FACTORS INFLUENCING WOMEN'S HEALTH IN DEVELOPING AFRICAN COUNTRIES

Valerie Janet Ehlers, RN, D.Litt. et Phil.
Senior lecturer, Department of Advanced Nursing Sciences
UNISA

OPSOMMING

In Sub-Sahara Afrika verrig vrouens 80% van die landbouarbeid. Boonop versorg baie vrouens van Afrika ook groot gesinne, insluitende gestremde, siek en ou persone, op karige inkomstes wat hulle noodsaak om brandhout en water ver te dra en graan te maal. Die meeste gemeenskapsprojekte word ook deur dié vrouens vervul, wat lei tot 'n drie-dubbele rolvervulling (naamlik dié van produktiewe of inkomste-generende werk, reproduktiewe werk of die baring en versorging van kinders, sowel as gemeenskapswerk soos die deelname aan kerkaktiwiteite en die versorging van bejaardes en minderbevoorregtes in gesinne en in gemeenskappe) wat van vrouens - veral plattelandse vrouens - vereis word. Die driedubbele rolvervulling laat weinig tyd, ruimte of geld oor vir die vrou se selfvervulling, en kroniese ooreising benadeel baie vrouens se fisiese en geestelike gesondheid ongeag die beskikbaarheid van of die gebrek aan gesondheidsdiente.

Die artikel spreek sommige politieke-, ekonomiese-, omgewings- en sosiale faktore aan wat die gesondheid van Afrika se vrouens kan benadeel. Veral die vrou se status in die gemeenskap bepaal haar besluitnemingsvermoëns wat verreikende gevolge vir haar gesondheidstatus (asook vir dié van haar kinders) kan inhou. Die vrouens van Afrika se gesondheid is van deurslaggewende belang vir die oorlewing van hulle kinders en uitgebreide gesinne, asook vir die voortbestaan van die kontinent se ekonomie en ontwikkeling. Verpleegkundiges wat bewus is van faktore wat Afrika vrouens se gesondheid benadeel, kan 'n kernrol speel om vrouens, gemeenskappe, politici en gesonheidsorgbeplanners te motiveer om die faktore aan te spreek ten einde die gesonheid van Afrika se vrouens, en dus uiteindelik van die totale Afrika bevolking, te verbeter.

ABSTRACT

In Sub-Sahara Africa, women perform 80% of the agricultural labour. In addition to this many African women also care for large families, including disabled, sick and old persons on scarce incomes necessitating them to walk long distances to fetch water and firewood and to mill grain. These women also perform most community work, resulting in triple role performances (namely those of producer or performing income-generating work, reproducer - giving birth to and taking care of children, and community work - including participation in church activities and taking care of the aged or less privileged persons in families and in communities). This triple role performance leaves little time, space or money for these women's self-fulfilment, and chronic over-exertion can debilitate many women's physical and psychological health irrespective of the availability of or the lack of health care services.

This article addresses some of the political, economic, environmental and social factors, which may detrimentally influence African women's health. The women's status in the community is especially significant in determining their decision-making powers, with far reaching consequences for their - and their children's - health status. African women's health status is critically important for the survival of their children and their extended families, as well as for the continued existence of this continents economic and general development. Nurses who are knowledgeable about factors influencing the health status of Africa's women, can perform a key role in motivating women, communities, politicians and health care planners to address these factors in order to enhance the health status of Africa's women, and ultimately of the entire African population.

INTRODUCTION

The World Health Organisation (WHO) defines health as a "state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO, 1986:30). Health has also been defined as "... the ability of a system... to respond adaptively to a wide variety of environmental challenges (for example, physical, chemical, infectious, psychological, social)" (Brody & Sobel in Stanhope & Lancaster, 1988:29). This definition emphasises health as a positive process and acknowledges the importance of environmental influences on biological and mental well-being. Both these definitions of health can be applied to women's health, because "health" involves more than the mere absence of symptoms. It might be assumed that women have the same health care needs as men, with additional health care needs related to gynaecological and obstetric issues. Indeed for many decades "women's health" had been equated with gynaecology and obstetrics. Women's health is no longer limited to reproductive organs. The broadening scope of women's health care is a critically important issue in this period of rapidly changing health care systems ... yet attaining holistic care to meet basic needs remains a struggle for many" (Youngkin & Davis, 1998:xii). There are limitations to maintaining a biomedical approach towards women's health issues. Women's health approaches should not only consider the inside of the female bodies, but should "... step outside to investigate the ways in which women's lives can make them sick. Through examining economic, social and cultural influences on their well-being it identifies the major obstacles that prevent women from optimising their health (Doyal, 1995:1). "The total health of the women is crucial for the survival of the child and family, as well as the sustenance of the national economy and development" (Mworia, 1995:80). This paper will attempt to address some political, economic, environ-

