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**WOMEN'S SOCIAL POSITION AND THEIR HEALTH:  
A CASE STUDY OF THE SOCIAL DETERMINANTS  
OF THE HEALTH OF WOMEN IN  
KHAYELITSHA, CAPE TOWN, SOUTH AFRICA**

**BY**

**DIANE COOPER**

**THESIS PRESENTED FOR THE DEGREE OF  
DOCTOR OF PHILOSOPHY  
IN THE DEPARTMENT OF COMMUNITY HEALTH  
UNIVERSITY OF CAPE TOWN**

**MARCH 1995**

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**This thesis is presented in fulfillment of the requirements for the degree of Doctor of Philosophy (PHD) in the Department of Community Health, Faculty of Medicine, University of Cape Town. The work on which this thesis is based is original research and has not, in whole or in part, been submitted for another degree at this or any other university. The university is empowered to reproduce all or part of the contents for the purposes of research.**

Signed by candidate

**Diane Cooper**

**March 1995**

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## **DEDICATION**

**This thesis is dedicated to my parents, Kitty and Hilman Cooper**

## **USE OF TERMS AND NAMES**

In this thesis distinctions on the basis of race have sometimes been made by the author. This should not be taken to confer political legitimacy on these categories. Nevertheless the legacy of the South African Apartheid system of racial discrimination is that differences in disease patterns, health knowledge and access to health services have a racial basis to them. Most references on the basis of race are to African women who are representative of the most disadvantaged women in South Africa. In terms of previous South African legislation, all people not classified white were disenfranchised and suffered racial discrimination under Apartheid. Therefore where relevant to highlight differences, the term black is used to refer to African, coloured and Asian people collectively.

In the period during which the research for this thesis was conducted and written up South Africa has been transformed into a non-racial democracy. Reflecting this, changes have occurred in the names of various geographic areas of the country as well as in the names of some health and local authorities that existed at the time the research was conducted. In the text reference is made therefore to former 'homelands', the former Transkei and the former Ciskei (the latter two are now part of the Eastern Cape Province) for example. In addition, there may be inconsistencies in the names of the health authorities referred to.

The term 'homelands' is used to refer to the impoverished rural areas to which African people were limited in owning land under the racial segregation laws of the former Nationalist party government.

## ACKNOWLEDGEMENTS

This thesis arose out of ongoing women's health research in the Department of Community Health at the University of Cape Town (UCT). I am greatly indebted to this department for its material and other support. I would like to make special mention of Professor William Pick who was based in the department at the time the research was conducted and is now Head of the Department of Community Health at the University of the Witwatersrand, and Professor Jonny Myers and Dr Margaret Hoffman of the Department of Community Health at UCT. They collaborated in the research and gave substantial support in the write-up of the results. Many thanks to Mr Rauf Sayed for his plentiful advice and assistance in statistical analysis. Drs Margaret Hoffman, Mamorena Mofokeng, Ross Bailey and Nicol Coetzee have shared a collaborative interest in various aspects of women's health from which I have gained much.

In addition, Professor Myers gave me enormous support, and encouragement in his role as my supervisor and reviewed numerous drafts of the thesis. His critical insights and comments have been invaluable.

I am grateful for the insights into women's health in Khayelitsha provided by Karen Harrison, Kuku Jacobs and the Women's Wellness workers at the Zibonele Community Health and Women's Wellness Project.

The research on which this thesis is based formed part of the research conducted under the auspices of the National Urbanisation Programme of the South African Medical Research Council, to which I am most grateful for its financial support. Special thanks go to Dr John Seager for his support and input.

**ABSTRACT**

This thesis examines the social determinants of women's health status, health knowledge and knowledge and use of health services in a peri-urban area, using Khayelitsha in Cape Town, South Africa as a case study.

It argues for the importance of women's health as a specific focus, looks at some trends in women's health internationally over the past two decades and reviews the main factors affecting women's health. Some key issues in women's health of special relevance to developing countries such as South Africa are discussed. There is a special focus on newly urbanised women in peri-urban areas.

Against this background the results of a community-based survey, preceded by indepth interviews, and conducted amongst 659 women in Khayelitsha in 1989 and 1990 are presented. Data collected were statistically analysed using univariate, bivariate and multivariate analysis.

A number of priority social and health problems are identified: poverty; poor environmental conditions; lack of education, particularly skills training appropriate for finding work and the subordinate social status of women. Major health concerns included reproductive tract infections, especially sexually transmitted diseases, infertility, contraceptive use and ante-natal care during pregnancy. There were inadequacies in cervical screening conducted by health services and deficiencies in respondents' knowledge of AIDS, cervical smears and where to obtain various health services.

Young, newly urbanised women, living in the poorly serviced and unserviced informal housing areas were particularly vulnerable in their socio-economic and health status within a peri-urban African community such as Khayelitsha. They also had poorest health knowledge and least knowledge of where to acquire health services.

Some recommended interventions focussing on certain of these areas are suggested. It is argued that changes in the provision of women's health services within a primary health care setting can only be part of the process of improving women's health. Improvements in women's economic status and their social status are fundamental to any initiatives to improve their health status.

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**CHAPTER 1**

**BACKGROUND AND AIMS OF STUDY**

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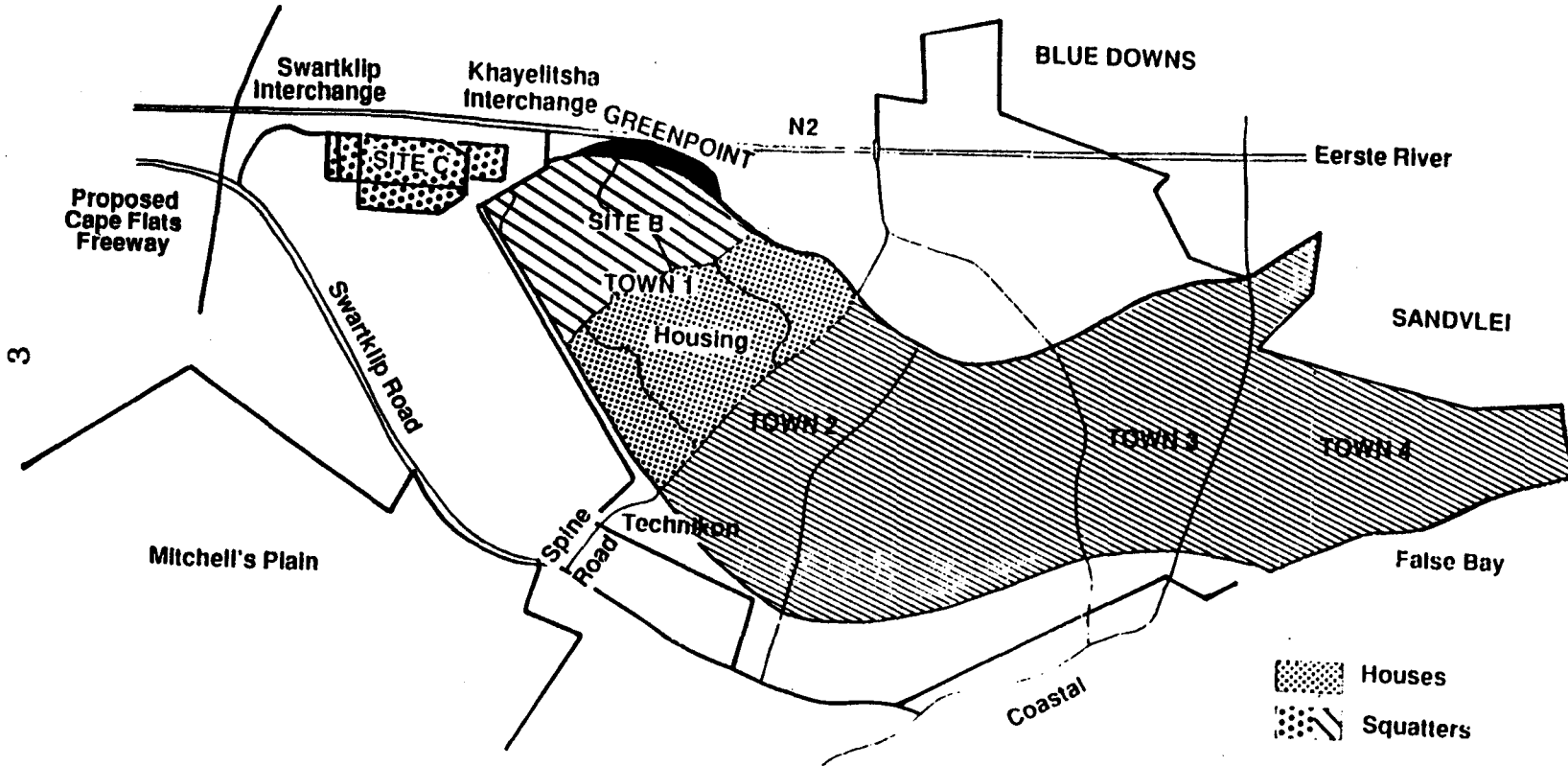
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Figure 1 - Map of Khayelitsha

# Khayelitsha

## Figure 1



## 1.1 BACKGROUND

This thesis has its origins in research in which I have been involved in the Khayelitsha Women's health and Urbanisation Project in the Department of Community Health at the University of Cape Town. The project formed part of the National Urbanisation and Health Programme of the South African Medical Research Council, which supported it financially.

Khayelitsha is a large peri-urban African settlement situated 32 km from central Cape Town, in South Africa. It was established in 1983 and current estimates of its population range from a quarter to more than a half million residents. It is an area of rapid growth and continuing urbanisation. It was originally established by the previous Nationalist party government with the aim of moving the populations of the other Cape Town African townships of Langa, Guguletu and Nyanga there'. In addition the previous government wanted to dismember the politically volatile informal settlement of Crossroads and resettle most of its inhabitants in Khayelitsha. While this latter plan culminated successfully in 1986, the former aim was abandoned due to its political non-viability<sup>1</sup>.

The history of Khayelitsha is inextricably bound up with the demise of Crossroads in 1986. In 1986 civil conflict broke out within Crossroads, which had long been a 'thorn in the side' of the former Nationalist Party government due to its political militancy. A conservative grouping known as the 'witdoeke' ('white head-scarves') waged battle with progressive groupings (known as the 'comrades') who were aligned to the broad anti-apartheid democratic movement. The former were assisted by the police. Areas in which the progressive groupings lived were decimated and thousands of their supporters forced to flee Crossroads. Some of these refugees set up new informal settlements close to Crossroads. Large numbers took refuge in informal settlements in Khayelitsha. The Greenpoint area in Khayelitsha was originally entirely settled by refugees from the civil strife in Crossroads<sup>\*\*</sup>.

\* *Under the former National Party government's Apartheid policy a residential segregation law, known as the Group Areas Act was enacted. This law forced African people (as well as others who were classified under Apartheid legislation as not white) to live in specifically demarcated residential areas. They were prohibited from residing outside these areas.*

\*\* *A more detailed recount of the civil conflict in Crossroads can be found in Cole<sup>1</sup> and Seekings<sup>2</sup>.*

Khayelitsha consists of predominantly informal housing, the majority of residents living in shacks (corrugated iron, wood and plastic construction) on serviced stands. The first area settled is an area known as Site C (Figure 1) which was originally an area of legalised squatting accomodating a group called the Cathedral\* squatters who left Crossroads and moved to Khayelitsha on the basis of a government promise to legalise their urban status prior to the lifting of influx control legislation<sup>1,2</sup>. Because of the rapid influx of residents to the area and the shortage of serviced stands, many have settled on sites without any services, and in areas not designated for housing. Within Khayelitsha there is also a limited amount of formal housing. A detailed description of Town 1 of Khayelitsha in which this study was conducted is provided in Chapter 3.

Two outpatient curative state health centres (Day Hospitals) exist in Khayelitsha. There are a number of fixed facility and mobile preventive health clinics (Family planning, Tuberculosis, Child Health and Sexually Transmitted diseases) run by local government. A Mid-Wife Obstetric Unit, run jointly by Groote Schuur Hospital and the Department of Obstetrics and Gynaecology at the University of Cape Town, is located adjacent to one of the curative health centres and provides ante-natal and obstetric services. At the time of the study there were 12 General Practitioners based in Khayelitsha<sup>3</sup>. There were also a number of non-governmental health projects, primarily engaged in preventive and health promotion work. State health services in Khayelitsha are fragmented, run-down and inadequate in serving a population the size of Khayelitsha and constitute an example of the legacy of the Apartheid health system.

When this study was planned, little available information existed on the health status and knowledge and use of health services by women living in peri-urban areas such as Khayelitsha. Similarly, there was little information on their socio-demographic and economic status.

The growing concern internationally and nationally with the health of women and the effects of urbanisation on health which will be described in Chapter 2, makes Khayelitsha an appropriate setting for providing information on the social determinants of the health of peri-urban African women in South Africa.

\* the name comes from having had a live-in protest against the influx control laws in the St Georges Cathedral in central Cape Town

## **1.2 AIMS AND OBJECTIVES**

The aim of the study was to examine the social determinants of the health of women in Khayelitsha.

The objectives were :

1. To describe the components of women's social position in Khayelitsha.

1.1 Environmental and household factors were examined through establishing:

- geographical area of residence
- housing type
- housing tenure
- household size
- household composition

1.2 An individual social profile of women was provided in terms of:

- age
- marital status
- education
- employment status
- income
- urbanisation status
- and social well-being status

2. To determine factors affecting the health status of women in Khayelitsha by examining:

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- and social well-being status

2. To determine factors affecting the health status of women in Khayelitsha by examining:

- pregnancy outcomes
- loss of a live-born child
- place of birth of last born child
- use of contraception
- types of contraception used
- attendance of ante-natal care
- intended and actual use of health services when ill
- types of acute, chronic and gynaecological illness
- incidence of acute, chronic and gynaecological illness
- awareness and experience of cervical smears
- knowledge of where to go for various health needs
- and awareness and knowledge of AIDS and its prevention.

3. To examine to what extent women's social position, as described, affects their health status and knowledge of and use of health services as described.

Definitions of all variables for the data collected are contained in Chapter 3.

As this thesis focuses only on those aspects of women's social position and health defined in the objectives, it does not represent an exhaustive study of women's health in Khayelitsha, but is rather an attempt to illuminate some key aspects.

### **1.3. STUDY PROCESS**

The initial stages of work on the project involved becoming familiar with the study area. Considerable time was spent planning and making contact with key informants in the community and with health service providers. A wide variety of health and community groups, organisations and knowledgeable individuals working in Khayelitsha were consulted. Appendix A gives a list of organisations consulted.

Links were established with community organisations and development agencies in order to facilitate access to the community and to ease the conduct of the study. State and non-governmental health services were consulted in order to identify relevant health problems, to assess the problems they face and to discuss their capacity to cope with any practical health interventions that could flow from the study.

Consultations were followed by exploratory in-depth interviews with key informants in Khayelitsha. The qualitative information gained through these interviews provided the basis for the formulation of questions included in a structured questionnaire, administered via a Household interview survey and conducted amongst a random sample of 800 households in Town 1 of Khayelitsha between September 1989 and February 1990. A copy of the questionnaire used appears in Appendix B. This cross-sectional, descriptive study aimed to provide generalisable information about women's socio-economic and health status. The survey provided the findings on which the bulk of this thesis is based.

The survey findings were obtained as a result of team work co-ordinated or led by the author and included a fellow senior researcher and thirteen fieldworkers selected from women resident within Khayelitsha. Research training was provided for fieldworkers. Efforts were made to include field staff in the research process and thus to develop research capacity and skills within the Khayelitsha community.

In 1991, interviewers returned to the same households in which they had interviewed respondents in 1989 in order to distribute pamphlets containing the overall results of the survey. This was in fulfillment of an undertaking made at the time of the survey to report the results to study participants.

Reports containing results of the study were disseminated to the community and non-governmental and state health services in Khayelitsha with whom the original consultations relating to the study had taken place.

#### **1.4 CONCLUSION**

The body of the thesis is to be found in Chapters 5 through 9, where the findings of the survey are presented and discussed. Chapter 2 is an attempt to situate the survey results within the broader context of women's health internationally and in South Africa. Chapter 3 describes the study methods used and Chapter 4 presents and discusses the findings of the in-depth interviews conducted prior to the survey. Chapter 10 concludes the thesis and provides some suggestions for further research and for meeting the health needs of women in Khayelitsha.

**1.5. REFERENCES**

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**CHAPTER 2**

**WOMEN'S HEALTH  
IN DEVELOPED AND DEVELOPING COUNTRIES:  
DETERMINANTS AND KEY ISSUES**

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## **2.1 INTRODUCTION**

The first part of this chapter defines women's health and provides a rationale for studying its importance. Changes in the focus of women' health research are explored and gender differentials in mortality and morbidity discussed.

Factors influencing women's health are also dealt with. The socio-economic and political determinants of women's health are examined in the following categories: women's work, income, political status, education, social status and environmental conditions. As the study that forms the bulk of this thesis was undertaken in Khayelitsha, a rapidly growing peri-urban area, with in-migration from rural areas, there is also a sub-focus on urbanisation and its influence on health.

The second part of this chapter discusses some key areas of women's health. The areas chosen are of importance to women's health in general and have either direct or contextual relevance to areas of women's health which formed the basis of enquiry of this study. These include in the area of reproductive health: fertility and contraception, reproductive tract infections, infertility, menstrual problems, maternal health, and gynaecological cancers (cancers of the cervix and breast). Some neglected areas of women's health are explored, including: women and work and violence against women. Given that fewer women live till old age in developing countries due to mortality as a result of reproductive health problems, particularly pregnancy-related to problems, reproductive health problems constitute a major part of an examination of key issues.

Throughout, there is a primary focus on women in developing countries and in South Africa in particular.

## **2.2 PART 1: DEFINING WOMEN'S HEALTH AND DETERMINING FACTORS**

### **2.2.1 WOMEN'S HEALTH: DEFINITIONS AND OPERATIONALISATION**

Women have both general health needs common to all people as well as specific health needs. Women's health problems are those which are either exclusive to women due to biological differences between the sexes or health problems or illnesses which are more prevalent in women or are experienced differently or more severely by women.

Until the mid-1970's, women's health concerns and women's health needs were largely confined to maternal and child health (MCH), or to those activities related to pregnancy and childbirth. This led to a focus on fertility and maternal morbidity and mortality. Holloway<sup>1</sup> suggests that " Social customs, health policies and a largely male medical community have tended to treat women as wives or wombs and little else ". The preoccupation with women's health only in relation to bearing children, has led to neglect of a broad range of women's health issues, as well as neglect of particular categories of women in their pre or post reproductive years (adolescence or old age). Minimal attention has been paid until recently to health issues such as<sup>1</sup>:

- \* undernutrition
- \* diagnosis and care of women with AIDS
- \* cancer of the cervix in middle-aged women
- \* diseases which are more prevalent in women such as osteoporosis, cardiovascular disease post-menopausally, immunologic diseases, mental disorders and Alzheimer's disease<sup>2</sup>
- \* domestic and other violence against women

- \* sexually transmitted diseases
- \* the damaging effects of illegal abortion
- \* and female genital mutilation.

Current definitions of women's health focus on " her total well-being, not determined solely by biological factors and reproduction, but also by the effects of work load, nutrition, stress, war and migration among others"<sup>2</sup>. The move away from a biological model is common to the study of health as a whole, with the health of all people being viewed as situated within a socio-economic and political context. Health is defined by the World Health Organisation as not only the absence of disease or infirmity but emotional and social well-being too<sup>3</sup>. However, as documented later in this chapter, the structured inequality between men and women has an additional major impact on women's health.

The changes in women's health enquiry have occurred for the most part because of changes in women's health status and their socio-political status in developed countries. Dramatic changes have occurred in women's health during the last fifty years, leading to higher life expectancy. Improvements are attributable to economic development and changes in women's social and political status as well as improved health technology and health care delivery<sup>4</sup>. A decrease in fertility and safer childbirth has led to lower maternal mortality. For example in the United States, less than 2% of deaths in 1975 amongst women in the reproductive age (15-44 years) were attributable to pregnancy or contraception<sup>5</sup>. During the last decade, greater organisation and empowerment of women has led to a concern with gender issues which has broadened the scope of women's health enquiry. Women's struggles for equality in developing countries have contributed to the concern with gender' issues in women's health.

- \* *Sex differences are biological, based on differences in the anatomical structure and physiological functioning of female and male bodies. Gender in this thesis is used to denote the collapsing of biological differences by society into social differences between women and men. These social differences do not in fact derive from biological differences but are based on unequal relations of power between women and men in society.*

Improvement in women's health status has lagged behind in developing countries. The United Nations Decade for Women between 1976 and 1985 was declared in recognition of the urgent need to improve the situation of women, particularly in developing countries. Worldwide women share a common experience of occupying subordinate positions in most social and cultural contexts. However, large differentials exist between women internationally on the basis of race, class and geography. These differences exist between the richer and poorer countries, as well as within countries<sup>1,4,6</sup>. While infant mortality fell by 50% and fertility rates fell by 40% in developing countries between 1962-1992, maternal mortality has remained high<sup>6</sup>. Maternal deaths in developed countries are 26 per 100,000 livebirths, while in developing countries there are 420 per 100,000 livebirths<sup>4</sup>.

The health of women in developing countries is still primarily affected by problems of childbearing and diseases of poverty such as communicable diseases and undernutrition<sup>7,8</sup>. A third of the healthy days of life lost to women in the 15-44 years age group in developing countries is accounted for by reproductive health problems such pregnancy related complications, sexually transmitted diseases including HIV and genito-urinary problems<sup>9</sup>. While reproductive health remains a concern of women's health in general it is of major concern in an examination of women's health in developing countries.

Reproductive health includes physical, mental and social well-being in all matters relating to the reproductive system and in its functions and processes<sup>9</sup>. Important areas of women's reproductive health are: maternal health (preconception, ante natal care, delivery and post natal care, including lactation), fertility regulation, abortion, infertility, sex education, sexually transmitted diseases and cancers of the reproductive tract and breast.

The approach to women's health which emerged in the 1980's emphasises that it is subject to socio-economic, cultural, physical and environmental influences **throughout the life-cycle**. A life cycle approach to women's health takes into account both the specific and **cumulative** effects of poor health<sup>6</sup>. Many problems begin in childhood or adolescence and have effects on later health problems. For example, inadequate nutrition in childhood or adolescence can lead to anaemia or stunting which can cause complications in childbirth. Insufficient calcium can lead to osteoporosis in later life<sup>6</sup>.

Since the late 1980's, there has been a growing body of women's health research in South Africa with African women, particularly those in rural and peri-urban areas, identified as an especially disadvantaged and vulnerable group<sup>10</sup>.

South Africa reflects patterns of socio-economic and political status and health of both the developed and developing worlds. While all women in South Africa suffer gender discrimination, the extent of this varies by class and race and stark differentials exist between white and black women in a number of spheres. This is reflected in their health status. For example African women's life expectancy (55-60 years) is similar to that of African men. Conversely, white women have a life expectancy of 74.2 years, similar to that of women in developed countries, 7.6 years higher than their white male counterparts<sup>11</sup>.

Official figures for 1991 of maternal mortality rates, while being an underestimate of African maternal mortality, reflect the differentials in access to health care by white and black women. The number of maternal deaths per 100,000 live births were 8 for white women, 5 for Asian women, 22 for coloured women and 32 for African women<sup>12</sup>. While teenage pregnancy represented 8.4% of all white births, it represented 11.4% of African births<sup>10</sup>.

The commonest causes of death due to neoplasms in white women were cancer of the breast (20%), followed by lung cancer (12%) and cancer of the cervix (3%). For African women cancer of the cervix was the most common (25%), followed

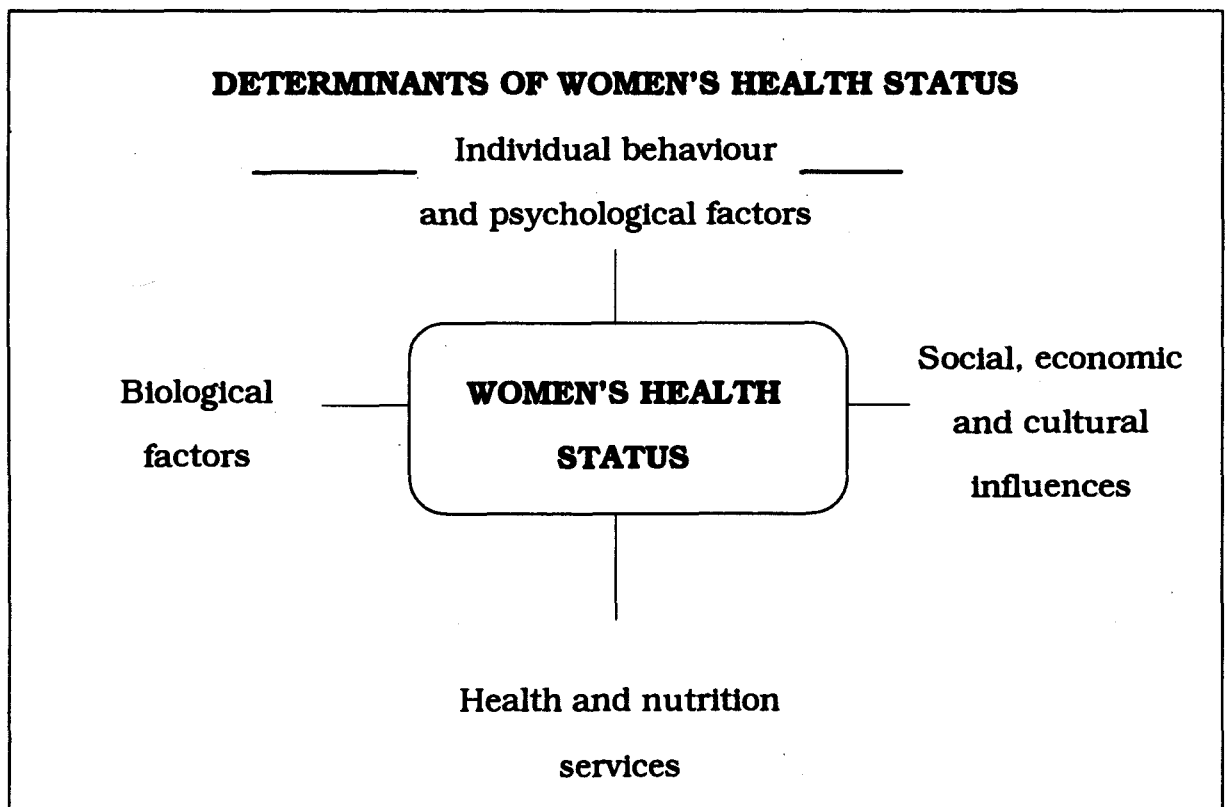
by cancer of the oesophagus (14%) and cancer of the breast (8%)<sup>11</sup>. These diverse patterns of deaths due to neoplasms reflect the differing lifestyles and access to health knowledge and services of white and African women.

Research to determine the needs of women has been given greater impetus by the establishment of a new government in South Africa in April 1994. One focus of the Reconstruction and Development Programme (RDP) is on ensuring women's full and equal role in all aspects of the economy and society. Black women, historically disadvantaged by racial discrimination in addition to gender discrimination are specific targets for affirmative action. The RDP makes special mention of the development of appropriate health services for women.

### 2.2.2 FACTORS INFLUENCING WOMEN'S HEALTH

Women's health is determined by a complex matrix of interrelated factors.

**Figure 1**



Source: Reproduced from The World Bank report on Women's Health and Nutrition<sup>6</sup>.

Individual behaviour includes life-style factors. Socio-economic and cultural factors include: work and income levels, education, demographic factors, factors relating to politics and policy decisions, environmental factors, violence and the status of women.

### **2.2.2.1 Gender differentials in Health: Females biological advantage**

#### **Mortality and morbidity**

High maternal mortality rates were responsible for a shorter life expectancy in women in the pre-industrial age<sup>4</sup>. Today, however, men in developed countries have higher mortality rates than women<sup>13.14.15.16</sup>. Men's higher mortality rate is attributable to several factors. Females have a biological advantage over males in that girl babies tend to be physically hardier than boys. Given equal care women's life expectancy at birth is 1.03 that of men<sup>6</sup>. Endogenous female hormones protect women against certain life-threatening illnesses such as cardio vascular disease during their reproductive years. Greater male mortality is also related to life-style factors such as greater substance abuse and more deaths from violence and accidents<sup>4.8.13</sup>.

In many developing countries however, overall mortality rates are high, and there is little difference between the life expectancy of females and males. Average life expectancy in developing countries was 51 for men and 53 for women in the late 1960's. While this has risen, to 59 and 61 respectively in the late 1980's, there has been no widening of the gender gap<sup>8</sup>. In some countries in South Asia, life expectancy for women is lower than for men and contrary to biological expectations, infant and child mortality is higher for girls than boys<sup>17</sup>. In countries where a higher death rate is experienced by women, this is largely attributable to high reproductive mortality (deaths resulting from pregnancy and the side effects of preventing conception<sup>5.6.17</sup>. Discrimination against

women in society and in the family is considered to be a major factor underpinning women's higher death rate during their reproductive years and some countries during in infancy and childhood<sup>1.5.8.17</sup>. Lack of adequate and available health care which affects all poor people in developing countries and women in particular, is an additional contributing factor.

Paradoxically women in both developed<sup>18-21</sup> and developing<sup>2.6.7.8.17</sup> countries experience greater morbidity than men. Part of the greater morbidity experienced by women in developed countries, may reflect different health seeking behaviour by women and men. A consequence of their gendered upbringing may be that women find it easier to seek help than men. In addition women's role in childcare leads them to have greater contact with health services through taking their children to visit a health service. Women are more likely to take preventive measures and use health services for established disease<sup>16</sup>. In developing countries the greater morbidity experienced by women is due to the social, political and economic disadvantage of women in some cases cancelling out females' biological advantage. Factors contributing to greater morbidity amongst women are complex and interrelated. They are dealt with below under the socio-economic and political determinants of women's health.

#### **2.2.2.2 Socio-Economic and political determinants**

Doyal<sup>4</sup> argues that the "the specific ways in which women live their lives can make them sick." She suggests that instead of identifying diseases and searching for causes, one should begin with identifying major areas of activity that constitute women's lives and analysing their impact on their health.

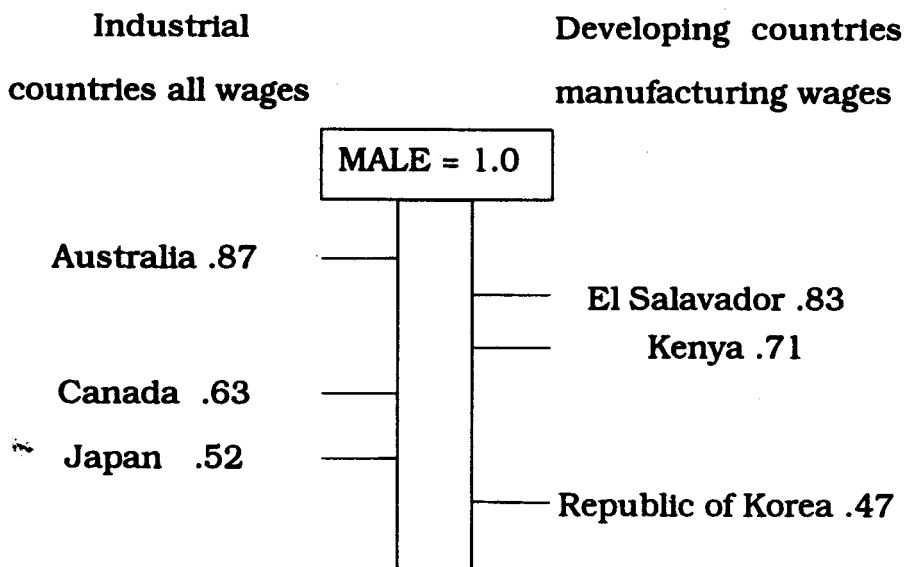
##### **Economic factors: work and income**

While more than a billion<sup>8</sup> people in the world live in extreme poverty, women are more likely to be poor than men and to be amongst the poorest<sup>6.7.8.22</sup>. Fewer

women are in wage employment, women generally occupy lower status, have lower paid jobs and are more vulnerable to losing their jobs in an economic recession than men<sup>22,23</sup>. In the mid 1980's women's lagging wages were as follows in selected developing and developed countries:

**Figure 2:**

**Women's lagging wages in selected developed and developing countries**



Source: Reproduced from World Health Organisation. Women's Health: across age and frontier<sup>24</sup>.

Women's world at work encompasses both wage employment in the formal or informal economy and domestic labour in the home. In the formal economy, women's rates of economic activity vary across the world. Interestingly and in need of further exploration is the fact that amongst the developing regions, sub-Saharan Africa and South-eastern Asia have the highest rates of economic activity amongst women, ranging from 45-50%<sup>22</sup>. According to the 1985 census, African women in South Africa constituted 35% of all African people employed. Regional variations occur within South Africa. A study in a Durban African

residential area found employment percentages to be 68% for men and 45% for women, whereas in rural areas this was found to be 66% for men and 26% for women<sup>23</sup>. Female waged labour is concentrated in particular sectors of the economy. Agriculture and domestic work in the homes of others are the predominant waged activities for African women in South Africa. In manufacturing women predominate in the food, clothing, textile and service sectors<sup>23</sup>. The fact that women are generally the lowest skilled and the lowest paid affects their ability to maintain their health and pay for health care.

Work in the domestic sphere involving the social and sometimes (such as during lactation) biological reproduction of the family adds substantially to women's workload. As can be seen in Table 1, women in both developed and developing countries are disadvantaged by having primary responsibility for unpaid housework.

Table 1: Distribution between women and men of unpaid housework: Selected developed and developing countries

Country	Year	Unpaid housework (% share of women and men)	
		Women	Men
United States	1986	64	36
United Kingdom	1984	72	28
Norway	1981	76	24
Netherlands	1980	79	21
USSR	1986	65	35
Venezuela	1983	90	10
Guatemala	1977	82	18
Nepal	1979	78	22
Indonesia (Java)	1973	87	13

Source: United Nations. The World's Women 1970-1990. Trends and Statistics<sup>22</sup>.

In urban areas, domestic work involves the physical work of cooking, cleaning, laundry, shopping and frequently childcare or care of the aged. In rural areas and some peri-urban areas women are burdened with the heavy labour of fetching and carrying water, wood or other fuel and agricultural activities. For most women, domestic labour includes the emotional labour of caring for a family. Domestic labour is unpaid and therefore undervalued, contributing to women's lower status. Doyal<sup>4</sup> argues that the domestic environment involves complex processes of cooperation and conflict over resources, rights and responsibilities with male partners and other family members. The results of this are often detrimental to women's well-being leading to overwork and stress.

### **Political factors: Politics and policy decisions**

While women almost all over the world have the right to vote, few occupy leading political or public positions. Although some of the gaps in public life and leadership have narrowed, particularly in developed countries, the role of women is still severely limited. Of the United Nations member states, 3.8% were headed by women by the end of 1990. Only 3.5% of cabinet ministers were women and in 93 countries there were no ministerial positions occupied by women. In 1987, only 10% of parliamentarians in all countries were women<sup>22</sup>. Women are employed in large numbers in the public sector, but are poorly represented in the upper echelons. The same pattern exists with respect to positions within the economy. Women's poor representation in public, political and economic decision-making means that their needs are seldom taken into account.

In the struggles against Apartheid in South Africa, except for in women's organisations, women were poorly represented within leadership structures of local, regional and national political organisations<sup>10</sup>. However, some organisations have fought for furthering the rights of women. For example, in the late 1980's

a number of trade unions in the Congress of South African Trade Unions campaigned around gender issues inside and in the work place. In April 1991, the African National Congress Women's League re-established itself inside the country. The National Women's Coalition was launched in 1992. It had 94 affiliated organisations in 1994 and drew up a charter to fight for women's rights to be entrenched in the new constitution. While the number of women occupying political leadership positions has improved since the first democratic election in April 1994, women are still a minority. In the new parliament 100 of the 400 parliamentary seats are occupied by women. In the Government of National Unity only 3 of the 27 cabinet ministers and three of the twelve deputy ministers are women<sup>23</sup>. The transition to democracy in South Africa is a critical period for women's organisations to pursue the recognition of women's rights and empowerment of women.

### **Social factors: Educational and social status**

#### **Educational status**

Women's formal education lags behind that of men in most developing countries, particularly for post-primary education. Using a denominator of 1.0 for men as a point of comparison, women in developing countries rated 0.91 for primary education, 0.70 for secondary education and 0.54 for tertiary education for the year 1987-88<sup>24</sup>\*. The situation in South Africa contrasts sharply with this, with a counter tendency existing for primary and secondary education. Figures show slightly more African boys in attendance at primary schools, and slightly more girls in secondary schools<sup>25</sup>. This may reflect the relative development of South Africa, with it occupying a transitional position between developed and developing countries. Budlender<sup>26</sup> argues that job opportunities for women in teaching and nursing are one reason for girls' predominance in high school. She suggests that girls who leave school early have access to a much smaller range of unskilled jobs and parents therefore try and keep girl children at school long enough to

enable them to get these qualifications. She argues that another factor may be a realisation amongst families, especially those headed by women, that they are more likely to be able to rely on their daughters for future financial support. However, in South Africa in keeping with the rest of the developing world, men dominate in the attainment of tertiary qualifications. For example in 1987, except for teaching and nursing qualifications, more than twice as many men as women received diplomas from technikons<sup>25</sup>.

Higher levels of education amongst women have positive effects on health. Mamdani<sup>26</sup> argues that basic literacy in women promotes changes in their traditional roles and status, increasing their power within the family. This is an important determinant of their reproductive behaviour. Education has positive associations with a number of factors which promote health such as<sup>8,26</sup>:

- \* Continued education may cause marriage at a later age leading to an older age of first pregnancy
- \* a greater earning capacity
- \* use of modern family planning methods and having a smaller family
- \* seeking ante-natal care and having safer childbirth.
- \* greater use of health services generally
- \* having healthier children (higher immunization rates, less infant and child mortality)

### **Social status**

Gender inequality underpins the socio-economic and political determinants of women's health. The subordinate social status of females in some societies determines the differential effects of inadequate nutrition, lack of immunisation and education. While gender differences in these areas may not be noteworthy

in transitional, developing countries such as South Africa, gender inequity is reflected in differential access to health care, the division of labour and physical and sexual abuse.

In most societies women are less valued than men. The varied role which they play as: wives, bearers and rearers of the children, food producers, food processors, carers of the sick and elderly, providers of water and fuel and workers in the paid labour force are less recognised and valued than men's roles.

The subordinate status of women is reflected in a number of areas already discussed: they do more work but their work is less valued; they receive less pay than men for paid work; they receive no pay for household domestic work. In addition, they are poorly represented in higher paid, more powerful jobs and in political and community decision-making<sup>4,10,22</sup>.

Women's subordinate status has direct effects on their health.<sup>23</sup> The value attached to having many children in some societies leads to repeated pregnancies and the responsibility for caring for many children. This impacts negatively on women's health<sup>6</sup>. Women may be socialised into a forbearance with respect to body functions which disadvantages them in recognising health problems and seeking care<sup>6</sup>. In some parts of the world female's lower status has meant that they receive less food, poorer treatment when sick and often treatment at a more advanced stage of disease. A study in Matlab, Bangladesh found that free health services were more likely to be used for sick male children than for sick female children<sup>27</sup>. Another study in India showed that boys were fifty times more likely to receive treatment for malnutrition despite this condition being four to five times more prevalent in girls<sup>1</sup>. Discrimination against females has also been documented in areas of access to food<sup>1,7,17,27</sup> and immunisation<sup>1</sup>. A study conducted in Colombia and Thailand<sup>28</sup> found that six times as many adult men attended clinics for malaria than women even though the incidence was the

same for both sexes. Extreme manifestations of the impact of gender discrimination on women's health are evident in the higher mortality rates in female infants and young children in South East Asia contrary to elsewhere in the world<sup>29</sup> and in evidence of preferential abortion on a gender basis<sup>1</sup>. Violence against women is also a reflection of their subordinate status.

The indirect effects of women's subordinate status on their health are difficult to measure. However, as Doyal<sup>4</sup> argues, society's dominant message to women that they are socially inferior impacts negatively on their mental health, leading to feelings of incompetence and lack of self-worth.

The World Bank<sup>6</sup> argues that women's health status should be seen not only an individual issue but a national issue as well as it affects the next generation through children, and affects productivity at the level of the household, the formal and the informal economy.

### **2.2.2.3 Environmental factors**

Poor living conditions pose health risks for all who live in them, including women. Risks include: water-borne diseases due to inadequate or poor quality water supply; communicable diseases spread through overcrowding; respiratory conditions as a result of damp; poorly insulated dwellings and diseases spread through poor sanitation; and inadequate refuse storage and collection.

Women's role as resource managers - providers of food, fuel, water and other household resources, place them at additional risk<sup>8</sup>. Women in rural and peri-urban areas frequently walk long distances and spend extra working hours collecting fuel and water. Women face additional risks in contracting water-

borne diseases while fetching water. The smoke pollution from biomass fuels such as wood, charcoal and dung affect women most severely because they spend much time within the dwelling cooking and performing household chores.

In South Africa, 30.7% of African people in urban areas live in informal dwellings (shacks). Only 17.5% of African people have internal piped water, 25.8% have an outside tap and 23.8% fetch water from a public tap. The remaining 32.9% do not have access to piped water. People in the more developed regions of South Africa fare better in their access to water supplies. In the Western Cape 37.3% of African people have internal piped water, 31.7% an outside tap, 29.6% access to a public tap and 1.4% no access to piped water. In the urban areas of the Western Cape 63.6% of African people have flush toilets, 9.1% pit latrines and 27.3% have none. In 1993, 57.4% of African people in the Western Cape had no access to electricity (from grid)<sup>30</sup>. The impact of the lack of infrastructure on the health of women living rural areas and in informal settlements in peri-urban areas is most severe.

#### **2.2.2.4 Urbanisation**

##### **Urbanisation: its magnitude world-wide**

While less than 3% of the world's population lived in urban areas in 1800, this figure will rise to 66% by the year 2025. The United Nations projects an increase in the world's population from 4.4 billion in 1980 to 6.2 billion in the year 2000, an increase of 41%. It is estimated that the urban population will increase by 78% during the same period. The fastest increases are occurring in developing countries. It is estimated that 83% of the population in developing countries will live in urban areas by the year 2000<sup>31</sup>.

Increasing numbers of people in urban areas in developing countries live in urban or peri-urban slums. In the 1960 and 1970's shanty town and slum

dwellers represented between 30-60% of the urban population in developing countries, whereas it is now estimated that they constitute between 50-79%<sup>32</sup>. The major proportion of population growth in the urban areas (61%) is estimated to be due to natural increase. This is so even in developing countries, mostly attributable to the fact that migrants to the urban area tend to be young and therefore in the most fertile group<sup>26</sup>. However a significant 39% of population growth in urban areas in developing countries is estimated to be due to rural-urban migration<sup>33</sup>.

### **Urbanisation in South Africa**

In 1985, 63% of the total South African population lived in urban areas, defined as areas with high population density and the absence of agricultural activity. The Urban Foundation projects that in the next two decades urban growth will occur at a faster rate than population growth and that the number of people in the urban areas will be 73% of the total population by the year 2010<sup>34</sup>. The fastest urban growth will be amongst African people. In 1985, 53% of the total African population lived in the urban areas. It is projected that this will increase to 69% by 2010<sup>34</sup>. Conversely it is projected that the population of the formerly independent 'homelands' (largely rural) will decrease by 1 million people between 1985 and the year 2000<sup>35</sup>.

South Africa's colonial and apartheid history has had a major impact on the process of urbanisation of African people, particularly those living in the Western Cape. Legislation in the 18th century imposed poll and hut taxes on African people in rural areas in order to secure migrant labour for the diamond and gold mines. The 1913 and 1936 Land Acts set aside only 13% of the land surface area for occupation by African people. This land allocation became the basis for the formation of 'homelands' under Apartheid. Influx control legislation was introduced allowing African people to remain in a particular area outside of a

'homeland' only so long as they were in registered employment. As most employment was for male migrants, women's migration to the cities was most restricted. This created a male-dominant pattern of urbanisation. These policies were accompanied by economic decentralization, residential segregation and forced removals of Africans from areas within cities reserved for whites and from rural areas to the 'homelands'. By 1986, it was estimated that 3.5 million people had been forcibly removed to the former 'homelands' over a period of twenty-five years and 17 million South Africans had been arrested under the pass laws over a period of seventy years<sup>36</sup>.

These measures shaped the pattern of African urbanisation in South Africa in that there was more limited female migration and migration of male contract workers accommodated in urban areas in specially created single sex hostels. However it did not prevent urbanisation from occurring. By the time influx control was lifted in 1986, massive urbanisation of African people had already occurred<sup>37</sup>.

The Western Cape was designated as a coloured labour Preference Area. As a result influx control was particularly stringently applied in Cape Town. Indicative of government attempts to severely limit the number of African people living in Cape Town was the fact that virtually no family housing was erected between 1962 and the 1990's'. In the late 1970's and 1980's intense struggles occurred between African people in Cape Town and the government over the right to stay in the area<sup>38</sup>.

Improverishment of rural areas, the desire of women to join their partners and the abolition of the pass laws, has accelerated female rural-urban migration since 1986.

\* A limited number of family houses were erected in the 1980's in an area known as New Crossroads. This anomaly was a result of political struggles to remove people from Crossroads, a large informal housing area.

## **Definitions and causes of urbanisation**

Urbanisation is the relative increase in the urban population as a proportion of the total<sup>33</sup> as a result of rural-urban migration. The definition of urban is complex. A WHO definition focuses on the size of the population, urban areas having a population in excess of 20,000 people<sup>31</sup>. Graaff<sup>39</sup> suggests a number of additional criteria including: size and density of population, the form of local government or administration in the area, industrial as opposed to predominantly agricultural economic activity and access to basic services. Yach<sup>40</sup> argues this masks intra-urban differentials and that it is more useful to adopt indicators to define urban within the context of a particular study rather than to have universal indicators. As migration processes are complex it is important to collect information on the migration history of adults over a life time and on seasonal movement.

While urban areas may offer more opportunities for employment and access to services than rural areas, the environmental conditions prevailing in urban slums and peri-urban shanty towns are extremely inadequate. They are characterised by poor housing, sanitation, water supplies and rubbish collection, overcrowding, lack of electricity, and the presence of standing water. The following description of socio-economic conditions prevailing amongst the urban poor described by Hollnsteiner<sup>32</sup> could be a description of virtually any urban or peri-urban lower socio-economic area in South Africa:

" Inside the tiny, ramshackle dwellings live often six, ten, twelve or more family and kin members...joblessness and alcoholism make men angry or hopelessly drunk, and lead to abandoned wives and children. Women must go to work to survive without a male breadwinner, or if he is present and has work, to help him to make ends meet through additional income. For some of them, domestic service and prostitution are virtually the only options... Money is always scarce.

This situation ...is one of powerlessness vis-a-vis the urban planners, policy makers and administrators who decide what kind of world they live in."

South Africa's political legacy is an additional exacerbating factor for African poor people living in urban and peri-urban areas.

The causes of urbanisation internationally as well as in South Africa has been an area of much debate. Theories in the 1950's and early 1960's tended to see urbanisation in developing countries as part of a positive modernisation process. Urbanisation was defined primarily in terms of a 'pull' to the city<sup>32</sup>. More recent theories<sup>32</sup> argue that urbanisation is the result of increased rural landlessness due to structural changes in the peasant agricultural mode of production. Writers on urbanisation in South African argue<sup>41,42,43</sup> that permanent rural-urban migration is uncommon with many people oscillating annually or even more frequently between urban and rural areas and that much circular migration occurs (movement within cities and rural areas).

### **Urbanisation and health**

There has been renewed concern with the health of the urban poor world-wide. Rossi-Espagnet<sup>31</sup> states that as the urban poor are at the interface between two worlds their health status reflects the problems of infectious diseases and malnutrition of underdevelopment and the chronic and social diseases of industrialisation. Factors detrimental to health include low income, limited education, under-nutrition, overcrowding, pollution, traffic, stress, alienation and factors relating to social and psychological instability.

The urban poor are more vulnerable and have greater exposure to pathogenic agents, hence diseases such as tuberculosis, diarrhoeal diseases and urban malaria in some areas are serious health problems. There is also a high

prevalence of preventable diseases in children such as meningococcal meningitis, measles, whooping cough and polio. Sexually transmitted diseases and substance abuse are growing problems.

The impact of migration and urbanisation on health has received greater attention in the last twenty years. In developing countries where rural-urban migration is an important feature of the growth of urban populations, there has been increasing concern with the health of the newly urbanised poor. The Alma Ata International Conference on Primary Health Care in 1978 recommended a special emphasis on rural and urban development programmes as a means of strengthening primary health care within national development programmes. The WHO Health for all by the Year 2000 strategy also explicitly mentioned urbanisation and its related health problems<sup>32</sup>.

The process of urbanisation is characterised by a number of changes including: movement from rural to urban areas, population increase and concentration, a predominance of young migrants, movement within urban areas, high mobility, changing physical environments, improved access to education and employment, socio-cultural changes (for example in the structure of the family), changes in health seeking practices and impoverishment of rural areas<sup>26,40</sup>. Such changes may be both beneficial and detrimental to health. It has been argued<sup>40</sup> that some peri-urban areas may be more disadvantaged in their access to water, sanitation and sewerage and employment than some rural areas, as the provision of basic services is often outstripped by the growth of these areas. They therefore accommodate communities with increased vulnerability to health risks. The WHO and UNICEF<sup>40</sup> argue that urbanisation is associated with an increase in three groups of disease: The first are diseases of poverty including communicable diseases and malnutrition (especially in children). The second includes diseases associated with industrialisation and lifestyle. These include: cardiovascular diseases, some cancers, psychiatric problems, and diseases associated with

pollution (for example increased incidences in respiratory and allergy related conditions such as asthma). The third are health problems associated with social instability such as a high prevalence of sexually transmitted disease, a high rate of teenage pregnancy and health problems related to substance abuse, crime and violence.

In developing countries, a large number of young, single people migrate to the cities. This often results in the loosening of traditional restraints on sexual activity<sup>44</sup>. Factors influencing diseases of poverty are social class (education, income and employment status), the physical environment (access to water, sewerage facilities, housing) and health service availability, accessibility and quality. Social class and risk behaviour influence diseases associated with industrialisation such as smoking which is a relative risk factor for ischaemic heart disease and major risk factor for lung cancer. Products in the industrial working environment and the structure of the work process also increase risks for diseases associated with industrialisation. Peri-urban areas are sometimes situated close to industrial sites and are therefore more vulnerable should industrial pollution accidents occur. Social instability is exacerbated by physical environmental factors (poor street lighting, bleak environment) and socio-economic conditions such as unemployment as well as political factors.

African urbanisation in South Africa has been accompanied by political repression and restriction, leading to social disorganisation and feelings of powerlessness. Political and social instability has fostered endemic violence common to many rapidly developing cities<sup>40</sup>. The male dominant pattern of migrant labor has increased the risk of marital infidelity both by men in the urban areas and women left behind in the rural areas, as well as the risk of abandonment of families by male migrant workers<sup>45,46</sup>. Health effects include an increase in sexually transmitted diseases and alcoholism and other psychosocial problems<sup>47</sup>.

Women (and children) suffer predominantly as a result of increased teenage pregnancy, sexually transmitted diseases and violence. Rhampele<sup>48,49</sup> states that women who were born and grew up in rural areas in South Africa had very limited opportunities to escape rural impoverishment. She describes how sexual liaisons with male migrants living in hostels provided many women migrating to the cities with a means to obtain accommodation and financial support. This highly dependent position of women migrants has made them particularly vulnerable to sexually transmitted diseases and violence. Newly urbanised women migrants could also be especially at risk for industrial hazards as they are disadvantaged as newcomers in obtaining safe work. Lack of knowledge or access to health services in a new urban environment affect their own health status and needs, and place stress on them in their nurturant role as carers of children and the sick. In addition, Cassel<sup>50,51</sup> hypothesises that incongruity exists between the culture of the new arrivals and their social situation as a result of urbanisation. He argues that the adjustment individuals need to make jeopardises their psychological and social well-being.

## **2.3 PART 2: SOME KEY WOMEN'S HEALTH ISSUES**

### **2.3.1 REPRODUCTIVE HEALTH**

Factors which impact negatively on reproductive health include: inadequate levels of knowledge about human sexuality, inappropriate or poor quality information and services in reproductive health, the prevalence of high risk sexual behaviour, discriminatory social practices and attitudes towards women and girls and the limited power many women and girls have over the sexual and reproductive aspects of their lives<sup>9</sup>. The United Nations identifies adolescents as at particular risk because of their poor access to knowledge and services in most countries. It also notes that the reproductive and sexual health needs of older women and men have been neglected.

Women's risk of premature death and disability is greatest during their reproductive years<sup>9</sup>. Conditions contributing to this include: unplanned pregnancy and abortion, pregnancy-related complications and reproductive tract infections.

