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AFRICAN WOMEN: THEIR HEALTH AND THEIR FUTURE

by

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INTRODUCTION

As one approaches a rural village in many of the African nations, the scene is quite similar. Children, from those just able to walk to teenagers, are numerous and actively playing a variety of child games in the dusty yards. Girls the age of 9 or 10 are half carrying and half dragging their toddler siblings along in their games. They occasionally call to the younger children under their supervision who might be wandering beyond acceptable bounds for watching. Men are gathered under the closest tree, sitting on fallen trees or makeshift benches or on the ground. They are talking animatedly and more often than not, drinking the local beer. A few may be heard to complain that their noon meal is late, but then quickly return to talk of politics, friends, or agriculture. It is the hottest time of the day, mid-day, and at first glance the scene is one of relaxation and contentment.

A closer look into this village, however, reveals the women of the village in their traditional role - that of worker. Women in their late teens through mid-forties provide the principal work force for the entire village.

In fact, it is usual to see a barefooted young woman in a brightly colored dress with a baby on her back, a baby in her belly, and the day's supply of firewood or water on her head as she returns from her 3-4 hour journey to collect this wood or water. Other women are similarly adorned with small children while weeding the family's maize plot or small vegetable garden. Older women (though rarely more than 50 years old) without young children may

be seen carrying a basket on their head and one in each hand with a day's purchase (if, indeed, any money is available for such purchases) from the market several kilometers away. These brief encounters with the village women reveal much about their role and status within the tribe; in fact, much about the role and status of women throughout much of sub-Sahara Africa.

PURPOSE OF PAPER

The overall purpose of this ICUS conference is to search for absolute values which can unify the sciences toward improving our global existence. The specific goal of this committee is to attempt to develop a scientific solution to the problems of the Third World, more particularly Africa. My particular role, based on a background in public health, international health and nurse-midwifery, will be to explore the health status of African women and offer suggestions for improvement based on medical technology, bioethical concerns for humanity, and a genuine caring for our sisters throughout the world.

The purpose of this paper, therefore, is to examine the role and status of women in predominantly rural Africa as reflected by their state of health, and to offer suggestions on how the future of African women and all of humanity can be improved with changes in the health and status of its women. The paper is organized around three major themes: 1) a broad definition of health including psychological, physical, and spiritual wellbeing (mind, body, spirit) and how it may be achieved; 2) the benefits of viewing women as persons; and 3) the concept of responsible parenting promoting health and wellbeing for all in society.

This paper includes a value orientation toward health and its impact on any society, women as persons who deserve the respect accorded all who are "persons", and companion values of equality, justice, autonomy and love. The view of medical science and technology as adjuncts to improving the condition of all humanity will be applied to exploring how the health of African women can be improved, and what this improvement in women's health can mean for the whole village, society and the world.

AN INTEGRATED VIEW OF HEALTH

Health can be defined or viewed in a variety of ways. For many, health is simply defined as the absence of disease. Millions of Africans (especially children) would certainly improve their state of health and avoid early death with the elimination of diseases such as malaria, measles, and diarrheal infections. Likewise, many physicians and nurses working in Africa would welcome fewer illnesses and improved diagnostic and treatment tools. With this definition, however, one is looking primarily at physical aspects of living, the body. What about the mind and the spiritual dimensions of "healthiness"? The body can be disease free, but if the mind and spirit are wanting, health is limited.

My definition of health is much broader and based on a combination of the World Health Organization's definition and that of Parsons.[1] Health is much more than the absence of disease. Health is the state of optimum capacity of an individual which allows her/him to effectively perform roles and tasks which have been accepted as appropriate life goals. Health involves the interaction of mind, body, and spirit in achieving one's life

goals, and optimum health cannot be achieved without positive performance from all three.

Some may think it inappropriate to discuss this idealistic view of health when talking about Africa or any other developing nation, especially since the absence of food, and preventable infectious diseases are killing many as we talk. Yet if we only concern ourselves with improving the food supply and immunization programs, we condemn even more healthier children and adults to death from overpopulation, crowding, environmental pollution and apathy. Women who can barely maintain enough health to care for the many children they already have will have the additional burden of more surviving children, more mouths to seek meager food for, and even less time to develop into important members of society as women. With our modern technology, knowledge of factors which contribute to total health, and a caring concern that all people have equal access to good health, we must share our vision of total health for all peoples.