mental and social factors, which detrimentally influence the health status of many African women - especially those living in rural areas of developing countries on this continent.

POLITICAL FACTORS

Most of Africa's countries lag far behind other developing countries in improving their health services, often hampered by weak political commitment to health reform and mismanagement of national health systems. Most African governments make promises of improving primary and environmental health care, yet "... they have seldom made the institutional and financial changes necessary to bring it about. Many African governments still devote most of their attention and funding for health to high-priced curative care and relatively cost-ineffective services provided through hospitals ... benefiting a small share of the population" (World Bank, 1995:2).

Donor funds could help to maintain some African countries' health services, but the application of donor funds are often prescribed according to the donors' priorities and do not necessarily address the country's major health care problems. Mismanagement and poor supply of drugs cause many patients not to receive optimum treatment. The World Bank has estimated that in some countries patients get the benefit of only $12 worth of drugs for every $100 spent by the government - due to wastage in buying, transporting, storing, prescribing and dispensing drugs. Most African governments maintain strict centralised control of the health sector, which denies the health care providers the ability to make and implement decisions appropriate to the unique needs of the patients in their areas, unless they manage to go through endless procedures. Improved health care in Africa " ... depends on an overall decentralisation that encourages African households and communities to become more responsible for their own health and more capable of achieving it" (World Bank, 1995:4).

The country's politicians usually establish health care expenditures and priorities. Very few women in Africa concern themselves with political decision-making processes. Thus the health care system, in most African countries, attempts to address health care priorities as determined by the politicians, not by the (rural) women. Politicians, mostly men, decide how much money will be spent on antenatal care, immunisations, clinics and family planning programmes. Politicians also make laws determining or denying women's access to health care. For example, in certain African countries, the husband still needs to give written permission for his wife to undergo a sterilisation, or in some cases even to use contraceptives. Politicians decide, through the laws enacted, whether women can and do have access to abortions on demand or whether they need to resort to backstreet abortionists. Even if the laws permit abortions on demand, it is mainly the politicians who determine whether these services are actually available, accessible and acceptable in any specific area. Globally, governments' primary role should be leadership - identifying and promoting cost-effective approaches to health and facilitating the activities of public and non-government providers (World Bank, 1995:9). Women, especially rural women in Africa, usually do not constitute important political pressure groups because they are not sufficiently organised, educated or mobilised to exercise any pressure on political decision-makers. Thus the health care received by these women might not meet their real health care needs. To compound this problem, most health care workers in rural Africa are female nurses who do not customarily resort to political pressures because they are women and nurses. Unless health care workers, especially nurses, alert political decision-makers to the real health care needs of their respective rural areas, it is unlikely that rural African women will receive the health care they require. If nurses could become politically more knowledgeable, they might succeed in helping the rural women to voice their collective health care needs. In this way nurses would be able to render meaningful contributions towards enhancing the health care received by rural women, but also towards empowering these women to realise future needs.

However, the greatest political impact on Africa's rural women's health relates to the continued wars waged throughout many countries of the continent. Wars prevent food and medicines from reaching rural communities and disrupt communications to such an extent that the authorities might not be notified about an epidemic in an area until many unnecessary deaths (for example from measles or cholera) have occurred. Warring countries allocate inadequate budgets to health care - and even these amounts are spent on caring for the sick and wounded soldiers rather than on the country's women's and children's health needs. Many rural women care for the men disabled during wars - adding to their workload. Wars disrupt families and frequently necessitate rural people to leave their fields and livestock - their only food supplies - to flee to other areas or even other countries adding to their hardships and debilitating their health status. Unless wars decrease, it seems to be unlikely that the health of Africa's people can begin to improve irrespective of the amounts of foreign aid and services received.

