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W O M E N & H E A L T H

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Concerned Social Workers
and
The School of Social Work
University of the Witwatersrand, Johannesburg

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SOCIAL WELFARE POLICY IN NATIONAL RECONSTRUCTION AND SOCIAL DEVELOPMENT

21st and 22nd June, 1991

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Editorial

Women provide fundamental but often unrecognised contributions to the functioning of our society - as mothers, home-providers and in many cases in South Africa as the sole bread winners. Despite this, women seem to have poorest access to society's resources. They are employed in the lowest wage areas, they have the lowest literacy level and the least access to education. These factors place heavy demands on women and can undermine their physical and mental health. Yet the health services tend to concentrate on women's needs as prospective childbearers almost to the exclusion of other health needs. In this edition we have chosen to concentrate on the range of health problems women face and to link them to those broader issues that determine women's health. A healthy society is not obtained by improving health services alone. Women's status in society needs to be addressed in all spheres; political, legal, economic and cultural.

Women, Health and Reproductive Rights

Historically, the health care system has approached women's reproductive health in ways that do not necessarilly reflect women's needs. The emphasis has been on control over women, rather than empowering women to control their own fertility and lives.

* In the first article in this edition, Kate Truscott focusses on women's health issues raised at the recent Cosatu Workers' Charter conference. The article argues that women should campaign for "reproductive rights" to be included in a new constitution.
* The second article, by Beverley Oskowitz and Stephanie Moore, looks at family planning in South Africa. The authors argue that women, and their partners, should have access to information, education, and the means, to choose how many children to have as well as when to have them.
* Less than 1% of the total number of abortions which are performed in South Africa each year are performed legally. Helen Rees's article examines the arguments around women's rights to abortion with specific emphasis on the law.
* Discrimination against women as well as their reproductive role affects not only their access to jobs but also the kind of work that they are employed to do. Anne Hilton examines the assumption that so called "women's work" is lighter and less hazardous. She argues for greater choices in the work that women do, and for reproductive, and other health hazards at work, to be addressed.
* While infant mortality rates are unnacceptably high amongst sectors of the South African population, women too suffer high mortality rates as a result of pregnancy and childbirth. Deborah Maine argues that issues around maternal mortality are often neglected. She suggests reasons for this.

Women and AIDS

Two articles in this edition look at the implications of the AIDS epidemic, for women. In particular AIDS is said to threaten women, firstly as individuals, secondly as mothers of children born and unborn, and thirdly in terms of the nurturing role of women in society, which results in women carrying most of the burden of caring for those ill with AIDS.

* Eleanor Preston-Whyte, Quarraisha Abdool Karim and Maria Zondi, look at problems faced by women in protecting themselves, and their children, against AIDS. Issues such as, migrant labour and the resulting separation of families, and the oppression of women, are looked at in relation to the difficulties that women face in negotiating safe sex.

* *Critical Health* interviewed two women who are working in the field of AIDS. They argue that both men and women should bear equal responsibility for protecting themselves and each other against AIDS. Issues to do with prostitution and AIDS are also discussed.

International perspectives

* The third section opens with a look at a recent international conference on women's health, focussing on the issue of violence and women's health. At a time when violence is intensifying in our society, it is important to examine the ways in which it affects women.

* Highly developed capitalist countries have benefitted from the exploitation of the natural and human resources of poorly developed countries. These less well developed countries are now in desperate need of money and find themselves under a lot of pressure to accept loans from international bodies such as the International Monetary Fund (IMF) and the World Bank. The major capitalist powers have a strong influence over the IMF and World Bank who, in turn, only grant loans to governments if they agree to impose harsh economic policies. Structural adjustment is the term which is used to describe these policies.

The article by Nazneen Kanji looks at the negative effects of structural adjustment policies on women. As a result of recent political developments the South African government is likely to be offered more loans than was the case previously. We therefore need to be aware of the implications of accepting these kind of loans.

Multiple Oppression

In addition to class, racial and sexual oppression, rural, lesbian and disabled women, all

experience an additional marginalisation. This is reflected in the health care that they receive.
* Caroline Ntoane ties some of the issues of the health of rural women together. She examines the historical origins of women's subordination in rural society and looks at how apartheid has contributed to the male-female nature of the urban-rural divide.
* While rural women lack health care facilities, lesbian women are faced with anti-lesbian attitudes in society. As a result of these homophobic attitudes of some health workers, lesbians are often reluctant to use health services. GLOW, a progressive gay organisation, examines these problems.
* Disabled women are also discriminated against by our health care system. They are treated as people who do not have ordinary needs and expectations in relation to their sexuality, childbearing and marriage. This has implications for the health care they receive.

In this period in South African much hope is being pinned on fundamental change. It is a crucial time for organisation to ensure that the the ''new'' South Africa is one which responds to the aspiratioons of all its people. The needs of women, therefore, must be addressed.

Price increase

Over the years *Critical Health* has tried to keep its price affordable. While in the long run we hope to become self sufficient, the publication is at present largely subsidised. We have however decided to raise the price in order to bring it closer to the actual costs involved in producing the publication.

"In general"

* We apologise for the delay in getting out this edition.
* Our next three editions will focus on: the creation of a national health service, building the welfare sector, and the first joint national health workers conference, due to be held in July.
* *Critical Health* will be conducting an evaluation. The aim is to find out how our readers feel about the publication and identify ways of improving its contents and distribution. We look forward to working with readers in making *Critical Health* more effective, relevant and viable!
* Finally, the *Critical Health* collective would like to express our thanks to Shereen who over the last couple of years has put so much of her energy into *Critical Health*. At the end of last year Shereen decided to leave her job at *Critical Health*. She continues to be involved in our collective.

SECTION A

WOMEN, HEALTH & REPRODUCTIVE RIGHTS

Historically, women, especially working class women, have tended to do most of the work in the home, whehther or not they work outside of it. Positions of power and influence in society are, on the other hand, usually held by men. Related to this, issues that concern women are often relegated to second place in deciding on priorities. This section focuses on a number of women's issues which urgently need to be addressed on our national health agenda.

Our Bodies, Our Lives

Women, Health and the Workers' Charter

by Kate Truscott

Women's health issues were amongst the issues discussed at last November's Cosatu Workers' Charter conference. This article gives an outline of the health and health related issues of relevance to women that were discussed at the conference. It argues that there is a need for a campaign which focuses specifically on "reproductive rights". An outline is given of the kind of demands that would be put forward in such a campaign. The ideas in the article are based on discussions conducted by the author with trade unionists and others.

The Cosatu Workers Charter Conference, in November 1990, marked an important step towards putting forward clear working class demands for inclusion in a new constitution. The debate was lively and contentious. Topics covered included: the right to strike, the right to take industrial action on political issues, and the participation of unions in state structures.

Issues relating to women's oppression and women's health were discussed in the "Gender Commission" under the heading, "Gender and the Constitution". The word gender was used as a way of showing that the issues raised must be dealt with by men and women.

"Gender" issues and the trade union movement

Although 75% of those at the conference as a whole were male, most participants in the Gender Commission were women. But it was encouraging that there was a vocal minority of men who were prepared to take up these gender issues and outline strategies for including these in workers' demands and struggles. From unions like SACCAWU, (South African Commercial, Catering and Allied Workers Union), involved in the struggles for parental rights and pap smears, it became clear that when women and men mobilise together on gender issues, the union takes on a new strength and confidence.

Union Power: when men and women mobilise together on gender issues the union gets stronger

It was a male delegate from CWIU (Chemical Workers Industrial Union) who madethe report back from the "Gender Commission". His words were sobering. He reminded male delegates that all too often at trade union conferences, they would smile and snigger when "women's issues" were raised, and these issues would be relegated to the bottom of the trade union movement's list of priorities.

This time there was no sniggering. Delegations supported most of the proposals of the Gender Commission, including the demand for free legal abortions. Opinion was, however, divided on polygamy and lobola, both of which were referred back to the individual unions for further discussion.

Women's Health Issues in the Workers' Charter

A draft Workers' Charter was drawn up and it includes 10 basic demands relating to gender. These include demands relating to:

(a) Violence - including the right to protection from rape, battery, abuse and harassment.

(b) Parental rights - the right to maternity and paternity leave.

(c) Health Care - including (1) the need for state provision of accessible and safe health care; (2) the problems of South Africa being used as a dumping ground for third rate contraceptives; (3) the need for free pap smear tests; (4) the need for an affirmative

health care programme, especially for contraception; (5) the need to legalise abortion.

There are also demands dealing with: Marriage; Domestic Work; Work; Education; Culture; Media; and Gay Issues.

In addition, there are other places in the draft Charter where women and health issues are addressed. For example, the section on "Trade Union Rights and the Constitution" has a direct bearing on whether or not health care workers, most of whom are women, and other workers in "essential services" can take industrial action. Should workers in essential services have the same right to strike as other workers? One view was that the unions should decide what an essential service is. Another view was that it should be defined in the constitution. The matter was referred back to the unions.

Under "Economic Rights and the Constitution", the Conference discussed a range of issues which also relate to women's (and men's) health. For example, a living wage; no discrimination on the basis of sex or race; unemployment benefits; decent housing; adequate health care; parental rights, child care facilities and support; reduced hours of work; extended sick leave; healthy and safe working and living conditions; recreation facilities; disability benefits; nutrition.

A campaign on women's health

It is clear, that *all* these issues are important. They touch on the need to transform not only health care services but also the appalling social and economic conditions which give rise to widespread poor health among the vast majority of the population. These issues need to be taken up together and separately by unions, health workers and communities if the Workers' Charter is to have a meaningful role in the struggle for socialist transformation of our society.

Having said this, there are some health issues which have particular relevance for women as *women*, as mothers, lovers, wives, daughters and sisters. These are issues of reproductive health: contraception, sexually transmitted diseases, fertility and infertility, abortion, teenage pregnancy, and AIDS. These crucial issues are rarely addressed openly. However, they underlie much of the tension, anxiety and frustration of personal life in our society.

While the Workers' Charter touches on most, if not all, of the important issues of women' s health, it does not offer a focus on which to wage a massive campaign to win some of these demands. Our view is that the unions should reach out to various organisations to launch a major campaign on reproductive rights as a way of building women's support for the Workers' Charter and working class demands in the Constitution. The Workers' Charter could gain massive support from women all over the country, including the partners of male trade union members.

Typical sex and reproductive health issues

We compiled the following three cases representing typical sex and reproductive health issues which are presented daily at surgeries, clinics and hospitals:

· Valerie is 23 years old. She works in a supermarket and is a member of a trade union. She has persistent lower abdominal pain. She has a steady relationship with her boyfriend, John, and they would like to have a child, but she cannot fall pregnant. When she was 15, her mother took her to a doctor to have an IUD (intra uterine device) inserted because she wanted her to finish her schooling and not have a baby too early. She had her IUD removed two years ago. The clinic suspects that her fallopian tubes are blocked and her chances of having a baby are slim.

· Sibongile is 38. She had four children by the age of 25. After this she wanted to stop, but her husband (a trade unionist) does not approve of contraceptives. She went to a clinic to get an injection (Depo Provera) so that her husband would not find out. She has had no more children since then. Recently her husband has been complaining that he wants another son. She has stopped the injections but she cannot fall pregnant. She has been suffering from abdominal pain for about two years. The doctor suspects she has

cancer of the cervix.

· Shadrack is 42 years old and works as a factory watchman. He has been married for 18 years and has three children. He has had various girlfriends throughout his marriage, but currently has only one. He says that if he doesn't have at least one girlfriend in addition to his wife, his friends will make fun of him and call him weak. He is a good provider for his family and always gives most of his wages to his wife. His present girlfriend, Hope, recently got pregnant and had a backstreet abortion which Shadrack paid for. Complications set in and she was admitted to hospital. She took a long time to recover and now believes she may have AIDS.

Women, sex, and health

The fictitious cases of Valerie, Sibongile and Shadrack illustrate some of the most common issues of sexual and reproductive health in our society. They also give the lie to the common belief that sexual illnesses are confined to prostitutes or single promiscuous men. In fact, the vast majority of cases of reproductive ill health occur among women and men who are trying to keep their marriages, relationships and jobs together.

These cases also show that people have access to very little information when it comes to sexual and reproductive health. Worse still is the lack of information about drugs, contraceptive methods, medical procedures and their potential side effects. Medical staff often maintain a paternalistic attitude towards patients, and withhold information, on the basis that patients are "ignorant" and "stupid".

The problem is enormous. What can be done about it? The proposed Workers' Charter represents the best attempt made so far to push forward issues of workers rights. We feel that these should include rights to control our bodies as a way of extending the fight to seize control of our lives. Some tentative suggestions for doing this are outlined below.

Suggested Demands for a Popular Campaign for Reproductive Rights

1. Surgeries, clinics and hospitals which deal with reproductive health care are currently totally inadequate and understaffed. We need community-based, specialised family planning or reproductive health care clinics staffed by trained, sympathetic staff and counselors. They should also do popular outreach work in schools, community forums and workplaces. Unions, civics, and other groups could campaign to have such facilities in their workplace or community.

2. Safe, affordable contraceptives and full information on their use and side effects. Unsafe contraceptives should be banned.
3. Free (or affordable), legal, safe abortion.
4. Free pap smears on a regular basis, (at least once every two years), for all women.
5. Full and clear information, for men and women and children, about how our bodies function. The unions could sponsor the publication of booklets like "Our Bodies, Ourselves" for distribution and sale among members, and in schools and communities.

Unions, civics, student structures, PTSAs, and other groups could campaign for the above as part of the struggle to transform health care towards meeting peoples' needs. Of course, these are only some initial suggestions. We would welcome further ideas on such a campaign.

Kate Truscott is a member of WOSA (Workers' Organisation for Socialist Action)

The People's Health and Social Services: First National Joint Conference

19 - 21 July 1991
University of Western Cape

The first joint national health workers conference is hosted by the following organisations:
HWS - Health Workers Society, **NAMDA** - National Medical and Dental Association, **OASSSA** - Organisation for Appropriate Social Services of South Africa, **PPHC** - Progressive Primary Health Care network, **SAHWCO** - South African Health Workers Congress

Workshop Topics

Theme A: Equity, Financing and Control
Theme B: Personnel and Workers' Issues
Theme C: Integration of Separate Services and Special Needs into Comprehensive Primary Health Care

For more information, contact the Conference Committee, P.O. Box 459, Athlone 7760 or phone (021) 696 0684, fax (021) 696 8349

Family planning as a human right in South Africa

by Beverley Oskowitz and Stephanie Moore

The authors of this article argue that future family planning needs to be distanced from the old policy which is negatively associated with population control. Family planning policy in the future has to be linked to programmes of comprehensive health and development strategies for communities. Moreover, the authors assert that family planning should be regarded as a human right which recognizes the need for women to control their reproductive capacity and health.

Family planning and health

Family planning is often considered an extremely sensitive topic throughout the world, South Africa being no exception. However, family planning programmes and services have contributed to what Dr. Halfdan Mahler, former Director-General of the World Health Organisation, termed "striking improvements in the health of mothers, children and indeed whole families."(1) This has been documented by research worldwide.

With regard to its emphasis on child spacing, family planning is accepted as an essential component of primary health care. The United Nations sponsored World Summit for Children Conference, held in September 1990, featured family planning programmes and services as key elements in its primary health care, and international community development strategies.

While initially these programmes were funded by the United States and other Western governments, at a later stage, developing country governments and international development organizations also began to contribute.

Suspicion of family planning

Past public suspicion of family planning, whether for cultural, religious, or political reasons, has often served to negate the positive role that family planning can play in enhancing community development. For the most part, this suspicion relates to the association of family planning with population "control", a reflection of the orientation of many early large scale family planning programmes.

In the 1960's and 1970's in particular, policies placed a heavy emphasis on the control of population growth rates, especially in the developing regions of sub-Saharan Africa, Latin America and Southeast Asia. Although many of these early programmes promoted the health and welfare of citizens, a primary consideration remained the slowing of high fertility levels.

Experience gathered from these initial family planning operations has demonstrated the fact that programmes which concentrate on the "population problem", and address the issue through the mass distribution of modern contraceptives, are inappropriate. The human factors - cultural, religious, economic and socio-political - are too often ignored in the process

The demand for children

What are some of these factors which need to be taken into consideration? In traditional societies in sub-Saharan Africa, the demand for children has developed from the

interaction of cultural, economic and other factors which have been important in ensuring the survival of rural societies. Children in these communities have long served in important supportive capacities as:

* a vital source of labour in assisting with both food production and household chores;
* a ''store of value'' for parents for the provision of additional income during a child's productive years. It is hoped that income can be secured through employment in an urban area;
* a source of economic and social security for parents in old age; and
* a source of status in those societies where women ''attain'' status and recognition through the production of children.

Family planning policy must take account of these factors as well as the fact that most women have little control over their own fertility. Male opposition to the practice of family planning is well documented. This opposition is largely based upon fears that family planning will threaten male authority within the household, encourage marital infidelity, and conflict with accepted religious dogma.

Human sexuality and human reproduction are highly intimate areas of human existence and involve extremely sensitive aspects of human relations. Any programmes, which are designed to alter existing social practices, must be planned and implemented with the utmost regard for both personal and social welfare. Concern for the health of individuals and couples, particularly women, and the quality of patient education and clinical care are all important as the potential for human rights abuse is high.

Right to reproductive self determination

The fundamental human right to reproductive self determination, the right of an individual to freely decide on the size of one's family, and the benefits of access to information, education and the means with which to exercise this right was first internationally recognized at the International Conference on Human Rights in Teheran in May 1968. (2) The right to reproductive self determination was acknowledged later that year by the member states of the United Nations.

Fertility based population policies and related family planning programmes, on both national and international levels, must take full cognizance of such rights. Such action is essential if all individuals are to enjoy access to quality family planning and reproductive health care services and to make informed decisions regarding their reproductive health and well being.

Given this country's political history, family planning in South Africa faces unique difficulties if it is to be accepted and utilized. Those who view family planning as a population control measure need to be challenged. A new orientation for family planning, based upon identifiable human needs, and rights, is clearly needed.

Fostering public awareness

Public health policy makers, government officials, health care professionals and community workers must commit themselves to the development of programmes which will foster public awareness and understanding of the benefits of family planning. Such an orientation must be incorporated into comprehensive health and development strategies and programmes.

Population control cannot continue to be considered as the primary factor on which to base future family planning policies. What is required is a commitment to recognizing the human rights which underlie human sexuality and reproductive health issues.

