Rural Women and Health

by Caroline Ntoane

This paper firstly examines how the status of women in rural communities is defined for them by patriarchy and sexism. The second part of the paper examines the consequences of the low status of women for health and health care. Lastly, measures to improve the health of rural women are suggested, using a holistic approach.

Women in rural areas

Women are discriminated against in all areas of life, even as young girls in the home. This extends to discrimination in the allocation of resources at school, at institutions of higher learning, at work, and in society in general. The situation is worse in rural areas, where women are at the base of the economic pyramid because of the added problem of scarcity of resources and more rigid sexist practices (1).

The role and status of black women in rural communities in South Africa should be understood historically. In traditional societies land was communally owned but controlled by the male heads of society. The chiefs allocated land to the male heads of households who, in turn, allocated small portions of land to their wives for subsistence production. With their children, women provided labour for their husbands on the pieces of land allocated to them.

During the colonial period, in particular from the time of Union (1910) onwards, black communities were systematically uprooted from the land. The African population was shifted into areas which were often less productive. They were only allowed to produce their own crops in these areas which were later called "homelands" by the Pretoria government. Men were forced to sell their labour for cash on the mines and in the cities. This was the beginning of a migrant labour system characterized by disruption of family structures. In terms of influx control regulations, women were prevented from going to live with their husbands in the cities. In effect many women were forced to maintain their role as producers on the land.

The people in the rural areas, a large proportion of whom were children, women, or

elderly folk, became increasingly impoverished as more and more of them were forced into the reserves.

Socialization into sexist roles

The subordinate position of women is reinforced in our day to day lives. Socialization into sexist roles first begins in the family during childhood. Attitudes, for example, about who should do the housework, are learnt by us as children during our formative years. When we are asked to explain these attitudes, we say that it is "nature".

Often it is men who decide what is "normal" female behaviour. They may expect the woman to unquestioningly obey their authority and refuse to recognize her as an independent human being.(2)

Consequences of the low status of rural women

The adverse socio-economic, cultural and political context weighs more heavily on women than men and thus exposes them to burdens that men do not face;

1. Educational Status of Rural Women

Because of their low educational status, rural women have less access to vital information regarding their legal rights, health care and other opportunities. Furthermore their cultural beliefs and attitudes inhibit their participation in the non-domestic macro levels.

2. Migrant Labour and its Consequences for Health

Women get involved in activities which physically deplete them such as plowing, hoeing, harvesting, building of houses and carrying wood. At the same time they have to take responsibility for looking after the household, as well as young children. These activities make them more vulnerable to disease and premature death. (3)

Maternal mortality is a particular risk for rural women because of the physically draining activities listed above. Combined with poor nutrition and isolation from antenatal services, the chances of low birth weights, haemorrhaging, and death are great.

The migratory labour system does not only disrupt family life, but also affects the health of men, women and children. Sexually transmitted diseases (STDs) are a huge problem in rural areas, with resultant infertility for men and women as well as congenital syphilis and gonorrhea in young children. (4)

The level of STDs in rural areas are not only a consequence of sexual behaviour

patterns conducive to their transmission. Cultural beliefs also inhibit people from seeking treatment for them. The stigma attached to STDs is greater for women, due to beliefs which associate STDs with manhood, whilst regarding it as immoral for women to have them. Consequently, rural women are at great risk of HIV infection. This is further aggravated by their lack of control over their lives.

3. Utilization of Health Facilities

Even when health facilities are physically available poverty limits people's access to them. In some rural areas, for example, traditional birth attendants are the only affordable source of maternal health care. They will probably continue to be the foundation of maternity services, as long as poor transport and lack of money are the rule rather than the exception. (5)

4. The Law guiding Abortion in South Africa

The Abortion and Sterilization Act 2 of 1975 in South Africa allows abortion only under certain circumstances. (6) Many women are so desperate to end unwanted pregnancies that they seek illicit and dangerous abortions.

