

PROMOTING BREAST-FEEDING (CONT.)

8. Data appear to show that employment outside the home does not influence the initiation or the continuation of breast-feeding. In many countries the rate of initiation and the duration of breast-feeding among women who work in the formal labor force is not significantly different from that of women who remain at home. Nevertheless, whether paid and working, or unpaid and working, all women have multiple roles which they often perform simultaneously. These multiple roles must be understood in seeking an explanation as to why women do not breast-feed exclusively and on demand for the four to six recommended months.
9. Mother support groups (MSGs) provide individual counselling, information, support and group discussions to enable women to practice breast-feeding and child care well. MSGs attempt to fill the void for a mother when breast-feeding is not the cultural norm and when she lacks family and peer support.
10. The promotion of breast-feeding has been framed as a health issue of importance to the infant and a moral imperative for the mother. However, an understanding of the obstacles women face in breast-feeding exclusively for four to six months must be grounded in the realities of their daily lives, including how decisions are made at the household and couple level. Breast-feeding is not only a "women's issue" but a social issue where other responsible parties include family members, particularly male partners, the social sectors, including education and health, and employers and policy makers.

Issues to Think About

1. Legislation that has been enacted in some countries to ensure that employers uphold women's right to breast-feed have backfired, and in some cases employers are reluctant to hire young married women.
2. WHO and UNICEF recommend that breast-feeding be continued beyond 6 months until two years of age, with the introduction of adequate complementary foods. How feasible is this in the light of gender roles and responsibilities?
3. There is little known about men's attitudes to breast-feeding and their view of the importance of this practice for the health of the child. Why is an understanding of male attitudes important to promoting breast-feeding? What might you expect to find (in attitudes as well as support practices to the lactating wife) in men in general in Latin America and the Caribbean?
4. Why would some women's groups take issue with the way breast-feeding traditionally has been promoted?
5. How might the emphasis society places on slimness and sexual attractiveness for women influence women's decisions as to whether or not to breast-feed?

DETECTION AND CONTROL OF TUBERCULOSIS¹

General Findings:

1. In developing countries, men and women have similar TB notification rates until adolescence, after which males have higher notification rates. Some reasons for this that have been postulated are:
 - a. Women may be less susceptible to TB infection during and after adolescence because hormonally mediated immunological differences protect them.
 - b. Women may exhibit lower delayed type hypersensitivity (DTH) responses than males; males and females may have similar prevalence of infection but the degree of skin reaction in infected women is not large enough to be interpreted as a positive test during and after adolescence (this lower DTH reaction in women has been substantiated). It is not clear why older men have a higher risk of progression from infection to disease in comparison to women of older ages. Cellular immunity may diminish more quickly in men than in women and more men smoke and drink alcohol than women, which can weaken their immune system.
2. Women between the ages of 15 and 40 are almost twice as likely to progress from TB infection to TB disease than men of the same age, and men are more likely to progress from infection to disease after age 40. One of the possible reasons for women's rapid progression during reproductive years may be due to the stress of pregnancy. Some studies show that the risk of progression of infection to disease in women is particularly acute during post partum periods for women. A series of factors may account for this, including rapid hormonal changes, post partum descent of the diaphragm and reexpansion of the lungs, nutritional strain during lactation and insufficient sleep due to the demands of the new child.
3. Women have greater TB case fatality and mortality than men up until age 30. Some studies posit that this may be a consequence of decreased immune and nutritional status that may or may not be a result of complications during pregnancy. There may also be poorer levels of care provision for women, or women may arrive at the health services in more advanced stages of the disease. A study in Bolivia showed that the delay from the onset of symptoms to diagnosis was more than 6 months in the majority of women compared to 1 to 6 months in the majority of men. This diagnostic delay may account for some of the increased case fatality and mortality rates observed in women.
4. Passive vs active case finding²: men have higher notification rates than women at all ages through passive case finding. Greater numbers of infected women are found than infected men through active case finding. One reason for this may be that women going to health service for pre-natal or post-natal care are not being diagnosed for TB. Additionally, women may not seek care, despite their symptoms. Because men are more involved in the "public" sphere (military duty, formal employment), they are more likely to be screened for TB, whereas women who are more likely to be involved in domestic activities are not candidates for such screening.