#### **2.3.1.1 Fertility and Contraception**

Although the world population is at its highest ever in absolute numbers, fertility rates are declining. The world population grew at a rate of 1.7% a year in the period 1985-90 and is expected to decline to 1.0% per year by the period 2020-2025<sup>9</sup>. Fertility rates nevertheless remain high in developing countries, particularly in Sub-Saharan Africa which had higher fertility rates than any other region in 1990, with a total fertility rate (TFR) of 6.5<sup>22</sup>. In South Africa the TFR is 4.2 and declining. The African TFR is 5.7 in rural areas, 4.2 in semi-rural areas and 2.8 in urban areas<sup>10</sup>.

Just over half (52%) of all fertile women in South Africa use contraception. Contraceptive use amongst African women is estimated to be 50.4%<sup>53</sup>. Unmet contraceptive need is thought to be about 38%<sup>\*\*</sup>. There is a need amongst many users for more effective, more satisfactory or safer methods and unmet needs for special groups such as teenagers and sex workers. Men constitute a neglected group for contraceptive programmes. There is a need for access to safe abortion services after contraceptive failure.

Injectables are used by 70-80% of African contraceptive users<sup>53</sup>. Anecdotal evidence suggests that many women use intramuscular hormones due to limited choice, provider bias or because a sexual partner may object or fail to cooperate with the use of a more visible method requiring male participation.

The development of South African family planning programmes has until recently been based on demographic goals of population control with strong racial overtones. A reasonably well developed system of service delivery exists. There are currently about 65 000 family planning service points in the South African government's health delivery system. This excludes former 'independent homelands', on which data is not readily available, but which historically are likely to be poorly serviced<sup>53</sup>. While there are a large number of service points in South Africa there is inequitable distribution between urban, peri-urban and rural areas, with people living in the latter two areas, particularly rural areas, having limited or no access.

\* *The total fertility rate (TFR) represents the number of children that would be born (ignoring mortality) to a hypothetical group of a 1000 women who, as the reproductive ages, experience the particular age specific rates on which the index is based* <sup>52</sup>.

\*\* *Personal communication, Dr Helen Rees, Director, Reproductive Health Research Unit, Baragwanth Hospital and Johannesburg City Council.*

Family planning services are provided through fixed or mobile clinics by nurses, backed up by a small number of doctors, mostly as part of primary health care (PHC) services. Some family planning services still exist as vertical services. Both service providers and recipients have identified a range of problems with the current family planning service delivery system. A very heavy service workload, particularly in services points in African residential areas, has been in part responsible for inadequate quality of care. In addition, clients are frequently turned away leading to problems with accessibility.

#### **2.3.1.2 Gynaecological illness: Reproductive Tract Infections**

Reproductive tract infections (RTIs) are a significant health problem for women in developing countries. RTIs usually originate in the lower reproductive tract as vaginitis and cervicitis. These may be asymptomatic. Symptoms include abnormal vaginal discharge, burning micturation, vaginal bleeding, genital pain or itching<sup>44</sup>. Untreated RTIs may ascend into the upper reproductive tract causing pelvic inflammatory disease (PID). Complications of PID include: infertility, ectopic pregnancy, recurrent and chronic infection, chronic pelvic pain. RTIs of the lower and upper reproductive tract may lead to adverse birth outcomes such as low birth weight, fetal wastage and congenital infections<sup>44</sup>.

The three main causes of RTIs in women are sexually transmitted diseases, iatrogenic infections including unsafe abortion, and endogenous infections. Other harmful practices associated with RTIs are early initiation of sexual activity in young girls, female genital mutilation and the insertion of potions or other materials into the vagina<sup>54</sup>.

The pathophysiology of RTIs and their sequelae are the same in developed and developing countries, but generally RTIs are more common and more severe in developing countries. Factors influencing the prevalence of RTIs in developing

countries include urbanisation, low levels of education and lack of health information which promotes misconceptions about illness and limits preventive practices, and the low status of women. Some cultural prescriptions against intercourse at specific times in a women's reproductive life may promote male extra marital encounters. For example in Ibadan, Nigeria, it is estimated that wives were not 'available' for intercourse with husbands 69% of the time<sup>44</sup>. Factors influencing morbidity include social customs which fetter women's capacity to seek health care for genital problems and difficulties in diagnosing and treating RTIs by health services. Women in developing countries tend to receive care at a later stage of infection, hence upper tract infection is more common than in developed countries. For example, PID accounts for 17-40% of acute gynaecological admissions to hospitals in Africa. Sexually transmitted infection is responsible for the majority of Pelvic Inflammatory Disease hospitalisations<sup>44</sup>.

### **Endogenous infections**

Endogenous vaginal infections such as bacterial vaginosis (BV) and vulvovaginal candidiasis are caused by overgrowth of normal vaginal flora. Bacterial vaginosis may cause upper reproductive tract infection, may lead to premature birth in pregnant women and can lead to infertility or ectopic pregnancy. Candidiasis does not result in long-term complications but repeated episodes of vaginal discharge or irritation cause discomfort and can interfere with normal functions (including sexual functions). Women therefore need to recognise symptoms and be able to access diagnostic and treatment facilities.

### **Unsafe childbirth or medical procedures and unsafe abortion**

Transcervical procedures such as the improper insertion of intrauterine devices and induced abortion can cause ascending infection in the reproductive tract.

Unsafe abortion is a major cause of mortality and morbidity. Worldwide about 55 million unwanted pregnancies are terminated annually by induced abortions. About half are illegal, most of these occurring in developing countries. It is estimated that unsafe abortion is the cause of 40% of the world's maternal deaths. Besides death, complications from unsafe abortions include: sepsis, haemorrhage, uterine perforation, cervical trauma, reproductive tract infection, infertility and psychological and social stress<sup>55</sup>. Throughout sub-Saharan Africa, abortion is severely limited. Only seven countries permit it in circumstances other than those which directly threaten a woman's life and only in Zambia can it be performed for socio-economic reasons. Information on abortion in sub-Saharan Africa is limited to information on hospital admissions for abortion complications<sup>56</sup>. In South Africa, due to stringent constraints on legal abortion and limited contraceptive services it is estimated that there are approximately 200,000 illegal abortions each year with 100 deaths<sup>10</sup>. The law on abortion in South Africa may soon be liberalised. However, access to safe termination of pregnancy could continue to be limited by its' lack of social legitimacy and the poor availability of services, particularly in peri-urban and rural areas.

### **Sexually transmitted diseases (STDs)**

Women are at increased risk for STDs and HIV infection. This is attributable to biological, and socio-economic, cultural and socio-sexual factors<sup>57,58</sup>. Women's biological vulnerability may relate to the fact that deposits of infectious semen remain for some time in the vagina and the mucous membrane of the vagina has a greater surface area and greater permeability than that of the penis. It is also thought that the virus is more heavily concentrated in semen than in vaginal fluids<sup>4</sup>. Socio-economic and cultural factors which increase vulnerability are numerous. Women often lack access to education and health care, are frequently economically dependent on men, and are susceptible to sexual coercion by men. While barrier methods of contraception offer the best protection against STDs

and HIV, unequal sex roles often make it difficult for women to negotiate their use. Women who are infected with STDs are often asymptomatic and hence go undiagnosed and untreated. While in many cases these diseases may be truly asymptomatic, in some cases this may be due to forbearance amongst women, who have been socialised to see pain and discomfort arising from their reproductive roles as normal.

It is estimated that there are 250 million new cases of sexually transmitted infections, annually<sup>8</sup>. Data on STDs amongst women in developing countries is limited. The prevalence of maternal syphilis in Africa ranges from 4-15%<sup>59</sup>. Studies in Africa found the median prevalence for the general female population to be 10% for Gonorrhoea and 20% for Trichomoniasis. Two studies in Gambia and Kenya found 6-7% of women attending ante-natal clinics to be infected with Chlamydia<sup>44</sup>. HIV/AIDS, which is primarily sexually transmitted, is spreading particularly rapidly in sub-Saharan Africa where nearly 4 million adult women are infected<sup>6</sup>. It is estimated that worldwide by the end of the century, there will be as many women as men infected with HIV<sup>4</sup>. In some African countries such as Uganda, a review of clinical cases of AIDS shows nearly equal numbers of women and men<sup>57</sup>. In population-based studies women were found to have a higher infection rate of 1.4:1. There is also evidence of earlier infection, with younger women (15-19 years) being at greater risk of being infected with HIV than men in a similar age group<sup>57</sup>.

In South Africa, Sexually Transmitted Disease is a major public health problem. The World Bank estimates the prevalence of STD in South Africa to be 11%<sup>60</sup>. In Alexandra township (Johannesburg) 20% of the population over 15 years is treated at least once a year for an STD<sup>10</sup>. The prevalence of syphilis alone amongst ante-natal women attending the mid-wife and obstetric unit in Khayelitsha in Cape Town is 12% overall and 33% for 'unbooked' women (those attending only for delivery)<sup>61</sup>. There is epidemiological evidence that both

ulcerative and non-ulcerative STD's facilitate HIV transmission<sup>62</sup>. In 1993 South Africa was estimated to have a prevalence of HIV infection amongst adult women of 4.69%<sup>63</sup>. Studies in Natal show HIV infection to be 3.2 times more prevalent among women than men<sup>58</sup>. It has been suggested that the HIV epidemic in Africa is in large part due to neglected STD control<sup>64</sup>. Control programmes have typically been vertical and have proved ineffective, particularly for women, due to the stigma attached to attending such services.

### 2.3.1.3 Infertility

Infertility affects approximately 10% of couples world-wide<sup>60</sup>. It is estimated in some parts of sub-Saharan Africa that 30-50% of couples cannot conceive<sup>45</sup>. Reported infertility affects 12% of the African population (excluding the ex-TBVC areas)<sup>10</sup>. In the Western Cape accepting 10% as background prevalence and using known rates of ectopic pregnancy and pelvic inflammatory disease for the region, a total infertility prevalence figure of 22% has been calculated<sup>60</sup>. Infertility has an important impact upon the use of contraception and overall fertility patterns.

Strong links exist between infertility and sexually transmitted diseases (STDs). It is estimated that 50-80% of infertility in African regions is postinfectious (due to STDs and pregnancy complications) with a history of STDs being the major risk factor<sup>44</sup>. The majority of cases (57%) of infertility which reach infertility services in South Africa are due to tubal infertility resulting from STDs\*.

Most societies place importance on women producing children. Reproduction most often takes on social or cultural significance as a sign of womanhood, desirability as a wife and for continuing the family line. Most men are unable to contemplate that they may be infertile and blame women for infertility and

\* *Personal communication, Dr Carol Thomas.*

divorce is not uncommon<sup>44,60</sup>. Infertility in women is therefore stigmatised and can cause women to be socially marginalised particularly when they are abandoned by their partners<sup>8,44</sup>.

#### 2.3.1.4 Menstrual problems

Menstrual dysfunction is a neglected area in reproductive health. In the United States, visits for menstrual dysfunction constitute twenty percent of all visits for problems of the female genital tract<sup>2</sup>. Limited research has been done on the effects of menstrual cycle patterns on women's health status. One area of research has focused on the relationship between surgery for breast cancer and the menstrual cycle. Several studies have shown that the timing of surgery with particular phases of the menstrual cycle has a major impact on the duration of survival of women with breast cancer<sup>65,66</sup>. Research on menstrual disorders in developing countries is non-existent.

#### 2.3.1.5 Maternal Health

It is estimated that approximately half a million women die annually of pregnancy-related causes and that maternal mortality rates are up to 200 times higher in non-industrialised than in industrialised countries<sup>9</sup>. In 1990 the Department of Health reported a maternal mortality rate (MMR) of 24 per 100 000 births for African women (excluding the former 'independent homelands')<sup>10</sup>. This figure is unreliable, as it excludes rural areas of high mortality and because so many deaths are unregistered. Regional studies at hospitals servicing a predominantly African population show an MMR of 287 for Pelonomi Hospital in Bloemfontein<sup>67</sup> and 170-192 for King Edward VIII hospital in Durban<sup>68</sup>. A current estimate is that an overall MMR for Africans would be 258 / 100 000\*. The

\* *Personal communication. Draft document on the question of maternal mortality prepared for the Women's Health Conference, Johannesburg (?), December 1994.*

Cape Peninsula Maternal and Neonatal service, monitoring maternal deaths at hospitals and midwife obstetric units in the Cape Peninsula, found an MMR of 52 for African women for the period 1981-1983<sup>69</sup>. The major medical causes of maternal death are infection, problems resulting from hypertension, hemorrhage, obstructed labour and septic abortion<sup>2</sup>. Most of these problems are preventable by ante-natal care and safe delivery and access to safe abortion. This is highlighted by the fact that maternal mortality for African women in Cape Town between 1978 and 1983 was higher amongst unbooked women<sup>68</sup>. Risks to woman and child are greatly increased in home deliveries. A community survey in a rural area of Natal/Kwazulu which had a home delivery rate of 92% showed an MMR of 550<sup>70</sup>.

Apart from maternal mortality, chronic morbidity as a result of pregnancy-related complications affects about 15 million women a year and more than 50 million experience acute conditions globally<sup>6</sup>. Women's risks of complications or death related to pregnancy and childbirth are increased for teenagers and those over 30 years of age, or multiparous women (those with three or more children)<sup>71</sup>.

Worldwide, the proportion of teenage mothers is between 10 and 50 percent. Pregnant women in their teens have a 20% greater likelihood of maternal or infant death than women in their twenties<sup>6</sup>. In 1987 teenage pregnancies constituted 11.4% of all births in South Africa (excluding the former 'independent homelands'). In Khayelitsha in the Cape they constituted 15.1% of all births<sup>10</sup>. Apart from the greater likelihood of pregnancy-related complications and maternal death amongst teenage mothers, they are also disadvantaged socio-economically. For example, teenage mothers are rarely able to finish their schooling<sup>6</sup>. There is resultant high unemployment and few are able to provide financial support for themselves and their children. A negative psychological impact has also been documented<sup>10</sup>.

A wide range of underlying determinants are responsible for the more proximate medical causes of maternal mortality and morbidity. Access to health services during pregnancy, childbirth and post-natally is an important factor. Lack of access to contraception, too many pregnancies or short periods between these, and both extremes of age are other important factors. Related to these are deeper, underlying socio-economic and cultural forces affecting women detrimentally - low status and discrimination, lack of education, and government policies which do not give high priority to women's needs<sup>6</sup>.

#### **2.3.1.6 Gynaecological cancers: Cancers of the cervix and breast**

Cancer of the cervix and breast are the most common gynaecological cancers world-wide. Breast cancer is most common in the developed countries with a prevalence of 105 per 1000 women in North America and 162 per 1000 women in Europe compared with 27 per 1000 women in Africa. While cancer of the cervix is 37/1000 in Africa, it does not feature amongst the three most common cancers for women in the developed world<sup>24</sup>. Despite the possibility of detection through cervical screening, about 183,000 women have been estimated to die annually from cervical cancer in developing countries and 158,000 die from breast cancer<sup>6</sup>. Patterns amongst African women in South Africa are similar to those of other developing countries. Cancer of the cervix is the most common cause of cancer of deaths in South African women, closely followed by cancer of the breast<sup>11</sup>. Over thirty-two percent of histologically diagnosed cancer in women in South Africa are accounted for by these two cancers<sup>72</sup>. Women in South Africa have a lifetime risk of developing cancer of the cervix of 1 in 32 with similar figures for breast cancer<sup>72</sup>. As reported earlier, the risk differs on the basis of race and class with cancer of the cervix being more common in African women who tend to be located in lower socioeconomic groups, and breast cancer being more common amongst more affluent white women. A study in Soweto

yielded prevalences of 28 per 1000 for cervical intraepithelial neoplasia and 13 per 1000 for unsuspected invasive carcinomas, unequalled in world literature<sup>10</sup>. Risk factors for cancer of the cervix include beginning sexual activity at an early age, increased number of sexual partners, smoking and low socio-economic status. Long term use of oral contraceptives may also be a risk factor<sup>73</sup>. There are strong links between cancer of the cervix and infection by the Human Papilloma Virus (HPV), an STD<sup>54,73</sup>.

While cervical cancer is largely preventable through cervical screening, obstacles to prevention include poor knowledge amongst women of the disease and of cervical screening as a preventative measure, and the availability of screening services<sup>10,74</sup>. In addition opportunistic screening practices have targeted family planning and ante-natal services which tend to serve younger women. This has led to largely lower risk women being screened while few of those at greatest risk (35+ years) are screened. This means that screening has therefore had little impact on cervical cancer morbidity and mortality<sup>75,76</sup>.

There are as yet no proven practical methods for the primary prevention of breast cancer, however early detection is the most effective means of reducing its impact<sup>77</sup>. Three basic techniques of early detection have been developed: breast self examination, physical (clinical) examination by health workers and mammography<sup>77</sup>. The emphasis of screening programmes should be on maximising coverage of women at risk. However, most developing countries are unable to afford mass mammography screening programmes.

## 2.3.2 SOME NEGLECTED AREAS OF WOMEN'S HEALTH

### 2.3.2.1 Women and work

In formal workplaces, women are disadvantaged by regulations which have been formulated for an all-male workforce. Examples include exposure limits imposed for hazardous substances and the design of protective devices. Common occupational problems include dermatoses, muscular-skeletal and respiratory problems<sup>78</sup>. The small scale enterprises in which women frequently work are often unregulated.

Women in agriculture may be directly and indirectly exposed to pesticides. Occupational hazards pose particular risks for the unborn children of pregnant women as they are often exposed before pregnancy is known, during the crucial first trimester of pregnancy. Women also suffer uncertainty regarding continued employment and loss of earnings due to poor maternity leave benefits. Sexual harassment is an important factor affecting women's well-being in the work environment. In a study of female Johannesburg office workers, 60% reported sexual harassment<sup>10</sup>.

Women predominate in the informal sector. Their position in marginalised, less lucrative activities has been documented in a number of studies in South Africa<sup>23,79,80,81</sup>. The informal sector is unregulated and the hazards of work in which women are commonly involved such as home care, hairdressing, work with water and animal products in developing countries, is under-researched.

In addition women's low socio-economic status can lead to engagement in occupations such as commercial sex work with its concomitant risks of sexually transmitted diseases and violence.

Domestic labour in a person's own home is characterised by its open-endedness and its large volume. There is no obvious end to the working day and it is difficult

to separate work activities from leisure activities<sup>4</sup>. It tends to be invisible, unrecognised and can be monotonous, making the domestic environment stressful. Studies from various parts of the world have found that women work on average longer hours than men, mainly as a result of their additional domestic workload<sup>7,22,82</sup>. These long hours of work are detrimental to health. They lead to physical fatigue and affect women's psychological well-being in that they have little time to pursue personal activities which may enrich their lives as individuals. In addition, as already discussed, the domestic environment can carry particular environmental hazards to women's health. In rural areas and some peri-urban areas, in-door pollution from smoke and toxic gases as well as accidental burnings make the home a hazardous environment<sup>8,83,84</sup>.

### **2.3.2.2 Violence against women - rape and battery**

Violence against women is a problem world-wide in nearly all regions, classes, ages and cultures<sup>3,6</sup>. Violence includes physical abuse such as rape and battery as well as emotional abuse. The World Bank estimates that domestic violence and rape account for one out of every five healthy days of life lost to women of the reproductive age<sup>6</sup>. Violence against women is different to violence against men. Women are most at risk at home from men they know and violence tends to be chronic and less likely to be reported. It is often associated with sexual abuse<sup>6</sup>. In addition it is symptomatic of the subordinated status of women.

South African society is characterised by high levels of violence<sup>\*\*</sup>, particularly against women. Police statistics show that 28,318 rape cases were reported in 1993<sup>23</sup>. This is a gross under-estimate as police estimate that only about 3% of rapes are reported<sup>23</sup>. Domestic violence is a particularly unrecognised and

\* *This is probably the 'tip of the iceberg' as so much violence and abuse of women goes unreported.*

\*\* *Sixteen percent of deaths are due to unnatural causes<sup>10</sup>.*

under-reported problem. Regular physical assault by male partners is estimated to affect one in six women<sup>10</sup>. Violence against women is cited as the cause of breakdown in the relationship in over a third of divorces in South Africa<sup>23</sup>.

Rape and battery affect a woman's physical and emotional well-being. Frequently women do not speak about the experience as a result of feelings of shame and guilt and are isolated and unsupported. While women may experience acute injuries as a result of rape or battery, other physical symptoms include abdominal and pelvic pain, backache, headaches and fatigue. Signs of depression such as sleep and eating disorders and sexual dysfunctions are common<sup>85</sup>. Services for survivors of rape and battery are very limited in all regions of South Africa.

## **2.4. CONCLUSION**

This chapter has argued for the importance of women's health as a specific focus and looked at some trends over the past two decades. It has reviewed the main factors affecting women's health. As the World Bank<sup>6</sup> states: "Women's disproportionate poverty, low social status, and reproductive role expose them to high health risks, resulting in needless and largely preventable suffering and premature death." Newly urbanised women may be additionally disadvantaged by their incongruence and isolation in an urban social environment.

Some key issues in women's health, particularly in the reproductive sphere and of special relevance to developing countries, have been discussed. Some national statistics on women's health in South Africa have been presented, highlighting the race and class differences affecting women within a developing country such as South Africa.

**This chapter provides the background against which the results of women's socio-economic and demographic status and health status, knowledge and use of services presented in Chapters 5-9 are explored, analysed and interpreted.**

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**CHAPTER 3**  
**STUDY METHODS**

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**Figure 1 - Hand drawn map of unserved area**

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### 3.1 A BACKGROUND TO THE CHOICE OF STUDY METHODS

This study was conducted by means of a sample household health interview survey (HHIS) supplemented by in-depth interviews with key informants and group discussions.

Little available information exists on the health status, health knowledge and knowledge of or use of services by women living in peri-urban areas such as Khayelitsha. Similarly there is little information on their socio-demographic and economic status.

Households were selected randomly in order to obtain a representative sample. In this way selection by way of the 'volunteer effect' or clinic-based sampling were eliminated. It is therefore possible to generalise the results to the population of women in Khayelitsha.

The use of the household as the sampling unit was based on a number of considerations. It is virtually impossible to create a complete sampling frame of individuals. The household is considered important as a social unit, impacting on individual health behaviour and on health status. Household surveys have become a common and reliable method for collecting health information<sup>1</sup>.

Collection of data on illness and health service utilisation using interview methods are used for a number of reasons. Standardised questionnaires can obtain information on illness without the use of more intrusive techniques. The latter are expensive, time consuming, logistically difficult and sometimes ethically sensitive. Reported illness prevalence information can be collected and self-perceived illness measured. The need for services as opposed to the demand can be assessed. Information on illness for which treatment was not sought from the health services can be obtained.

There are a number of advantages in collecting socio-demographic information through a structured questionnaire. It allows a large amount of socio-demographic information to be collected in a standardised manner. Social information can be quantified and hence overall social patterns in the community determined. It also enables the effect of social conditions on illness and utilisation of health services to be examined and estimated.

However, surveys need to be backed up by some familiarity with the community being studied and knowledge of the appropriateness and relevance of the research questions. Little in-depth qualitative information existed on the socio-demographics of Khayelitsha. Therefore prior to formulating the questionnaires and conducting the survey, in-depth interviews were held with key informants in the area. The aim of these interviews was to determine meaningful areas for inquiry, appropriate variables for measurement, to be aware of the type of responses that could be expected, and to gain a picture of the social patterns that existed.

## **3.2 POPULATION, DESIGN AND SAMPLING**

### **3.2.1 STUDY AREA AND POPULATION**

The study area was Town 1, Khayelitsha, Cape Town. A description of the origins of the study area can be found in Chapter 1. The survey was restricted to Town 1, as it was the only area of Khayelitsha at the time of the survey with a settled population, Towns 2, 3 and 4 being in the process of construction.

Town 1 was divided several distinct geographical areas.

1. Villages 1 and 2 were made up several formal housing areas :
  - the core housing area: These were the first houses built and were originally intended to house the Crossroads community. In reality, they accommodated mostly people who had moved from living in 'backyard shacks' in other African townships. Each core house was situated on a plot of 150 to 200 square metres.
  - the Greyling houses were larger than the core houses but also built at low cost.
  - Private development schemes such as Khulani Park existed for upper income housing.
2. Site C was a site -and -service informal housing area. Each unit was on a plot of approximately 70 square metres. Two sites shared a bucket toilet and a number of sites shared a standing tap.
3. Site B which included villages 3 & 4, constituted a site- and- service informal housing area similar to site C, but with improved sanitation (flush toilets).
4. Greenpoint, was originally a tent area erected for refugees from the Crossroads and KTC crises of 1986. At the time of the survey it was a very poorly serviced informal housing area.
5. Unserviced (without sanitation and services) informal housing areas were scattered within Sites B and C and the housing area, and situated adjacent to Greenpoint.

Baseline data was collected from a sample of the estimated more than 200,000 people living in Khayelitsha.

The study population consisted of adult women (15 years and over) in the areas described. For the purposes of collecting household information in households in which no women were present a limited number of men were also interviewed. Male respondents were not interviewed on their health status, health knowledge or knowledge of or use of health services.

### 3.2.2 STUDY DESIGN

The study had a cross-sectional analytic design.

### 3.2.3 SAMPLING

A random stratified sample of 800 sites was selected for study. While in the formal housing area and serviced site areas, demarcation boundaries were available for sites, this was unavailable for the unserviced areas. For the purposes of this study, therefore, one unserviced site was seen as being equal to one dwelling.

The sample size was considered by sampling experts\* to be adequate for the collection of descriptive data. Double\*\* stratification took place on the basis of area of residence (geography) and housing type. The four strata for area of residence were: Site C, the housing area (Villages 1 and 2), Site B (Villages 3 and 4) and Green Point. The stratification on the basis housing type was on the basis of: formal housing, serviced informal housing and unserviced informal housing. Sample size in each of these strata was proportional to the estimated population in each geographic area in Khayelitsha<sup>2</sup>.

\* *Personal communication, Dr Debbie Bradshaw, Medical Research Council*

\*\* *While what was known as the housing area (area of residence) consisted of predominantly formal housing there was unserviced informal housing scattered within this area. Hence housing type did not always coincide with the predominant housing type in a particular area of residence.*



### **Area of residence and type of housing**

The geographical areas of residence of Sites B and C, and Greenpoint which included serviced and unserviced sites will be referred to as the informal housing areas and the areas in Villages 1 & 2 will be referred to as the housing area or formal housing.

### **Household and household composition/types**

A household was defined as a group of people living together and sharing expenses.

Household composition was categorised in terms of the following:

nuclear type - a male and female partner or mother, father and children.

extended type - relatives living together

female-headed\* type - woman on her own or with children

alliance household - mixture of family, friends and lodgers

### **Urbanisation status**

Urbanisation involves complex societal changes. As discussed in Chapter 2, it is not possible to look at the effects of urbanisation in terms of one single factor. In this study a number of indicators of the 'state of urbanisation' of the respondents were examined, reflecting physical and psycho-social attributes. These included:

- \* place of birth
- \* patterns of migration
- \* ties with rural areas

- \* *Female-headed households in this study refers to households, in which a male head was nonexistent as opposed to temporarily or seasonally absent.*

- \* whether respondents identified most strongly with an urban or rural area as indicated by the place they saw as home and where they wished to live when old
- \* and length of stay in an urban area ('urban years').

### 3.3.2 HEALTH STATUS, HEALTH KNOWLEDGE AND KNOWLEDGE OF AND USE OF HEALTH SERVICES VARIABLES

Table 2 shows the data collected for health status, health knowledge and knowledge of and use of health services information\*\*:

Table 2: Health variables:

- whether respondent had ever been pregnant
- number of pregnancies
- age at first pregnancy
- pregnancy outcomes
- loss of a live-born child
- place of birth of last born child
- use of contraception
- types of contraception used
- attendance of ante-natal care
- intended and actual use of health services when ill
- prevalence of acute, chronic and gynaecological illness
- patterns of types of acute, chronic and gynaecological illness
- awareness and experience of cervical smears
- knowledge of where to go for various health needs
- awareness and knowledge of AIDS and its prevention.

**Place of birth of last born child:** This was categorised into urban or rural area, and health facility (Hospital, Midwife and Obstetric Unit or clinic) or homebirth.

\* This was considered an important quantitative measure of urban 'exposure'.

\*\* Details are given in Chapter 6

- \* whether respondents identified most strongly with an urban or rural area as indicated by the place they saw as home and where they wished to live when old
- \* and length of stay in an urban area ('urban years').

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- prevalence of acute, chronic and gynaecological illness
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\* This was considered an important quantitative measure of urban 'exposure'.

\*\* Details are given in Chapter 6

**Attendance of ante-natal care:** The respondent was asked if she had attended ante-natal care if she had been pregnant in the preceding five years. The number of visits and issues of quality of care were not probed.

**Use of contraception:** While all women were asked if they used contraception, analysis was performed for women within the reproductive years (15-45 years).

**Illness:**

**Acute and chronic \***

Information on the acute and chronic illness of respondents was based on **reported** cases of illness rather than diagnosed cases. The recall period used for acute illness was **TWO WEEKS** preceding the interview, The recall period for chronic illness was **THREE MONTHS** preceding the interview.

**Gynaecological**

Respondents were asked if they had been **treated** for **reported** gynaecological illness. The recall period for gynaecological illness was **THREE MONTHS** preceding the interview.

**Use of health services included:** preference for use of a service when ill and reasons for this. The method of transport used to reach a service, the cost and time taken to get to a service when actually ill was investigated.

**Knowledge of services included:** where to have a child immunized, where to buy milk for an infant, where to have tuberculosis testing, where to have an injury treated, where to have a cervical smear taken and where to go for an emergency illness at night.

A full list of all variables used and an explanation of their content is provided in the glossary in the Appendix C.

\* *Acute illness and chronic illness were derived from questions 2 & 3 on page 24 and question 4 on page 25 of the questionnaire respectively (see Appendix B). Interviewers were trained to distinguish between acute and chronic illness.*

### **3.4 MEASUREMENT OF VARIABLES**

#### **The pre-pilot phases**

The initial steps of becoming familiar with the study area through making contact and consulting with community-based key informants, health service deliverers and other relevant groups or organisations in Khayelitsha were described in Chapter 1.

In-depth interviews conducted during the pre-pilot stage took two forms:

- i) In-depth discussions with key informants.
- ii) In-depth discussions with groups of residents in the different areas of Khayelitsha.

It was felt that this mix of in-depth interviews and the household interview survey methodology was appropriate given the nature of the study<sup>3,4</sup>. Discussions with key informants were used to evaluate the relevance and sensitivity of questions and whether the appropriate people would be reached by the survey. The qualitative information gained provided the basis for the formulation of the questions included in the questionnaire. Greater detail of the rationale for the qualitative stage of research that preceded the survey and results of these interviews are documented in Chapter 4.

Consultations and indepth interviews were conducted by the author.

#### **Questionnaire development**

The questionnaire was developed over a period of months. A full copy of the questionnaire can be found in Appendix B. The questionnaire was based on a review of the literature and the in-depth interviews conducted with key informants described in Chapter 4. The questionnaire was further modified through discussion with the interviewers during training and after being pre-tested through a pilot study.

### **The study team**

The study team consisted of 11 field workers (interviewers), 2 field coordinators, two researchers (including the author) and 3 coders.

### **Interviewer Selection**

The following criteria were set in the interviewer selection: Interviewers were to be female, mature and had to have a minimum qualification of 10 years of formal schooling. Other criteria were fluency in English and Xhosa and experience in dealing with people. Interviewers were to be resident in Khayelitsha. Persons with similar characteristics plus managerial/co-ordination skills were appointed as field coordinators.

Interviewer posts were advertised through community projects and organisations with whom contact had been made during the consultation phase of the study. A total of 50 candidates were recommended by these organisations and projects. Final selection was made through interviews with candidates by two or three members of the research team.

### **Interviewer Training**

Interviewers were trained over a period of ten days prior to the pilot study. Re-training occurred after the pilot study in order to familiarise interviewers with the changes to the questionnaires. Supervision and ongoing training of the interviewers continued throughout the project.

Interviewers were assigned to areas in which they lived. However, respondents whom they knew were re-assigned to be interviewed by other interviewers to reduce bias which could have resulted from familiarity. Households were assigned in equal proportions initially amongst interviewers. Due to greater difficulties in some areas finding respondents and other personal factors, households were reassigned from some interviewers to others who had finished their quota. Two interviewers continued conducting interviews in January and February 1990 and therefore completed a larger proportion of the interviews than the rest.

### **Pilot study**

The aim of the pilot study was to assess all procedures and the questionnaire for their suitability. The pilot study was conducted within Town One of Khayelitsha. Non-study areas within Khayelitsha did not exist as the survey was to cover the whole of Town One and conducting the pilot study in areas outside Khayelitsha was considered unsuitable as they were too different to act as appropriate areas in which to pre-test the questionnaire. A convenience sample of 47 women resident in Khayelitsha were chosen by the interviewers from amongst their neighbours or acquaintances. Should any of the same respondents be randomly selected in the survey they were to be excluded without replacement. The pilot study revealed that interviews lasted too long

- \* *The final proportion of household interviews conducted by the 11 interviewers were as follows: one interviewer completed 6% of the interviews, three completed 7% each, two completed 8% each, a further two 9% each, one completed 11% and the two who continued interviewing into 1990, 14% each.*

(approximately 2 hours) and that some questions lacked clarity. As a result many of the questions were changed and a few excluded.

The final questionnaire was translated from English into Xhosa with each question appearing in the questionnaire in both languages. The Xhosa translations were 'workshopped' with the field worker team and the final wording in Xhosa decided upon by consensus. This method of translation was used in order to reduce ambiguity, obtain standardisation in the way questions were asked and uniformity in meaning.

### **Mapping unserviced sites**

Approximately 10,000 shacks on unserviced sites were mapped over a period of three weeks after the pilot study. This was done in order to draw a random sample of these sites for inclusion in the study. Using previously obtained maps as a starting point, interviewers' knowledge of the area was used to identify where unserviced sites were located. Interviewers walked through these areas and produced hand-drawn maps. (Figure 1) These shacks were then numbered and a random sample selected for interview. While this was a costly procedure, it greatly increased the representativeness of the sample. At the time of the survey, aerial photographs that were available were out of date and with the rapid increase in the number of unserviced informal housing, it was likely that sampling would have excluded the newest arrivals in Khayelitsha. Earlier experience in a study examining vaccination coverage in the unserviced informal housing areas showed that large areas could not be identified from aerial photography. For example, 30 areas with unserviced sites, identified from the drawn maps had not been identified from aerial photographs\*. As it was expected that these areas would be most vulnerable from a socio-economic and health perspective, it was considered important that proper sampling occurred in these areas.

\* *Personal communication, D Berry*

# Map of unserviced area

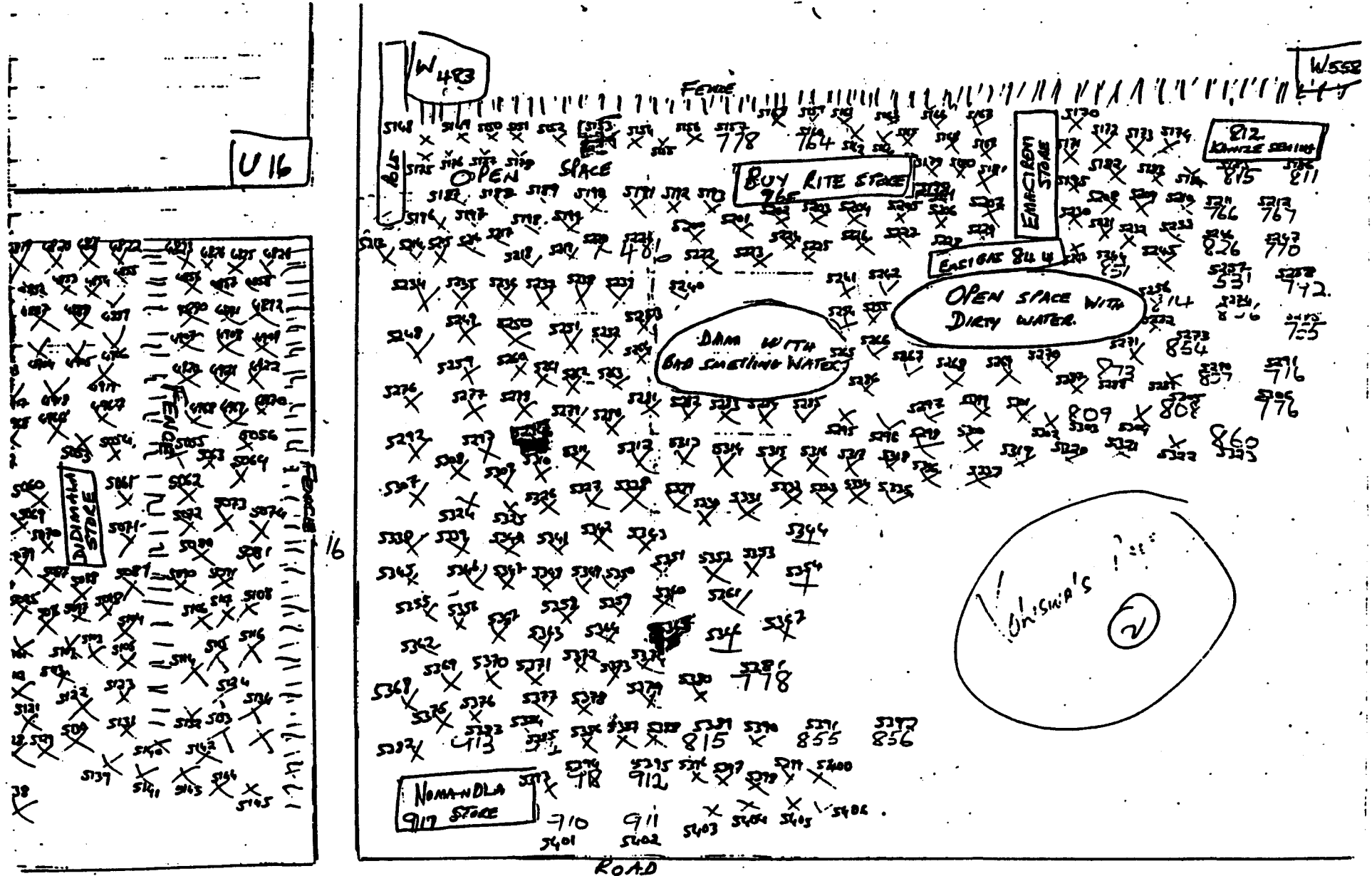
SITE B W AREA

2ND OCT 89

Figure 1

ROAD 16

78



## **The survey**

The household interview survey was conducted between September 1989 and February 1990. Interviewers met initially on a daily basis and later twice a week or on a weekly basis to hand in completed questionnaires to the field coordinators for checking and to discuss any problems. The author kept in regular contact with both the interviewers and field coordinators.

### **3.5 PROBLEMS IN THE FIELD.**

#### **Leadership problems**

Despite misgivings by the researchers about meeting with the discredited governing local authority at the time, the Lingeletu Town council, community advice was followed and a meeting held with this body to inform it about the study. In the informal housing areas, an informal hierarchy of leadership existed in the form of 'shack lords' (headmen) controlling certain blocks. There were several rival area committees of headmen whose approval had to be sought in order to gain access to the area. Meetings with individual 'leaders' were held as the need arose. For example, after selection of the interviewers, one 'leader' in a block of Site B and another in Greenpoint refused the research team access to their respective communities on the grounds the interviewers whom they had recommended, had not been selected. Discussion with them revealed that they felt that not acting on their recommendation damaged their credibility in their community. Access was obtained after a meeting during which the criteria laid down for selection of interviewers were explained. There was an instance where, even after consultation with 'leaders' in the area, two interviewers were denied access to an area by a headman who was unknown to the researchers. They were obliged to obtain written permission from the Lingeletu Town Council before he would permit them to interview householders in his area.

The situation was aggravated by the fact that rivalry existed between different factions so that it was difficult to know whether to mention the names of 'leaders' or organisations that had been consulted with prior to commencement of the study.

The problem of interviewer safety was a further area of concern. One of the interviewers was assaulted during fighting that erupted between rival mini-bus taxi operators\* in Khayelitsha for a few weeks during the survey. Apart from the risks to their safety, this also slowed down the pace of the survey as interviewers were hampered in acquiring transport to different areas within Khayelitsha, while the taxi conflict lasted. In addition one interviewer was bitten by a dog. While it was hoped safety problems not occur, as a precaution insurance had been taken out which covered interviewers in cases such as those described above.

One interviewer experienced sexual harassment from a male member of a household where she had gone to conduct an interview.

\* *Mini-bus taxis have become a common form of commuter transport. For many Black South Africans who have long commuting distances between work and home this is generally the most convenient, cheapest and quickest form of transport. However there are a large number of taxi operators serving a limited commuter community. This as well as a deficient licencing system have been some of the factors which have led to intense rivalry between mini-bus operators over acquiring passengers and serving particular passenger routes. Sporadic conflicts exists to this day in Cape Town and other parts of South Africa.*

## **Problems of Geography**

Field workers experienced some difficulty in following up households in the unserviced informal housing areas during the latter part of the survey and during the repeatability and validity studies. This was due to the transient nature of many of the dwellings as well as new dwellings being constructed. The hand drawn maps became rapidly out of date as a result.

## **Finding the Respondent**

Difficulties were experienced finding respondents. In the housing area, for example, it was usually more difficult to find people at home during the day as residents were generally at work. In the informal housing areas, where the rate of unemployment was high, despite expectations, it was not easy to find respondents by day as people were usually away from home looking for work. Much of the fieldwork thus took place at night and over weekends. As weekends were a time of recreation for most of the people in Khayelitsha, interviewers encountered other problems such as inebriated and un-cooperative interviewees.

## **3.6 DATA ANALYSIS**

### **3.6.1 DATA MANAGEMENT, CODING, QUALITY ASSURANCE AND CAPTURE**

In the field, all questionnaires were checked for completeness and consistency by the two field coordinators. In addition a sub-sample was checked by the author during field work. Any missing data were referred back to interviewers for correction. If necessary, a repeat visit to the household concerned was made. Questionnaires were placed in individual envelopes by interviewers with their name, that of the respondent, the area of residence and a checklist for completion of the questionnaire on the outside.

Questionnaire data were coded by three trained coders, during the same period in which the field work was carried out. They were able to check that responses entered for each respondent were consistent and logical. They referred questionnaires back for correction to interviewers, where necessary. The author also checked a sub-sample of coded questionnaires for accuracy. Closed questions were coded numerically according to a preset schedule. Open-ended questions were post-coded by the coders in discussion with the author. Lists of answers were grouped into categories and numeric values assigned. Areas of employment in the formal sector were coded using the Standard Industrial Classification of all Economic activities (SIC) schedule (Department of Statistics, Pretoria, January 1991) Social position or class was coded using the CASS provisional index for occupational categories, groups and prestige ratings (Schlemmer and Stopforth, Durban, 1979). Illness data was coded using the ICHPPC system International Classification of Health Problems in Primary Care) (Oxford University Press, Third Edition, 1983)

Questionnaires were designed and coded in such a manner to enable data entry onto the Vax mainframe computer by the Data capture service at the University of Cape Town.

The BMDP statistical programme (Dixon, 1985) on the mainframe vax computer was used to perform data cleaning and run univariate and bivariate analyses. Multivariate analyses were performed using PC/BMDP software (BMDP Statistical Software Inc., Los Angeles, 1990). The Epi info version 5 statistical programme (Centre for Disease Control, Epidemiology Program Office, Atlanta, USA, April, 1990) was used to test bivariate analysis results for significant associations by calculation of Odd Ratios (ORs),  $X^2$  test scores and p values.

All data were cleaned by examining the frequency distributions and univariate printouts of the BMDP statistical programme (program PID) for outlying or

ineligible data. Where the error was located in the raw data, the relevant respondent's data envelope was drawn and checked for errors.

A data description program (P1D), describing the variables and their characteristics was written. The raw data yielded 163 variables which were analysed for the purposes of this thesis.

There were 4 continuous variables. The remainder were categorical variables. For bivariate and multivariate analysis, continuous variables were transformed into categorical variables using appropriate cutpoints of interest.

### 3.6.2 STATISTICAL METHODS

#### **Univariate analyses**

Univariate analyses were conducted using the BMDP P2D programme. This provided frequency distributions, means, medians and the ranges of different variables. Univariate analyses of socio-economic and demographic variables are presented in Chapter 5 and health variables in Chapter 6. Transformations of a number of variables were performed: migration patterns were transformed to create the variable for the number of years spent in an urban environment (urban years); illness data were transformed from alpha numeric coding to numeric coding. Transformations were also performed to reduce data. For example, income data were transformed to summarise weekly and monthly paid categories and to reduce the number of income categories from 9 to 2. Household composition was transformed to condense eight categories into four main categories.

#### **Bivariate analyses**

Bivariate analyses were performed using the BMDP P4F programme. Continuous variables were transformed into categorical variables by means of cutpoints.

OR's and Chi-squared tests were examined for statistical significance. Results of bivariate analyses are presented in Chapters 5, 6, 7 and 8.

These results factored into a multivariate modelling process.

### **Multivariate analysis**

Multivariate analysis was performed using the BMDP Stepwise logistic regression (LR) programme. Potential explanatory and confounding variables in Table 1 were examined in relation to the health outcome variables shown in Table 2. In addition, some socio-economic variables were explanatory or confounding variables for other socio-economic variables viewed as outcomes, and likewise a few health variables were found to be explanatory variables for other health outcomes.

Explanatory and outcome variables included varied in their presence and their combination in different analyses depending on the issue under examination. The specific explanatory and confounding variables and outcome variables of interest used in models are shown in each chapter containing multivariate analysis results.

Selection of variables for inclusion in logistic regression models was based on a combination of *a priori* decisions and the results of initial exploratory bivariate analyses:

1. The review of the literature and prior qualitative research identified some variables as *a priori* variables for various health outcome variables. Examples of these included age, education and employment status.

2. Socio-economic and demographic variables found to be significantly associated with each other and/or with health outcome variables were included in logistic regression models to control for potential confounding or effect modification.

Continuous explanatory variables such as age, and age at first pregnancy and outcome variables such as number of pregnancies were transformed into categorical variables using cutpoints. Appropriate cutpoints were chosen for the different logistic regression models. Choice of cutpoints was based either on those which yielded significant associations in the exploratory bivariate analyses, by common sense with respect to the variable under study (for example determining the cutpoints of <20 years and 20+ in an examination of teenage pregnancy), or by using the median value for the distribution.

Initially all variables fitting the criteria for inclusion outlined above were included in the model. Forward stepping then selected the final models based on significant contribution to the explanatory model by the variables entered. Only final models are included in the results.

Results for the multiple regression analyses are presented in tables listing the adjusted odds ratios for each explanatory variable, with an associated 95% confidence interval and a p-value for the regression coefficients based on a significance test [ $\beta/SE(\beta)$ ] for these coefficients.

Results of the multiple regression analyses are presented in Chapters 7,8 and 9.

### **3.7 RELIABILITY OF DATA COLLECTED**

An interviewer other than the original interviewer conducted repeat interviews on a 10% systematic sample of households, using a selected number of original questions. Repeatability of responses or inter observer agreement was measured using Cohen's Kappa statistic. In addition two field workers who were not part of the original group of interviewers conducted a validity study on a 10% systematic sample of households. This involved a repeat visit to this sub-sample of households to request documentation such as birth certificates and clinic or hospital record cards to verify selected information collected. Questions included in the reliability and validity studies are included in Appendix C.

### **3.8 ETHICAL CONSIDERATIONS**

All participants were fully informed by the interviewers at the time of interview that the purpose of the study was to study determinants of women's health in Khayelitsha with a view to possible intervention. They were told that they were free to refuse participation. All participants were informed that the individual results of the study would be confidential.

The study was approved by the Ethics and Research committee of the University of Cape Town.

The dissemination of information resulting from the study was discussed in Chapter 1.

### 3.9 REFERENCES

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**CHAPTER 4**

**IN-DEPTH INTERVIEWS IN KHAYELITSHA**

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## **4.1 INTRODUCTION**

In-depth methods have their origins in social and cultural anthropology. They involve less structured and informal methods of study of a community. One of these methods, the ethnographic research method, most often involves participant observation in which the researcher lives in the community being researched for a period of time. This method is no longer confined to anthropology but has also become widely used in sociological research. However, while it is suited to examining more covert and spontaneous behaviour, it has certain drawbacks:

1. It is laborious and time-consuming.
2. It presents problems with respect to the typicality and representativeness of the group researched.
4. It also presents some problems with respect to the reliability of the observer status and hence replication - i.e. would another observer using the same methods get the same results.
4. There are may also be problems with access to a particular community by some researchers due to class, race or language barriers.

On the other hand there may also be problems with survey methods. A sample survey enables the collection of a large amount of information in a relatively short period of time and is generalisable to the whole population of the area under study. However sensitive issues in the community may be difficult to measure and the survey method may lead to superficiality in measuring these. There may also be certain areas of research that in a particular context, are inappropriate to research via a survey.

Arguments have been made for a mix of methods involving exploratory, relatively unstructured interviews at a pilot or pre-pilot stage, followed by a formal survey involving structured questionnaires to provide larger and more generalisable information<sup>1</sup>

For example, Preston-Whyte<sup>2</sup> argues it may be problematic to rely solely on quantitative methods to investigate social and economic environments alien to the researcher. She argues that the formulation of questions in a survey without prior qualitative research, may lead to researchers missing important areas of experience which, due to coming from a different social context, they may not anticipate. She suggests that an informal schedule ( '*aide memoire*' ) be used in discussion with the respondent in the early and exploratory stages of research and that qualitative case studies can also be used to expand and check quantitative data.

Cooper<sup>3,4</sup> found that case studies of male mine workers and female-headed households in Botswana towns served to provide in-depth insights into what was occurring socio-economically and to generate perspectives and hypotheses which could be followed up and tested by a later survey. He suggests that large scale surveys be supplemented or co-associated with in-depth studies.

#### **4.2 RATIONALE FOR DOING IN-DEPTH INTERVIEWS PRIOR TO SURVEY IN KHAYELITSHA**

The in-depth interviews in Khayelitsha were conducted for the following reasons:

1. Scant baseline information for the research areas was available for Khayelitsha. There was thus a need to formulate definitions and categories in these areas. There was a need to obtain a picture of general trends in the socio-demography and in the use of health services in Khayelitsha.

2. The information obtained in the in-depth interviews could be used as background against which to compare the information emanating from the survey.
3. In-depth interviews could be used to check the relevance and appropriateness of questions in the draft questionnaires, whether questions had been appropriately phrased and whether the appropriate respondents had been targeted.

#### **4.3. TYPES OF IN-DEPTH INTERVIEWS CONDUCTED**

Prior to the Household Health Interview Survey, eight in-depth interviews were conducted. Two types of interviews were conducted. These were with:

1. **Key informants:** the aim of which was to obtain an overview of life in Khayelitsha.
2. **Groups of residents:** the aim of which was to obtain information on a typical group of residents in the various geographical areas of Khayelitsha.

#### **4.4 CONTENT AREA OF IN-DEPTH INTERVIEWS**

The areas of discussion for the in-depth interviews were based loosely on the areas ultimately to be covered in the survey. These included determining amongst the people living in Town One of Khayelitsha:

1. Environmental conditions.
2. Household composition
3. Patterns of urbanisation/ rural - urban migration.
4. Educational levels.
5. Sectors of employment and income levels

6. The manner of acquisition of sites and houses.
7. Local government power relations and structures

In addition, they included determining among women:

7. Childcare arrangements and social isolation.
8. Selected areas of women's reproductive health.
9. Patterns of health services used in acute and chronic illness.

The results of the in-depth interviews consist of a summary of themes emerging from the interviews conducted. Some individual examples will be cited to illustrate the information obtained.

#### **4.5 METHODS**

A set of guide questions revolving around the nine areas outlined above were used to conduct the in-depth interviews. It was not possible to tape record and transcribe the interviews due to sensitivity to this on the part of respondents. For example informants would have been reluctant to provide information on areas such as the manner of acquisition of sites and houses and power relations and structures if they were to be recorded. Interviews were therefore recorded by writing detailed notes during discussions and adding any information and insights gained immediately after the interview. Content analysis was used to 'cut and paste' individual interviews into themes. Themes were organised into areas of focussed interest and expressed as a range of views and opinions. A total of 10 in-depth interviews were conducted. Three interviews were conducted in the formal housing area, one with a group of 5 typical male resident in formal sector employment and two with female key informants, one of whom worked in the area and one of whom worked and resided in the area. In Site C three interviews were conducted, one with a group of 10 typical women residents and

two separate individual interviews with a female and a male key informant who worked and resided in the area. In Site B two separate individual interviews were conducted with one female and one male key informant who worked and were resident in the area. In Greenpoint two interviews were conducted, one with a group of 8 typical women residents and one with a female key informant working but not resident in the area. No residents or key informants from the informal unserviced housing areas were able to be interviewed. Limited information was obtained through observation and from informants living in other areas.

## **4.6 RESULTS AND DISCUSSION**

### **4.6.1. ENVIRONMENT**

#### **Formal housing area**

Informants were all from the 'core' house area. The basic core house was built of brick and had two rooms (a bedroom and a kitchen/ living room) and a bathroom with a flush toilet and running water, but no bath. Residents had to put in their own bath and ceilings. At the time of the study, there was no electricity installed.