Much research in recent years has highlighted the importance of an integrated approach to healing or attaining a state of health. The psychological and spiritual dimensions of healing have been known and practiced for centuries in the so-called developing nations, but it took "scientific research" to verify for modern-day Western medical practitioners that it was okay, even warranted, to consider one's psychological and spiritual wellbeing when treating a physical illness. Hope, trust, confidence in one's ability to get well, as well as motivation to learn and follow healthy patterns in life are important factors in regaining and maintaining one's total health.[2] It

takes little effort to understand why a village woman seems lacking in concern for her sick infant when she barely has enough energy to care for her other six children. If this child dies, some of her daily burden will be lifted, even though her grief for the child will continue with her. These and other important factors which contribute to lack of health must be considered as we search for improvement in the health of African women.

Determinants of Health

Blum[3] has postulated that medical and nursing care and the provision of health services are relatively minor inputs into one's state of health. We must look beyond the providers of health and illness services to other factors. He goes on to suggest that the greatest impact on whether one is healthy is the environment in which we live, including one's early fetal and current physical environment, followed closely by sociocultural, educational and employment factors. Next in line for determining one's state of health is one's personal behavior or lifestyle, followed by health services and then hereditary factors. If we accept this set of determinants of health for all the world, not just our Western settings, then we can more fully understand why it is imperative to discuss a multi-science approach to improving health in Africa. Health workers need to work closely with agricultural experts and environmental specialists, as well as those who are working on a program of education and economic and political strategies which together will enhance the life of all African people.

I will leave the discussion of non-health approaches to improving the lives of Africans to the other experts on this Committee. I would like to

concentrate on the determinants of health which can be affected by professional and traditional healers and workers, primarily related to the ways we interact with our patients and our educational roles. I follow the ideas of McKeown[4] and others [5] who state that the main determinant of health is the way of life an individual chooses or is forced to follow. In Africa currently, the emphasis is on "forced" lifestyle, especially for most women. Culture, tradition and lack of knowledge of any alternatives keeps the rural African woman barefoot, pregnant, and not asking any questions about her lot in life. This is the way it is for most women. Should it be this way? How can health workers, who are predominately women, help to inculcate a different set of expectations for other women, a different set of values, if you will?[6] I will return to these questions throughout this paper.

Since lifestyle is influenced by one's environment, socioeconomic status, culture, and educational level as well as personal choices, I suggest lifestyle is the most important variable in determining the health of an individual. Given this reasoning, it follows that an integrated approach to health and health care (mind, body, and spirit) is indicated if we wish to alter the overall health of the women in Africa. Without healthy women, there will be no healthy children, no men and no further development of the nation.

THE STATE OF WOMEN'S HEALTH IN AFRICA

I will begin with a description of the current health status of women in Africa and then offer suggestions for improvement. This description is based

on personal work and observations in Sierra Leone, Liberia, Kenya, Malawi, Swaziland, and Lesotho. It is not research based, as information on health status and determinants of health in Africa is very limited. One may also note that statistics do not always truly reflect the individual and her personal experiences. Given the limitations of a Western health professional observing and interpreting African behavior, I offer the following for thought and discussion.

General Health

Survival of the fittest has real meaning in many African nations. With very high neonatal and infant mortality rates and overall life expectancies in the 40s, those women who survive to teen years and begin their families are usually among the healthiest of the tribe. With repeated, closely spaced pregnancies, however, and heavy work responsibilities, the general health of women gradually deteriorates by the mid to late twenties. If the woman does not die in childbirth (a common occurrence today), she faces threats to life from malaria, malnutrition, and accidents.

Part of the poor health status of women can be ascribed to their lack of concern for themselves. It is very unusual to have a woman seek health supervision in a rural clinic or urban center for herself. She makes the effort to walk to these dispensaries because one of her children needs attention. In some African nations, the only health supervision a woman receives is during pregnancy and childbirth, and this may be done by traditional birth attendants (TBAs) with little preparation in overall health supervision for non-pregnancy related conditions. I will return to pregnancy

care in a moment.

If one were to question the women about their own health, you would gather little information beyond, "I'm okay". Generalized complaints of dizziness, bad stomach, or backache may be shared, but these usually come from the older, non-childbearing women. From physical examination you might find severe anemia, malnutrition, and evidence of parasitic diseases, but it is rare that women complain about these or their symptoms.

Some would suggest that the women's lack of concern for her own health comes from ignorance, and that education is the answer. I think education and information sharing about health and disease are vital parts of any campaign to improve health status, but education only works if the individual is willing to learn and ready to learn. How does one convince a woman that she is important enough to need attention to herself so that she is motivated to learn how to protect herself from disease and keep herself healthy? The key to this health dilemma centers on the woman's image of herself.[7] All the medical technology in the world is rendered useless if the woman does not think she is important enough to avail herself of medical or health care. Importance in this context is defined as whether the needs of the woman are sufficient to take time to seek care for herself. Very often her time is given to her children's needs and those of her man. More on this later.