1 Sources: Scientific publications based on results of research from 1966 to 1995 which describe relationship between sex, gender and the epidemiology of tuberculosis. We wish to thank PAHO's Regional Program on Communicable Diseases for this material.

2 Passive case finding refers to patients presenting to the health services of their own accord, whereas active case finding refers to random sampling conducted in a population to screen for TB, or to an entire population being screened for TB.

DETECTION AND CONTROL OF TUBERCULOSIS (CONT.)

- 5 HIV is strongly associated with TB and this may have a particularly severe impact on young women in developing countries because they are at increased risk for HIV infection at a time when they also appear to be at increased risk for progression to TB. Studies have found that the odds ratio for HIV infection in smear-positive cases for TB is significantly higher in females than males in the 15-34 year age group.
- 6 The impact of TB on family members is acute. As primary care givers of male family members that are infected, women are exposed to increased risk. While a woman takes care of others when they are ill, when she herself becomes sick there often is little support for her.
- 7 Worldwide, more disability adjusted life years (DALY) are lost due to TB than to HIV, other STDs or malaria. This burden must be viewed in the light of the added possibility of under-reporting in women.

Issues to Think About:

1. Why might the notification of infection in males during and after adolescence be higher than in females?
2. Why would there be such differences between men and women with respect to active vs. passive case finding? What difference might there be between men and women in terms of access (geographical, economic, cultural, etc.) to health services and, in particular, to TB diagnostic health services?
3. Why would women of reproductive age progress more rapidly from infection to disease than men in the same age cohort? Why would this reverse after 40 years of age?
4. Why would the case of fatality rates for women be greater than for males until age 30?

DESIGN OF COMMUNITY BASED INTERVENTION FOR PROMOTION OF MENTAL HEALTH OF ELDERLY¹**General Findings:**

- 1 Over the next three decades, the percent growth in the older population of Latin America will range from 25% in Uruguay to 282% in Costa Rica. The growth rate of the oldest old (persons 85 years and older) is higher than for all other ages in Latin America and the Caribbean.
- 2 Women live longer, on average, than do men
- 3 Education in early life has a major effect on the well-being of the elderly. Illiteracy is almost always higher in older women than in older men.
- 4 In surveys of elderly persons living in communities, rates for dementia² are much higher in those with little education.
- 5 Societies have varied reactions to dementia in aging. Some societies are more tolerant than others, which can regard dementia as pathological.
- 6 Mental health problems can relate to lack of food. The World Bank estimates that 780 million people of all ages worldwide are energy deficient. The elderly, particularly women, are disproportionately poor and therefore more likely than the general population to be malnourished. Lack of food can lead to confusion and forgetfulness.
- 7 Studies show that the elderly can avoid some mental health problems if they stay active in society. Social changes associated with industrialization often isolate the elderly from their previous roles and increase dependency, resulting in loss of dignity, self-respect and weakening of filial support networks.
- 8 The burden of caring for the elderly falls predominantly on their children, mainly, their daughters.
- 9 There is a high prevalence of multiple coexisting physical conditions with age: incontinence, hip fracture, sensory loss. These influence mental health through the loss of self-esteem and independence. These conditions are more prevalent among elderly women than elderly men.

Issues to Think About:

1. Do elderly men and women have sex-specific biological needs that are derived from different immunological, genetic or physiological differences? Could this be associated with women's higher incidence of chronic diseases and diseases such as urinary incontinence, diabetes, hypertension, etc? How might these differences have an impact in the kind of information provided to health care workers and family members caring for the elderly and the elderly men and women themselves?

1 Source: World Mental Health: Problems and Priorities in Low-income Countries. Dejarlais, R., Eisenberg, L., Good, B., Kleinman, A. New York, Oxford University Press, 1995

2 Gradual loss of cognitive function resulting from diseases that appear late in life

**DESIGN OF COMMUNITY BASED INTERVENTION FOR
PROMOTION OF MENTAL HEALTH OF ELDERLY (CONT.)**

2. How might gender roles protect or increase the risk for men and women to suffer from these diseases that characterize the aging?
3. Given the importance of education and continued involvement in society to ensure the mental health of elderly men and women, how might a program be structured to respond to or enhance the different opportunities each sex has had for developing their intellectual and social abilities?
4. Given the preponderance of care of the elderly on female family members, what can the state do to promote more equitable distribution of the care of older persons within their families?