ECONOMIC FACTORS

National economies

Per capita expenditures on health in Africa was averaged at $14 during 1995 but ranged widely. (Nigeria and Zaire spent $10 whilst Botswana and Gabon spent $100) (World Bank, 1995:7). Many African governments reduce their per capita health expenditures. Such measures will make it impossible to render health to all by the year 2000. Obtaining and managing user fees effectively could help to ensure the financial sustainability of health services.

Household economies

According to an UNESCO study women do two thirds of the world's work, earn 10% of the world's income and only own 1% of the world's wealth. In sub-Saharan Africa (SSA),

women are the major agriculturists accounting for 80% of Africa's agricultural production (Mworia, 1995:80). In addition to this heavy physical productive agricultural work, African women also need to fulfil their reproductive roles in rearing and raising families, tending to the sick and elderly, collecting firewood and water, and milling maize to prepare the family's meals. "The total health of the women is crucial for the survival of the child and family, as well as the sustenance of the national economy and development" (Mworia, 1995:80). Community projects are usually carried out by women - leading to triple role performances by many African women, exhausting them both physically and mentally and "... leaving them little time for self-care and for self-development" (Goosen & Klugman, 1996:2).

At the household level, economic stringencies determine where the family lives, what they eat and whether they have access to clean water and sewage systems. In Zambia an estimated 30% and in Botswana 35% of women live and raise their families in rural areas, whilst their husbands work as migrant labourers in cities - often in the mines of the Republic of South Africa (RSA) (Fair, 1992:34, 59). These migrant husbands may or may not send money to their rural wives, and may or may not "accept" other wives in the city. This situation leaves the rural women in a financial predicament. Very few of them can depend on receiving regular financial help from their urban-based husbands. This leaves the rural women of Africa without money, without work, with a huge work overload of fetching water, firewood, tilling the fields and tending to their children as well as to their aged parents. They work long hours, have poor transport, poor markets, poor housing, poor access to health services and poor prospects for an improved future - aggravated by chronic illness, multiple pregnancies, malnutrition and parasitic infestations.

Because of financial stringencies girls often need to drop out of school to help sustain the family. This perpetuates the cycle of economic hopelessness for Africa's women and girls. The only way to achieve a radical improvement in the lives of most rural African women would be to enable them to improve their (and their daughters') education, to assist them to earn their own cash on a regular basis, to gain access to credit to engage on more profitable farming and commercial ventures, to become full members of agricultural co-operatives, to own land, and to own and manage their own bank accounts.

African women need sustainable incomes to have at least an improved level of household food security for themselves and their families. This would seem to be the first prerequisite to enable African women not only to improve their own and their family's economic situation but also their health status. A good starting point would seem to be to expand the household production and marketing of woven baskets, grass mats, pottery and wood carvings. However, it seems unlikely that the already overburdened rural African women could have time and energy left for performing such additional work. Small beginnings could be co-ordinated by an agency, such as a women's co-operative, buying any surplus items from rural women, and selling them at tourist outlets. Once rural women start earning their own cash, independently from their husbands' fields and/or salaries, they can be helped to become empowered, not only economically but also socially. Women could take turns to sell their produce; to look after all the small children; to cook a communal meal once per week enabling the other women to make items for sale. Once money is available, women might be able to afford to buy fuel, or even gas burners, which will save them many hours of backbreaking work collecting ever scarcer firewood.

Economic empowerment will enable African women to make independent decisions benefiting their own and their family's health. Destitute women, totally dependent on their husbands' goodwill for their own and their children's survival, cannot make any decisions without their husbands' prior approval. This implies that poor African women cannot use contraceptives, cannot insist that their husbands use condoms, and cannot complain if their husbands are alcoholics, abusers or have polygamous marriages and/or extramarital affairs. Only through the economic empowerment of Africa's women, can these women's health status be improved.

Economic stringencies also affect health directly. African women, overburdened by the triple role fulfilment obligations, hardly ever have time or money to visit a clinic or a health service - they simply cannot afford the transport fees, clinic fees, medicines or medical tests. Thus an unknown number of African women could suffer from malaria, onchocerciasis, worm infestations, tuberculosis, carcinomas and even AIDS without being diagnosed. The lack of finances prevents many African women from seeking medical help, which could probably account for the popular saying throughout the continent that "African women do not get sick, they simply drop dead". Health care workers who are aware of this issue, should co-operate with other community workers and with the rural women themselves in making health care accessible to rural women.

