The Impact of Women's Organisations on Health and Community Development

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Abstract

Introduction: Women's organisations in their health and economically focused activities play an important role in improving communities' quality of life, and as such should be supported in their efforts. The Elim Care Group and Akanani women's organisations have been in existence for a period of time and their impact on health and development of the Hlanganani community at Elim in the Northern Province, South Africa has not been assessed. The study under discussion will explore the impact these organisations have had at household level in terms of the outlined health and development indicators.

Method: An exploratory descriptive household survey was conducted whereupon households of Elim Care Group, of Akanani and of people who did not belong to any organisation were interviewed to determine their health and development status.

Results: Responses from 90 questionnaires (30 from each category i.e. households of members of Elim Care Group, of Akanani and of non-members) were analysed. There was an association of better health with the Elim Care Group members as demonstrated by their knowledge in health related issues.

Discussion: In view of the results, it was recommended that the activities of the two women's organisations be integrated as their benefits complement each other.

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Introduction

The concept of community development and health is a collective action that is central to primary health care. It includes health promotion, prevention of disease, community participation, creation of jobs and improvement of living conditions. In areas where the government cannot readily provide for these, women's organisations are often established to respond to those needs that affect and threaten the health and development of communities. These women's organisations serve as a link between the government and communities and, also as a means to involve the community in the identification and resolution of their own needs through means available and acceptable to them.

Health authorities through health workers are spending substantial amounts of money and time setting up women's organisations, because it is believed that these organisations play an important part in improving the people's quality of life at personal and community levels.[1] To support this belief, programmes in primary health care are emphasising community participation in preventive and promotive health care activities. To this effect many women's organisations under the directive of health and government funded non-governmental organisations have been in operation for some time.

Examples of such women's organisation are the Elim Care Group and Akanani Rural Development Association, located in Elim, Northern Province, South Africa. The Elim Care Group was managed and supervised by health personnel at Elim Hospital. The organisation was established in 1976 and its focus, although mainly health-oriented, also made provision for community development by empowering members with skills that promote self sufficiency[2]. Akanani Rural Development Association, commonly known as ***Akanani***, on the other hand, was involved in purely economic endeavours. It was established in 1980 as a rural producer co-operative to initiate an income generating process. The organisation offered a variety of programmes related to training in skills for production, marketing and adult education.

Little research has been done to examine the health and well-being of households that belong to members of the women's organisations. In this study the researcher undertakes to explore and describe the impact made by the health-focused woman's organisation, Elim Care Group, and the economic generating organisation, Akanani.

This is done by comparing the effects the organisations have had on their

members and member households in relation to health and development against households of those people who did not belong to any organisation.

The research question was: is there a difference between the households of the Elim Care Group, of Akanani and of those people who do not belong to any of these organisations in terms of the following health and development indicators respectively?

- frequency of diarrhoea and upper respiratory tract infection in children under five years of age; nutritional status of children under five years of age; immunisation coverage of children aged 12 – 24 months; antenatal attendance; child survival rate and dental health of a family member.
- material possessions, sanitation, adult literacy income per household and utilisation of financial institutions in the community.

The concept of community development is not new.[3] It was adopted in a conference in Cambridge in 1948 and was defined as: "a single programme of approaches and techniques which relies upon local communities as units of action and attempts to combine outside assistance with organised self-determination and effort, and, which correspondingly seeks to stimulate local initiatives and leadership as primary instruments of change."[3] Following this conference community development was defined as a tool to promote better living conditions for the whole community at the community's initiatives and participation.[3] The view was shared by the World Health Organisation when it described community development as "a progressive improvement of the living conditions and quality of life enjoyed and shared by society and its members."[4,5] Supporting views express the concept as a natural expression of solidarity and a process of social organisation through education to increase the people's power base.[6]

In projects meant for community development women, by virtue of their availability both physically and emotionally, find themselves most accessible. Women are also most available because of social attitudes that place them in the capacity of nurturers rather than employees, even at work places.[7] Economic empowerment of women in rural communities is increasingly becoming the focus of development agencies, while primary health care nurses are simultaneously seeing rural communities as the natural target for involvement in health-related activities. The high illiteracy rate found among women renders them unemployable in labour markets committing them to poverty while survival is by interaction with their fellowmen. In some developing African countries, adult women's literacy is as low as 6%.[8] This affects their employability and money generating mechanisms. The most affected are those that live in the rural areas who often find themselves alone as their men folk leave for the cities for better employment opportunities. Some authors[9-12] reflect on the rural situation as being particularly tough for women who depend on land that is no longer productive from prolonged exposure to poor and obsolete farming methods exacerbated by environmental hazards and natural weather disasters. In these circumstances the women usually organise themselves to face the challenges of the day as a collective.