CAMPAIGN TO STOP TOBACCO ADDICTION

General Findings:

- 1 According to WHO, tobacco use is estimated to account for 3 million deaths per year, about half a million of which are among women. Slightly more than half of those women live in developed countries. The number of deaths is expected to rise dramatically from 3 to 10 million in the next 20 years. Only if there were to be a substantial fall in smoking prevalence among adolescents would the epidemic of tobacco-related deaths be moderated since the majority of these deaths will occur among youth and young adults of today.
- 2 The women most likely to smoke in developed countries are those on low incomes with low-status jobs or who are economically inactive. On the other hand, today, affluent and educated young women in Latin America are more likely to take up smoking than their lower income counterparts.
- 3 Studies from the United Kingdom show that spending on tobacco among low income households with children is higher than among low income households without children. The highest per capita expenditure on tobacco is among one-adult households with children. Qualitative studies of caring highlight the experiences that underlie the association between smoking, poverty and caring for children. Cigarettes were reported by mothers caring for children in low-income households as the way women coped when their children's demands became "too much to cope with." Within a lifestyle devoid of personal spending, cigarettes were the only item that women bought for themselves.
4. Studies in Latin America and in the United States show that girls are smoking for two very different reasons than boys are. Girls use cigarettes to control their weight and appear grown-up, neither of which are reasons boys give for smoking.
- 5 In Latin America, surveys show wide variations in the prevalence of smoking among women, from 3% in La Paz to 49% in Buenos Aires. Most reports of recent surveys indicate that prevalence among women is increasing, particularly in countries that have higher rates of urbanization.
6. In general, countries in which smoking was first taken up were the first to show a decline in the prevalence of smoking among women in certain age groups. However, recent data in the United States and Canada have shown higher rates of smoking among young women ages 14 to 19 years than among their male counterparts.
- 7 An Australian study (1995) of 60,000 students from grades 7, 9 and 11 indicates that teenage girls who smoke cigarettes regularly do so because it is a balm for depression and anxiety. A study in Chile found that girls who smoke score lower on measures of self-esteem than those who do not, which is not so for boys where self esteem is not a factor in boy's initiating and sustaining smoking.
8. For boys, the importance assigned to religion seems to play a key factor in whether or not they take up smoking, with a strong association between importance assigned to religion and not smoking (not the case in girls). For both sexes, the fact that friends smoke is strongly linked to the likelihood of initiating smoking. For girls, the belief that smoking is harmful is a deterrent to taking up smoking, but this is not the case for boys.
- 9 For biological reasons, the consequences of tobacco use are different for both sexes. In women, smoking has particularly adverse consequences for their own health as well as the health of their children. For example, those who use oral contraceptives are more likely to suffer from cardiovascular problems later in life.

CAMPAIGN TO STOP TOBACCO ADDICTION (CONT.)

Additionally, data collected in the United States indicates that the association between smoking and early menopause has generally been found to be highly significant. The public health implications of this association are derived from the adverse effect of early menopause on morbidity and mortality for several conditions, including the link between menopause and cardiovascular mortality, as well as between menopause and bone fracture

10. Many women are becoming more aware of the dangers of smoking during pregnancy, but are unaware of the risks of smoking after delivery. Few regular smokers realize that their children are passively smoking. Children whose parents smoke have a tendency to suffer from a series of health problems in the first few years of life, especially respiratory illnesses and infections. There is a condition known as the "Monday morning syndrome," which occurs when children who have been inhaling smoke during the weekend develop otitis and respiratory infections on Sunday evening and have to see a doctor on Monday morning.

Issues to Think About:

1. Tobacco consumption in Latin America appears to be associated with gender relations. In population subgroups in which there is greater subordination of women, tobacco consumption is less than in subgroups in which there is greater gender equity. What do you think might be underlying this finding? How might messages be tailored to counteract this trend in women?
2. A study in Chile finds that knowing that smoking is harmful does not dissuade men from taking up the habit. What do you think might be underlying this finding? How might messages be tailored to counteract this trend in men?
3. If you were to receive a grant to study whether nicotine is more addictive in either sex, for biological reasons only, would you expect to find that it is more addictive in men, in women, or that it is equally addictive for both? Why would this type of study matter for smoking cessation programs?
4. In Canada a smoking cessation program found dramatic gender differences in the ability of married men and married women to give up smoking. For married men it was much easier than for married women. Why do you think this was the case? How would you tailor a smoking cessation program with this in mind?
5. In the United States, President Clinton announced a series of policies to curb tobacco use in teenagers. Much of this had to do with banning the promotion and advertising of all tobacco products, revision of legislation regarding the sale of tobacco to minors to include stiffer penalties, and legislation banning tobacco sales through vending machines in places where children and teenagers might frequent. Taking gender considerations into account, which of these policies, in your estimation, will have greater effect in curbing smoking in girls? in boys? or will there be no difference? Why?