The right to control one's fertility and to do so in a safe and accessible way should be the emphasis of family planning

Family planning should enable individuals and couples to choose the number and spacing of their children

Future strategies

Future strategies which could be undertaken to promote such a commitment include the provision, throughout South Africa, of:

- high quality and comprehensive family planning programmes and services which will enable individuals and couples to regulate their fertility safely and effectively;
- complementary reproductive health care services which include counseling, guidance and referral services for areas relating to human sexuality, infertility, and sexually transmitted infections and diseases;
- comprehensive antenatal, child delivery and postnatal care services to promote healthy pregnancies, safe births and healthy children;
- school and community based family life information and education programmes for adolescents and young people;

- public policy and health professional support for the practice of beneficial traditional beliefs and customs which enhance the health of women and children; and
- information, education and support services for redressing related individual and family societal problems of sexual violence and abuse.

Public trust and support

A commitment, from professional bodies and policy makers, to human rights based family planning programmes, would assist in engendering public trust and support of family planning. This would also encourage communities to participate in programmes and activities. This is crucial as community preventive education is going to be urgently required to slow HIV transmission.

Human rights based family planning

It is essential that public policy makers commit themselves to human rights based family planning if we are to ensure future individual and family health for all citizens of South Africa. Such an approach will be fundamental if individuals and couples are to be empowered to:
- choose freely and responsibly the number and spacing of their children and to have access to the information, education and means with which to make these choices;
- advocate for the universal access to quality and comprehensive reproductive health education and clinical services from appropriate public and private health service providers; and
- comprehend more fully the importance family planning and related reproductive health programmes play in improving the health of themselves, their partners, children and families.

References:

(1) Mahler, Dr. H., Director- General of the World Health ,Organisation; Address at the World Conference on Population, Mexico City, August 1984.
(2) United Nations, The Symposium on Law and Population: Proceedings, Background Papers and Recommendations, Tunis, 21-24 June 1974, (New York: United Nations Fund for Population Activities), 1975, pg. 5.

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The Abortion Debate in South Africa

by Helen Rees

This article identifies pro and anti-abortion lobbyists as being the main contenders in the debate about abortion in South Africa. The basic elements of their respective positions are outlined. The present South African law, the Abortion and Sterilization Act of 1975, is explained. The Act is said to have failed in achieving its purpose and also in meeting the needs of South African women. The Act is compared with the law in Britain. The author argues that the laws on abortion in South Africa should be liberalized. The effects of liberalizing the law are discussed and questions about the practicalities of changing the law are raised.

In South Africa, unlike many other countries, the debate over women's right to abortion has not been a source of major controversy. This situation is now beginning to change In April 1990, Dr. Rina Venter, Minister of National Health and Population Development, requested that interested parties give their comments on whether the abortion laws should be changed. One year later she told Parliament that of the 48 846 respondents, 98.62% were in favour of keeping the law as it was, Therefore, she said, no amendments would be made.

Also in April 1990, the Maputo Health Conference, a meeting of the ANC and progressive health and welfare organisations, supported a recommendation that abortion should be available on demand, and that there should be comprehensive abortion counseling services.

What is clear about these two positions is that the abortion issue is set on a collision course. Why is abortion such a contentious issue?

The core of the argument against abortion is that life is present from the time the egg is first fertilized, and that this life must be preserved at all costs. It is felt that most women are in a position to prevent pregnancy if they want to. When an unwanted pregnancy occurs, the argument goes, organisations exist that will support that woman through her pregnancy and with her child. This point of view is supported by showing the "evils" of abortion, using vivid photographs of aborted foetuses with beating hearts and moving limbs.

The pro-abortion lobby argues its case from both a political position and from a more pragmatic point of view. At a political level they argue that the entire economic structure

Minister of National Health and Population Development, Dr. Rina Venter, said that no changes would be made to the current abortion laws

of South Africa is patriarchal. The women's role is to service men, to provide a pool of disorganized and cheap labour in the workplace, to bear children and to look after them, and to run the home. If this position is to be challenged, and if women are to play a full part in society, then they must be able to choose when, and if, they want to have children. Abortion is seen as a vital part in this liberation.

On a more pragmatic level, pro abortionists believe that women are having abortions anyway, despite its illegality, and therefore that the abortion law should be amended so that thousands of women are no longer criminalised.

South African law - the present situation

Until 1975, abortion was prohibited in South Africa, except in the case of absolute necessity. An abortion would only be granted if the mother's life would be at risk if the pregnancy was to continue.

In 1975, the Abortion and Sterilization Act was introduced. This is the legislation that specifies who can get a legal abortion today. It also discourages illegal abortions with heavy penalties of 5 years imprisonment or a R5000 fine or both for people doing such abortions. The overall aim of the Act is to decrease the total numbers of abortions which are done.

The Act only allows for an abortion where:

- continued pregnancy would endanger the life or constitute a serious threat to the physical or mental health of the women.
- there is a serious risk that the child will suffer from a serious physical or mental handicap.
- the pregnancy has resulted from rape or incest.
- the pregnancy is conceived by a woman who is mentally handicapped or unable to understand the full implications of parental responsibility.

The Act excludes the majority of women who are seeking abortion. Furthermore the procedure that has to be gone through to obtain an abortion is made deliberately difficult so that fewer legal abortions are done. The procedure is as follows: a doctor must suggest an abortion. Two other doctors must agree in writing that the suggested abortion falls within the law. These two doctors must in no way participate in, or assist with, the abortion. At least one of them must have practiced for a minimum of 4 years. Where the ground of the abortion is mental health, or rape or incest, there are other special provisions in the Act.

Furthermore, the abortion must be performed in a state controlled institution or an institution that has been designed for that purpose by the Minister. The written authority of the person in charge of the institution is required.

A procedure as cumbersome as this makes it difficult for the majority of South African women to qualify for an abortion even if they are legally entitled to it. The health and legal infrastructure to support this kind of legislation is simply not available to the vast majority of people in South Africa today.

Effects of the 1975 Abortion and Sterilization Act

The act has certainly been successful in restricting the number of legal abortions. Approximately 40 % of applications for legal abortions each year are successful. Only 800 - 1 000 women get a legal abortion each year. Over 70% of these are done on psychiatric grounds. Due to the difficult procedure involved, a high proportion of these abortions are done on white women.

It is interesting that the private health sector, understanding that there was a demand for abortions that the state health sector would not meet, found legal ways to give women their abortions. In 1988 Sandton Clinic did 257 abortions, 241 of which were done on psychiatric grounds. While this service was much appreciated by the women able to use it, in 1988 the procedure costed R800. This restricted these abortions to the rich, and predominantly to white woman.

The Act has, however, not led to a decrease in the total number of abortions. In a recent court case where a doctor was being prosecuted for doing an illegal abortion, the judge commented that "if the [legal] grounds upon which an abortion may be procured are too restrictive, the paradoxical situation arises that this would increase the number

of criminal abortions". This is exactly what has happened in South Africa today.

The Abortion Reform Action Group (ARAG) estimates that 200 000 to 300 000 illegal abortions are done here each year. Because of its illegality, accurate statistics are difficult to establish. However, it is accepted that less than 1% of legal and spontaneous abortions usually become infected. This is unlike the situation with non-legal abortions which frequently result in some degree of infection. At Baragwanath alone, about 15 000 patients each year are admitted with infections that are often associated with non-legal abortions. This suggests that ARAG's estimate is not exaggerated.

The Abortion Act has failed in its aim to control the total number of abortions. It has also failed to respond to the needs of our society. A future South African government will be faced with the task of reviewing this law.

The law in other countries

Most countries have some kind of legislation on abortion. In many countries where Catholicism is the dominant religion, such as Italy and the Republic of Ireland, abortion is forbidden except in very strict circumstances. Other countries such as Yugoslavia, have very liberal abortion laws, so that abortion really is "on demand" and has become an alternative to contraception. South African abortion law is based on British law. However the British law is much more liberal than ours is.

The British (excluding Northern Ireland) law was introduced in 1967. It outlines specific circumstances when to give an abortion is not a crime. One of these grounds is that the continuation of pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated. Another is that the continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated.

Two medical practitioners have to certify "in good faith" that these conditions have been satisfied. The abortion must be done in the first 28 weeks of pregnancy.

The British law can be interpreted in many different ways. Some doctors refuse to do an abortion unless there is a real risk of death to the mother. At the other end of the scale are doctors who believe that it is a woman's right to decide. These doctors tend to interpret the law very liberally arguing that abortion always falls within the terms of the law. Abortion, they say, is statistically always safer than a pregnancy going full term.

Why the South African abortion law should be liberalized

Abortion is an historical and international reality. In countries where abortion has been made illegal, women continue to have 'backstreet' abortions. In South Africa today,

despite many new forms of contraceptive, abortion is used by women of all races and all classes to terminate unwanted pregnancies.

To understand why South Africa should move towards the liberalization of its abortion laws, we need to consider why women have unwanted pregnancies, and whether the factors producing unwanted pregnancies will continue to exist in a future South Africa.

Health services are often inaccessible or unavailable to women. Where they do exist, the methods of contraception offered to women are often unacceptable, either because of the way that they have to be used, or because of their side effects. Even when women do find a method of contraception that suits them, there is a risk of contraceptive failure with all methods except the combined pill and injectable contraceptives. Some women are forbidden by their partners from using contraception. Others, either because of their low level of education, or because of their young age, simply do not know about contraception. Many women have times in their lives when they use contraception effectively, and times when they use it irregularly or not at all, even though they don't want to be pregnant. The alternatives to running the risk of pregnancy are often not that attractive to women.

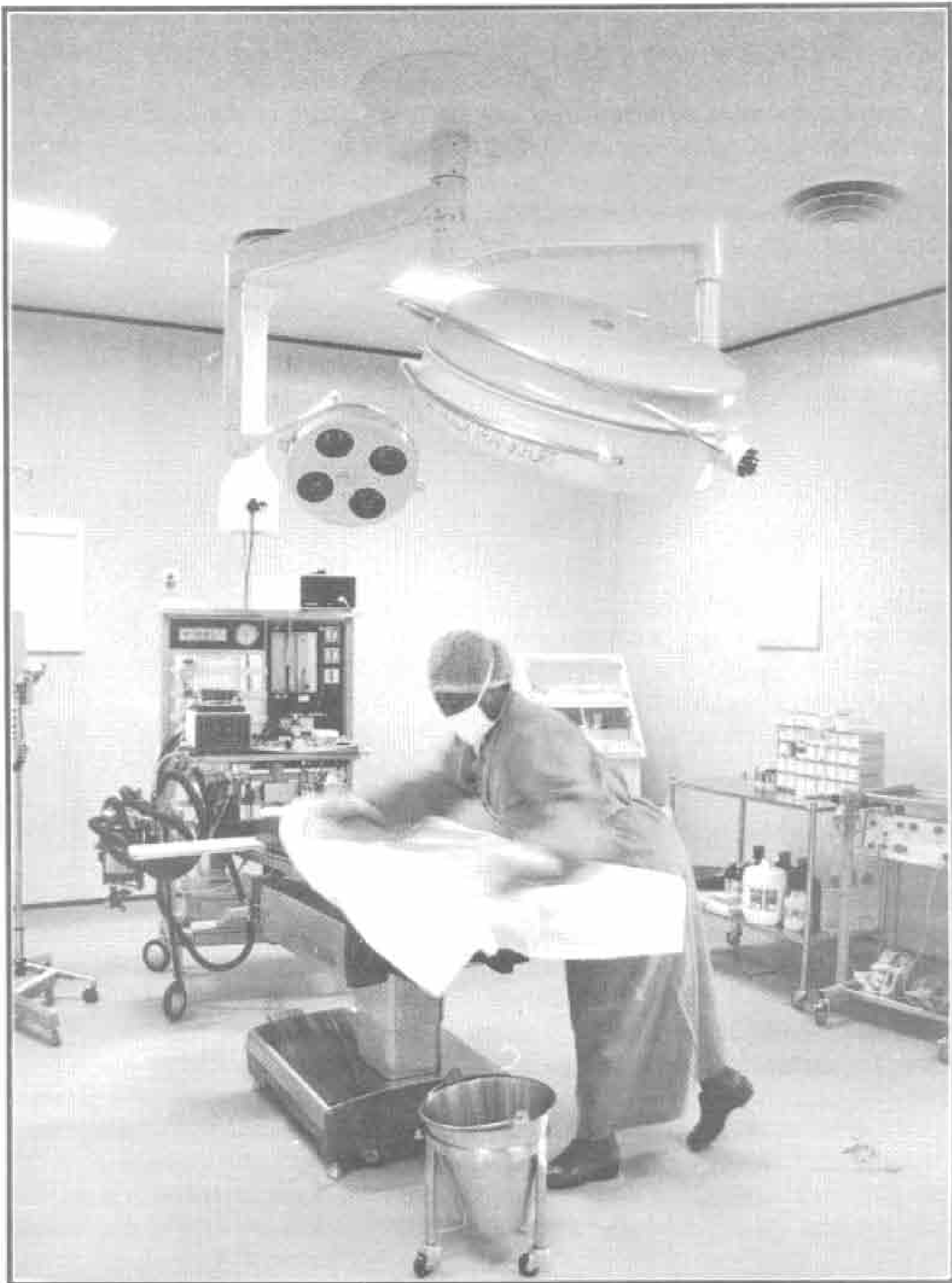
Because of the history of apartheid, many black South African women have a further suspicion about using contraception. A widely held view is that family planners often prescribe contraceptives, not in the interests of the individual woman, but because of an unwritten State policy which seeks to control the population growth of the black interest.

Lastly, we should consider the babies of women who are forced to continue with unwanted pregnancies. A study from Sweden of children of women who were denied abortions 20 years earlier showed them to be in poorer health, with histories of more psychiatric care, and with a higher rate of alcohol use than a control group of young adults. Sweden has extensive welfare and support services which South Africa does not. Here large numbers of children suffer from malnutrition. Problems of child abuse and of abandoned and neglected children are widespread. The outlook for the children of unwanted pregnancies in South Africa is no doubt much worse than in a country like Sweden.

Effects of liberalizing the abortion laws

The most obvious effect of a more liberal abortion law would be that the number of legal abortions will increase, and that of illegal abortions will decrease. Legal abortion, and particularly early legal abortion, has a very low risk of producing bleeding, infection or death in the women, when compared to illegal abortion. Women tend to present earlier for abortion when it is legal. The physical trauma that they go through is also reduced.

Secondly, the psychological trauma for women of either illegal abortion, or of



continuing with the unwanted pregnancy, is diminished by legalizing abortion. Many studies show that the woman's psychological and mental state, and interpersonal relationships, improve after counseling and therapeutic abortion.

Anti-abortionists often argue to the contrary and give many examples of women who have had abortions and are very unhappy afterwards. Both these arguments are probably true; many women with `unplanned' pregnancies feel ambivalent about them. They partly want the pregnancy and partly don't want it. A woman must feel very sure that she wants an abortion if she is not going to feel some kind of regret afterwards.

Some practical questions

There are many issues still to be addressed in developing a new abortion policy in South Africa. Firstly, how would a new abortion law be worded? Would it be written in the kind of way that British law is written, enabling liberal health workers to allow women to decide for themselves, and allowing health workers who are against abortion to prevent women from doing so.

Secondly, would we have a cut off point for foetal age beyond which an abortion could not be granted? In the U.S.A., the supreme court has made a ruling that once the foetus is viable (able to live outside of the mother), the interests of the foetus are more important than the rights of the mother and abortion is illegal. Before this time it is the woman's right to decide whether to have an abortion or not.

Thirdly, in South Africa are we really in a position to have 2 health workers as signatories for each referred abortion, and if so, who should these health workers be? In many rural areas, women only have access to nurses but little access to doctors. The Nursing Council has traditionally been very reserved about the role of nurses even under the existing act. Would they permit nurses to be the consenting health worker for abortions?

And lastly, what exactly do we mean by abortion on demand? With the introduction of new abortion technologies, women may well be able to get effective over the counter abortions at a very early stage in their pregnancy. Given the poor state of our health services, is this the only realistic approach to the abortion problem? The South African ''abortion debate'' is just beginning!

Helen Rees is involved in the Women's Project at the Centre for Health Policy

Women, Health and Work

by Anne Hilton

This article looks at how the subordinate position of women in society affects not only their access to jobs, but also the kind of work that they do when they are employed. This affects the nature of the occupational health hazards that they are exposed to but, the author contends, this does not mean that "women's work" is necessarily safer than other forms of work which are usually reserved for men. Reproductive health issues in the workplace are also discussed. The implications of the double burden of labour that is often carried by women - housework in addition to employment - are also discussed. The article also looks at issues relating to the provision of family planning as part of occupational health services.

Health in the workplace is an important area of struggle for women. Traditionally approaches to occupational health and safety have tended to discriminate against women. Women are defined as unsuitable for certain tasks or are removed from the sight of specific hazards. This needs to be replaced by an approach which recognizes the right of women to work at jobs of their own choice, the right to have a job and be a mother and the right of all workers to a healthy and safe work environment.

Gender Oppression and Exploitation

The status of women is defined by social, economic and political conditions in society. A women's role is defined predominantly as a subordinate one. This subordination is experienced by women as exploitation in the workplace and oppression in gender relations in society.

A woman's ideologically defined domestic role and her capacity to have children play a role in negatively determining her marketability as a wage earner. This manifests itself in low wages, unequal remuneration for the same work, lack of training and unequal job opportunities and work that is often repetitive, boring and not very stimulating.

These conditions of employment are rationalized on the assumption that women do not represent a permanent factor in the labour force, that their reproductive function will

inevitably interrupt their work careers.

Furthermore women are assumed to exist in relations with men as subsidiary partners and as such their wages are seen to be subsidiary to man's earnings. This attitude persists in the face of overwhelming evidence that many women are single and self supporting or may have dependents where a woman may be the sole breadwinner.

In the workplace women are mostly employed in areas considered to be women's work, that is, in jobs similar to what they do at home. This is an extension of the so-called "traditional role" of women, that is, the labour women engage in is transferred from the home to the workplace. Women are usually given jobs in supportive roles and not as decision makers.

Women make up a large section of the working population in and out of the industrial sector. In industry women make up the majority of the workforce in sectors like food or garment manufacture. A very clear example of this is in the motor industry where women are employed to sew the car seats. They are often employed for their so-called dexterity, doing jobs requiring fine work, for example, in the computer industry, making components or working with fine wires.

In this article three areas of health affecting working women will be dealt with:
1. Occupational hazards
2. The "double shift"
3. Family planning

1. Occupational Health

Myths of occupational health

One of the common myths associated with occupational health is that men are at greater risk because of the work they do. It is true that men do many jobs which are very dangerous like mining, foundry work and construction. But thousands of women are also doing jobs which are hazardous to their health - problems caused by unsafe machinery, chemicals, noise and stress. Women therefore face the same hazards as men. They may also face different health hazards in the workplace, but this is more likely to be due to the marked differences in the type of work done and not because they are women.