Reproductive Health

Probably the most important role of women in African society today is that of child-bearer. In several tribal traditions, a woman who produces many children is revered, and a woman who is childless is cast out of the village,

or maybe worse, takes second place to the new wife who can produce children. This offers little opportunity for the woman to choose to do anything else but bear children, even if most of them die shortly after birth of infections or starvation. The fact that the woman might die in childbirth seems less relevant than the responsibility to keep having more children, even if it kills her. Power, prestige, and "wealth" for a man are often described in terms of the number of children and the number of cows he has, with little concern for the overall health and status of the woman, the cows or the children.

Let us take a brief look at pregnancy care in Africa with the knowledge that it may have limited impact on the overall health of women. It can, however, sometimes spell the difference between life and death for a given laboring woman, depending in tradition, superstition, and integration of "modern" technology. It is important to note that what I define as "modern" technology during pregnancy does not include our Western models of hospital delivery for all women, ultrasound, electronic fetal monitoring, and amniocentesis. I am referring to minimal prenatal supervision, referral of women needing cesarean section or close monitoring of preeclampsia, etc., to a facility where these are available, improved nutritional intake with good foods available and eaten, and basic knowledge of how to prevent infections during labor, birth and the immediate postpartum period.

The primary health worker used for pregnancy care and delivery in rural Africa is the Traditional Birth Attendant (TBA). This person is characteristically a woman of middle age (40s), a respected member of the

village or tribe, and had many children of her own, and learned her birthing skills in an apprentice manner from TBAs before her. The content of her learning varies greatly, and her laboring practices are a generous combination of myth, superstition, herbal preparations, and practical advice learned from observing many labors and births. In the bush areas of Sierra Leone, for example, obstructed labor is treated by hitting the uterus with a large stick to drive out the demon causing the stopped labor. As expected, the most frequent cause of maternal death in these areas is ruptured uterus. In other areas of Africa, obstructed labor indicates that the woman's husband was having an affair with another woman during her pregnancy, and therefore this child refuses to be born. On the positive side, TBAs with their natural approach to pregnancy and birth are more patient and intervene much less than modern obstetrical practitioners. They also do not confine the woman to a bed on her back and force her into uncomfortable and non-physiological positions which can hinder the progress of labor and birth. They support the woman with massage, soothing words, and the presence of familiar women of the village. TBAs in general are committed to women and their care, and they in turn maintain status within the village with a job well done. Therefore, many TBAs have been most receptive to increasing their knowledge and skill in birthing as well as expanding their influence in the village with the assignment of other health screening tasks.

In many areas of Africa there has been a concerted effort to upgrade the knowledge and skills of the TBAs, fully recognizing that they will continue to be the dominant pregnancy provider for African women.

They are accepted by the people, they are available in rural and bush areas where "modern" health workers rarely choose to work, and they are committed to caring for women.

Superstitions and cultural traditions surround pregnancy and birth throughout the world. Tales about what the pregnant woman should or should not eat, wear, or do abound. It is important to listen to these tales, though, as some are very health-promoting and others are potentially harmful. Most are harmless. The importance of knowing and understanding these traditions lies with any educational effort promoting improved health for pregnant women. One must know and support the harmless and helpful traditions, and encourage change in the harmful ones. Gaining acceptance for any modern technology surrounding birth is predicated on the provider's acceptance of cultural traditions, the TBA and her status, and proof that the modern technology offers something of value to the pregnant woman. Once again, it is important to remember that not all modern technology in obstetrics is helpful to women; indeed, some of it is harmful as demonstrated in the U.S. (unnecessary cesarean sections, indiscriminate use of electronic fetal monitoring, lack of ambulation and food during labor, separation of mother, baby and father, and hospital based births for low risk women).[8] Be clear what technology you think will be helpful in the area in which you are working before suggesting same.

On a recent trip to Africa, I witnessed a distressing scene. My first impression was "modern technology gone awry". I was touring a large maternity hospital staffed by registered nurse-midwives and students. This

facility reported over 14,000 births a year, so many that more than half of the postpartum women were lying on the floor without benefit of blanket or sheet. The equipment was minimal, the floors were filthy, the professional staff were few and the patients many. Postpartum mothers stayed 24-36 hours if healthy, and there were separate wards for those having C-section, infections or complications of pregnancy (toxemia, twins).