Health and community development is related in that just as community development is a product of community participation, health is a desirable return from community development. Community development aims at improving the economic, social, psychological and cultural conditions of communities and by implication their health as well.[13] The interrelationship of community development, community participation and health is based on the social support theory whereby the "ability to do" that people gain in community development is synonymous with health because individuals participate effectively in development tasks if healthy.[14] To support this it has been stated that " healthy people are productive and capable of living lives that are not only long but also rich in quality."[5]

The close relationship between health and community development is indicated by the nature and origin of many community development projects. In the United States of America local health departments and communities have used models like healthy cities and healthy communities to include communities and to encourage them to participate in health projects[15]. Growth monitoring in children has also been identified as an entry point to community involvement in primary health care.[16,17] The project has been successful because it addresses parents' interests.

The study under discussion was conducted in a rural area of Hlanganani, commonly known as Elim, Northern Province, South Africa where the two women's organisations were operating side by side. According to the annual report of 1994, there were about 148 000 mainly Tsonga speaking people residing in Hlanganani. The lifestyle is traditional and includes collecting firewood, fetching water from the river and working in the fields during the appropriate seasons. There are no industries to provide employment and able-bodied young men and indeed women migrate to the neighbouring

Gauteng Province to seek employment. Family income is usually low and unpredictable. Homesteads are characterised by one or more thatched rondavels connected by a short wall known as a 'lapa.' The inspectorate report indicated 86 schools in the area i.e. 2 pre-primary with an enrolment of 631, 58 primary with an enrolment of 32491 and 26 post primary with an enrolment of 19 275.

Methodology

An exploratory descriptive survey was done to explore the impact of the women's organisations on health and development at household level by analysing the health and development indicators (as outlined in the research question) in the three categories of households (i.e. the households of members of the Elim Care Group, of Akanani and of those people who did not belong to any organisation).

The sampling was in two stages. First, the villages in Hlanganani were grouped according to geographic proximity, magisterial administration and representation in community development activities. Twelve such village clusters were identified.A random sample of five villages was done from the twelve village clusters. Secondly, within each of the five villages, a systematic sampling of every 15th household was done until ninety households (i.e. thirty from each category) were sampled. Inclusion criteria for such households were that the sampled household must have a female adult aged twenty years and older who is responsible for the management of the home and would be the respondent to the questions posed to that household, have a child aged five years or younger and hold membership to any of the two organisations for at least ten years. Similarly respondents from the non-member group should have been in that charge ship position for ten years. Permission was sought and obtained from the relevant authorities. At household level informed consent was obtained and respondents were assured confidentiality, respect and anonymity and were to participate voluntarily, being free to withdraw from the study and interview at any time they so wished without penalty.

The researcher using a household interview schedule collected data. The services of a trained Tsonga speaking research interpreter were enlisted to assist the researcher with language where the respondents could not speak Northern Sotho. The interview schedule consisted of 48 items, sixteen of which were dealt with by observation.

Results

For analysis the five villages were allocated numbers. Within this allocation the distribution of members and non-members was significant with a tendency of women from certain villages to either or not belong to an organisation. *See Table I.*

Most respondents were biological mothers to children aged five years or younger. The age of the women who did not belong to any organisation was significantly lower than that of the women in the other two groups (X^2=16.3, df=4, P=0,026).

