre et santé, de la prévention du sida, de l'environnement et plus largement dans l'appui aux communautés.

Le programme s'articule autour de trois axes majeurs:

1) renforcer et réorienter les services de santé suivant le concept de zone sanitaire;

2) inaugurer et appuyer des actions de promotion de la santé au niveau des populations et renforcer les capacités d'intervention relativement à des problèmes épidémiologiques prioritaires;

3) appuyer la réforme sectorielle et la décentralisation du système de santé, et créer de nouveaux partenariats pour la promotion de la santé.

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ERIC BURNIER

# QUESTION DE GENRE ET AGENCE DE DÉVELOPPEMENT

L'IUED est l'un des régisseurs de la Coopération Suisse (DDC), c'est à dire que lui est confié la charge de l'exécution technique de programmes de développement financés par la Coopération. Parmi ces programmes, trois relèvent du secteur de la santé publique, à Madagascar, au Bénin et au Mali et tous trois ont déjà une longue histoire.

La stratégie d'intervention est celle de l'appui institutionnel, au secteur public, mais aussi à tout ce qui émane de la société civile, associations, groupements, ONGs, visant à une amélioration de la santé de la population.

En réfléchissant à cette question de genre, dans le contexte de cette régie de programme, plusieurs faits ressortent:

- ❏ Certes les femmes, quand on parle de santé, ont toujours joué un rôle prioritaire, en raison de tout ce qui a trait à la santé maternelle et infantile, du suivi des grossesses à la salle d'accouchement, de la planification familiale à la formation des sages-femmes – mais les femmes sont alors des cibles d'intervention plus que des partenaires et constituent en quelque sorte un groupe vulnérable (parmi d'autres). Or, c'est en tâchant de réduire les vulnérabilités qu'un programme peut espérer faire du développement à long terme.

- ❑ On constate également que dans les institutions appuyées, il y a bien peu de femmes… à une exception notable cependant puisqu'actuellement aussi bien à Madagascar, qu'au Mali ou au Bénin, le Ministre de la Santé est une femme!
- ❑ Mais l'organisation de nos programmes ne fait pas exception: une réceptionniste au Mali, une secrétaire à Madagascar – sinon que des hommes!
- ❑ C'est lors de la mise en place des comités de gestion de la santé, au Bénin, que cette préoccupation genre est apparue: ces COGES sont censés représenter la communauté mais les membres proposés étaient tous des hommes, et des hommes âgés: où étaient les jeunes? les femmes? Mais aussi: comment intéresser les hommes à la problématique santé maternelle, au rôle des femmes dans le développement de leur village, à leur point de vue?

C'est à l'insistance des partenaires au programme pour que les voix des différents groupes de la communauté puissent se faire entendre, et se faire entendre directement et non par l'intermédiaire des hommes, que ces derniers ont accepté de faire venir quelques jeunes, quelques femmes – appartenant au Centre de Santé d'ailleurs, donc techniciens du Centre avant d'être des usagers. Mais leur présence n'a, au moins au début, pas changé grand chose aux débats: c'était les hommes qui parlaient. Et s'ils avaient accepté de faire siéger des femmes, c'était par politesse – ou par intérêt et non pas spontanément.

- ❑ Le programme de mutuelles de santé au Bénin, également financé par la DDC*, vise à proposer la constitution d'associations mutualistes dont les membres, volontaires, cotisent à l'année une certaine somme couvrant, en cas de maladie, les frais de traitement de base. C'est lorsque les responsables ont commencé leurs enquêtes dans les villages qu'ils se sont aperçus de la richesse en associations, réseaux d'entraide, groupements divers, existant déjà depuis longtemps, pour notamment palier les inévitables «coups de malchance» qui peuvent survenir. Et cette solidarité repose essentiellement, pour ce qui touche à la santé, sur les femmes. Des exemples en ont été donnés, du Mali et du Bénin.

- ❏ La découverte (par nous, de la coopération, donc expatriés) de tout ce tissu de la société, sous-jacent, peu visible mais connu de nos partenaires, nous a posé quelques questions:
  - pourquoi l'ignorions-nous?
  - nous l'avait-on caché?
  - était-ce une menace pour le pouvoir local de révéler la force de ces réseaux?
  - en connaissait-il lui-même d'ailleurs la variété?
  - en faisant de l'appui institutionnel visant à une amélioration des indicateurs de santé, notre rôle n'est-il pas justement d'appuyer ce genre d'associations féminines qui contribuent au développement?
  - de renforcer leur pouvoir de négociation?
  - mais alors, comment soutenir efficacement, sans tuer l'initiative, ou la détourner?