AGRICULTURAL FACTORS

The rural areas of sub-Saharan Africa accommodate 75% of its population, approximately 470 million people, which doubled since the 1960s (Fair, 1992:1). Most African countries depend primarily on the rural economies to feed these nations and to supply export commodities. Governments which overvalue their currencies, make exports expensive and less competitive with those of other regions, reduce the export demands, including the demand for exported agricultural products. Governments depend primarily on urban votes to remain in power. Rural people (especially women) often do not vote and are usually too poorly organised to participate in any political activities. Thus most African governments fall victim to "feeding the urban masses whilst starving the rural farmers", by paying poor prices for foodstuffs so that the urban voters can obtain reasonably priced foods.

Agriculture in Africa is subject to numerous hardships such as poor soil, irregular rainfall, very few permanent water sources, only three navigable rivers, few harbours, poor railways, poor roads, poor transport, poor communications and numerous parasitic infestations of both man and animal. Traditionally African women cultivated food for the household and men cultivated crops for sale. However, when the colonialists introduced mining, many men became migrant labourers, leaving the fields to the women to cultivate. When the colonialists introduced cash crops, the situation of most African women deteriorated. The cash crops can usually only be sold through agricultural co-operatives allowing only men to be registered members in many African countries. Thus the situation can, and does, arise where a woman cultivates cash crops at great expense to her physical abilities and often her health, only to have the financial returns paid to her husband - who is the co-operative member. This money does not necessarily come back to the hard-working wife and her children, but might be spent on luxuries such as watches, radios and "city women". Growing of cash crops could thus actually reduce the household food security situation of many rural female-headed households - if the women are forced to cultivate cash crops at the expense of food crops. Health care workers, agricultural extension officers and rural women should co-operate to enable the rural women to cultivate the most nutritious foodstuffs for their families suitable to their specific fields. In order to enhance the health status of Africa's rural women and their children household food security should be promoted by cultivating maize, beans and vegetables rather than growing cash crops such as cotton, coffee, cocoa and tobacco. Rural women also need to be informed about the correct ways of storing food supplies, and about the most nutritious ways of preparing food. Such knowledge could help to combat malnutrition in many parts of the continent. However, communication problems seem to persist because most agricultural extension officers are men, wanting to share their knowledge with other men, not women who constitute the majority of Africa's farmers. Women might resist attending agricultural meetings because of lack of time, transport and finances but especially because they regard these to be "men's meetings". Health care workers and agricultural extension officers could overcome this problem by offering combined health and agricultural education sessions for specific communities. Rural women with more knowledge about agriculture and about food preparation and storage could become more empowered women - benefiting their health status as well as that of their children.

ENVIRONMENTAL FACTORS

Clean water, sewage systems and rubbish disposal

A Kenyan health worker reportedly said: "The most effective way to empower women is to give them freedom. To give them freedom, give them water - clean water" (Goosen & Klugman, 1996:13). In Africa many households do not have access to safe clean drinking water, toilets and waste disposal. Women have to walk long distances to collect water usurping much of their time and energy. Carrying buckets of water on their heads cause musculo-skeletal problems and strained ligaments. Long journeys on foot to collect water, make women vulnerable to robbery, assault and rape. Girls sometimes have to miss school, or neglect doing their school work, in order to help collect the family's water. In many rural parts of Africa, it is not unusual to see a group of women washing their laundry, herds of animals drinking water, children urinating and defecating, and women collecting drinking water - all from the same stream. "Polluted water, insufficient toilets and inadequate rubbish removal systems lead to diseases such as typhoid fever, cholera, diarrhoea, dysentery, hepatitis, polio, skin and eye infections and intestinal worms" (Goosen & Klugman, 1996:17).

All these conditions can permanently impede a woman's health and her quality of life, as well as her earning capacity. Although timely diagnosis and treatment can help these sufferers recuperate, the environment will cause them to fall ill again with the same or another disease attributable to the unhealthy environment in which they live. Thus the cure for these diseases lie in their prevention by cleaning up the environment - which needs manpower, money and will-power from the inhabitants, as well as from the authorities. Health care workers should strive to co-operate with other community services, such as the security services, the schools and church organisations to attempt specific cleaning sessions preceding environmental upgrading efforts.