Dangerous jobs

Many of these jobs are in fact dangerous and pose serious health problems, such as;
i) Stress resulting from doing boring repetitive work, at low wages with few prospects for training, stress resulting from being a working mother.

Women often receive less pay than men for doing the same work

cotton dusts in the textile industry which is a well known cause of lung disease.
iii) exposure to chemicals such as carbon and etrachloride, heat and humidity in laundries.
iv) exposure to heat, cold, cleaning chemicals and slippery floors in the catering industry.
v) fatigue and menstrual disorders as the result of shiftwork.
vi) exposure to a range of hazards in the health care industry, including, chemicals, anaesthetic gases, radiation, exposure to infection from a range of organisms, for example, Hepatitis B and HIV and the lifting and carrying of heavy loads.

"Women's work"

It is clear from these examples that the assumption that so-called "women's work" is lighter and less hazardous is a dangerous myth. It has meant that women's occupational health problems are not well studied. The belief in the relative safety of "women's

work'' has been perpetuated without appropriate research or relevant data to support it.

Most of the work done on non-reproductive related health problems has involved male workers. This is significant for a number of reasons: women are often exposed to similar hazards as men and many of the jobs considered ''women's work'' are also very unhealthy.

There are some basic physical and physiological differences which require consideration in the workplace if women are to participate in the economy. Women may not be able to handle certain kinds of industrial machinery designed essentially for men. It is the machine design which is unsuitable and not the woman who is badly designed.

Employers also determine Threshold Limit Values (TLVs) according to the needs of male workers. The limits are set by testing healthy male army recruits weighing an average of 70kg. Women often weigh less than men and have proportionally more fat on their bodies. This affects their absorption of certain substances, such as chemicals. These TLVs then need to be redefined or adjusted to meet the needs of women workers.

It is asserted that women suffer from occupational health problems because they are biologically weak and more susceptible. This concept persists despite any real evidence to support it and manifests itself in a number of ways, including job discrimination. This also translates into an underestimation of the health risks faced by women at work.

Job discrimination merely means that exposure to the hazard is transferred from the female to the male and does not reflect any attempt to eliminate the hazard. Exclusion of women may simply mean that men face the health risks.

Reproductive Health Issues

Again it needs to be stressed that these considerations should be used to make the workplace safer to work in rather than exclude women from the option to work.

Women face the possibility of job discrimination as employers and legislators have used the occupational dangers associated with fertility and foetal damage to exclude women from job choices and employment.

This is dangerous at two levels;

1. It does not improve conditions in the workplace and, again,
2. May ignore the hazards to male reproduction.

Occupational hazards can be reproductive hazards for both men and women and cause a variety of problems:

1. Infertility and impotence in men and women
2. Foetal growth retardation and deformity
3. Miscarriage or abortion
4. Childhood cancers

Reproductive risk can occur before conception, at conception or during pregnancy. The reproductive function of all women therefore needs to be protected at all times and not only during pregnancy.

Some of the workplace hazards which have been implicated are;
- lead, solvents, eg. benzine, mercury, pesticides, radiation, anaesthetic agents

2. The Double Shift

One of the major factors affecting the health of working women is the reality of the 'double shift', that is, a woman often does two jobs - one paid at work and one unpaid at home - thus shouldering a double burden as worker and housekeeper and parent. There are many stresses related to this situation;
- exhaustion & fatigue
- little time for oneself - this can manifest itself in a variety of ways like frustration or neglecting one's own health needs because of a lack of time.
- anxiety, for example, working mothers worrying about their children.

This situation is particularly stressful for women who do shiftwork. Creche facilities are few and far between in the South African workplace. Tired, anxious, stressed and fatigued, these women can be at great risk in the workplace from accidents.

3. Family Planning

Women in the workplace are often under a lot of pressure from employers not to fall pregnant. Often their jobs depend on compliance with family planning services, which are sometimes offered in industry. These are offered for the purpose of keeping women on the job, the emphasis being on birth control rather than reproductive freedom. Often family planning is run in the absence of comprehensive health care or education for women.

A study done in Natal in 1985 illustrated some of these problems (Hilton 1986). This study was conducted by interviewing occupational health nurses (OHNs) in the Durban/Pinetown area:

1. The OHNs reported the following possibilities for pregnant women;

- lack of job security for pregnant women
- women having to take unpaid maternity leave to have a baby
- that women on maternity leave are often the first to be retrenched
- a few companies simply fired pregnant women
- of the 15 nurses interviewed who worked in factories with large female workforces, 4 had offered education on women's health and 5 had offered pap smear tests as part of the municipal family planning service. Breast examinations were done in a couple of cases.

Conclusion

Despite the important role women play in the economy, little is being done to improve the conditions of women workers, to facilitate their role as wage earners, or, to provide the support needed by working women during pregnancy. Prevailing conditions in the workplace are defined by the dominant ideologies of the oppression of women in society.

I believe that women have the right to be pregnant and to have a job. They also have the right to work in conditions which will not endanger their lives, or the development of their babies, while they are pregnant. We are still very far from this being a reality for working women in South Africa.

What can be done?

1. At the broadest level attitudes toward women and their role in the family and economy need to change.
2. Women need to have greater choices in the work they do. They need to be informed of the risks associated with their work.
3. Occupational health services can improve the health conditions of working women if they are sensitive to their needs. They can:

- monitor the workplace to identify health hazards.
- monitor workers exposed to hazardous substances.
- identify possible reproductive hazards for female as well as male workers and inform them of the risks.
- recommend changes and improvements which will make the workplace safer (management seldom informs workers of the risks of the job despite legislation which provides for employee access to such knowledge).
- provide services based on the health needs of working women, for example, education on breast examinations, pap smears.
- provide contraceptive services based on the concepts of informed consent and choice.

Health workers and management need to consult workers, both female and male, as they are the ones at greatest risk and they often are the best experts on the dangers of the workplace.

> "While we must care for women workers and their unborn children, we must also move beyond the popular myth that reproductive hazards are specific to women workers. We must stop and think before we start making endless regulations to try and protect women from jobs they really want to do. Women are susceptible to hazards at work, but so are men. Many factors can make men impotent or, more subtly, reduce the quality of their sperm. In the long term there is only one solution: to clean up the workplace so that work is safe and pleasurable for both women and men. If a woman cannot do a job today it means there is something wrong with the job, not that there is something wrong with the woman".
> (Dr. John Denning, Women's Work and Health Hazards.1984.)

Maternal mortality and international agencies

by Deborah Maine

Maternal mortality is one of the highest causes of death among women, particularly young women, throughout Africa. On average, more than 50% of women in sub-Saharan Africa give birth before age 20, and in some African countries as many as 40 % of women have their first child before age 18. Women under 20 suffer more pregnancy and delivery complications, such as premature delivery, prolonged labour, cervical trauma, and death, than do women who bear children at age 20 or later. Factors such as level of education, nutrition, number of pregnancies, advanced age and the physical size of the mother, also contribute to mortality rates. Reliable statistics on the incidence of maternal mortality in South Africa are, however, hard to find, particularly regarding the incidence of maternal mortality amongst black women.

This article looks at the incidence of maternal mortality in Africa and argues that international agencies have neglected maternal mortality in their funding of health care. Part of the reason for this, the article argues, is that maternal health has been lumped together with child health in maternal and child health (MCH) programs. In these programs infant mortality has been the focus of attention while maternal mortality has been almost entirely neglected. The author suggests that sexism has been one of the reasons for this neglect. It also raises the question of what kind of approaches will be effective in dealing with maternal mortality.

Maternal mortality is the leading cause of death among young women in many poor countries. Although relatively few adequate studies have been done in underdeveloped countries, those that exist clearly show the seriousness of the problem.

In many African countries, more than one out of every 200 women who gives birth dies as a result. By comparison, in the United States the figure is about one out of 8 000. This discrepancy between developed and underdeveloped countries is much larger than that for infant mortality.

Furthermore, a woman's risk of dying accumulates with each pregnancy. Consequently, her lifetime risk of maternal death may easily be one in 30. This means that unless something is done, we can look at a group of young African women and know that

Maternal health care has largely been neglected in health care programmes

one in 30 will die of a pregnancy related problem in the prime of life. The worst part is that we have for decades possessed the ability to prevent almost all maternal deaths.

Recently, there has been a surge of interest in maternal mortality. In Februrary 1990, the First International Conference on Safe Motherhood (the Safe Motherhood Initiative) was held in Nairobi. Subsequently, virtually every international agency and foundation is getting involved in programmes to prevent maternal deaths.

I will review some aspects of the former inattention to this problem and discuss some of the challenges of the new era.

The years of neglect.

Women and children are a key concern of any health care system. In many developing countries, women of reproductive age and children comprise about two-thirds of the total population. Furthermore, women are responsible for bearing and raising the next generation. Therefore, it makes sense to pay particular attention to their well-being.

Indeed the World Health Organisation estimates that more than half of all resources devoted to primary health care are allocated to maternal and child health ("MCH") programs.

Many people assume that women's health has been receiving a substantial proportion of the available health resources, and that helping women survive pregnancy and delivery has been a high priority. Unfortunately, this is not the case. For decades, maternal mortality has been neglected in both health programmes and research.

The sad fact is that there is little in the conventional MCH package that can reduce maternal mortality. The common components of MCH programs today are: immunization of young children to prevent measles and other infectious diseases; teaching mothers to perform oral rehydration of infants with diarrhoea; weighing of young children to monitor their growth; encouraging women to breastfeed for the sake of their children's health; and immunizing pregnant women against tetanus so that they can pass the antibodies on to the foetus. While all these activities involve women in one way or another, women are not the direct beneficiaries of any of them (although tetanus immunization may incidentally prevent a tiny proportion of maternal deaths).

Other components of MCH programs are food supplementation, antenatal screening, and family planning. The costs and benefits of antenatal screening are too complex to discuss here. Suffice to say that when antenatal screening for women at high risk of complication is carefully studied, either in developed or underdeveloped countries, its potential to substantially lower maternal mortality is dubious.

Preventing maternal deaths

Of all the activities listed so far, the one that has the greatest potential to prevent maternal deaths is family planning. If only women who say they want no more children had no further pregnancies, I estimate that maternal deaths in sub-Saharan Africa would be immediately reduced by nearly one-sixth.

Once they become pregnant, however, women must have access to medical care if maternal deaths are to be prevented. Even in industrialised countries, a certain proportion of pregnant women (perhaps 15%) will develop serious complications. Without banked blood for resuscitation in haemorrhage, antibiotics to treat infection and caesarean section to relieve obstructed labour, many such women will die.

Neglect of maternal mortality

The neglect of research into maternal mortality became obvious to me through the process of writing two articles on the relationship of family planning to MCH - one in 1980 and the other, five years later. Going back to this literature I was struck by the

More research and resources are necessary to lower maternal mortality rates.

contrast between the tremendous progress made in our understanding of infant mortality in developing countries, and the paucity of new data or writing on maternal mortality.

Of course, there are lots of health issues that need more attention and more research. The difference with maternal mortality is that the neglect is disguised by the apparently encompassing title "maternal and child health." Because MCH programmes comprise such a large part of primary health care activity, and because women are the recipients of some of these services (even though the beneficiary is the foetus or child), it appears that women are being cared for and receiving a relatively large share of the health resources.

Why the neglect?

There are probably many reasons why maternal mortality received so little attention in the past. I will consider only a few.

In some recent articles on maternal mortality, it is implied that the reason that there is such a surge of interest in this topic is that the international health community has only recently learned the extent and severity of the problem. I think of this as the "we didn't know" excuse. It just is not true. For example, well over a decade ago the results of one of the best maternal mortality studies ever done were published. This study, in the Matlab area of Bangladesh, showed that maternal mortality rates were extremely high, and in fact raised the death rate for young females above that for males.

Another possible reason for the neglect of this issue may be that maternal mortality had declined drastically in the west by the end of World War II, when international assistance became a major force in health systems in the underdeveloped countries. At the local, as opposed to the international level, fatalism may have been a factor - women have always died in childbirth - the thinking may go, that they always will.

Sexism as a reason for the neglect

What about sexism as a reason for neglecting the issue of maternal mortality? By now feminists may have recognised in my description of the situation a pattern that is found in many areas of life, not just in international health: women's well-being has been subsumed into and subordinated to that of other family members - in this case, their children. Is it paranoid to suspect that the neglect of maternal mortality is just one more manifestation of systematic disregard of women?

Consider for a moment a curious feature of recent articles on maternal mortality. The great majority of these articles start with some statistics demonstrating the size of the problem (such as the number of maternal deaths that occur annually). So far so good. However, the second sentence in the article usually states that maternal mortality is important not only because women die, but because their death often leads to the dissolution of the family and a serious reduction in the likelihood that their children will live to adulthood.

While these consequences of maternal death are indeed important, it appears that the authors feel a need to justify their concern for maternal health on some basis of wider, societal good, as though the fact that women are dying unnecessarily is not sufficient grounds for concern and action. Certainly, maternal deaths have wide significance. For example, from the point of view of society's investment in an individual, the death of a women in the prime of life is a much greater loss than is the death of an infant. Yet there seems to be no comparable need to justify actions to prevent infant deaths.

Challenges of the future.

The corollary to the question of why was maternal mortality a neglected issue is: why is there all this interest all of a sudden? To this question I have no good answer.

Nevertheless, for those who have bemoaned the lack of attention to maternal mortality, the recent rush of interest and funds is very welcome. However, there are pitfalls ahead. One of them is that every agency is eager to have a maternal mortality programme, but there are still major questions to be answered as to what approaches will be effective in preventing maternal deaths in developing countries.

For example, the response of the U.S. Agency for International Development (AID) to the Safe Motherhood Initiative was to call for proposals on ways to spend funds on nutrition for Safe Motherhood. The scientific underpinnings for such an approach are unclear. While anaemia among pregnant women in underdeveloped countries is a common problem, I know of no evidence that giving women supplemental food during pregnancy will reduce deaths from the common causes of maternal deaths. In fact, it seems just as plausible to me that this kind of programme might increase rather than decrease the number of maternal deaths, since small women might start having larger babies.

Careful evaluation needed

Of course, there will be false starts in any new initiative. Agencies and health services may just continue doing variations on the same old MCH programs, hoping that if they do them more and better, somehow maternal deaths will be prevented.

What is needed is to think critically about the programme options, and then to carefully evaluate their effects and costs. Given the fads in international funding, there isn't very much time in which to do this. Perhaps we have five years, maybe as long as ten, to develop effective, efficient ways to prevent maternal deaths within the context of existing health systems in developing countries. If we do not succeed, maternal mortality will join the dozens of other health problems that had a short period of attention and increased funding, but then sank back into obscurity.

Deborah Maine is Program Director at the Maternal Mortality Prevention Program, Columbia University, New York, USA.

Women & AIDS: An International Handbook
Edited by: Marge Berer
Projected publication date: September 1982

A CALL FOR INFORMATION AND MATERIAL

You are invited to become involved in preparing an international handbook on women & AIDS. The handbook will be for women, women's groups and organisations, NGOs and other agencies.

The handbook will contain information on: patterns of infection among women in different regions; how women get and transmit HIV and how this can be prevented; HIV and other sexually transmitted diseases; counseling and testing of women for HIV infection; the consequences for women's sexual lives and relationships; HIV and pregnancy, birth control and abortion; women's roles as carers for themselves and others with HIV/AIDS, as health care workers and as sex workers; the many education, support, self-help, counseling and training programmes and services that exist for women; discrimination against women with HIV; and what agencies, networks and resources there are for women internationally.

Contributions of existing and original material for the handbook are welcome - personal experiences; leaflets, pamphlets, books, papers; cartoons and posters; transcripts of interviews, and discussion sessions; training and educational materials; guidelines for women and health care workers; descriptions of groups, resources, networks and training programmes; laws and policies affecting wome. ..

For further details and to contribute material, contact: Marge Berer, PO Box 16801, 1001 RH Amsterdam, Netherlands, tel. (31-20) 235005.

SECTION B

WOMEN & AIDS

A person who wishes to reduce his or her chances of contracting AIDS may practice "safe sex". However, if one's sexual partner refuses to practice "safe sex", it may be difficult for one to avoid contracting the disease. In many relationships between men and women, women find themselves in a subordinate position. Because of this they may find it difficult to insist that their partners follow "safe sex" practices. This problem is one of many which are focussed on in the articles in this section.

Women and Aids - the triple imperative

by Eleanor Preston-Whyte, Qurraisha Abdool Karim & Maria Zondi

In this article the problem of AIDS in South Africa is contextualised. It explains how apartheid and its manifestations - the migrant labour system, the legacy of family planning as a means of social control, and the subordinate position of women in our society - provide obstacles to controlling the spread of the disease.

The article examines some of the difficulties that women face in negotiating "safe sex" with their sexual partners. It looks at the problem experienced by women, of dealing with male sexual partners, who have a number of sexual partners and refuse to use condoms.

