"HOMELAND" WOMEN

This article aims to explore conditions which lead to health problems for women in the bantustans. It will examine the conditions of rural women's daily lives, as well as the social, economic, and political context that shapes their lives. For health problems of rural women arise directly from the conditions of their lives.

In the bantustans the majority of the adult population is female. This is no accident. The entire system of influx control and the pass laws are geared to keep women in the rural areas so that the migrant labour system remains intact. As government commissions have pointed out time and again - if the women come to town there will be an increasing necessity for the provision of family housing, schools and hospitals to provide for the needs of an urban working class. The maintenance of families in bantustans has also been a convenient rationalisation for low wages paid to migrant workers.

Despite this women have not stayed trapped in the bantustans. They have come to towns to look for work and to live with their families. But as the pass laws have become more strict and unemployment has become worse and worse - it is harder for women to leave and they are forced to survive as best they can.

The bantustans are overcrowded; their agricultural capacity is pretty well exhausted. There are enormous problems of landlessness; there is virtually no work for people. And this situation stands only to become worse. The apartheid dream of stemming the rate of urbanisation may have well become true. The latest population census shows that more and more africans are in bantustan areas.

So from the start, women in the rural areas have to grapple with an environment that is hostile to them. Poverty, unemployment and landlessness define their lives. And the illnesses and diseases that they suffer are a direct reflection of this.

Let us look at this more closely:
Women in rural areas have very heavy, and often very lonely responsibilities. They are the adults who have to bring up families and care for the aged. They have to feed and clothe them, have to look after their health. But as most women know, to obtain food, or the cash to buy it is in itself a major battle. In conditions of extreme poverty, it is often the adult women who go without and starve themselves rather than their families.

Apart from diseases directly related to malnourishment and stress, this situation is one of extreme stress. Tension-related illnesses and mental breakdowns are the outcome. The daily lives of rural women are also physically very hard. By far the majority of rural villages do not have piped water, or adequate roads. Many women spend large parts of their day trudging up and down stony hills to fetch water, find wood, go to the trading store, or get to the main road to catch a bus. And these are tasks that are often carried out by very young, or very old women.

Agricultural work too is very heavy. Apart from cultivating their own land - if they are lucky enough to have any - the agricultural labour force is increasingly female. Work for white farmers is not pleasant. The pay is low - sometimes not even a rand a day for 12 hours work. There is no security for the farmers prefer to pay their labour on a daily basis; there is no midday meal provided; there is no protective

clothing; and there is no legal protection at all for farm-workers. Worst of all, the way the recruiting operates sometimes forces women to turn their families into child labour. A woman with a child is far more likely to get a day's work than a woman alone.

As far as medical services are concerned, the situation can at best be described as bleak. Medical facilities are not free. And in situations of desperate poverty, the ± R3 needed for hospital attention, the ± R1 for the clinics may mean that people put off attending to their sicknesses for as long as possible. The hospitals and clinics that do exist are overcrowded and understaffed. The long distances that have to be travelled to get to them also mean that people do not seek medical attention lighty. Most serious for women is that this general situation applies to maternity care. Delivery and ante-natal care are costly and beyond the reach of many.

Apart from, the attitude of health workers towards women, is

in itself problematic. Endless lectures about balanced diets regular examinations and sanitation are a joke in conditions of extreme poverty. Rural women, like their urban sisters, often end up feeling that it si they who are totally responsible for both their own illnesses and those of their family.

Lastly the rural power structure militates very heavily against women being able to control any aspect of their healtl needs and care. Tribal authorities are male only. They are an elite grouping who often act in their own interests rather than those of the majority. Issues such as the siting of clinics and dams are ones crutial to the health of rural people. Women have no say in these decisions - particularly the poorest who need them most.

The depressing nature of the situation is in many ways overwhelming. But the health of rural women and indeed all rural people, is something that has to be fought for - not through charitable stop-gap solutions - or through 'gifts' from the authorities, but through grassroots organisation and educatior that can mobilise people to develop their own alternatives, and challenge the bases of the system that perpetuates their exploitation, oppression and ill-health.

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