Political mobilisation to acquire safe, clean water supplies for a specific community, might be the most empowering and health promoting step any rural community could embark upon. Unhealthy water supplies pose a major threat to Africa's rural people, especially the women and children.

Parasitic infestations

Approximately one million children in Africa die annually from malaria (Elliot, 1994:25). Estimates reveal that one-tenth of the world's population suffers from parasitic diseases. Poor farmers cannot farm along the fertile banks of certain rivers because they are infested with black flies causing river blindness. Tsetse flies occur in vast areas of Africa's surface, killing men and animals and making large areas unsuitable for farming. Schistosomiasis (bilharzia), occurring along many African rivers and irrigation canals, is a major cause of liver and urinary tract infections and of carcinoma of the bladder. Parasitic infestations exact huge costs in treatment and prevention programmes. Few drugs are effective against parasitic infestations, and often these drugs cause serious side-effects. Parasites do get resistant to drug treatments. Drugs against tropical diseases comprise only one percent of the pharmaceutical market's profits. Consequently there are few economic incentives in researching and expanding the range of anti-parasitic drugs (UN Chronicle, 1992:50). Numerous other parasitic infestations can debilitate Africans, especially childbearing women who suffer from

intestinal parasites. Even if parasitic infestations do not kill their victims, they cause severe debilitation, reducing the person's quality of life and impeding their physical productivity, decreasing their potential incomes, and further debilitating their health by the resultant malnutrition.

Nutrition

African women frequently have to grow food and/or make a living in deteriorating environments. Exhausted soils yield smaller crops each year. Scarcity of firewood may necessitate families to have a cooked meal only every second or third day, and to eat foods requiring less cooking, but which are also often less nutritious. "Malnutrition underlies more than one-third of infant and child mortality in rural and urban districts of many African countries... and 20 to 80 percent of maternal mortality. Protein-energy malnutrition, nutritional anaemia, vitamin A deficiency, and iodine deficiency disorders have been identified as the most serious problems" (World Bank, 1995:32-33). These nutritional problems could be readily addressed by effective district based nutritional health education sessions followed by the supplying of basic supplements, such as kelp pills to remedy iodine deficiency, supplemented by the everyday use of iodised table salt. Shopkeepers should be encouraged to sell iodised salt. Co-operation between health and agricultural workers can go a long way towards helping families to grow their own food gardens. However, in areas where water needs to be carried to the gardens, the additional burden on the women might be intolerable.

Health care workers can identify and help to remedy many factors contributing to malnutrition among rural people - adding quality to the lives of such people.

SOCIAL FACTORS

Factors affecting women's health are numerous and diverse, but social factors might be equally important to political or economic issues. It is impossible to illuminate a complete list of social factors, but the following social issues definitely affect the women of Africa's health.

Women's status in society

The status of women in African societies vary from country to country, culture to culture and even village to village. However, general trends affecting women's health can be identified across the continent. Many health improvement and health education efforts in Africa fail to achieve results because they are directed at women. Such efforts might meet with more success if they consider the familial, social, and cultural environment within which the women live. Usually the husband, sometimes the mother-in-law, and sometimes the whole family group are the decision-makers, not individual women. It seems worthless to direct education efforts at women who have limited decision-making powers, especially concerning sexuality and procreation - often regarded as being family and/or community affairs (AbouZahr, Vlassoff & Kumar, 1996:451).

Generally African women's status is regarded as being inferior to that of African men. Women of inferior status cannot and do not make decisions affecting their own and/or their family's lives. Thus uneducated poor women, dependent on their husbands for their livelihood, cannot oppose their husbands' wishes concerning the number of children, at the risk of losing their only source of financial support for themselves and for their children. The issue of women's status in society is very intricate. At the risk of oversimplification, only selected aspects will be addressed.

Payment of bridal prize (lobola)

In most African cultures, the prospective husband has to pay a price to his chosen wife's family, formerly usually a specified number of cattle, but currently it is often cash. Having paid for his wife, the husband might regard her as any other possession he has bought, paid for, and thus legally possesses. Consequently, not only does the wife in such a traditional marriage have no status, but also no say concerning the number of children to be born. Indeed in some traditional cultures, it is possible for the husband to reclaim the bridal price if the wife is unable to bear children. In many cases the man can insist that the woman prove her fertility by bearing a child, or even children, before marriage. "In African culture children are an anchor in a marriage relationship. They give dignity and status to the couple as parents, and also give them a purpose in life. As a result a marriage can never be complete without children" (Pretorius, 1994:19).