Car les pièges sont nombreux:

- ❏ chercher à tout prix un équilibre homme-femme dans un contexte culturel qui n'y est pas habitué,
- ❏ concevoir un groupement féminin comme homogène, en occultant les différences de niveaux économiques (voire de classes), les aspects religieux, les niveaux d'éducation,
- ❏ répondre aux demandes au 1^er^ degré (l'exemple de l'unité villageoise de santé du Kpakpa) sans chercher ce qu'il peut y avoir d'intérêts derrière cette demande,
- ❏ ne pas voir que certains groupements féminins sont peut-être mis en avant, ou même créés, parce que meilleurs ambassadeurs, plus convainquants, de leur communauté, et devenir ce qu'on appelle «des courtiers du développement».
- ❏ susciter la création de groupements artificiels, éphémères, parce que c'est à la mode, etc…

Enfin, dernière question qui nous préoccupe : comment arriver à montrer par des indicateurs de santé, ce qui tient à l'influence de rapports sociaux? Est-ce possible?

En conclusion, cette question de genre nous conduit à envisager notre travail sous un éclairage nouveau – mais un éclairage parmi d'autres – et apporte une nouvelle curiosité dans notre réflexion.

ANNE ZWAHLEN

# POSTFACE

Yvonne Preiswerk, dans le débat final, relève qu'il est plus facile de parler des relations sociales hommes-femmes dans le domaine de la santé que dans le domaine de l'économie par exemple. Le fait que les études et professions de la santé sont ouvertes aux femmes depuis longtemps n'y est sans doute pas étranger ; en outre, dans ce domaine, la prise en compte des différences hommes-femmes apparaît comme une évidence. Mais va-t-on toujours au-delà du biologique? Ne limite-t-on pas la différenciation à la sphère de la santé reproductive?

Sur le plan de l'approche conceptuelle, le colloque fait apparaître de grandes avancées. Le sujet des inégalités et des déséquilibres y est clairement abordé. Dans maintes sociétés, hommes et femmes n'ont pas le même accès aux services de santé, reflet d'un déséquilibre social plus profond qui touche au statut des hommes et des femmes, à leur pouvoir économique et politique, au temps dont ils disposent pour soi, pour se former et s'informer, pour se reposer… Le colloque a ainsi, à très juste titre, insisté sur un point central de l'approche genre, qui est la mise en évidence des relations de pouvoir.

D'autres aspects, également importants, sont abordés mais demandent à être encore plus profondément explorés. On a beaucoup dit que le genre, c'est le «féminin» et le «masculin» tels que construits socialement et beaucoup d'efforts ont été faits dans ce sens pour déconstruire le prétendu «naturellement féminin», pour en montrer les aspects variables et arbitraires, soumis aux aléas de l'évolution des sociétés. Mais qu'en est-il donc des hommes? Lesley Doyal a présenté un cadre d'approche « genre et santé» qui s'efforce d'interroger le «masculin» comme le «féminin». C'est une voie à suivre, qui n'est encore qu'amorcée. On peut par exemple se demander comment la santé des hommes en Europe et ailleurs a pu être influencée par le fait que dès le XIX$^{e}$ siècle ils furent considérés comme les principaux *breadwinners*, comme les soutiens essentiels de la famille sur le plan matériel, la femme jouant un rôle surtout sur le plan affectif et moral? Rejetés de la sphère domestique, ils sont exclus de la culture des soins et de la prévention, supposées relever de la «nature féminine». Ainsi, le «masculin» lui aussi gagnerait à être vu sous un autre angle. La situation des hommes n'est pas forcément une norme indiscutée et indiscutable.

Si l'on considère maintenant les présentations qui touchent plus à des expériences pratiques qu'à l'élaboration d'un cadre théorique, on retrouve à nouveau cette préoccupation centrale, liée au problème du pouvoir et des déséquilibres sociaux. Chez les gens du Sud, actifs dans leur propre société, cette approche est plus directement politique et militante. Et il est bien qu'il en soit ainsi. Toutefois, certaines expériences de terrain – plus particulièrement celles qui se situent dans le cadre de la coopération au développement – ont encore quelque peine à se détacher d'une approche strictement «femmes et développement» pour prendre réellement en compte les enjeux d'une approche «genre et développement». Aucune véritable analyse de la situation respective des hommes et des femmes dans la société concernée ne semble avoir été préalablement menée ; on parle essentiellement des femmes comme d'un groupe spécifique sans prendre suffisamment en considération les relations sociales dans lesquelles elles s'insèrent. Ce faisant, on ne se donne pas les moyens de soutenir un changement réel qui passe par un rééquilibrage des relations, et on court le risque d'accroître encore la surcharge des femmes : elles ont toujours plus de charges et de responsabilités sans pour autant accéder aux mécanismes décisionnels.

En définitive, le colloque « Tant qu'on a la santé» fait bien ressortir les tendances actuelles : de très fortes avancées dans la théorie et dans certaines pratiques, mais aussi des tâtonnements et des expérimentations qui, certes, manifestent un souci légitime de s'adapter au contexte mais qui, si elles s'appropriaient plus les concepts et les instruments de l'approche genre, gagneraient probablement en force d'innovation et de changement.

Les colloques sont non seulement un lieu d'échange, mais aussi un lieu de stimulation réciproque. Les expériences présentées se poursuivent et s'approfondissent, et gageons que le colloque de l'an 2000 nous permettra de faire un pas de plus.