AIM

To attempt an historical review of the impact of Primary Health Care (PHC) on Women in Africa;

and

Demonstrate the need for vigilance in the implementation of programmes meant to transform gender relations
MAIN ARGUMENTS

Courtesy of Dorothy L. Hodgson and Sheryl A. McCurdy, "Wicked” Women and the Reconfiguration of Gender in Africa, I argue that:

1. Certain institutions and opportunities have afforded women chances to challenge and positively reconfigure gender inequalities; while others have created traps for them,

2. The execution of certain well meant national and international development programmes sometimes have ambiguous effects for women,

3. Primary health care movement in Africa has produced the features expressed in the above points.
THE INTERNATIONAL COMMUNITY AND WOMEN’S HEALTH

International lobby for women’s empowerment in general, and through quality health care in particular, is now more than 3 decades old:

1. 1967, United Nations General Assembly Declaration on the Elimination of Discrimination against Women:
   “Discrimination against women, denying or limiting as it does their equality with men, is fundamentally unjust and constitutes an offense against humanity”.

2. 1975, International Women’s Year, followed by the Decade for Women (1975-1985) Emphasis was on the equal participation of women in national development.


4. In 1987, WHO sponsored a study published under the title *Women as Providers of Health* (Compiled by Helena Pizurki, et al) [We shall come back to this report later]
5. The 1994 Cairo Conference on Population raised awareness on sexual and reproductive health;
In that same year, the World Bank published its own mindset *A New Agenda for Women’s Health and Nutrition*;

6. Then, in 1995 was the Fourth World Conference on Women in Beijing;
And then,

7. The latest high profile pronouncement on women’s health and empowerment is contained in the MDGs

**Outcome**

1. Revelation of very important knowledge on the determinants of women’s health; biological, socio-economic and psychological

2. Identification of strategies for the delivery of health, prominent among them being PHC
PHC

A now well known health strategy enunciated at Alma Ata in 1978

The Four Pillars of PHC

Social Equity; Multi-sectoral Approach; Appropriate Technology; Community Involvement

And the Essential List of Eight

- Education concerning prevailing health problems and the methods of preventing and controlling them;
- Promotion of food supply and proper nutrition;
- An adequate supply of water and basic sanitation;
- Maternal and child health care, including family planning;
- Immunization against the major infectious diseases;
- Prevention and control of locally endemic diseases;
- Appropriate treatment of common diseases and injuries;
- Provision of essential drugs
Why PHC for Women?

Question can be answered by considering the following contending views on health delivery;

1. The Consumer Good Approach – which sees health as a commodity to be purchased

2. The Investment Approach – which sees health as an important factor to ensure community productivity. In this idea resources should be targeted towards those whose productivity can be easily increased (e.g., 1994 World Bank report)

3. The Humanist/Human Right Approach – sees health as an inalienable right which should not depend on a person’s potential productivity or ability to purchase.

*PHC seems to be more inclined towards approach no. 3.

The Golden Rules of PHC are;
Equity; Accessibility; Affordability & Sustainability
In Addition...

PHC is officially recognized & accepted strategy internationally

It is revolutionary – it de-emphasizes the vertically inclined biomedical approach & observes the linkage between health and underdevelopment, poverty, illiteracy etc.

There hasn’t been any formidable challenge to the internal consistency and legitimacy of the strategy;

**NB.** Alternative Health Sector Reform Theories are not challenging the core of PHC, but are frustrated with the failure of the public sector to meet its obligations.

Legitimacy of PHC also boosted by...

The successful experiences of China, Sri Lanka, Costa Rica & Indian state of Kerala
The 1985 Bellagio (Italy) Observations on China, Sri Lanka, Costa Rica...

- Societies there recognized equity

- Governments gave priority to health

- Female literacy was improved

- Social organization motivated people to/health workers to act beyond personal interests

- Appropriate use of technology
PHC and the Influence of WHO

“All health programmes and the health infrastructure should be built on primary health care. The individual, the family and the community are the basis of the health system, and the primary health worker, as the first agent of the health system that the community deals with, is the central health force” (The World Health Report, 1998)

NB: “All health programmes” includes women's!

More Overtly Gendered Views
The WHO-sponsored report compiled by Helena Pizurki et al (1987), argued;

“If WHO and its member states are to design and implement successfully a strategy whose cornerstone is primary health care and which aims at ‘Health for All by the Year 2000’, it is essential to concentrate on women as resources”. (Added emphasis)
More Overtly Gendered Interpretations.[contd.]

- World Bank[1994], because many of the interventions that address women's health are cost effective – PHC is one such cost effective strategy.

- Ethel G. Martens, an international public health scholar, argues that PHC's stress on prevention than cure is a very important that touches women's health more closely – PHC has inbuilt strategies that promote the health of women and that of their families. [The Greatness Which Might be Theirs; PHC and the Empowerment of Women, 1995]

- Pascal Allotey, UN Division for the Advancement of Women [2005], argued, that given the consensus reached at Alma Ata it will be apposite to use PHC to solve women's sexual and reproductive health problems.
Victims of Resourcefulness: PHC & Women in Africa

Implementation coincided with certain negative developments:

1. Economic recession in the 1980s leading to poverty

2. Fall in health expenditure

3. Low priority given to health as opposed to employment, etc

4. Growth of anti-state sentiments – belief in the power of the market to provide wealth and welfare

5. Change in the ruling values on which PHC rested in the 1970s due to ideological shifts

6. Contradictory economics of PHC: emphasis on cost-effectiveness has spawned variegated interpretations.
Women & PHC

Problems

1. The burden of community care – 'the dumping ground'.

2. Low funding for community primary care institutions where women are the majority.

3. Low status of community primary care as a result of low status of PHC.

4. Lack of programme continuity.

5. Continuation of gender stereotypes and other cultural barriers.
A Pictorial View of the Effects

It really looks good that African women can be doctors too...
However, this doesn’t look encouraging...
Pictorial View...(Contd.)

...or even this, ...

It has to be women always...
Conclusion: Suggestions

1. Raise the prestige of PHC

2. Give financial priority to PHC – this has to be community capital

3. Involve both men and women in PHC

Men and women lobbying together on South Africa’s Women’s Day