PROGRAMS AND PROJECTS DERIVED FROM MODERNISM**WID APPROACHES****EARLIEST WID APPROACH**

Welfare approach →→→→→→→ **Passive beneficiaries**

- To help the most vulnerable groups, including women;
- Sees women as passive recipients of development;
- Perspective centered on the family as unit, emphasizing the reproductive role of women;
- Views better child rearing as the principal contribution of women to development;
- Has a practical gender approach.

SECOND WID APPROACH

Anti-poverty approach →→→→→→→ **Gender inequalities reflect poverty, not gender subordination**

- Attempts to ensure increased productivity of poor women;
- Women are poor because of economic limitations, not gender structured constraints;
- Recognizes the productive role of women;
- Emphasis on small income-generating projects;
- Has a practical gender approach.

THIRD WID APPROACH, NOW PREDOMINANT

Efficiency approach →→→→→→→ **Women cushion impact of structural adjustment process**

- Women seen in terms of their ability to compensate for deterioration of public services;
- Rely on all three roles of women and their supposed free or flexible time;
- Women seen entirely in terms of delivery capacity and ability to extend working day; most popular approach with governments and multilateral agencies;
- Has a practical gender approach.

PROGRAM AND PROJECT APPROACHES ORIGINATING FROM WOMEN'S GROUPS

Equality approach <-----> Affirmative action to ensure women have active role in development

- Women are the target population of programs and projects;
- By means of legislation, policies are designed to assure the incorporation of women in the paid labor force, in educational institutions and to ensure that their autonomy and rights are respected;
- Projects are designed to reduce inequality between men and women, especially with respect to the division of labor by gender, increasing the political and economic autonomy of women;
- Directed to any of the three roles (reproductive, productive or community);
- Has a strategic gender approach, through top-down state interventions giving political and economic autonomy to women in order to decrease their inequality.

Empowerment approach <-----> Defines empowerment as access to and control of the use of material/ economic resources, political, information/ education and time

- Its origins in Third World women's grassroots organizations; Freire's theory has great influence on awareness of oppressed peoples;
- In health, it proposes a new relationship of "shared power" between the health sector and different groups of a population;
- Seeks to empower women through greater self-reliance: women's subordination seen not only in relation to men at the individual level, but also of predominant development models;
- Tries to serve the particular needs of men and women in their multiple roles, through mobilization from the bottom up as a way to confront different types of oppression;
- Bottom-up mobilization around concrete health needs in a manner that incorporates strategic gender approaches—can be a practical and strategic gender approach.

POLICY DOCUMENTS: EXTRACTS

- Investment in health and education for women produces significantly greater benefit to the society than similar investments in men because of the close correlation between the health, nutritional level and education of women and the health, educational level and productivity of future generations. These correlations are still greater when women have control over how resources are distributed within the home.
- Lack of access to credit, land, information and technology aggravates gender inequity. When women have access to credit, the effect on the well-being of the family and its members is notable. The provision of financial resources to women is related to improvements in the health levels of children.
- Women are more vulnerable than men to micronutrient deficiencies which damage health. Bad health and nutrition diminish productivity and the ability to take advantage of the gains from investments in education. Recent estimates suggest that the combined effects of only three types of deficiencies on morbidity and mortality—vitamin A, iodine and iron—could waste up to 5% of the gross domestic product, and that correcting these deficiencies would cost less than 0.3% of GDP in developing countries.
- Malnutrition of infants is related to poverty and the low educational level of mothers.
- Data from Brazil indicate that when women are given more control over resources, there is a greater impact on the anthropometric measures of their children, a greater level of nutrition in their families, and a greater proportion of the family budget devoted to the health and education of children, than when the man controls the resources.
- There is a critical connection between the provision of public health services and women's access to educational opportunities. A mother who has been taught to seek preventive care and timely treatment for her own illnesses and those of her children, particularly her daughters, will reduce expenditure for health care and in many cases will prevent premature death. Many of these services are cost effective and can be provided in primary health care centers.