Children of Akanani members had more diarrhoea episodes per child than the other two groups, with the Elim Care Group reporting the least episodes. *See Table II.*

There was no significant difference among the three categories in the mean number of respiratory infection episodes per child. There was, however, difference in the knowledge displayed

***Table I:** Distribution members of organisations in villages*

Village	Care Group	Akanani	Non-member	Total
1	6	4	4	14
2	6	12	2	20
3	5	10	7	22
4	5	1	15	21
5	8	3	2	13
Total	30	30	30	90

F=3.63, df=2, P=0.031

***Table II:** Number of diarrhoea episodes*

Household	Diarrhoea episodes per child	Mean No. episodes
Care Group	18	0.633
Akanani	51	1.667
None	27	0.9

F=3.63, df=2, P=0.031

***Table III:** Height of children in the different household categories*

Household	Stunted	Normal	Total	%Stunted
Care Group	10	58	68	14.7
Akanani	19	42	61	31.3
Non-member	19	40	59	32.2
Total	48	140	188	25.5

about signs of respiratory infections, with the Care Group scoring the highest (36.6%) in this regard. The other two groups, apart from the general mention of a running nose, did not know any other important signs relating to respiratory infections other than respiratory rate and temperature. This result could be attributed to the focus of the Care Group on health. All women indicated having attended antenatal clinic during pregnancy. The majority (66.6%) had started to attend by six months. Immunisation coverage was good (96,66%). Poor nutrition was evidenced by height in children aged five years and younger. There were fewer (14.7%) stunted children in the Elim Care Group when compared to children in the other categories. *See Table III.*

Akanani members experienced more dental caries per household than the other two groups. This group had in comparison more money to buy processed foods, hence the state of the teeth.

All households had experienced a high number of deaths among children aged five years and younger before the organisations were established. This has since been reduced.

Development indicators were listed in terms of material possessions and the environment around the household. Akanani members were found to be significantly better off in material possessions as evidenced by solid brick-built houses with large glass pane windows. Care Group members were significantly better off in those aspects related to cleanliness and vegetable garden upkeep. Nearly three-quarters (62.2%) of all the households did not use any financial institution. *See Table IV.*

Table IV: ***Summary of the development indicators as they affect the three categories***

Indicators	Significant difference	Category showing positive difference
Wall material	X	Akanani
Condition of walls	X	Akanani
Condition of roofing	X	Akanani
Framed windows	X	Akanani
Large size windows	X	Akanani
Door material	X	Akanani
Flooring	X	Akanani
Space in the home	X	Non-member
House cleanliness	X	Care group
Condition of latrines	X	Care group
Furniture pieces	-	-
Condition of furniture	X	Care group
Condition of vegetable garden	X	Care group
Financial institution	-	-
Literacy	-	-
Total	12	

Discussion

From the findings women in the health-focused organisation had the advantage of health knowledge and often engaged in activities that promoted good health in their households.[10] Factors like a clean environment, a viable vegetable garden, decreases in diarrhoea episodes, knowledge of the signs of respiratory tract infections and early attendance of the antenatal care clinic seem poised for development. Stunting is a critical indicator for chronic malnutrition and helps to evaluate mothers' knowledge about nutrition. Stunting in Akanani's and non-members' children could indicate chronic malnutrition, which could in turn compromise the health of these children.

The economic focused organisation had contributed to its members' quality of life through processes that enabled them to generate income increasing their buying power. Members through their earnings were able to build modern houses, wear trendy clothes and obtain modern housekeeping equipment like paraffin and coal stoves and in some instances electrical appliances. Akanani members should have been in a better position to purchase the necessities for health than the other two groups, but from the data it would seem that the presence of money does not necessarily translate to improved health, as eleven Akanani households did not have latrines. There seems to be two reasons why Akanani members' health did not improve. Firstly, they may lack the necessary knowledge and secondly, their economic oriented activities may be taking all of their time.

From the data non-members could perform better if they had the added advantage of belonging to an organisation. The impact of the women's organisation at village level is evidenced in the comparative observation made on the cleanliness in the households and villages. A higher number of houses belonging to non-members were found to be dirty and village 4, which had a higher number of non-members, also presented with fewer and dirtier toilets.

From the data there was an association of better health with the Care Group. It is therefore recommended that the primary health care nurses involved with this group, in line with Lund's recommendations[14] should integrate economic activities as well. The Elim Care Group has also over time achieved its objectives and would be better suited to engage in other activities. This integration might help to attract younger women and some of the Akanani members as well.

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