

## Women and Health - A Question of Control — Barbara Klugman



Ms BJ Klugman

Centre for Health Policy  
10th Floor Wits Medical School  
7 York Road  
PARKTOWN  
2193

### Curriculum vitae

Barbara Klugman qualified with MA Social Anthropology at Wits. She has worked in women's organisations for many years. She worked at the Health Information Centre in Johannesburg, focusing on issues of maternity rights and other women's occupational health. She also lectured for five years in the Department of Social Anthropology at Wits, and is now with the Women's Health Project at the Centre for Health Policy, Community Health, Wits. Barbara has published extensively on women in South Africa, especially women workers and contraception and population policy.

### Summary

*A picture is described of women functioning in a world where men decide and control; where women carry the double burden without having the education or confidence to develop a sense of control over their bodies or their future. GPs are often their first port of call and they are asked to see a woman as a whole person when she enters their consulting rooms, to ensure that she is fully informed about her health, not to reinforce her subordination but to build up her capacity to take control over her body and her life. This seems to be no-one's job. GPs are asked to make it theirs.*

*S Afr Fam Pract 1992; 13: 519-24*

### KEYWORDS:

Physicians, Family; Womens Liberation; Self Esteem.

### Paper presented to the 8th Family Practice Congress

My task is to explore the context in which women live their lives in South Africa, and the impact of that context on their health, using the concept of health broadly, as in the World Health Organisation definition of 'a state of complete physical, mental and social wellbeing'. Put differently, I am asking, who is the woman who walks through your rooms' door in search of medical help?

The first and most important answer to this question is that she is an individual. Whatever her problem,

and whatever she hopes to get from you, arises out of her own emotional, social and physical history. But having said that, it is also true that all of us, for all of our individuality, are categorised in ways which give us meaning, and which allow those around us to determine who we are and what to expect from us. Women are socially constructed in this way, first and foremost as women (as opposed to men). And when a woman walks through your door, in addition to the individual, you see those characteristics that you associate with "woman".

Many women who walk through your door come bearing another socially constructed concept - "mother", with all the trappings that we associate with the experience and responsibility of motherhood.

Because men and women are largely seen as different from each other, and because of the sexual division of labour in society, which allocates the bulk of emotional and practical responsibility for both childcare and family life to women, there are a wide range of experiences that, while not exclusive to women, are shared by most women in society. It is this context that I am going to discuss.

Given that women's worlds differ, not only from person to person, but because of differing cultural, geographical, race classification and class backgrounds, and given that this paper can only make some sweeping generalisations, I am going to focus more on the majority of women in South Africa - that is, rural, poor, African women. However, as I will show, their experience is in many ways simply an extreme of an experience that is shared by most South African women.

## ... Women and Health

As a framework for understanding women's place in society, I suggest the following six categories:

- gender equity
- political access
- infrastructure
- education
- income
- assertiveness and control.

I am going to illustrate how the women who walk into your consulting rooms are very likely to be disempowered, to lack sense of control, not only over their futures, or their present lives, but also over their bodies, and to show how this relates to the six categories I've outlined.

### Gender equity

Let us begin at the level of the constitution and law. There is nothing in our constitution which establishes a principle of equity between people. As a result, there is a wide range of legislation and practice which not only marks women as

---

A woman walking into your rooms is very likely to be disempowered and lack a sense of control.

---

different from men, but discriminates against them, and establishes them as second class citizens in society: from the relegation of married women teachers to temporary status so that they are denied access to basic employment benefits, to the taxing of married women at higher rates than

men or unmarried women;<sup>1</sup> from the denial of the right to land inheritance for women (under Customary Law) to the allocation of township housing rights to the husband irrespective of who is most responsible for the upkeep and nurturance of the family; from the failure to guarantee working women the right to keep their jobs during pregnancy and after having a child, to the exclusion of women from access to a wide range of jobs which are the preserve of men.

This discrimination against women is based on a deep seated social belief, and practice, which holds that women and men are fundamentally and naturally different. While we would not argue against this, given women's capacity to bear children, we do not accept the validity of the widely held view that this capacity to bear children should translate into full responsibility for child rearing, cooking, cleaning, ironing, emotional healing and overall domestic welfare. Indeed, the fact that the majority of adult women today are either employed outside of the home, or seeking such work, indicates that they are certainly able to take on tasks previously considered part of the male terrain. Unfortunately, however, this has not led society to expect men to develop skills in the domestic terrain. And so women suffer what is commonly known as "the double burden" which causes not only physical and emotional stress, but also means that such women have little or no time available for getting involved in leisure activities or in political and social organisations of public life.