5. Relocation of Rural Communities

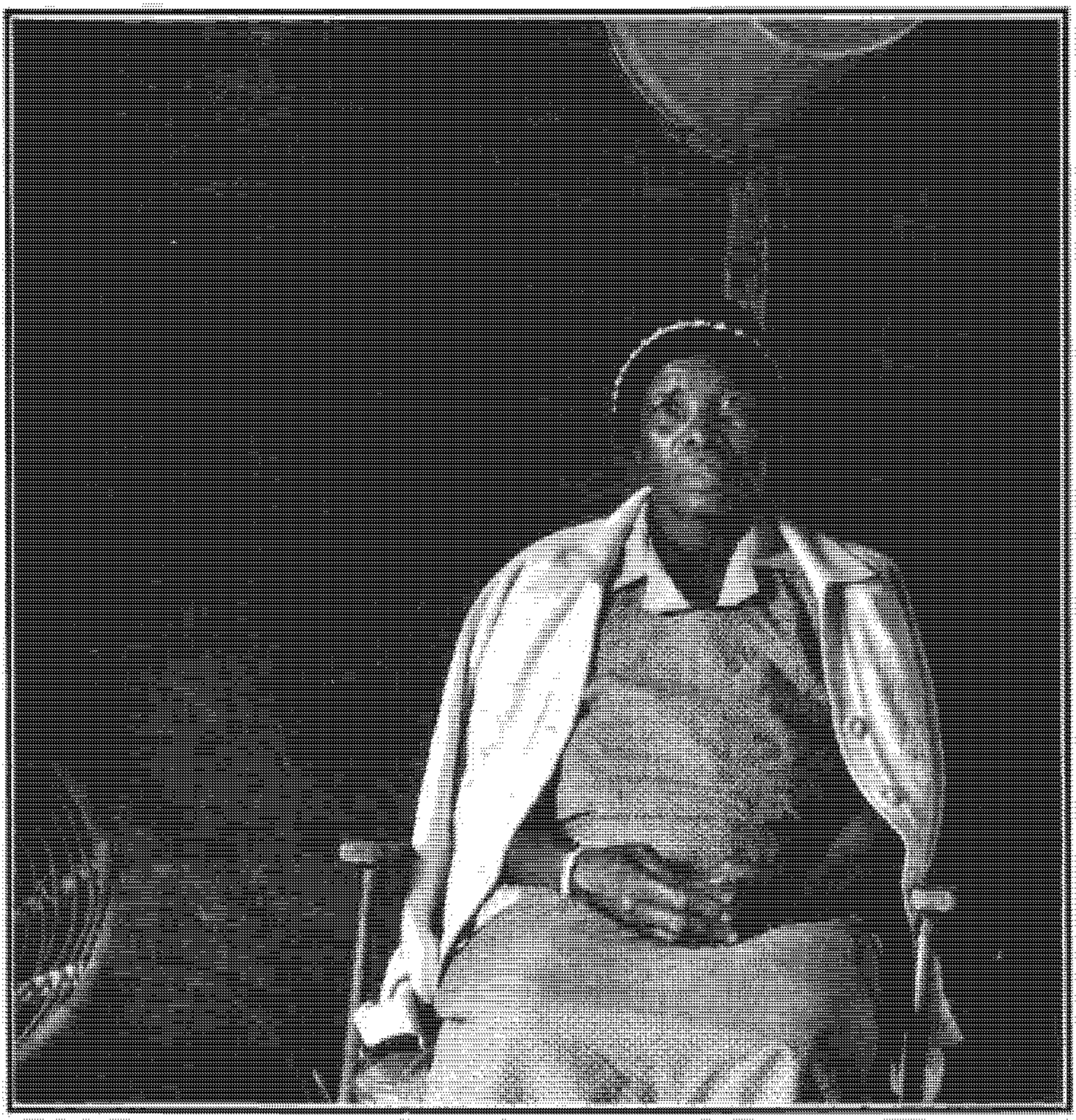
Poverty, malnutrition and ill-health among the rural women and children in South Africa have been exacerbated by the relocation of communities.

Recommendations for a future health care system

To make recommendations for rural women exclusively, would seem to endorse their already assigned subordinate status. The following recommendations are therefore presented comprehensively.

1. Reallocation of available resources

A great challenge lies ahead for donors and national leaders alike, in reallocating available resources to meet the needs of those who need them most. The national budget that favours high cost, high tech curative care for a small urban elite, should be redirected to low cost preventive measures which are desperately needed by the rural poor (7). To overcome the problem of limited resources, communities must be mobilized to define their health problems, and to find solutions to them.



Woman in resettlement camp – resources need to be redirected to those who need them most.

2. The primary health care approach

A commitment to the primary health care approach is essential. This recognizes that health is not just the absence of disease and that the provision of adequate and accessible health services is the responsibility of the state. Primary health care systems and family planning services must include indigenous based health education packages which should aim at:

- legitimizing and demystifying the idea of family planning
- providing information regarding specific methods of family planning, and allowing a wide range of choice. This should include the training of traditional birth attendants. There should be full governmental support and recognition for them from midwives.
- encouraging behavioural practices conducive to good health, such as use of condoms and responsible sexual behaviour
- raising awareness of the risk factors for specific maternal diseases and how they can be prevented
- educating families about the importance of nutrition
- educating people about the spread of AIDS and the concept of safe sex.

3. Literacy, employment and equality

The situation can be altered only if within the overall strategy of development, women are no longer subordinated. Due attention should be given to female literacy and employment.

In addition the legal system should be revised to enhance equality between men and women regarding:

- marriage contracts and divorce
- ownership of property

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