Women and AIDS

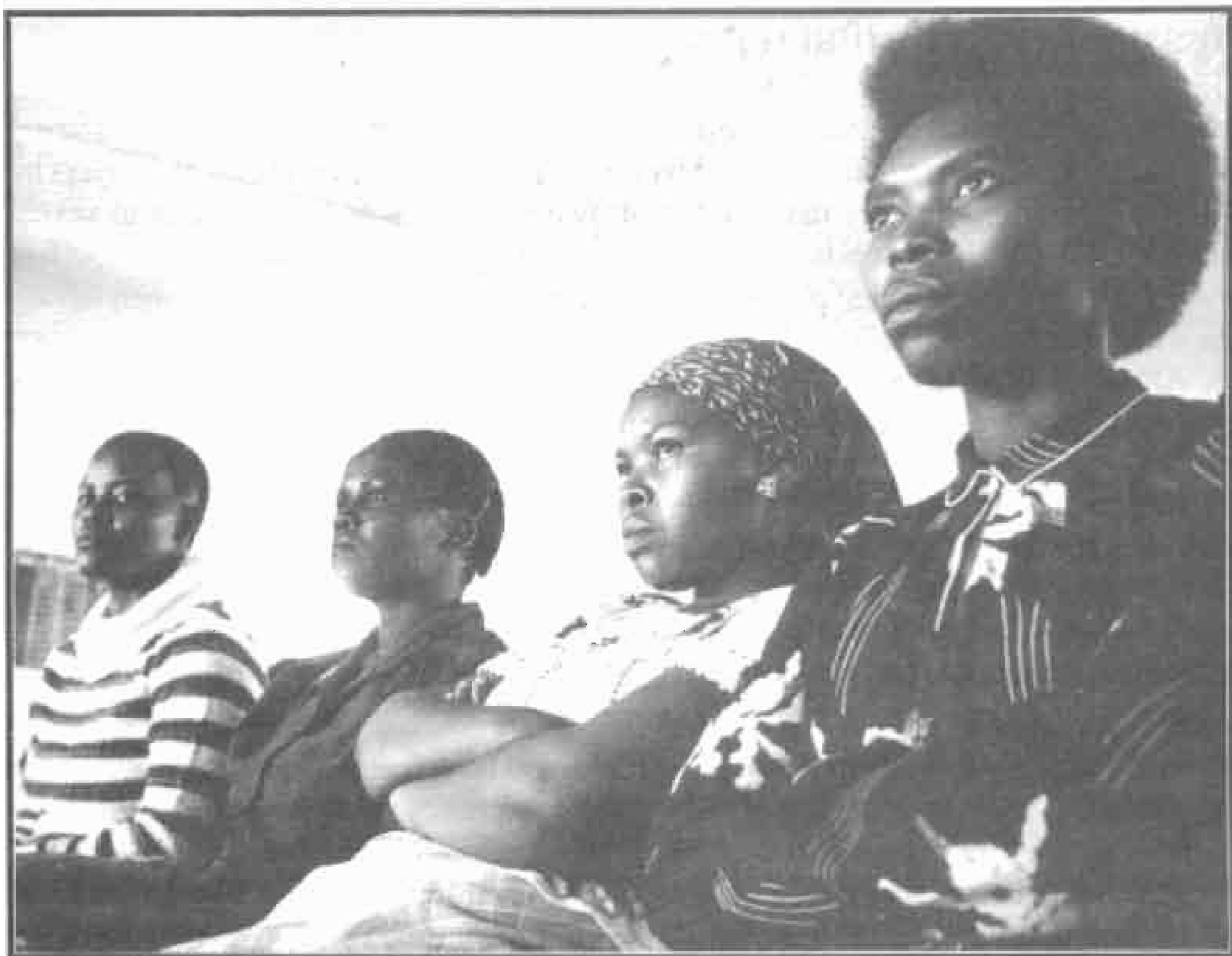
The AIDS epidemic has focussed a triple imperative on women - to save their own lives, those of their sexual partners and finally those of their as yet unborn children by ensuring that they remain infection free.

Furthermore, it is women (either mother, mother-in-law, sister, nursery and junior school teacher or domestic worker) who are responsible for most of the care and socialisation of children.

In our society the majority of nurses and community health workers are women. Inevitably it is on the shoulders of women that much of the burden for caring for the infected and dying will fall when the AIDS epidemic reaches its peak in this country.

WIth our existing health care facilities already over-burdened, the home and the family will be where those dying from AIDS will return for care. When the women who run these homes and who are the providers of health care in them, themselves become sick, there will be nothing to fall back on.

The impact of AIDS worldwide has forced people to look seriously at ways of preventing the disease, given that there is no cure at present. The main focus currently has been around educating people around AIDS. Particularly how to adopt "safe sex" practices in order to prevent the spread of the disease.



Women will carry much of the burden of caring for those with AIDS

Gender relations

There are many obstacles to women's exposure to educational material as well as to their adopting"safe sex" practices. Factors such as poverty and lack of access to health care centres are only the more obvious of these. Others are more subtle and difficult to address. These stem from the very nature of the relationships which women have with men.

Specifically, the constraints which many women are subject to in other spheres of life also impose themselves in sexual relations and is manifested in the tendency for women to be subordinate to men. This has serious implications for women's ability to persuade their lovers to adopt "safe sex" practices.

The everyday experience of most women as they face the threat of AIDS, is often one of inability to persuade their lovers to jointly adopt "safe sex" practices. This was borne out in a recent survey of black mothers from a Durban township which found that several women felt that they were at risk because of their partner's infidelity.

Apartheid and marital relations

Migrant labour has, for decades, left both men and women without normal marital relations. The long separations forced on rural women and their partners and lovers by migrant labour exacerbates the situation in two ways - by adding an edge to sexual relations when men are at home, and, by making it more likely that both parties will at some time have other sexual partners. This diminishes the possibility of women having the kind of control of their sex lives required to practice "safe sex".

Although to some extent, having more than one sexual partner is common to both rural and urban women, this problem is particularly urgent for rural women because of their poverty and lack of access to medical information and assistance.

Although white South Africans have not been subjected to the same political forces, many are also involved in a number of sexual relations at the same time and/or serially.

Women and knowledge of AIDS in Natal

There is a scarcity of information on the attitudes and behaviour of South African women in relation to AIDS. Recent studies in the black community show that media campaigns focussing on informing the public about AIDS have been successful.

In a random sample of households in a black township in Durban it was found that all women interviewed had heard of AIDS either from the radio, television, friends, clinics or newspapers.

While there were a few misconceptions about the nature of the disease, the majority of the women knew that having one partner and using a condom reduces the risk of becoming infected with HIV. However, not a single woman had experienced sexual intercourse during which a condom was used.

Some did not believe that AIDS could kill and the small proportion that accepted it as fatal, felt helpless to do anything about changing their or their partner's sexual lifestyle.

The gap between knowledge and action

What makes it so difficult to effect the behavioural change towards "safe sex"?

One of the issues is personal incentives. The findings above indicate that many women were under the misconception that AIDS was not fatal. This means that the ultimate incentive for behaviour change, saving your life, is absent.

Another issue is the ability to implement an intent. Women tend to take the lead in sexual matters from their partners and many do not feel free, let alone insist, on the

changes which they may have recognised will save their lives.

It is not only the sexual interaction itself which is touched by AIDS: as important are the repercussions for the relationship of the partners as a whole. What will be the effect of a woman's relationship with a partner, were she to insist on precautionary steps to which he is antagonistic?

If a woman denies her partner sexual access on the grounds that he is likely to infect her and will not use condoms what effect could this have on the relationship?

Educational programmes in addition to disseminating information on "safe sex" need to incorporate the transfer of skills required to negotiate a change in sexual behaviour with a partner who has more power within the relationship.

We believe that the major problem in fighting AIDS is one of empowering women to say "no" to unprotected sex. Related to this are other practical problems that need to be overcome such as the lack of availability of condoms, technical knowledge of how to use condoms, and the bad public image which condoms have and which influence men against their use.

Condoms and birth control

While health personnel may be preaching condoms as the answer to remain uninfected at this time, it must be remembered that they have being doing much the same for years with respect to fertility control.

Condoms have also played another role, both men and women have been issued with them when suffering from other sexually transmitted diseases. It is no wonder that condoms have a bad name: in addition to being seen by many black people as part of the white government's desire to limit the black population they are also seen as an admission of having a sexually transmitted disease. The prevalent attitude among both men and women towards condoms therefore comes as little surprise.

Apart from the political implications attached to family planning programmes, most women want to have children. Fertility is highly valued and a large family is essential as security in the context of socio-economic deprivation. Condom use threatens this ideal.

The crux of the problem - who decides?

Regardless of these impediments to condom usage, the question remains of whether women can be realistically expected to suggest or insist that their husbands and lovers indulge in "safe sex".

Reasons why many women may not insist on condoms include the wish to conceive

Single sex hostel - the separation of partners because of migrant labour makes it even more difficult for women to make the demand that their partners practice "safe sex".

or that the joy of reunion blots out the fear of infection. When a migrant returns home it is hardly the time to enter a discussion about the need to use condoms.

Importantly, many women do not regard it as their place or right to take the initiative in suggesting condoms. Some quotes illustrating these problems: "I could not do it", "What would he say - he would just brush it aside", "No, it would be so difficult ... we have made beer to celebrate his return - can I then begin about the condom?"

The choice facing many women at present is whether or not to accede to male sexual preference if these involve more than one partner and/ or not using condoms.

The alternative will endanger many marriages and long term relationships. Some women may have the strength to persist, but it will be an empty victory for many as they lose their lovers and fathers of their children to other women, let alone the AIDS virus.

Others may fall prey to the physical violence which the anger and frustration which confrontations about sex so easily engender. It is here that the need for counselling

centres and support of other women is imperative. Campaigns need also to be launched which are directed to changing men's attitudes to sex.

The answer: support for women and persuading men to change

In the light of the above we believe that if women are to be protected from HIV infection, three distinct, but related initiatives need to be embarked upon.

Firstly, women need to be given information about, as well as cheap access to, condoms. More importantly, they need long term back-up and support to ensure they can use these methods. This might involve the setting up of a network of counseling centres throughout the country where other women are available to discuss problems and provide the support necessary to give them the courage to insist on safe sexual practices. To the best of our knowledge few of the otherwise excellent AIDS counseling centres already in place have programmes whose explicit aim is to empower women in this manner.

The urgency for this type of support demands that involvement at the community level be sought without delay.

Secondly, attempts to develop and promote barrier methods that women can use, such as the female condom, should be supported. The female condom is not yet available in South Africa but is currently undergoing extensive research in the United States. This method, if successful, may provide a method of preventing the spread of HIV that women can have greater control over.

Thirdly, men must be targeted, preferably at the same time as the women. In addition to being given information, they must be made sensitive to the dilemmas facing women. It is of limited value to expect women on their own to intercede with their lovers and to take the initiative in insisting the use of condoms. Safe sex for both men and women needs to be marketed to men as much as to women.

Eleanor Preston-Whyte, Professor of Social Anthropology, University of Natal, Durban
Quarraisha Abdool Karrim, Research officer, Medical Research Council, Durban
Maria Zondi works for the Kwazulu Nursing Services in Durban

Women speak out about AIDS

An interview by Critical Health

A & B are two women who are involved in AIDS work in the Johannesburg inner city. They spoke to Critical Health about the subject of women and AIDS, as well as the work that they are doing in informing sex-workers about AIDS. For professional and ethical reasons they asked that their names not be used in this article.

Critical Health: Do you accept this idea that certain campaigns around AIDS and HIV should be directed specifically at women?

A: My feeling is its okay to have certain campaigns directed specifically at women. But those really shouldn't be the only campaigns to be undertaken. Just as much emphasis should be put on men and the general community as such because if everything is directed at women people will tend to think this is a woman's responsibility. Women shouldn't have to feel that they are the ones that have to teach their children or their husbands about AIDS. Because most of the time it is quite difficult for women to actually do that.

CH: As I understand the form of most campaigns that have been undertaken to inform people about AIDS have been directed at the community generally rather than identifying either men or women specifically as their target.

B: Recently, there has been a shift to look at the impact of AIDS on women in particular. So for example World AIDS Day[1] last year focussed on women specifically and I think the World Health Organisation (WHO) has identified women and AIDS as a particular issue. One aspect of this has been the recognition that when it comes to caring for people who are sick, that largely gets done by women. Most health workers are also women, so in terms of hospital care as well, most of the care will be undertaken by women. Part of the concern is that resources and support work should reflect the role of women in dealing with the AIDS epidemic.

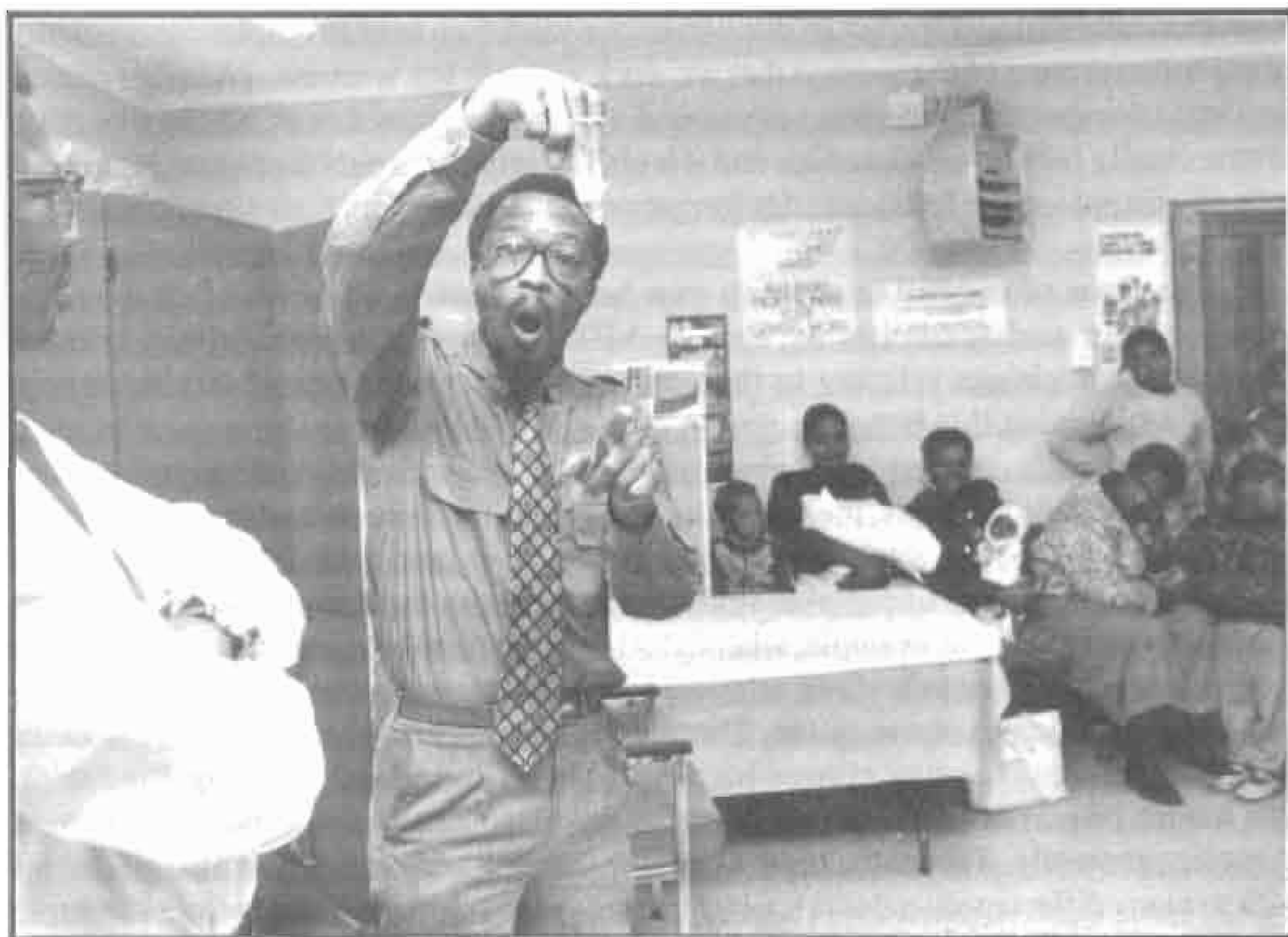
Please note: the term "sex-workers" is used interchangeably with the term "prostitutes" in this article.

1: International AIDS Day was on 1 December 1990.

But then there is also this whole issue of women as educators - this idea that women should be able to persuade men that they must use condoms. To a certain extent I think it reflects the way most family planning campaigns have been conducted. It's always the woman who must go to the clinic and sort out contraception and now some people are saying that it's women who must ensure that men wear the condoms. Of course that's very difficult because women inside relationships aren't usually the strongest party when it comes to negotiating about sex. So I do feel a concern that now there's this shift towards focussing on women and AIDS that it's not necessarily counterbalanced by looking at the specific role of men in relation to AIDS.

CH: So, women being in the less powerful position in these relationships between the sexes, what then would you say are the issues for women? Isn't it firstly that unless women take much greater control of their sexuality they are going to be vulnerable to AIDS and that it's a question of survival for them?

B: What we're saying is that if that's the only thing that you're saying then what are you saying to men? From our experience of AIDS work the real block comes in convincing



men that condoms are important. A lot of women, if they're aware of AIDS, understand that condoms are important, and the issue then is how do we persuade men to use the condoms. We must have a strategy which empower women to feel that they've got a greater sense of control over their own sexual relationships, but we shouldn't do that, I think, unless we also bring men in to talk about their sexuality and their concerns in relationships.
A: Actually it's very difficult, due to the position that women find themselves in, for anyone to say, "Look AIDS is a threat and you must take more charge of your sexual life because it's a matter of life and death". It may also be a matter of life and death if the man leaves because of the woman insisting that he uses a condom. She might not have any food to feed herself and her children and might not even have a roof over her head. So, for most women it is very difficult for them to say to men, "Look you put on a condom or else", because then the men will probably just leave. So it's difficult for them to get that power.

CH: In one's approach to AIDS education shouldn't one emphasise "safe sexual practices" first of all rather than specifically condoms?
B: I'm sure in a general public education set-up that you would also look at things like monogamous relationships but in relation to our work [we tend to emphasise condoms more] because most of the women that we work with are sex workers. [Another reason for emphasising condoms] is that you can underestimate the number of people who don't have mutually faithful relationships and it is also an important public education strategy to be able to put forward advice and information which deals with their situation as well.

CH: This issue of control over one's own body relates to all kinds of things, like contraception and sexuality, as well as AIDS. How can women attain greater control over decisions relating to their sexuality and their bodies? Are their real ways of addressing this issue?
B: This is a really general issue about the kind of power relationships people find themselves in, the structures, the lack of opportunities for women, and the whole issue, as well, of how society deals with sexual relations in particular. We haven't really thought enough in terms of concrete strategies to deal with these things. Things like sex education in schools, for example, where you bring together boys and girls and you start at a fairly early age to talk about relationships with women, shared responsibility in terms of precautions, contraception. Those things are all part of moving in a direction which tries to create a better climate for discussion around sexual relations. But I think also it must be part of an overall push to give more opportunities and power to women in society generally. The whole issue of how we see sex and sexuality is also all tied up with so many different attitudes in society towards various things like, for example, rape. Until we can deal with issues like rape we're never going to be able to take women seriously in relation to other issues of sexuality. We need to be able to break through

some of those things in order to understand what it means for individuals to have control over their bodies.

A: One of the things that we have to consider in this country, as well, is that in some cultures there are certain things that are not done and cannot be done. Like with some people who do actually practice traditional culture the woman isn't supposed to talk back to her husband. She's supposed to do what her husband says, what the in-laws say, those sort of things. So that she actually has no right to say to the husband, "Look there's this problem of AIDS, lets use a condom". She cannot even begin to discuss those sort of issues because of her culture. She might know about the problem from reading or talking to friends but to actually put that into practice is an extremely difficult problem.

CH: Is a pregnant woman who is infected with the AIDS virus legally entitled to an abortion?