Beyond these basic conditions there was a large degree of variation, due to people making improvements to their homes.

These variations differed according to the financial situation and personal preferences of residents. For example while one informant had extended her house, another had installed a bath.

The core houses were rented for R20 a month. Refuse was collected in black plastic bags by the Lingeletu Council twice a week.

Gas was the most common source of energy for cooking and paraffin or candles used for lighting. Paraffin was most commonly used for heating in winter.

Ownership of commodities such as radios, televisions and telephones varied greatly. Those who owned television sets ran these off a battery. There was wide variation in the occupancy of the rooms due to differences in household composition. Due to the small size of the houses however it was common for both rooms in the house to be used as sleeping places at night. In many cases there was a significant degree of overcrowding.

### **Informal housing areas**

Shacks were generally built from corrugated iron, canvas, plastic or wood.

Paraffin stoves were most commonly used for cooking. Candles and oil lamps were used for lighting. In Site C it was reported that wood was also used for cooking and burnt in tins to provide heating. Many people had radios and some had television sets, run off batteries. There were no telephones. Some people with shops owned a fridge but it was uncommon for other residents in the site and service areas to own a fridge.

### **Site B**

Site B is a site and service shack area. The size of the shacks built varied. Generally they were two or three roomed. The size of the shacks was limited by the size of the plot which was 90m<sup>2</sup>. Depending on occupants' financial position, some laid cement floors, while others used plastic or sheets of metal as flooring. The presence of a ceiling varied according to affordability.

Each dwelling had its own outside flush toilet. An outside tap was shared by two dwellings.

### **Greenpoint**

Greenpoint had initially consisted of large tents erected by the army to accommodate refugees who fled to the area during the Crossroads crisis in 1986. Residents had since erected shacks to replace the tents and the council had demarcated sites and provided some services. The shacks were mostly two roomed, consisting of a kitchen and a bedroom. The kitchen was generally used as a sleeping space at night. The size of the shack was limited by the small size of the plots, which had previously accommodated tents.

There were no inside toilets or water supply. The water supply consisted of two taps at each end of every row of shacks. The number of families sharing this facility was difficult to determine, as it acted as a water supply outlet for residents of the unserviced informal housing areas as well. This led to a strain on water resources in the serviced areas. Each tap was thought to serve about fifty families.

Most of the toilets were of the bucket type. More recently flush outside toilets had been installed in some areas of Greenpoint. Toilets were shared by 2 - 4 families.

The roads were untarred. The situation with respect to refuse removal was hopelessly inadequate. There were 4 large bins at each end of a row of shacks. Refuse removal was very erratic. As the bins were inadequate to cope with the amount of refuse and were some distance away for many of the households, refuse often lay scattered around the area.

Informants reported that children frequently used a polluted lake at the one end of Greenpoint, as a playing area.

### **Site C**

There seemed to be a similar pattern with respect to the size of the dwellings to the other site and service areas of Town 1. At the time of the study, each dwelling had its own bucket toilet and outside taps were shared by a number of dwellings in the street.

### **Unserviced informal housing areas**

Due to the lack of informants no detailed environmental information was obtained on the unserviced informal housing areas. However, personal observation revealed these areas to be growing extremely rapidly and to be greater in density than the serviced areas. There were no taps or toilets provided. People sometimes built their own toilets, or used those in the serviced areas.

#### **4.6.2. HOUSEHOLD COMPOSITION**

In all areas of Khayelitsha there was a wide variety of types of household. The following types of household composition were identified:

1. The nuclear family - mother, father and children.
2. The extended family. (This would often include, parents, children , grandchildren, aunts, uncles etc.)
3. A woman on her own living with her children.
4. A single person living on her or his own.
5. Relatives living together.
6. Family members as well as a lodger/s.

Lodgers would generally occupy an extension to the family dwelling. It was common for a household to have absentee members. These were frequently children staying with a grandmother or other close relative in a rural area of the former Transkei or Ciskei.

#### **4.6.3 URBAN - RURAL MIGRATION AND LINKS**

##### **Overview**

##### **Formal housing**

##### **Core Houses**

The residents of this area of Khayelitsha were commonly born in Cape Town or urban residents of long standing. Many had lived in backyard shacks in the other African townships and had moved to Khayelitsha to acquire their own house. Others were men who had previously lived in hostels, with or without their families, and who had moved with their families to Khayelitsha after the easing of the influx control laws.

It was considered uncommon to find new arrivals from the rural areas in the housing area of Khayelitsha, except in the case of extended family members joining the categories of people described above.

##### **Site B**

The largest category of residents were refugees who had fled Crossroads during the 1986 'Crossroads Crisis'. The general migrational pattern was from former Transkei to Old Crossroads and then to Site B, Khayelitsha. Many previous

residents of Crossroads who came to Site B originated from Cala in the former Transkei indicating that kinship or rural friendship ties may have influenced where people settled.

Other smaller categories included: Residents who had come from 'backyard shacks' in other townships, in the hope of using Site B as a 'stepping stone' to the housing area of Khayelitsha and new arrivals from the rural areas. The latter were usually relatives of the other categories mentioned.

### **Greenpoint**

Residents of Greenpoint were mostly refugees from the Crossroads crisis of 1986.

More recent arrivals were relatives of the above.

There were some new arrivals consisting of people removed from other squatter areas. For example, squatters from Noordhoek had been moved to Greenpoint until they were allowed back to Noordhoek by a court decision.

At the time of the study, some of the original residents had begun to be moved to site and service areas in Town 2.

While most adults had been born in a rural area, many had lived in Cape Town for some time.

### **Site C**

The majority of residents of Site C were part of the 'Cathedral Squatters' who moved to Khayelitsha in 1984. They were initially given 1 month permits to

remain legally in Cape Town, followed by 18 month permits, till the influx control regulations were lifted.

Newer arrivals were likely to be relatives or friends of the original residents.

### **Unserviced informal housing**

Informants from other areas could not provide information on patterns of rural-urban migration in these areas.

### **URBAN / RURAL LINKS:**

There was a great deal of variation, due to people's specific circumstances.

Some case studies will be presented to maintain the richness of these variations.

### **Core houses**

Of the group of five male informants, one was born in Cape Town, and while he visited relatives in the former Transkei, he had no material links and expressed no desire to live there. Two were originally contract workers from the Transkei, who had come to Cape Town in their early adulthood to work. Both expressed a preference for living in a rural area and for returning there when they are old, despite the fact that their wives and children lived in Cape Town. One owned land and had maintained a home in the former Transkei. The other had no land or house and although he expressed a preference for living in a rural area and returning there when old, he felt he might not be unable to do so as he lacked any material resources in a rural area. Both had worked and lived in Cape Town continuously for more than 30 years. The remaining two were from small towns outside of former homelands. One had his wife and baby living with him in Cape

Town, while his three older children lived with his mother in a small town, where he owned property. Despite this he saw Cape Town as his home and expressed a preference for remaining. The other had left his wife and family in a small town in the Eastern Cape and saw his stay in Cape Town as temporary.

There were some links with rural areas for all five. A common denominator was relatives staying in a rural area and 'cultural' ties such as the desire to send their sons to a rural area for their initiation ceremony. The respondents stated that it was common regardless of strong or weak rural ties, to send children to a rural area for schooling. The reasons for this were practical rather than a desire to maintain rural links: they feared disruption of their children's schooling as a result of frequent school boycotts in the cities. It thus appears that schooling of children in a rural area is not in itself, necessarily a good indicator of stronger rural ties.

According to informants, some younger urban-born people attached a stigma to the maintenance of close links with rural areas. The reasons for this were political, relating to their status as 'homelands' at the time of the study.

The two women informants were both born in Cape Town. Both had been sent to the former Transkei for part of their schooling but had lived their adult lives in Cape Town. Both visited relatives in former homelands or their adjacent towns and one had sent her elder daughter to stay with her mother in the former Transkei. They expressed a preference for living in a city for personal, life style, and financial reasons.

### **Site B**

Informants interviewed had varying birth places and rural links. One female respondent and her husband were from the Cala area of the former Transkei and

had come to Cape Town as young adults. They had relatives in Cala, whom they visited regularly and although owned no land or house in Cala, wished to do so. Their son would be sent to the former Transkei for high school and initiation. This was because of the disruptions in urban schools as well as due to the perception of a better and quieter life in a rural area. She expressed a clear preference for life in a rural area and stated that she wished to return there when old. The male informant interviewed was born and grew up in Cape Town. While he had close relatives in Cala in the former Transkei, he saw himself as urban-based as he had no experience of any other kind of life.

### **Greenpoint**

A discussion was held with a group of women who have very recently moved from Greenpoint to Town 2. All except one, who had arrived recently, had fled Crossroads during the crisis of 1986. They had initially been housed in tents in the Nyanga area and then moved to tents in Khayelitsha. Most had resided in the Nyanga bush area of pre-1986 Crossroads. All the women in the group had been born outside of Cape Town either in the former Transkei or its bordering towns. Except for one who had moved in the 1960's, all had moved to Cape Town in the early or mid-1980's. The majority had move to Cape Town to join partners or parents. One had moved to be closer to health services as her child had been ill. They had relatives in rural areas and visited them regularly. There was variation in material ties. Although not all had sent their children to school in a rural area, most expressed a preference for doing so. All felt a rural area was the most appropriate place for a son's initiation. Reasons given were that it was 'home' and that it was only there that the 'real thing' could be experienced. The majority of the informants spoke of the rural areas as 'home', felt they would rather live there if they could and expressed a desire to return to a rural area when old. Reasons given were that it was thought possible to survive on the land

in the rural areas even if one has no children, job or money in a way that it is not possible to in the cities. Another comment was that when one died, one's children would not be thrown out of one's house, as happened in the cities.

### **Site C**

The group of women informants interviewed in Site C had all come to Cape Town from the former Transkei or small towns in the vicinity in the 1960's or early 1970's. Some had lived in Langa, others in Crossroads and one in a town in the Western Cape prior to moving to Khayelitsha. Reasons for the move to Cape Town were: to join family, find work or seek medical treatment. Their rural links seemed to be strong. They emphasised they had only been drawn to Cape Town for financial reasons. They all had relatives in the former Transkei whom they visited regularly. They stated they would prefer to send children back for ceremonies such as initiation and expressed a desire to return when old. The issue of the importance of sending children to a rural area for their schooling seemed to be a less clear cut issue. Informants reported that their children were in school in Cape Town.

#### **4.6.4. ACQUISITION OF SITE/TENURE IN KHAYELITSHA**

##### **Core houses**

When this area was settled initially, a house was acquired by placing one's name on a housing waiting list for Khayelitsha. Houses had been obtained fairly easily in this manner because at that time, it was government policy to persuade residents of other townships to move to Khayelitsha despite a community campaign against this\*.

\* For details of this campaign see Cole<sup>5</sup>.

At the time of the study, no rented formal houses were being built in Khayelitsha. The procedure followed by those wanting a house was to pay someone vacating a house to gain occupation. The amounts paid varied, but were often in the region of about R1000. The council would be approached by the person vacating the house and the person wishing to take occupation, to arrange for a transfer. It appeared that the housing authorities acquiesced easily and turned a 'blind eye' to formal waiting lists. Sometimes bribes were involved in this process. Once a house had been acquired, a rental of R20 a month applied.

According to the informants, some people rented several houses in different names and then sublet these to others for a profit.

#### **Sites B & C and Greenpoint:**

When the Greenpoint area was first settled no payments were made to move into a tent on a site. Residents then built shacks in place of the tents.

At the time of the study, in all site and service informal housing areas sites were acquired by approaching headmen in control of the area. On payment of a fee of R25, a site number was allotted.

It was common thereafter for representatives of a headmen or a committee to ask for further payments. According to the informants, many people in Site B ignored these demands for further payments, while in Site C tighter control seemed to exist for continued payments which were between R7 - R12 per month. These were said to be for services. In Greenpoint, further payment was requested on an ad hoc basis.

**Unserviced informal housing areas:**

Informants outside of the unserviced areas reported that no squatting took place in Khayelitsha without permission from the Lingelethu council. The squatting in the unserviced areas was temporary. The council surveyed plots and allocated numbers, despite no provision of services. It was believed that people paid R25 to obtain a site. In addition they were supposed to pay a regular monthly amount of R7. As no services were provided it was unclear what this was for. Promises had been made to them that they would get a serviced site at some stage.

According to informants, almost every open area in Khayelitsha was occupied by informal squatting. One of the biggest areas was near the station, opposite Site C and an area running next to the N2 highway. Other informal unserviced settlements were adjacent to Greenpoint and scattered within Site B. Residents in these areas had generally been living with family or friends in Site B and C and had moved to unserviced areas as they wanted to erect their own dwelling.

**Business sites:**

According to informants there was no payment for sites for stalls in the informal business sector. It appears that no permission was needed to set them up. The small scale and tenuous financial nature of these operations perhaps rendered them neither worthwhile nor possible to monitor and tax.

**4.6.5 POWER RELATIONS****The Lingelethu Town Council**

Informants in the core housing area saw residents in the informal housing areas as providing the basis of support for the official local government authority at

paid the monthly levy for their site. The homeguards were thought to be modelled along the lines of those that existed in Old Crossroads<sup>5</sup>. Information as to who constituted the homeguards was unclear. They were thought to live in the informal housing areas and to consist of a range of people - municipal police, some officials of the board, and some unemployed people. It was the informant's view that most of the official leadership's support was based on historical allegiance as part of the original group of Cathedral squatters described in Chapter 1 and on fear.

#### **4.6.6. EDUCATION**

Predictably, in a heterogeneous population such as Khayelitsha, educational levels varied widely. Some of the informants had only primary school education while others had post- secondary school qualifications or training.

#### **4.6.7 OCCUPATION AND EMPLOYMENT**

The unemployment rate in Khayelitsha was believed to be high. Some non-governmental service organisations working in Khayelitsha, consulted in the process of the research, estimated unemployment to be 60%, in some areas even higher. Those in formal employment particularly in the informal housing areas, tended to be unskilled or semi-skilled. For example many men worked as labourers in the construction industry and most women as domestic workers. Some were employed in seasonal (temporary) work in the agricultural sector. Some job-seekers had obtained very low paying Council jobs within Khayelitsha: sweeping of roads; carrying bricks; tarring of roads; and chopping trees in the bush around Khayelitsha for wood. Both men and women occupied these jobs. The going rate for the job mentioned was R20 a week.

Some of those in formal employment were also engaged in activities in the informal sector, for example, selling second-hand clothes on weekends.

## **The informal sector**

Due to the high unemployment, the informal sector was considered to be large.

### **Activities:**

#### **Retail**

**Hawking:** This included the hawking of vegetables, meat and entrails, and cooldrinks.

It was thought that women predominated in most of these activities.

**Shops:** Some of those in the informal sector ran small spaza\* shops. It was common in the informal housing areas to see residential shacks with signs displayed advertising a shop.

There were also some large supermarket operations. These were located in the housing section.

Other retail activities included: sale of second-hand clothing, furniture, appliances, gas, paraffin, building materials (usually corrugated iron and wood) and the sale of herbs for traditional medicine.

Informants felt that in general, the retail section of the informal sector sustained a very tenuous hand-to-mouth type of existence. Minimal available outlay kept operations small, there was much duplication in activities and the market was not good as customers did not have much money. Most of those in the informal sector were believed to have been thrust there by virtue of being unemployed rather than through choice.

\* *Spaza shop is the term used for informal grocery shops run from the home, common in most black townships.*

Shebeens and some grocery shops were successful. They required greater initial capital outlay, however, and were therefore out of the reach of the average unemployed person. These small businesses generally employed family, often child labour at very low wages.

### **Services**

Small scale service operations included the mending of garments, door to door collection of drycleaning, puncture repair, photography, and hairdressing. According to informants, the multitude of signs advertising hairdressing salons were not an indication of business in this sector flourishing. Often signs are put up merely in the hope of customers calling.

Involvement in the mini-bus transport industry was considered to be a lucrative activity. Taxi owners were usually employed elsewhere and employed drivers to run their taxis. Taxi owners lived in all areas of Khayelitsha.

Participant observation while conducting interviews provided further information on the informal sector. For example while conducting an interview in Greenpoint, a person came around selling plastic cups; another came around asking if there was any dry-cleaning for collection; and the house next door to the one where the interview took place had a sign up indicating that window glass was for sale.

Informants felt that during a survey, participants in the informal sector would be willing to provide information on their activities but that financial information would be unreliable.

#### **4.6.8 THE DISTRIBUTION OF DOMESTIC WORK IN THE HOUSEHOLD**

The picture obtained of the division of household domestic chores was that women were primarily engaged in these. Where women were working outside the

home, and where other unemployed adult women were present in the household, the latter would perform the bulk of the domestic chores. In many cases these chores were performed by teenage daughters.

#### **4.6.9 ATTITUDES OF WOMEN AND THEIR PARTNERS TO WORKING OUTSIDE THE HOME**

There was much variation in attitudes to women working outside the home, reflecting the differing social positions and levels of status and power of women in Khayelitsha.

For example, a woman informant in the housing area was the head of her household and enjoyed working outside the home and bringing in her own income. Financial decisions were taken by herself.

The group of women interviewed from Greenpoint held a variety of views. Younger women had stronger preferences for working outside the home than older women in the group. The former felt that working outside the home was desirable as it could provide a stable and reliable income.

Younger women stated that their male partners did not mind them being in employment. Older women reported that partners preferred them not to work outside the home. For example one of the older informants stated that her husband wanted her to stay home despite the fact that no-one in the household had a job.

#### **4.6.10 CHILD CARE ARRANGEMENTS**

As many women were unemployed, they looked after their children themselves. Despite the fact that a number of sites had been allocated within Khayelitsha for official, formal creches few had been established. It was more common for

creches to be run from private homes. However, many women could not afford to send their children to creches and so informal arrangements were common. These took the form of relatives or other members of the household who were not working, caring for young children. Another regular means of childcare was to leave a younger child with a neighbour till older children came home from school. The older children then took over the care of the younger ones. It was common for older children to care for themselves after school. On occasion, neighbours cared for children. They were sometimes remunerated in cash or in kind, while at other times it was done as a favour.

#### **4.6.11 SOCIAL ISOLATION OR SUPPORT AMONGST WOMEN**

The only information obtained on social isolation or contact was from the key informant in the Greenpoint area.

She stated that women in Greenpoint did not appear to be socially isolated. The Catholic church in the area was a common meeting place for women. Those women not in formal employment socialised much. Routines such as doing the laundry became social occasions, with women conversing outside while they worked. Women also socialised while fetching water at communal taps. Reciprocal arrangements such as doing each other's hair, keeping an eye on each others' children and so forth existed. Once a woman became employed, her membership of this social circle tended to lapse, as there was no longer an opportunity to meet as much. Employed women may therefore be more isolated.

According to the informant, the sense of community amongst residents of Greenpoint was evident amongst those who had recently moved to Town 2 into upgraded site-and-service areas. They tended to remain together not mixing much outside of their original circle. The informant suggested however that people may become more isolated in Town 2 over time. In Town 2 they lived

Informants expressed problems relating to day hospital staff. They perceived the care by health personnel to be deficient, due to inadequate consultation time. Clients were also unhappy with the fact that they were often treated by nurses rather than doctors. Opinions varied on the attitudes of staff at the state health services. While some said that nursing staff were rude or indifferent, others said it varied from person to person - some were caring, others not. Some informants expressed the view that some of the nursing staff at the day hospital in Site B discriminated against residents from the informal housing areas. Hospitals such as Groote Schuur or Tygerberg tended to be used for chronic complaints needing more specialised treatment. However, transport to services outside of Khayelitsha was considered expensive and time consuming. Despite this, if residents had sufficient money, it was common to seek health care outside of Khayelitsha. This was largely due to their negative views on the the state health facilities provided within Khayelitsha,

With the exception of Red Cross hospital which was viewed as a state health facility offering good quality care for children, private health care services were generally experienced as being qualitatively better than state health care services. Many of the non-governmental health services were respected. Transport costs placed constraints on the use of NGO services outside of a person's residential area.

In addition to the health services mentioned above, there were a fair number of traditional healers in Khayelitsha.

The informants in the core house area believed that within their community, traditional healers were used primarily for psychological problems rather than for physical complaints. According to informants in Site C, there were many traditional healers operating in the area. They suggested that people may make more use of them than the Day hospital. They felt there was much faith in

traditional healers. They were consulted for both physical and psychological complaints. For example, a person may consult with a traditional healer for interpretation of a troubling dream. People tended to consult traditional healers for physical illnesses that had defied cure by conventional medicine. For example, they may go for treatment for cancer that had not been successfully treated by conventional medicine. People would be unlikely to go to a traditional healer for more common and less life-threatening ailments such as colds or influenza. Many used both conventional and traditional medicine. Sometimes they went to a conventional doctor to obtain a sick certificate for work, but to the traditional healer for a cure. The socio-economic profile of those using traditional healers varied.

Informants showed some reticence and embarrassment in discussing use of traditional healers. They indicated that the reliability of the information obtained on use of traditional healers from respondents during the survey may be unreliable. Respondents would be reluctant to admit they made use of traditional healers to anyone perceived to be against this method of treatment.

#### **4.6.13 WOMEN'S REPRODUCTIVE HEALTH**

##### **Knowledge and experience of pap smears**

The two informants in the housing area had heard of a cervical smear, but had never had one. This was interesting as they both had high levels of formal education.

The group of informants in Site C to whom access had been obtained through one of the health service organisations with whom consultations had been held, had agreed to be interviewed on the basis they would be provided with

information about cervical cancer. The service organisation which arranged this group interview had mentioned the researchers interest in women's health in screening for cervical cancer in particular.

Despite the fact that many in the group were using contraception obtained at family planning clinics, only one was aware of having had a cervical smear. When an explanation was given as to what a cervical smear was, how it was done and what it was for, a handful of women said they were aware that they had in fact had one. Many questions were asked about the role of cervical smears in the prevention of cervical cancer.

Similarly, in the group discussion with Greenpoint informants only one had had a cervical smear. This had been performed during pregnancy and she was unaware of the reasons for it. Others had seen posters about cervical smears at the family planning clinic but no-one knew what they were for. When an explanation was given, one additional woman stated that she was aware that she had had one. Once again interest was expressed in receiving further information on the subject.

#### **4.7 ADVICE AND COMMENTS ON CONDUCTING THE SURVEY**

4.7.1 People tended to be suspicious of people going door-to-door asking questions. It was suggested that meetings be called and information adequately disseminated before starting the survey.

4.7.2 The best time for interviewing was thought to be in the early evening, during the week. Problems of safety may occur at night in the informal housing areas, particularly in Site C, where the home guard operated. As a result, interviewers may encounter suspicious attitudes from the guard and residents. The best time to conduct interviews in these

areas would probably be on weekends. However, it was pointed out that on weekends church and social events as well as drinking parties may serve as competition to the survey.

4.7.3 The informants felt mature women resident in Khayelitsha would be the best choice for interviewers. This would ensure an optimum response rate. It was felt that interviewers who came from Khayelitsha would be in the best position to elicit honest responses, as respondents would be aware that they were in possession of knowledge of local conditions. Non-medical people would elicit more reliable responses on the health questions than nurses. Women would tend to feel constrained by what they knew to be desirable answers, for example on issues such as contraception, age of first pregnancy, attendance of health services and so forth, when interviewed by a health professional.

4.7.4 Duration of interview: The optimal duration would be approximately 1/2 hour.

#### **4.8 COMMENTS ON PHRASING OF QUESTIONS IN QUESTIONNAIRE**

##### **4.8.1 Occupational status**

It was advised that financial information may be difficult to obtain from people. People may be suspicious, particularly in the informal housing areas with their history of dues collection, as to how it would be used. It was also suggested that financial categories be used to gather this information, rather than probing the exact amount earned.

#### **4.8.2 Domestic work**

It was thought that women may have difficulty quantifying the amount of time spent on housework.

#### **4.8.3 Emotional stress**

It was felt that difficulty may be experienced getting information from women on this area.

#### **4.8.4 Morbidity and sexual history**

It was felt that questions in this area could be sensitive. Some should be omitted and others rephrased.

#### **4.8.5 Tenure**

It was advised that questions about forms of tenure and payments for sites would be of an extremely sensitive nature in the informal housing areas.

### **4.9 CONCLUSION**

In-depth interviews cannot provide quantitative and representative information. However they are particularly useful in gathering information of a sensitive nature as can be seen from the information obtained about tenure and power relations. Useful advice can be obtained on how to ask some questions within a specific community, for example, financial information and information on some areas of women's health. Valuable information was gathered on occupation in the informal sector that may not be uncovered through the less probing techniques of a survey.

The information obtained in the in-depth interviews was of importance in the process of modifying the questionnaire to be used in the survey. Some questions were eliminated as they were found to be superfluous. For example questions regarding environmental conditions were omitted from the final questionnaire as the required information had been obtained through the in-depth interviews. Environmental conditions appeared to be fairly standard within defined geographical areas deeming the collection of representative data unnecessary. This enabled the questionnaires and the interview time to be shortened. Other questions were omitted as they were too sensitive. Initially it was envisaged that a number of questions would be asked around the issue of tenure. This included how the respondent had obtained her house or site and how much was paid for it. As it emerged that enquiry in this area would prove difficult, in the final questionnaire, the only question asked of respondents was whether her dwelling was rented, owned or free of charge. A question included in the draft questionnaire about where respondents sent their sons for initiation was also omitted. Given the variability in the practice and complexity in the reasons for sending sons back to a rural area for initiation, it was felt that this would not be a good indicator of urbanisation.

Some questions were rephrased. For example, questions about the earnings of respondents were rephrased to probe the financial bracket the respondent fitted into, rather than her exact earnings. The original question in the area of women's reproductive morbidity included listing a range of gynaecological symptoms and asking women to respond whether they had experienced any of these symptoms. The in-depth interviews showed that this question may elicit an embarrassed response. In the final questionnaire women were only asked whether they had had any gynaecological illness and if they had, what this was.

In addition the in-depth interviews provided valuable information on socio-economic and demographic patterns and categories in Khayelitsha against which to compare subsequent information collected in a survey.

Poor environmental conditions were evident across all but the homeownership areas of Khayelitsha. Features such as the lack of electricity, poor infrastructure, lack of social facilities and the high density of dwellings, although variable in their severity, cut across all areas of Town One. The environmental conditions prevailing in the site-and-service areas were particularly deplorable. The poor living conditions were exacerbated by the total absence of any basic sanitation at all in the unserviced areas.

These extremely poor living conditions clearly have important implications for the physical and psychological well-being of members of this community.

Important indicators of household composition in Khayelitsha were revealed through the case studies. Common features were the existence of extended family units and of many female-headed households. A common feature of many households was absentee members. Frequently these absentee members were children, cared for by a grandmother, aunt or other relative in the former Ciskei or Transkei.

Those residents born in Cape Town or those who had lived in Cape Town for a long period, were concentrated primarily in the housing area of Khayelitsha. It would be unusual to find residents in this category in Site C and Greenpoint. While residents born in Cape Town generally maintained some contact with rural areas through occasional visits to family, they were unlikely to have material links. They were also less likely to see a rural area as a place they would return to when old.

Many residents of Sites C, B and Greenpoint were from Crossroads, being mostly refugees from the 1986 crisis. Due to the effects of influx control on African women, women tended to be more recent arrivals. Indications were that Greenpoint residents were the most recent arrivals to Cape Town.

It is of interest that many of the residents in Site B came from the same district in the former Transkei, indicating a tendency of people from the same rural area to settle together or join each other in an urban area. This may have provided a network which eased access to jobs, accommodation and social support.

The information and advice obtained in this series of in-depth interviews in Khayelitsha highlights the case for the usefulness of large scale surveys being supplemented or co-associated with in-depth studies.

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**CHAPTER 5**

**THE SOCIO - ECONOMIC AND DEMOGRAPHIC STATUS OF  
WOMEN IN KHAYELITSHA**

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## 5.1 INTRODUCTION

Chapter 2 discussed factors influencing women's health and argued for the major role played by socio-economic factors in determining women's health status. Important socio-economic factors included: women's work, income, political status, education, social status and the environmental conditions in which they live. In addition, the increased concern particularly in developing countries with the health of the newly urbanised poor and the association between urbanisation and certain groups of disease was discussed. This chapter describes the socio-economic and demographic status of women living in Khayelitsha. This is presented against the background of some information about the population of Khayelitsha as a whole. Chapter 6 will discuss women's health status, health knowledge and use of health services and Chapter 7 will discuss the impact of the socio-economic and demographic status of women, discussed in this chapter, on their health.

## 5.2 METHODS

The statistical methods of analysis used are described in detail in Chapter 3. Appendix C contains a full list of variable names analysed and their description. Definitions of variables used in the analyses in this chapter are dealt with below.

The data collected includes information on the following:

### TABLE 1 : INFORMATION ON POPULATION OF KHAYELITSHA

Gender and age

Household size

Household composition

Number of dwellings per site

Material of dwelling

TABLE 2: INFORMATION ON WOMEN RESPONDENTS

**Environmental factors**

- geographical area of residence
- housing type

**-Demographic factors**

- age
- education

**Urbanisation factors**

- place of birth
- places moved to while growing up (migration patterns)
- number of years spent in an urban area after growing up
- where respondents had lived prior to Khayelitsha (rural-urban and urban-urban migration patterns)
- urban-rural ties

**Economic factors**

- employment status
- areas of formal and informal employment
- income
- socio-economic position

**Other factors**

type of housing tenure

head of household status

## **Definitions**

### **Household**

Due to the difficulties of applying conventional definitions of household to a peri-urban area such as Khayelitsha, this was defined as any group of people who participated together in social activities within the dwelling (such as cooking and eating together) and who participated in the economics of the group living within the dwelling.

### **Household composition**

Initially this was categorised into the following eight types: man, woman and their children; a man, women, their children and relative/s; woman and children; woman on own; family and friend/s, family and lodger; man and women without children and relatives living together. These categories were then conflated into four main types:

- nuclear family type (a man and a woman with or without children)
- female-headed (a woman with her children or on her own)
- extended family type (nuclear family + relatives)
- ‘alliance’ type (a loose combination of family members and friends, lodgers or relatives living together).

### **Material of dwelling**

Was categorised into: brick; corrugated iron; canvas, plastic and sacking or ‘other’.

### **Environmental factors**

Area of residence was defined in terms of the core housing area, Site B, Site C and Greenpoint (SEE MAP OF KHAYELITSHA)

Housing type was categorised in terms of formal housing, serviced informal housing, unserviced informal housing and 'backyard' shacks.

### **Demographic factors**

Education included: Formal schooling and after school vocational training. The question of whether the vocational training was formal was not probed.

### **Urbanisation factors**

In view of the difficulty of measuring urbanisation status, indicators or proxy measures were used:

- \* Place of birth: Cape Town, other city, 'white' farm, and former 'homeland'. This was further divided into regions and towns.
- \* Number of years spent in an urban area since the time of leaving school. The number of years spent in an urban area was calculated from detailed migration histories of the respondents. It serves as a crude indicator of 'exposure' to the urban environment
- \* Rural-urban and urban-urban migration patterns: whether respondents had migrated within rural areas and where they had lived immediately prior to Khayelitsha.
- \* Indicators used to reflect urban-rural ties were:
  - having a house or room in a house in a rural area

- having land or livestock in a rural area
- having a spouse, children or relatives in a rural area
- sending remittances to a rural area
- the place respondents saw as 'home'
- and the place where respondents would like to live when old

### **Economic factors**

Employment status was defined in terms of: employment in formal sector, employment in informal sector and unemployed.

Sectors of employment in the formal sector was classified according to Standard Industrial Classification of all Economic activities (SIC) schedule (Department of Statistics, Pretoria, January 1991)

Income was categorised into income brackets of weekly and monthly paid respondents in the formal and informal sectors.

Social class classification was in terms of the CASS provisional index for occupational categories, groups and prestige ratings (Schlemmer and Stopforth, Durban, 1979).

These variables so defined provided the outcome measures for socio-economic, demographic and urbanisation status.

A social profile of women was obtained by univariate analysis.

This provided frequency distributions, means, medians and the ranges of different variables.

Socio-economic and demographic variables were examined to determine significant associations with urbanisation and environmental variables and certain other variables of interest through bivariate analysis.

Continuous variables were transformed into categorical variables by the insertion of cutpoints. Chi squared tests were used to test for significant associations ( $p < 0.05$ ).

### **5.3 RESULTS**

The household results presented concern persons living in 722 out of the 800 sites sampled. This represents a response rate of 90.3%. Of the respondents interviewed in the 722 households, 659 (91.3%) were women and 61 (8.4%) were men. Excluding the household results presented in this chapter all further results in this thesis relate to female respondents only.\*

#### **5.3.1 HOUSEHOLD**

Of 719 sites 93.5% contained one dwelling. The maximum dwellings per site was 3. There was an average of 4.9 (range 1 to 14) people per household.

Figure 1 shows the age structure of the population illustrating a very young population, with 38% below 15 years and 77% below the age of 35 years. There was a relatively low proportion of children under the age of 5 living in Khayelitsha and a preponderance of females in the this age group.

The distribution of household composition is shown in figure 2.

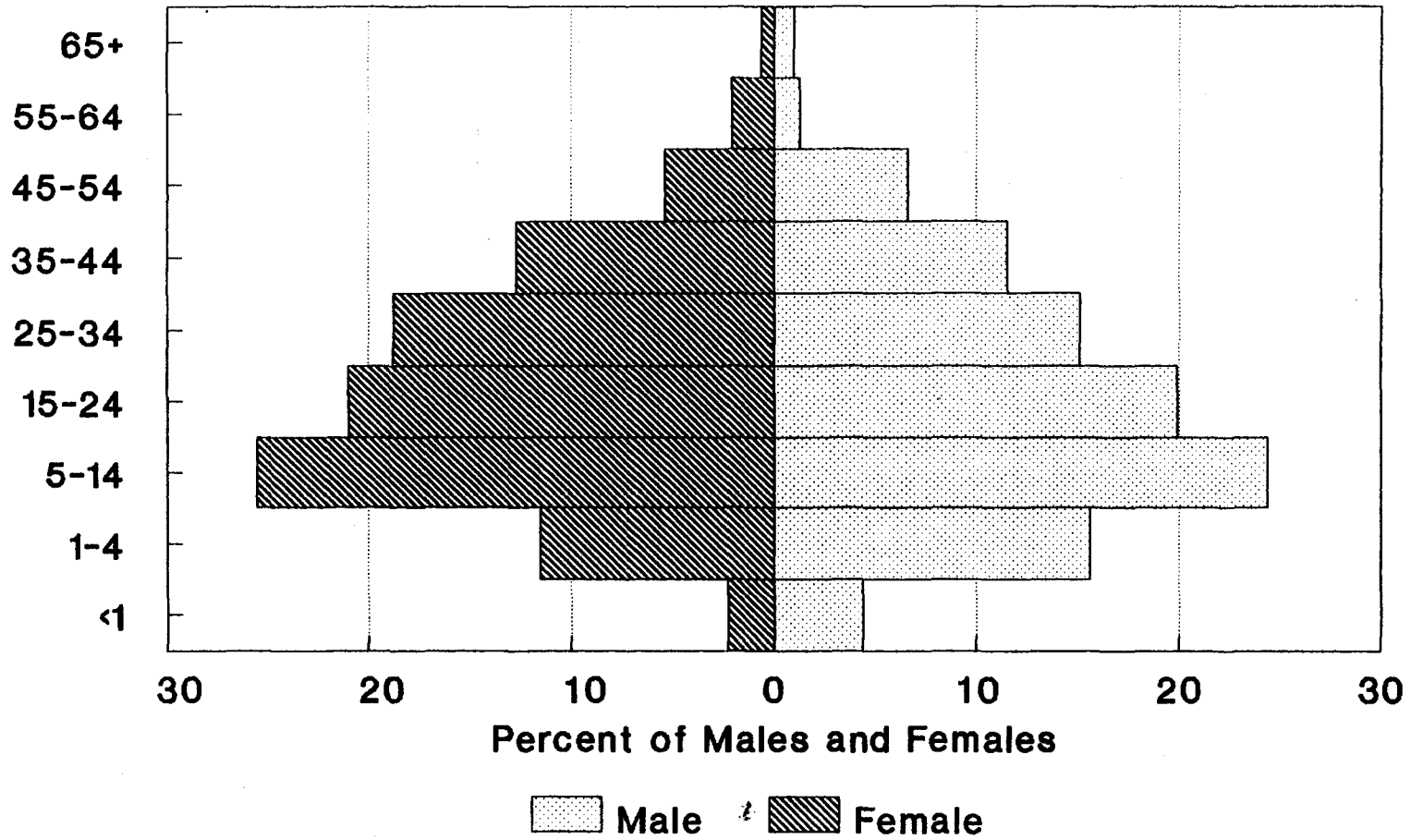
As can be seen in figure 3, most dwellings were made of corrugated iron (68%).

\* *The denominators on which analyses are based may vary throughout this chapter. Not all women answered all questions. Hence the response rate sometimes varies.*

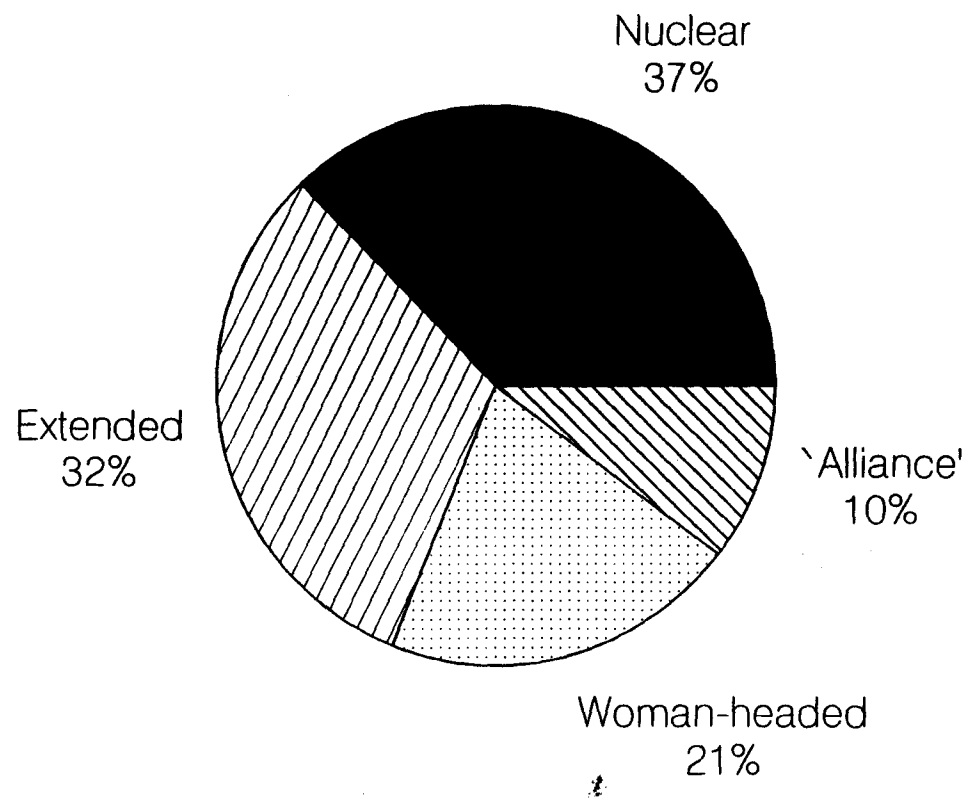
# Age distribution of population

Figure 1

Age

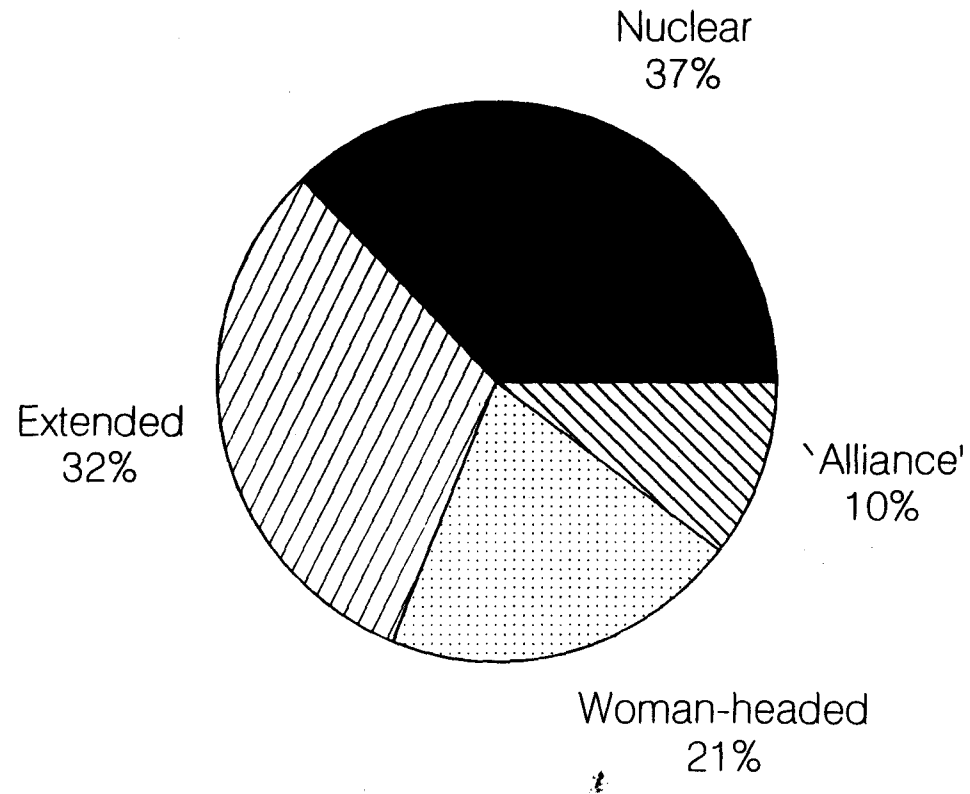


# Household composition (n=656) Figure 2



# Household composition

(n=656) Figure 2



### 5.3.2 FEMALE RESPONDENTS

#### 5.3.2.1 Environmental factors

##### Type of housing and area of residence

Of the respondents interviewed, 13.7% (n=90) lived in formal housing (in Villages 1 & 2), 54.3% (n=358) in serviced informal housing (in Sites C, B and Greenpoint) and 31.7% (n= 209) in unserviced informal housing, in Greenpoint and its adjacent areas and scattered within Sites C and B and the housing area. Only 2 respondents (0.3%) lived in 'backyard' shacks.

Figure 4 shows the distribution of respondents into areas of residence within Town 1 of Khayelitsha.

Of the 659 respondents 59.6% (n=392) lived in accommodation where no formal rental was charged, while 38.1% (n=251) lived in rented accommodation and 2.3% (n=15) owned their dwelling.

#### 5.3.2.2 Demographic factors

##### Age

Figure 5 shows the age distribution of respondents.

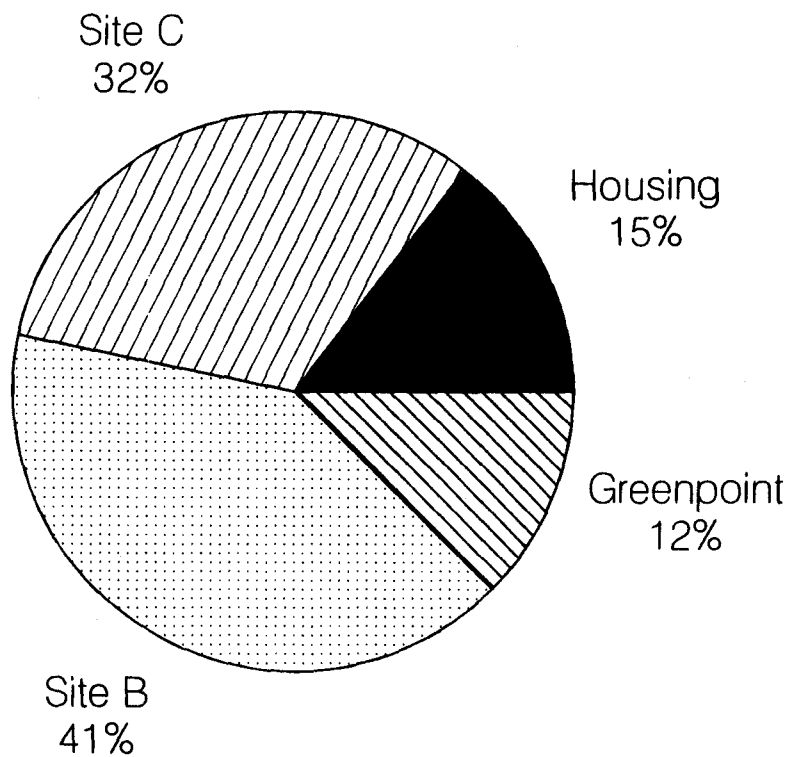
The mean age was of 34.3 (range 16 to 77). Mean ages ( in years) in the formal and informal housing areas were 39.0 and 33.6.(t=4.77, p < 0.001)

##### Education

Figure 6 shows the distribution of respondents' education levels.

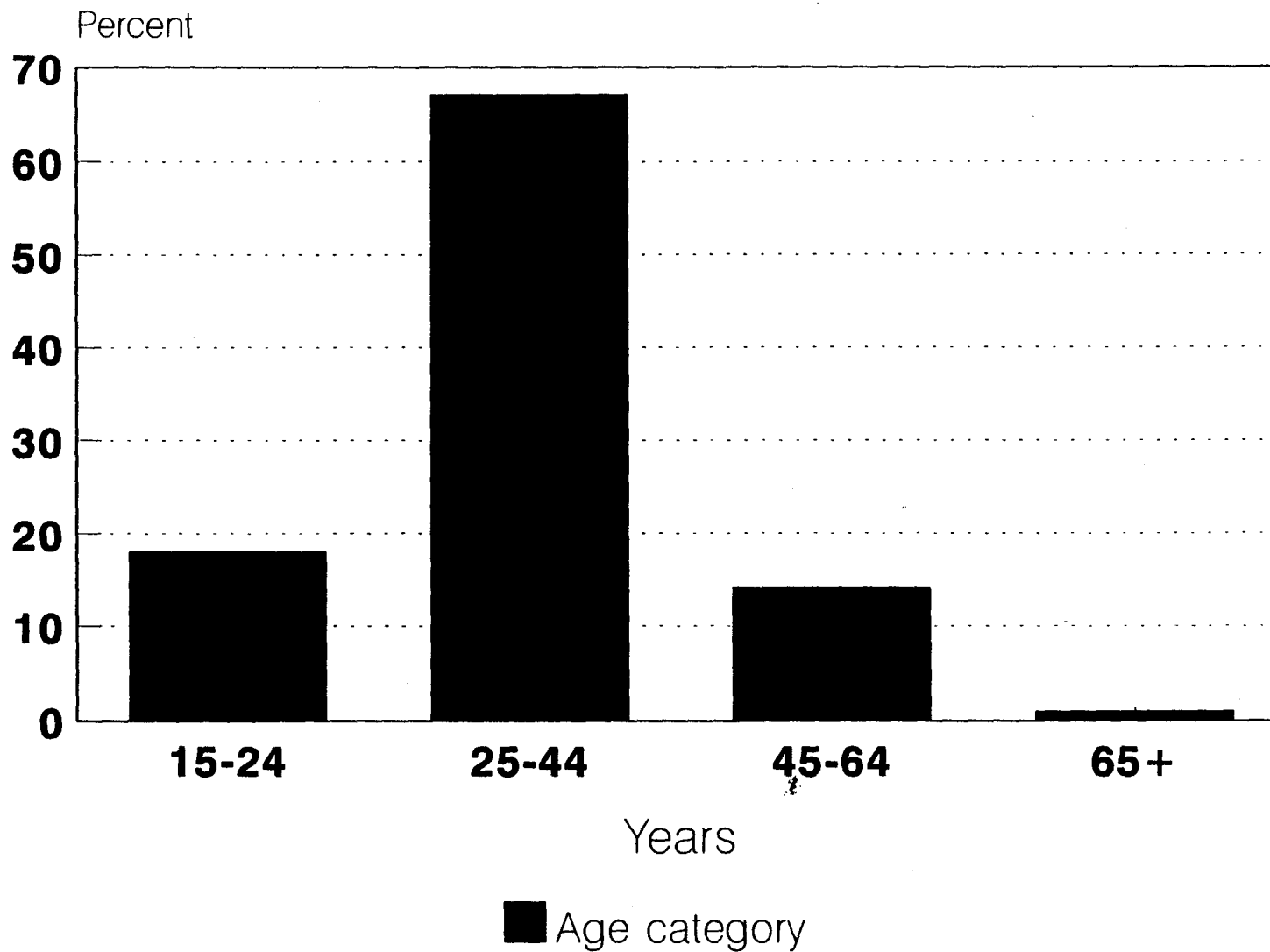
# Distribution: Area of residence

(n=658) Figure 4



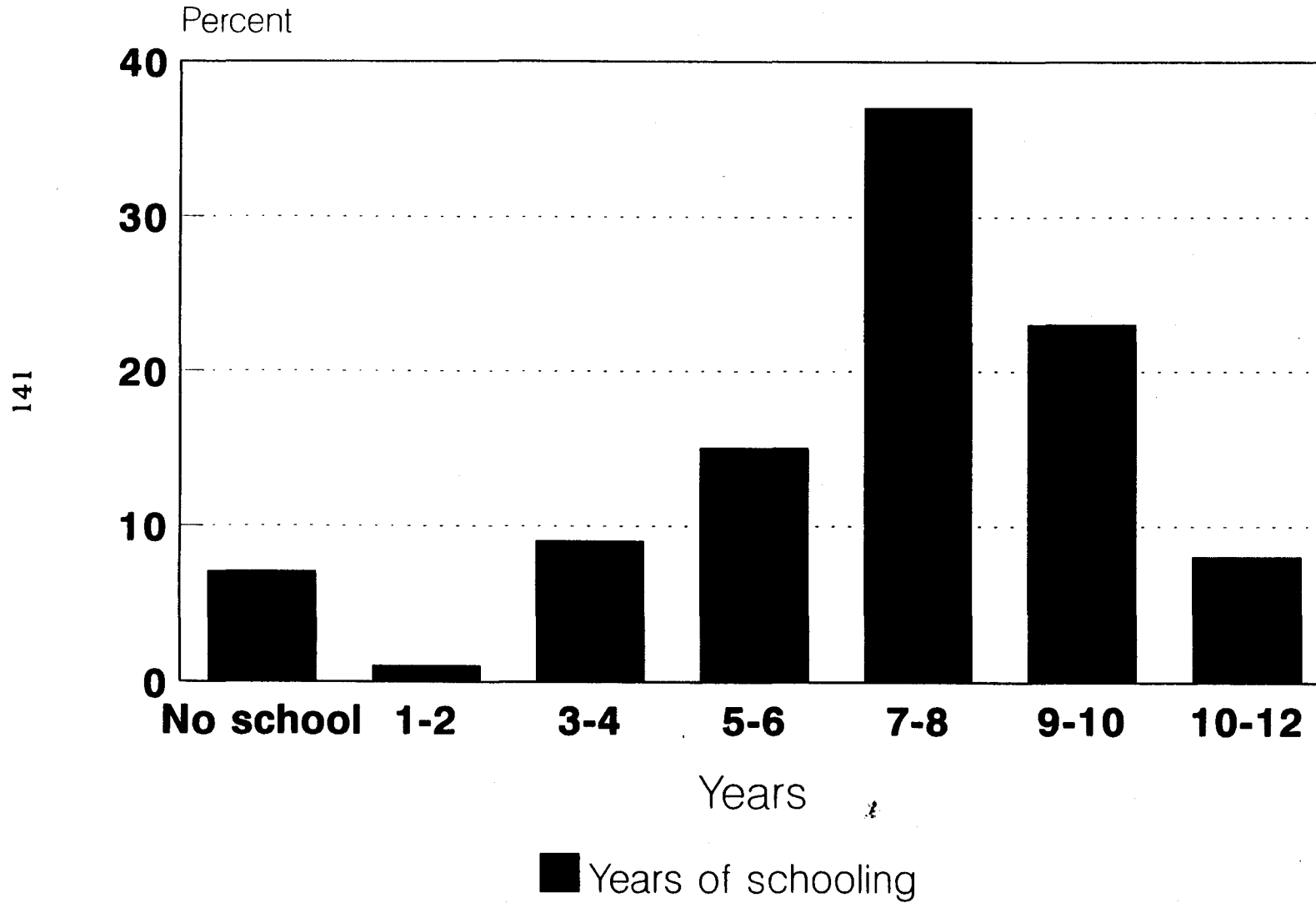
# Age of respondents

(n=656) Figure 5



# Levels of Education

(n=655) Figure 6



Seven percent of respondents had no formal schooling. Thirty-nine percent had some level of primary school education and 54% had some level of secondary school education and 22.7% were 'functionally illiterate' (less than 6 years of formal schooling). The mean number of years at school was 7.3 years.

The majority of those without formal education were in the informal housing areas. Eighty-five percent of those in the formal housing area had an educational level of 7 years and above, compared to Sixty-four percent in informal housing areas ( $X^2 = 16.6, p < 0.0005$ ). Respondents born in Cape Town were more likely to have levels of education of 7 years and above (89%) than those born in a former 'homeland' (66%) ( $X^2 = 16.2, p < 0.0001$ ). There were no major differences between the educational levels of respondents according to the number of years they had spent in an urban area.