This problem is exacerbated in Kenya where girls marry as early as between 12 and 14 years of age. Some girls are even betrothed at the age of six (Kadandara, 1994:30). This issue of "proven fertility" of women, makes adolescents wary of using birth control measures lest it should make them infertile. Adolescent pregnancies precipitate a vicious cycle of poor education, joblessness, poverty and often prostitution to survive.

Effective utilisation of family planning techniques can definitely help girls and women to plan when to have their children and to plan their lives not to be destined to poverty and hopelessness. However, family planning (or family spacing) programmes need to be offered with sensitivity to cultural issues to make any impact whatsoever on the lives of rural people.

Polygamy and Promiscuity

Polygamy continues to be an accepted practice in many African communities. In polygamous marriages, the wife mothering the largest number of children is likely to be the husband's favourite wife. Consequently, a woman in a polygamous marriage is unlikely to practise birth control and thereby jeopardise her position of being or of becoming the husband's favourite wife.

Pretorius (1996:25) reported that African men do by and large engage in extra-marital affairs because they claim that men have insatiable sexual needs. In cases of infertility, or

even small families of one or two children, the husbands can engage in extra-marital affairs because they want more children. Within a traditional African framework a man is never regarded as infertile (except perhaps when he is impotent); it is the woman who is infertile and who is made to feel unhappy, guilty and depressed (Pretorius, 1994:19).

Women who want their partners to use condoms have to rely on these partners' goodwill to do so. Female condoms are not yet freely available in many African countries. This facility might enable more women to practise safe sex if the women can make decisions concerning the use of female condoms.

African men regard it as their marital right to demand sex without condoms from their wives. No research could be traced documenting the use of condoms among South African men of various races. However, it is common knowledge that unmarried women do accept condoms at clinics and proclaim to insist that their partners use them. Married women generally refuse to be seen with condoms - because that would give their husbands cause to doubt their fidelity. On the other hand, men generally do not seem to demand fidelity from themselves - only from their wives - because men do accept condoms at clinics. This cultural practice condoning the use of condoms for all men but denying their use by married women, increases the risks for married women to get infected with HIV/AIDS.

Female circumcision (Female genital mutilation - FGM)

It seems ironic that while society at large seems to condone men's promiscuity, many communities continue to practise female circumcision to "...dampen women's sexual desire and vulnerability to sexual temptation ... Girls grow up knowing that circumcision is essential if they are to some day be considered fit to marry, find a man willing to marry them, and raise a family" (Morris, 1996:46).

Female circumcision takes on more and more significance as circumcised African women travel to and seek medical aid in Western countries, unfamiliar with this practice, and usually considering it to be abusive to the women concerned. Almost 84 million women world-wide have undergone female circumcision leading to lifelong morbidity, reproductive hazards, the potential to become infected with HIV due to unhygienic surgery, and even the risk of dying. Most circumcised women live in Africa where they undergo the procedure between the ages of 1 and 13 years of age - depending on the country (Mworia, 1995:213). An estimated 6 000 girls are circumcised daily in at least twenty-six African countries. There are basically three types of "surgery" performed depending on the specific culture. In the first type the clitoral hood is excised but the clitoris and labia minora are preserved (practised in Kenya); in the second type a clitoridectomy is done and adjacent parts of the labia minora are removed (practised in Liberia); and in the third type a clitoridectomy is done together with removal of the labia minora and the medial parts of the labia majora and thereafter the two sides of the vulva are sutured together leaving a small opening for the passage of urine and menstrual flow (practised in Somalia, Sudan, Mali and northern Nigeria). A most surprising fact is that women, especially elderly women, are proponents of the continuation of this practice - in order to comply with societal expectations and for pleasing the men in their lives (Morris, 1996:43-45).

Total fertility rates

The rate of population growth on the African continent exceeds 2%, but the total fertility rate is reported to be 4,2 for the RSA and 7,6 for Malawi (Cornwell, 1996: 35-37).