CASE STUDY 1: CENTER FOR INTEGRAL COMMUNITY HEALTH

The population of the District of Orange Creek is comprised mainly of migrants who have moved from interior parts of the country. Having set up their settlements around the periphery of a major city, they lack infrastructure and services. Most of the population in the District works in the informal sector of the economy.

Some of the communities in Orange Creek have organized commissions that focus primarily on issues related to property rights; these entities are comprised of men. Women have also organized themselves into mothers' clubs, and the focus of these groups revolves around their children's health.

In an effort to improve health conditions, particularly of women, an NGO secures funding for a project that targets five communities of the District. The selection of those communities is based on their degree of organizational capacity, as evidenced by the formation of two umbrella groups made up of leaders from the five communities: The Pro-Land Commission (PLC), which organizes around issues related to land tenure, and the Intercommunity Coalition of Mothers (ICM), a coalition which draws together women leaders from the different communities to catalyze initiatives of interest to all women that live there.

The NGO that proposed the health project already has been conducting adult literacy programs and supporting, through the ICM, educational programs for children. The ICM, in turn, has been running a children's soup kitchen for the past 4 years, and, after discussions with the NGO, agreed to participate in the health project.

The project proposed the execution of a pilot experience that could be replicated through a District Health Plan in other marginal urban communities of Orange Grove.

The project purpose is:

The health conditions and quality of life of the inhabitants of the district of Orange Grove improved as evidenced by a reduction in diarrheal diseases in children, and in women's morbidity.

Expected results include:

In the five selected communities of the District of Orange Grove:

1. In one year's time, an Integral Health Service Program with a focus on disease prevention and care through prenatal, pediatric and gynecological services is in place and functional for children under 6 and women of reproductive age
2. The Integral Health Service is promoted through continuous dissemination of health information using printed material and loudspeakers.
3. Ambulatory services attached to the Integral Health Service provide immunization and prenatal care in the target communities and draw 75% of the population of expectant mothers and 95% of children under 6 years of age.
4. Women's organizations strengthened, particularly in the design, development, and management of a District Health Plan, in close coordination with the Municipal government of the area that encompasses all the communities in the Orange Grove District.

CASE STUDY 1: CENTER FOR INTEGRAL COMMUNITY HEALTH (CONT.)**SALIENT ACHIEVEMENTS OF THE PROJECT:**

- A1. According to the evaluation by the mothers, the ambulatory services attached to the Integral Health Services were highly effective for reducing infectious diseases in their children.

DIFFICULTIES OF THE PROJECT:

- B1. A considerable number of the women that were treated in the ambulatory care services had to be referred to the Integral Services for follow-up. However, the Integral Services had little capacity to respond to these complications.
- B2. From the outset of the project, the Integral Health Services faced financial sustainability problems. In an effort to address the financial situation, the focus, which had initially been children under 6 years and women of reproductive age, had to be expanded so as to include the general population. This expansion resulted in an increase in user waiting time, both for getting appointments with doctors and in the time users were kept waiting on the day of their scheduled appointment. It also increased delays in the delivery of laboratory results, and diminished the quality of professional-user interaction.
- B3. With respect to community organization networking and negotiations, problems emerged concerning the determination of health priorities. The Pro-Land Commission (PLC) felt that one of the ways of resolving the financial viability of the Integral Health Services was by dropping the gynecological services, a cutback which was put into effect after heated discussions because of the opposition to this reduction by the Intercommunity Coalition of Mothers (ICM).
- B4. In addition to this difficulty, the PLC, claiming its track record in negotiating with the authorities, were of the opinion that only their members could participate as community representatives in the formulation of the District Health Plan.
- B5. Members of the ICM who wished to engage in these negotiations with the PLC were forced to dedicate more time to this process, time which they did not have because of their need to generate an income and to fulfill tasks involved in maintaining their households. The difficulties inherent in devoting the needed time to ensure that their views were taken into account in formulating the District Health Plan culminated in frustration and exhaustion for the members of the ICM, who gradually ceased to participate in the meetings to design the Health Plan.

NOTE: To facilitate a discussion of this case study, three groups will be analyzed: women of reproductive age in Orange Grove; the ICM, and the PLC. The first two groups are mutually exclusive.