A: HIV-positivity hasn't actually been included specifically in the laws regulating abortion. But apparently one of the things which they say in this law is that if the woman's physical or emotional health is endangered then she can have an abortion or if the foetus is abnormal or ill then she can have an abortion. It is proven that women who are pregnant and who have HIV develop AIDS much faster and also that there is a chance the child will have the virus. I think on those grounds they do qualify for abortions.

CH: Does AIDS make it important to address this question of whether prostitution should be legalised?

B: I don't think AIDS makes it important. I've never seen any figures on this but I think it's suggested that legalisation doesn't necessarily make it easier to control the AIDS epidemic even if you are able to register sex-workers and then insist that they have regular checks. The basis for singling them out in the first place is the belief that sex-workers are an important component in spreading the AIDS epidemic. And I think that kind of thing needs to be validated because from our experience you seem to find that many of the women actually do use condoms and are keen to use them. So I think you have to be a bit careful when you assume that just because someone has multiple sexual sexual partners that they are responsible for HIV transmission to the wider community.

If prostitution was legalised I don't think many of the women would come forward and register themselves, would go for regular checks. It's only really sex-workers who work in areas where they may be more organised, working for places like some of these escort agencies in town, where they've got clients who earn more money, who may feel more able to register themselves, to put themselves through regular checks, and to be discerning about clients who they have sexual intercourse with.

But I think many women who are sex-workers in South Africa are not in that bracket at all. It's really quite a poor, quite difficult existence. Just earning enough money to pay for the next days rent. It's not something which gives you plenty of money to live on. And I don't think that women who are involved in prostitution for those reasons, have got

The real block comes in convincing men about the importance of condoms.

options around deciding which men they are going to sleep with. You're asking people to take long term decisions in terms of their health when they may be far more concerned with the here and now and where am I going to stay tomorrow if I don't get enough money tonight.

CH: So then for the vast majority of sex-workers you don't think it would make a significant difference.

B: Well I can't see how it would work in say rural areas or in township environments. It's often useful to make a distinction between legalising and abolishing any kind of legislation around prostitution. There's a group in Britain who call themselves the English Collective of Prostitutes. They call for the abolition of prostitution laws because they say these laws penalise women for being poor and for doing something about it.

What they would like to see is an abolition of all laws about prostitution so women can be involved in prostitution but don't have to be harassed by anyone. [They say it should be] like any other job.

Why should the state feel that in the area of prostitution specifically they must legislate for control over it. So perhaps you can only work from certain premises or if you have monthly checks. That kind of thing. In relation to AIDS that's what people would be saying.

CH: So what would one say to a woman, in a counseling situation say, who has been

identified as being HIV-positive?

A: The bottom line is always that it's the women's decision to decide what she does. In pre-test counseling hopefully all the facts will have been given on how to protect yourself and all that stuff. She has all the information. It will have to be her choice what she decides to do.

I think what people want is for women who are HIV-positive to stop working. Now I mean, obviously it's fine if the women doesn't want to be a sex-worker and she wants to do something else. We would all want to support that anyway. But for this to happen it must be with more resources and training and opportunity being made available to women.

B: Some people would feel that what you've got to do is you've got to stop women doing this. Which I always find irritating because basically women wouldn't do it if there wasn't a market. We're not saying we must stop all these men needing sex. You know they're always saying we've got to stop these women from doing it. We have got to rehabilitate them. You can't just say those things. It's like empty slogans.

CH: But don't you think that legislation would be significant to the women that you are working with, wouldn't it make a difference to them?

B: Lets just discuss what we mean. Do you mean, to say prostitution is now legal but to legislate for certain controls as a means to control the AIDS epidemic? Or are you saying we just want to get rid of all laws around prostitution?

CH: I'm talking about the argument that (a) we get rid of the laws around prostitution and (b) there should be no compulsory registration or other controls. The motivation is that it would then be easier to encourage sex-workers to become informed about AIDS and to engage in safe sex practices.

B: If you took away the prostitution laws the good thing would be that it wouldn't be forced underground in the way that it is now. Doing the work that we do you enter into a grey world of illegality. I think it would impact much more on things like the level of abuse that these women experience in terms of police harassment, physical assault, being raped. You know I think that then women would be in a much stronger position to say, "I don't accept this, I'm going to the police to report what's just happened to me". I think it would have a massive impact on that level.

But in terms of the AIDS epidemic I don't think it would have an impact. Because ultimately you see we are reaching them. We are doing all the things you mentioned. We're talking about safer sex practices, we're giving out condoms free, we're encouraging women to come here if they need further advice about things they're worried about. We're telling them where they can get tests free of charge. All of those kind of things. But I don't think your scenario will do anything in addition to what we're already doing.

I'm all in favour of what is being suggested but I don't think it would do much in relation to AIDs.

TRIPLE JEOPARDY - WOMEN & AIDS

A Panos Dossier. The Panos Institute, 1990.

In September 1990 the World Health Organization (WHO) reported 283 010 cases of AIDS worldwide. Of these 25% were in sub-Saharan Africa.Taking under-reporting into account the WHO estimates that approximately 800 000 people worldwide have AIDS.

In the Western World the majority of people with HIV were men infected through homosexual transmission or men and women infected by sharing needles for drug use. In sub-Saharan Africa the overwhelming majority of those with HIV were infected heterosexually. As a result women make up roughly 50% of those with HIV. HIV infection among children is also relatively high.

It is anticipated that the numbers of those who are infected with HIV will increase in the coming years, particularly in the countries of the developing world. WHO projections estimate that by the end of 1992, sub-Saharan Africa will have a total of 600 000 cases of AIDS in women and a similar number of children.

In addition to the danger of contracting AIDS and the risk of their passig it on to their children, the work of caring for people with AIDS is also overwhelmingly carried out by women, throuoghout the world. Financial costs saved through the informal health sector are enormous. The hidden costs of taking time off work, providing food, and meeting other needs are borne by homecarers and their communities. Emotional demands on carers are also huge. Reallocating resources to support home and community carers can spread the load more evenly and reduce the stigma surrounding AIDS.

Most studies show that between 25 - 50% of HIV-positive women pass on the virus to their baby before or during birth. During the 1980s, estimates are that approximately 90% of those infants born HIV-infected worldwide, were in sub-Saharan Africa.

"Triple Jeopardy" looks at a variety of issues facing women in confronting the AIDS epidemic. (All the above information comes from the book).

Available from the Panos Institute, 9 White Lion, London N1 9PD, UK. Fax: 0944-071-278-0345.

SECTION C

INTERNATIONAL PERSPECTIVES

Sexual abuse is one manifestation of violence against women, and of violence more generally, in our society. The first article in this section looks at the issue of violence, as raised at an international women's health confeence. Also, on an internatiunal level, the second article looks at the negative effects of structural adjustment policies on women. In addition to their more direct effects, these policies can be seen to add to the kind of social conditions which often promote violence

"Global Solidarity for Women's Health"

A Report on the 6th International Women and Health Meeting

Debby Bonnin

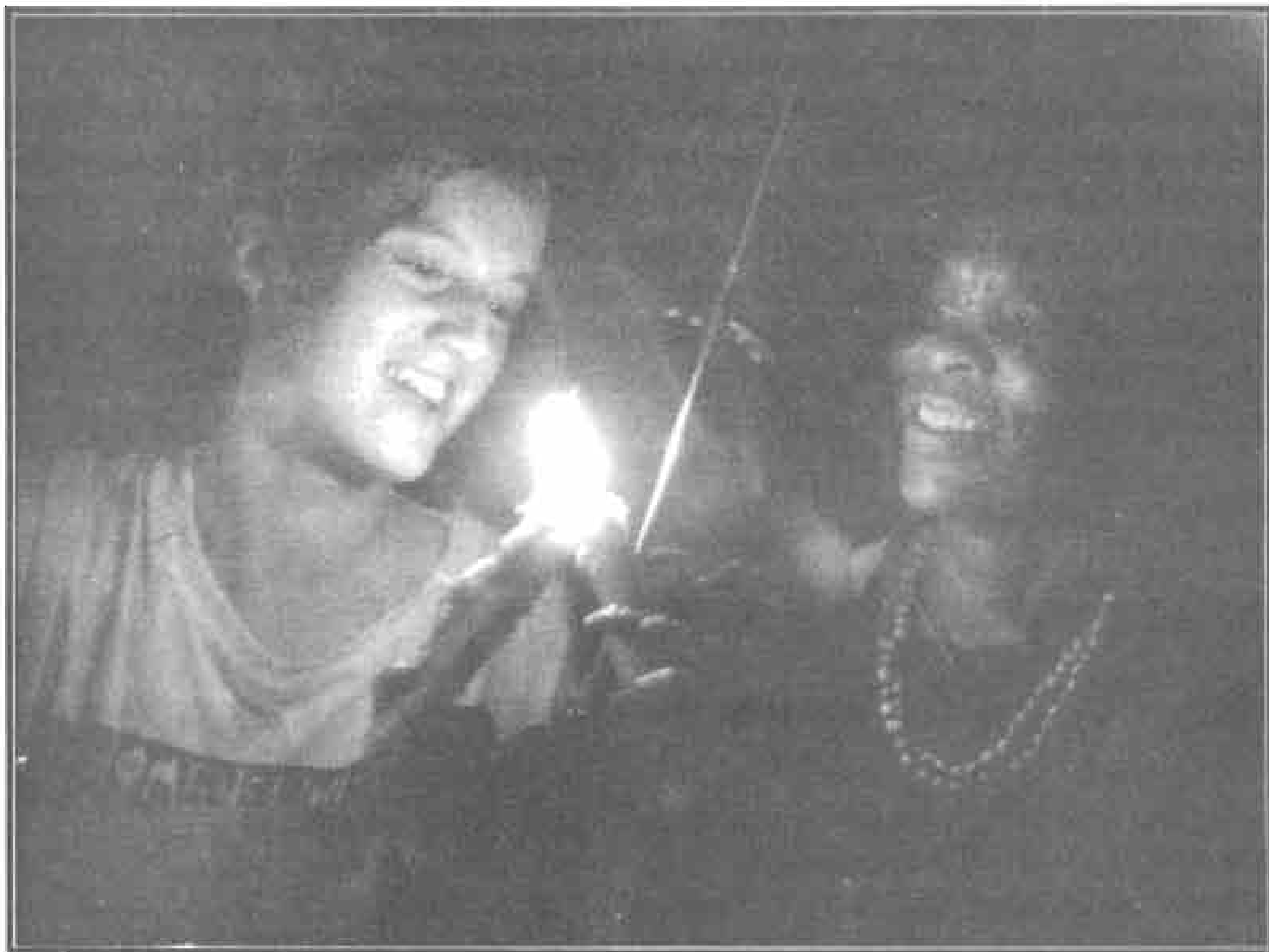
The author of this article attended the 6th International Women and Health Conference in the Philippines in November 1990. Her report focuses on issues that were raised at the conference relating to violence against women - including militarisation, sexual violence, and female circumcision - and those relating to sexuality and infertility.

International meetings of the women's health movement have been held every 3 years since the first meeting in Rome in 1977. During the past 13 years the nature of the meetings have changed, from a small number of participants based mainly in Western Europe to a large meeting, with participants from all over the world. The focus has also changed; from being centred around reproductive rights to now encompassing a large number of issues that affect all aspects of women's social, mental and physical well-being.

The impact of the global economic crisis, reproductive rights, militarisation, sexuality, violence against women, religion, transnational corporations, popular education and feminist ethics were all part of the programme of the 6th International Women and Health meeting in the Philippines in November 1990.

The 6 day conference was attended by 300 women from over 80 countries and 100 Philippino women. Most of these women represented grassroots women's health organisations. Many representatives were angry that funding organisations and government linked groups such as the United States Population Council were allowed to attend. They said that much of their work brought them into direct confrontation with the policies that these groups championed.

Representatives from the Latin American and Caribbean, South-East Asian, and the African regional women's health networks, were also amongst those who attended. African women held their first network meeting in October 1989, with the second



International Women's Day, Hillbrow, 8 March 1991 - solidarity against violence against women.

meeting being planned for later this year in Zambia (see end of article for details). Two of the main themes of the conference are focussed on in this article:

(a) Violence against Women - including militarism and violence against women, sexual violence, and traditional cultural practices.

(b) Sexuality and infertility

Violence against women

Most of the women at the conference from Latin America, Africa, Asia, the Caribbean and Pacific, had at some time lived under repressive governments or lived in areas close to United States military bases. This gave women common reference points in talking about the effects of violence and militarisation on women.

During the discussion, women from Eritria, Palestine, Bangladesh, Chile and Malaysia described horrifyingly similar experiences of military rape, sexual abuse of minority women, air bombardment, and detention by military or repressive regimes.

"The disappeared"

In her paper, Maria del Rosario Cuevas of the "Comision de Dereohos Humanos Central America" spoke about "the disappeared". "The disappeared" refers to people who have been detained or abducted, usually by members of the local "security" forces, and are never seen, or heard of, again. It is believed that they are usually executed and buried in mass graves. In Latin and Central America about 150 000 people have been detained and disappeared in the last three decades. Women feel the effects of these human rights abuses, both as victims (30% of the total) and as widows and mothers, left to cope with the deep emotional and psychological scars.

Military bases

Another area of concern was the effects of the presence of military bases on women. These problems were reflected all over South East Asia where members of the US military forces were present.

In the Philippines, where the U.S. is supporting the Aquino regime's counter insurgency programme, there is the problem of increased militarisation. One of the delegates talked about the consequences of the presence of US bases in the Philippines. She said that in effect the bases encourage prostitution and the economic dependence of women on the bases. Officially there are 749 ''amusement places'' in the immediate vicinity of the bases. Registered ''hospitality girls'' number around 300 000 while child prostitutes (7 - 15 years) number around 20 000.

Delegates discussed the role of US servicemen in the spread of AIDS and other sexually transmitted diseases. A women from Thailand explained the situation in her country where every two months US navy boats stop. She said "4 000 to 10 000 US navy men disembark for 'rest and recreation'. Sex workers come from all over the country. One of the consequences of this is that 50% of sex workers are HIV positive". But the US government refuses to take any responsibility for the health care of the women.

There is also the problem of unwanted pregnancy. Women have to resort to back-street abortions or are left to care for 'souvenir' babies as the Amerasian children are called.

Personal violence against women

Betty Yeom from the "All Women's Action Society" explained how women's organisations in Malaysia had formed a Joint Action Group to deal with sexual violence against women. In their work on sexual harassment at the workplace, rape and domestic violence in the home they have focussed on public education forums, meetings with public authorities, eg. police, health workers, and legal reforms. Over the last five years they

have had some success in getting laws amended, educating the public on sexual violence and getting the police to have a more sympathetic attitude to victims of sexual violence.

Women from Australia described how after pressure from women's organisations the government gave $3 million for a central campaign on criminal assault and violence against women. The campaign involved TV and newspaper adverts, a national survey on attitudes towards violence, and educational projects - including community and professional education.

In Canadian hospitals nurses have an 'emergency' code which they call when they experience abuse. When the other nurses hear it, they all move to that area to give the nurse being abused solidarity support.

Female circumcision

Berahne Ras-work from the ''Inter - African Committee on Traditional Practices Affecting the Health of Women'' spoke about the practice of female circumcision. She said: "genital mutilation is a living reality and a clear manifestation of social violence against women. Women are made to believe that their body, especially their reproductive parts are unholy and unclean. Millions of women submit to the mutilation of their body and their most sensitive parts in order to be clean, chaste and loyal to their husbands. In order to reduce their women's sexual desire, society found it necessary to reduce her physically".

Sexuality, Fertility and Solidarity

Women's oppression is experienced by them, in various ways which affect their sexuality. Examples are: the number of female AIDS victims, through limited notions on sexual preferences, acts of sexual violence committed against women, through their lack of control over their fertility, and in dehumanising traditional practices.

In most cultures womanhood and motherhood are seen as being synonymous. This may result in infertile women feeling alienated. Infertility in women are may be the result of scientific or military interventions eg. a consequence of the use of contraceptives like the Dalkon Shield or a result of the use of Agent Orange.

There are also different approaches to fertility and infertility with respect to First and Third World women. As Jocelyne Scutt said; "Where a white middle class woman is diagnosed 'infertile' the 'treatment' in the developed world is to 'make her pregnant' by whatever means possible. Third World women may be encouraged to attend sterilisation camps or may have other contraceptive measures forced on them. The infertility rates of women in Third World countries are high. Nonetheless both fertile and infertile Third World women are seen as candidates for population control".

What is needed though is women's solidarity on issues affecting their sexuality.

However, solidarity, as Rina Nissim who spoke on lesbianism pointed out, is often not forthcoming. Heterosexual women don't support lesbian women's issues; western women don't support African women in their campaigns; the examples are endless. The dominant women (western, white, middle class, heterosexual) need to recognise other women's needs and even though they might be contrary to their own, provide solidarity and support.

Conference resolutions

The last session of the conference was spent discussing resolutions that had come out of the different themes and sessions. Women from the United States who were attending the conference, presented resolutions condemning the presence of US bases in the Philippines. Other resolutions called for safe, effective contraception and sterilisation, comprehensive health services for women, full information about sexuality and reproduction and safe, legal abortion. There were also demands around access to clean water, low-cost food and housing, sanitation, daycare and cultural changes.

In conclusion here are the impressions of Clara Ejembi from Nigeria; "The conference is a real meeting of the minds. But though I may not agree with all that has been said (eg. in the sexuality session), it did, however, give an insight into other women's perceptions of issues. Meeting women from all over the world and from different organisations has also allowed for some networking. Salamat!"

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· The Second African Regional Meeting on Women and Health takes place in Zambia, 1991. Contact Christine Ngambi, NGO Coordinating Committee, P.O. Box 37879, Lusaka, Zambia.

· The Seventh International Women and Health Meeting will be held in Uganda in 1993. Contact Josephine Kasolo, WGNRR - Uganda, P.O. Box 2395, Kampala, Uganda.

Debby Bonnin is a member of the AGENDA editorial collective. AGENDA is a forum for comment and debate on all aspects of women's lives.

Structural Adjustment Policies

Shifting the Costs of Social Reproduction to Women

by Nazneen Kanji.

International loans and aid will become increasingly available to South Africa in the near future, as a result of changing political conditions. While we are certainly in need of resources to redress the inequalities of apartheid, aid and loans often carriy with iit dependence on donor countries and varying degrees of control from outside agencies. One such example of outside intervention in the recipient country's economy is structural adjustment. This often involves the promotion of privatisation of social services such as health. In South Africa, the development of a progressive national health service would be undermined by this type of intervention in our economy.

This article, taken from a paper presented at the Workshop on Economic Policy, Equity & Health in Zimbabwe in February 1991, looks at how structural adjustment policies affect low income women.