After having all my senses accosted by smells, sights, and sounds, I asked the obvious question, "Why do women choose to come here to deliver their babies? Why don't they stay at home or in their village?" The response was a confident, "Oh, it's the thing to do today to deliver in a hospital. It's better for the mothers, you know." All I could think of was the malnutrition caused by the "modern" way of feeding babies with formula several years ago. And I wondered if the industrialized nations would ever stop exporting their bad and inappropriate technology, along with the good, to the developing nations. Professionals too often get caught up in the "modern" ways of doing things without stopping to think. These ways may not fit the culture and facilities available. Modern technology may not offer any advancement over the current practices in the country. Science is valuable, yes, but not willy-nilly applied in every case. It is time we learned to use our scientific minds to adapt technology to other situations in ways that will do good instead of harm, rather than exporting technology for technology's sake. The Hippocratic Oath's "Do good or at least do no harm" is a value that is not limited to the Western world.

One of the positive advances in modern health care is that of pregnancy or

prenatal care prior to birth. It is during this prebirth time that a knowledgeable, watchful attendant can pick up cues which indicate whether the woman remains healthy or whether she will experience some complications of the pregnancy or birth. TBAs traditionally met the pregnant woman on a few occasions prior to birth and may have talked with her about eating and exercise habits, but no testing of the urine or blood pressure readings were taken. We have learned repeatedly in the developed world that good prenatal care can spell the difference between good and bad outcomes of pregnancy for both woman and child.[9] Therefore, prenatal care emphasizing health screening (minimum blood pressure, fundal height growth, and general inspection of the woman for signs of illness) will contribute to better health of the pregnant woman and her child.

This prenatal care must be taken to where the woman live. Many African nations have perfected a system of district and rural health clinics including prenatal care. A minimal system of prenatal supervision is being introduced into the TBA training programs throughout Africa. It is based on pictures and encourages record keeping as well, though many of the TBAs are illiterate at present. Simultaneously, expanded programs for nurses and midwives are developing in the government, university, and mission hospitals. A renewed emphasis on public health and community based health screening and supervision with regionalized illness centers has been accepted by most government leaders.

Much remains to be done. There are logistical problems in transporting the sick from the bush to care centers. Supplies must be available with

refrigeration for vaccines and other medications. Educated health workers must work in the district and rural centers for an extended period of time. At present, the least prepared health workers are carrying the bulk of the responsibility for health and illness care throughout Africa. Incentives need to be worked out so that the highly trained and experienced health workers are available to the rural population as well as the urbanities. We have the technology. We are sharing it. Now we need to work with national health care providers to get it to the common people in an acceptable, affordable and appropriate manner.

Child Spacing

The very nature of the current role of African women as procreators takes its toll in the health of every woman. Frequent, closely spaced pregnancies eventually sap the very essence of the woman's body as she struggles to keep up with lactation while she is again pregnant. Yet the industrialized world has known and used modern contraceptive methods over 40 years. These methods for preventing or spacing children are just beginnning to appear in Africa. There are many cultural, political and religious taboos on the use of contraceptives. However, as with American Catholic women, African women exposed to the idea of contraception are more and more willing and eager to use it. The benefits of use are quickly evident to a woman.

Multinational service organizations, mission groups and corporations have joined together to provide technical expertise and the actual contraceptive methods for Africans. Acceptance of this assistance has varied by African nation and tribe, and success with child spacing programs has also varied.

It is important to note that early on technical experts found that the concept of spacing one's children to the benefit of the health of the woman and child was much more acceptable in Africa than the idea of preventing conception. Political leaders who espouse concern for the health of their nation have accepted child spacing on the one hand, but continue national awards for women who bear many children.

The success of modern contraceptive use in Africa is related to a variety of factors. First of all, contraceptive methods which are easy to use, highly effective, and relatively unnoticeable are those preferred. These include the oral contraceptive (pill), the intrauterine contraceptive device (IUCD), Depo-Provera injections, and sterilization. The latter is used quietly when women no longer feel they can survive childbearing or by the urban couples who connect fewer children with greater wealth and economic stability.

A few comments on the actual contraceptive methods used in Africa are in order. First of all, one might question the export of Depo-Provera to developing nations when our own FDA refused permission for its use in this country.[10] Is something which may be potentially harmful to the user (woman) of value simply because it is convenient and does prevent conception? Should African women be given the choice of whether to use it with information on its potential harm? Is long-range potential harm versus shortterm benefit in avoiding pregnancy a concept which can be understood by the unhealthy, tired and malnourished African woman? What is the ethical obligation of modern health care workers in prescribing this or any other form of contraception when understanding is limited? These are just a few of

the concerns raised by exporting modern contraceptive technology to a developing nation, and they need to be kept in mind as we discuss our role in improving the health and welfare of Africans.