Only 21% of respondents had received vocational training. Respondents in the formal housing area (50%) were significantly more likely to have acquired such training than respondents in the informal housing areas (16.6%) ( $X^2 = 54.3, p = 0.000$ ). Table 3 shows the types of training acquired by respondents.

**TABLE 3**  
**TYPES OF TRAINING**

	<u>Number</u>	<u>%</u>
Sewing	60	43
Knitting	16	11
First Aid	8	6
Nursing/nursing assistant	7	5
Secretarial	6	4
Teaching	5	4
Knitting and sewing	5	4
Cooking	4	3
Other	<u>29</u>	<u>20</u>
<b>TOTAL</b>	<u>140</u>	<u>100</u>

\* In all the bivariate analyses presented in this Chapter unless otherwise stated DF=1 throughout.

### 5.3.2.3 Urbanisation status

#### Place of birth

Over two thirds of the 651 respondents were born in a former 'homeland'. Most respondents born in a former 'homeland', were from the former Transkei (n=392,60.2%). Only 6,5% (n=44) of respondents were born in the former Ciskei. Women tended to migrate to Cape Town from certain districts within the former Transkei, with over 70% of the 392 of women born in the former Transkei coming from the Southern or South Western regions.\* People born in some towns tended to settle together in specific area of Khayelitsha. Women from Lady Frere were significantly more likely (n=39,50.6%) to be living in Site C ( $X^2=13.98, p=0.00018$ ) than women from other former Transkei towns (n=126,35.3%).

Only 11% (n=71) were born in Cape Town. A minority (n=29, 43.9%) of women born in Cape Town were born in the formal townships of Guguletu, Nyanga and Langa. most women having been born in areas from which African people were subsequently removed under the former apartheid Group Areas legislation such as Athlone, Kensington, Simonstown and central Cape Town.

Of the 658 respondents, 86.6% grew up or went to school in a former 'homeland'.

A high proportion of respondents living in the formal housing area were born in Cape Town compared with the informal housing areas ( $X^2=83.9, p=0.000$ )

- \* *There are a number of key towns within these and other regions from which the majority of women originate. Within the South Western Transkei, these towns are: Lady Frere 20% of Transkei-borners, Coftmvaba (11%) and Cala (9%). Other key towns are Willowvale (8%) and Nqamakwe (6%) within the Southern Transkei, Tsolo (5%) in the Central region, and Mount Fletcher (7%) and Qumbu (6%) in the Northern region.*

TABLE 4

	AREA BIRTHPLACE		
	CAPE TOWN %	'HOMELAND' %	OTHER %
HOUSING (n=96)	38.6	42.7	18.7
SITE C (n=212)	6.1	81.1	12.8
SITE B (n=268)	7.5	72.8	19.7
GREEN- POINT (n=82)	4.9	72.0	23.1
TOTAL (n=659)	11.2	71.0	17.8

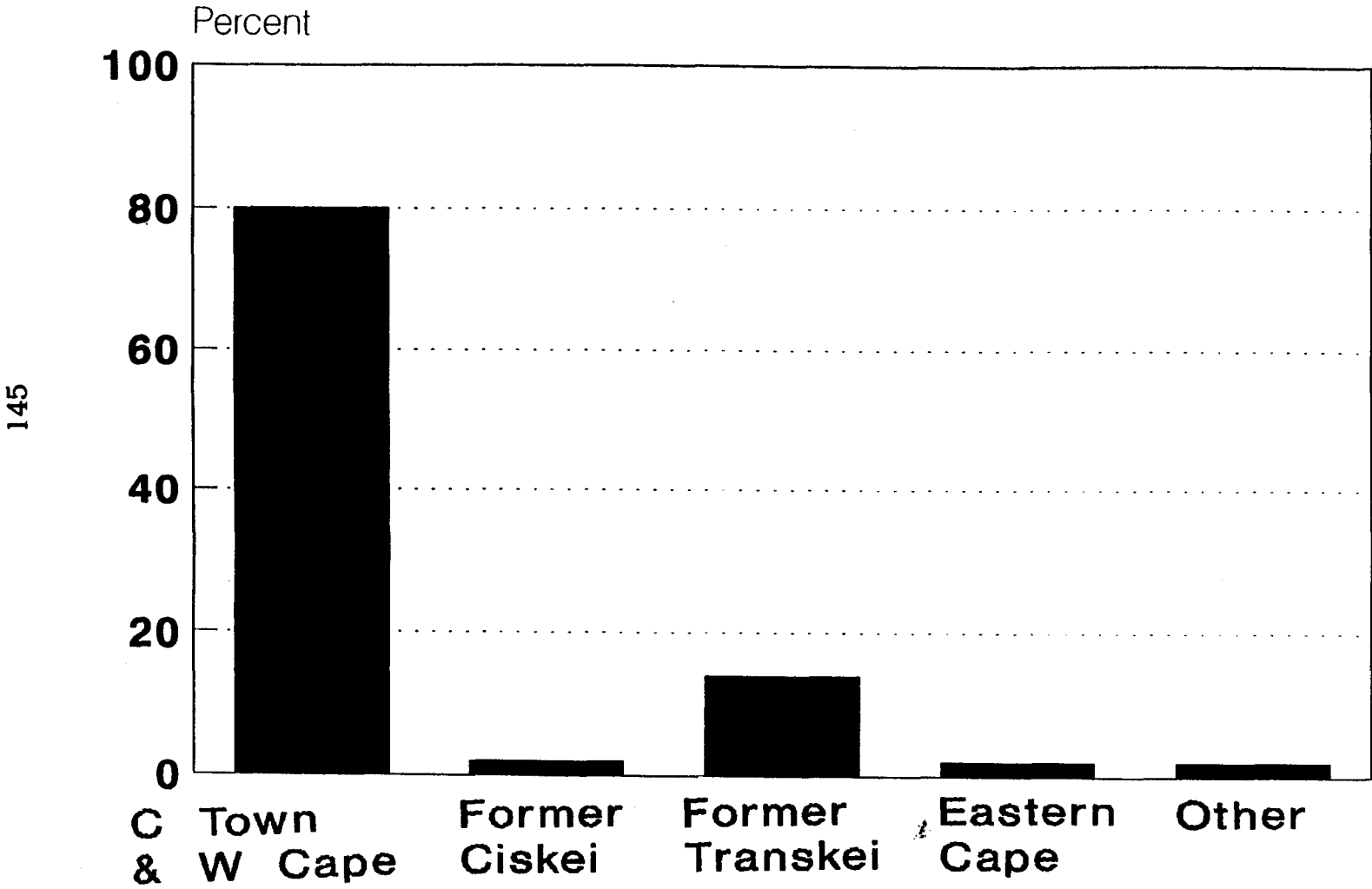
### Patterns of movement

The results show very limited rural-rural movement prior to moving to Cape Town. Only 1.2% (n=4) of former Transkei-born women, and 2.4% (n=1) of former Ciskei-born women moved from their place of birth to another region within a former 'homeland' before moving to Cape Town.

The vast majority (86%) of people moved from a rural to an urban area, with 57% of respondents moving straight from their place of birth and area where they grew up to Cape Town. Three-quarters of women had relocated from within Cape Town to Khayelitsha. This is most marked for residents in the housing area and Greenpoint. Over a quarter (27%) moved to Khayelitsha from Crossroads. Details of where respondents lived prior to Khayelitsha are shown in Figure 7.

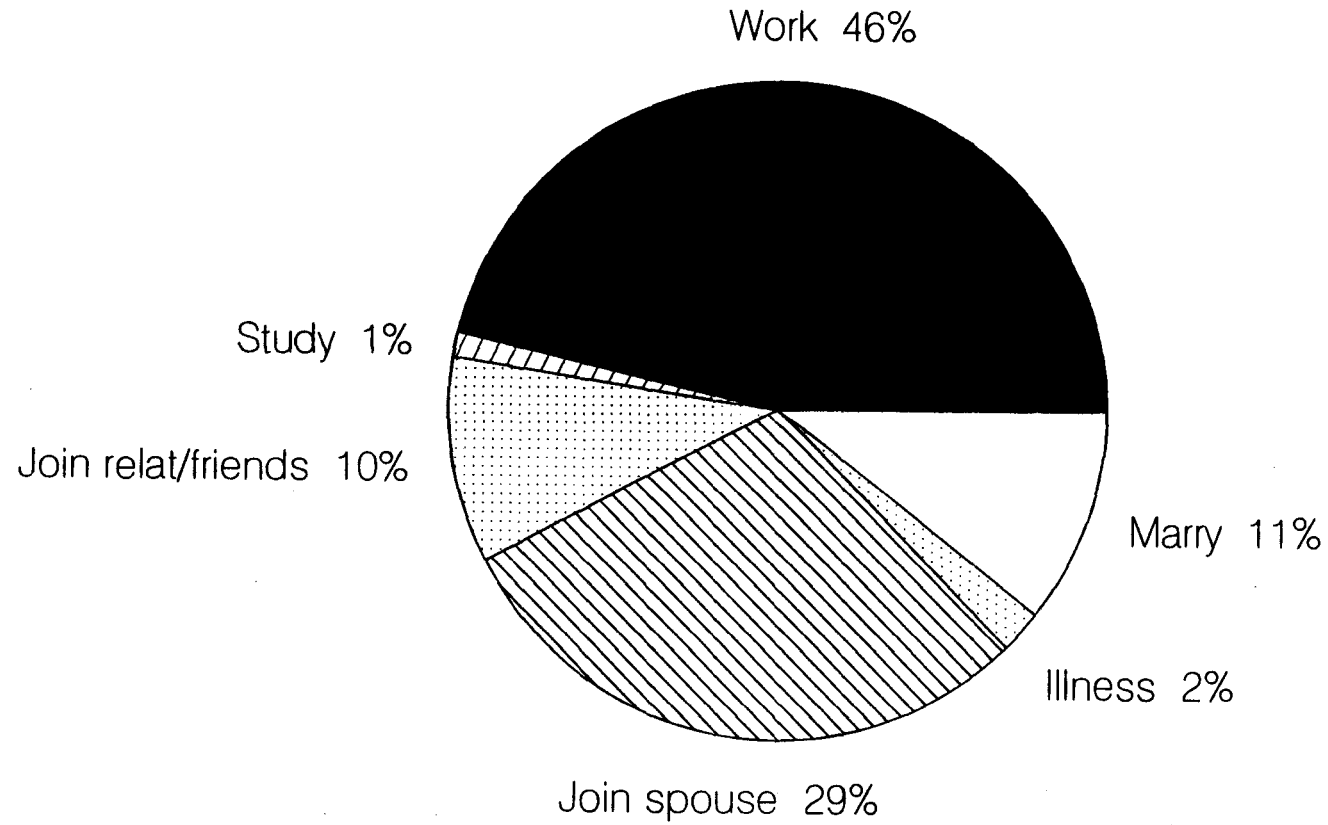
Figure 8 shows the main reasons for respondents moving from their place of birth to Cape Town.

# Area of residence prior to Khayelitsha (n=656) Figure 7



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# Reasons for moving to Cape Town (n=590) Figure 8



### **Urban years**

Of the 651 respondents, 69.7% had migrated to an urban area prior to 1985. As can be seen in figure 9 younger women were the most recent arrivals to an urban area. The differences amongst respondents in terms of years in an urban area by area of residence are indicated in figure 10. The respondents in the housing area were significantly more likely ( $n=74, 80.4\%$ ) to have been in an urban area for 10 or more years than those in the informal housing areas ( $n=235, 43.4\%$ ) ( $X^2=43.7, p = 0.000.$ )

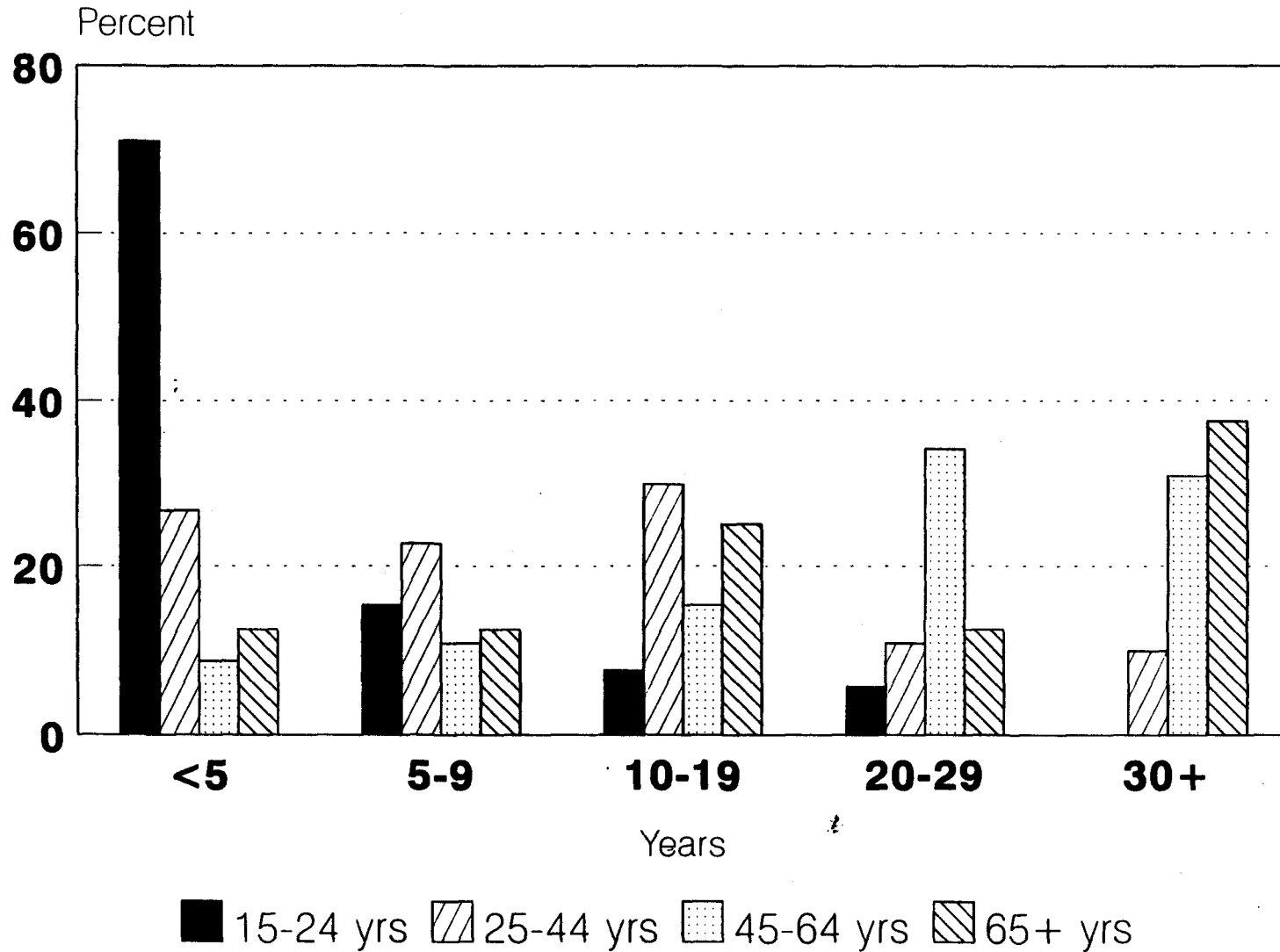
### **Rural ties**

Material and emotional ties to a rural area. These were significantly stronger for respondents in the informal housing areas of Site B & C and Greenpoint. Residents in these areas were significantly more likely to have had a dwelling ( $n=407, 72.4\%$ ) ( $X^2=49.64, p=0.000$ ), to have had a preference for living in a former 'homeland' when old ( $n=335, 59.5\%$ ) ( $X^2=60.45, p=0.000$ ), and to have viewed a former 'homeland' as 'home' ( $n=345, 61.3\%$ ) ( $X^2=59.96 p=0.000$ ) than those the housing area ( $n=36, 37.5\%$ ,  $n=16, 16.6\%$  and  $n=18, 18.8\%$  respectively).

A minority of respondents had other ties in rural areas: land (29%), livestock (21%) and a spouse (3%). Over half (57.7%) of all respondent sent remittances to a rural area. Two-thirds of remittances were to parents, 23% were to relatives and 7% to children. The vast majority (88%) of ties were with a former 'homeland'.

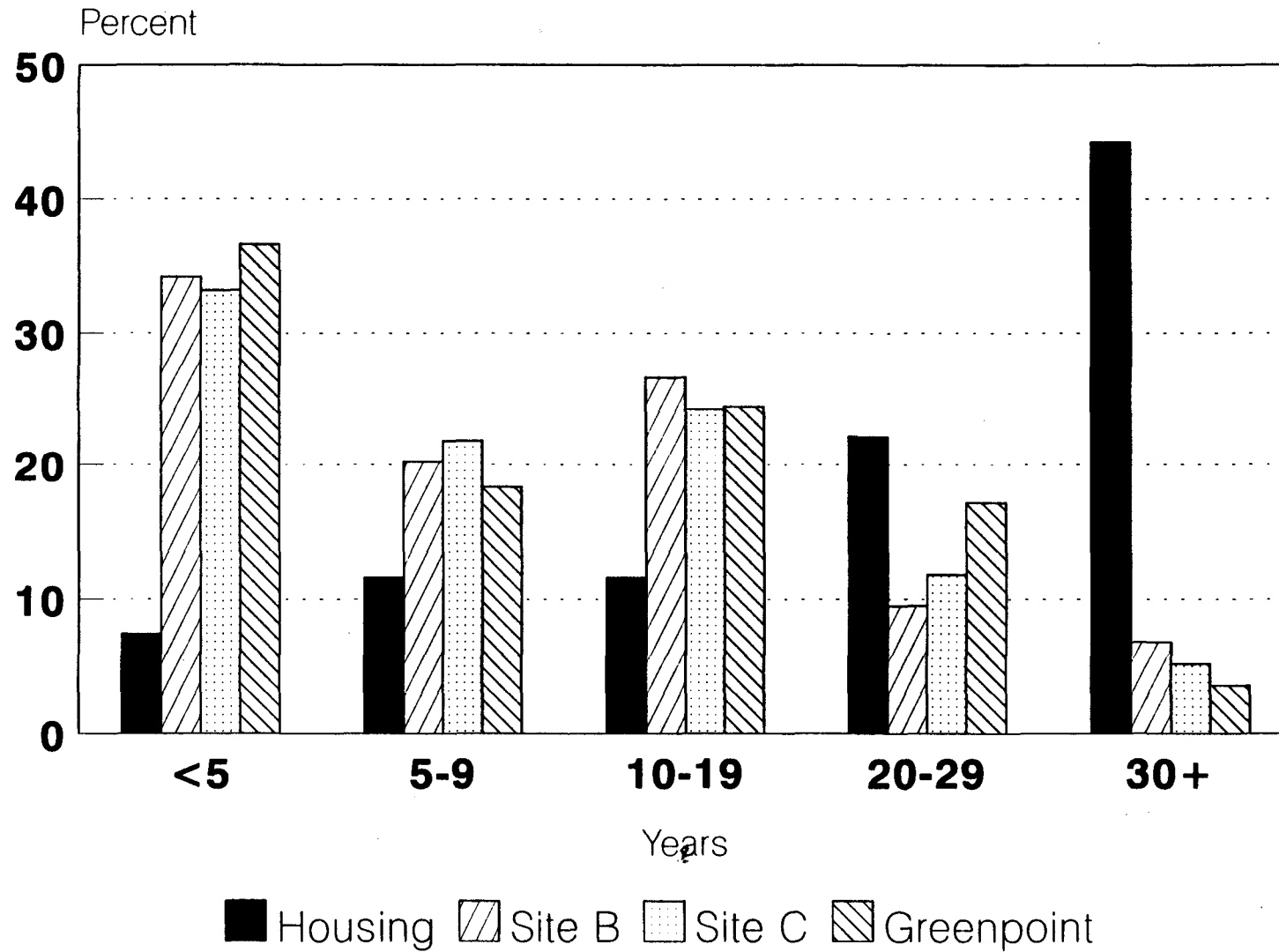
# Urban years by age of respondents

## Figure 9



# Urban years by area of respondents

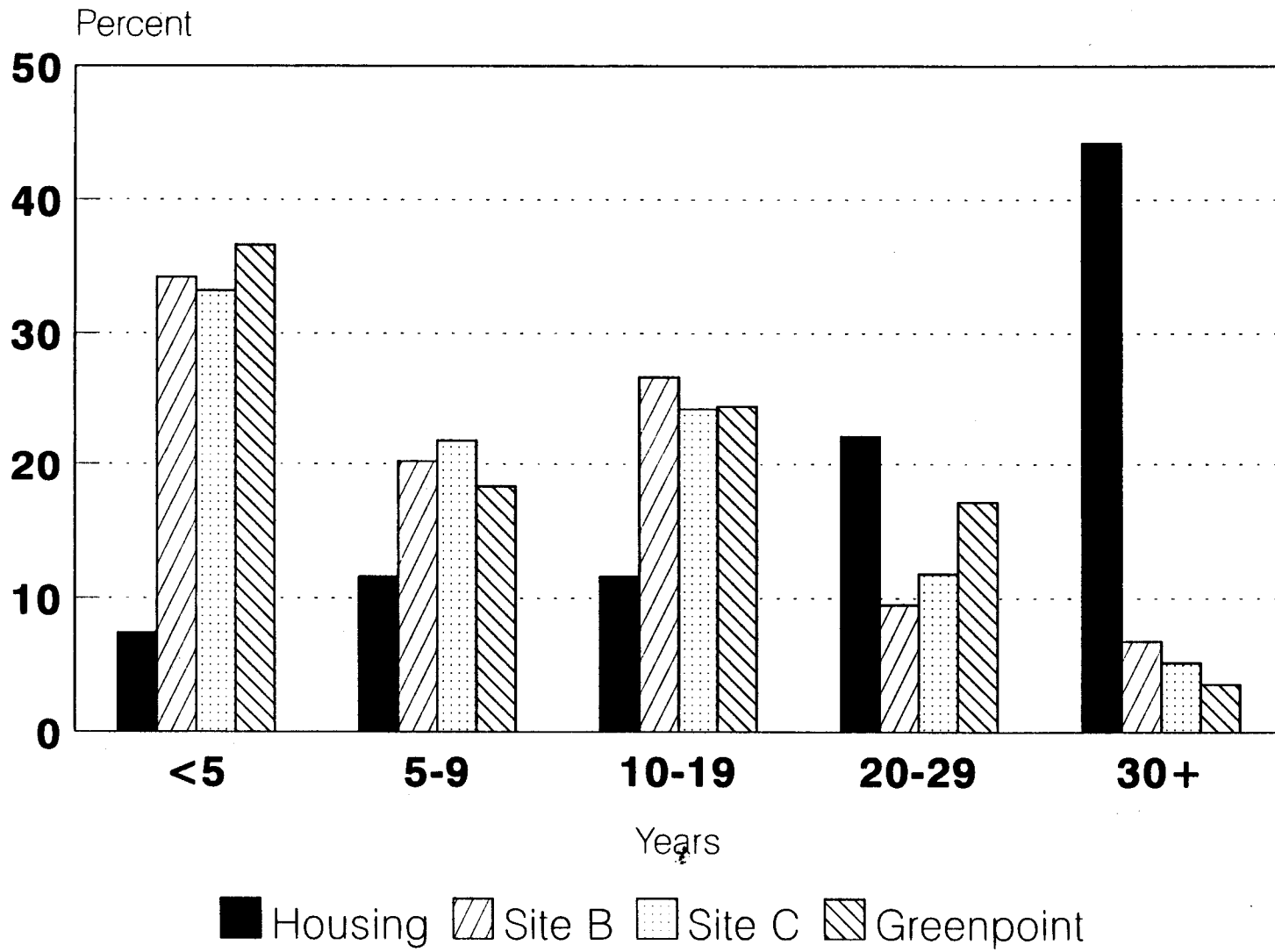
## Figure 10



# Urban years by area of respondents

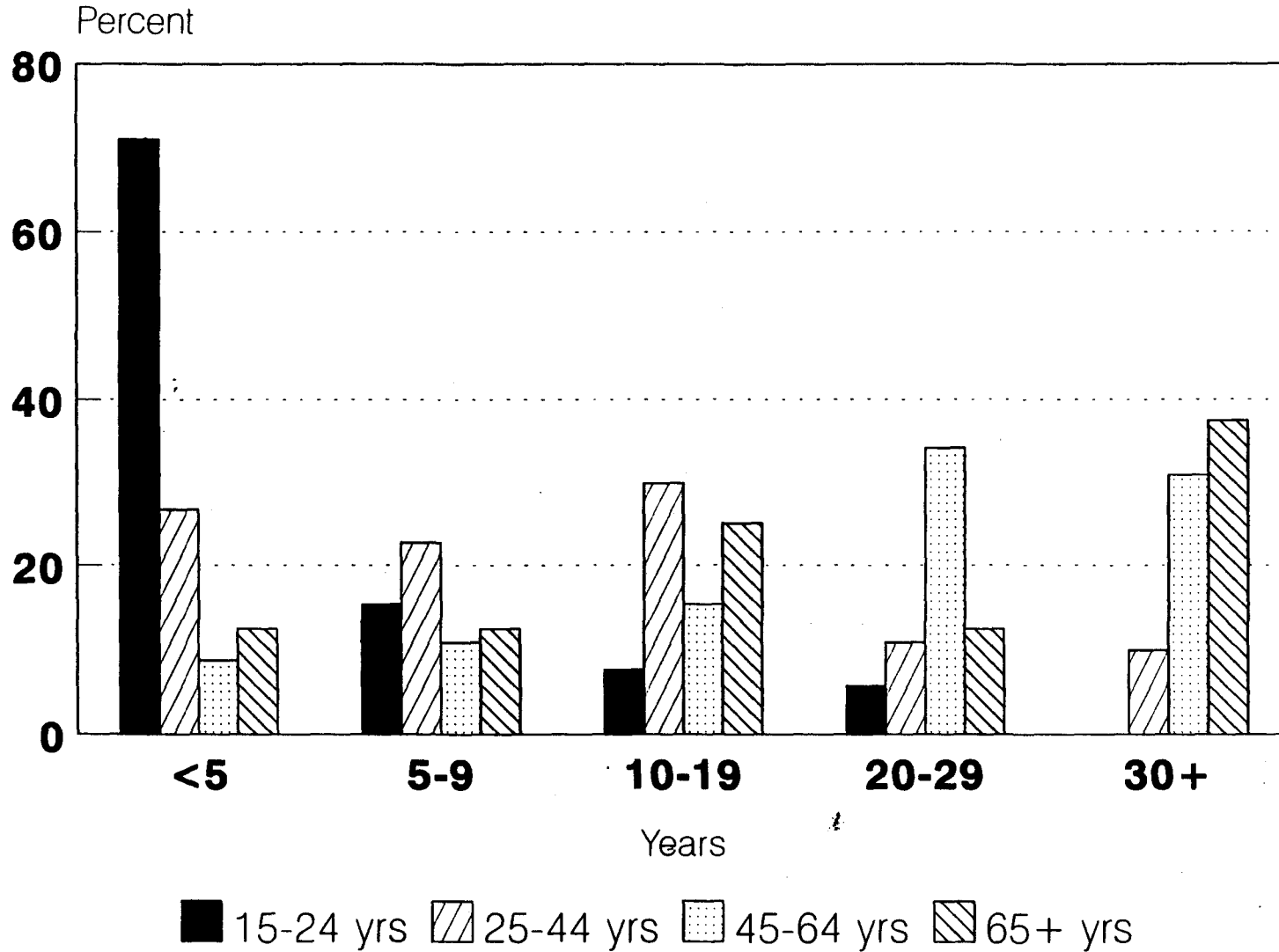
## Figure 10

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# Urban years by age of respondents

## Figure 9



#### 5.3.2.4 Economic status

##### Employment

Of the 659 respondents, 45% had no employment in either the formal or informal sector. 67 % were unemployed if employment in the informal sector was excluded. Of the 361 who were employed, the majority (60.7%) were employed in the formal sector, of whom 66.2% were in domestic service. The remaining 39.3% of those employed worked in the informal sector.

Unemployment decreases with length of stay in an urban area.

Women who had spent less than 10 years in an urban area were significantly more likely to be unemployed ( $n=175, 61.8\%$ ) than women who had spent longer in an urban area ( $n=97, 31\%$ ) ( $X^2=57.0, p=0.000$ )

Of the 298 respondents who were unemployed, 272 (64.2%) were work-seekers and the remaining 152 (35.8%) were voluntarily unemployed. Figure 11 shows that the three **main** reasons for not seeking work were that the respondent was pregnant or looking after an infant (28%), ill or disabled (20%), or refusal by a husband (17%).

Number of years spent in an urban area does not appear to have a significant impact on employment in the informal sector. Figure 12 shows the distribution of respondents in activities in the informal sector.

### Income

Amongst both formal and informal sector employees, 80% earned less than R100 per week, while 89% of formal sector employees and 80% of informal sector employees earned under R400 per month. In addition, 65.8% of informal sector employees reported that their income was irregular.

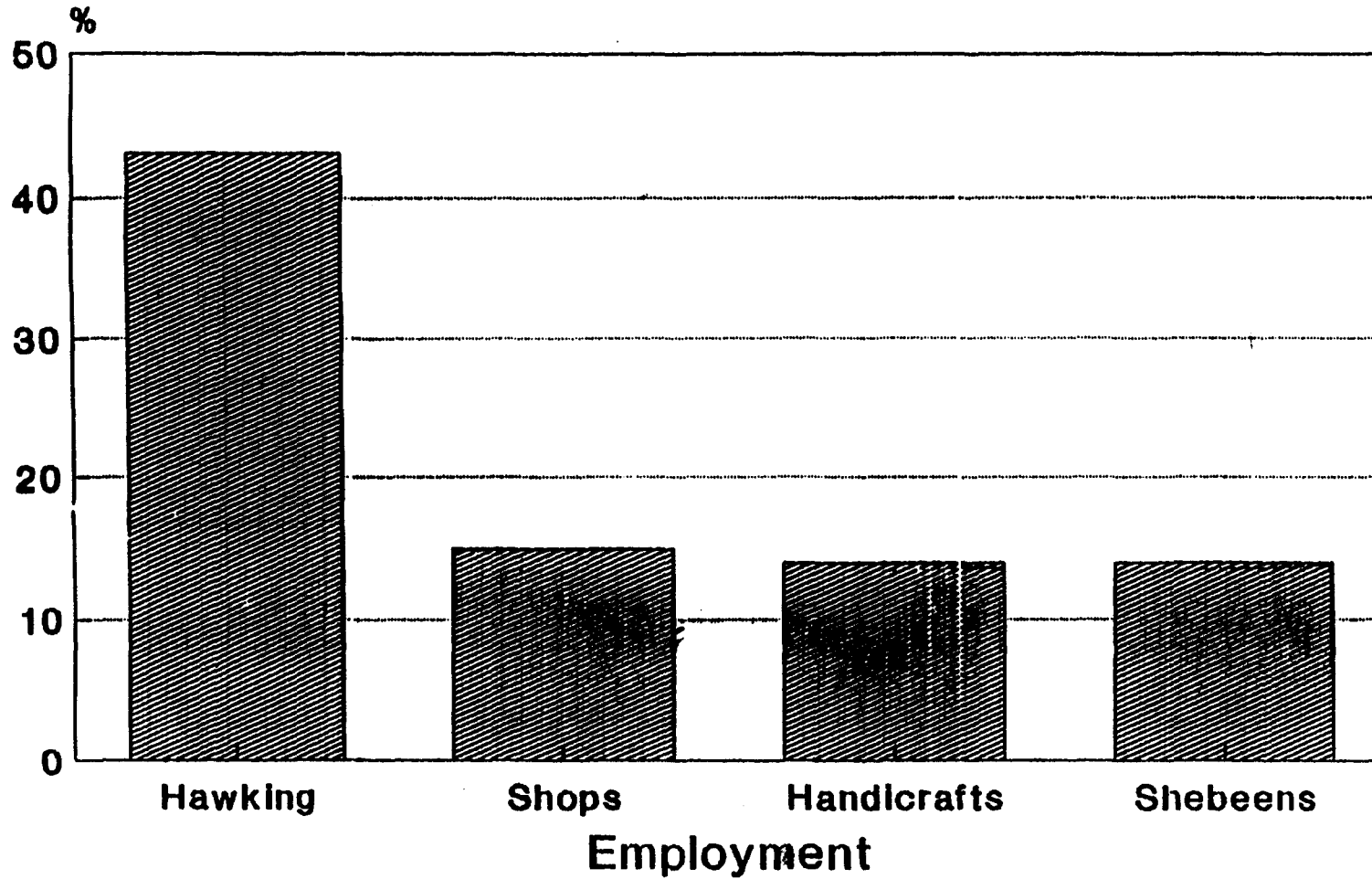
Table 5 shows that respondents in the formal housing area have a very different occupational profile to those in the other areas.

**TABLE 5**  
**AREA OF RESIDENCE AND OCCUPATIONAL PROFILE**

AREA	OCCUPATIONAL PROFILE				
	PROFESSIONAL/ MANAGERIAL %	TEACHER/ NURSE	SEMI- SKILLED	UNSKILLED	OTHER
HOUSING (n=95)	3.4	13.6	8.5	67.8	6.7
SITE C (n=211)	0	1.6	6.5	91.0	0.9
SITE B (n=268)	0	1.2	4.9	93.9	0
GREEN- POINT (n=82)	0	6.0	6.0	88.0	0

# Activities in the informal sector

Figure 11



### 5.3.2.5 Other factors

#### Head of household status

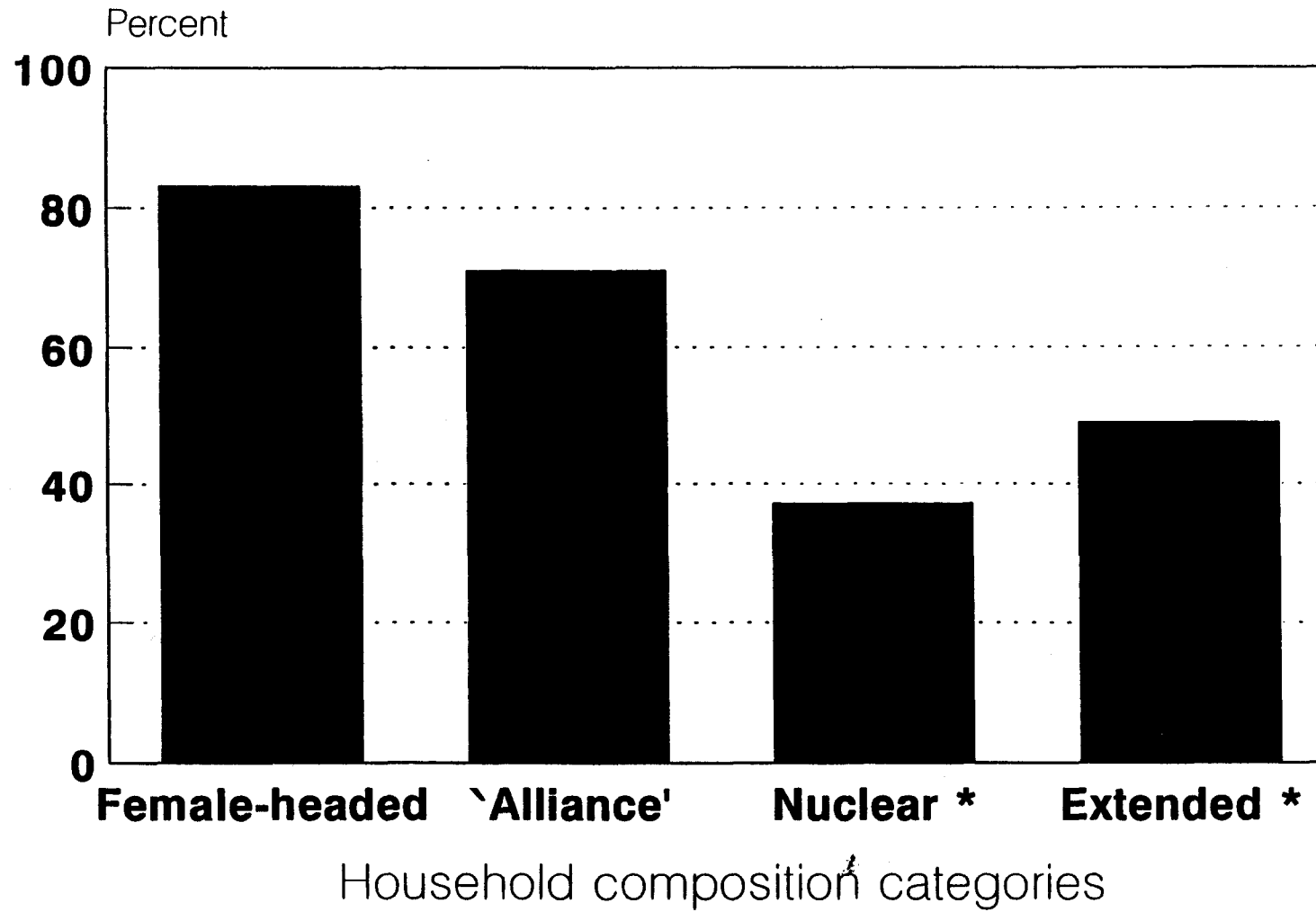
A significantly greater proportion of women living in female-headed households had been born in an urban area ( $n=26,22\%$ ) than women in other household categories ( $X^2 = 4.67; df=10; p = 0.030$ ). Female-headed households were significantly less likely to have a home ( $n=56,47.5\%$ ) or livestock ( $n=11,9.3\%$ ) than women in other household categories ( $n=350,72.3\%$  and  $n=119,24.6\%$  respectively and  $X^2=26.69, p=0.000, df=2$  and  $X^2=13.06, p=0.0003, df=2$  respectively).

While the overwhelming majority of families lived in informal housing, a significantly larger proportion of female-headed households lived in formal housing ( $n=26,22\%$ ) than women in other household categories ( $n=53,10.9\%$ ) ( $X^2=10.28; df=6; p=0.001$ ). A significantly larger proportion of women found in female-headed households were 35 years or older ( $n=83,70.3\%$ ) than women in the other household categories ( $n=187,38.6\%$ ) ( $X^2 = 38.77; df=2; p = 0.000$ ).

The level of income of all the women was extremely low irrespective of household composition. When the income of the male spouse was added to that of the female respondent nuclear and extended households had a significantly smaller proportion of households in the R0-423 income category than female-headed households ( $X^2 = 43.5; p0.0001$ ).

# Household joint income in R0-R400

(n=289) Figure 1 2



(\* excl if ptr income miss)

## 5.4 DISCUSSION

The phenomenon of individuals and families living in 'backyard' shacks (common in the other African residential areas of Cape Town) was uncommon in all areas of Khayelitsha. The relatively low density of people per dwelling (4.9) in all areas of Khayelitsha, confirms other findings on household size in this area<sup>1</sup>. The average household size in Khayelitsha is slightly higher than the current average for peri-urban informal settlements in the Western Cape (4.1)<sup>2</sup>. By contrast, a study in other African residential areas in Cape Town (predominantly in formal housing) conducted by the Bureau for Market Research (BMR) in 1985 found a much higher density of 6.4 persons per household. This too is confirmed by a more recent study of household occupancy in formal housing areas<sup>2</sup>. This is probably due to the greater ease with which people could move off and build their own shack compared with building a formal house and the relative ease in obtaining a site in Khayelitsha, compared to other African residential areas<sup>3</sup>. The local authorities in Khayelitsha have been strong proponents of site-and service rather than of formal housing development. •

The Khayelitsha population has a youthful profile (77% under 35 years of age). The relatively low proportion of children resident in Khayelitsha may be a consequence of the large numbers of respondents who send their children 'back home' for childcare and schooling.

A much higher proportion of people resident in Khayelitsha lived in shacks than the national average for urban African people (86% as opposed to 30.7%)<sup>2</sup>. Almost a third (31.7%) lived in unserviced informal housing. This places pressure on services such as housing, water supply, sanitation and refuse removal in the serviced areas. Living in environmental conditions such as exist in the unserviced areas has major implications for the spread of communicable diseases in these areas.

\* *As described in chapters 1 & 3, Khayelitsha consists of formal housing (brick or concrete structures) and informal housing (shacks made of corrugated iron or some temporary material.) The informal housing areas predominate and consist of serviced informal housing (site-and-service) and unserviced informal housing. In the former, the local authority demarcates a site or stand on which a shack can be erected and provides services such as water, sewerage and garbage removal. In the latter, shacks are not erected on a demarcated site and none of the abovementioned services are provided.*

The high proportion of female-head of households is notable and confirmed by other studies<sup>4,5</sup>. A similar proportion is represented for African people, nationally (23.8%) for the under 64 year age group. This rises to 31.3% if all age groups are included<sup>2</sup>. There may be a concentration of the single parent family units in poorer peri-urban areas such as Khayelitsha.

In line with another study in South Africa<sup>5</sup> and international trends discussed in Chapter 2, the findings showed that women in woman headed and 'alliance' households (single women) appeared to be economically worse off than those in nuclear and extended households. This has potentially adverse effects on health<sup>5,6</sup>.

Higher levels of education ( 7 years and above) were found compared with an earlier study in Khayelitsha<sup>1</sup>, but this may be due to the inclusion of the housing area in this study. There were higher levels of education amongst women in Khayelitsha than for African women over 14 years of age, nationally, where 21.6%, 32.6% and 45.8% have no schooling, some level of primary schooling and some level of high school education respectively<sup>2</sup>. This is probably due to the inclusion of rural women in the national figure.

The lack of significant differences in educational levels of respondents, based on length of stay in an urban area may be due to an age effect, as younger people generally have significantly higher levels of education<sup>7</sup>. The low levels of after school training confirms the historical lack of access to skills training by Black South Africans, particularly those in lower socio-economic groups. As noted in Chapter 2, women in South Africa are particularly disadvantaged with respect to obtaining tertiary education. Table 7 reflects the gender related nature of vocational training with most women having received training in traditionally 'female' areas.

Official national estimates of unemployment during the period of the study, excluding the former 'homelands', ranged between 25 and 54 %, depending on the definition of unemployed<sup>8</sup>. The proportion of unemployed women in Khayelitsha was high. A disproportionate number were young, new arrivals who lived in the informal housing areas. The 1993 national figure for unemployment was even higher, with only 27% of African women in the age groups 16-64 working<sup>9</sup>. This latter figure is likely to be inflated by the inclusion of rural areas in the sample.

Most formal employment amongst women was in domestic service. The low income, poor working conditions and low status involved in this sector has been widely documented<sup>3,9</sup>. An increasing number of younger, newer arrivals had entered factory employment.

The predominance of marginal retail activities in the informal sector, associated with arduous work, low income and a 'hand to mouth' type of existence, suggests that thus far, informal sector employment has not been an adequate solution to unemployment<sup>10,11</sup>. Subsequent quantitative and qualitative studies have confirmed these findings<sup>12</sup>. Substantial changes in the allocation and re-allocation of resources and training in the informal sector and affirmative action for women in particular, is needed in this area.

Despite this, and taking into consideration the limitations of collecting income data in household surveys, those employed in the informal sector did not appear to be worse off in terms of income than those employed in the formal sector. While this may at first sight appear to be counterintuitive, it may be understood in terms of the wide-spread poverty amongst women in Khayelitsha. More than 90% of respondents earned below the extremely meagre, Minimum Living Level

\* This includes all employment - regular, casual and self-employment.

of R570.81 a month for the Cape Peninsula for the last quarter of 1990'. Most women in formal sector employment were in domestic service which has notoriously poor conditions of employment. A 1981 survey of domestic wages revealed that average earnings for women in Domestic Service in Cape Town were R74 per month<sup>9</sup>. No updated information is available currently on average wages. In 1994 wages of full-time domestic workers ranged widely between R150-500 per month<sup>10</sup>.

Khayelitsha's class structure is heavily weighted towards the lowest social strata, apart from the relatively small housing area population, and could well be operating as a 'social sink' where the poorest individuals (particularly single women) end up.

The vast majority of women had been born or grew up in a rural former 'homeland' and had therefore experienced rural-urban migration. Our findings confirm the suggestion made in Chapter 2 that influx control laws did little to halt migration to the cities, despite the extreme hardship it imposed on African people migrating, as most migration occurred prior to its abolition. These findings are in line with another study in Khayelitsha<sup>1</sup>.

A significant minority of respondents (30%) had, however, migrated from outside Cape Town, mostly from the former Transkei in the five years preceding the study. This migration is likely to have increased in recent years. New arrivals to the urban area were young, mostly unemployed and lived in the worst environmental conditions. The largest percentage of women who migrated in the five years preceding the study, lived in the informal housing areas and were concentrated particularly in the unserviced site areas (47.6%). A study identifying children at risk in the Cape Town area<sup>13</sup> found that carers of children in the unserviced site areas were least informed about immunization, least visited by

<sup>9</sup> *Personal communication, Labour Research Service, Cape Town*

<sup>10</sup> *Personal communication, Domestic Workers Association, Cape Town*

a Community Health worker and had least knowledge about treatment of diarrhoea. These are therefore important target areas for a study of the health effects of urbanisation and for possible interventions.

The small number of women who moved from Cape Town to a former 'homeland' indicates that migration of women from an urban centre to the former 'homelands' appeared to be uncommon.\*\* The results also showed limited circulation of people within the former 'homelands'. Hence, people tended to stay in their area of birth before making a move to an urban centre. Knowledge of these patterns of movement have important bearing on where it is most appropriate to provide various services such as health services for under 6's and services for the aged.

The fact that Crossroads constituted an important **prior** area of residence for respondents reflects the fact that the history of Khayelitsha is bound up with that of Crossroads as described in Chapter 1. Many residents fled Crossroads to Khayelitsha, during the fighting of 1986<sup>15</sup>.

The findings on the areas of Cape Town in which women were born underscores the effects of the Group Areas Act, which forcibly removed African people from their original places of residence to designated African townships.

The fact that women from Lady Frere tended to live in certain areas of Khayelitsha, may indicate that kinship is a determining factor in women's migration destinations, with women moving to a base where relatives or friends from 'back home' live.

\* *It is assumed that this reflects movement away for long periods. Patterns of oscillation are complex<sup>14</sup> and movement for short periods to visit relatives, attend events such as funerals and so forth were not explored. In addition, perceptions of what constitutes a 'move' may also have affected the results. For example it is unknown whether returning to a rural area to get assistance with the care of infants is seen as a 'move'.*

\*\* *Only one respondent who had been born in Cape Town reporting moving to live in a former 'homeland' before moving to Khayelitsha.*

Substantial ties to the rural areas in terms of relationships, attitudes and property, even for the most urbanised were identified. Many of those who had spent most of their lives in an urban area, still sent remittances to the former 'homelands'. This underscores the fact that the African urban population constitutes a major source of social welfare for those who remain in the rural areas, especially for the young and the aged. This practice reflects the absence of adequate state social security, particularly in rural areas.

The study documents the practice of sending children to a rural area for childcare and for schooling, away from the turmoil that has characterised black education in the cities during the apartheid era.

A strong relationship emerged between area of residence, and the indicators of urbanisation. Those in the housing area were more likely to have been born in Cape Town or another urban area and had a longer length of stay in an urban area. They showed a greater orientation toward life in Cape Town and weaker links with the rural areas.

Women in Khayelitsha were disadvantaged socially, economically and politically. The study identified the poorly serviced and unserviced areas in Khayelitsha as accommodating a particularly disadvantaged population. In addition to occupying the lowest socio-economic status, they were the youngest and most recent arrivals to the urban area. They were most likely to be vulnerable to disease and to have had least access to health knowledge and health services **16,17,18,19,21**.

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## 6.1 INTRODUCTION

The preceding chapter described women's socio-demographic and economic status. This chapter describes aspects of the health status, knowledge and utilisation of health services and health knowledge of women in Khayelitsha. The chapter following this one examines the relationship between the two, viz. women's health and their socio-economic status.

## 6.2 METHODS

The statistical methods of analysis used are described in detail in Chapter 3.

Table 1 shows the data collected for health status, knowledge and use of health services and health knowledge:

### **TABLE 1 HEALTH DATA**

- whether respondent had been pregnant
- number of pregnancies
- age at first pregnancy
- pregnancy outcomes
- loss of a live-born child
- place of birth of last born child
- use of contraception
- type of contraception used
- attendance of ante-natal care
- intended and actual use of health services when ill
- incidence of acute, chronic and gynaecological illness
- types of acute, chronic and gynaecological illness
- awareness and experience of cervical smears
- knowledge of where to go for various health needs
- awareness and knowledge of AIDS and its prevention.

All data were gathered from reported information from respondents. Details on how the above variables were defined are contained in Chapter 3.

Univariate analyses were conducted to provide frequency distributions, means, medians and the ranges of different variables. Illness data was analysed using the International Classification of Health Problems in Primary Care (ICHPPC) system. (Oxford University Press, Third Edition, 1983)

Illness data was transformed from alpha numeric coding to numeric coding.

A health profile of women was obtained by univariate analysis. Certain health variables of interest were examined to determine significant associations with other health variables through bivariate analysis.

## **6.3 RESULTS**

### **6.3.1 REPRODUCTIVE HEALTH**

#### **Fertility**

Of the 659 respondents 95% had been pregnant. The number of pregnancies ranged from 1 to 15. The mean number of pregnancies was 3.82. Of the 625 women who had been pregnant, 15% (n=92) had had 1 pregnancy, 63% (n=396) had had 2 to 5 pregnancies, and 22% (n=137) had had more than 5 pregnancies. The total fertility rate (TFR\*) for the sample was 4.64.

Of all pregnancies 91% (n=2116) resulted in live births, 6% (n=144) in miscarriages and 3% (n=61) in stillbirths.

\* The total fertility rate (TFR) is defined in Chapter 2.

Of the last child born to 595 respondents, 69% had been born in Cape Town and 31% in a 'homeland'. Of these, 84.5% had been born at a health facility and 15.5% at home. As can be seen in Figure 1, only 3.9% (n=16) of the children born in Cape Town were born at home as compared to 41.5% (n=76) of those born in a 'homeland' ( $X^2=139.39$ ,  $p=0.000$ )

### **Teenage pregnancy**

The age at first pregnancy ranged from 13 years to 38 years, with the mean age of first pregnancy being 19.8 years. As can be seen in Figure 2, more than half (53%) of the women reported having had their first pregnancy before the age of twenty years. Nearly a quarter (24%) had had their first pregnancy at the age of 17 years or younger.

### **Infertility**

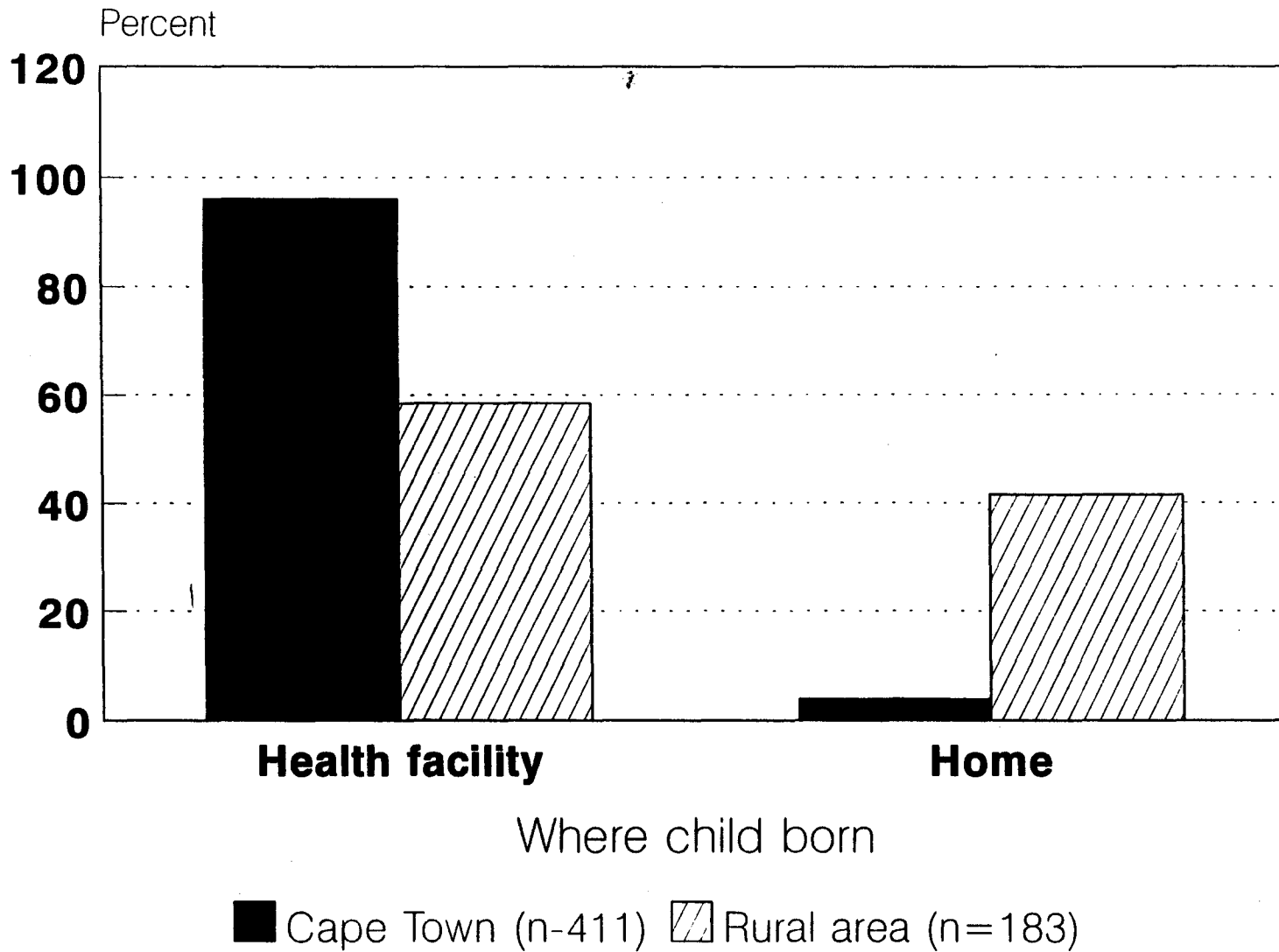
Of the 298 women not on contraception,\* 57 (19%) reported difficulties falling pregnant. Thirty-one women (54%) had not had a pregnancy in the previous five years. Of all women experiencing difficulty falling pregnant, 74.7% had sought help from a doctor and 6.9% from a traditional healer. Nine percent had not sought any help.