Recession, Adjustment Policies, Low Income Groups, and the Sexual Division of Labour

Introduction

The period 1980-82 marked a deep recession in the international economy. Stringent monetary policies were adopted in the US, UK and other industrialised countries. These countries sharply increased the real rates of interest on loans and decreased overseas development aid (Cornia et al, 1987).

In Africa, the combination of unstable and declining export earnings, poor terms of trade, declining development aid and debt repayments has led to persistent and

deteriorating balance of payments deficits and crises. In response, international banking institutions have advocated stabilization and structural adjustment policies.

Adjustment policies in the 1980's

Adjustment policies are designed to reduce financial imbalances in the economy, by cutting down on state, business and household expenditure, thereby reducing credit creation and budget deficits. These measures combined with devaluation of the currency have a deflationary effect. They also tend to have rapid positive effects on the balance of trade through a reduction in imports.

Structural adjustment policies, as the name implies, are concerned with changing the structure of the economy over the medium term. The policies mainly involve expanding the supply of exports, with the objective of improving the balance of trade. Loans from the International Monetary Fund (IMF) and the World Bank are tied to the implementation of adjustment policies. International donors are increasingly giving aid on condition that these policies are implemented.

The IMF and the World Bank argue that underdeveloped countries have a relative advantage in the production of primary exports and see this as the only growth pole for African economies. The private sector, they argue, is able to promote production in a more competitive and efficient manner than the state sector. According to their arguments, African governments have over-subsidised state enterprises and overspent in social sectors such as health, housing, education, basic services and social welfare. A typical adjustment package therefore includes:-

- cumulative devaluation to discourage imports and encourage exports (that is devaluing the local currency)
- reduction of government expenditure in the social sectors through privatisation, introduction or raising of user charges and the withdrawal of subsidies and wage freezes.
- trade liberalisation through the abolition of price and import controls and freer entry for multinational corporations.

As a result, education, health, and other social services, which were considered basic needs and basic rights, are increasingly seen as commodities for purchase.

The Effects of Adjustment Policies on Low-income Groups

By the mid 1980s, there was mounting evidence of the negative effects of adjustment policies on the living conditions of the poor. Lower real incomes, higher costs of living and restricted government expenditure in the social sectors were producing an alarming deterioration in living conditions, reflected in indicators like infant mortality rates and children's nutritional status (Cornia et al, 1987). In sub-Saharan Africa, per capita incomes fell by over one quarter in the 1980s and there was widespread unemployment.

Adjustment Policies, Low-income Households, and the Sexual Division of Labour

Low income households will be affected differently depending mainly on the nature of their members' employment and income. Yet all members of the household will not be affected in the same way since there is an unequal sexual division of labour within households. The nature and composition of the household (including the number of earners, the number, age and sex of children, the presence of other female members to share the reproductive work) would also be important variables in determining specific effects on women.

In addition, neither equal sharing of resources, nor joint decision making, is at all common (Mascarenhas & Mbilinyi, 1983, Raikes, 1989; Stamp, 1989). As Tibaijuka describes the situation in Tanzania, " although women do most of the work, men control the resources. In some cases, they even control female labour" (Tibaijunka, 1988, p15).

Structural Adjustment, the Household, Women and Health

If anything, the effects on women are worse because of the levels of absolute poverty. Evidence is growing that women are worse affected due to expenditure cuts in the social

Cuts in health services mean that women must spend more time caring for sick members of the household.

sectors, such as the health sector. One reflection of this is the rates of maternal mortality. Maternal mortality is 973 per 100 000 live births in sub-Saharan Africa, as compared to 346 per 100 000 in developing countries as a whole. The figure is 11 per 100 000 in industrialised countries (Commonwealth Secretariat, 1989).

Food production

A study in Zambia (Evans, 1989) found that rural producers reliant on selling traditional food crops, predominantly women, found their incomes being squeezed by stagnating producer prices, rising transport costs, and rising consumer good prices. In male headed households producing maize for sale, wives were allocating a greater proportion of labour time to maize production, often at the expense of other food crops like millet, beans and groundnuts. The men controlled the income from the maize, with some indications that their priorities were not for food items for the family.

Spending priorities

Studies have shown that men and women do have different spending priorities. Women buy goods and food for household consumption, while men buy items for their own personal use or as investments. When men buy investment goods they are usually for production and trade, rather than maintenance in the household (Bruce, 1989; Feldman, 1989). Gender ideologies support the notion that men have a right to personal spending money, while women's income should be used for collective purposes.

Household food

In Ghana and the Ivory Coast, as in most countries implementing adjustment policies, incentives have been given to export crop production like cocoa and cotton, with no support for subsistence crop production in which women are most heavily involved (Commonwealth Secretariat, 1989). Thus women continue to bear the primary responsibility for satisfying household food needs, while their access to and control of resources are reduced. The focus on increasing cash crop production, and expenditure switching, increases women's labour and decreases their income with negative implications for their own health and that of their household.

Waged work and the informal sector

In waged work, women are disproportionately represented in low paid and low skilled occupations which have been the most affected by adjustment policies. Within the "informal sector", there are also gender specific characteristics with men being more

involved in the more lucrative businesses (like electrical and mechanical repairs, transport, carpentry, etc.) and women more involved in the service sector: petty marketing of food and related items, domestic service, etc. Incentives, if any, are directed to "tradeables" as opposed to "non-tradeables" like the sale of cooked food for low paid workers in urban areas.

Cuts in Government Social Spending

The cuts in government expenditure in the social sectors has also had a disproportionate effect on women because they have primary responsibility for child rearing and family health and nutrition. The cuts in health services and/or the introduction or raising of user charges mean that women must spend more time caring for sick members of the household at home, more time queuing for health services (if utilized).

The situation is well illustrated in a study in North Zambia where women said they themselves could not afford to be ill both because of the direct costs of treatment and because of time spent away from productive work. They also pointed out that they were spending more time caring for sick members of the household, particularly children, at home (Evans & Young, 1989). This represents a direct shift of responsibility for health care from the state to women.

Similarly, cuts in food subsidies and rises in prices put more direct pressure on women because they are responsible for shopping and cooking food. Cuts or a deterioration in water services put more direct pressure on women because they, and their children, are primarily responsible for fetching water for household consumption.

Participation, Exploitation and Time

In addition to productive and reproductive work, women in low income communities are being asked to have a greater role in the organisation of items of collective consumption, like water and health services. This community level work is usually carried out on an unpaid basis, often in the name of "participation" in projects. If women are paid, for example, as community health workers, they do not receive salaries but "allowances" or "incentives" which almost always amounts to less than the minimum wage.

Tibaijuka points out that women in Tanzania have recently been targets for mobilisation to undertake unpaid activities like road building, building and maintaining schools for the community (Tibaijuka, 1988). In the same way, many health, housing and water projects assume that women have free time to give towards meeting these social needs.

Time use data, however, has shown that women consistently work longer days than men and that low-income women face severe time constraints in getting through what is often a continuum of productive and reproductive tasks. In many countries in sub-

Cuts in food subsidies and rising prices put more pressure on women as they are usually responsible for buying food.

Saharan Africa, a 16 hour workday beginning at 5 a.m. and ending at 9 p.m. is not uncommon. Mothers often balance the conflict between working for an income on the one hand, and domestic work and childcare on the other, by reducing their sleep and leisure time (Bruce, 1989).

Women-headed households

The situation may well be particularly acute in women-headed households which are disproportionately represented amongst the poor in many countries. Survey classifications of family types greatly underenumerate de facto women-headed households. As many as one third of households in the world are women-headed, and in some areas the figure is as high as 50% (Bruce, 1989). Yet, the stereotype of male-headed households

prevails and seriously limits an adequate understanding of and policy responses to the problems of production and reproduction faced by women-headed households.

Conclusion

In summary, because of inequalities in the sexual division of labour, low income women are bearing the brunt of adjustment policies, having to balance productive and reproductive work. The latter not just in terms of biological reproduction but the wider concept of social reproduction. Much of the expenditure switching and so-called efficiency measures of adjustment policies are in fact transferring the costs of social reproduction from the paid to the unpaid economy, with low income women footing the bill.

Moves towards state allocation of resources for social reproduction are in the process of being completely undermined by recession and adjustment. Profits for capital are maintained by further exploiting labour and, in particular, women's labour, thereby deepening both class and gender divisions.

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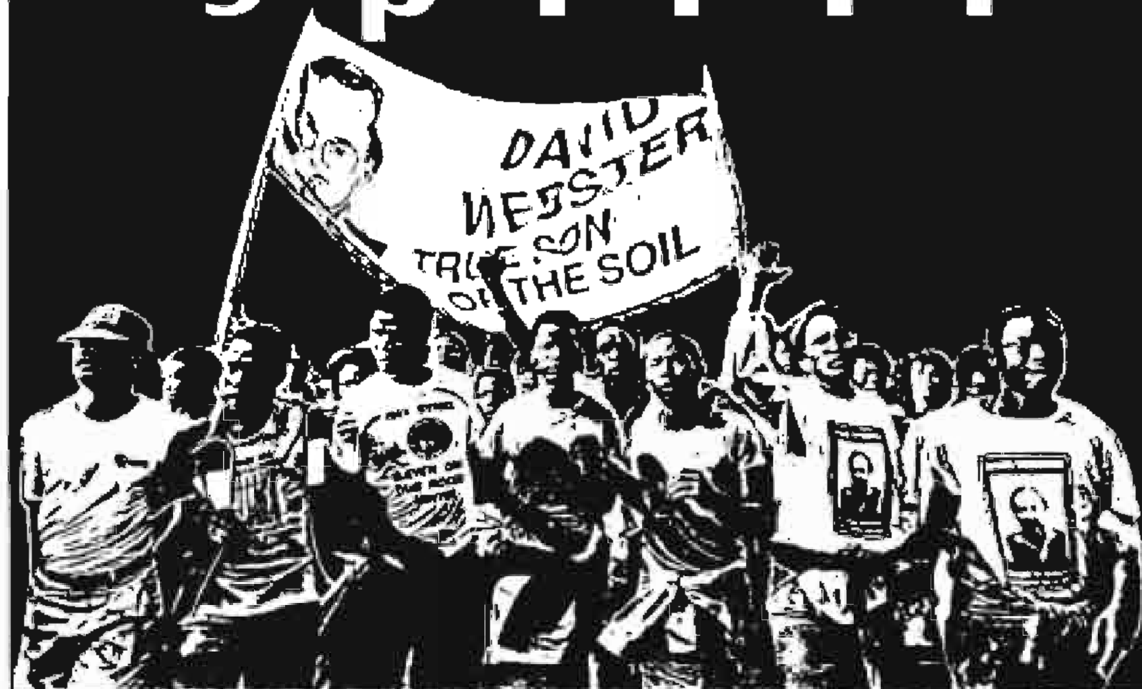

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SECTION D

MULTIPLE OPPRESSION

The issue of solidarity amongst women was raised in the article on the Philippines Conference in the previous section. One delegate at the conference remarked, "heterosexual women often don't support lesbian women, western women don't support African women". The three articles in this section look at the health issues of different women who together make up different facets of the "sisterhood" in South Africa.

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

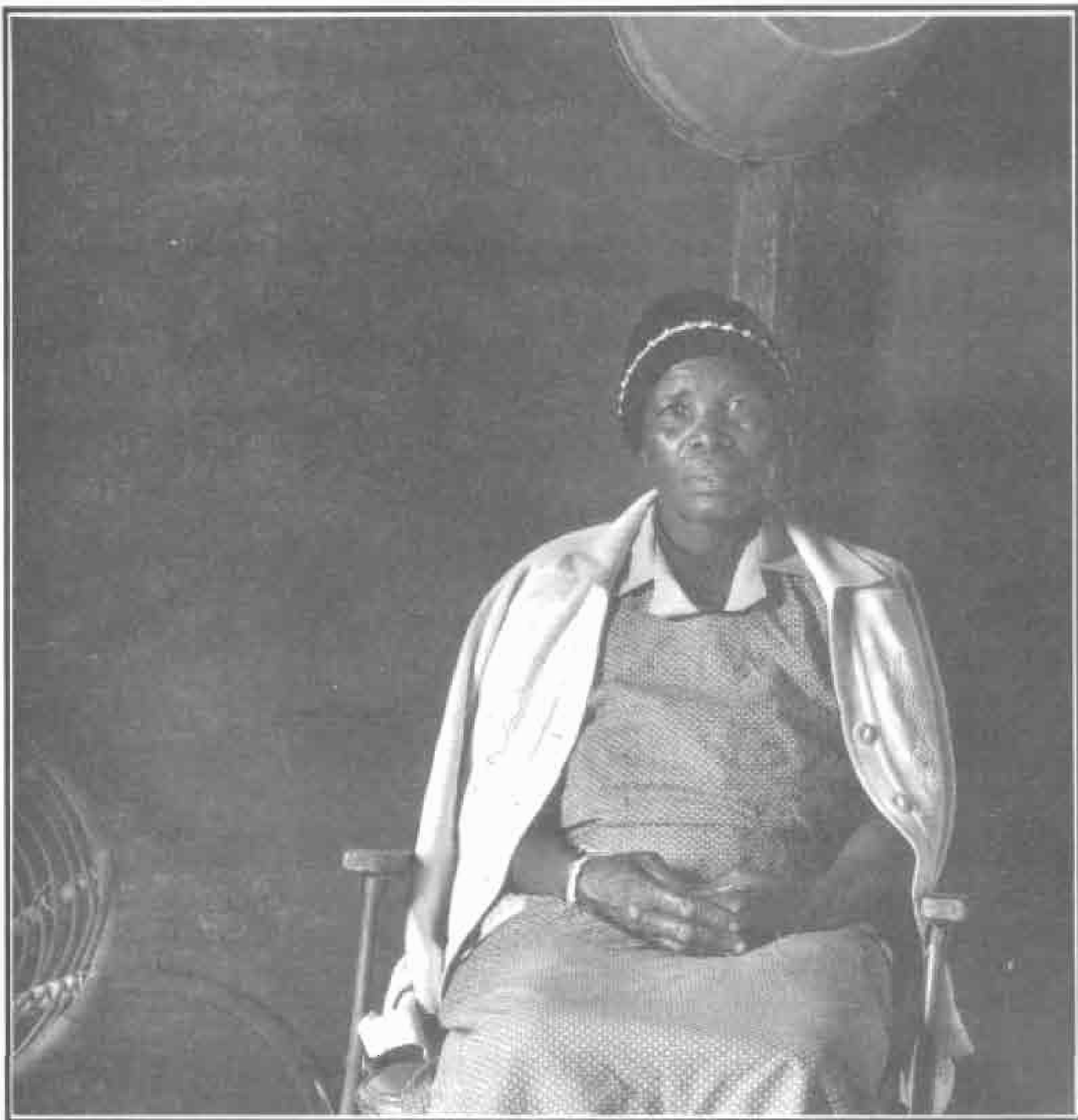
Poverty, malnutrition and ill-health among the rural women and children in South Africa have been exacerbated by the relocation of communities.

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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A Matter of Visibility - lesbian health issues

by Dee Radcliffe

The author of this article has to use a pseudonym, Dee Radcliffe. She fears that if she uses her real name, she runs the risk of losing her job as a health worker in the Transvaal Provincial Administration (TPA). In her article she highlights the particular concerns of lesbian in a society that is not sympathetic to lifestyles that it considers 'deviant' or 'abnormal'. Lesbians are shut out from all other institutions, including the health system. Consequently, lesbians are faced with a number of health related issues which heterosexual women do not have to confront.

Health is an area in which lesbians are particularly vulnerable and have specific concerns which are not always addressed by the health care system. Our chosen lifestyle carries a label of 'deviant', and puts us outside of the 'normal' community and thus, for the most part, outside of the sympathies of the mainstream health care system. Our low visibility as a group means that our health needs also have low visibility, and there is very little research and writing on them.

What, then, are some of the health issues that are specifically relevant for lesbians?

Silence and social sanctions

Firstly, we have to build our abilities to feel healthy and whole in the face of others reviling us as 'diseased' or 'unnatural'. Being mentally and emotionally well-adjusted as a lesbian is a victory against social prejudice. All of the major institutions of society - religious, schools, the health care system, the job market - tend to be anti-gay and do not perceive homosexuality as a valid and healthy sexual and affectional preference. Most of us have probably grown up with feelings of being different and abnormal, and have spent time at some point in our lives wondering what is 'wrong' with us.

Because it is hard to avoid internalizing the ridicule and shameful messages lesbians receive, many of us have had a traumatic time as we discover our identities. The accompanying feelings have brought some of us to seriously contemplate or actually

attempt suicide because of feelings of intense loneliness, confusion or shame.

Building a positive self-image in the absence of good role models and community support is a slow and difficult process. Young women growing up today are the first who are beginning to have at least some access to healthy images of lesbians in the press and in society at large, and hopefully this will lead to less shame and self-hatred. Still, we are a long way from a society that will lovingly embrace its lesbian members and support their development into sexuality and socially fulfilled adults.

Stress and Support

We also have to cope with severe stresses not shared by heterosexual women. These include the need to decide whether, when, and how to share our sexuality with others; being 'exposed' against our will; dealing with hostile responses; coping with homophobic family members, co-workers or communities; not being acknowledged or recognized for who we are; having to keep silent about our relationships; building networks of support when we may not know how to find others like ourselves and lacking the legal ability to protect and cement those relationships. Acting on our own sexuality, in our own homes and with consenting partners, constitutes an illegal act which can lead to arrest and prosecution.

These stresses can be aggravated by the fact that we are more likely to live isolated lives than heterosexual people, outside of socially sanctioned units like the heterosexual nuclear family, and might thus have limited support systems. This is particularly true in some cultures and small towns and rural areas, where the gay and lesbian communities are small, scattered or closeted, and where consciousness about gay and lesbian issues is very low.

Lesbians facing these sorts of stresses are susceptible to mental and emotional breakdowns and physical illnesses, and may turn to unhealthy coping mechanisms such as drug/ substance abuse. When stress leads to conditions which require treatment, it is not always easy or possible for us to talk to our health practitioners about the kinds of stresses we face, for fear of hostile or unempathetic responses. This may mean that we receive only superficial symptomatic treatment that doesn't really help with the underlying problems.

Causal Theories Aplenty

Society tends to hold certain stereotyped views on the health status of lesbians. We are frequently depicted as 'spiritually sick' or 'perverted'. Alternatively, we are seen as the product of a disturbed family arrangement - absent or ineffectual fathers or dominant and embracing mothers have made us the way we are (no matter that most of us have

heterosexual siblings!). People bandy about theories of genetic or hormonal imbalance, the implication being that we would all choose to be 'fixed' if only someone could find a way.