Training programs for indigenous health workers have been established throughout Africa. As noted earlier, identifying traditional healers or village health workers and introducing new ideas through these persons may be the best in gaining village acceptance. Many Western nurses, midwives, and physicians have volunteered time and effort to teach the African health workers about contraceptive methods and how to use them. These programs were originally held in the Western nations with moderate success, but became much more successful when placed in various African countries. Realities of prescribing the pill to someone who cannot read or trying to insert an IUCD under clean conditions in the dusty outpost of bush Africa need to be dealt with during the education program. They are more likely dealt with when the program is based in the country it is meant to serve. Africa based training programs also offer the opportunity for more native health workers to participate, and are less prone to political favoritism (a trip to the U.S., whether you are interested in family planning training or not, was a common misuse of Western funds and training programs).

Circumcision and Birth Injuries

The final woman's health issue to be discussed is that of injuries that result from childbirth. Female circumcision is widely practiced in various areas of Africa, and the extensive disfigurement of the vulva which results, often leads to severe lacerations during childbirth. These circumcisions

also can impede progress in the second stage of labor when the infant is being pushed through the lower vagina and perineum. The increased pushing effort required, combined with poor nutrition and exhaustion, result in a precariously thin recto-vaginal wall and subsequent tearing or fistula formation. Once a fistula forms, it results in constant leakage of urine mixed with feces and an offensive odor. These women are then ostracized to the outskirts of the village and no man will touch them again. However, they may also have no food, no source of shelter, and certainly no emotional comfort from friends. Recto-vaginal fistulas can only be corrected by surgery which is unavailable to most women. Therefore, these women become permanent outcasts of society, the untouchables. This is a poor reward for the woman who submitted to the will of men for circumcision and to have the children that were so important to her man, her village, and her own security. It does, of course, lower the birth rate but there are much better ways to accomplish that goal.

Psychological and Spiritual Health

This last vignette is a classic example of the struggles for health in its broadest sense. It is difficult to assess the psychological and spiritual health of another, especially one of a totally different culture and circumstance. But a few comments are offered for discussion. As I was visiting with a group of highly educated women who were faculty in one of the schools of nursing in Africa, I was surprised to hear the following comment. When I inquired about the family structure of one of my African colleagues, she described her husband, his work with an international mission

organization, and her two daughters. Then she immediately added, "And I owe my husband a son". I could not contain my curiosity that such an educated nurse-midwife would speak of her "duty" to produce a son for her man. I suggested that we all knew that the man determines the sex of the fetus, and that if two girls were the products of her two pregnancies, then her husband was responsible for those two females. She acknowledged that both she and her husband knew the laws of genetics, but she still owed him a son and was trying to decide when she would become pregnant again as she already was forty years old.

This encounter was a reminder that education and socioeconomic status may not be sufficient forces to overcome cultural expectations and traditions. It was also a reminder that even in the developed nations, the preference for males and women's role as a producer of sons (children) is still very much with us. Is there a role for the woman who chooses not to bear children or cannot do so physiologically? How much can a woman's psyche withstand the negative status ascribed to those who have not birthed children, especially if her very being is defined in terms of the children she has? This is only one of the psychological burdens most women carry throughout the world. It must be overcome by the childless as well as those with few children in order to attain a high level of health. It requires a values change and sensitive education and support toward this end.

Another mind set in developing nations that women face daily is their lack of status and importance, whether it be in denied education or eating the scraps of food left after all the males have eaten, or being repeatedly threatened

that if they don't do what their man demands, they will be kicked out of the hut and another woman will take her place. These external threats to a woman's security leave little space or time for thinking about developing one's own potential.

I would suggest that most African women do not spend time thinking about work outside the home, political activities or education. They accept that their lot is not to have these, and they do not waste time thinking about them. Even the educated women in Africa who are beginning to be politically conscious and seek employment outside the home will often end such discussions of personal growth with an apathetic, "Who will listen? Who cares? I do what I have to do, and try not to make waves". As a woman and a Westerner, I think all women need to think about fulfilling their own potential and becoming the healthiest they can be, for I believe that it is only through equal partnership in life and society that the whole of society will improve. As someone once said, the slaver resides in the gutter just as much as the slave, because he has to stay there to keep the slave down. Likewise, men will remain oppressed and stagnant as long as they keep women subservient. True progress and growth is possible only when all are liberated, when all can develop their full potential as productive members of society and the world. Convincing tribal leaders and government heads of this is the task ahead for all modern scientists and religionists.