The sexual division in society also affirms men's right to be the household head; to make decisions

on behalf of the family, so that women are often relatively powerless even in this context. In addition, there is a conventionally held belief that marriage gives men sexual rights over women - as illustrated in the fact that rape in marriage is not recognised by law.

---

Women feel a lack of control over their present lives, over their bodies and over their own future.

---

This reinforces the sense that not only in public life, but even in the private realm of the home and even in relation to their own bodies, women live within a terrain controlled by men.

### Public and political access

In addition to the legislation and policies which deny women the possibility of enjoying the options available to men, the overriding notion that men's terrain is that of public life, while women belong to the private world of the home, means that women's experiences and needs are not taken into account in decision-making about, and the organisation of, institutions of public life. This is amply reflected in the virtual absence of women in parliament and from the leadership of political parties,<sup>2</sup> regional and local government, companies, trade unions, religious bodies, the police and the military. In addition, women are barely reflected in any of the professions and other skilled employment, except in the low-pay 'womanly' caring

## ... Women and Health

professions of nursing and teaching. This situation means that the world in which women live is framed by men. The dominant values, and the wellbeing of the society as a whole (such as whether to put money into aeroplanes or water supply, whetherto resolve conflict through negotiations or the gun) are made by men, in terms of men's understandings of the interests of society as a whole. The experience of being defined out of public life is particular to women (and in other ways to children). Women's opinions are often not elicited on any issues other than those specifically related to motherhood and domesticity and even in the domestic realm they are often subject to the decisions of men.

As a result, women tend to see themselves in terms of male definitions of women, and this undermines their confidence and capacity to engage effectively in the broader society. The woman who stays at home to take responsibility for her home and children describes herself as "only" a housewife; the

---

Women suffer what is known as "the double burden".

---

woman who plays this role in addition to holding a full time job is just doing what women should do - the fact that she is carrying two jobs, with all the resultant stress and exhaustion that this can mean, is largely ignored by both her husband, and society at large.

The general absence of childcare

facilities, paid maternity leave, options for part-time work without loss of benefits and the failure to count women's domestic labour into the GNP (as expected by signatories to the United Nations) attests to society's failure to acknowledge its

---

The capacity to bear a child should not be translated into full responsibility for cooking, cleaning, ironing and child rearing.

---

dependence on women to keep its members going from day to day, and to give birth to and raise new generations.

In addition to the experience of living in a society which devalues their work, women have to cope with the physical burden of domestic work. A survey of 835 African working women found that the majority worked for between 16 and 18 hours a day;<sup>3</sup> a study of women engaged in subsistence agriculture or wage-employment on farms found that they worked for 60 - 70 hours a week.<sup>4</sup>

#### Infrastructure

This situation is compounded, for the majority of South African women, by the absence of the basic infrastructure required for healthy living: adequate housing, water, fuel, sanitation and refuse removal. While these conditions are shared with other members of society, because of the division of labour described above, water and fuel provision are socially

constructed as women's responsibility.

Seventy percent (70%) of South Africans do not have electricity in their homes.<sup>5</sup> While in urban areas these people use fuels like paraffin, bottled gas and coal (with their associated health hazards), in rural areas people rely on firewood. It falls to women to carry this wood.<sup>6</sup> Niehaus describes how most women in Tseki, QwaQwa cannot afford to spend R12,15 a week on wood or coal and instead they walk an eight hour round trip to collect wood.<sup>7</sup>

Likewise in relation to water, while the length of time spent waiting for and carrying water, and the weight of the containers of water, differs from area to area, the absence of accessible provision of this essential resource is a key factor compounding women's low health status.

While data on the impact of chronic overwork on women's health in South Africa is unavailable, a number

---

A belief that marriage gives men sexual rights over women.

---

of studies elsewhere in Africa have shown that chronic overwork, coupled with poor nutrition, undermines women's health.<sup>8</sup>

#### Education

In the 1985 census, less than 1% of whites aged 15 and above said they were illiterate, as opposed to 15,5% of coloureds, 7,6% of Indians and 33,1%

## ... Women and Health

of African people.<sup>9</sup> A survey by de Lange found an African literacy rate of only 48%.<sup>10</sup> A household survey in KaNgwane found that 37% of women interviewed could not read at all, and 16% read with great difficulty, so that 53% of these women could not use written material.<sup>11</sup> A household

---

The world in which women live is framed by men.