Some assume that all lesbians and gay men are weak, unhappy and maladjusted, without acknowledging that (just like heterosexual people) some of us lead healthy and creative lives and others do not. Some psychiatrists and doctors also still hold the outdated opinion that homosexuality is a disorder requiring treatment.

Misconceptions

There are also stereotypes and misconceptions about our physical health - for instance it is frequently assumed that homosexuals are universally at high risk for AIDS (whereas lesbians are in fact a lower-risk group than heterosexual men and women).

Likewise, doctors may have all sorts of misconceptions about the gynaecological needs of lesbians. For instance, doctors and nurses may assume that gynaecological needs are different whereas they aren't. The assumption is that lesbians don't have the same menstrual cycles as heterosexual women and possibly develop strange and unusual cycles totally unique to lesbians. Our real health can easily become lost in the assumptions about what our needs are.

Access to Health Services

Lesbians tend to have poorer access to appropriate health care than do heterosexual women. We do not have the same medical aid benefits accorded to straight people, because our partnerships are not officially recognized and we cannot claim for each other as spouses or dependents. Also, the thought of having to deal with the homophobia and heterosexism often found in the health care system may prevent us from seeking the care we need.

Coming Out for Treatment: Health Service Judgement & Morality

Finally, when we do seek out health care we cannot always reveal pertinent lifestyle factors (which might be important determinants of the treatment needed). We have to make a conscious decision whether or not to 'come out', and if we decide to do so we must then consider when, how, to whom, and how to deal with possible negative responses. It is quite often important for us to come out, to be able openly and comprehensively to discuss the health issues relating to our lifestyles and the anxieties we face - sometimes for medical reasons, sometimes because our being gay or lesbian is a central issue (often the case in psychotherapy, for instance), sometimes because our sense of integrity and

desire to be seen as a whole person demands it, and sometimes to ensure that our partners will be recognized and respected by the health care system (for example, if someone is about to undergo major surgery and wants to ensure that his or her partner will have full access to her or him afterwards).

On the other hand, coming out can lead to our receiving, not neutral medical treatment, but an irrational and emotional response or 'moral treatment' - punishment or judgement at the hands of homophobic health professionals. It also raises the question of whether coming out will lead to medical aid scheme/ employer/ family finding out before I'm ready to inform them myself?

Vulnerability

Lastly, when lesbians have health problems or disabilities we are more vulnerable to resulting social or economic problems. Proportionally more of us have been rejected or disowned by our families and cannot rely on them for support in times of medical or financial crisis. Others have chosen to have little or no contact because it is too painful to identify our sexual preferences or to deal with negative attitudes from family members who know.

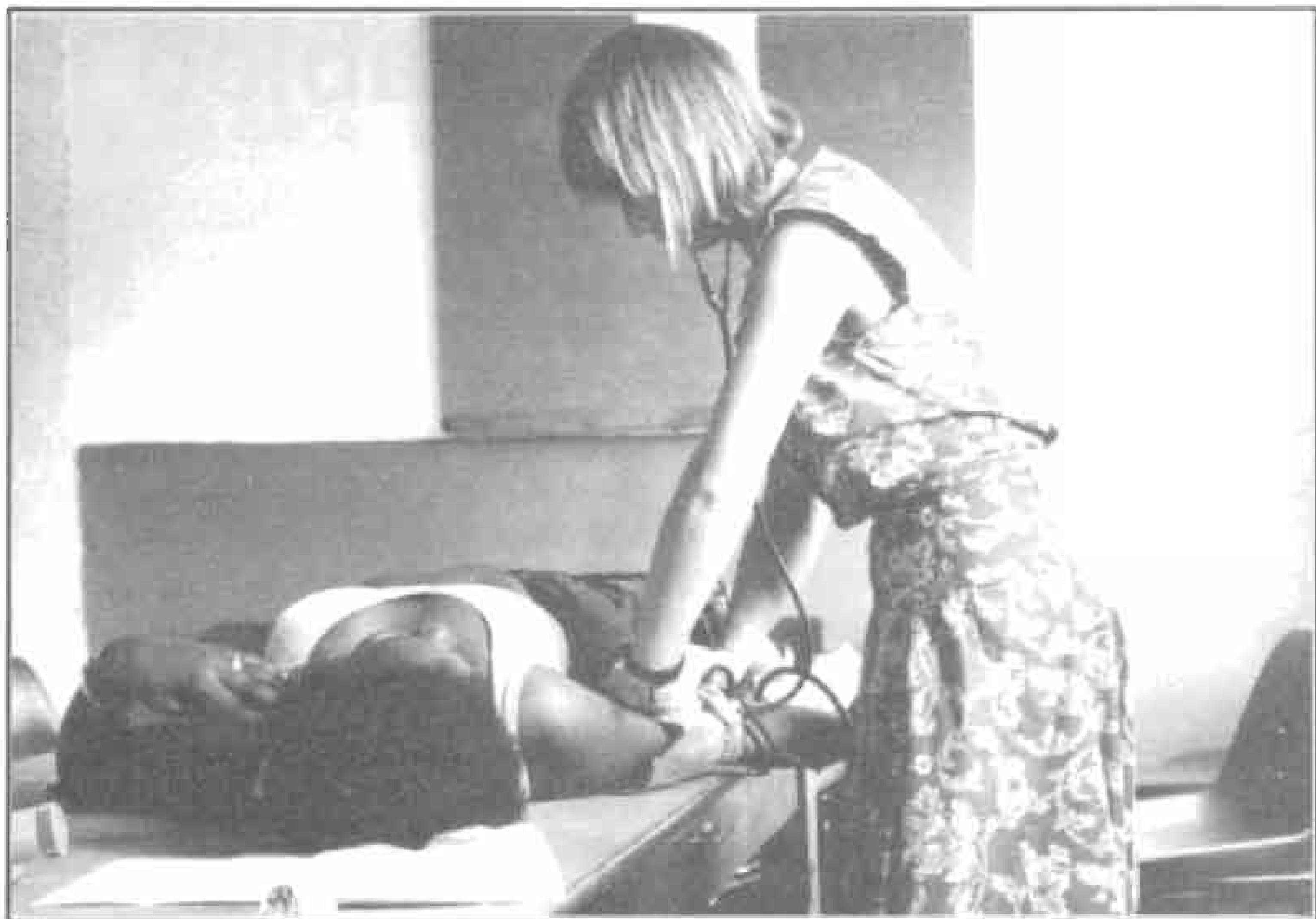
We are also vulnerable to being separated from our gay/lesbian friends if we become 'unfit'. The case of Sharon Kowalski in the United States, forcefully separated from her lover of many years and consigned to the 'care' of her unsupportive parents after she became brain-damaged in an accident, illustrates this starkly. Some lesbians draw up contracts specifying each other as their partners and next of kin, or give each other power of attorney for some degree of security, but the fact remains that society's opinion is weighed against us and the health care system, in particular, is not geared to deal with 'alternative' couples and families and their needs.

Health for All?

Now what is good health care specifically to us, as lesbians? It is health care that is non-homophobic, non-judgemental, supportive and respectful of our lifestyles, and insightful of the stresses and experiences faced by gay men and lesbians. However, this kind of health care is rare. It may exist in parts of the country, but finding relatively good health care for ourselves can be an uphill battle.

In South Africa, in general, the situation is that most people have to settle for less than ideal health care, because of poor access to services, financial constraints, as well as transport and other difficulties. As gay people, we too have few choices, and even if we have secure financial resources and full access to transport and to health care facilities, we still have no guarantee that we will receive non-homophobic health care.

Clearly, some major changes need to happen before we as gay men and lesbians have



Good health care is comprehensive, appropriate, non-judgemental and non-homophobic.

access to really good health care. In the meantime, we can try and obtain better health care for ourselves by using the gay community grapevine and word-of-mouth referrals to locate non-homophobic (or homosexual) health workers. We can also use listings and information provided by services like the Gay Advisory Board and crisis lines, and we can 'interview' our health workers before making appointments to see them (but beware - many people react with surprise and sometimes anger to simple questions about whether they are homophobic, and many have never even heard of the concept!)

There are also more long-term, broad ranging strategies which we can use, both as individuals and in gay and lesbian organisations. These include raising consciousness about our health concerns (in the media and within the health care system), providing alternative non-homophobic services (some, such as certain AIDS counseling services, already exist), and working to change the existing health care system.

In South Africa we have much work ahead of us to improve our health care. Lest we feel that this entails a battle of "us" against the health care system, it's good to bear in mind that there are countless numbers of gay and lesbian workers already within the health system, and it is as much as anything else a matter of finding these people, giving them our support, and working together with them to bring about change.

Health and disabled women

by Critical Health.

This article looks at the experience of disabled people in South Africa. It suggests that the quality of life for disabled people is influenced in an important way by the attitudes of others to disability. It looks at how disabled people are treated within the health care system focussing on the problems of disabled women.

You could be deaf, you could be blind.
You could have a speech impairment.
You could be physically disabled, having no use of your legs and feet and forced to rely on your hands and arms to move yourself around. If you are lucky you might have a wheelchair.
You could have cerebral palsy, or multiple sclerosis, or some other disease which cripples one or other of the functions of your body.
You could be mentally disabled. Perhaps this also contributes to a speech impairment. Perhaps your mental disability makes it virtually impossible for you to learn to read or write, or even count.

Maybe age has started to take it's toll on you.
Perhaps when you were born you were already severely disfigured.
It could have been the result of a slight error of judgement by the doctor who was taking care of your mother when you were born.
Or an accident on the road.
Maybe you were raped and brutalised by some thugs - or shot by the police in the riots in 1976.
Or a few years ago your boyfriend was in the SADF in Namibia and a landmine exploded virtually under his feet.

According to UN statistics, on average 10% of the population of every country is disabled. The Department of National Health's 1987 report on disability in South Africa notes that 12,7% of South Africans are disabled. (1987; Vol.1,p.14) (These statistics do not take into account the "independent homeland" populations).

The experience of disability

But what does disability mean?

The World Health Organisation (WHO) makes the following distinction:
Impairment: Any loss or abnormality of psychological, physiological, or anatomical structure or function.
Disability: Any restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being. (UN Action Program, 1983:3)

Access

So if you're disabled one big problem may simply be that of getting access to places, your doctors rooms, the hospital or family planning clinic, for example.

You may be a physically disabled person who actually can't get to the hospital without accessible public transport. Or you may have learning disabilities and when you get to the hospital, you are sent to stand in a long queue. After waiting in the queue for the whole morning you finally get to speak to someone. They get impatient with you because you can't immediately answer some of their questions. They send you away telling you to come back with someone from your family.

Maria Rantho

Disabled People South Africa (DPSA) is an organisation of disabled people which deals with disability rights issues. One of their more outspoken members is Maria Rantho. Maria grew up in Mamelodi where she passed Matric in 1973. She trained as a nurse, working at Tembisa hospital until her spine was fractured in a road accident. Subsequently she has lost the use of her lower pelvis and her legs. She stays in Garankuwa and works in Soshanguve. She has a ten year old son who was conceived and born after she became disabled.

About the problem of access to buildings Maria says, "you sometimes fear to go to such places because you won't be able to reach who you want to reach. When you look at the set-up in our hospitals they've been designed to accomodate non-disabled persons. There are certain areas where I for example cannot reach. As a result you fail to get adequate health services." If you are staying outside of the city, and have to travel long distances to get to a hospital or clinic, this problem of access becomes much, much worse.

Admission to a hospital doesn't necessarilly mean an end to your troubles. "The high beds with wheels, narrow bathroom doors, and small bathrooms," were amongst the

Mozambican war victims - war and violence have added considerably to the number of disabled people in Southern Africa.

difficulties experienced by one disabled woman in an American hospital. Said another, "I couldn't get the tops off the food with my atrophied hands. I couldn't properly wash myself because I couldn't squeeze out the washclothes, hold soap or reach my legs. I was forced to use a bedpan because I couldn't walk on the highly polished floors". (Crabtree, 1990; p.4,5).

Disability grants, education, employment

If you're disabled you may get a government disability grant. But this doesn't add up to that much, and if you're black it's less. There are various assistive devices which you can get, a wheelchair for example, but they may be far too expensive.

There's the problem of getting an education and of finding employment. According to a Human Sciences Research Council Survey, only 10% of South Africa's disabled people have permanent jobs. (Star, 20/9/89). In some countries regulations define a quota of disabled who must be employed by larger businesses. But even this is a source of controversy amongst disabled people. Some argue that they would rather not be employed by quota because they are disabled. Rather they would prefer the oppurtunity to prove themselves and to be employed on merit.

Living through pain

Perhaps your body is racked by excruciating pain and being alive is virtually unbearable. There may be those amongst the ranks of the disabled who feel there is no point in going on living. In 1990, 31-year-old American quadriplegic, Kenneth Bergstedt, petitoned the Las Vegas courts for permission to be given a sedative, have his life support system turned off and be allowed to die in peace. According to an affidavit, Bergstedt, who has been linked to a respirator for than 20 years, "receives no enjoyment from life, and is tired of suffering".

But, Paul Longmore, an assistant professor at a US University who also uses a respirator, is critical of cases such as Bergstedt's. The reason why people such as Bergstedt feel that they have no hope, "is not fundamentally because of their disability, it's because of their social situation". Actually, he says, "there is nothing inevitable about the social isolation and the deprivation of self determination of even the most severely disabled people". (Johnson; 1990a, p.19)

"Other people"

Which means that the experience of being disabled has got a lot to do with the way that other people treat you. There are those who mock, who bully, who laugh at you. There's the loneliness, the isolation, just being ignored by other people. Says Maria Rantho, "basically people treat us as people who are really sick and cannot do anything for themselves.

It may start with your family. Says Maria, "People are ashamed to have a disabled child in their own home. We are viewed as people who must be hidden away within our own families."

She continues, "If you look at the rate of illiteracy among disabled persons, that starts from the family itself, from not really accepting the disabled child as someone who can be sent to school and can be educated and can be somebody in his community."

"And when you look at people in general, whenever there's a disabled child in the family, it has certain connotations [for them] as if maybe you have been bewitched or [it is] a bad omen. As a result you are isolated from the rest of the community for just having a disabled child."

Even the non-disabled child of disabled parents may be singled out, blamed and stigmatised, because of the disability of his or her parents.

Referring to her own experience as a disabled person, Maria says, "I'm taking particularly about black disabled people or children. In the sense that our culture doesn't accomodate disability. It's only now that disabled people are actually living to a certain life-span but previously, you realise, they were killed for being disabled."

"Society still treats us as if we don't exist. But," says Maria, "we've got a right to live,

a right to express ourselves."

Health care

These attitudes are reflected in the attitudes of health care workers. "They can discuss you as a patient in a hospital, without taking into consideration the fact that you are there, just talking as if they are talking about a third or fourth person, not really consulting you in anything. The result is that they can take any kind of decision without actually telling you that this is what is happening with your body, or with you."

Says Linda Crabtree, about herself and another disabled woman, "I realised that her hospital experiences paralleled mine: lack of sensitivity, not listening to us to learn how things have to be done (after all, we're the experts on us), ignorance of any underlying conditions relating to our disabilities and how we must cope, and a disregard for the patient's basic sense of dignity." (1990, p.4)

Being alive

On another level these attitudes are also relevant in relation to decisions, made by people, women, health care professionals, others, as to whether to abort a child. Says Mary Johnson, writing in The Disability Rag, a magazine written by disabled people,

"This is not a discussion about a women's right to choose. It is a discussion about the thinking that prompts the woman, or the couple, to make certain specific decisions based on cultural assumptions that have been shaped by discriminatory practices and attitudes - against disabled people. A decision to abort based on the fact that the child is going to have specific individual characteristics, such as mental retardation......says that those characteristics take precedence over the living itself. That they are so important, and so negative, that they overpower any positive qualities there might be in being alive." (1990b, p.34)

Disabled women

For disabled women, these problems, problems based on other people's attitudes and assumptions, affect all aspects of the health care that they receive.

Sexuality and contraception

So when you speak to the family planning nurse about contraception she may be horrified at the idea that someone in a wheelchair could even think of having sex.

"You know if you go and seek contraception," says Maria Rantho, "it will be as if you are under cross examination. 'What are you going to do with this.' 'Hey you are naughty, you are silly.' Who told them that as a disabled person I cannot fall in love? Who told them I cannot be involved in a sexual relationship?"

Whilst one problem for a disabled woman may be that health workers refuse to accept that you can be involved in a healthy sexual relationship, and regard giving you contraceptives as a way of encouraging irresponsibility on your part, another problem may be when contraceptives are forced on you without your even being consulted.

Depo Provera

You have some kind of brain damage which in some way impairs your speech. The nurse is aware that you are sexually active because you have a sexually transmitted disease. Next thing they have stuck a needle into your arm. It contains Depo Provera, a contraceptive. As a result of the side effects, you don't menstruate for three months.

A problem which is experienced by all disabled people, particularly the mentally disabled, is that you are often treated as if they you have no decision making ability. Health workers are often inclined to be paternalistic and assume that they need to protect

Brain-damaged child with loving grandmother - disabled children are sometimes discriminated against within their own families.

the disabled. In fact they may be preventing the disabled person from taking responsibility for his or her own life.

Motherhood

The question of motherhood may be another source of contention. Says Maria Rantho, "I fought with one doctor. He was nasty and arrogant and insulting. I was pregnant. I was disabled. I was on a wheelchair. He didn't take me as a human being, he didn't take me as a woman in the first place. He wanted to know who the bloody hell that guy was. And it's the very same guy who [I'm now married to.] We've got a very beautiful relationship. We've got a right of deciding whether we want to have children or not. That's very personal. It doesn't have anything to do with anybody else."

"For the fact that I'm disabled I am viewed as someone who can not be a mother, who can not look after anyone. I am looked at as someone who will be a patient for the rest of my life. That connotation will always be attached to me as a disabled person. I will never be able to get away from it because that's the way society, the way medical professionals, the way everybody views me, as a sick person you see. And boy I'm telling you, many of us are well capable of looking after our own lives as well as the lives of so many people who are not disabled."

One of the assumptions that people make is that the child of a disabled person will also be disabled. In certain instances, it is true, disabilities are passed on as a result of genetic factors. It is believed that 25 to 30 % of blindness, for instance, is caused by hereditary factors. Genetic counselling services are provided at hospitals, to advise disabled people, or people in whose families disability has occurred, on the chances of their children being born disabled. Says a former medical social worker, "there is quite a severe judgement against people who decide to bring potentially disabled children into the world." What would be preferable, she says, would be an approach which emphasises people making their own decisions.