Suggestions for Improvement in Women's Health

One of the strategies I think will improve the health of women in general is to have all district and rural health clinics or dispensaries institute a

comprehensive health clinic model rather than a segregated, illness or age specific clinic on a given day. In this way, women who have to travel several kilometers on foot with a sick child may also have the opportunity to have the pregnancy and their own health needs looked after on the same day. This model of primary health care services is predicated on the use of trained health workers who can spot symptoms of illness in all ages, and who are willing, when looking after a small child with dehydration from diarrhea, to also look at the mother and her health status. It is also important for health workers to view the woman as worthy of attention, and to praise even her smallest effort in improving her health and that of her family.

These primary health centers have been most successful in integrating child spacing teaching and services for the same reasons of availability. An additional advantage to having the child spacing clinics within the structure of a multi-purpose clinic is that some women prefer that no one else knows of their decision to use contraception. Privacy of all services is vital to success, but particularly when it comes to child spacing activities newly introduced to areas with cultural and religious taboos.

An additional technological solution to women's surgical needs can be implemented through flying doctor squads, roving surgical teams and the like. This means surgical availability on a monthly or bi-monthly basis, but the surgery would be available and the women made acceptable once again to their village. All of these corrective activities are important. But we also need to pay attention to the reasons for and possible elimination of female circumcision, the prevention of maternal malnutrition and prolonged

pushing during labor. To simply correct the injuries of childbirth without removing the causes is akin to what the U.S. government advocates in treating defective neonates instead of preventing their birth in the first place.

However, if women are simply objects to be treated in whatever way males choose, we will continue to focus our technological powers on treatment of problems instead of prevention. Society will stagnate, wars will increase, and all will be destroyed in the name of science, power and dominance. I suggest there is an alternative to this gloom and doom. A beginning step is to accord women full personhood. Their ideas and efforts can be used as we work together for a world of peace and prosperity where everyone is respected and loved.

WOMEN AS PERSONS

One of the major concerns in health care ethics is how professionals treat their clients or patients.[11] This is a valid concern whether one is practicing in Washington, D.C. or in the most rural parts of Africa. If one accepts the Golden Rule as the bedrock of health care ethics, we are called upon to treat our clients as we would want to be treated. This includes respect for human dignity, genuine caring, a willingness to gather information and design treatment which is appropriate to the illness and acceptable to the client. A basic respect for human dignity is required. The individual who comes for health or illness care is a person. Human beings carry both the rights and responsibilities of living in society as adults.

Traditional and current societies and patterns of health and illness care, however, tend to discount the personhood of women. Women are too often treated as objects to be used (or abused) for the training or experiments of others, for the pleasures of men, for the production of children, or for chattel.[12] This view of woman as less than a person has a significant bearing on the health and status of each woman. It is central to understanding the current health or lack of it among women in Africa.

Let us take a brief historical look at how this view of women came to be in an attempt to understand whether and how it might be changed in the future. For purposes of the present paper, I will set aside all the debate on fetuses and children as persons, and concentrate my efforts on adult women and men.

Historical View of Women

The roots of unequal treatment of women go back to the dawn of time. Unequal laws and moral codes favoring males go back to the earliest writings of the ancient near eastern world. The history of humankind is very largely one of domination by men over women. Even the early religious writers held the view that women were less than men, less than persons. Thomas Aquinas (1225-1274) considered women misbegotten males and Martin Luther (1483-1546) viewed woman's sole purpose in being to produce children. If she died in childbirth, so be it. This attitude is reflected in Freud's famous statement about anatomy as destiny, and in the idea that a woman is a uterus surrounded by a supportive mechanism.

Explanations for male dominance throughout history vary. One is that men went to war and were the protectors of their families, including the

accumulation of property and goods. They wanted to have sons as heirs, and they wanted to make sure their sons were biologically theirs so virginity became a property value to ensure inheritances. Another view is that women, because of their capacity to be pregnant and nurse infants, were unable to fight in the wars conquer new territories. The more powerful male (property and protector) achieved dominance. Others point to the generally greater physical power of males and claim male dominance is the natural order. Religion either sanctioned this view or was used to sanctify it, so that male dominance became the "will of God" or "the gods".

We are concerned with a crucial issue here. If male dominance is "natural" or of divine origin, some may doubt that it should be changed. If it is simply a matter of "might makes right", then women can reverse roles whenever they achieve power and political influence. I suggest that neither of these positions fits our modern world. I believe the enhancement of society is a major reason for man-woman relationships and dominion by either is counterproductive. Equal partnership is the goal, and requires that women be seen and accepted as full and vital partners in all of society.