\* In all the bivariate analyses presented in this Chapter, unless otherwise stated,  $DF=1$  throughout.

\* \* These included women who reported not using contraception at the time of the interview.

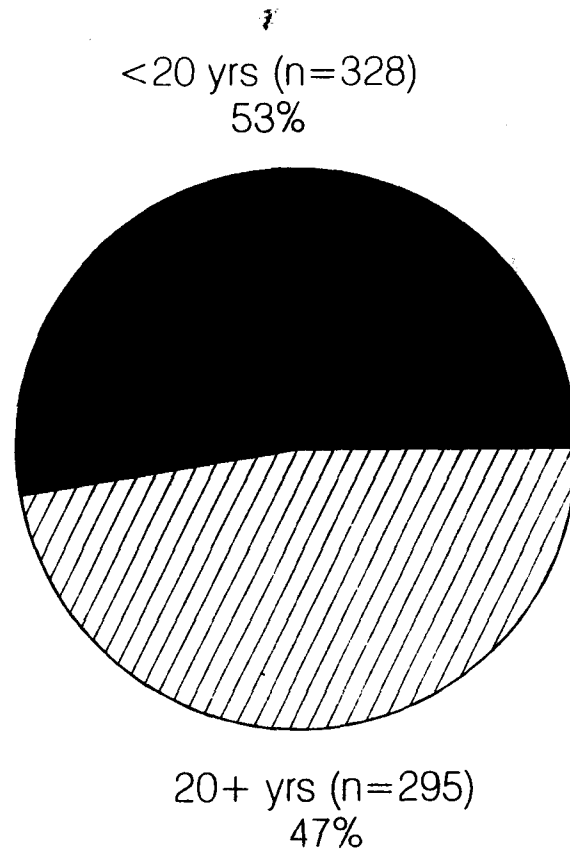
# Place of birth of last born

## Figure 1



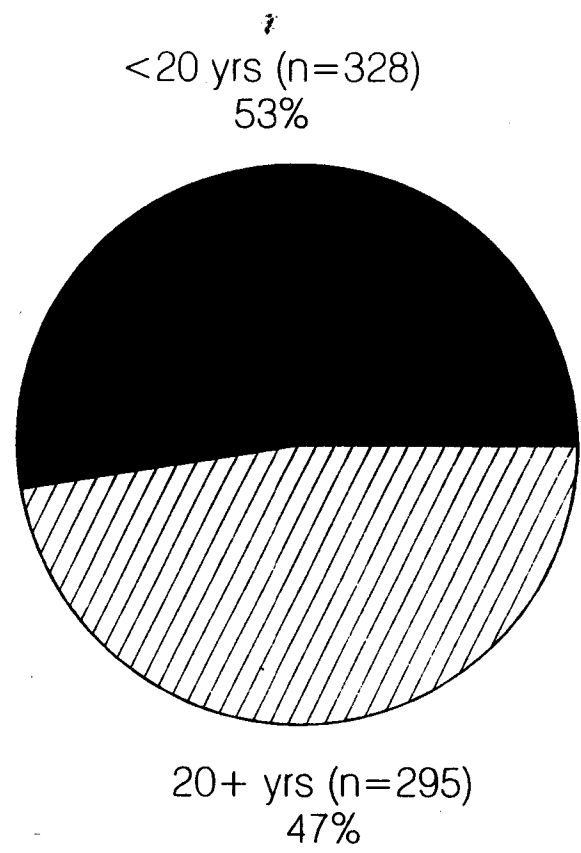
# Age at first pregnancy

## Figure 2



# Age at first pregnancy

## Figure 2



### **Gynaecological illness**

Of the 659 respondents, 117 (18%) reported that they had received treatment for gynaecological illness over the preceding three months. As can be seen in Figure 3, the prevalence of the commonest gynaecological problems were 9.4% for pelvic inflammatory disease, 2.7% for abdominal pain, 1.8% for vaginal infections, 1.4% for urinary tract infections and 0.9% for menstrual problems.

### **Loss of a liveborn child**

More than a quarter of women (28%) had lost a liveborn child at some stage of their lives. As can be seen in Figure 4, child loss increases with the number of pregnancies. ( $X^2$  for trend = 119.09,  $p < 0.001$ )

## **6.3.2 ILLNESS**

### **Acute illness**

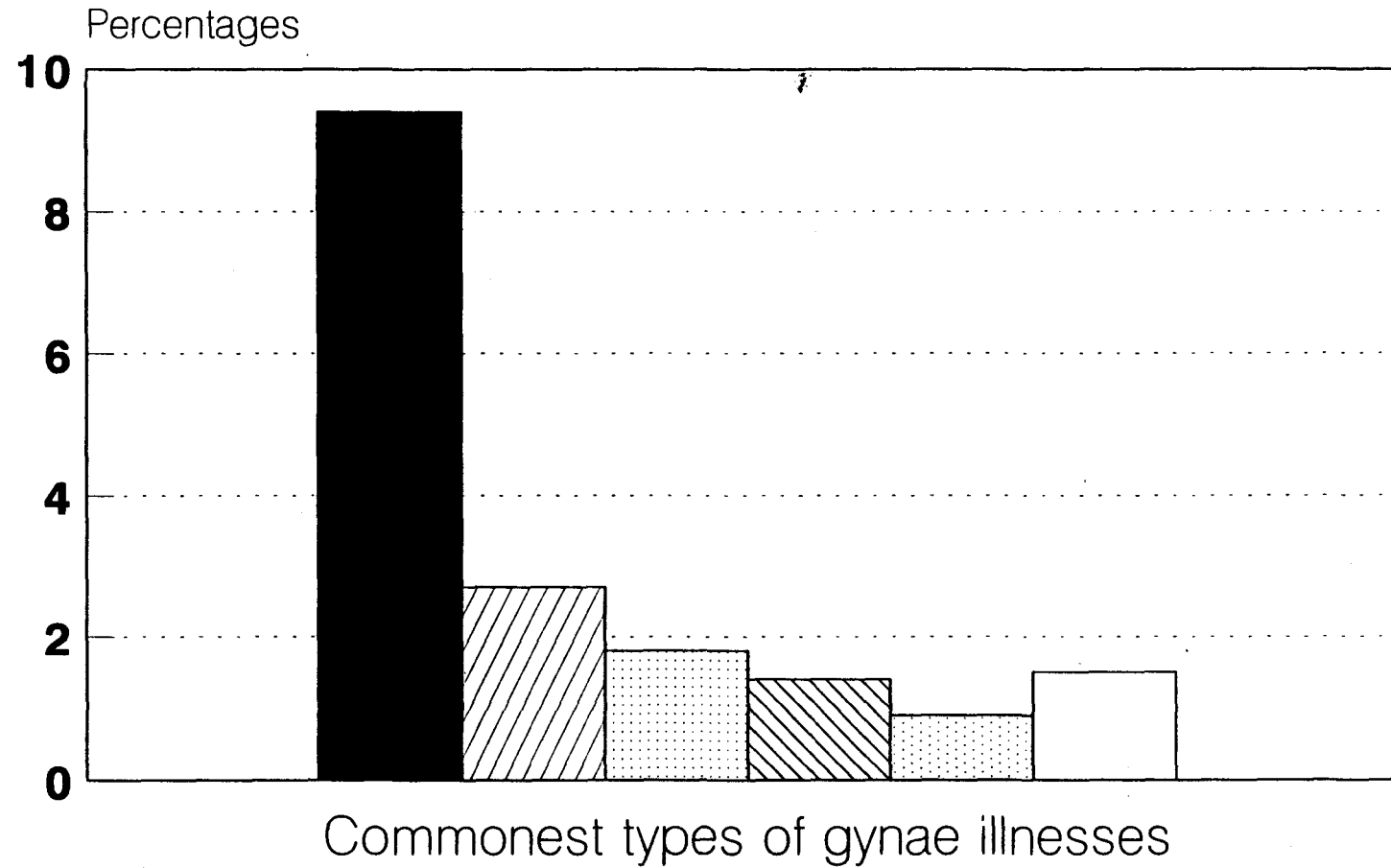
Of the 659 women, 51 (7.6%) reported acute illness. Respiratory tract infections (tonsillitis, bronchitis, asthma, coughs and influenza) constituted 29.4% of all illnesses.

### **Chronic illness**

Thirty-three (5.0%) women reported chronic illness. Hypertension (14 cases) was most common giving a prevalence of 2.1% followed by diabetes (3 cases) with a prevalence of 0.5%. There were only 2 cases of tuberculosis reported amongst the 33 women reporting chronic illness.

# Prevalences: gynae illness

## Figure 3



■ PID

▨ Abdominal pain

▤ Vaginal infections

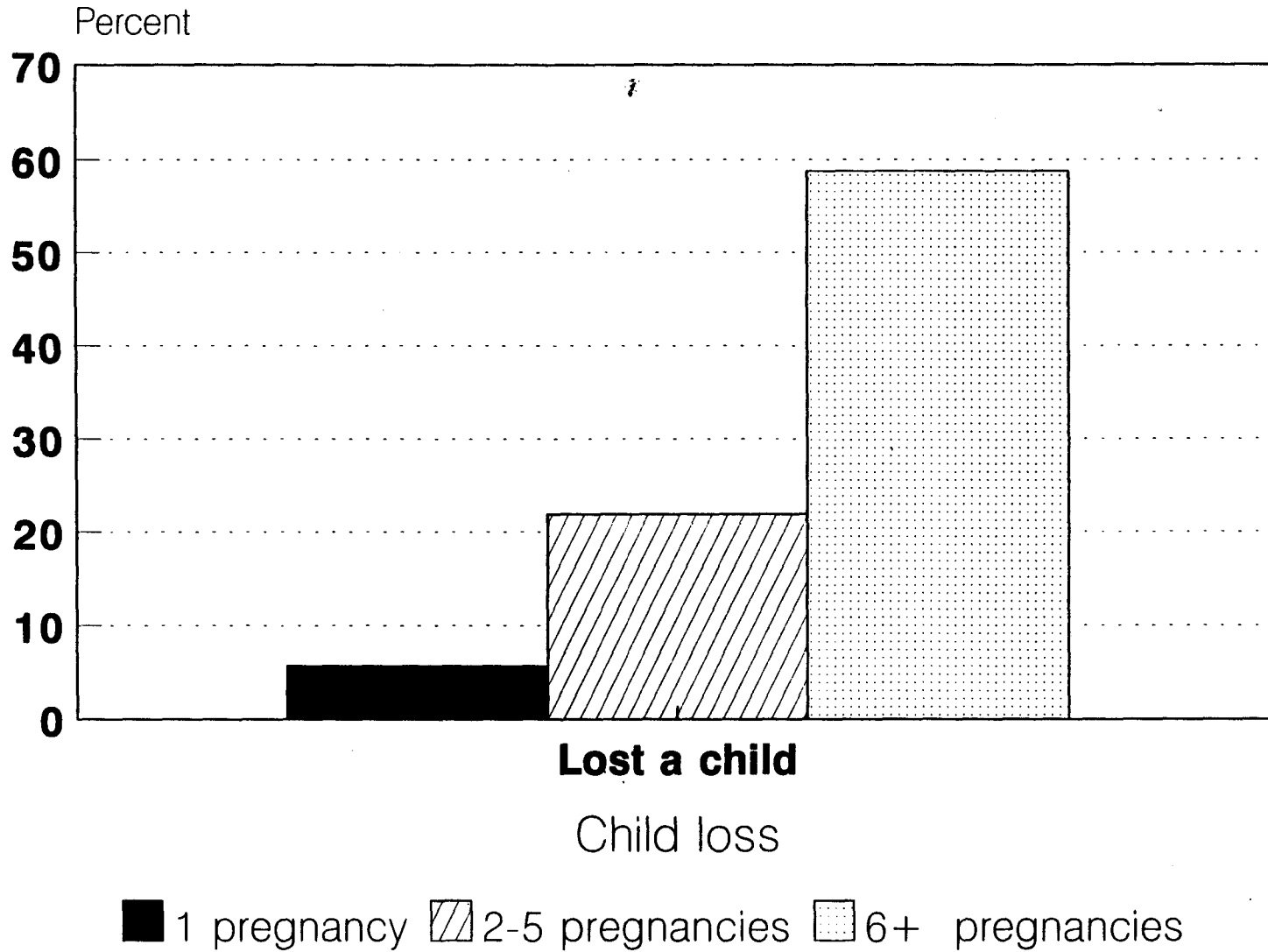
▧ Urinary tract infec

▥ Menstrual problems

□ Other

# Child loss and number pregnancies

## Figure 4



### 6.3.3 USE OF HEALTH SERVICES

#### **Attendance of Ante-natal care**

Of the 397 women who had been pregnant over the preceding five years, 373 (93.9%) had attended ante-natal care at some stage during the pregnancy\*.

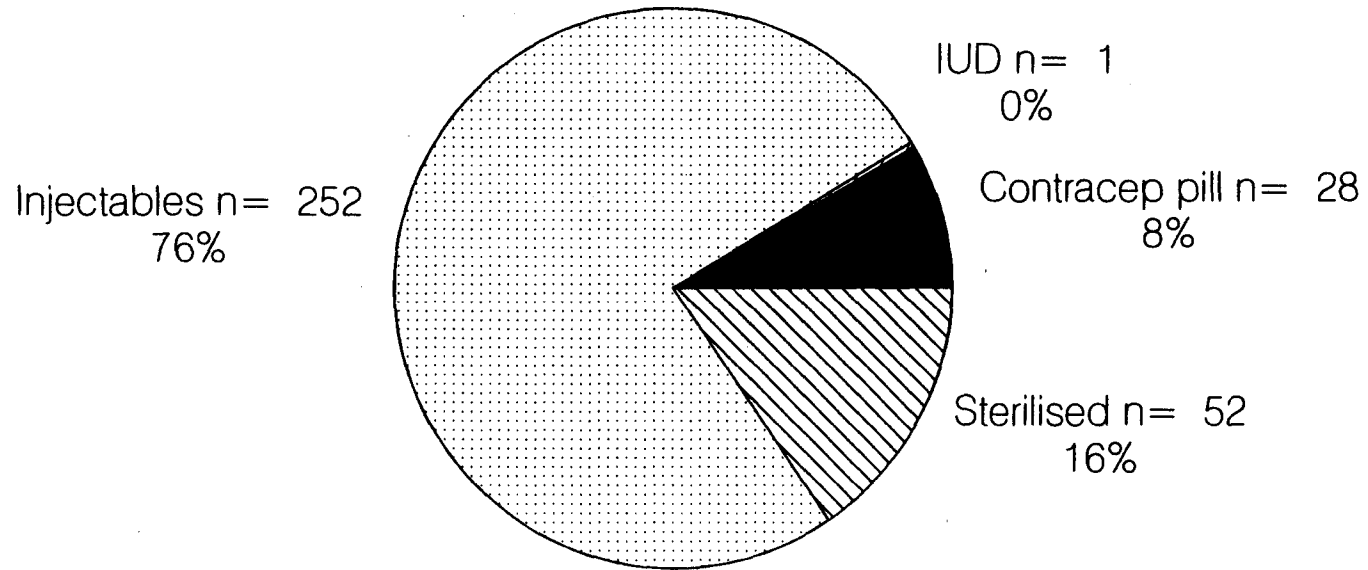
#### **Contraceptive use**

Of the 565 respondents of childbearing age (15 - 45 years), 320 (56%) were practicing some form of contraception. As can be seen in Figure 5, of these, 76.2% reported using intramuscular hormones, 15% had been sterilized 8.5% used the oral contraceptive pill, and 0.3% used an intrauterine device. No condom usage was reported as a contraceptive method.

\* *This does not reflect how early in their pregnancy, how often they attended or on the quality of such care.*

# Types of contraception

## Figure 5



### General health service use

Responding to a hypothetical question as to where they would go if ill, Table 2 shows which health services respondents would use.

TABLE 2

#### CHOICE OF HEALTH SERVICES TO USE WHEN ILL

	<u>No.</u>	<u>%</u>
Hospital	76	11.7
Day Hospital/clinic	452	69.6
Private doctor	110	17.0
Non-governmental health organisation (Philani, SACLA, Shawco)	5	0.8
Traditional healer	2	0.3
Other	<u>4</u>	<u>0.6</u>
<b>TOTAL</b>	<u>649</u>	<u>100.0</u>

As can be seen in Figure 6, the three commonest reasons for choosing a facility was because it was the cheapest (27%) or the nearest (22%) or because it were both cheaper and nearer (5%).

The high proportion of respondents who gave the reply that they used a particular health service in order to be cured reflects a misunderstanding in the meaning of the question. This answer should therefore be disregarded.

In cases of reported acute illness, 70.2% used a public service and 29.8% a private service. In the case of chronic illness this was 93.8% and 6.3% respectively. Most women reached the health services by walking or using a taxi.

Of the women reporting acute illness, 45.1% (n=23) used taxis and 35.4% (n=21) walked. In the case of chronic illness, 63.6% (n=21) used a taxi and 13.3% (n=6) walked.

Most women took no longer than half an hour to reach a health service in the case of acute (n=26,51%) and chronic illness (n=18,54.6%). Out of the total of 84 women who had experienced acute or chronic illness, 16.6% (n=14) took 1-2 hours and 2.3% (n=2) more than two hours.

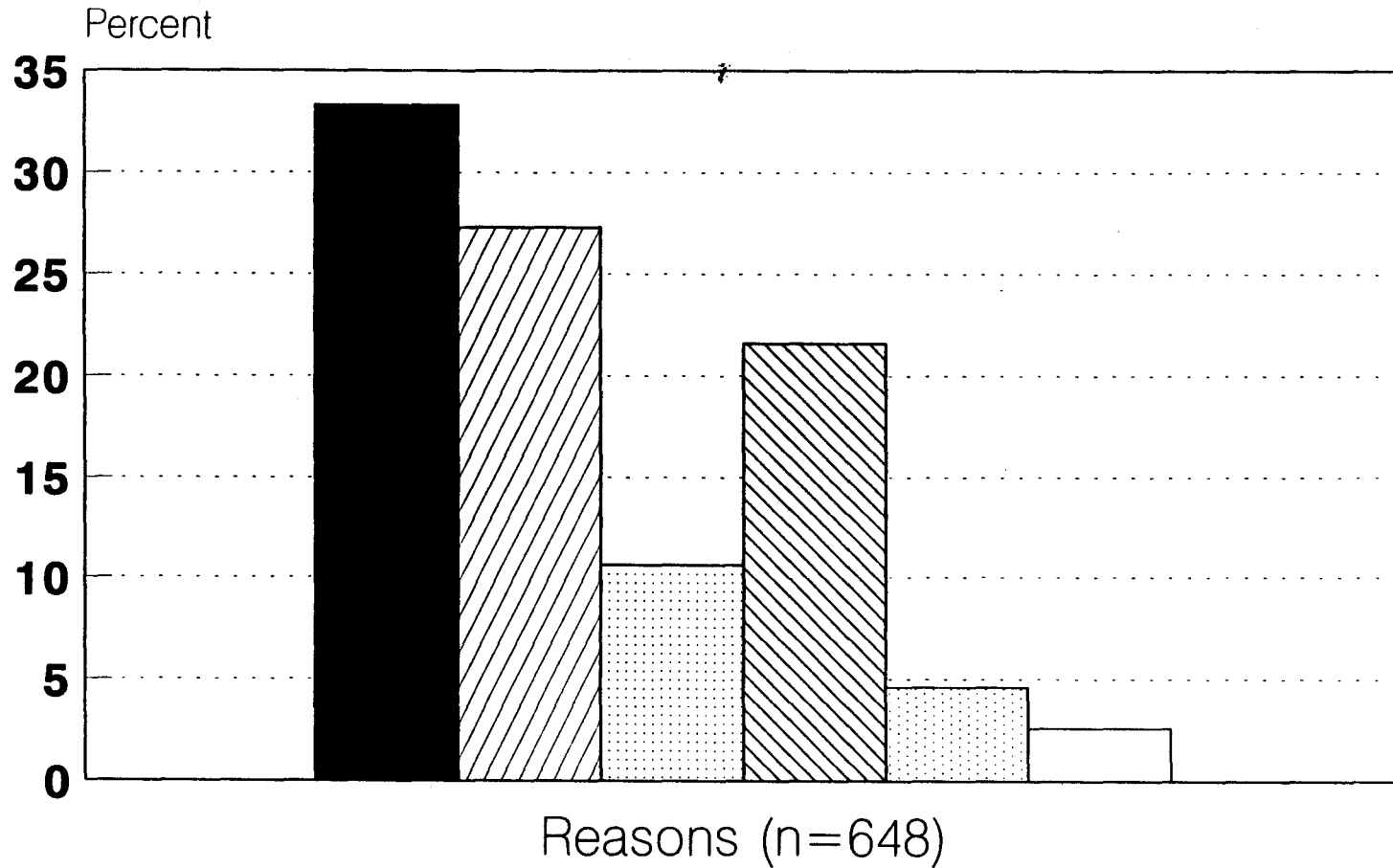
Reflecting the fact that most women walked to a health service, 45% reported not paying for transport, 23.3% paid less than R3 and 2% more than R9. In the case of acute and chronic illness, 12.5% did not pay for visits to a health service. Fifty-six percent and 78% paid less than R3 and 2% and 6% paid less than R9 in the case of acute and chronic illness respectively.

### **Knowledge of where to go for services**

Most women knew where to go for key services as can be seen in Figure 7. However, a high proportion of respondents did not know where to go for a cervical smear (n=223,33.8%).

# Reasons: choice of health service

## Figure 6



■ To be cured\*

▨ Cheaper

▤ Good quality care

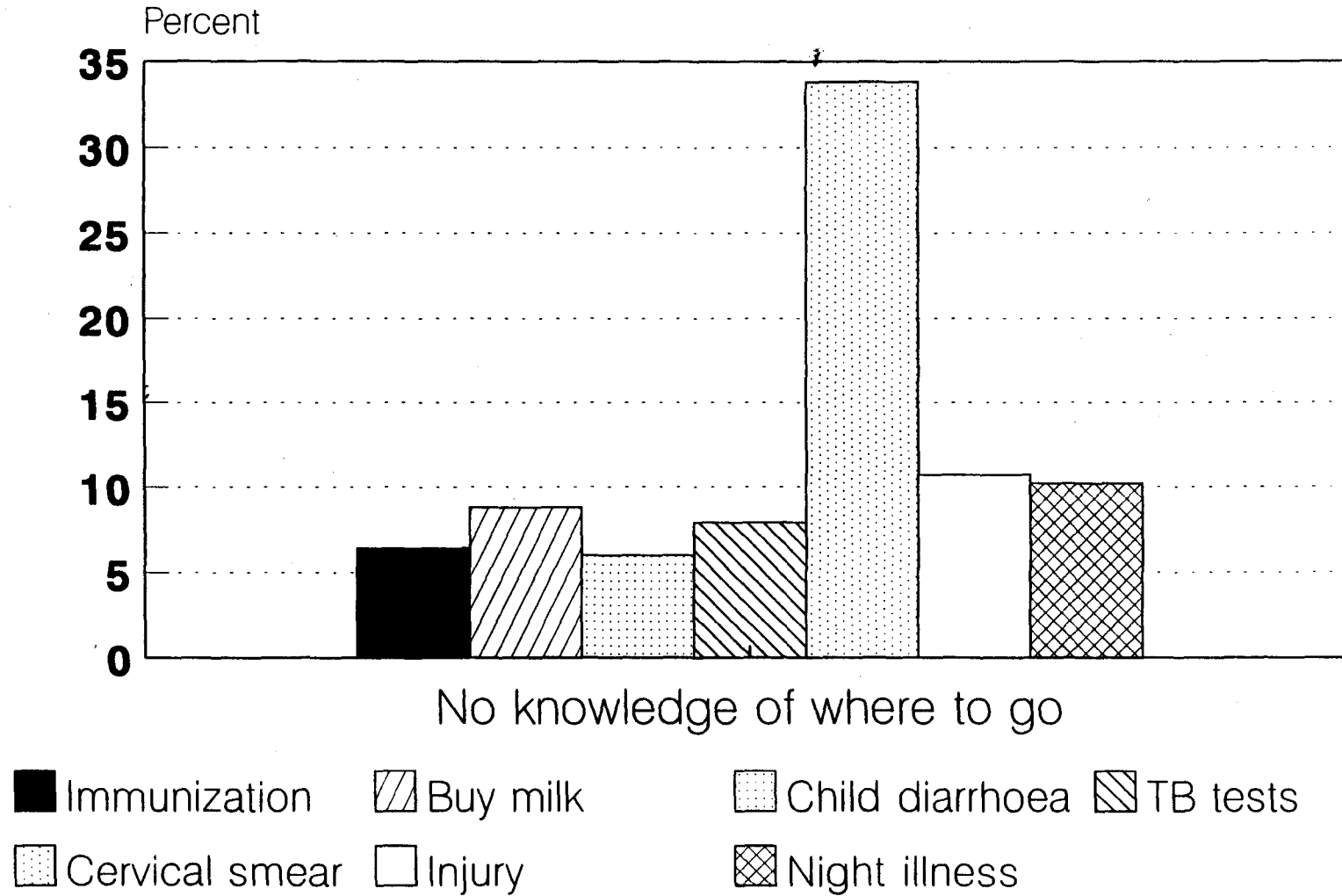
▩ Nearer

▦ Nearer and cheaper

□ Other

# Knowledge of health services

## Figure 7



(n=658)

### 6.3.4 HEALTH KNOWLEDGE

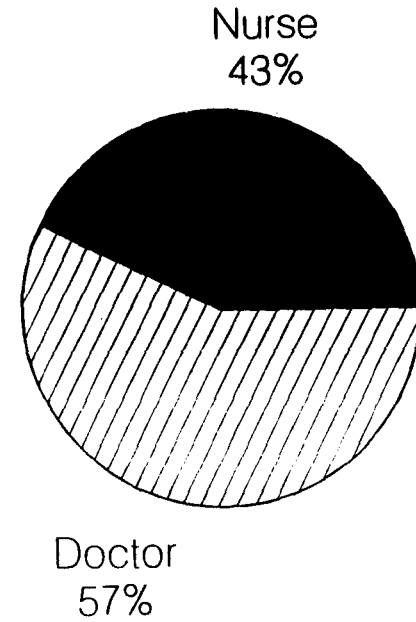
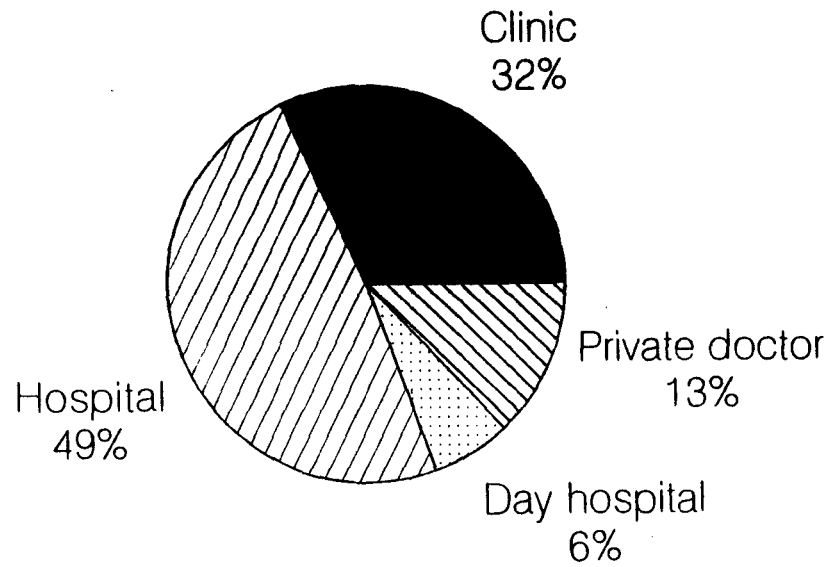
#### Awareness and knowledge of AIDS

A high percentage of respondents (86%) had heard of AIDS. However, respondents displayed poor knowledge of AIDS and its prevention, as can be seen in Table 3.

**TABLE 3 KNOWLEDGE OF AIDS**

	<u>No.</u>	%
Don't know	309	53.8
Dangerous, kills, incurable, infectious	118	20.6
Transmitted through having multiple partners	25	4.3
Incorrect knowledge (kills cells, through kissing, rash, disease, homosexually)	<u>122</u>	<u>21.3</u>
<b>TOTAL</b>	<b><u>574</u></b>	<b><u>100.0</u></b>
 <b>HOW TO PREVENT AIDS</b>		
	<u>No.</u>	%
Don't know	298	52.3
Discourage sex/engage in protected sex	28	4.9
Use condoms	3	0.5
Doctors must find cure/vaccine	26	4.7
Seek medical advice	184	32.3
Need information	10	1.8
Other	<u>20</u>	<u>3.5</u>
<b>TOTAL</b>	<b><u>569</u></b>	<b><u>100</u></b>

# Where cervical smears performed (n=343\*) Figure 8



By whom (n=341\*)

### **Knowledge and experience of cervical smears**

Almost half (n=295, 44.8%) of the respondents had heard of a cervical smear and cervical smears had been performed in 44.7% (n=252) of cases. Figure 8 shows where and by whom cervical smears were performed.

### **6.4 DISCUSSION**

Till recently, fertility has been an emotive political subject internationally particularly in developing countries where it has been underscored by demographic imperatives of population control.

In many developed and developing countries the age of menarche has decreased (due to improved nutrition and other improvements in health status) and young people may be sexually active for a lengthier period in their teens, often without access to sex education or contraception<sup>2</sup>. In South Africa, teenage pregnancies have become increasingly common and those who fall pregnant are generally of lower socio-economic status and single<sup>3</sup>. \* The associated health risks for the young mother and child have been well described<sup>4</sup>. They include an increased incidence of stillbirth, low birth weight and other post-natal complications for the baby. The impact on the mother's health includes an increased risk of hypertension, difficult labour and cephalopelvic disproportion and almost double the risk for maternal mortality than for women between 20-24 years old<sup>3</sup>.

The total fertility rate (TFR) for the sample was found to be similar to the national figure of 4.4<sup>1</sup>

Teenagers accounted for more than half of first pregnancies in the study sample.

\* *There are insufficient data to determine the reasons for the increased tendency towards teenage pregnancy within the context of this study.*

It was surprising to find in these results that the age at first pregnancy was not related to an increase in the number of pregnancies that women had had. This is in contrast to findings of studies done elsewhere in Africa and developing countries<sup>5,6</sup>.

A higher proportion (19%) of women in the study reported problems with infertility than the national average of 12% for African people<sup>3</sup>. Research in developing countries has focussed primarily on population control and family spacing. Non-governmental agency health workers in informal housing areas of Town 2, Khayelitsha, report infertility as a common problem for consultation<sup>4</sup>. The cultural and social implications for women relating to infertility have been described in Chapter 2. Reproductive tract infections which include sexually transmitted diseases (STDs), endogenous and iatrogenic infections<sup>\*\*</sup> are estimated to cause 50-80% of infertility in Sub-Saharan Africa<sup>7</sup>. STDs can cause tubal scarring or blockage, leading to infertility. Approximately 15-20% of women who develop pelvic inflammatory disease become permanently infertile<sup>8</sup>. In South Africa 57% of infertility cases referred to centres dealing with assisted reproduction are due to tubal infertility (primarily as a result of tubal infections). Services for infertility are extremely limited in the Western Cape with referrals for investigation being made only to the two teaching hospitals, Groote Schuur and Tygerberg. The waiting list for in-vitro assisted reproduction at Groote Schuur is currently one year<sup>\*\*\*</sup>.

Investigation of perceptions of infertility and the restructuring of health services to deal with the problem will have important bearing on family planning and STD programmes.

\* *Personal communications: Drs M Mofokeng and J Moodley, Zibonele Women's Wellness clinic and Women's Wellness workers, Masikhayise Women's Wellness Project*

\*\* *Endogenous infections are those which occur due to an overgrowth of organisms which normally exist in the reproductive tract and iatrogenic infections are those which occur as a result of medical procedures.*

\*\*\* *Personal communication: Dr Carol Thomas.*

The high proportion of reported pelvic inflammatory disease (PID) amongst women in the study who reported gynaecological illness is of great concern and indicative in part of a hidden, sexually transmitted disease (STD) problem. For socio-economic, cultural and physiological reasons women are particularly vulnerable to STDs and HIV infection<sup>9,10</sup>. Women often lack access to education and health care, are frequently economically dependent on men, and are susceptible to sexual coercion by men. Women who are infected with STDs are often asymptomatic and hence go undiagnosed and untreated, till PID develops. While in many cases these diseases may be truly asymptomatic, in some cases this may be due to forbearance amongst women, who have been socialised to see pain and discomfort arising from their reproductive roles as normal. Subsequent research in Griffiths Mxenge in Town 2 of Khayelitsha highlights the existence of this large hidden STD problem. While 19% of women reported gynaecological illness, only 47.5% had sought treatment<sup>11</sup>. In addition, of the 93 women who participated in a cervical screening programme, 78% had reproductive tract infections the vast majority of which was sexually transmitted\*. Measures are needed to improve diagnosis and treatment of STDs, particularly in women.

A high proportion of women (28%) had lost a child. The infant mortality rate for Khayelitsha was 31.4 per 1000 live births, based on notified births and registered deaths<sup>12</sup>. A later study conducted in Griffiths Mxenge<sup>13</sup> in Town 2 of Khayelitsha found the IMR to be 29.9 per 1000 births and the under 5 mortality 40.9 per 1000 births. The major cause of death in this latter study was infection (60%). Of this, 40% was due to intestinal infection.

\*Personal communication: Karen Harrison, Zibonele Women's Wellness Project.

There is a strong relationship between greater parity and loss of a child. A number of other studies have demonstrated a positive relationship between infant and child mortality and fertility<sup>5</sup>. There may be several reasons for this. Loss of a child may lead to greater parity in that the mother seeks, albeit it unconsciously to replace a dead child by having more children. Conversely, greater parity (>3), particularly if children are born close together, reduces a child's chances of being born healthy and surviving the first few years of life<sup>14</sup>.

While a large proportion of women in the study who had been pregnant had attended antenatal care during their last pregnancy, the quality of this care and frequency of attendance is not known. A subsequent study in Khayelitsha found that teenagers were the poorest attenders of ante-natal care, often attending few times and late in their pregnancy<sup>11</sup>. Those attending ante-natal care frequently perceived its purpose as being to book for delivery rather than as a means of preventing complications in pregnancy and detecting those at high risk in childbirth. Further research is needed to assess the quality of ante-natal care and to determine obstacles to appropriate attendance in order that educational and other interventions can be planned.

The level of use of contraception was higher amongst women in the study than the national rate for women in South Africa (45%)<sup>15</sup>. The level of contraceptive use is higher for South Africa when compared with the rest of the sub-Saharan African region where this is often less than 20%<sup>3</sup>. This is likely to be a function of the extensive family planning infrastructure developed through the National Family Planning Programme from 1974 onwards. The approach in past South African family planning programmes was based on demographic goals of population control with strong racial overtones. This contrasts with an approach which would enable women and men to regulate their own fertility - to exercise choice over whether to have children, and if they desire children, when to have them and how many.

Use of injectable contraceptives in South Africa is extremely high. Current national estimates of use of injectables for African women, is that it constitutes 70-80% of contraceptive use<sup>5</sup>. The predominant use of injectable contraceptives in Khayelitsha is confirmed by this study. A study based at a family planning clinic in Khayelisha showed 96.7% use of injectable progesterone<sup>16</sup>. Anecdotal evidence suggests that many women choose intramuscular hormones due to limited or lack of informed choice, provider bias or because a sexual partner may object or fail to cooperate in the use of other methods<sup>6</sup>. Further research is needed in this area.

The low prevalence of acute and chronic illness is likely to reflect undiagnosed disease. Studies which conducted medical examinations rather than relying on reported illness bear this out. A study which measured blood pressure in the Western Cape found a prevalence of high blood pressure of 8.9% amongst African women in the 16-64 year age group as opposed to the 4.3% reported in this study<sup>17</sup>. A Glucose tolerance study in the Western Cape<sup>8</sup> showed similar differences in that a rate of 6% of diabetes was found compared with 0.5% in this study<sup>18</sup>. Hypertension and diabetes are often only diagnosed when they present with complications. The low number of reported cases of tuberculosis is clearly a reflection of the existence of much unrecognised and undiagnosed illness. The official rate of tuberculosis for this area was 541 out of 100,000<sup>12</sup>. The official rate is most certainly likely to be lower than the actual rate as it is based only on notified cases. A 1993 study showed a national rate of TB for African people of 26.8 per 1000 (2680 per 100,000) based on reported illness of individuals for the two weeks preceding the survey on which the study was based<sup>19</sup>.

\* *Personal communication, Helen Rees. Background document prepared for the steering committee of the WHO special programme of research, development and research training in human reproduction. 1994.*

The prevalence of acute and chronic illness was lower in this study than that found in community-based studies in other countries<sup>20,21,22</sup>. Some reasons for this may be underreporting of illness or stoicism rather than a truly low rate of acute and chronic illness. As only illness requiring a visit to a health service was reported, lack of access to a health service may also be a contributory factor. For example, a later study in Town 2 of Khayelitsha showed that a third of those with acute illness did not seek treatment<sup>11</sup>.

The fact that almost a third of respondents used private health services for acute illness represents a significant minority. Acute illness may need immediate attention, therefore overcrowding at the public health services and the difficulties of access at night may be explanatory factors. Perceived greater quality of care may also play an additional role in the use of private services. The reported low use of traditional healers, while similar to that of another national study where 2.9% of African urban women reported using traditional healers<sup>19</sup>, is likely to be inaccurate and may be due to reluctance by respondents to report on this.

The high profile of AIDS in the media, is reflected in the finding that a greater proportion of women were aware of AIDS than cervical cancer. The results also showed lack of knowledge of where to have a cervical smear done. Women in South Africa have a lifetime risk of developing cancer of the cervix of 1 in 32 and cancer of the cervix is the most common cause of death from neoplasms amongst women in South Africa, constituting 25% of cancer deaths amongst African women<sup>23,24</sup>. There is a need for the development of an appropriate cervical smear screening policy, substantial health promotion in this area, as well as the provision of services.

The high level of AIDS awareness was not matched by adequate knowledge of AIDS transmission and prevention. This, together with lack of condom use is of great concern. In 1993 South Africa was estimated to have a prevalence of HIV

infection amongst adult women of 4.69%. The Western Cape had a lower HIV prevalence than the rest of South Africa of 1.33%<sup>25</sup>. However, over a third of the HIV positive cases notified for the Western Cape were resident in Khayelitsha<sup>26</sup>. In addition, several studies have reported increasingly high rates of sexually transmitted disease (STD) in Khayelitsha<sup>11,27</sup>. STDs are a major co-factor in HIV transmission<sup>28</sup>. Underscoring women's greater vulnerability to contracting STDs and AIDS<sup>9,10</sup> are some of the same social and cultural factors which limit women's power over sexual behaviour in relationships and hence their ability to decrease risk. Appropriate clinic and community-based education is needed in the area of HIV and STDs for sexually active men **and** women. Improvement in diagnosis, management and control of STDs is an important health service priority.

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**CHAPTER 7**

**THE RELATIONSHIP BETWEEN WOMEN'S  
SOCIO - ECONOMIC AND STATUS AND  
THEIR HEALTH AND HEALTH BEHAVIOUR**

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## **7.1 INTRODUCTION**

Health is subject to a wide range of influences. Physiological and anatomical differences and the socio-economic, physical and political environment in which people grow up and live are all important determinants of health status. Socio-economic status is affected by factors such as occupation, income, education, the physical, social and biological environment, medical care, life style and culture. These factors all affect health status to varying degrees and in different combinations. Many of these factors have effects over the lifespan of an individual with events as a child influencing an individual's health as an adult.

Several studies report differences in mortality and morbidity on the basis of socio-economic status<sup>1,2</sup>, with people of lower socio-economic status having a shorter life expectancy and higher morbidity and mortality rates. Poverty is seen as a one of the major explanatory factors for differences in health status in that lower socio-economic groups live and work in a disadvantaged physical, social and psychological environment which increases their vulnerability to disease. They also have poorer nutritional status and less access to adequate medical care. Poorer health status perpetuates itself as less healthy individuals tend to remain at or move to lower socio-economic levels<sup>3</sup>.

While the poor may be more ill, as they are unable to buy sufficient food for adequate nutrition, housing to provide adequate uncrowded shelter and medical care and medicine when ill, the relationship between health and income specifically is inconclusive<sup>4</sup> indicating the need for the inclusion of a wider range of variables as indicators of poverty or lower socio-economic status.

Education can lead to people being better informed and therefore tends to have a positive relationship with health. People may be better able to recognise symptoms of ill health, practice better health maintenance habits and have better knowledge of the health care system<sup>4</sup>.

Physical aspects of the environment affecting health include light, heat and space. Crowded living conditions are a factor promoting the spread of communicable diseases.

As has been argued in Chapter 2, urbanisation may have important implications for health, affecting health status, knowledge and access to health services.

Chapter 2 describes the impact of poverty, the environment and social status on women's health, arguing that women and African women in particular, form a disadvantaged group in terms of all these factors. It is suggested that women who are new arrivals to a peri-urban area are particularly vulnerable in their health status.

This chapter relates to succeeding chapters as follows. Chapter 5 dealt with the socio-economic and demographic status of women living in Khayelitsha and the relationship of these variables with urbanisation status. Chapter 6 presented aspects of their health status, health knowledge and knowledge and utilisation of health services. Women's social well-being is described in Chapter 7 and the relationship between women's health and their social well-being examined in Chapter 8.

This chapter explores the relationships between women's health status, their health knowledge and their knowledge of health services on the one hand and their socio-economic and demographic status, in particular their urbanisation status on the other. It examines how these factors combine to affect their health. In addition it determines the relative importance of the variables affecting different aspects of health status, health knowledge and knowledge and use of health services.

The relationships between the following health and socio-economic variables were examined:

**TABLE 1 HEALTH OUTCOMES AND SOCIO-ECONOMIC VARIABLES**

VARIABLES	
<p><b>HEALTH OUTCOMES</b></p> <p><b>Reproductive</b>            -fertility (no of pregnancies)            -age at first pregnancy</p> <p>-infertility            (problems-falling pregnant)            -gynaecological illness</p> <p><b>Health Service knowledge and use</b>            -attendance of ante-natal care            -use of contraception            -use of health services when ill            -having had a cervical smear            -knowledge of where to go for a variety of health services</p> <p><b>Illness</b>            -chronic            -acute</p> <p><b>Health Knowledge</b>            -awareness and knowledge and prevention of AIDS            -awareness of cervical smears</p> <p><b>Other</b>            -place of birth of children            -loss of a live-born child</p>	<p><b>SOCIO-ECONOMIC VARIABLES</b></p> <p><b>Environmental factors</b>            -geographical area of residence            -and housing type</p> <p><b>Urbanisation factors</b>            -place of birth            -number of years in an urban area            -material and emotional rural ties</p> <p><b>Socio-economic factors</b>            -employment status            -age            -education            -household composition            -income</p>

## **7.2 METHODS**

Statistical analytic methods are described in detail in Chapter 3.

Chapter 5 presented the univariate results of the socio-economic outcomes. Chapter 6 presented the univariate results of health status, health knowledge and knowledge and use of health services outcomes.

In this chapter the relationship between socio-economic variables and health status, health knowledge and knowledge and use of health services are explored through bivariate and multivariate analysis.

Chapter 3 described the manner in which bivariate analysis was performed and the multivariate modelling process.

A list of all variables used in final models arrived at by the process described in Chapter 3 for the analyses presented in this chapter is given in Table 2 .

TABLE 2 VARIABLES USED IN FINAL LOGISTIC REGRESSION MODELS

<b>OUTCOME VARIABLES</b>
<p>High Gravidity (&gt;5 Pregnancies)            Had teenage pregnancy            Infertility (Had problems falling pregnant)            Had attended ante-natal care            Had had a cervical smear            Used a private doctor            Had had an acute or chronic illness            Was aware of AIDS            Knew of a cervical smear            Had lost a live-born child</p>
<b>EXPLANATORY OR CONFOUNDING VARIABLES</b>
<p>Rural ties (rural home)            Years spent in an urban area (urban years)            Urban or rural area considered to be home            Place of birth            Age            Education (years of formal schooling)            Household composition            Marital status            Area of residence            Type of housing            Employment status            Income (in earning categories)</p>

Not all explanatory or confounding variables were used in the multivariate models. Varying combinations were used in the different models, based on the the process of *a priori* selection and the results of bivariate analysis described in Chapter 3.

## **7.3 RESULTS**

### **7.3.1 REPRODUCTIVE HEALTH**

#### **7.3.1.1 Fertility**

Factors associated with a high number (more than five) of pregnancies included urbanisation status, environmental factors, education, marital status, income and age at first pregnancy\*.

As is shown in figure 1 the number of pregnancies increased with an increasing length of stay in an urban area.

Women who had spent more than 10 years in an urban area were significantly more likely (n=86,30.8%) to have had more than 5 pregnancies than women with less urban years (n=49,14.7%)

( $X^2 = 22.92$ ,  $p=0.000017$ )

However, the number of pregnancies also increased with stronger ties with the rural areas. Women who had a rural home were significantly more likely to have had more than 5 pregnancies (n=108,25.4%) than women without such ties (n=29,14.6%) ( $X^2 = 8.67$ ,  $p=0.003$ ). Women who were born in a rural area were significantly more likely to have had more than 5 pregnancies (n=128,24%) than those who were born in an urban area (n=9,9.9%) ( $X^2=8.28$ ,  $p<0.000$ ).

Women who had lived in the formal housing area were less likely to have had more than 5 pregnancies (n=18,19.6%) than women in informal housing (n=192,35.9%)( $X^2=8.31$ ,  $p=0.003$ ).

\* *In all the bivariate analyses presented in this Chapter, unless otherwise stated DF=1 throughout.*

As the level of education increased the number of pregnancies per woman decreased. No women with more than 10 years of education had more than 5 pregnancies. Women with less than 5 years of education (n=51,35.2%) were significantly more likely to have had more than 5 pregnancies than those with between 5 and 10 years of education (n=86,20.0%) ( $X^2=12.82$ ,  $p=0.00034$ ).

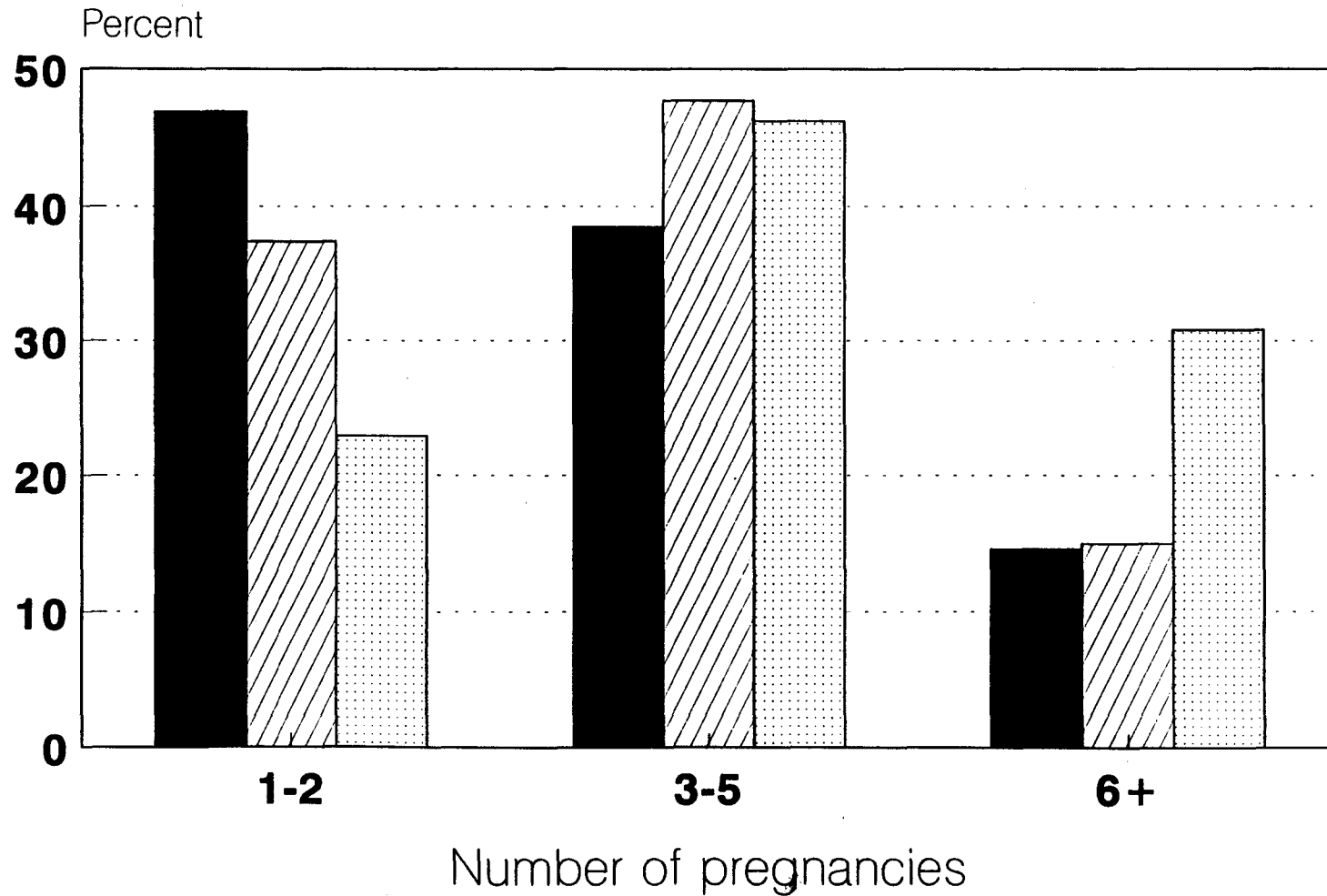
Figure 2 shows that the number of pregnancies increased with age.