---

survey in Alexandra township, Johannesburg, found that 11% of women could not read at all, and another 10% read with difficulty.<sup>12</sup>

While girls do not have less access to schooling than boys, the overall crisis in black education means that women's educational status is low.

The issue in relation to the health and wellbeing of such women, is the lack of control over one's life experienced by women who are illiterate. While in certain rural contexts the deprivation may not be a daily experience, although even then, without literacy and numeracy there is no way of reading one's family's letters or ensuring one's pension pay out is correct. In an urban context, where every activity from buying food to catching a bus requires literacy, an illiterate person cannot function as a fully independent member of society. Dependency denies one's sense of adulthood and lowers one's self esteem. Illiteracy, or even a low educational level, reinforces one's sense that others know more, and that one's own knowledge is questionable. In the doctor-patient context, a less educated person is that

much less able to approach the doctor with confidence, without being intimidated, that much less able to assert her understanding of her problem, let alone to choose between options offered by the doctor.

## Income

Women's level of employment is lower than that of men. In the "common area" (excluding all "homelands") in 1980, 84% of African men and 52% of African women of working age were economically active. These figures drop to 52% of men and 20% of women in the "homelands".<sup>13</sup> Thus not only is there a problem of unemployment, but it is markedly worse for women, even though many of them are sole supporters of their families.

In addition, women tend to find employment in the least paid, least skilled jobs, which offer little legal protection, such as domestic and agricultural work, or work in the informal sector. Many training opportunities are still reserved for

---

Women were working between 16 - 18 hours a day (a survey of 835 African women).

---

men. Women's work tends to be less valued than that of men, hence the trade union demand for equal pay for work of equal value - an attempt to revalue women's work at a level equal to work done by men requiring equivalent skills. In addition, women's experience of work is

frequently marred by sexual harassment.<sup>14</sup>

Most women are formally dependent on men for money, even though such money is often not forthcoming, particularly in the case of remittances from migrant husbands. This, coupled with the general context of

---

A less-educated person is much less able to approach a doctor with confidence.

---

poverty, substantially limits women's capacity to take control over their lives and make choices which meet their needs. It is thus not surprising that women in this situation are often very passive and lacking in self-esteem.<sup>15</sup>

## Assertiveness and control

The picture I have described may seem rather extreme, when one considers that many women are reasonably well educated, and living fairly comfortable lives, materially speaking. However, they too live in permanent engagement with a world controlled and defined by men; many of them too have to manage the strain of carrying full time work and domestic responsibility; many of them live under the threat of, or actual violence from their men. For this reason it is fair to argue that the majority of women are disempowered to a lesser or greater extent. It is also fair to argue that most women are overburdened, tired and stressed. Women's experience of living in a society in which they are not fully in control of their lives, nor of the way

## ... Women and Health

they are perceived, undermines many women's sense of self-esteem and identity. While this does not make women "mentally ill", their capacity to fulfil their human potential and live with a sense of wellbeing is undermined.

### What does this mean for the general practitioner?

The context of women's lives cannot be changed by medical practice. It requires a development programme which not only gives priority to such things as water and electricity, but also ensures that avenues are opened for women's participation in the institutions of public life, and that both discussion and options are opened for men's participation in domestic life.

### Listen for her interpretation of her world.

However, the process of development is not a linear one, and the medical practitioner certainly has a role to play. This role is three fold.

Firstly, you can contribute to ensuring that your patients are fully informed about their health and about basic preventive practices. You may not feel that you have the time to do this personally. But since your practice or clinic is the only possible avenue for information for most women, you need to find some mechanism, whether ongoing talks or videos in the waiting room or appropriate pamphlets, to give women information about their bodies, and how to prevent disease.

You could also, as an organisation of family practitioners, lobby for school education programmes which explain how the body works, promote healthy behaviour and explore questions of sexual behaviour and responsibility.

Secondly, it is essential that you, the practitioner, take into account the

### Help her to take control over her life and her body.

context in which your patient lives. The woman who arrives with a headache is probably unable to articulate the deeper stresses which are really her problem. The woman who says she is using the pill but arrives pregnant with a sixth child is reflecting the reality of lacking control over her life, and her body. By understanding the overall problem, you can ensure that at least her interaction with you does not reinforce her sense of helplessness. By taking her seriously, and listening for her interpretation of her world, you can ensure that you are offering her at least a moment of appropriate support. You can ensure that you, as a person in a position of authority over her, don't reinforce her structural subordination.