Involuntary sterilisation

Or they go to your aging mother who is with you and they get her to fill in her name and signature on a form. They say, "We're just giving you a little injection." But this one contains an anaesthetic which puts you to sleep. When you wake up you realise that some kind of operation has been performed on you. No one even bothers to tell you that you have been sterilised.

For people who are severely mentally disabled there may be people who say that sterilisation is for the best. But, says Maria Rantho, "to just go on with sterilisation procedures and the like without actually going into the details about whether this is what is actually needed - I don't think this is in any way right. This person is a human being

and people have to respect that."

"They just tell you that they are doing an operation, what operation you are not told, and the next thing you are sterilised. And there you are, you fall in love, you get married, and you want to start a family, and the chances of you now starting a family are completecy destroyed." Sometimes even the woman's parents aren't consulted.

In addition to making a thorough appraisal of whether sterilisation is advisable, and in the absence of a patient being able to give her own informed consent, the health worker should take care to ensure that the patient's parent or guardian, who would be required to give their approval to the operation, is informed about the nature of the operation which is being undertaken. In South Africa, where health worker and patient often speak different languages, this problem of communication may be an especially difficult one.

Looking forward

Over the recent period the outlook for disabled people has improved in certain respects. An important part of this is that disabled people have become more vocal and more militant in asserting their rights. On an international level an organisation, Disabled People International, now provides a link between disabled people from all parts of the world. In South Africa DPSA acts as an umbrella body for self-help groups.

One place where the public have increasingly been exposed to the reality of disablement is at the movies. Films like the Elephant Man, Children of a Lesser God, Rain Man, My Left Foot and Born on the Fourth of July, present the experience of disabled people in a way which makes this more tangible to people generally.

But a more positive climate for disabled people doesn't mean that things have really changed. There is still much that needs to be done.

Assertiveness

For the disabled person the battle is not only against the handicap imposed by one's disability, but also to escape from the cage which one is trapped in as a result of other people's assumptions and prejudices. "The skill of assertiveness is one which needs to be encouraged," says one woman who has done a lot of work with disabled people. "For many it is an uphill battle to break away from an attitude which says "there is nothing I can do.""

Assertiveness can be of value to disabled people not only on an individual level but also, through organisations like DPSA, in the political and public arena. Disabled people can be mobilised to confront others, the person on the street as well as political and other organisations, to become more attentive to their needs.

For disabled women the battle is an even harder one. Many people will see a disabled

women who asserts herself as having failed to accept her lot in life, as pushy, and as failing to acknowledge "reality". She may be accused of not knowing her place and of not being grateful for what others have done for her. As Maria Rantho says, to assert yourself, "You have to be a very strong person and you are definitely going to be very unpopular."

Health care workers

For health care workers part of the task is to confront their own prejudices and assumptions, as well as those of people around them, and to work towards providing disabled people with more effective assistance. Treating a patient holistically involves addressing their physical, psychological, social and spiritual needs. Health care workers should aspire to being agents of the liberation of disabled people rather than perpetuators of their oppression.

Educationists

For health educationists the challenge is to better prepare health care workers to recognises the humanity of disabled people. More broadly, health and other educationists, need to assist in the process whereby disabled people become fully integrated into our society.

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Crabtree, L. - "Health Care and Women with Disabilities." Rehabilitation Digest, Fall 1990, p. 3-7.

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Institute of Race Relations - Annual Survey, 1988/89.

Jagoe, K. - "Disabled people in a reorganised health care structure." Critical Health, No.21, December 1987, pp.33-40.

Johnson, M. - "Unanswered questions" in the Disability Rag, Sept/Oct, (1990a).

Johnson, M. - "Defective fetuses and us", in The Disability Rag, March/April, (1990b).

Glossary

Sex vs. Gender - **Sex** refers to the biological/physiological difference between men and women.. **Gender** refers to the "male" and "female" roles which society assigns to men and women. These relate to, for example, their responsibilities in the home, the kinds of work which they do, and the kind of behaviour which is expected from them. Gender roles differ culturally from community to community. The expectations and definitions which they impose are oppressive to men and especially to women.

Reproductive labour vs. Productive Labour - work done in maintaining the household, providing food, and caring for members of the family or household. It is usually done by women who do not receive a wage for it. (Domestic workers are employed to do reproductive labour usually for a wage). Because the labour is "hidden" in the home, it goes by unaccounted for and unacknowledged. It is seen as "unproductive" labour and accorded a low status in society.

Reproductive labour must be seen in relation to productive labour which is done outside of the home, in return for some kind of wage income. Historically, men have mainly done productive labour. Women usually do almost all the reproductive labour and often/ usually do productive labour as well. In terms of the distinction that is being made here, work on factory production lines and in mines, as well as clerical and sales, or provision of professional services, is regarded as productive labour.

Women are said to perform a reproductive role in society in that they bear the children and do most of the reproductive labour. Feminists argue that men and women should carry equal responsibility for reproductive labour in the household.

TLVs - Threshold Limit Values. Refers to the quantity of a particular hazardous substance, (eg.lead, pesticides), that a worker can be exposed to without the substance damaging their health.
Maternal mortality - refers to the death of a woman during either pregnancy, chldbirth, or 42 days thereafter.

AIDS - Acquired Immune Deficiency Syndrome. People get AIDS as a result of having HIV in their blood. They may only get AIDS as much as 10 years after they get HIV.
HIV - Human Immunodeficiency Virus. People get AIDS as a result of having HIV in their blood. HIV is mainly transmitted through:
- unprotected sexual intercourse (intercourse without a condom),
- via infected blood - in transfusions, and through the reuse of needles, syringes or other skin-piercing instruments,
- from an infected mother to her baby - before, during or after birth.

HIV-positivity - a person whose blood is tested and who is found to have HIV is said to be HIV-positive.
Safe-sex - the term is used to refer to sexual practices which lower ones risk of contracting HIV and other sexually transmitted diseases eg. having only one sexual partner, using condoms, non-penetrative sex. Celibacy is an option that people could also consider.
Sex worker - in this edition the word "sex worker" is used interchangeably with the word prostitute. Generally the term refers to anyone working in the "sex industry", that is, escorts, prostitutes, strippers, etc.

Resources

The following articles on women's health issues appeared in the publication *Agenda*:

No. 1 1987
Parental rights proposal. (p.25)
No. 2 1988
Phumelele Ntombela: *Parental rights - a response.* (p.17)
Ramphele Mamphele: *Review of "The Circumcision of Women - Strategy for Eradication" by Olayika Koso-Thomas, London, Zed Press,* 1987.
GAWU: *Strip searches at SA Clothing.* (p.59)
International day of action for women's health. (p.81)
Shamim Meer: *Review of "Take back the night - Women on Pornography" edited by Laura Lederer, New York, William Morrow and Co.* (p.87)
No. 3, 1988
Taffy Adler: *Women and Shiftwork in South Africa.* (p. 23)
Pat Anderson: *Cape Town's Rape Crisis Shelter for Battered Women.* (p. 62)
Anthony Swift: *Brazilian Prostitutes Organize.* (p. 65)
No. 4, 1988
Eleanor Preston-Whyte and Maria Zondi: *To Control their own Reproduction: the Agenda of Black Teenage Mothers in Durban.* (p. 47)
Pat Horn: *Pap Smear Campaign.* (p. 69)
Sandy O'Dowd: *Clitoridectomy and Women's Resistance.* (p. 79)
No. 6, 1989
Carol Sterling: *Review of "The Sexual Face of Violence: Rapists on Rape" by Lloyd Vogelman, Raven Press, Johannesburg, 1990.* (p. 31)
Debby Bonnin: *First Regional Meeting of Women and Health in Africa.* (p. 31)
Recommendations and Resolutions of 1st African Regional Meeting on Women and Health. (p. 37)
President Museveni's Speech at the closing of the Women and Health in Africa Meeting. (p. 53)
No. 7, 1990
Ann Levett: *Childhood Sexual Abuse and Problems in Conceptualization.* (p. 38)
Roger Davis; Tim Quinlan; Amanda Stavrou; Cathy Woods: *Making Women fit the Plan: Commentary on "the Role of Women" in South Africa's Population Development Programme.* (p. 75)
No. 8, 1990
Pat Anderson: *'Another drop in the Ocean' - Coordinated Action for Battered Women.* (p. 65)
No. 9, 1991
Vicci Tallis: *'AIDS - what does it mean for women'*
Debby Bonnin: *'Women and Health - 6th International Women and Health Meeting'*
Review: "Reproductive Rights and Wrongs - the Global Politics of Population Control and Contraception" by Betty Hartmann. Reviewed by Barbara Klugman.

The following articles on women appeared in various editions of *Critical Health* through the years. Not all editions are available. However, we would be willing to make copies of the articles available for a small contribution.

Issue No. 1, 1979 (not available)
Women in medicine - Susan Goldstein shows that in the health sector the majority of women work as auxiliary personnel, in badly paid jobs with little control over their working conditions.
Issue No. 2, 1979 (not available)
Multi-nationals and health, Part 1: the decline in breast feeding, the promotion of infant formulas by multinationals and the consequences for the health of impoverished people.
Issue No. 4, February 1981 (not available)
Breast feeding, multinational and infant formulas.
Issue No. 5, May 1981 (not available)
Overpopulation and family planning - traces the economic and political forces contributing to overcrowding.
Issue No. 9, May 1983 (not available)
Women health workers - examines the working conditions to which black women health workers are subjected.
Chronology of women's struggles in health: 1913 - 1982.
Women workers, maternity benefits and trade unions.
How to claim maternity benefits.
Homeland women - the conditions leading to health problems for women in homelands.
Organizing for mental health - women psychiatric patients in a rural community talk about the problems they experience and how they cope with their problems through collective action.
Rape - some of the reasons for rape and how it affects women.
Contraception - an interview with Sowetan women reveals interesting opinions of family planning services, abortion and contraception.
Cancer of the cervix - the incidence of cervical cancer in black South African women is amongst the highest in the world. This article exposes the politics at play in the lack of provision of screening facilities for this illness.
Issue No. 12, May 1985
Childcare and the working mother - looks at problems of working mothers in Soweto and the decisions financial pressures force them to make.
Issue No.24, November 1988
The edition examines nursing in South Africa. Articles include: *The politics of nursing* - this article examines the hospital hierarchy, and that within nursing itself in the context of the socioeconomic and political experiences of women.
Burnout - looks at causes and possible solutions to the "burnout" syndrome.
Issue No. 26, May 1989
Women and detention - this article examines aspects specifically related to women.
Issue No. 31/32
Special Issues: Women - discusses the marginalization of women's issues at the Maputo conference. Deals briefly with the workshops on women and mental health and child health and reproductive rights.

Issue No. 33, November 1990
Negotiations around maternity benefits: where to now - Sharon Fonn identifies some of the issues which still need to be tackled.

Offer to *Critical Health* readers: photostats of any of the above articles from editions of *Critical Health* which are no longer available or the following papers which were prepared for the Maputo Conference. Prices: R1.50 per article from back-copies of *Critical Health*, R3 for articles from the Maputo Conference.

The following papers which were prepared for the Maputo Health Conference, April 1990. Subject to the permission of the authors:
* *Women and health in South Africa: towards a women's health charter* - Helen Rees
* *A look at the health of women during pregnancy and childbirth* - Sue Goldstein
* *Women and violence* - People Opposing Women Abuse (POWA)
* *Abortion: a woman's right to choose* - Helen Rees
* *Mental health issues in relation to S.A. women* - G. Eagle, L. Frenkel, J. Green, W. Wolman

The following articles on women's health appeared in the publication *Speak*
Health issues from the following editions are not listed: 1, 2, 3, 4, 9.
No. 5, March 1984
The IUCD/ the loop
No. 6, July 1984
Looking at maternity benefits
Two worlds of motherhood
The diaphragm and the condom
No. 7, December 1984
Sterilization & permanent contraception
No. 8, April 1985
Health chart on contraception
No. 10, February 1986
Rape
Deadly contraceptive - women must claim
Getting to know our bodies
No. 11, June 1986
Periods
No. 12, October 1986
Periods - we all have them
She still wanted to scream
No. 13, January 1987
'No to Rape' say Port Alfred women
For each of us its different - our health
No. 14, March 1987
Our health - vaginal infections: what they're all about

No. 15, June 1987
Opening medicines: the harm they cause
No. 16, August 1987
Skin lightening creams - banned at last
No. 17, November 1988
Pregnancy - finding out, talking, sharing.
No. 18, March 1988
I'm pregnant: what is happening inside me.
No. 19, April 1988
Breaking the silence - women say our men must stop beating us.
Our health - I am pregnant: what happens at the clinic.
No. 20, June 1988
AIDS - lets talk about it
I am pregnant - what can go wrong?
No. 21, September 1988
I am pregnant - how can I prepare for labour
No. 22, December 1988
I am pregnant - what will happen in labour?
No. 23, April 1989
Health is our right - union women are organizing to fight cervical cancer
What is cervical cancer and how can we prevent it
I am pregnant - what can go wrong?
No. 24, June 1989
My baby is born - how will I feel after the birth?
International Women's Health Day
No. 25, 1989
Breastfeeding your baby
No. 26, 1989
Rape in marriage
Dear doctor
What is breast cancer?
No. 27, 1990
We can't make a baby - the problem of infertility
No. 28, 1990
Dear SPEAK doctor
Understanding AIDS
No. 29, 1990
No to rape! say Soweto women
Sexually Transmitted Diseases - what are they?
No. 30, 1990
Parental rights and PAP smears
No. 31, 1990
The silence must stop! Talking about abortion
Teenage pregnancy
Preventing pregnancy

No. 32, 1990
Screams of silence
Preventing pregnancy - the Pill
No. 33, 1991
Take back the night!
Preventing pregnancy
I told them I was here to help my wife
No. 34, 1991
Organizing around AIDS
Being a woman can be bad for your health
Preventing pregnancy - diaphragms and the condom

Workplace Information Group (WIG)
These are publications that WIG has produced on a one-off basis:
Working Women - Pregnancy & Maternity Rights.
Contraception.
P.O. Box 5244, Johannesburg, 2000. Tel. (011) 337 9413

Work in Progress
No. 27, 1983: *On 'The Family'*
No. 36, 1985: *CCAWUSA: Maternity benefit through breakthrough*
No. 43, 1986: *Uniting against rape: the Port Alfred women's stayaway*
No. 47, 1987: *Maternity Benefits for Metal Workers*
No. 55, 1988: *Combining employment with family life*
No. 61, 1989: *Challenging sexual exploitation*
Work in Progress (WIP) backissues are available from WIP, P.O. Box 32716, Braamfontein. Tel. (011) 403 1912

South African Labour Bulletin
Articles on health which appeared in the *SALB* are listed on pages 66 - 69 of Critical Health #30
SALB, P.O. Box 3851, Johannesburg 2000

Childbirth
Beverley Chalmers: *African birth - childbirth in cultural transition.* Berev Publications. 1990.
Maternity benefits and parental rights
Sharing the Load - the struggle for gender equality, parental rights and child care. Prepared and written by Lacom for SACCAWU. Published by Learn and Teach Publications. 1991.
Menstruation
Esma Anderson: *G'n siekte, maar 'n seen.* Vrye Weekblad, 12 April, 1991. bl.12.
Pornography
Mark Gevisser: *Porn in the RSA - are these photos degrading, could they lead to sex abuse?* Weekly Mail, 3 May, 1991. p.8.

Pearlie Joubert: *Pornografie, erotiek of kuns?* Vrye Weekblad, 1 Februarie, 1991, bl.16-17.

Rape

Lloyd Vogelman: *The Sexual Face of Violence - Rapists on Rape*. Ravan Press. 1990. Johannesburg.

Reproductive rights

Women's health and reproductive rights in the workplace (written for Learning Nation July 6-13, 20-27 1990)

Organisations

Gay and Lesbian Organisation of the Witwatersrand (GLOW)
P.O. Box 23927, Joubert Park 2044
Contact: Simon Nkoli 837 6413 or Donne Rundle 614 5301

People Opposing Women Abuse (POWA)
Contact: Margaret 642 4345 (6 p.m. - 10 p.m.)

ANC Women's League
Head Office, Lisbon Building, 54 Sauer Street, Johannesburg 2001
Tel. 011 - 834 2071

Black Sash
Syfrets Building, Marshall Street, P.O. Box 2827, Johannesburg 2000
Tel. 011 - 834 8361

Planned Parenthood Association (PPA)
National Council, 3rd Floor, York House, 46 Kerk Street, Johannesburg 2001
Tel. 011 - 838 1525/6

South African Domestic Workers Union (SADWU)
269 Bree Street, P.O. Box 9559, Johannesburg 2000
Tel. 23 2223

Disabled Peoples of South Africa (DPSA)
P.O. Box 39008, Booysens 2016
Tel. 011 - 982 1130

Township AIDS Project
P.O. Box 4168, Johannesburg 2000
Tel. (011) 982 1016/ 1027

International Publications and Organisations

Passages: the International Centre on Adolescent Fertility (ICAF)
(formerly the International Clearinghouse on Adolescent Fertility)
Passages is published quarterly and works to reduce unintended teenage pregnancy through programmes to enhance decision-making in key areas of education, to promote family planning, and to improve access to health care.
ICAF, 1025 Vermont Avenue, #210, Washington D.C. 20005, USA

Conscience - a news journal of Prochoice Catholic Opinion.
Catholics for a Free Choice (CFFC) is a national education organization that supports the right to legal reproductive health care, especially family planning and abortion. CFFC also works to reduce the incidence of abortion and to increase women's choices in childbearing and childrearing through advocacy of social and economic programmes for women, families, and children.
Catholics for a Free Choice, 1436 U St. NW, Washington D.C. 20009-3916, USA

Women's Global Network for Reproductive Rights
This is an autonomous network of groups and individuals all over the world who are working for and support reproductive rights for women - that is, a woman's right to decide if, when and how to have children, regardless of nationality, class, race, age, religion, disability, sexuality or marital status.
P.O. Box 4098, 1009 AB, Amsterdam, Netherlands

Women's International Public Health Network News (WIPHN)
- is part of an initiative to bring together women with a commitment to safe motherhood.
7100 Oak Forest Lane, Bethesda, Md 20817, USA

Panos Institute
Publishes "Point of View" which focuses on AIDS. It comes out 6 times a year. The Panos Institute has also published a book called Triple Jeopardy: Women & AIDS. This book is the first global study on AIDS and women. It explores the implications of the HIV epidemic for women, children and families and highlights the steps women are taking to protect themselves.
9 White Lion Street, London N1 9PD, United Kingdom

The Disability Rag - a magazine by and for disabled people
Box 145, Louisville, KY 40201, USA

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