As the level of income increased the proportion of women with more than 5 pregnancies decreased. Women who earned less than R400 per month were significantly more likely to have had more than 5 pregnancies (n=58,24.7%) than women who earned more than R400 a month (n=7,8.9%) ( $X^2=7.85$ ,  $p=0.005$ )

Marital status was associated with the number of pregnancies in that a significantly larger proportion of widowed and divorced women (n=28,37.3%) had more than 5 pregnancies than the rest (n=109,19.8%) ( $X^2=11.83$ ,  $p=0.00058$ )

# Urban years and number of pregnancies

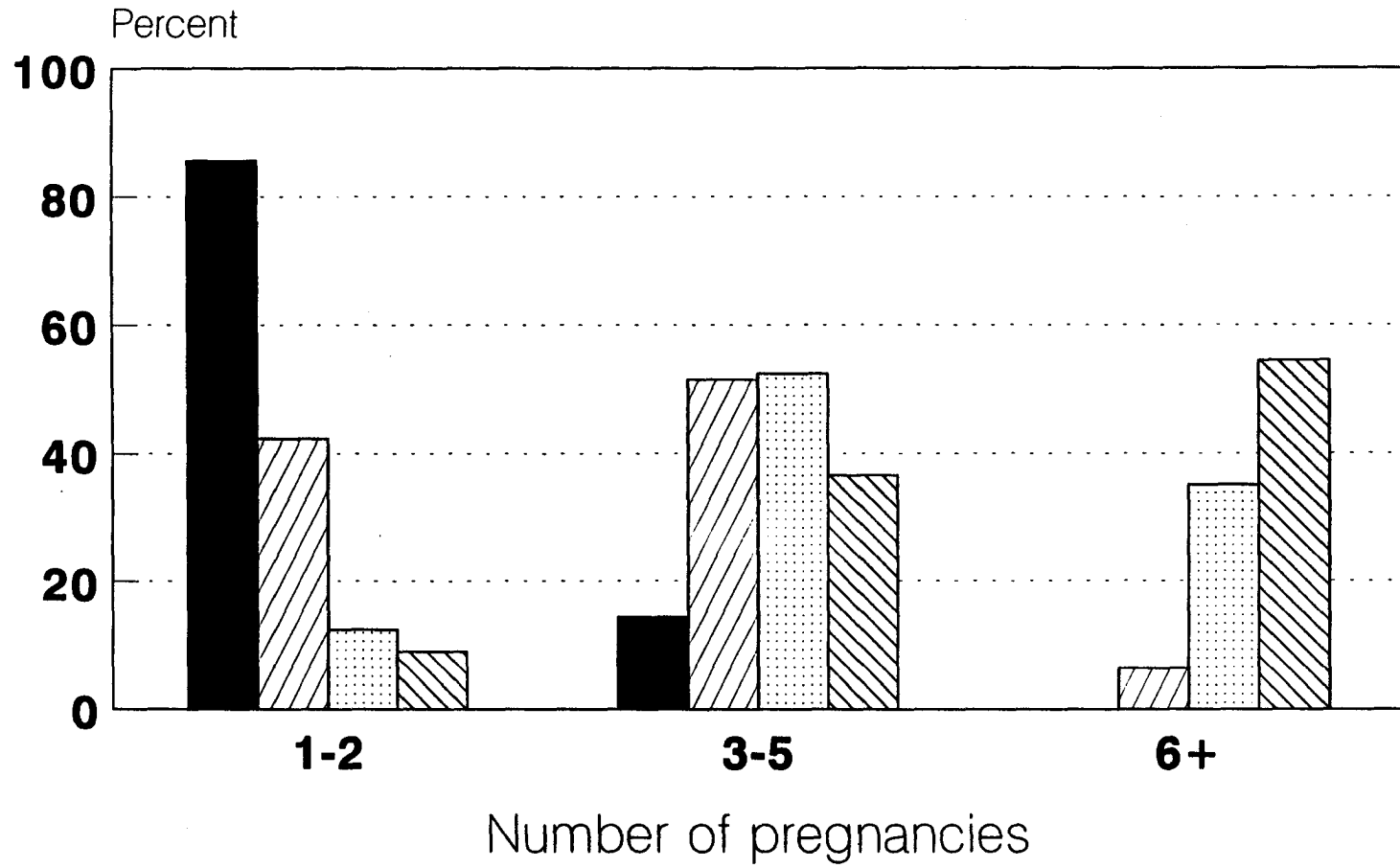
(n=612) Figure 1



■ <5 Urban yrs (n=226) ▨ 6-10 Urban yrs (n=107) ▩ 11+ Urban yrs (n=279)

# Age and Number of pregnancies

(n=625) Figure 2



■ 15-24 yrs (n=97)    ▨ 25-34 yrs (n=239)  
▩ 35-44 yrs (n=185)    ▧ 45+ yrs (n=101)

The final model in Table 3 shows that in a logistic regression analysis forcing in and out factors, being older (age), living in informal housing, and having a lower level of education and income were associated with higher gravidity. The earlier association between greater length of stay in an urban area and increased number of pregnancies was confounded by age.

**TABLE 3:**

**EXPLANATORY VARIABLES FOR HAVING >  
5 PREGNANCIES IN A LOGISTIC REGRESSION**

VARIABLES	OR	95% CI	P VALUE
AGE 35+YRS (<35YRS)	6.58	(3.28,13.2)	0.0000
HAS RURAL HOME/HOUSE (NO RURAL HOME)	1.77	(0.924,3.40)	0.0804
PERSONAL INCOME <R400 MTH (R400+MTH)	2.47	(1.16,3.77)	0.0128
EDUCATION <6YRS (6+YRS)	3.54	(1.74,7.20)	0.0003
LIVES IN SITES B & C OR GREENPOINT (HOUSING)	2.44	(1.08,5.47)	0.0253
URBAN YEARS 11+ YRS (<11YRS)	1.17	(0.603,2.27)	0.6434

(Baseline in parentheses)

### 7.3.1.2 Age of first pregnancy

Having had a first pregnancy as a teenager was associated with urbanisation status, education, age and area of residence.

Women who had lived in an urban area for more than 20 years (n=70,41.6%) were significantly more likely to have had a first pregnancy as a teenager than women with less than 20 years in an urban area (n=247,55.9%) ( $X^2=9.86$ ,  $p=0.001$ ) Women with less than 10 years of formal schooling (n=308,54%) were more likely to have been pregnant as a teenager than women with more than 10 years of schooling (n=16,32.6%) ( $X^2=8.49$ ,  $p=0.003$ ) and women living in the housing area (n=34,36.9%) were less likely to have had a teenage pregnancy than women residing in the informal housing areas of Sites B&C and Greenpoint (n=292,55.5%) ( $X^2=10.82$ ,  $p=0.001$ ). Older women (+35 years) were less likely (n=114,41%) to have been pregnant as teenagers than younger women (<35yrs) (n=207,61.7%) ( $X^2=26.31$ ,  $p<0.000$ ).

Table 4 shows that in a logistic regression analysis, being younger (age) and having a lower level of education are explanatory variables for having had a teenage pregnancy.

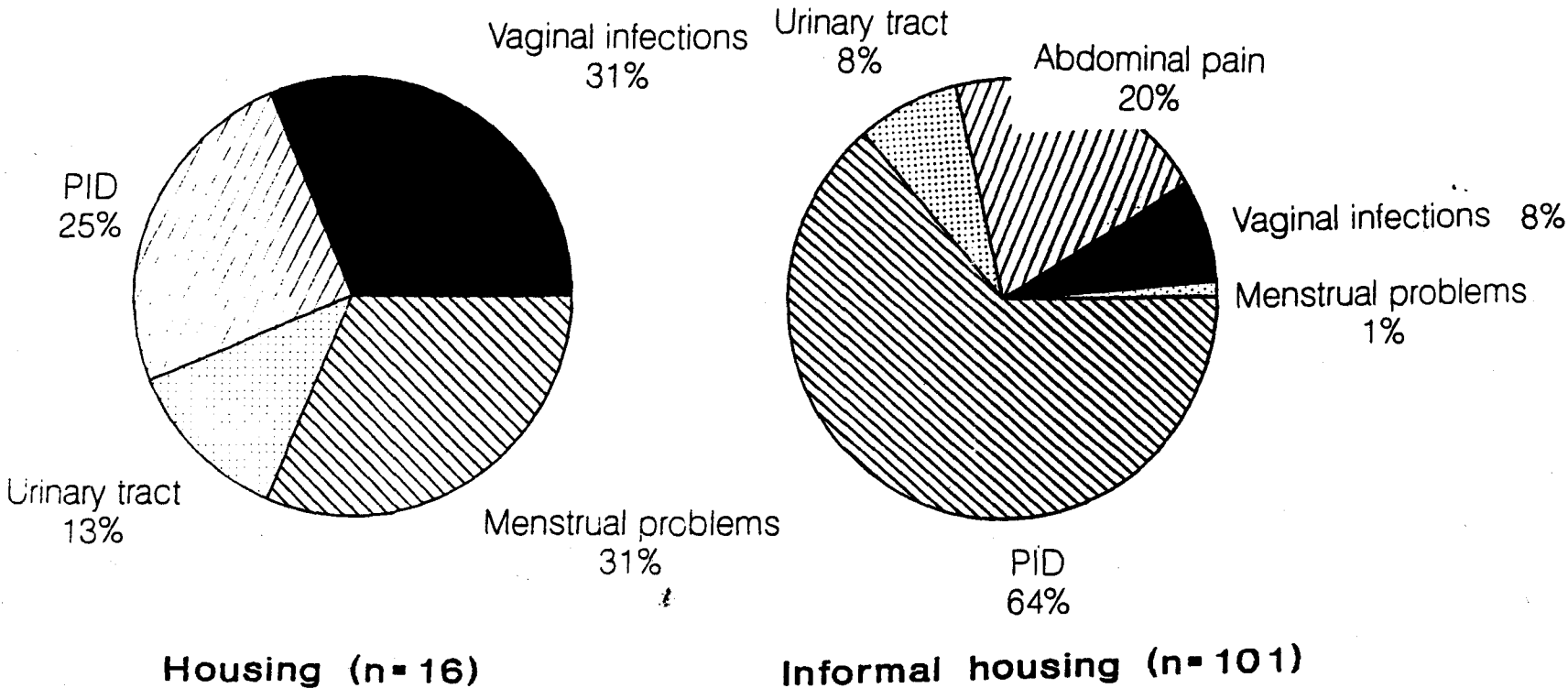
**TABLE 4**  
**EXPLANATORY VARIABLES FOR FIRST PREGNANCY**  
**BEING A TEENAGE PREGNANCY**

VARIABLES	OR	95% CI	P VALUE
AGE <35YRS (35+YRS)	2.18	(1.54,3.10)	0.0000
EDUCATION <10 YRS (10+YRS)	1.62	(1.06,2.48)	0.0265
AREA SITES B&C, GREENPOINT (HOUSING)	1.47	(0.882,2.45)	0.1369
URBAN YEARS <20 YRS (20+YRS)	1.38	(0.906,2.09)	0.1333

(Baseline in parentheses)

# Patterns of Distribution of gynaecological illness

Figure 3



### 7.3.1.3 **Gynaecological illness**

No socio-economic variables were significantly associated with having reported gynaecological illness.

There were different patterns of gynaecological illness in the housing area and the informal housing areas of Sites B&C and Greenpoint as be seen in Figure 3. Pelvic inflammatory disease and abdominal pain predominated in the informal housing areas and menstrual problems and vaginal infections in the housing area. However the number of cases of reported gynaecological illness in the housing areas was too small to show any conclusive patterns.

### 7.3.1.4 **Infertility**

Problems falling pregnant were associated with urbanisation status, education, marital status and income.

The proportion of women who reported infertility decreased with increasing length of stay in an urban area. Women who had spent more than 10 years in an urban area were significantly less likely to report infertility (n=24, 8.5%) than women who had spent less than 10 years in an urban area (n=59, 16.4%) ( $X^2=8.89, p=0.002$ ). Women with 8 or more years of formal education reported problems with infertility less frequently (n=17, 8.2%) than women with fewer than 8 years of formal education (n=70, 15.7%) ( $X^2=6.70, p=0.009$ ). Women with a rural home were significantly more likely to have reported infertility (n=68, 15.4%) than women without such rural ties (n=19, 8.9%) ( $X^2=5.21, p=0.022$ ). Women who reported gynaecological illness were significantly more likely to report infertility (n=24, 21.2%) than those who did not (n=61, 11.4%) ( $X^2=7.97, p=0.004$ ).

### 7.3.1.3 **Gynaecological illness**

No socio-economic variables were significantly associated with having reported gynaecological illness.

There were different patterns of gynaecological illness in the housing area and the informal housing areas of Sites B&C and Greenpoint as be seen in Figure 3. Pelvic inflammatory disease and abdominal pain predominated in the informal housing areas and menstrual problems and vaginal infections in the housing area. However the number of cases of reported gynaecological illness in the housing areas was too small to show any conclusive patterns.

### 7.3.1.4 **Infertility**

Problems falling pregnant were associated with urbanisation status, education, marital status and income.

The proportion of women who reported infertility decreased with increasing length of stay in an urban area. Women who had spent more than 10 years in an urban area were significantly less likely to report infertility (n=24, 8.5%) than women who had spent less than 10 years in an urban area (n=59, 16.4%) ( $X^2=8.89, p=0.002$ ). Women with 8 or more years of formal education reported problems with infertility less frequently (n=17, 8.2%) than women with fewer than 8 years of formal education (n=70, 15.7%) ( $X^2=6.70, p=0.009$ ). Women with a rural home were significantly more likely to have reported infertility (n=68, 15.4%) than women without such rural ties (n=19, 8.9%) ( $X^2=5.21, p=0.022$ ). Women who reported gynaecological illness were significantly more likely to report infertility (n=24, 21.2%) than those who did not (n=61, 11.4%) ( $X^2=7.97, p=0.004$ ).

Table 5 shows that in a logistic regression analysis, having spent a shorter period in an urban area and having had a gynaecological illness were explanatory variables for reported infertility.

**TABLE 5**

**EXPLANATORY VARIABLES FOR  
REPORTED INFERTILITY**

VARIABLES	OR	95% CI	P VALUE
EDUCATION <8YRS (8+YRS)	1.05	(0.651,1.70)	0.8355
URBAN YEARS <10YRS (10+YRS)	1.91	(1.16,3.16)	0.0098
GYNAECOLOGICAL ILLNESS YES (NO)	2.18	(1.27,3.76)	0.0066
RURAL HOME (NO RURAL HOME)	1.58	(0.897,2.80)	0.1025

(Baseline in parentheses)

### 7.3.2 HEALTH SERVICE USE

#### 7.3.2.1 Attendance of ante-natal care

No variables were significantly associated with attendance of ante-natal care.

#### 7.3.2.2 Use of contraception

Women with more than 10 years of formal schooling were significantly more likely to use contraception (n=36,69.2%) than those with less than 10 years schooling (n=278,54.5%) ( $\chi^2 = 4.15, p=0.041$ ). Very few women under the age of 20 years and over 45 years reported using contraception. A subsample of women between the ages of 20 and 45 years showed that younger women (20-35 years) (n=224,58.0%) were significantly more likely to report using contraception than women aged 36-45 years (n=162,38.4%) ( $\chi^2 = 24.11, p > 0.000$ ). As can be seen in Table 6a both age (<36 yrs) and education (having 10+ years formal education) were independently associated with use of contraception.

**TABLE 6A EXPLANATORY VARIABLES FOR USE OF CONTRACEPTION**

VARIABLES	OR	95% CI	P VALUE
EDUCATION 10+YRS (<10 YRS)	2.04	(1.08,386)	0.0231
AGE 20-35YRS(36-45YRS)	2.07	(1.50,2.87)	0.0000

(Baseline in parentheses)

### 7.3.2.3 Having had a cervical smear

The likelihood of having had a cervical smear done was inversely related to having a rural room/house ( $X^2=45.04, p<0.000$ ). Women with more than 10 years of education were more likely to have had a cervical smear ( $n=26, 59.0\%$ ) than those with less than 10 years education ( $n=225, 43.4\%$ ) ( $X^2=4.02, p=0.044$ ). Women who used contraception were more likely to have had a cervical smear ( $n=142, 50.7\%$ ) than women not using contraception ( $n=110, 38.7\%$ ) ( $X^2=8.19, p=0.004$ )

Table 6 shows that the absence of rural home, having a higher level of education and using contraception were independently associated with having had a cervical smear.

**TABLE 6B**

### EXPLANATORY VARIABLES FOR HAVING HAD A CERVICAL SMEAR

INDEPENDENT VARIABLES	OR	95% CI	P VALUE
EDUCATION 10+YRS(<10YRS)	1.88	(1.19,2.96)	0.0063
AGE <35YRS (35+YRS)	1.05	(0.718,1.52)	0.8164
NO RURAL ROOM/HOUSE (RURAL ROOM/HOUSE)	3.19	(2.18,4.68)	0.0000
USE CONTRACEPTION (DID NOT USE CONTRACEPTION)	1.52	(1.06,2.19)	0.0233

(Baseline in parentheses)

### 7.3.2.4 Use of health services when ill

The preferred use of private services was associated with area of residence and urbanisation.

Respondents living in the housing area (n=40,58.3%) were significantly more likely to intend using a private health service when ill than those living in Sites B, C and Greenpoint (n=70,12.5% ( $X^2=49.35, p<0.000$ )). This was also the case with those who had been in an urban area for 20 years or more (n=36,22.9%) compared with those who had spent less than 20 years (n=70,14.9%) ( $X^2=5.36, p=0.020$ ) in an urban area.

Table 7 shows that only residing in formal housing was associated with preferred use of a private doctor when sick.

**TABLE 7**  
**EXPLANATORY VARIABLES FOR PRIVATE DOCTOR USE**

VARIABLES	OR	95% CI	P VALUE
LIVES IN FORMAL HOUSING (INFORMAL HOUSING)	5.18	(2.96,9.08)	0.0000
LIVED IN URBAN AREA 20+ YRS (<20 YRS)	1.13	(0.655,1.94)	0.6631
EMPLOYED IN FORMAL SECTOR (EMPLOYED IN INFORMAL SECTOR OR UNEMPLOYED) (REST)	1.07	(0.672,1.71)	0.6631

(Baseline in parentheses)

### 7.3.3.2 Chronic illness

Significant associations were found between chronic illness, urbanisation status and age.

Older women (45+) were significantly more likely (n=27,26.5%) to have reported chronic illness than younger women (n=44,8.0%) This difference was statistically highly significant ( $X^2=30.44, p<0.000$ ). Women who had spent more than 5 years in an urban area were significantly more likely (n=59,14.0%) to have reported chronic illness than those who had spent a shorter period in an urban area (n=12,5.5%) ( $X^2=10.58, p=0.001$ ).

Table 9 shows that in a logistic regression analysis, being older and having spent a longer period in an urban area were both explanatory variables for having reported chronic illness.

**TABLE 9**

**EXPLANATORY VARIABLES  
FOR REPORTED CHRONIC ILLNESS**

VARIABLES	OR	95% CI	P VALUE
AGE 45+YRS (<45YRS)	3.57	(2.05,6.21)	0.0000
URBAN YEARS 5+ YRS (<5YRS)	2.14	(1.10,4.16)	0.0181

(Baseline in parentheses)

### 7.3.4 HEALTH KNOWLEDGE

#### 7.3.4.1 Awareness of AIDS

Awareness of AIDS was associated with area of residence and seeing Cape Town as their home. A significantly smaller proportion of respondents in Greenpoint (n=48,58.5%) had heard of AIDS than in other areas (n=515,90%)( $X^2=59.40$ ,  $p<0.001$ ). Respondents who saw Cape Town as their home were significantly more likely to have heard of AIDS (n=231,93.9%) than those who saw a former 'homeland' as home (n=288,80%)( $X^2=22.97$ , $p<0.000$ )

Table 10 shows that seeing Cape Town as one's home, education (10+ years) and living outside of the Greenpoint area were associated with awareness of AIDS.

**TABLE 10**

**EXPLANATORY VARIABLES FOR  
AWARENESS OF AIDS (HAVE HEARD OF AIDS)**

VARIABLES	OR	95% CI	P VALUE
EDUCATION 10+YRS (<10YRS)	2.57	(1.27,5.99)	0.0050
CONSIDER CAPE TOWN TO BE HOME (RURAL AREA)	2.35	(1.27,4.38)	0.0045
EMPLOYED (UNEMPLOYED)	1.07	(0.649,1.75)	0.8010
LIVES IN HOUSING, SITES B & C (LIVES IN GREENPOINT)	5.04	(2.84,8.95)	0.0000

(Baseline in parentheses)

No variables showed significant differences for knowledge of AIDS and its prevention.

### 7.3.4.2 Knowledge of cervical smears

Awareness of cervical smears was associated with urbanisation status, area of residence and education.

Women born in Cape Town (n=46,62%) were significantly more likely to be aware of a cervical smear than those born in a former 'homeland'(n=192,41%)( $X^2=11.49, p=0.0007$ ).

A significantly greater proportion of women living in the housing area (n=58,60.4%) had heard of a cervical smear than women in other areas (n=237,42%)(  $X^2=11.13, p=0.0008$ ). Women who used contraception were more likely to have heard of a cervical smear (n=168,51.1%) than those who did not (n=127,38.6%) ( $X^2=10.33, p=0.001$ ). Women with 10 or more years of formal education (n=29,57%) were more likely to be aware of cervical smears than women with lower levels of education (n=262,43%). However, this difference was not significant.

Table 11 shows that having 10 or more years formal education, living in formal housing and using contraception were associated with having heard of a cervical smear.

**TABLE 11**

<b>EXPLANATORY VARIABLES FOR KNOWLEDGE OF PAP SMEARS</b>			
<b>VARIABLES</b>	<b>OR</b>	<b>95% CI</b>	<b>P VALUE</b>
<b>EDUCATION 10+YRS (&lt;10YRS)</b>	1.74	(1.12,2.71)	0.0139
<b>BORN IN CAPE TOWN (BORN IN RURAL AREA)</b>	1.94	(1.11,3.40)	0.0196
<b>LIVES IN HOUSING (LIVES IN SITES B&amp;C AND GREENPOINT)</b>	1.27	(0.738,2.19)	0.3877
<b>USED CONTRACEPTION (DID NOT USE CONTRACEPTION)</b>	1.49	(1.04,2.12)	0.0268

(Baseline in parentheses)

#### 7.3.4.3 Knowledge of health services

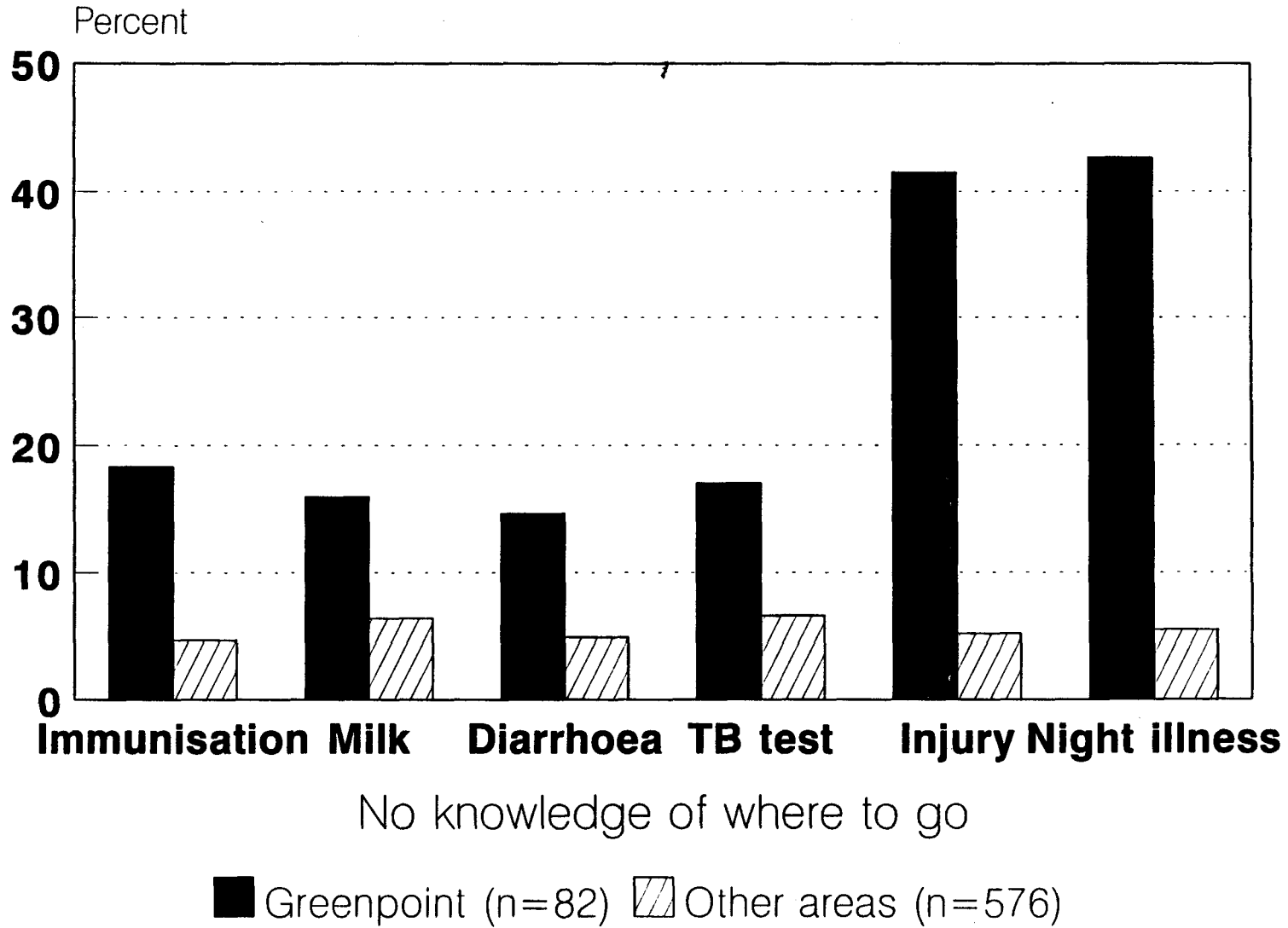
Figure 4 shows that a higher proportion of the 77 Greenpoint respondents (n=13,16.5%) did not know where they should go for the following services compared with the housing area and Sites C and B: immunization of a baby/child (n=15, 18.3% as opposed to n=27, 4.7%) ( $X^2=22.24$ ,  $p<0.001$ ); to acquire milk for a baby (n=13, 15.9% as opposed to n=37, 6.4%) ( $X^2 = 9.09$ ,  $p=0.0025$ ); if a child had diarrhoea (n=12, 14.6% as opposed to n=28, 4.9%) (Fisher exact test  $p=0.00189$ ); for TB tests (n=14, 17.1% as opposed to n=38, 6.6%) ( $X^2=10.82$ , $p=0.001$ ); for an injury (n=34, 41.5% as opposed to n=30, 5.2%) ( $X^2=107.46$ , $p<0.001$ ) and if a family member was ill at night (n=35,42.7% as opposed to n=32,5.6%) ( $X^2=108.19$ , $p<0.001$ ).

(Figure 4)

Lack of knowledge of where to go for a cervical smear was associated with marital status, education and urbanisation. A greater proportion of married women did not know where to go for a cervical smear (n=138,37.4%) than women occupying

# Knowledge of Health services

Figure 4



other marital status (n=85,29.4%)( $X^2=4.61,p=0.031$ ). Similarly a greater proportion of women with less than 6 years of formal schooling (n=62,41.6%) did not know where to go than women with higher levels of education (n=160,31.6% ( $X^2=5.58,p=0.018$ ). A significantly greater proportion of women who had been in an urban area for less than 11 years did not know where to go for a cervical smear (n=136,37.8%) than women who had been in an urban area longer (n=82,28.9%) (5.46,p=0.019).

In Table 12, multivariate analysis shows that level of education and urbanisation status were explanatory variables for lack of knowledge of where to go for a cervical smear.

**TABLE 12**

**EXPLANATORY VARIABLES FOR  
LACK OF KNOWLEDGE OF WHERE TO GO FOR A CERVICAL SMEAR**

VARIABLES	OR	95% CI	P VALUE
MARRIED (OTHER MARITAL STATUS)	1.32	(0.938,1.86)	0.1094
EDUCATION <6YRS (6+YRS)	1.52	(1.03,2.23)	0.0346
URBAN YEARS <11YRS (11+ YRS)	1.41	(1.0,1.99)	0.0483

(Baseline in parentheses)

### 7.3.5 OTHER VARIABLES OF INTEREST

#### 7.3.5.1 Place of birth of last born child

As can be seen in figure 5 place of birth was associated with area of residence.

A significantly higher proportion of women in the housing area had last -born children who were born in Cape Town than those who lived in Sites B & C and Greenpoint ( $X^2=22,60$ ,  $p<0,001$ ).

A significantly greater percentage of women in the housing area had given birth to their last born child in a hospital compared than those in Sites B & C and Greenpoint. ( $X^2=14,37$   $p<0,001$ ).

#### 7.3.5.2 Child loss

Loss of a live-born child was associated with area of residence, age, education and number of pregnancies.

A significantly higher proportion of respondents in Greenpoint had lost a child ( $n=32,41.6\%$ ) compared with the those in the housing area and Sites B & C ( $n=141,25.8\%$ ) ( $X^2=8,39$ ,  $p=0.003$ ).

Women older than 35 years were more likely ( $n=116,40.5\%$ ) to have lost a live-born child than younger women ( $n=53,16.0\%$ ) ( $X^2=46.49$ ,  $p<0.000$ ). This was also the case for those who had no formal schooling ( $n=45,57.8\%$ ) compared with those with who had some level of formal schooling ( $n=573,25.1\%$ ) ( $X^2=22.30$ ,  $p<0.0000$ ). Of those women who had 6 pregnancies or more, 58.8% ( $n=80$ ) had lost a live-born child as opposed to 19% ( $n=92$ ) of those who had had less than 6 pregnancies. This difference was highly significant ( $X^2=83.96$ ,  $p<0.000$ )

# Place of birth of last born child

## Figure 5

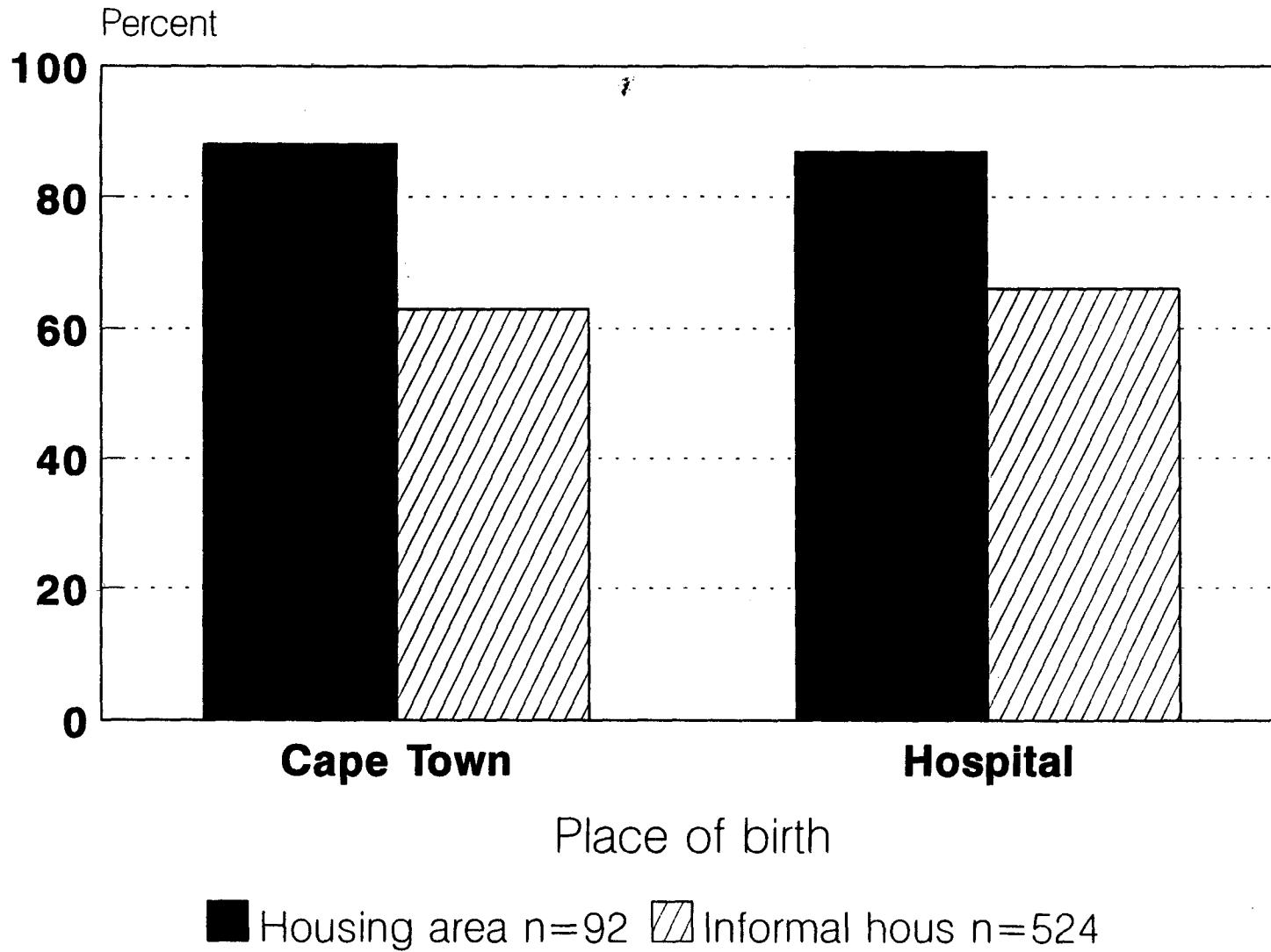


Table 13 shows that in a logistic regression analysis all these factors were explanatory variables for having lost a live-born child.

**TABLE 13**

**EXPLANATORY VARIABLES  
FOR HAVING LOST A LIVEBORN CHILD**

VARIABLES	OR	95% CI	P VALUE
NUMBER OF PREGNANCIES 6+ (<6)	3.63	(2.20,5.99)	0.0000
NO FORMAL EDUCATION 1+ YR FORMAL EDUCATION	2.50	(1.24,5.04)	0.0100
LIVES IN GREENPOINT (LIVES IN SITES B&C)	2.28	(1.31,3.98)	0.0039
AGE 35+YRS (<35 YRS)	2.00	(1.25,3.20)	0.0041

(Baseline in parentheses)

#### 7.4 DISCUSSION

Socio-demographic and economic variables (age, area of residence, education, marital status, urbanisation status and income) in varying combinations, impacted on health. The relationship between education, urbanisation and a large number of health variables is particularly marked. Income showed an effect on only one health outcome measure (number of pregnancies). This may be due to the fact that only the respondent's income level rather than that of her partner and her household was included in the analysis. In addition, women in Khayelitsha may have constituted too uniform a group in terms of income levels limiting the ability to detect associations. In Chapter 5 a strong relationship was found between area of residence in Khayelitsha and socio-economic status.

Except in the case of women living on their own, with no other means of financial support, area of residence may provide a better proxy of economic status than the individual women's income and employment status.

The positive relationship between education and fewer children is confirmed in this study. Similar findings were reported by Roberts and Rip elsewhere in South Africa in 1984<sup>5</sup>. Basic literacy in women leads to greater power within the family leading to them having greater control over their reproductive behaviour. An inverse relationship has been found between female education and fertility in other countries. Studies in Jamaica, Burkina Faso and Nigeria all found that women with a higher level of education tended to have fewer children<sup>6</sup>.

The well known<sup>7</sup> inverse relationship between income and fertility is confirmed by the results. It is likely that women with more income also have easier access to contraception both through their greater purchasing power and by the fact that it may be made available at their places of employment.

Obviously older women will have had a greater number of pregnancies over their life-time.

More educated women in Khayelitsha tended to have had their first pregnancy at an older age, which is similar to the findings of Lotter<sup>8</sup> who found that women with high educational status were 1.5 to 2 years older when they gave birth to their first child. Studies have found that fertility tends to decrease when marriage occurs at an older age leading to fewer children. Education has been found to influence this in that marriage is often delayed due to women seeking to further their education<sup>6</sup>. The fact that younger women were more likely to have had a teenage pregnancy tends to confirm an increase in the early onset of sexual activity in recent times, leading to an increased teenage pregnancy problem. It has been argued that urbanisation is accompanied by a loosening of family

ties and this may lead to increased adolescent fertility. Contraceptive services are often aimed at married women and other studies in Africa and Latin America have shown low contraceptive usage amongst sexually active teenagers<sup>6</sup>. This indicates a need for special teenage contraceptive services. A special contraceptive service opened in Site B, Khayelitsha, in 1992 is a positive step in addressing this problem.

The fact that more recently urbanised women reported greater infertility is likely to be related to differing fertility expectations. There is a tendency for rural and recently urbanised women to seek larger families than urbanised women. Recently urbanised women's fertility tends to be intermediate to their rural and urban counterparts<sup>6</sup>. Hence problems falling pregnant may be perceived as a more serious problem.

The association between reported gynaecological illness and infertility confirms the suggestion in Chapter 5 that a large proportion of the infertility is as a result of sexually transmitted diseases (STDs). Sexually transmitted diseases can cause tubal blockage, leading to infertility<sup>9</sup>. As many STDs are undetected the association with infertility is likely to be stronger than that shown by the results, illustrating the serious magnitude of this problem.

The fact that pelvic inflammatory disease (PID) constitutes most of the gynaecological illness in the informal housing areas is of considerable concern. The long-term consequences of PID include chronic pelvic pain, repeated occurrence of upper reproductive tract infection, infertility and tubal pregnancy. During pregnancy, it increases the chance of spontaneous abortion and prematurity. Acute cases of PID require hospitalisation and can be fatal<sup>9</sup>. Women in the informal housing areas are less likely to have had access to information on reproductive tract infections and to health services for their treatment. The combination of lack of recognition of earlier symptoms of lower reproductive

tract infection such as abdominal pain and abnormal vaginal discharge and the failure or inability to seek treatment could explain the preponderance of PID in these areas. The preponderance of vaginal infections and menstrual problems in the housing area may be due to respondents in this area perceiving these as problems and seeking treatment, rather than an actual higher incidence of these conditions.

The association between higher levels of education and increased use of contraception is confirmed. Klugman argues that access to education and income means that women are more likely to be in control of their lives and therefore more able to make decisions regarding their future including those concerning childbearing<sup>10</sup>.

Women with higher levels of education and women who are more urbanised, adjusted for age, are more likely to have had access to information on the importance of cervical smears in preventing cervical cancer. They are therefore more likely to have acted on this information by adopting preventive health behaviour. The association between use of contraception and having had a cervical smear amongst women reflects the fact that family planning services were one of the main primary health care sites where cervical smears are performed. A similar association was found in another community-based study on knowledge, attitudes and practices to cervical screening in Khayelitsha<sup>11</sup>. The other major site at which cervical smears were known to be performed were ante-natal clinics. The fact that no association was found between attendance of the latter and having had a cervical smear may be attributable to the fact that a very small number of women in this population did **not** attend ante-natal care, making differences difficult to detect. A study<sup>12</sup> which compared the number of cervical smears by age at the Groote Schuur and Tygerberg Hospital\* cytology

\* *These two hospitals provide laboratory services for all cervical smears taken at public health facilities in the Western Cape.*

laboratories with that that of the population found that proportionally far more smears were taken amongst younger women. An association between age and cervical screening could not be confirmed in this study as respondents were not asked at what age they had had a cervical smear. However the association found between use of contraception and cervical screening would tend to confirm that older women, beyond their reproductive years who are at great risk for cervical cancer are disadvantaged with respect to screening. Current policy proposals for cervical screening recommend three free cervical smears, 10 years apart starting at the age of 30, with the emphasis on screening older women who had never had a smear\*.

The association between preferred use of private doctors and area of residence is a function of the higher socio-economic status of women in the formal housing area and the fact that all private general practitioners in Khayelitsha were geographically located in this area<sup>13</sup>.

The association between lower education and poorer health status reported in the literature is confirmed by the association found between lower education and more reported acute illness. The association between reported acute illness and being widowed needs further investigation. This association may reflect poorer socio-economic status as a result of the loss of a male bread-winner leading to poorer health status or the effects of psychological factors such the mental stress that may occur with widowhood.

The relationship between age and chronic illness is predictable. The association between increased urbanisation and increased reported chronic illness is interesting. This may be a result of life-style changes which occur when living

\* *Document Number 13. Summary of Key Issues on Cancer. Women's Health Conference. Johannesburg, 4 December, 1994.*

in an urban area which impacts negatively on health status, particularly in the area of chronic diseases, such as asthma, allergy as well as cardiovascular disease and cancers as described in Chapter 1. The relationship between hypertension and increased urbanisation has been well documented<sup>14-18</sup>. It may also relate to differing perceptions of what constitutes illness with less urbanised people who live physically burdensome lives, further from health facilities having become accustomed to greater stoicism when ill leading to less reporting of illness. It may also be attributable to differing patterns in health seeking behaviour.

The proportion of women having lost a child is particularly high for Greenpoint, where the younger, least urbanised respondents lived in the poorest environmental and socio-economic conditions. Differences in access to health services may be an explanatory factor. Another factor relating to child loss was the mother's level of education. A higher level of education leads to greater knowledge of disease, its symptoms and its treatment options and is likely to increase preventive behaviour. Other factors associated with child loss were the child having been born in a rural area and a woman having had a greater number of pregnancies. The reasons for the association between a greater number of pregnancies and child loss are discussed in the preceding chapter. A higher proportion of women whose last children were born outside Cape Town lived in informal housing. Studies have found<sup>19</sup> that children born outside of Cape Town have the lowest immunization coverage. Children in the informal housing areas who are more likely to have been born outside of Cape Town represent an important target group in disease prevention as they are at highest risk for child morbidity and mortality.

People who lived in the poorest environmental conditions and who had arrived more recently had the least knowledge of preventive health measures and where to acquire health services. Greenpoint, which accommodated younger, more

recent arrivals to an urban area, who lived in the poorest socio-economic conditions, exemplified this. Women in Greenpoint had the least knowledge about where to go for a variety of services. They also showed much lower AIDS awareness than in other areas.

Lack of knowledge of the purpose of performing a cervical smear was particularly marked in the informal housing areas, amongst those with less education and amongst women who did not attend contraceptive services. Lack of knowledge of where to go for a cervical smear was associated with less education and being less urbanised. The finding that women who were more urbanised in that they saw Cape Town as their home, were more likely to have heard of AIDS, may be a function of the greater dissemination of information in an urban area - through health institutions, workplaces, educational institutions and through the media. The important relationship between higher levels of education and increased health knowledge is repeatedly confirmed. The positive relationship between awareness of AIDS and education indicates that programmes are required to inform all women, especially those who have been denied access to formal education.

Efforts for health promotion, prevention and improved access to health services need to be targeted at residents in the particularly vulnerable areas identified. These include residents in the Greenpoint area and other poorly serviced or unserviced informal housing areas and younger, more recently urbanised women, who have been denied most access to formal education.

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**CHAPTER 8**

**THE SOCIAL WELL-BEING AND SOCIO-DEMOGRAPHIC  
STATUS OF WOMEN IN KHAYELITSHA**

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**Table 9 - Explanatory variables for child being cared for by own mother**

**Table 10 - Explanatory variables for having an alternative carer for child**

**Table 11 - Relationship between employment status and time spent on housework**

**Table 12 - Explanatory variables for women spending a whole day on  
housework**

**Table 13 - Explanatory variables for women spending half the day on  
housework**

**Table 14 - Explanatory variables for performing the domestic chore of cooking**

**Table 15 - Explanatory variables for male disapproval for female partner working**

**Table 16 - Explanatory variables for male partner deciding on how to spend female partner's earnings**

**Table 17 - Explanatory variables for a woman having no partner**

## 8.1 INTRODUCTION

This chapter describes aspects of social well-being of women in Khayelitsha and their relationship with a number of socio-demographic factors.

Some measures of assessment of social and psychological well-being include positive 'quality of life' indicators such as: the meeting of basic material needs (food, water, sanitation, shelter, clothing and work), the availability of cultural and leisure activities, a satisfactory social and sexual life, environmental safety and comfort<sup>1</sup>. Other assessments are made using indicators of social and mental pathology such as suicide, homicide, other acts of violence and crime, road accidents and lifestyle type abuses. The WHO notes that definitions of psychosocial health and quality of life, are very culture-specific. Assessing women's social well-being involves taking into account in addition the effects of gender inequity.

Women's social well-being is linked to a number of factors which include social contact, social support and women's role and status.

Human communication and interaction through social contact is a key component of a person's sense of well-being. Some theories suggest that the main origin of self-image and self-esteem is through other's reaction to us<sup>2</sup>. Membership of a group or community is important in that it gives a sense of belonging<sup>3</sup>. Lack of social contact can lead to loneliness and in extreme cases of isolation can lead to various forms of mental dysfunction. Social contact provides the ties from which individual's social networks are constructed<sup>4</sup>. Social networks are defined by a number of characteristics: their range or size; the multiple roles or functions served by their members (multiplexity); and the extent to which the members of the network contribute to feelings of solidarity and cohesiveness (density)<sup>5</sup>. Also important are the quality of interaction, frequency, intensity and durability over time<sup>4</sup>. Gender differentials have been found in the relative

importance of quality and quantity of social contact or interaction. Findings of a number of studies<sup>5</sup> suggest a stronger relationship between fewer contacts (smaller network size) and loneliness for men than for women. Closeness of contact and intimacy seems to be more important for women. Hence, particularly for women, the quality of social contact is most important.

Social contact or networks and social support are distinct from each other. Social support can be seen as the interpersonal resources (material, social or psychological) mobilised to deal with life's stresses and provide assistance in coping<sup>6</sup>. A number of mechanisms in the social environment exist which provide social support. This includes institutions, social roles, self-perceptions and relationships<sup>7</sup>. Social contact (relationships with others) is an important basis for support as most sources of social support are those with whom we share close relationships<sup>8</sup>. Hence one definition of social support is that it is the instrumental (practical), emotional or financial assistance that is obtained from an individual's social network<sup>4</sup>. Weiss<sup>5</sup> has identified six social needs which are met through social relationships: feeling nurtured; emotional closeness; sense of identification and belonging; reassurance of worth; guidance (advice or information); and that persons can be counted on for tangible assistance ('reliable alliance'), emphasising the support aspect of social relationships. Different characteristics and social needs may be important depending on what kind of support is sought. Support can also be measured through investigating subjects' perceptions of having received support and their satisfaction with it.

Roles, or expected patterns of behaviour associated with a particular position are defined primarily by age, gender, and class. Two of the main ways roles are distinguished are in terms of status and power<sup>9</sup>. Status has to do with relative value, worth or competence - a person's position or rank in relation to other people. Dictionary definitions of power include the ability to do something or act.

Power indicates control, as illustrated in a definition that states it is "the ability of an individual to effect a change in someone's behaviour - a change that might not otherwise occur"<sup>10</sup>.

Gender inequity as a major variable underpinning differences in health patterns between men and women has been explored in Chapter 2. Social relations between men and women are generally rooted in power relations in which women enjoy lower status than men. Inequality between the sexes and gender discrimination is almost universal to varying degrees in most countries of the world<sup>11</sup>. Smyke argues that the subordinate status occupied by women is often best defined by example:

"Women are half the world's population, receive one-tenth of the world's income, account for two-thirds of the world's working hours, and own only one-hundredth of the world's property"<sup>12</sup>.

Klugman et al<sup>13,14</sup> argue that women's subordinate position in society is found in a number of public domains: gender discrimination at the level of the constitution and law; women's lack of access to the political domain and hence their lack of power in decision-making; lack of access on the part of all women, but rural women in particular, to infrastructure and inferior access to education, jobs and income. Patriarchal attitudes are common in the domestic domain where work in the home and childcare are regarded as 'women's work'<sup>15</sup>. In the home, subordinate relations in their extreme form are reflected in the increasing incidence of domestic violence<sup>14,16</sup>.

In South Africa, where Black people in general were subordinated and denied power under Apartheid, Black women's subordinate position was exacerbated by Apartheid legislation, particularly influx control which prevented freedom of movement and discouraged female urbanisation<sup>17,18</sup>. An additional major obstacle to women's equality in South Africa has been African customary law. The latter

has entrenched the subordination of a large number of women by placing them under the control of their husband and his family through the bridewealth (lobola/bohadi) system. It has also discriminated against women in terms of inheritance and property ownership.

Women occupy multiple roles including those of wives, mothers, carers of the household and the sick and elderly and as members of the paid workforce. Women bear most of the practical and emotional responsibility for childcare and family life. For working class women in particular, their nurturant and multiple roles often mean that they have little time or energy left to devote to their own needs and well-being. There are gender disparities in the total number of hours worked by men and women in most countries. In many developing countries it is estimated that working class women work an average of twelve to eighteen hours a day as opposed to an average of ten to twelve hours for men<sup>11</sup>. Some of women's many roles may be also be contradictory and hence additionally stressful.

Despite their socially subordinate position, women should not simply be seen as 'victims'. Many individual women and groups of women in South Africa have displayed strength and resourcefulness in challenging aspects of gender inequality and their oppression more generally<sup>19-21</sup>.

## **8.2 METHODS**

A limited number of variables were used to operationalise aspects of women's social well-being in Khayelitsha, on the basis of the literature reviewed. These variables were based on areas of enquiry that could provide information on the following factors:

- **Women's social networks:** individual contact and satisfaction with this and group affiliations. Group affiliation would also provide an index of women's participation in community affairs (for example civic organisations) and in organisations which strive to empower women such as women's organisations.
  
- **Instrumental (practical) social support** through whether women had persons they could count on for tangible assistance in times of need for childcare.
  
- **Social relations between men and women in the home:** the domestic division of labour, reflecting women's multiple roles and the extent of 'overwork' and their status in domestic decision-making regarding themselves as income earners.

Table 1 provides a list of variables used and their definitions.

**TABLE 1**

**OPERATIONAL VARIABLES USED**

**1. SOCIAL CONTACT**

**1.1 INDIVIDUAL SOCIAL CONTACT: Quantity and quality**

**Variables**

SOCIAL1	Contact with neighbours
SOCIAL2	Contact with friends
SOCIAL3	Contact with relatives
SATISFY1	Satisfied with contact with neighbours
SATISFY2	Satisfied with contact with friends
SATISFY3	Satisfied with contact with relatives
NEIGHB	Respondent had a neighbour as a best friend

**1.2 GROUP SOCIAL CONTACT**

**Variables**

MEMBORG	Respondent was a member of an organisation
ORG1	Belonged to a church organisation
ORG2	Belonged to a civic/community organisation
ORG3	Belonged to a women's organisation
ORG4	Belonged to any other organisation

**2. WOMEN'S DOMESTIC STATUS**

**2.1 GENDER ORGANISATION OF HOUSEWORK IN THE HOME**

**Variables**

HOUSEWK1	Respondent performed cooking in household
----------	---

**TABLE 1 (CONTINUED)**

HOUSEHWK2	Respondent performed cleaning in household
HOUSEHWK3	Respondent performed laundry in household
HOUSEWK4	Respondent performed childcare
TIMEHWK	Amount of time spent on housework

## **2.2 RELATIONS OF POWER BETWEEN PARTNERS**

### **Variables**

PREFEARN	Whether respondent preferred to work outside the home
PTNRPREF	How partner felt about her working outside the home
WHODECID	Who decided about the spending of the earnings of the respondent

## **3. SOCIAL SUPPORT IN CHILDCARE**

WHOCARE 1-6	Who cared for children (possibility of 1-6 children) under the age of 10 during the day
OTHCAR 1-4	Alternative carers for children when mother is unable to care for them

## **4. ATTITUDES TO LIVING IN KHAYELITSHA**

LIKELIVE	Did respondent like living in Khayelitsha
----------	---

Women were further categorised in terms of individual social contact into 'isolated', those with 'some contact' and 'not isolated'.

These operational variables so defined provided the outcome measures for social well-being.

The statistical methods of analysis used are described in detail in Chapter 3. Some brief summary points are mentioned here.

A social well-being profile of women was obtained by univariate analysis. This provided frequency distributions, means, medians and the ranges of different variables.

Socio-economic and demographic variables were examined to determine significant associations with social well-being variables.

In order to determine the explanatory variables for specific outcomes in social well-being multivariate analysis was performed. *A priori* decisions and the bivariate analyses formed the basis for multivariate modelling.

A list of all variables used in final models is given in the Table 2 in the box below.

**TABLE 2 - VARIABLES USED IN FINAL LOGISTIC REGRESSION MODELS**

**Outcome (dependent ) variables**

Having contact with neighbours

Having a neighbour as a best friend

Being a member of a civic organisation

Being a member of a women's organisation

Performing childcare duties

Using formal childcare

Child being cared for by own mother

Having alternative carer for child/ren

Spending the whole day on housework

Spending half the day on housework

Performing the domestic chore of cooking

Male partner disapproving of female partner working

Male partner deciding about female partner's earnings

Woman having no partner

TABLE 2 (CONTINUED)

**Independent variables**

Age (in years)

Rural ties (rural home)

Years spent in an urban area

Income (in wage categories)

Education (years of schooling)

Area of residence

Marital status

Employment status

Type of housing

Place of birth

Household composition

**8.3 RESULTS****8.3.1 Social Contact**

Nearly all women spent time with relatives (n=639,97.3%) and neighbours (n=600,91.6%), and 85.5% (n=562) spent time with friends. The vast majority of all women were also satisfied with their contact with neighbours, friends and relatives (93%, 86% and 97% respectively). A very large proportion of women (n=567,86.4%) saw a neighbour as their closest friend. Of the 659 women

\* *This question was asked of all women regardless of whether they had contact or not.*

interviewed, 89.5% of women fell into the category 'not isolated'. Most (81%) had some organisational affiliation, mostly to a church organisation (n=435, 81.3%). A smaller proportion were members of a civic organisation (n=228, 43%) or a women's organisation (n=148, 28%).

As can be seen from Table 3, a model with social contact with neighbours as the dependent variable and area of residence and employment as independent variables, showed that having social contact with neighbours was a function of being unemployed. No variables were associated with social contact with friends or relatives.

**TABLE 3 EXPLANATORY VARIABLES: CONTACT WITH NEIGHBOURS**

VARIABLES	OR	95% CI	P VALUE
UNEMPLOYED	1.76	(1.00, 3.08)	0.0503
(EMPLOYED)			
AREA OF RESIDENCE:			
NOT GREENPOINT	0.262x10 <sup>-4</sup>	(0.118x10 <sup>-5</sup>	0.0002
(LIVES IN GREENPOINT)		- 0.582x10 <sup>6</sup> )	

(Baseline in parentheses)

As can be seen in Table 4, a logistic regression analysis shows that length of stay in an urban area (20+yrs) is associated with having a neighbour as the closest friend.