But at a third, and deeper level, you can contribute to building her capacity to take control over her life and her body. You can give her support in her decision to use contraception when her husband is not keen on the idea; you can suggest she sees a social worker or other counsellor to take

on her family problems, rather than suppressing them under panado or other drugs; you can explore the cause of her recurrent injuries - is her husband abusing her?; you can discuss with her why she repeatedly returns with a sexually transmitted disease; you can explore how the fifteen year old feels about being pregnant, help her reflect in an informed way on all her options, including abortion, and ensure this is her last unwanted pregnancy. All of these issues reflect the problem of control, and the extent to which women may not be able to own their own bodies. You can play an essential role in confirming her right to control her life and her body.

You may not feel that this is your job. But at the moment it is no-one else's. Part of your role as an organisation of family practitioners may be to lobby

### See the whole woman as she stands before you - and do not only treat the symptom.

for the training and recognition of nursing counsellors, or for more social workers in the public service. But right now, you are the first port of call for many women, and it is your responsibility to see the whole woman as she stands before you, and to not only treat the symptom, but to recognise the totality of her experience, and respond accordingly.

### Endnotes/References

1. In this classification, men are designated as "persons" and women as "women", by implication men being true "persons", and women being some other kind of being.

## ... Women and Health

2. It goes without saying that the sense of living in a world controlled by others must be that much more complete for black people, women and men, in South Africa, who are disenfranchised.
3. Cock J, Emdon E, Klugman B. The care of the apartheid child: an urban African study. In: Burman S, Reynolds P (eds.) *Divided society: the contexts of childhood in South Africa*, Johannesburg: Raven Press, 1986: 66-92.
4. Place J. Women and children in Southern Africa - an introduction. *Women and children at risk in Southern Africa*. Conference proceedings, Boston. April, 1990: 9-17.
5. Gandar M. The imbalance of power: energy and the environment. In: Cock J, Koch E. (eds.), *Going Green*. Cape Town: Oxford University Press, 1991: 94-109.
6. It is not known to what extent women are relying on substances such as cattle dung and crop residues for fuel. Doyal notes that these fuels are associated with air pollution and that cooks who inhale their fumes are at risk of respiratory and eye disease. This issue requires further research in South Africa.  
  
Doyal L. Health at home and in waged work: Part one: Hazards of hearth and home. *Women's Studies International Forum*, 1990: 13 (5), 501-17.
7. Niehaus I. Relocation into Phuthaditjhaba and Tseki - a comparative ethnography of planned and unplanned removals. *African Studies*, 1989: 48 (2): 157-81.
8. Rutabanzibwa-Ngaiza J, Heggenhougen K, Walt G. *Women and Health. A review of parts of Sub-Saharan Africa, with selected annotated bibliography*. London School of Hygiene and Tropical Medicine, London: EPC Publication No. 6. Summer 1985.  
  
The virtual absence of such research in relation to South African women reflects the fact that men-dominated research institutions tend to tackle research on problems that are of direct concern to men, rather than to women.
9. Budlender D. *Women and the economy*. Johannesburg: Centre for Applied Social Enquiry, 1991.
10. Rispel L, Behr G. *Health Status Indicators: Policy Implications*. Centre for Health Policy, Department of Community Health, University of the Witwatersrand, 1992.
11. Marais S, Schneider H, Price M and Doherty J. *Report on intersectoral factors affecting health*. Review of health services in KaNgwane and the South Eastern Transvaal. Centre for Health Policy, Johannesburg, 1991; Vol 5.
12. Rees H, Buch E, De LGM Ferrinho P, Grownwald HT, Neethling A. Immunisation coverage and reasons associated with non-immunisation in Alexandra township. *S Afr Med J* 1991; 80: 378-81.
13. Budlender D. *Women and the economy*. Johannesburg: Centre for Applied Social Enquiry, 1991.  
  
Official figures do underestimate women's employment because they exclude subsistence agriculture, which is the major occupation of most rural women.
14. Sutherland C. Paying for stolen kisses: sexual harassment in South Africa. *Conference on Women and Gender in Southern Africa*, Paper No. 37, University of Natal, Durban, 1991.
15. Bhengu L. The role of a community nutritionist in a rural, poor community: is it to feed and empower or simply to teach? *Agenda*, 1992 (forthcoming).