"Africa is a continent of exceptionally high fertility and very low contraceptive use. In 1992 the total fertility rate ... was approximately 6.5, compared to 3.6 for all developing countries. Contraceptive use rates were only 11 per cent on average, compared with approximately 51 per cent for all developing countries and 71 per cent for the industrial countries" (World Bank, 1995:20). In Kenya and Senegal, women spend 47 % of their reproductive years, between the ages of 15 and 49, either pregnant or breast-feeding. This impairs the women's mental and physical wellbeing when they should be at the prime of their productive lives (Mworia, 1995:212). If this high fertility rate is viewed against the background of hard physical labour, poor nutrition, poor environmental conditions and poor access to health services, it is not surprising that the maternal mortality rate of 686 per 100 000 births in Africa is twice as high as in all low-income developing countries (308 per 100 000 births) and six times higher than in the middle-income developing countries (107 per 100 000 births) according to the Word Bank's report (1995:12-13).

"The phenomenon of population momentum and the current inevitability of high population growth have serious socio-economic implications. The requirement in terms of infrastructure, physical facilities and services are tremendous, so that the population explosion could be regarded as the main factor inhibiting development in African countries" (Cornwell, 1996:46).

Effective utilisation of birth control measures requires some knowledge about bodily functions which few African women, especially in the rural areas, possess. Birth control facilities, such as pills, injections and condoms, need to be available which is often not the case in Africa where these facilities might only be regularly available in large cities and towns whilst the majority of the women live in the rural areas.

Tribal security

The populations of most African countries do not identify with the national political entity, but rather with the tribes. These tribes are sensitive about their relative power (measured in terms of numbers) in the political hierarchy. Therefore there is tribal opposition to birth control practices among its women. Indeed Gould (1984:96) claimed that some communities could regard family planning programs to be "... a disguised form of genocide".

Tribal issues also affect health care workers offering family planning services. If nurses from one tribe offer family planning services to women of another tribe, it could be interpreted as efforts to reduce the numbers of the other tribe. If nurses and clients are from the same tribe, they could fear retaliation from family or village members.

Religion

Religions disempower women to make and implement decisions, including those affecting their own and their family's wellbeing. Islam tends to restrict the rights and status of women leaving men to decide about the number of children for the family. Roman Catholicism, practised by many African communities, opposes modern methods of birth control. This religion approves of the rhythm method but this could be a most problematic method to practise effectively in Africa where large numbers of men are migrant labourers.

Age of the African population

The United Nations Organisation (UNO) estimates that more than 45% of Africa's population is below the age of fifteen years. Demographically this means that a momentum for future growth is built into the population structure. Even if the fertility rate should be brought down to two births per female, the African populations will continue to grow for another fifty years. This implies that even if fertility rates were to drop to replacement levels now, Africa's population will still grow by a further 80 to 100 per cent as a result of the momentum generated by the youthful population structure (Goliber **in** Cornwell, 1996:44). This aspect poses daunting challenges to be overcome by the health care system of any African country.

Unless African women can be empowered to make decisions concerning health and family planning issues, and unless they can help their daughters to get some education and earn their own money, the health of African women can only decline with such a projected population growth.

The abortion debate

This debate is generally divided between those who believe that abortion on demand is every woman's right and those who regard abortion as committing murder. Whatever position the health care services might adopt in a specific country, it needs to consider that incomplete abortion patients, suffering mainly from haemorrhage and/or septicaemia occupy the majority of gynaecology beds in many hospitals. The aspect, which needs the most urgent attention, is that almost all patients suffering from abortion complications had not used an effective method of contraception prior to becoming pregnant, especially adolescent patients. Reasons for not using contraceptives include fears about the safety of contraceptives, lack of knowledge about family planning techniques and facilities, and lack of access to services. Research about post-abortion contraception appear to be almost non-existent (Benson **et al.** 1996:117-123).

CONCLUSION

It is a well accepted typology in Africa that disease creates poverty and that poverty maintains the conditions that foster disease. Consequently poor people are often sick people. Attempts to solve Africa's health problems have failed to appreciate that socio-economic-political and health care measures must to some extent operate in tandem. Urban-based curative-orientated health services do not succeed in addressing the health care needs of the African women, most of who live and work in rural areas (Macgregor, 1991:174).