**TABLE 4****EXPLANATORY VARIABLES: HAVING A NEIGHBOUR AS A BEST FRIEND**

VARIABLES	OR	95% CI	P VALUE
YRS IN URBAN AREA 20+YRS (< 20 YRS)	4.05	(1.15,14.2)	0.0172
EMPLOYED IN FORMAL SECTOR EXCLUDING DOMESTIC WORK (DOMESTICWORK)	2.55	(0.933,6.98)	0.0638
LIVES INFORMAL HOUSING (FORMAL HOUSING)	1.61	(0.515,5.04)	0.4139

(Baseline in parentheses)

Table 5 shows that membership of a civic organisation is a function of living in formal housing, age ( 45+ years), and being unemployed or employed in the informal sector.

**TABLE 5****EXPLANATORY VARIABLES FOR BEING A MEMBER OF CIVIC ORGANISATION**

VARIABLES	OR	95% CI	P VALUE
LIVES IN FORMAL HOUSING (INFORMAL HOUSING)	5.16	(2.60,10.2)	0.0000
AGE 45+ YRS (<45YRS)	2.42	(1.35,4.34)	0.0026
UNEMPLOYED/EMPLOYED IN INFORMAL SECTOR (EMPLOYED IN FORMAL SECTOR)	1.62	(1.02,2.57)	0.0379
YRS IN URBAN AREA 20+YRS(<20YRS)	1.48	(0.907,2.40)	0.1171
BORN IN CAPE TOWN (BORN IN RURAL AREA)	1.15	(0.554,2.37)	0.7127

(Baseline in parentheses)

**TABLE 5****EXPLANATORY VARIABLES FOR BEING A MEMBER OF CIVIC ORGANISATION**

VARIABLES	OR	95% CI	P VALUE
LIVES IN FORMAL HOUSING (INFORMAL HOUSING)	5.16	(2.60,10.2)	0.0000
AGE 45+ YRS (<45YRS)	2.42	(1.35,4.34)	0.0026
UNEMPLOYED/EMPLOYED IN INFORMAL SECTOR (EMPLOYED IN FORMAL SECTOR)	1.62	(1.02,2.57)	0.0379
YRS IN URBAN AREA 20+YRS(<20YRS)	1.48	(0.907,2.40)	0.1171
BORN IN CAPE TOWN (BORN IN RURAL AREA)	1.15	(0.554,2.37)	0.7127

(Baseline in parentheses)

Table 6 shows that membership of a women's organisation was a function of living in formal housing or serviced informal housing, age (over 44 years) and having a home in a rural area.

**TABLE 6**

**EXPLANATORY VARIABLES FOR BEING A MEMBER OF A WOMEN'S ORGANISATION**

VARIABLES	OR	95% CI	P VALUE
LIVES IN FORMAL HOUSING/ SERVICED INFORMAL HOUSING (UNSERVICED INFORMAL HOUSING)	2.00	(1.27,3.16)	0.0020
HAS RURAL HOME (NO RURAL HOME)	1.95	(1.25,3.02)	0.0023
AGE 45+YRS (<45YRS)	1.82	(1.13,2.94)	0.0154

(Baseline in parentheses)

**8.3.2 Childcare and patterns of childcare organisation for children under 10 years**

The majority of the 659 women (69.5%) performed childcare.

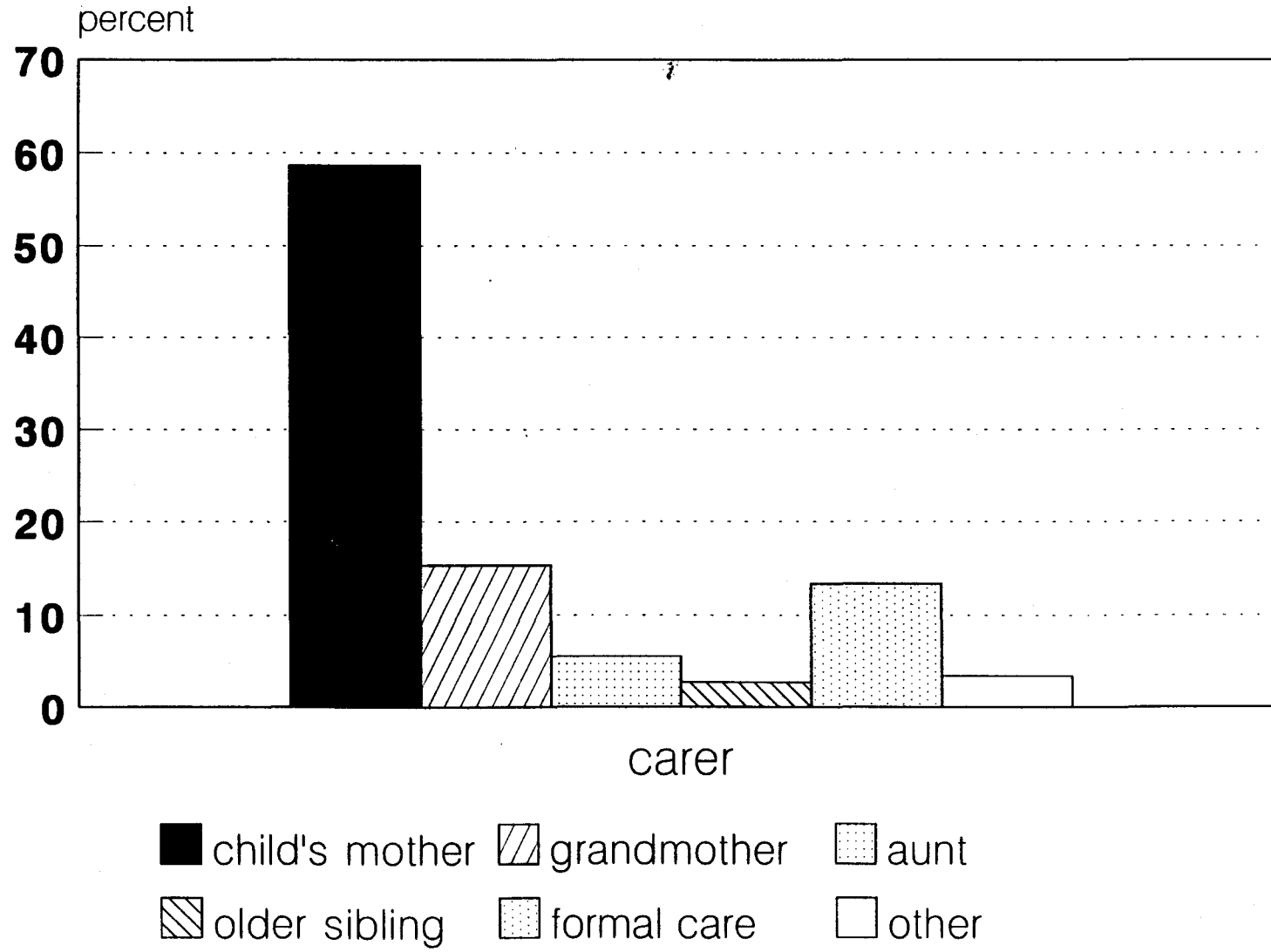
Many women (41%) reported having sent children to a rural area to be cared for. Of those children under ten years of age and resident in Khayelitsha, 54% were 4 years or younger. As can be seen in Figure 1, for those children resident in Khayelitsha, the child's mother was the most common usual carer, followed by the child's grandmother, formal childcare, an aunt and older siblings. The balance (3.4%) of childcarers were neighbours, other household members, childminders and unspecified carers. Of the 13.4% of children in formal care, 5.8% of children were in creches/pre-schools and 7.8% in afterschool care facilities.

Despite the fact that they worked, 68.6% (n=133) of women with children under 10 years of age and employed in the informal sector continued to look after their young children, as opposed to 22.8% (n=49) of those employed in the formal sector. ( $X^2=85.85, p=0.001, df=1$ ) The majority (66.2%, n=95) of women employed in the formal sector were in domestic service. While domestic workers were more likely to look after their children while working (n=25, 26.3%) than other formal sector workers (n=6, 12.5%) these differences were not statistically significant.

Over a quarter of women (26.5%) replied that they had no one else to turn to as an alternative carer for their children. Figure 2 shows the distribution of alternative carers.

# Patterns of childcare

## Figure 1



# Alternative carer -social support for childcare

## Figure 2

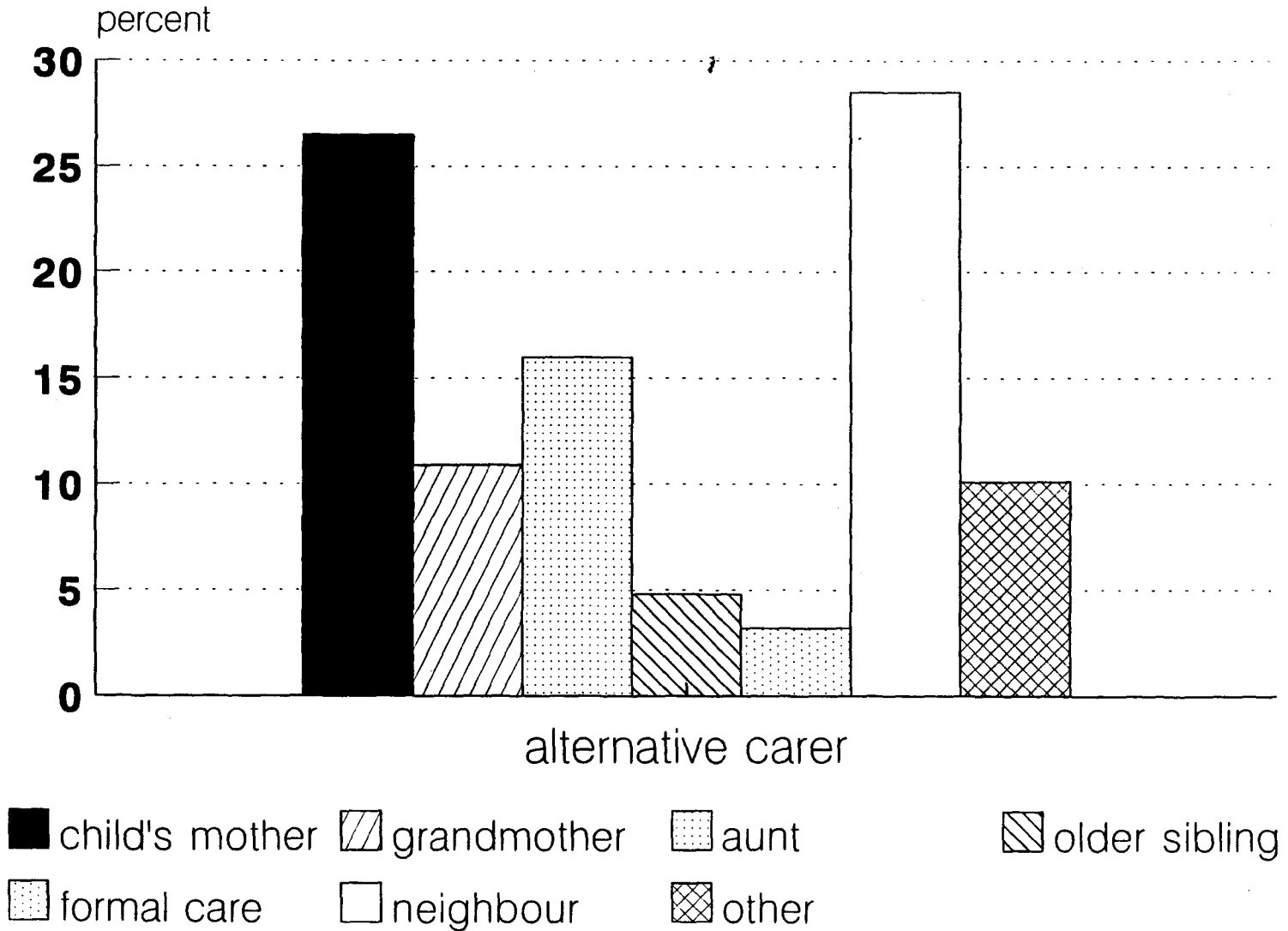


Table 7 shows that living in informal housing and being unemployed or employed in the informal sector were associated with performing childcare.

**TABLE 7**

**EXPLANATORY VARIABLES FOR PERFORMING CHILDCARE  
(EXCLUDES WOMEN WITHOUT CHILDREN UNDER 10 YRS AND WOMEN  
WHOSE CHILDREN ARE AWAY IN A RURAL AREA)**

VARIABLES	OR	95% CI	P VALUE
LIVES IN INFORMAL HOUSING (FORMAL HOUSING)	14.6	(6.35,33.4)	0.0000
UNEMPLOYED/EMPLOYED IN INFORMAL SECTOR (EMPLOYED IN FORMAL SECTOR)	2.49	(1.11,5.54)	0.0261
LIVES IN NUCLEAR/ HOUSEHOLD ('ALLIANCE' /WOMEN-HEADED HOUSEHOLD)	1.40	(0.626,3.14)	0.4102
URBAN YRS <11 YRS (11+YRS)	1.27	(0.548,2.93)	0.5779

(Baseline in parentheses)

As is shown in Table 8, use of formal childcare (creche/pre-school or school aftercare) is a function of being employed in the formal sector and having no home in a rural area.

**TABLE 8****EXPLANATORY VARIABLES FOR USE OF FORMAL CHILDCARE**

VARIABLES	OR	95% CI	P VALUE
EMPLOYED IN FORMAL SECTOR (UNEMPLOYED/ EMPLOYED IN INFORMAL SECTOR)	4.44	(2.57,7.70)	0.0000
NO RURAL HOME (HAS RURAL HOME)	2.11	(1.22,3.64)	0.0076
LIVES IN NUCLEAR/ EXTENDED HOUSEHOLD (WOMEN-HEADED/'ALLIANCE')	1.11	(0.635,1.93)	0.7223

(Baseline in parentheses)

Table 9 shows that care by the child's own mother is a function of being unemployed/employed in informal sector, having a rural home and being in a nuclear or extended household\*.

\* The categorisation into household types is defined in chapter 3.

**TABLE 9****EXPLANATORY VARIABLES: A CHILD WILL BE CARED FOR BY OWN MOTHER**

INDEPENDENT VARIABLES	OR	95% CI	P VALUE
UNEMPLOYED/ EMPLOYED IN INFORMAL SECTOR (EMPLOYED IN FORMAL SECTOR)	7.01	(4.36,11.3)	0.0000
LIVES IN NUCLEAR/ EXTENDED HOUSEHOLD (WOMAN-HEAD/'ALLIANCE')	2.30	(1.48,3.55)	0.0002
HAS RURAL HOME (NO RURAL HOME)	2.28	(1.45,3.58)	0.0003

(Baseline in parentheses)

As can be seen in Table 10, only living in informal housing was associated with women having an alternative carer for their children.

**TABLE 10**  
**EXPLANATORY VARIABLES: HAVING ALTERNATIVE CARER FOR CHILD**

VARIABLES	OR	95% CI	P VALUE
INFORMAL HOUSING (FORMALHOUSING)	2.12	(1.17,3.83)	0.0144
HOUSEHOLD COMPOSITION: WOMEN-HEAD/'ALLIANCE' (NUCLEAR/EXTENDED)	1.27	(0.770,2.08)	0.3454

(Baseline in parentheses)

### 8.3.3 Domestic chores (Housework)

Nearly all women were responsible for the domestic chores of cooking, cleaning and laundry (n=645, 98.3%). Figure 3 shows the distribution of time, women spent on housework.

65% of women in full-time formal sector employment, 69% of those in part-time formal sector employment, 85% of those in informal sector employment and 87% of unemployed women reported spending half a day (4 hours) or more doing housework.

# Time spent on housework

## Figure 3

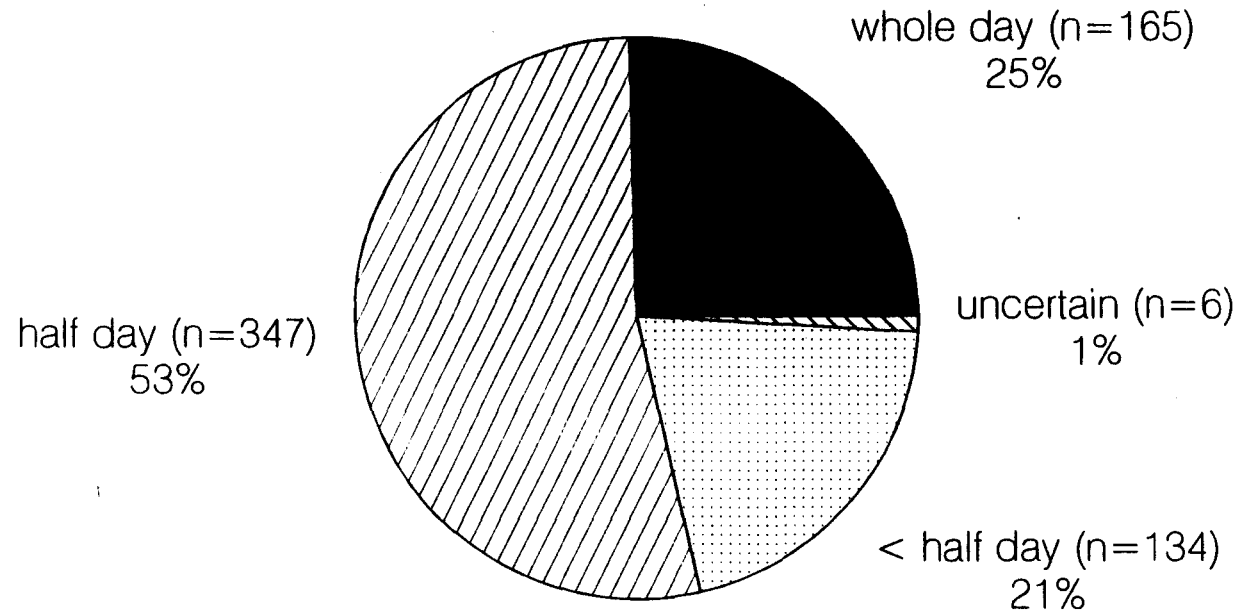


TABLE 11-

**RELATIONSHIP BETWEEN EMPLOYMENT STATUS  
AND TIME SPENT ON HOUSEWORK**

EMPLOYMENT STATUS TIME SPENT ON HOUSEWORK

	1/2 DAY LESS THAN <u>OR MORE</u>		<u>1/2 DAY</u>		<u>UNCERTAIN</u>		<u>TOTAL</u>	
	n =	%	n =	%	n =	%	n =	%
EMPLOYED IN FORMAL SECTOR (FULLTIME)	115	(65)	59	(33)	3	(2)	177	(100)
EMPLOYED IN FORMAL SECTOR (NOT FULL TIME)	25	(69)	10	(28)	1	(3)	36	(100)
EMPLOYED IN INFORMAL SECTOR	118	(85)	20	(15)	0	(0)	39	(100)
UNEMPLOYED	253	(87)	35	(12)	2	(1)	290	(100)

(Percentages in parentheses)

Table 12 shows that that being unemployed or employed in the informal sector and being married were associated with a woman spending the whole day on housework.

**TABLE 12**

**EXPLANATORY VARIABLES: WOMEN WILL SPEND  
WHOLE DAY ON HOUSEWORK**

VARIABLES	OR	95% CI	P VALUE
UNEMPLOYED/EMPLOYED IN INFORMAL SECTOR (EMPLOYED IN FORMAL SECTOR)	2.50	(1.59,3.92)	0.0000
MARITAL STATUS: MARRIED (REST)	1.70	(1.09,2.65)	0.0177
HOUSEHOLD COMPOSITION: NUCLEAR/EXTENDED (WOMEN-HEAD/'ALLIANCE')	1.24	(0.760,2.01)	0.3915

(Baseline in parentheses)

Table 13 shows that only living in informal housing was associated with a woman spending half the day on housework.

**TABLE 13****EXPLANATORY VARIABLES:****WOMEN WILL SPEND HALF THE DAY ON HOUSEWORK**

VARIABLES	OR	95% CI	P VALUE
LIVE IN INFORMAL HOUSING (FORMAL HOUSING)	3.05	(1.46,6.38)	0.0019
EMPLOYED IN FORMAL SECTOR: (UNEMPLOYED/EMPLOYED IN INFORMAL SECTOR)	1.09	(0.638,1.87)	0.7453
WOMEN HEADED/'ALLIANCE TYPE HOUSEHOLD (NUCLEAR/EXTENDED)	1.01	(0.616,1.65)	0.9732

(Baseline in parentheses)

In table 14, age (<45 years) and personal income (earning <R400 a month) are associated with the performing the domestic chore of cooking.

**TABLE 14**

**EXPLANATORY VARIABLES FOR PERFORMING  
THE DOMESTIC CHORE OF COOKING**

VARIABLES	OR	95 % CI	P VALUE
AGE <45 YRS (45+ YRS)	34.4	(3.79,312)	0.0001
PERSONAL INCOME <R400 (R400+)	9.59	(1.02,89.7)	0.0184
EMPLOYED IN FORMAL SECTOR (UNEMPLOYED/IN INFORMAL SECTOR)	1.60	(0.162,15.7)	0.6761
LIVES IN FORMAL HOUSING (INFORMAL HOUSING)	1.03	(0.187,5.73)	0.9691

(Baseline in parentheses)

### 8.3.4 Power relations within partnership relations

While nearly all women (n=647, 98.3%) said that they preferred to work outside the home and earn their own money, in 20% (n=109) of cases women stated that male partners would disapprove of them working. Just under a fifth of all women (17%) reported that they were **not working** as their partner would not allow them to. One fifth of all women stated that their male partners took the decisions over the money they earned. Figure 4 shows the distribution of who decided how to spend women's earnings

Out of 647 women, 16.6% (n=110) stated that they did not have a partner.

Table 15 shows that being married, being unemployed or in informal sector employment and having a home in a rural area were associated with a male partner's disapproval for his female partner working.

**TABLE 15**  
**EXPLANATORY VARIABLES FOR MALE DISAPPROVAL**  
**FOR FEMALE PARTNER WORKING**

VARIABLES	OR	95% CI	P VALUE
MARITAL STATUS: MARRIED (REST)	3.89	(2.08,7.28)	0.0000
UNEMPLOYED/EMPLOYED IN INFORMAL SECTOR (EMPLOYED IN FORMAL SECTOR)	3.86	(1.88,7.91)	0.0000
RURAL HOME YES (NO) (Baseline in parentheses)	2.31	(1.28,4.16)	0.0035

# DECISIONS ON WOMEN'S EARNINGS

## Figure 4

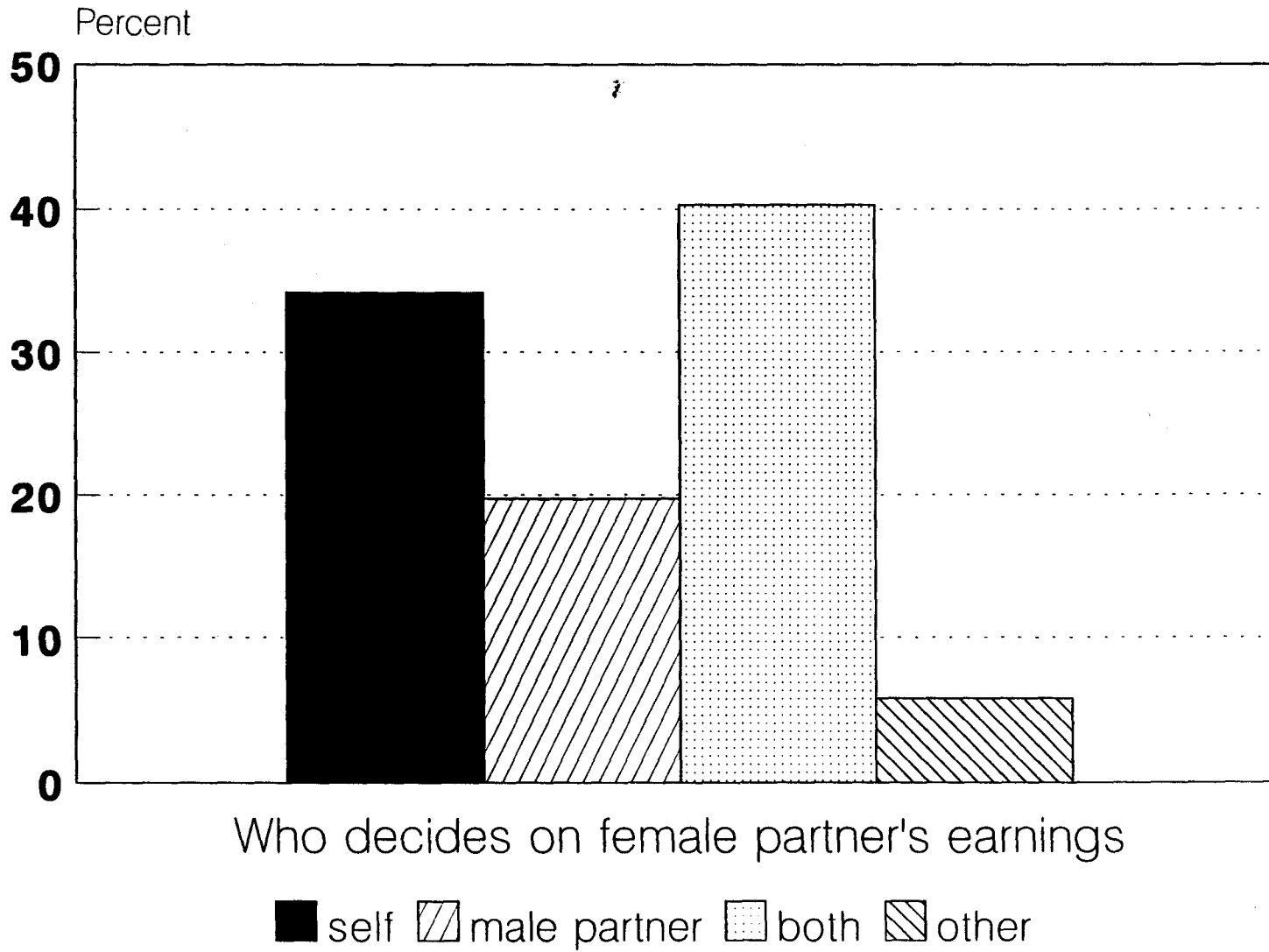


Table 16 shows that being married, having a home in a rural area and being unemployed or in informal sector employment were all associated with a male partner having sole decision-making powers over the spending of the money earned by his female partner.

**TABLE 16**

**EXPLANATORY VARIABLES : MALE PARTNER DECIDES  
ABOUT HOW TO SPEND FEMALE PARTNERS EARNINGS**

VARIABLES	OR	95% CI	P VALUE
MARITAL STATUS: MARRIED (OTHER)	8.73	(4.27,17.8)	0.0000
RURAL HOME YES (NO)	1.94	(1.10,3.42)	0.0179
EMPLOYED IN FORMAL SECTOR(UNEMPLOYED/ EMPLOYED IN INFORMAL SECTOR)	1.90	(1.03,3.50)	0.0317
URBAN YEARS <11YRS (11+YRS)	1.46	(0.877,2.42)	0.1406

(Baseline in parentheses)

Table 16 shows that being married, having a home in a rural area and being unemployed or in informal sector employment were all associated with a male partner having sole decision-making powers over the spending of the money earned by his female partner.

**TABLE 16**

**EXPLANATORY VARIABLES : MALE PARTNER DECIDES  
ABOUT HOW TO SPEND FEMALE PARTNERS EARNINGS**

VARIABLES	OR	95% CI	P VALUE
MARITAL STATUS: MARRIED (OTHER)	8.73	(4.27,17.8)	0.0000
RURAL HOME YES (NO)	1.94	(1.10,3.42)	0.0179
EMPLOYED IN FORMAL SECTOR(UNEMPLOYED/ EMPLOYED IN INFORMAL SECTOR)	1.90	(1.03,3.50)	0.0317
URBAN YEARS <11YRS (11+YRS)	1.46	(0.877,2.42)	0.1406

(Baseline in parentheses)

Table 17 shows that length of stay in an urban area and age were independently significantly associated with having no partner.

**TABLE 17****EXPLANATORY VARIABLES FOR A WOMAN HAVING NO PARTNER**

VARIABLES	OR	95% CI	P VALUE
URBAN YEARS 20+YRS (<20YRS)	4.46	(2.14,9.28)	0.0001
AGE 35+YRS (<35YRS)	2.86	(1.61,5.07)	0.0003
FORMAL HOUSING INFORMAL HOUSING	1.17	(0.556,2.46)	0.6764
BORN IN CAPE TOWN (BORN IN RURAL AREA)	1.46	(0.624,3.43)	0.3776
EMPLOYED IN FORMAL SECTOR(UNEMPLOYED/ EMPLOYED IN INFORMAL SECTOR)	1.07	(0.615,1.86)	0.8118
FORMAL EDUCATION 6+ YRS (<6YRS)	1.02	(0.525,1.98)	0.9536

(Baseline in parentheses)

### 8.3.5 Attitudes towards living in Khayelitsha

The majority (n=511, 77.7%) of women said that they liked living where they did.

Area of residence and type of dwelling had effects on this attitude. A significantly smaller proportion of women living in the unserviced shack areas (n=125, 59.8%) stated that they liked living in Khayelitsha when compared with the rest (n=384, 85.9%) ( $X^2=51.98, p<0.0001$ ). Significantly fewer women in the very poorly serviced informal housing area, Greenpoint (n=38, 46.3%) liked living where they did than women in serviced informal housing (Sites B & C) and the formal housing area (n=473, 82.3%) ( $X^2=52.96, p=0.00$ ).

## 8.4 DISCUSSION

Employment status had the major impact on women's social well-being, influencing social contact, domestic burden, childcare duties, childcare organisation and some aspects of gender relations. A social division existed amongst women in Khayelitsha between women employed in the formal sector on the one hand and those who are either unemployed or in the informal sector employment on the other. As others have pointed out<sup>22</sup>, in the current conditions of high rates of unemployment in South Africa, the social division between those who have formal jobs, albeit low paid ones, and those who don't, is increasingly significant in its impact on access to some of the basic material needs such as food, shelter, sanitation, clothing, education and health facilities. Age, household composition, and rural ties are other important determinants of social well-being, with place of birth and marital status having an effect on some variables.

The failure to find many associations between women's personal income and their social well-being is a reflection of the unreliability of income data and the well-known difficulties of determining the class position of women from their

income alone, without considering the economic resources of the household unit<sup>23,24</sup>. In addition it is likely to reflect the effect of a uniformly low income level prevailing amongst women in Khayelitsha, with 80% of reported earnings of women in formal and informal sector employment being under R400 a month. This creates an insufficient gradient in income to meaningfully measure differences on the basis of this variable.

Women in Khayelitsha were not found to be socially isolated, in terms of quantity of contact and satisfaction with their contact. This social contact is a potential source of social support.

Social contact with neighbours is affected by physical availability and therefore employed women are disadvantaged compared with unemployed women. This latter finding confirms impressions gained from key informants in the area in the indepth interviews conducted prior to the survey, details of which can be found in chapter 4.

Women who had spent a longer period in an urban area were more likely to see a neighbour as their closest friend. This can be seen as an index of stabilisation in this community. These women were mostly located in formal housing where there was less geographical mobility. This may lead to stronger neighbourhood friendships being forged.

There is widespread membership of church organisations. It has been suggested<sup>13</sup> that religion often provides meaning to "life in a painful world". In addition, it is possible that church groups are seen as 'safe' places for women to congregate as males are less likely to oppose their partners joining such groups. There is evidence to suggest that these groups provide some camaraderie to women as well as an opportunity for individual women to claim some independence from their male partners. For example, the Zibonele Women's Wellness Project in

Khayelitsha reports that women church group members stated that they actively conspired with each other to prevent disapproving husbands from finding out about their wives attending such groups. However, relations of support within these groups are not unequivocal. In workshops amongst church group women in Khayelitsha, it was felt that there was little opportunity to seek personal support within this context. In addition, some women may be marginalised in terms of access to church groups. For example, the rules of the Methodist church women's group exclude young (<25 years), single women\*.

Also, the nature of the tasks of women's church groups frequently reinforces their traditional service and care-giver roles.

A minority of women were members of civic organisations which is reflective at a local level of women's exclusion from political decision-making. Membership of a civic organisation was a function primarily of area of residence. This confirms other information obtained about residential organisation and leadership structures in Khayelitsha, detailed in Chapter 4. At the time of the survey, a civic organisation affiliated to a Western Cape Civic Association had a strong presence in the formal housing area. It had spearheaded the resistance to the discredited local authority, the Lingeletu West town council. In the informal housing area, 'shack lord' leadership which was autocratic in style, prevailed. To a lesser extent age and being unemployed or working in the informal sector were also predictors of membership of a civic organisation. Older women are less likely to perform domestic chores and childcare. Increased leisure time may enable them to become involved in other social activities. Older women were also less likely to have a partner. This too may influence women's ability to participate in civic organisations and other political kinds of organisation<sup>14,25</sup>. It

\* *Personal Communication from Karen Harrison, formerly the coordinator of the Zibonele Women's Wellness Project. This information was obtained from workshops the project ran with women in the Griffiths Mxenge, Town 2, Khayelitsha as part of its programme and not as qualitative research attempting to validate the findings of this study.*

has been suggested that older women have a cultural role in which they have more social authority<sup>26,27</sup>. Hence older women's participation in civic organisation may not only be more acceptable but also more worthwhile from the individual's perspective, as they are treated with greater respect by other members.

The finding that unemployed women or those working in the informal sector were more likely to be members of a civic organisation may be a chance finding attributable to the small number of women members of a civic organisation represented in the sample. It is possible, however, that these women may have more time to engage civic activities than women working in the formal sector.

Only just over a quarter of women were members of women's organisations. This reflects the lack of organisation and mobilisation of women at a local level. Klugman<sup>14</sup> argues that the lack of consolidated women's organisation at a local, regional and national level are an important obstacle to creating conditions which improve women's well-being. The fact that women living in formal housing and serviced informal housing were more likely to members of a women's organisation than those in unserviced areas, may mean that more recently urbanised women, living in the poorest environmental conditions, are marginalised from such social networks in the urban area. They constitute an important target group for women's organisations.

The majority of women had devised strategies for practical social support in the area of alternative childcare. Neighbours were the primary source of such support. However, despite the substantial social contact enjoyed by women in Khayelitsha, a **sizeable minority** lacked (instrumental<sup>3</sup>) social support in childcare. Women in formal housing were most vulnerable. It has been shown that closest friends are the commonest resource for support<sup>3,5,6</sup>. Yet women in the formal housing area, who were more likely to have been in an urban area for longer, and therefore most likely to have a neighbour as a closest friend, received less childcare support from neighbours. The reasons for this require further

investigation. This may be a function of a larger proportion of women in this area being in formal employment and therefore unable to take time off work to offer such support. In addition, as they are more urbanised and less likely to live in extended family households, they may lack the childcare support offered by relatives.

As elsewhere in the world, and particularly in Africa and Asia, women bear the major burden of domestic chores, even when they do other paid work. According to studies in Africa and Asia, women work as much as 13 hours a week more than men<sup>28\*</sup>. A study of 835 African working women in South Africa found that most women worked for between 16 and 18 hours a day<sup>29</sup>. Many women in Khayelitsha experience the stressful situation of working a 'double shift', outside and inside the home. As the results show, married women were particularly vulnerable in this regard. The findings show that the majority of the 182 women employed in full-time formal employment reported working an extra 28 hours or more a week, on domestic chores.

Our findings are in line with international experience, that mothers in the developed and developing world bear major responsibility for childcare<sup>28</sup>.

As can be seen in the multivariate analysis, a number of factors were independent explanatory variables for the performance of childcare. A greater proportion of women who had older children (over 10 years of age) did not perform any childcare duties. As the ages of these older children are unknown and it is not clear whether they were adolescent or adult, no specific conclusions can be drawn. Clearly women in formal employment are less able or unable to perform childcare as they are either away from their children for a large part of the day or completely absent when they have 'live-in' jobs. Women in formal housing may be less involved in childcare, also as a result of being employed.

\* *These figures do not differentiate between time spent on paid and unpaid work.*

The study documents the fact that many (41%) send children to a rural area for childcare and for schooling. In this manner relatives in rural areas provide childcare support in the case of young children. In the case of older children this may be a means of providing support to ageing relatives for domestic and agricultural chores<sup>30</sup>. It has also been suggested in Chapter 4 that parents reverted to sending children away to a rural area for schooling as they feared disruption of their children's schooling in the cities. Amongst those children resident in Khayelitsha, a high proportion of women looked after their children themselves. This may be by choice or due to the lack of availability of childcare facilities, as there were only 48 recorded preschool centers or creches in Khayelitsha<sup>31</sup>. Lack of affordability<sup>32</sup> is likely to be a further explanation. As South African women receive little state or employer support<sup>32</sup> in the area of childcare, relatively few women would be able to afford formal childcare. This is borne out by the fact that those who do use formal childcare are mostly those in formal employment and who therefore have a more stable income. Despite this, the fact that a significant minority<sup>\*\*</sup> of women use formal childcare indicates that a need exists for such facilities and that this is being met in part, by a large number of unrecorded childcare facilities.

The fact that women with weaker rural ties (those who had no rural home) made greater use of formal childcare may be related to differing attitudes to responsibility for childcare and greater opportunities for meeting alternative childcare needs.

- \* *For example, in a workshop conducted under the auspices of the Zibonele Women's Wellness Project revealed that many women could not afford creche fees which were around R30 a month and that this created problems for them with respect to seeking employment. Personal Communication from Karen Harrison, Zibonele Project.*
- \*\* *The figure for pre-school care is slightly higher than that estimated by Harrison and McQueen<sup>31</sup>. They estimated that a total of 3034 preschool children were accommodated in recognised creches and educare centres, constituting 4.4% of the total number of pre-school children in Khayelitsha.*

Where relatives looked after children, the pattern of grandmothers and aunts playing a major role in the care of the children (particularly of single mothers) is confirmed<sup>15</sup>.

The finding that most women in informal sector employment continued to look after their children while working has interesting implications. Women face great obstacles to seeking and keeping formal employment. Poor maternity provisions and few guarantees of being able to return to their jobs make it difficult for women to maintain formal employment through pregnancy and childbirth. The difficulties of arranging childcare in the post-natal period and during early childhood, adds to these difficulties. Does this force women wanting to have children and those with young children into informal sector employment? Or is it possible that women seek informal sector employment as this gives them greater freedom during the childbearing years and allows them to continue looking after their young children?

Some studies have found the latter to be the case when informal sector women operate from their homes. A study in the informal sector in Chatsworth, Durban found that the vast majority of women surveyed preferred working from home. The commonest reason given for this was having young children or disabled family members to care for<sup>33</sup>. In another study amongst women in Botswana<sup>34</sup>, it was found that women saw working from home as an advantage as they were close to family and children and in addition could perform domestic chores during quiet periods. Clowes<sup>35</sup> in her study amongst women in the informal sector in Cape Town also found that many women chose to work in the informal sector as they experienced difficulties reconciling domestic responsibilities with formal sector work outside of the home. Notable in this regard were childcare responsibilities. Our findings are supportive of this in that women in formal sector employment spent many additional hours a week on their own domestic

chores. Hence it may be less stressful in the context of the need to perform domestic chores within their own homes, for women to work in the informal sector.

However the question of 'what women choose' needs to be placed in the context of the lack of childcare facilities and their lack of affordability as well as the domestic division of labour in the home. As all of these factors militate against women working in the formal sector, it becomes difficult to disentangle personal preferences of women from societal and domestic constraints. As Reibstein<sup>33</sup> states these constraints place women in a situation which entrench them "in the 'private' sphere of society reinforcing their roles as 'housewives'".

Further research is needed into how satisfactory formal sector, employed women find childcare arrangements from a financial and practical point of view, as well as how they feel about being parted from their young children for long hours. Cock<sup>36</sup> states that many domestic workers feel that in looking after two families they neglect their own children.

Disapproval by male partners of female partners working and decision-making over money are but two aspects of unequal domestic social relations between men and women in Khayelitsha. Marital status (being married), being unemployed or in informal sector employment and rural orientation were associated with patriarchal attitudes regarding women working and male control over money. This association with marital status is confirmed by another study in a serviced informal housing area, Griffiths Mxenge, Khayelitsha conducted in 1992<sup>37</sup>.

The significant proportion of women in Khayelitsha who stated that they had no partner (16.6%) is not unlike the situation in many other countries<sup>28</sup>.

It is to be expected that older women would be less likely to have partners due to the greater likelihood of widowhood with age. However, the data from our survey shows no imbalance in the sex ratios in the population of Khayelitsha from age 35 years onwards. In line with other South African studies<sup>14,37,38,39</sup> this indicates that the absence of a partner is not only a function of widowhood but also of the disintegration of conjugal partnerships. Bonner<sup>40</sup> records the beginnings of female-headed households in the 1920's as a conscious striving for independence from men, particularly economic independence. It has been suggested<sup>41</sup> that there is an emergence of new family forms in the urban areas, centred on women and their children, at least partly as a result of women choosing to redefine their relationships with men<sup>35</sup>. Similar trends have been reported by Obbo in Uganda<sup>42</sup>. Despite the fact that truly women-headed families tend to be in the lowest income category<sup>43,44</sup>, it has been found that women generally, regardless of class and level of education seek financial independence to ensure that the household's money was spent responsibly. Our findings are supportive of this in that married women were reported to have least control over the spending of their earnings. Women employed in the informal sector and more rurally oriented women (those with a rural home) also bore a greater burden of control by male partners, in this regard. The tendency of households to converge to a women-headed type with increased stay in an urban area is also confirmed<sup>43</sup>.

However, it is likely that even in households where men have **formal** control over earnings, **real** control is negotiated and struggled over<sup>45,46</sup> and married women may wrest more control in some instances than can be gleaned from the findings of quantitative research. Based on her research amongst hostel dwellers, Ramphele<sup>17</sup> argues that "women are acutely aware of the fragility of the egos of their men and the need for men to feel like 'masters in their own domain'" and may skillfully allow men to feel this without this necessarily being the case. This is illustrated by the findings of workshops which were conducted as part of a needs assessment programme of the Zibonele Women's Wellness Project in

Griffiths Mxenge, Khayelitsha. Women stated: "If a boyfriend drinks and gives no money there is no definite solution. Neighbours try to talk but he does not often listen." However, in the case of married women, they reported : "...if a husband is wasting money, you quarrel and demand all the money." The women all said they forced their husbands to allow them to control the money'.

A researcher conducting qualitative research in Harare, Khayelitsha was told that a group of senior members of a women's group beat up the girlfriend of a married man whose wife objected to the drain on family resources caused by the girlfriend. The girlfriend moved and the husband returned to his wife". Interestingly, women church group members have reported that group rules allowed single women to have relations with a married man, **provided** she did not accept any financial support from him. These latter examples indicate pressure being brought to bear by some women on other women rather than on men.

Environmental conditions play the major role in women's attitudes towards living in Khayelitsha. The views of the residents of the Greenpoint area and the unserviced 'shack' areas, are directly related to the poor environmental conditions which prevail in these areas. Khayelitsha is far from work and social amenities which are concentrated in Cape Town and its immediate suburbs. The physical environment is sandy and desolate. It also experiences high levels of violence. The number of registered deaths due to trauma amongst younger men (<35 years) in Khayelitsha constitutes 44.8% of all deaths<sup>31</sup>. In the light of this, the reported positive attitudes of women to living in Khayelitsha, apart from those

- \* *Personal communication, Karen Harrison, formerly coordinator of the Zibonele Women's Wellness project.*
- \*\* *Personal communication, Anne Jellema, who was conducting research in the Harare area of Town 2, Khayelitsha for a PHD in Social Anthropology. The research was unconnected with this study.*

living in Greenpoint and unserviced informal housing, needs further investigation. This may reflect in part the high value placed on living in ones own home without the accompanying harassment which was so much part of the influx control enforcement of the past. It may also be a reflection of human beings' ability to adapt and make the best of difficult conditions.

Social well-being is complex. Assessments are heavily reliant on the domain of opinions, beliefs and values. Conclusions therefore need to be drawn with some circumspection.

Those aspects of social well-being explored in this study as well as the manner of exploration, were limited. A large number of areas of social well-being including: detail of the frequency and quality of individual and group social interaction; emotional social support; areas of practical support besides childcare; and other areas of domestic gender subordination, were not explored. As importantly, women's **perceptions** of their well-being and their levels of satisfaction with their lives, were not examined in any depth. Qualitative methods would be more appropriate to such an examination.

Nevertheless, within the limitations described ,the findings identify some women who were most disadvantaged in terms of the aspects of social well-being examined. Women who were younger, more rural, unemployed or in the informal sector and those living the poorest environmental conditions in informal housing were most likely to lack intimate social contact and access to group affiliation (particularly civic and women's groups). They also bore the greatest burden of domestic labour and tended to be most subject to patriarchal attitudes in the home.

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**CHAPTER 9**

**WOMEN'S SOCIAL WELL-BEING, HEALTH STATUS, USE AND  
KNOWLEDGE OF HEALTH SERVICES**

**CONTENTS**

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## 9.1 INTRODUCTION

This chapter examines the effects of women's social well-being on their health status, knowledge and use of services. Details of women's social well-being and its determinants are presented in the previous chapter.

Social well-being is considered to be an important aspect of women's health status. The World Health Organisation's definition of health stresses that health is not only the absence of disease or infirmity but includes emotional and social well-being too<sup>1</sup>.

Many problems in women's health, for example pregnancy-related deaths, are a reflection, in part, of sexual inequality in so far as they are evidence of a neglect of women's rights. A lack of confidence and control over their bodies and lives by women impacts negatively on their physical and psychological health<sup>2</sup>. Many issues related to women's health are difficult to tackle without addressing the inequality in status between the sexes and without a shift in power in gender relations<sup>3</sup>. For example maternal mortality is affected by the undernourishment of girls from birth. The undernourishment of girls is at its most marked in parts of Asia. Holloway<sup>3</sup> cites much evidence of discrimination against girls particularly on the Asian sub continent, including selective abortion and infanticide at the most extreme side of the spectrum. A study in Pakistan found that the mortality rate was 1.5 times higher for girls than for boys, even though given an equal ratio of care, male survival rates should be lower. A Harvard School of Public Health study conducted in India found that boys were 50 times more likely to be treated for malnutrition than girls even though the condition was 4-5 times more prevalent in girls<sup>3</sup>. Studies in Colombia and Thailand found while the incidence of malaria appeared to be the same for both sexes, men were six times more

likely to request medication or care than women<sup>4</sup>. Violence against women, in the form of rape or domestic battery is a widespread, women's health problem internationally<sup>4</sup> and is rooted in women's inequality with men.

Smyke argues that if women are considered, and hence consider themselves to be of lesser value as a result of their lower social status, this impacts negatively on their own health and health-seeking behaviour<sup>5</sup>. In addition, where women or girls are undervalued and have little political or economic power, less effort may be taken to provide them with access to the health care system<sup>4</sup>. A number of studies show a correlation between increased financial power of women (and greater educational opportunities) and their health as well as that of their children<sup>3</sup>.

Women occupy multiple roles spanning the domestic and public sphere. Multiple roles can lead to increased stress as a result of women having to contend with often conflicting demands as well as having to work longer hours as a result. This is exacerbated by a combination of domestic hardship and negative work conditions<sup>6</sup>. Brand and Hirsch found a strong link between the psychological well-being of married women employed outside the home and the satisfactory sharing of household work and childcare. In addition, negative spouse attitudes towards such employment were linked to higher job dissatisfaction, lower marital satisfaction and in turn higher levels of psychological symptoms<sup>7</sup>. There is evidence that women's nurturant roles result in their being more run down physically. This has been found to have negative health effects, particularly on single women with children<sup>8</sup>. Klugman and Weiner report that studies in other parts of Africa have shown that chronic overwork together with poor nutrition undermines women's health<sup>2</sup>.

- \* *In Papua New Guinea, 56% of married women in the cities reported being battered. 18% had been hospitalised due to this. In the United States, between 22-25% of visits by women to emergency rooms are for injuries from domestic violence<sup>3</sup>. In South Africa it is estimated that 50%-60% of all marriages involve wife-battering<sup>2</sup>.*

While studies on the effects of social contact on health show that it is likely to have some general disease consequence, there are difficulties in relating this to any particular category of disease<sup>9</sup>. It is often unclear whether social isolation leads to ill health or whether ill health leads to isolation.

Kaplan<sup>10</sup> argues that there are two types of psychosocial processes important in disease aetiology: stressor factors which enhance susceptibility to illness, and protective factors which act as buffers against illness. He suggests that factors common to most stressor situations include situations of role conflict or ambiguity and of blocked aspirations. Social support has a number of dimensions and the importance of different kinds of social support and the mechanisms through which support occurs varies from individual to individual and between different groups. Several studies have found that social support acts as a buffer against stress and can positively affect health<sup>11,12</sup>. The quality rather than the quantity of social contact may be beneficial, as too many demands for reciprocal support can in fact be stressful. However, the relationship between social support and health or illness is complex and appears to be indirect.

Studies reviewed by Kaplan and Berkman<sup>9,10</sup> show that social support acts more as a conditioning variable than a direct cause, undermining an individual's susceptibility to various illness outcomes. Social support seems to be protective in the presence of stressful circumstances rather than having effects on its own<sup>10</sup>. Some studies showing indirect evidence that the absence of social support has negative effects in the passage of disease. For example a study on Tuberculosis in Seattle found that TB occurred more frequently in socially marginalised people<sup>10</sup>. While another study of the joint effects of stressor and protective factors on outcomes of pregnancy found that a **combination** of life changes and low social support were associated with more complications in pregnancy outcomes<sup>13</sup>. A study of the effects of an urban renewal project on non-working mothers in Boston in the United States showed that women

experienced increased communication, sharing and exchanges of tangible support in their original crowded environment and relocation created difficulties for them in meeting these needs<sup>10</sup>. Various studies have shown negative effects of social isolation on psychological health<sup>14,15</sup>. Social support may have a more beneficial effect in women than men<sup>11,12</sup>.

## **9.2 METHODS**

The statistical methods of analysis used are described in detail in Chapter 3.

Table 1 shows list of the variables for the associations examined.

**TABLE 1 HEALTH AND SOCIAL WELL-BEING VARIABLES TESTED FOR ASSOCIATION**

**Variables**

**HEALTH**

**Reproductive:**

- no. of pregnancies (fertility)
- problems falling pregnant (infertility)
- gynaecological illness

**Health Service use**

- attendance of ante-natal care
- use of contraception
- use of health services when ill
- having had a cervical smear

**Illness:**

- chronic
- acute

**Health Knowledge:**

- awareness and knowledge of AIDS and its prevention
- awareness of cervical smears

**SOCIAL WELL-BEING**

**Social contact:**

**Individual:**

- with friends
- with neighbours
- with relatives

**Group:**

- member of a church organisation
- member of a civic organisation
- member of a women's organisation

**Social support:**

- alternative care for child/ren

**Women's domestic status:**

**Gender organisation of housework in the home:**

- does cooking
- does cleaning
- does laundry-
- performs childcare

**Relations of power between partners:**

- preference for working outside the home
- male partner's attitude to his female partner working outside the home
- decisions about spending of female partners earnings

**Attitudes towards living in Khayelitsha**

Health outcome, knowledge and use of health services variables were examined to determine significant associations with social well-being variables. Continuous variables were transformed into categorical variables by the insertion of cutpoints.

In order to determine which social well-being variables were the explanatory variables for specific outcomes in health status, knowledge and use of services, multivariate analysis was performed. *A priori* decisions and the bivariate analyses formed the basis for multivariate modelling.

A list of all variables used in final models is given in Table 2 in the box below.

TABLE 2

**Dependent variables**

Attended ante-natal care

Non-use of public  
health services

Awareness of AIDS

Knowledge of AIDS  
prevention

**Independent variables**

Contact with neighbours

Having a neighbour as a  
a best friend

Membership of a church  
organisation

Male disapproval for female  
partner working

### 9.3 RESULTS

No independent association was found between number of pregnancies, infertility, gynaecological illness, use of contraception, acute illness, chronic illness, use of private health services, having heard of a cervical smear and having had a cervical smear and any of the social well-being variables.

Table 3 shows that having contact with neighbours is the only explanatory variable for attendance at ante-natal clinics.

**TABLE 3**

**EXPLANATORY VARIABLES FOR  
ATTENDANCE AT ANTE-NATAL CLINICS**

VARIABLES	OR	95% CI	P VALUE
HAS CONTACT WITH NEIGHBOURS (NO CONTACT)	5.67	(1.30,24.7)	0.0272
AGE <35YRS (35+YRS)	2.52	(0.608,10.4)	0.1983
PERSONAL INCOME R400+ (<R400)	1.72	(0.424,6.97)	0.4396
EDUCATION <6YRS (6+YRS)	1.39	(0.222,8.74)	0.7170
URBAN YEARS 11+ YRS (<11YRS)	1.34	(0.314,5.70)	0.6920
INFORMAL HOUSING (RESIDES IN HOUSING AREA)	1.16	(0.119,11.4)	0.8979

(Baseline in parentheses)

Table 4 shows that being a member of a church organisation and having a neighbour as a best friend is associated with greater AIDS awareness.