Personhood of Woman

Many of the vignettes described previously in this paper portray women as objects rather than full persons. I suggest the objectification of women is unethical, wrong, discriminatory, sinful. This unethical treatment of women can be seen as a lack of sensitivity to the woman as a person. She is seen as a object to be cared for only if she produces the right number and sex of children at the right times, in addition to cooking, gardening, and other

work to maintain the health and well being of the male members of the family unit. Some might even say women is a sex object to be played with, abused, and then discarded for another, younger model. What is missing is simple human decency. Immanuel Kant (d. 1804), a Prussian philosopher, claimed that humans are ends in themselves and not a means to someone else's ends.[13] People, neither women nor men, are to be used for the good of someone else. Kant's idea says women are not breeding animals whose purpose is to provide troops for the nation's military or bodies for the factories or farms. Likewise, children are not to be produced as an insurance policy to provide retirement income and care in the parents' old age. Persons are people who are accepted for themselves - as ends in themselves - and not a means to someone else's ends, even if that end is itself good.

Most of the religions of the world have some form of the Golden Rule which says that we should not do to others that which is hateful or hurtful to ourselves. Regardless of the religion or the form this rule takes, the concept is clear enough. The rule is an utilitarian ethic designed to produce the greatest good for the greatest number.[14] I noted earlier this principle as the bedrock of health care ethics, and it certainly speaks to our responsibility to treat women and their health concerns with respect. Be that as it may, women in most societies have not been considered among the "greatest number" even though in actual counting, they are, and therefore have not been recipients of humanistic health care or equal treatment in life activities.

Another basis for requiring a more sensitive approach to women in health care

and the world at large is called the "love ethic". This concept has its roots in religion, the Judaic law, "Love thy Neighbor" (Lev. 19:18). Jesus quoted it so it is basic to the Christian tradition as well. It can be found as a moral standard of behavior for those who profess no religion as well, and requires one to go beyond gender, ethnicity or status to a deeper concern for all people.

Male dominance has gotten around the love ethic by considering women as something less than people, therefore not requiring the respect accorded a person. Freudian concepts of female sexuality have passed unquestioned into much modern thinking, including the training of health care personnel.[15] They emerge in such psychologizing as, "It's all in your head" when confronted with a woman's complaints about her physical body. This approach emphasized the emotionality of women, which is then thought to make them less than trustworthy. Their reports of pain or illness are discounted as being imaginary, psychosomatic, or even reflections of mental instability.

Suggestions for Improvement

One might question whether it is surprising that women, even African women, do not spend time seeking health or illness care for themselves. First of all, they don't have time for themselves, the services may be a distance away, and thirdly they won't be treated as worthy of respect, so why bother? I suggest another reason why women in general do not seek health supervision and illness care, whether in Africa or the developed nations. It is the lack of worth which repeatedly is reinforced by those in power, predominantly males, that offers the woman little reason to care for herself. She has

little or no self-esteem, and what is present is totally dependent on the way her man views her.[16]

For over fifty years nurse-midwives in the United States have been working with poor, uneducated pregnant women with positive results for both mother and infant. In fact, studies repeatedly demonstrate that nurse-midwifery care results in equal or better outcomes of pregnancy than care delivered by physicians.[17] As we look for reasons why nurse-midwives are so successful in their care giving, one factor being considered is the nature of the interaction between the nurse-midwife and the woman who is pregnant. This interaction is based on mutual respect, information sharing, and acknowledgment of the variety of concerns the women brings to the prenatal visit which are not related to the pregnancy (housing, food, care of other children, single parenting. It is also predicated on the fact that the woman who is pregnant is a person worthy of respect and love. She is listened to, given time to talk about herself and what concerns her today, and praised for all positive efforts to cope with her situation. I view this approach to caregiving as the empowerment of the woman to begin to feel worthy herself, to feel important enough to take care of herself, to feel good enough to deal with all her family problems and still care about herself.

I have repeatedly seen this approach to health supervision work with midwives throughout the world. It is simple enough, requires little or no extra time, and only a belief in the importance of women worthy of love and respect - full personhood. Deceptively simple, you might say? Yes and no. Before women health care providers can view women clients as persons, they must hold

the same view of themselves. This is often the rub, especially in developing nations where the chance to develop one's self-esteem and worth outside childbearing are very limited as yet. This is what we in the developed nations can share with our colleagues, as we also empower them to realize their full potential as persons who are also women. Many mission groups and other technical advisors in health and illness care are struggling to impart this respect while they also share modern technology. Technology without caring is disastrous, as noted earlier. As technical experts, we need to improve our efforts in caring while we are also learning to adapt modern ideas and medical technology to developing nations.