Finally and fundamentally the success of improving the health of women in Africa depends on empowering the African women to make their own decisions. Such empowerment will require socio-economic upliftment; increased financial independence of women; improved education for women and access to health care, including family planning (spacing) services. The common challenge is for women to improve their health status and reach their full potential. Women should value themselves and other women, become aware of their rights and claim these rights for themselves and for their daughters in predominantly male-defined health care systems prevailing in many African countries. "In the end, it isn't doctors that make women sick or healthy. It is the reality of their daily lives ... it is how society (and men) treat them that is the central issue. Instead of starting with diseases and looking for their causes, we need to start with women's daily activities and assess their potential for providing or destroying women's health" (Doyal **in** Goosen & Klugman, 1996:2).

In conclusion, a quotation from Margaret Sanger - a founding member of the Planned Parenthood Federation - aptly advocates the need for women to become independent decision makers. "A free race cannot be born of slave mothers. Women enchained cannot choose but give a measure of that bondage to their sons and daughters. No woman can call herself free until she can choose ... whether she will or will not be a mother" (Sanger **in** Roberts & Group, 1995:69).

LIST OF REFERENCES

AbouZahr, C; Vlassoff, C & Kumar, A 1996: Quality health care for women: a global challenge. **Health Care for Women International,**17(5): 449-467.

Anderson, R 1996: Magic, science, and health. The aims and achievements of medical anthropology. Fort Worth: Harcourt Brace.

Asthana, S 1996: Women's health and women's empowerment: a locality perspective. **Health & Place,** 2(1): 1-13.

Akerele, O 1984: WHO's traditional medicine programme: progress and perspectives. **WHO Chronicle,** 38(2).

Benson, J; Nicholson, LA; Gaffikin, L & Kinoti, SN 1996: Complications of unsafe abortion in sub-Saharan Africa: a review. **Health Policy and Planning. A Journal of Health Development,** 11(1): 117-131.

Cornwell, L 1996: Development Administration I. Study Manual 2. Tutorial Letter 107/1996. Pretoria: University of South Africa.

Cornwell, L 1995: Dynamics of development. Reader for OAD100-R. Pretoria: Unisa.

Doyal, L 1995: What makes women sick: gender and the political economy of health. London: MacMillan.

Elliot, JA 1994: An introduction to sustainable development. The developing world. London: Routledge.

Fair, TJD 1992: African rural development: policy and practice in six countries. Pretoria: Africa Institute of South Africa.

Goosen, M & Klugman, B 1996: The South African women's health book. Cape Town: Oxford University Press.

Gould, KH 1984: Black women in double jeopardy: a perspective on birth control. **Health and Social Work** 9(2):96-105.

Kadandara, J 1994: Women's health: a must for development. WHO: Global Commission on Women's Health.

Lewin, E 1985: Women, health and healing. London: Tavistock.

Macgregor, J 1991: Towards human-centred development: primary health care in Africa. **Africa Insight,** 21(3): 145-152.

Morris, R 1996: The culture of female circumcision. **Advanced Nursing Science,** 19(2): 43-53.

Mworia, K 1994: Gender issues and reproductive health. (**In** Cornwell, L **ed.** 1995: Dynamics of development. Reader for OAD100-R. Pretoria: Unisa.)

Pretorius, C 1994: Infidelity in African culture. **Siren News: Unisa Centre for Women's Studies Newsletters,** 2(1): 19.

Pretorius, C 1996: Women's vital role in culture, the family and socialisation. **Siren News: Unisa Centre for Women's Studies Newsletters,** 4(1): 25.

Roberts, JI & Group, TM 1995: Feminism and nursing: an historical perspective on power, status, and political activism in the nursing profession. Westport: Praeger.

Stanhope, M & laancaster, J 1988: Community Health Nursing: process and practice for promoting health. St Louis: CV Mosby.

UN Chronicle 1992: Tropical diseases: scourge of the South. **UN Chronicle**, September 1992: 50-51.

World Bank 1995: Development in practice: better health in Africa. Experience and lessons
learned. Washington DC.

World Health Organization 1986: Basic Documents, ed 36. Geneva.

Youngkin, EQ & Davis, MS 1998: Women's Health: a primary care clinical guide. Stamford: Appleton & Lange.