**TABLE 4**

**EXPLANATORY VARIABLES FOR AWARENESS  
OF AIDS (HAVE HEARD OF AIDS)**

VARIABLES	OR	95% CI	P VALUE
NEIGHBOUR BEST FRIEND: NO (YES)	9.16	(1.23,68.1)	0.0019
EDUCATION 10+YRS (<10YRS)	2.14	(0.866,5.28)	0.0756
CONSIDER CAPE TOWN TO BE HOME (RURAL AREA)	2.13	(1.11,4.12)	0.0188
MEMBER OF CHURCH ORGANISATION: (NO) YES	2.00	(1.03,3.86)	0.0448
MALE PARTNER OPPOSES WOMAN WORKING: NO (YES)	1.50	(0.719,3.12)	0.2881
EMPLOYED IN FORMAL SECTOR UNEMPLOYED/EMPLOYED IN INFORMAL SECTOR	1.43	(0.731,2.81)	0.2855

(Baseline in parentheses)

Table 5 shows that not belonging to a civic organisation is associated with greater knowledge of AIDS prevention.

**TABLE 5:**

**EXPLANATORY VARIABLES FOR KNOWLEDGE OF  
PREVENTION OF AIDS (ENGAGE IN PROTECTED SEX)**

VARIABLES	OR	95% CI	P VALUE
LIVES IN FORMAL HOUSING (INFORMAL HOUSING)	2.42	(0.541,10.8)	0.2677
EDUCATION 6+ YRS (<6YRS)	0.103x10 <sup>4</sup>	(0.871x10 <sup>-6</sup> , 0.0179 0.121x10 <sup>13</sup> )	
URBAN YEARS <11YRS (11+YRS)	1.24	(0.341,4.51)	0.7412
AGE <45YRS (45+YRS)	1.55	(0.179,13.4)	0.6749
MEMBER OF A CIVIC NO (YES)	5.20	(1.03,26.1)	0.0219
UNEMPLOYED/EMPLOYED IN INFORMAL SECTOR (EMPLOYED IN FORMAL SECTOR)	1.34	(0.388,4.62)	0.6414

(Baseline in parentheses)

## 9.4 DISCUSSION

The fact that limited associations were found between social and physical well-being is not unexpected. There are so many possible pathways of explanation making the exact determination of physical well-being complex. This study of social well-being was exploratory and limited in the aspects of social and physical well-being covered, and to quantitative findings. The findings illustrate the difficulty of using statistical analysis such as multivariate modelling to analyse the links between social and physical well-being in the context of a life-span perspective. Determinants of precise health endpoints may become blurred by the range and interlinked nature (co-variation) of many of the variables. Direct associations between social well-being and physical health have proved difficult to show elsewhere<sup>9,10</sup>. Numerous multiple comparisons may also have led to some nonsensical associations by chance. Many of the variables which make up domestic life are not readily amenable to measurement<sup>6</sup>. In addition there was a limited range of health outcomes. Psychological or mental health outcomes may have a more demonstrable association with social well-being.

Women in Khayelitsha may have constituted too uniform a group. For example, most shared a similar socio-economic status and experienced satisfactory social contact and support. Hence a restricted range of many key variables may have limited the ability to detect the subtle effects of social well-being on physical health. A study in Japan, in a socially cohesive community, noted few differences between people who were socially isolated and those who were not socially isolated and concluded that where social contacts are so routine in the lives of people, the effects of differences may be difficult to measure<sup>9</sup>. Further research comparing women in Khayelitsha with women in other areas may reveal interesting differences regarding the impact of social well-being on physical and mental health.

Nevertheless some evidence did emerge for social contact and domestic status having effects on health status independently of other socio-demographic variables. Some social well-being variables in various combinations predicted health outcomes of interest.

Contact with neighbours could positively influence attendance of ante-natal care clinics through the transmission of certain 'pro-medical care' values<sup>9</sup>. This takes the form of knowledge of how to obtain services, observing and adopting the preventive health behaviour of others and the transmission of knowledge on the importance of ante-natal care for mother and infant by neighbourhood peers. On the other hand it may be a proxy for other variables - for example, women who have contact more frequently with neighbours are likely to be unemployed. If pregnant, they may have had more time to attend ante-natal care. They are also newer arrivals in the urban area and may have migrated specifically to seek health care.

The fact that women who had a neighbour as a closest friend had greater AIDS awareness is likely to be a proxy for other variables. The greater awareness of AIDS amongst church organisation members may be as a result of the church raising the issue of AIDS as a 'moral' issue. It is most unlikely that belonging or not belonging to a civic organisation negatively affects knowledge of AIDS prevention. This is likely to be a chance finding.

Which social factors provide support and what are the mechanisms for such support in the context of women's lives in Khayelitsha need to be better understood. Further research is necessary to identify which measures of health status have a more demonstrable association with social well-being. More appropriate measures of psychological and physical stress need to be identified

amongst African women in peri-urban communities. This will contribute to a greater understanding of what constitutes stressor situations and what are supportive actions which buffer against stress amongst women in this community.

More focussed research on women identified by the study as potentially at risk physically and psychologically should be conducted. For example the following study areas need further investigation:

- An examination of the socio-cultural factors affecting psychological health such as the multiple roles occupied by the various strata of women in a peri-urban community such as Khayelitsha.
- A study of the health implications for women and their children, of women in the informal sector experiencing the dual stress of having to work while at the same time caring for young children. Research in a peri-urban community in Gambia found increased risk of child mortality for children of self-employed women<sup>16</sup>.
- An examination of its health effects of the relative social isolation\* of domestic workers.
- A study of the effects of the unequal domestic division of labour and power relations on women's psychological health.

Indepth qualitative research methods are likely to add substantially and to clarify the manner in which social, physical and psychological well-being relate to each other.

\* *The social effects of the relative isolation of domestic workers have been extensively studied in case study by Cock<sup>17</sup>.*

Both social contact and domestic status are amenable to organisational remedies. This presents a challenge to political, community, women's and health organisations to construct a concrete agenda capable of addressing women's social well-being and its impact on women's health status.

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**CHAPTER 10**

**CONCLUSION**

**CONTENTS**

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## **10.1 SUMMARY DISCUSSION OF FINDINGS**

The findings show that a significant proportion of Khayelitsha residents lived in unserviced informal housing. The lack of services and poor housing were identified in Chapter 2 as factors contributing to high health risks particularly for diseases of poverty, communicable diseases and respiratory diseases. Unemployment amongst women was high. Women in formal employment were predominantly in domestic service, which was characterised by unregulated conditions and terms of employment and low wages. Those in informal employment were mostly located in marginalised, irregular income activities such as hawking. It is therefore not surprising that widespread poverty existed even amongst employed women, with nearly all (more than 90%) earning below the minimum living level for 1990. The finding that a disproportionate number of female-headed households in Khayelitsha had the lowest incomes follows international experience that single women in female-headed households tend to be amongst the poorest of the poor. Strong links existed between urbanisation status and area of residence in Khayelitsha. The largest proportion of new arrivals to the urban area and those with the strongest rural ties, resided in the poorly serviced and unserviced informal housing areas. These women were also most likely to be younger and unemployed. While education levels amongst women in Khayelitsha were higher than the national average for South Africa, there were low levels of after-school training indicating poor access to acquisition of job skills. This impacts negatively on successful entry into the job market.

Employment status had the most marked effect on women's social well-being. Women who are employed have the potential to be financially independent of their male partners. The literature reviewed suggests that women who are financially independent of men enjoy higher domestic social status.

Subordination to male partners in decision-making in the areas of working outside the home and the spending of their earnings affected a significant minority of women. Those especially vulnerable to occupying subordinate domestic status were married women, those with stronger rural ties and those not in formal sector employment.

Women in Khayelitsha did not appear to be socially isolated. Women employed in the formal sector however, experienced greater isolation relative to women who were unemployed or working in the informal sector. This apparent paradox can be explained by the isolated nature of work in domestic service, the most common area of formal sector employment for women in Khayelitsha. Organisational affiliation was primarily to church organisations with few women being members of civic or women's organisations. Young, new arrivals to the urban area were most marginalised with respect to membership of civic and women's organisations.

As elsewhere in the world, women bore the major burden of domestic chores in the home, even when doing other paid work. In general they were only relieved of part of this burden when other women were present in the household. The effects of the fatigue and stress generated by this extra work could not be measured within the context of this study.

Most women, especially those not in formal employment looked after their young children themselves. This must be particularly burdensome for those women engaged concurrently in activities in the informal sector. However, despite this, as satisfactory childcare is difficult to procure, the possibility of continuing to look after children while working may make informal sector work a more attractive work option and militate against formal sector employment for women. A significant need for formal childcare was revealed and nearly a quarter

of all women, lacked social support for childcare when in need. Women residing in the formal housing area were most vulnerable with respect to social support for childcare.

In the areas of health status and knowledge of and use of health services, a number of problems were highlighted.

Teenage pregnancy is an important problem in this community. Hence a substantial group of women with high risk pregnancies lives in this community. While many women attended ante-natal care, information on the number of times they attended and at what stage of their pregnancy was not collected. The ability of ante-natal services to identify high-risk pregnancies and prevent pregnancy complications in this community is therefore unknown.

There is extremely high use of injectable contraceptives in Khayelitsha. This raises questions of method availability and choice at health services. While some women not using contraceptives may be consciously choosing not to do so, the fact that they constituted nearly half of women who were in their reproductive years in the study, raises questions of unmet need for contraceptives.

A fairly high proportion of women reported infertility. This is particularly important in the light of the high proportion of gynaecological illness reported as Pelvic Inflammatory Disease and the association found between gynaecological illness and infertility. Together with the high proportion of PID reported this indicated a large hidden STD problem. Possible lack of knowledge of gynaecological symptoms amongst women, and problems with health service availability and access may be contributing factors.

The large proportion (a third) of women using private health services for acute illness, in the context of this poor community, highlights problems with state health service availability, accessibility and quality. The reported lack of use of traditional healers is unlikely to be a true reflection of use. An assessment of the actual use of traditional healers within this community and what health problems and needs they address, particularly amongst women, needs further exploration. It is thought that there is substantial use of traditional healers in many communities in South Africa. Traditional healers are increasingly being recognised by the medical establishment as important within the context of overall health service delivery restructuring and may be particularly important in the delivery of appropriate health education.

The extremely poor knowledge of AIDS and lack of reported condom use is of great concern. While the prevalence of HIV infection is lower in the Western Cape than in the rest of the country, over a third of all notified HIV positive cases in the Western Cape were resident in Khayelitsha. In the light of the known large STD problem and the existence of a high proportion of undiagnosed STDs, action in this area is particularly urgent.

Relationships were identified between age, area of residence, education, marital status, urbanisation, income and health. The relationship between education and urbanisation and health was particularly marked. Education was associated with a lower number of pregnancies, an older age at first pregnancy, higher use of contraception, greater likelihood of having had a cervical smear, less reported acute illness and was negatively associated with having lost a liveborn child. This confirms the positive effects identified in the literature between higher levels of education and improved health status amongst women. Associations were found between women with stronger rural ties and a greater number of pregnancies, not having had a cervical smear and poorer knowledge of AIDS, indicating a relationship between urbanisation and the some areas of health

knowledge and use of health services. Women who had been in an urban area longer also reported more chronic illness, independent of age, confirming the link identified in the literature between urbanisation and illnesses related to industrialisation and lifestyle.

Women living in the poorest environmental conditions in the Greenpoint area had the greatest likelihood of having lost a child, the lowest awareness of AIDS and least knowledge of where to go for a variety of health needs.

Chapter 9 explores the reasons for the limited associations found between social well-being and physical well-being. In summary, this may be due to a number of factors:

1. a large degree of homogeneity in women's social well-being status as defined in Chapter 8, making it difficult to detect differences in social and physical well-being in the study population
2. an examination of the relationship between social well-being and inappropriate physical health variables
3. and the difficulties of detecting cumulative effects of changes in health status over a life cycle at one moment in time.

In addition this may be a reflection of human adaptability to poor conditions.

Nevertheless, social contact with neighbours was shown to have an independent effect on attendance of ante-natal care and greater social contact was found to be positively associated with awareness of AIDS.

Knowledge of cervical screening was poor. An important gap exists in health education and promotion of cervical screening in a population where cervical cancer is known to be an important health problem. The association between having had a cervical smear and use of contraception tends to confirm the suggestion in other studies that opportunistic cervical screening in family planning services has led to greater screening of lower risk, younger women. This highlights the need for a more rational national cervical screening policy targeting women at greatest risk.

## 10.2 FUTURE RESEARCH POSSIBILITIES

A number of future research possibilities have been suggested in this thesis. Some areas of further research include:

- assessing the quality of ante-natal care services and their appropriate coverage (quantity and timing with the stages of pregnancy) particularly of high risk young pregnant women in this community.
- examining in greater detail and depth the effect of women's work particularly in the informal sector and at home on their health. Specific studies could include: the effects of women's work burden on their social status and the levels of stress experienced and the health effects of caring for children concurrently with work in the informal sector.
- the incidence of infertility amongst women and their perceptions of infertility.

- **silent STDs: what knowledge do women have of the symptoms of gynaecological problems and what factors contribute to or discourage them from seeking help at health services. This would contribute to the design of appropriate educational programmes and to restructuring of services aimed at detecting and managing STDS in women.**

**A number of important areas of health were not explored in this thesis and represent important areas for future research. These include women's mental health and women and violence.**

**In all the above areas of research, studies which include intra-urban comparisons and hence less homogeneous populations would add to knowledge of the differential health status of women in poor peri-urban areas in South Africa. Studies which include a mix of methods - quantitative and qualitative methods of data collection would also greatly enhance our understanding of women's health, given the difficulty in defining and measuring relevant variables.**

### **10.3 PRIORITIES IN IMPROVING THE HEALTH STATUS OF WOMEN**

**A gender-sensitive approach to women's health status accords key importance to changes in women's socio-economic position. A two pronged approach is therefore necessary to improve women's health status:**

- \* **Programmes are needed for the socio-economic development of poor African people in South Africa. Special importance should be given to programmes to improve the economic and social status of women in the home and in the society.**
- \* **The provision of adequate, appropriate and accessible health services for women.**

For most of its population, South Africa is a developing country with scarce resources. The most vulnerable groups of women and priority health problems need to be targeted. This study has identified young, newly urbanised women, living in poorly serviced and unserviced informal housing areas as particularly at risk in terms of their socio-economic and health status within a peri-urban African community such as Khayelitsha.

Amongst women in this community, there is an urgent need for programmes to address poverty (lack of jobs, income and adequate housing) and lack of education, particularly skills training appropriate for finding work and to promote women's assertiveness and empowerment. Development, leadership and women's health programmes could provide vehicles to address these issues. Local initiatives exist in Khayelitsha in the form of a number of development and health projects. Two women's wellness projects, the Masikhanyise project under the auspices of the Western Cape Branch of the Planned Parenthood Association and the Zibonele project, a joint initiative of Department of Community Health and Student Health and Welfare Commission (SHAWCO) at the University of Cape Town are two examples. The latter was in part an outcome of the research conducted for the study presented in this thesis. Numerous other health, nutrition, disabled people's, gardening and income generation projects exist in Khayelitsha.

However the problems facing the Khayelitsha community and others like it in South Africa are momentous. Purely local initiatives without substantial state assistance run the risk of making little impact. A number of local income generation projects for women have been important in building women's gender awareness and leadership skills, increasing their self-confidence and self-esteem. However, there have been deficiencies in providing women with competent practical job skills. In addition, it has been difficult in an adverse political and economic climate to create a business environment with adequate opportunities

on a large enough scale to establish viable jobs and income. Proactive legislation and national state programmes such as those proposed by the new government's Reconstruction and Development Programme (RDP), with which local organisations could make links, are needed if any meaningful impact is to be made in changing the socio-economic conditions under which poor people in South Africa live. These need to incorporate a specific gender focus to address women's particularly disadvantaged position. Legislation such as that outlawing gender discrimination in the new South African constitution and other laws recognising women's rights such as a proposed law liberalising abortion, are extremely important in providing a framework for changing women's status. However change is not facilitated by legislation alone. To the many women living in rural and peri-urban areas, social beliefs and practices and lack of knowledge will mean that there will be little change in women's traditional roles and status and they will be unable to take advantage of legislative changes. The promotion of local and national women's organisations is important. When women are organised there will be there a greater chance of success in their playing an active role in bringing about changes in the gender division of power and making their needs a priority. Doyal<sup>1</sup> and Smyke<sup>2</sup> document internationally examples of improvements to women's status and health made by local and national organisations in Latin America and in some Asian countries assisted by international women's alliances.

#### **HIGH PRIORITY HEALTH PROBLEMS**

Important health priorities for African women in South Africa exist, a number of which have been highlighted by this study. Priority areas include:

- Reproductive tract infections, particularly STDs and AIDS
  
- Contraception

- Abortion
- Ante-natal care in pregnancy, delivery and post-natal care for women
- Infertility
- Cervical cancer screening
- Violence against women

At this time in South Africa's political history, with fundamental changes occurring in government structures, including health service structures, there is a great window of opportunity to lobby for changes in the focus and service delivery of reproductive health. A number of researchers and women's health policy-makers have formulated recommendations for health service restructuring in these areas. A recent conference was held in December 1994, convened by the Women's Health Project at the University of Witwatersrand addressing policy issues in women's health.

Some recommended health service interventions emanating from various policy fora which focus on certain of these areas\* include:

### **Contraception**

- Delinking family planning from population control

\* See for example: Klugman and Weiner<sup>3</sup>, and Rees H. Draft report: Assessment of reproductive Health Services in South Africa, focusing on family planning<sup>4</sup>, and the draft policy documents of the Women's Health Project intitled Women's Health Policy Conference. December 1994.

- Providing community-based information and education to women and men about the benefits of contraception
- Improving health service availability and accessibility
- Provision of information on methods and allowing and encouraging free choice of method
- Targeting specific groups of unmet need such as teenagers and men
- Considering complementary methods of provision of services such as community based distribution networks

### **Sexually Transmitted Diseases**

- community education programmes should be developed to create awareness about the transmission and treatment of STDs
- improved screening and diagnostic methods
- more effective partner referral systems
- contraceptive methods within women's control that are also protective against STDs
- Male motivation programmes should be introduced to encourage increased use of condoms

### **Infertility**

- Education and prevention of STDS
- Infertility referral, information and counselling should be incorporated into reproductive health services

### **Cervical Screening**

- community-based education and information about the importance of cervical screening to be developed and implemented nationally
- a policy appropriate to reaching women at greatest risk of developing cervical cancer to be developed and consistently implemented. Current proposals suggest that given the scarcity of resources in South Africa, provided that more frequent screening is not indicated by an abnormal cervical smear, a free cervical smear be performed on women three times in their life time, at ages 30, 40 and 50.

### **Abortion**

- increase community awareness about abortion
- support legislative change to make early safe abortion available to all women who need it
- make available accessible services to all women especially those whose access is more difficult such as rural and peri-urban women

There is a need to integrate all these services into comprehensive women's health services within a primary health care setting. These services must be accessible and affordable, and have a strong link with community-based health promotion, education and counselling programmes. Education programmes for

women need to be based on principles which build their knowledge and self-esteem and enhance their control over their bodies. Quality of services, particularly in the area of attitudes to clients, needs to be addressed.

There is no complete generic model for health service delivery. Initiatives at a local level need to be informed by specific local conditions in the community which they serve.

Changes in provision of women's health services can only be part of the broad process of improving women's health. As argued, improvements in women's economic status and their social status are fundamental to any initiatives to improve their health status.

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## **APPENDIX A**

### **LIST OF ORGANISATIONS CONSULTED**

**Philani Nutrition**

**The Congress of South African Trade Unions (COSATU)**

**The Khayelitsha Advice Office**

**The Khayelitsha Day hospitals (Site B and Nolungile)**

**The Movement of Young Christian Workers (MCW)**

**The South African Christian Leadership Association (SACLA) Health Project**

**The Student Health and Welfare Committee (SHAWCO) in Khayelitsha**

**The Theological and Ecumenical Movement (TEAM)**

**The Western Cape Regional Services Council, Health division, Khayelitsha**

**The Western Cape Civic Association - Khayelitsha branch**

8. What is the house made of?

1. Brick	
2. Corrugated iron	
3. Canvas, plastic or sacking	
4. Other, specify.....	

23

RECORD OF INTERVIEW

1. Number of visits to household.....

24

2. Number of people who should be interviewed in this household.....

25

3. Number of questionnaires actually completed for this household....

26

4. If you were unable to interview all those you should have, give reasons why.(1).....

27

.....  
(2).....

29

5. In the case of refusal to be interviewed, state the reason for refusal. ....

31

**UCT DEPARTMENT OF COMMUNITY HEALTH**  
**URBANISATION AND HEALTH STUDY**  
**SUMMARY AND INSTRUCTION FORM**

INTERVIEWER TO FILL IN BEFORE ENTERING THE HOUSE:

Card No

- 1. Interviewer name..... 2
- 2. Name of area..... 4
- 2. Household number..... 5
- 3. Sampling number..... 13
- 5. Date..... 15
- 6. How many dwellings on this site?..... 21
- 7. What type of house does the respondent live in?

1. House	<input style="width: 100%; height: 100%;" type="text"/>
2. Shack on serviced site	<input style="width: 100%; height: 100%;" type="text"/>
3. Shack on unserviced site	<input style="width: 100%; height: 100%;" type="text"/>
4. Shack in backyard	<input style="width: 100%; height: 100%;" type="text"/>
5. Tent	<input style="width: 100%; height: 100%;" type="text"/>
6. Other.....	<input style="width: 100%; height: 100%;" type="text"/>

22



7. ADDRESS OF RESPONDENT:.....  
.....

33									
41									

8 DATE OF INTERVIEW: .....

49							
----	--	--	--	--	--	--	--

9. TIME INTERVIEW BEGAN:.....

55				
----	--	--	--	--

10. TIME INTERVIEW ENDED:.....

59				
----	--	--	--	--

11. NAMES AND ADDRESS OF TWO PEOPLE WHO THE RESPONDENT CAN BE CONTACTED THROUGH NOT LIVING IN THE HOUSE.

Name:.....

.....

63									
71									

CARD NO. 2

Address:.....

.....

2									
10									

Name:.....

.....

18									
26									

Address:.....

.....

34									
42									

INSTRUCTIONS TO INTERVIEWER

Three people in each household need to be interviewed:

- (1) The woman head of household
- (2) The male head of household
- (3) One other woman in the house

The woman head of household answers the longer questionnaire (yellow)

The male head of household and one other woman in the house answer the shorter questionnaire. (green).

If there is more than one household in the house, all the questionnaires must be filled in for the other household as well.

INTERVIEWER TO TELL RESPONDENT : I AM NOW GOING TO ASK YOU SOME QUESTIONS ABOUT WHO LIVES IN YOUR HOUSEHOLD, WHERE YOU COME FROM, THE WORK YOU DO ETC.

I AM ASKING THESE QUESTIONS BECAUSE ALL THESE THINGS CAN AFFECT PEOPLE'S HEALTH. FOR EXAMPLE : HOW MUCH MONEY A PERSON HAS AFFECTS WHETHER THEY CAN AFFORD TO HAVE ILLNESSES TREATED WHEN THEY ARE SICK.

ALL THE INFORMATION I RECEIVE FROM YOU WILL BE TREATED CONFIDENTIALLY AND ONLY USED IN RESEARCH. SOMEONE MAY VISIT YOU AGAIN AT SOME STAGE ONLY TO FIND OUT WHETHER YOU WERE INTERVIEWED.

12. Was the respondent interviewed alone?

1.  YES

2.  NO

50

If no, who was present?  
.....

51

13. Was this the first choice respondent?

1.  YES

2.  NO

53

IF NO,  
Who was chosen and why?.....  
.....  
.....

54

HOUSEHOLD COMPOSITION

1. How many people live in this house?.....

2. Can you give me a list of those who cook or eat together or who share the money of the household. Complete for each household.

Include the respondent herself on the table and list the people from oldest to youngest. Remember if there is someone or more than one person who lives in the house but who is not part of the household, complete a separate set of questions for that person or household. Continue on a continuation sheet if necessary.

Name	Age	Sex	Relationship	Marital status	Permanent resident If no, where do they live
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

CARD NO 3

2. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

10. [ ] [ ]

12. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
20. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

27. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
35. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

42. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
50. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

57. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
65. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

CARD NO 4

2. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
10. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

17. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
25. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

35. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
40. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

47. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
55. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

62. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
70. [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

INTERVIEWER TO MARK OFF BELOW WHICH CATEGORY THIS PARTICULAR HOUSEHOLD FIT INTO:

1. man, woman and their children.	
2. man, woman their children and a relative or relatives.	
3. woman with her children.	
4. person living on their own.	
5. family members and a friend or friends staying with them.	
6. family members and a lodger ( someone they don't know well but who lives with them and contributes money or goods towards the household.)	
7. man and woman without children	
8. relatives living together	
7. Other,.....	

77

3. Whom do you regard as the head of your household?

.....

78

4. Is your house:

1. Rented	
2. Owned	
3. Free dwelling	
4. Sublet	
5. Other	

80

URBANISATION

INTERVIEWER TO ASK RESPONDENT THE FOLLOWING QUESTIONS.

1. Where were you born?  
Wazalelwa phi?

Card No 5

<u>Place</u>	<u>District/Area of the country</u>
.....	.....

11

2				
---	--	--	--	--

2. Where did you grow up ie during your school days or before you started working?  
Ukhulele phi?

<u>Place</u>	<u>District/Area of the country</u>
1) .....	.....
2) .....	.....
3) .....	.....
4) .....	.....

5				
6				
11				
14				

3. Since school, where have you moved to, why and when did you move there?  
 Emva kokugqiba esikolweni uye wenza ntoni?

WHERE	WHY	WHEN
(1) .....	.....	.....
(2) .....	.....	.....
(3) .....	.....	.....
(4) .....	.....	.....

17				
21				
23				
27				
29				
33				
35				
39				

4. What place do you regard as your home?  
 Yeyiphi indawo ocinga ukuba likhaya lakho?

Cape Town	<input type="checkbox"/>
Rural homeland	<input type="checkbox"/>
White farm	<input type="checkbox"/>
Both or either	<input type="checkbox"/>
Other city	<input type="checkbox"/>

41

5. Where would you like to live when you are old?  
 Ekwaluphaleni kwakho ungathanda ukukhlala phi?

Cape Town	<input type="checkbox"/>
Rural homeland	<input type="checkbox"/>
White farm	<input type="checkbox"/>
Both or either	<input type="checkbox"/>
Other city	<input type="checkbox"/>

42

6. Where did you live IMMEDIATELY before you came to live in Khayelitsha?  
Phambi kokuba uze ekhayelitsha ubuhlala phi?

Place	District/Area of the country
.....	.....

43

7. IF THE PERSON DOES NOT COME FROM CAPE TOWN  
ORIGINALLY ASK THIS QUESTION. IF BORN IN CAPE TOWN,  
WRITE 'CAPE TOWN BORN'.

Why did you come to live in Cape Town?  
Yintoni ekwenze ukuba uze eKapa?

.....  
.....  
.....

46

8. Do you still have any of the following  
back home?  
Usenalo ikhaya emva?

- 1. a house or room in a house 1.  YES 2.  NO
- 2. land 1.  YES 2.  NO
- 3. livestock 1.  YES 2.  NO
- 4. spouse 1.  YES 2.  NO
- 5. children 1.  YES 2.  NO
- 6. other relatives 1.  YES 2.  NO

48

49

50

51

52

53

9. IF YES TO ANY OF THE ABOVE,

Where? .....  
.....

54

10. Do you send goods or money to anyone back home?  
Uyathumela na ekhaya?

1. YES 2. NO

IF YES,

To whom ?.....  
Kubani?  
Where (Place and area)?.....  
Phi?  
.....

56

57

58

EDUCATIONAL STATUS

11. What was the highest standard that you passed at school?  
Uphumelela eliphi ibanga esikolweni?

.....

61

12. Do you have any training apart from schooling?

Unalo na olunye uqeqesho ngaphandle kwesikolo?

1. YES 2. NO

IF YES,

What training? (specify)  
Loluphi?

.....  
.....

63

64

**OCCUPATION**

13. Do you have a job?  
Uyaphangela na?

1. YES 2. NO

IF NO,  
Skip the next questions  
and start with question  
20 on page 12.

IF YES,  
continue with question 14

66

**FORMAL SECTOR EMPLOYMENT**

14. Who are you employed by?  
Uphangela phi? Uqeshwe ngubani?

.....  
.....

67

15. What sort of work do you do at your job?  
Wenza msebenzi mni?

Job description	Position
.....	.....
.....	.....
.....	.....

69

71

16. Is your job a full - time one? 1. YES 2. NO  
Ngumsebenzi osisigxina na?

72

Unexesha elingakanani?

17. How long have you been working in this job?

.....years ..... months

73

Wenza malini ngeveki okanye ngenyanga  
18. Are you paid weekly or monthly?

1.  Weekly

2.  Monthly

IF WEEKLY,

Ukuba wamkela ngeveki uqikelela  
ukuba uphakathi kwale mivuzo?  
How much money do you receive per week

Per week:

- 1. Under R 50 a week
- 2. R 51 - R 100 a week
- 3. R 101 - R 200 a week
- 4. R 201 - R 300 a week
- 5. Over R 301 a week

IF MONTHLY,

How much money do you receive per month?

Per month

- 1. Under R 200 a month
- 2. R 201 - R400 a month
- 3. R 401 - R 800 a month
- 4. R 801 - R 1200 a month
- 5. R 1201 - R 1600 a month
- 6. R 1601 - R 2000 a month
- 7. R 2001 - R 3000 a month
- 9. Over R 3001 a month

19. Ingaba ikhona into oyenzayo eyingeniso?  
Do you do anything else to earn extra money?

1. YES

2. NO

IF YES,  
Go to question 21

IF NO,  
Go to question 28 on page 15.

10

CARD NO  6

FROM QUESTION 13: NO JOB STATED.

20. Unalo na uncedo olwenzayo apha ekhaya?  
Do you bring in any money or goods into the household?

1. YES

2. NO

IF YES,  
Go to question 21

IF NO,  
Go to question 25 on page 14 .

2

INFORMAL SECTOR:

21 Wenza ntoni?  
What do you do?

.....  
.....  
.....

3

22. Zinto zini ozisebenzisayo?  
What type of items do you work with (specify) ?

1.....  
2.....  
3.....  
4.....

5   
7   
9   
11

23. Do you calculate your earnings weekly or monthly?

1.  Weekly

2.  Monthly

13

IF WEEKLY,

Wenza malini ngeveki okanye ngenyanga?  
How much money do you receive per week?

<u>Per week:</u>	
1. Under R 25 a week	<input type="checkbox"/>
2. R 26 - R 50 a week	<input type="checkbox"/>
3. R 51 - R 75 a week	<input type="checkbox"/>
4. R 76 - R 100 a week	<input type="checkbox"/>
3. R 101 - R 200 a week	<input type="checkbox"/>
4. R 201 - R 300 a week	<input type="checkbox"/>
5. Over R 301 a week	<input type="checkbox"/>

14

IF MONTHLY,

How much money do you receive per month?

<u>Per month</u>	
1. Under R 200 a month	<input type="checkbox"/>
3. R 201 - R400 a month	<input type="checkbox"/>
4. R 401 - R 800 a month	<input type="checkbox"/>
5. R 801 - R 1200 a month	<input type="checkbox"/>
6. R 1201 - R 1600 a month	<input type="checkbox"/>
7. R 1601 - R 2000 a month	<input type="checkbox"/>
8. R 2001 - R 3000 a month	<input type="checkbox"/>
9. Over R 3001 a month	<input type="checkbox"/>

15

IF THE PERSON IS ALTOGETHER UNWILLING OR UNABLE TO GIVE INFORMATION ABOUT THE AMOUNT OF MONEY THAT THEY MAKE, ASK THEM IF THEY MAKE THEIR MONEY:

	Oluginisekileyo	<input type="checkbox"/>
1	Regularly	<input type="checkbox"/>
2	Olungaqinisekanga	<input type="checkbox"/>
	Irregularly	<input type="checkbox"/>
3.	Alukho ungeniso	<input type="checkbox"/>
	Hardly ever	<input type="checkbox"/>

16

24. Unaye na umncedisi? Do you employ anyone? 1. YES 2. NO

17

IF THE PERSON HAS A JOB IN EITHER THE FORMAL OR INFORMAL SECTOR, GO ON TO QUESTION 28. ASK ONLY IF PERSON IS UNEMPLOYED.

25. If you are not working outside the home at present, are you looking for work? Ukuba awuphangeli uya wufuna na umsebenzi?

1. YES 2. NO

18

IF NO, what is the reason? Kutheni? ..... .....
--

19

26. Wawukhe waphangela na? Have you ever been employed? 1. YES 2. NO

20

27. Ixesha elingakanani? How long have you been out of work? .....Years ..... Months ..... Weeks

21	<input type="checkbox"/>	<input type="checkbox"/>
23	<input type="checkbox"/>	<input type="checkbox"/>
25	<input type="checkbox"/>	<input type="checkbox"/>

TO BE ANSWERED BY ALL RESPONDENTS ( EMPLOYED IN FORMAL OR INFORMAL SECTOR OR UNEMPLOYED)

28. Unayo na ingeniso ngaphandle komvuzo? Do you get any money other than from work you do ? 1. YES 2. NO

27

IF YES, Specify Chaza okanye cacisa

28

(Prompts: Rent, loan, grants, UIF, remittances from family etc.)

IF YOU ARE INTERVIEWING A MAN STOP AT THIS POINT! TO BE ANSWERED BY WOMEN ONLY

STRESS

HOUSE / DOMESTIC WORK

1. In your home - do you do any of the following: Phakathi kwekhaya ngaba wenza enye yenzi zilandelayo?

Cooking ukupheka 1. YES 2. NO

30

Cleaning ukucoca ikhaya 1. YES 2. NO

31

Laundry ukuvasa YES NO

32

Child-care ukujonga abantwana 1. YES 2. NO

33

2. If YES to any of the above -

How much time of your day is spent on domestic work? Ingaba uthatha ixesha elinga kanani?

.....  
.....

34

(Prompts: 1. whole day 2. half the day 3. less than half the day.)

ATTITUDES:

3. Do you prefer to earn own money? 1.  YES 2.  NO  
Ungathanda ukuzingenisela eyakho imali?

35

4. If you have a husband/ boyfriend/ partner, how does he feel about you working outside the home and earning your own money?  
Ukuba unomyeni okanye umlingane ingaba uyathanda na ukuba usebenze ngaphandle kwe khaya uze nengeniso

.....  
.....  
.....

36

5. Who decides what should be done with the money/ goods you bring into the household?  
Ngubani owenza izigqibo zekhaya malunga nemali?

.....  
.....

37

**CHILD CARE**

6. Who usually looks after your young children (under ten years) during the day?  
 Ngubani odla ngokujonga abantwana bakho abanga phantsi kweminyaka elishumi?

<u>Child</u>	<u>Age</u>	<u>Usual carer</u>	<u>Age of usual carer</u>
1.			
2.			
3.			
4.			
5.			
6.			
No child under 10			

38			
41			
45			
48			
52			
55			
59			
62			
66			
69			
73			
76			
80			

7. Ngubani obajongayo xa umlondolozisi engaphumeleli?  
 Who looks after them when the usual carer is unable to?

.....  
 .....  
 .....  
 .....

CARD NO

7

2

4

6

8

SOCIAL ISOLATION

8. Do you spend time with neighbours, friends or relatives?  
Uchitha ixesha na nabamelwane nezihlobo okanye nezizalwane?

INTERVIEWER TO MAKE A CROSS FOR WHICH EVER APPLIES.

Neighbours	Yes		No	
Friends	Yes		No	
Relatives	Yes		No	

10

11

12

9. Are you satisfied with the amount of time you spend with friends, neighbours and relatives?  
Uyaneliseka bubungakanani bexesha olichitha kunye nabo?

Neighbours	Yes		No	
Friends	Yes		No	
Relatives	Yes		No	

13

14

15

Ubona omnye wabamelwane bakho njengesihlobo esisenyongweni?

10. Do you see any of your neighbours as your closest friends? 1. YES 2. NO

16

11. Do you belong to any organisations?  
Ingaba ulilungu minye imimibutho elandelayo 1. YES 2. NO

17

IF YES, which: ←

Church	YES	NO
Civic/ community	YES	NO
Women	YES	NO
Other.....	YES	NO

18

19

20

21

12. How do you like living where you live and why?  
Uyakuthanda na ukuhlala kule ndawo ukuyo? Kutheni?

.....  
.....  
.....  
.....

22

24

I AM NOW GOING TO ASK YOU SOME QUESTIONS ABOUT WOMEN'S  
HEALTH AND ILLNESSES.

CARD NO.  8

PREGNANCY, CHILDBIRTH AND CHILD DEATHS

1.1 Have you ever been pregnant? 1.  YES 2.  NO  
Wakha wanzima?

2

IF NO,  
Skip the following  
questions. Start with  
question 2 on page 22.

1.2 IF YES,

How many times ? .....  
Amaxesha amangaphi?

3

1.3 Of these times, what was the outcome of  
the pregnancy?  
Kula masu yaba yintoni isiphumo?

Pregnancy No.	Live birth	Still birth	Miscarriage
1			
2			
3			
4			
5			
6			
7			

5

6

7

8

9

10

11

1.4 Of your children that were born alive,  
have any of them died since  
childbirth?

1.  Yes 2.  NO

Ingaba ukhona omnye wabantwana bakho owasweleka  
ekuzalweni?

12

1.5 If yes, could you tell us :  
Ungandichazela ngabo

Child	Age when died	Year when died	What did s/he die
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

13

--	--	--	--	--	--	--	--	--	--

20

--	--	--	--	--	--	--	--	--	--

27

--	--	--	--	--	--	--	--	--	--

34

--	--	--	--	--	--	--	--	--	--

If respondent does not know age: 1. not yet walking  
2. walking 3. not yet at school 4. at school

.6 How old were you when you were first .....  
pregnant?  
Wawuneminyaka emingaphi kowokuqala umtwana

41

--	--

1.7 If your last pregnancy was within the  
last five years, did you attend any  
clinics or hospitals for check - ups  
during the pregnancy?  
Ukuba ubukhe wanzima kwiminyaka emihlanu edlulileyo,  
ukhe waya kuhlolwa kwiziko lempilo ngelixesha, ubunzima

1. YES 2. NO 3. NO PREGNANCY IN  
LAST 5 YEARS

43

--

1.8 Where was your last child born ?  
Umbelekele phi umtwana wakho wokugqibela?  
Fill in both tables.

1. Cape Town	
2. Rural homeland	
3. Rural 'white farms	
4. Other city	
5. Other.....	

1. Clinic	
2. Hospital	
3. Home	
4. Other.....	

44

--	--

1.9 When was your last child born? (Year of birth)

.....

48

2. Did you ever want to fall pregnant and couldn't ?

Wakhe wafuna ukuba nomntana waze awabinakho?

1.  YES      2.  NO

49

IF YES,  
what did you do about it ?  
.....  
.....  
.....

50

3. KNOWLEDGE OF PAP SMEARS.

3.1 Have you ever heard of a PAP SMEAR? 1.  YES      2.  NO  
Ukhe weva nge pap smear?

51

3.2 Have you ever had a PAP SMEAR? 1.  YES      2.  NO  
Wakhe wayenza?

52

IF YES,	nini	phi	ngubani
	Date	Place	Performed by
First time			
Last time			

53

54

3.3. Were you ever asked to go back to the place where you had it done for regular follow ups?  
Wakhe wathunyelwa na kwakho na okukuba uqubekeke nonyango?

1.  YES      2.  NO

55

4. CONTRACEPTION

4.1 Do you use any method of contraception?  
Ingaba ikhona na into oyenzayo ukukusela okokuba ungakhulelwa kwakhona?

1. YES 2. NO

66

IF YES,  
Please specify what method(s) you use at present:  
.....  
.....

67

4.2 Did you choose this method of your own free will?

.....  
.....

69

5. ILLNESS

5.1 Have you had treatment for a gynaecological condition over the past 3 months?

1. Yes 2. No

70

IF YES,  
What?.....  
.....  
.....

71

6. AIDS

6.1 Have you ever heard of AIDS? 1. YES 2. NO

73

6.2 What do you understand by it?

.....  
.....

74

6.3 What do you think can be done about it?

.....  
.....

76

**INTERVIEWER TO TELL RESPONDENT:**

**I AM NOW GOING TO ASK YOU SOME QUESTIONS ABOUT WHICH HEALTH SERVICES YOU AND OTHER PEOPLE IN YOUR HOUSEHOLD USE WHEN YOU OR THEY ARE SICK.**

CARD NO

1. Should you become ill, where would you go for assistance, who would you see and why would you use this?  
Xa unokuqula ungaya kufuna uncedo phi?

Place	Health worker	Reasons for use	
1.....	.....	.....	2 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2.....	.....	.....	3 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
3.....	.....	.....	4 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
4.....	.....	.....	20 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

2. Have you or has anyone else in your household been sick over the last two weeks? 1  2  26

Ingaba kukhe kwakho ogulayo kweiveki ezimbini ezidlulileyo?

3. Have you or has anyone else in your household made use of any of the health services over the past two weeks? 1  2  27

Ingaba kukho umntu walapha ekhayeni kweziveki zimbini zidluleyo oyokucela uncedo kwelinye lamaziko empilo?

**IF YES,**  
Fill in the table over the page

**IF NO,**  
Go to question 4

Who (person) Igama	Medical reason Isizathu soncedo	Service Iziko	Transport used Isithuthi	Length of time to get there Ixesha	Cost of transport Ixabiso	Cost of service Ixabiso loncedo

28

43

58

CARD NO: | 0

3

18

33

4. Are you or any one else in your household being treated for any illness or condition at present? 1. YES 2. NO

IF YES,  
Fill in the table

IF NO,  
Go to question 7

Who (person) Igama	Medical reason Isizathu soncedo	Service Iziko	How often	Transport used Isithuthu	Length of time to get there Ixesha	Cost of transport Ixabiso	Cost of service Ixabiso loncedo

44

CARD NO | |

54

55

51

CARD NO | 2

3

ONLY TO BE ASKED IF THE RESPONDENT USED SERVICES.

5. Were you satisfied with the quality of the services you used?

1.  Yes 2.  No

19

6. Were you satisfied with the attitudes of the staff of the services you used?

1.  Yes 2.  No

20

7. Are there any health services your area that you know of, but have never used?

1.  YES 2.  NO

21

Ngaba kukho amaziko empilo kwingingqi yakho ongazange wawasebenzisa?

IF YES,

please specify -

Name of service	Type of service	Why never used

22

25

28

31

8. Where would you go for the following :

	Place	Don't know
For immunisation of your baby/child		
To buy milk for your baby/child		
If your child has diarrhoea		
For TB tests		
For a PAP test		
If you had cut/injured yourself so that it needed bandaging and/or stitches.		
If you had a member of your family who became ill at night		

34

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9. What health services are needed in Khayelitsha?

.....  
 .....  
 .....  
 .....  
 .....  
 .....  
 .....

41

(APPENDIX C continued)

Urbanisation

POBUR	Place of birth: Cape Town, other city, white farm, former 'homeland'
GROWPLAC1	Town in which respondent first grew up
GROWPLAC2	Any town to which respondent moved while growing up
GROWPLAC3	Any additional town to which respondent moved while growing up
GROWARE1	Area of country corresponding to GROWPLAC1
GROWARE2	Area of country corresponding to GROWPLAC2
GROWARE3	Area of country corresponding to GROWPLAC3
PLACMOV1	First town moved to during adulthood/after school
AREAMOV1	Area of country corresponding to PLACMOV1
WHYMOVE1	Reasons for first move
WHENMOV1	Year in which first move made
PLACMOV2	Second town moved to during adulthood/after school
AREAMOV2	Area of country corresponding to PLACMOV2
WHYMOVE21	Reasons for second move
WHENMOV2	Year in which second move made
PLACMOV3	Third town moved to during adulthood/after school
AREAMOV3	Area of country corresponding to PLACMOV3
WHYMOVE3	Reasons for third move
WHENMOV3	Year in which third move made
PLACMOV4	Fourth town moved to during adulthood/after school
AREAMOV4	Area of country corresponding to PLACMOV4
WHYMOVE4	Reasons for fourth move
WHENMOV4	Year in which fourth move made

## APPENDIX C

### GLOSSARY - Variables used in study and their definition

VARIABLES	EXPLANATION
<b>Demographic</b>	
AREA	Geographic residential areas of Khayelitsha: Housing, Site B, Site C and Greenpoint
TYPHOUSE	Type of housing: house, informal dwelling on service site, informal dwelling on unserviced site, dwelling in backyard, tent, other.
HOUSMADE	Material dwelling made of: brick, corrugated iron, canvas, plastic or sacking
AGE	Age in years of respondent
SEX	Of respondent
MARSTAT1	Marital status of respondent: married, single, living together, divorced/separated, widowed
HOUSECAT	Household composition: <ol style="list-style-type: none"><li>1. man, woman and their children</li><li>2. man, woman, their children and relative/s</li><li>3. woman with her children</li><li>4. person living on their own</li><li>5. family members and a friend/s</li><li>6. family members and a lodger</li><li>7. man, woman without children</li><li>8. relatives living together</li></ol>
These categories were grouped to form 4 main categories: nuclear, extended, woman-headed and 'alliance'	
HOUSHED	Whoever was regarded by respondent at the head of the household
TENURE	Whether dwelling was: rented, owned, free (no payment), or sublet
SCHOOL	Number of years of formal schooling
TRAINING	Any post school training: Yes, No
TRAINTYP	Type of post school training

(APPENDIX C continued)

WKPAYF	Amount of weekly salary categorised into : (1) under R50 (2) R51-R100 (3) R101-200 (4) 201-300 (5) over R301
MTHPAYF	Amount of monthly salary categorised into: (1) under R200 (2) R201-R400 (3) R401-800 (4) 801-1200 (5) 1201-1600 (6) 1601-2000 (7) 2001-3000 (8) over R3001
EMPLOYI	Whether respondent was employed in informal sector
TYPEWHI	Place of employment in informal sector (type of activity)
PAYTYPEI	Whether salary was paid weekly or monthly
WKPAYI	Amount of weekly salary in categories
MTHPAYI	Amount of monthly salary in categories
IRREGPAY	Whether money was earned regularly, irregularly or hardly ever
LOOKWK	Whether respondent was looking for work
REASUNEM	Reason for respondent not working
<b>Social status</b>	
HOUSEWK1	Whether respondent performed domestic chore of cooking
HOUSEWK2	Whether respondent performed domestic chore of cleaning
HOUSEWK3	Whether respondent performed domestic chore of laundry
HOUSEWK4	Whether respondent performed childcare
TIMEHWK	Amount of time spent on housework: whole day; half day; less than half day; uncertain
PREFEARN	Whether respondent preferred to work outside the home
PTNRPREF	How partner felt about her working outside the home

(APPENDIX C continued)

HOME	Area of country respondent regarded as 'home'
LIVEOLD	Area of country in which respondent wished to live when old
BEFOREK1	Town in which respondent lived before residing in Khayelitsha
BEFOREK2	Area of country in which respondent lived before residing in Khayelitsha
WHYCT	Reason for respondent's move to Cape Town
TIES1	Possession of a rural home/house
TIES2	Possession of rural land
TIES3	Possession of rural livestock
TIES4	Has a spouse in a rural area
TIES5	Has children in a rural area
TIES6	Has relatives in a rural area
TIEWHERE	Where respondent has TIES1-6
REMIT	Whether respondent remits money or goods to a rural area
REMITWHO	To whom remits
REMLAC	Town to which remits
REMAREA	Area of country to which remits
<b>Economic</b>	
EMPLOYF	Whether respondent was employed in formal sector
EMPLWHEF	Place of employment in formal sector (sector of employment)
POSITF	Position in which employed
FULLTIME	Whether job was a full-time one
PAYTYPEF	Whether salary was paid weekly or monthly

(APPENDIX C continued)

AGEPREG	Age (in years) at which first pregnancy occurred.
ANC	Did respondent attend Ante-natal care if she had been pregnant in the preceding five years
CHPOB1	In which area of the country was the respondent's last child born
CHPOB2	Whether last born child was born at a health facility (hospital, clinic, MOU) or at home
PROBPREG	Had respondent ever experienced problems falling pregnant
ACTPREG	What did she do about her problem falling pregnant
GYNAE	Had respondent been treated for a gynaecological illness in the preceding 3 months
WHATGYN	What gynaecological illness was treatment sought for

**Health knowledge**

KNOWPAP	Had respondent heard of a cervical smear
HEARAIDS	Had respondent heard of AIDS
KNOWAIDS	What did respondent know about AIDS
VSAIDS	What did respondent think could be done to prevent AIDS

**Morbidity and health service use**

HAVEPAP	Had respondent ever had a cervical smear
WHERPAP1	Where was the first cervical smear performed
WHOPAP1	Who performed the first cervical smear
GOBACK	Was respondent asked to go back for any follow up for a cervical smear
CONTRACEP	Did respondent use any method of contraception
TYPCONTR	What type of contraception was she currently using
PLACILL1-4	Where would she seek treatment when ill

(APPENDIX C continued)

WHODECID	Who decided about the spending of the earnings of the respondent
WHOCARE1-WHOCARE6	Who cares for children (possibility of 1-6 children) under the age of 10 during the day
NOCHILD	Respondent had no child under 10 years of age
OTHCARE1-4	Alternative carers for children when mother is unable to care for them
SOCIAL1	Did respondent have contact with neighbours
SOCIAL2	Did respondent have contact with friends
SOCIAL3	Did respondent have contact with relatives
SATISFY1	Was respondent satisfied with contact with neighbours
SATISFY2	Was respondent satisfied with contact with friends
SATISFY3	Was respondent satisfied with contact with relatives
NEIGHB	Did respondent have a neighbour as a best friend
MEMBORG	Was the respondent a member of an organisation
ORG1	Did she belong to a church organisation
ORG2	Did she belong to a civic/ community organisation
ORG3	Did she belong to a women's organisation
ORG4	Did she belong to any other organisation
LIKELIVE	Did respondent like living in Khayelitsha
LIKEWHY	Reasons for reply in LIKELIVE
<b>Reproductive health</b>	
PREGNANT	Had respondent been pregnant
PREGNO	How many times
OUTCOME1-14	What were the outcomes of all her pregnancies: live-birth; stillbirth; miscarriage
CHMORT	Had respondent ever lost a live-born child

(APPENDIX C continued)

WHEREG05	Where would respondent go to have a cervical smear taken
WHEREG06	Where would respondent go to for an injury
WHEREG07	Where would respondent go to for an illness of a family member at night

(APPENDIX C continued)

ACUTE1	Had respondent had an acute illness in the preceding two weeks
SERVICE	Did she seek treatment at a health service for this illness
WHATILA1	What was the acute illness
SERVA1	Which service did she seek treatment at
TRANSA1	What transport was used to get to the health service used
HRSA1	How long (in hours) did it take to get to the health service used
MINA1	How long (in minutes) did it take to get to the health service used
COSTTA1	How much (in SA currency) did it cost for transport to the health service used
COSTSA1	How much (in SA currency) did it cost to attend the health service used
CHRONI	Had respondent had a chronic illness in the preceding three months
WHATILC1	What was the chronic illness
SERVC1	Which service was used for the chronic illness
FREQ1	How often did the respondent need to attend the health service for the chronic illness
TRANSC1	What transport was used
TIME1	How long did it take to get there
COSTTC1	What was the cost of the transport
COSTSC1	What was the cost of the service
WHEREGO1	Where would respondent go to have a child immunized
WHEREGO2	Where would respondent go to obtain milk for an infant
WHEREGO3	Where would respondent go if a child had diarrhoea
WHEREGO4	Where would respondent go for TB tests

**(APPENDIX D continued)**

attached form. Ask respondents questions for information required in columns 5 -6. Ask for any documents which they have to check the information needed for columns 7-15.

## **APPENDIX D**

### **REPEATABILITY STUDY SCHEDULE**

#### *Instructions to interviewers:*

Go back to the repondents in houses on the lists given you and ask if you can repeat a few questions.

1. First ask her if she was visited and interviewed by and interviewer. Show her the yellow questionnaire to see if she recognises it. If the answer is no, note this down and do not ask any further questions. If the answer is yes, ask the following questions. Stress that you won't take up much time.

#### **Questions**

1. (Question no. 3 Page 1)  
How old are you?
2. (Question 7, Page 2) What is your address?
3. (Question 1, Page 4) Take a census again of all people permanently living in the dwelling.
4. (Question 1, Page 6) Where were you born?
5. (Question 11, Page 9) What was the highest standard you passed at school?
6. (Question 3, Page 16) Do you prefer to earn you own money?
7. (Question 8, Page 18) Do you spend time with neighbours, relatives or friends?
8. (Question 3.1, Page 22) Have you ever heard of a PAP smear?
9. (Question 4, Page 25) Are you being treated for any illness or condition at present?

### **VALIDITY STUDY SCHEDULE**

(Interviewers other than the original ones conducted the validity study)

#### *Instructions to interviewers:*

Go to the repondents in houses on the lists given you and ask if you can ask them a few questions and look at few documents. Observe and note information for columns 1-4 on