Benefits of Personhood for Women

The major benefit of according full personhood to all women, whether in Africa or other parts of the world, is that everyone in society will gain. We will gain new partners in the campaign to improve our village, our community, our country, our world. We will gain new partners in our efforts toward world peace. We will gain with the use of the minds of women who can add to the creative and positive solutions to world hunger, environmental pollution, and overpopulation. Equality of the sexes can eliminate needless time wasted on power struggles, territorialism, backbiting, etc. as competition is replaced with cooperation. This may be an ideal, but one worthy of striving for the benefit of all.

RESPONSIBLE PARENTING

My final suggestion for improving the health of women in Africa, and society as a whole, is embodied in the concept of responsible parenting. Who should

reproduce, when, and how often are valid questions for our modern age. The raising of these questions implies that there is no such thing as a "right" to bear children. Actually this reasoning or "right" has been touted in a variety of cultures and societies ever since contraceptive techniques, sterilization and abortion procedures were known. When one had the means to prevent pregnancy, many raised the loud cry against such action. However, in our modern age it is time to recognize that there exist no "rights" without corresponding responsibilities. Therefore, if one chooses to reproduce, it should be done responsibly. No one has a right to produce children. Rather, they have a responsibility not to procreate under certain circumstances.[18]

What does responsible parenting imply? Responsible parenting begins before conception when those who are unable or unwilling to raise a child responsibly should never conceive. While some claim that contraception and sterilization are wrong, I suggest the real immorality is irresponsible adults harming an innocent child through birth. To produce a child as a mere by-product of sexual activity is hardly respect for persons. This idea is based on Kant's concept that persons are ends in themselves, and not to be used for someone else's gain. I suggest it is immoral to use a child to accomplish the ends of adults, yet it happens frequently.

In some cultures, fathering many children is interpreted as "macho" - a symbol of maleness. Oddly enough, taking care of one's children is not seen as "macho". Some men make women pregnant without any intention or ability to care for the results of their maleness. In other cultures, many children are viewed as a sign of "wealth", even if the children are starving or die from

lack of care, food or shelter.

Responsible parenting is an ethical standard appropriate to the entire world. Children should be first of all wanted. Many African women will tell you that each of their children was "wanted", but why? Was it the security the woman needed to have a man willing to provide her a home and food, albeit a meager supply? Was the child the woman's confirmation of her own worth in her village? Or was the child wanted for its own sake? Let's go to the next step. No child should be born to parents who are unwilling or unable to care for it. Starvation, malnutrition, lack of clothing and shelter, lack of education and a decent standard of living, lack of love and emotional support are all harmful to children. To put it positively, every child has the right to be wanted and to be cared for - physically, emotionally, spiritually.

Unwanted children are harmful to parents as well. First of all, many children closely spaced causes physical deterioration of the woman's body and her general state of health. Each pregnancy then represents an even greater risk of maternal death from anemia, hemorrhage and general debility resulting in fatal infections postpartum. Unwanted children drain the financial and emotional reserves of the father, if he stays around and makes any attempt to care for them. They drain the emotional reserves of mothers as well.

To produce children irresponsibly also violates a basic concept of justice, which goes beyond the good the majority to a concern with all persons. Justice is also concerned with the allocation of resources, especially scarce resources. These resources in developing nations include food, shelter, land, health supervision and medical care, to mention only a few.

Overpopulation is a world problem which needs to be corrected quickly for the good of all people. Responsible parenting can contribute to a healthy solution, and thereby improve the conditions for all people. Availability of effective, acceptable contraceptives, technical expertise in their application, and a willingness to use them are required for successful control of population throughout the world. We have the technical expertise. We need to develop the expertise in helping others value the concept of responsible parenting and all that means for them and their own culture.

A CONCEPT OF A HEALTHY WOMAN AND SOCIETY

Throughout this paper I have reinforced the idea that when women are healthy and respected as persons, all of society stands to gain. A healthy woman is one who is physically sound, spiritually alive and psychologically strong. She is interested in contributing to the betterment of her tribe, village, and society, and willing to learn how to do this. She chooses to have children when and if she has the resources and support to care for them responsibly. She spaces her pregnancies so that her own physical health remains intact, and she seeks appropriate health supervision during her pregnancies.

A healthy woman is a person of the world. Her community is enlarged with a concern for all and a commitment to do her fair share in improving the living conditions for her family as well as her neighbors. She uses her mind to its fullest, contributing her ideas and efforts to the solution of the problems of her village, her country, her world. A healthy woman begets healthy

children and does everything in her power to see that they remain healthy throughout childhood. A healthy woman takes comfort, strength, and love into a marriage relationship, and works as an equal partner with her mate as both strive to improve the world in which they live. A healthy woman is a person to be reckoned with when injustice, discrimination, and apathy threaten her very existence. We need to contribute to the development of healthy women with our science, our technology, our loving concern for all people. We all stand to gain from these efforts.

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