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Wenn Frauen selbst bestimmen könnten...

Food for thought

Ignorant mothers?

Von Helen Fielding

Should we not be questioning our own approach rather than blaming mothers for not adopting recommended health practices?

For several years the annual reports and internal evaluations of the Terre des hommes (Tdh) mother and child health programme in Burkina have highlighted the same problems: "The mothers are ignorant." - "The mothers are not interested." - "The mothers don't follow our advice."

Although often presented as an incidental minor inconvenience, this is in fact a critical problem for a project based on the premise that the health of children is inseparable from the health of their mothers and that one of the best ways to improve the health of children is to "sensitise" their mothers concerning better health practices through health promotion activities.

Fortunately, rather than continuing to carry out more of the same activities, the health team is now taking the time to ask the questions: "Why are the mothers not interested?" - "Why don't they follow our (internationally approved) advice?" - "What do they already know and why don't they put this knowledge into practice?"

When asked the basic questions such as "who does what and when", "who makes the decisions?", "who controls the resources?", the staff were unanimous that mothers in the project areas have a heavy workload, do not make decisions about taking children for health treatment and do not control resources to pay for health care. Many women have learnt the lessons taught by health workers but are not in a position to put this knowledge into practice.

Although the mothers play a crucial role in the daily care of their children and in first aid treatment with local remedies, it is usually their husbands who decide whether to allocate scarce resources to pay for the treatment of a sick child. The staff also admitted that the mother in law often has more influence on healthcare practices than the mother herself. Yet somehow they had dissociated this cultural knowledge from their activities as health workers and had continued to blame the mothers for the problems encountered by the project.

Once the link was made it became increasingly clear that health promotion activities aimed at mothers to improve their health practices would not be effective unless the project also addressed fathers and mothers-in-law for, even if the mothers understood the message, they would often not be in a position to put it into practice unless the problems of resource allocation, cultural pressure and role allocation were also addressed.

Similar incoherences occur in many projects. Maybe this is because project staff have been used to operating in a certain way and have ceased to question the appropriateness of their actions in reality. Maybe it is due to the many competing priorities facing project managers or simply because of the lack of time to sit back and reflect on the underlying causes of problems we are addressing and on the real impact of what we are doing.

Sometimes it seems to be due to a divide between professional and private worlds. This was tragically illustrated recently during a Tdh planning workshop in Guinea by an influential health official who, despite campaigning for an end to female genital mutilation in his professional capacity, was unable to stop the practice being carried out on his own daughter when she was sent to relatives for a holiday.

This problem is a typical example of the practical need to use a gender approach taking into account the socially ascribed roles, the different needs of men and women and the relation between them.

The Search for a Solution

Tdh seeks to use a gender approach in all its projects, but this is not easy to implement in practice. Gender is considered to be a cross-cutting issue but therefore runs the risk of becoming a forgotten issue. How does a country manager, expected to be a jack of all trades and all too often conscious of being master of none, integrate a gender approach into its projects in practice? Some practical ideas are described below, together with some of their advantages and disadvantages:

Gender Guidelines: An inter-departmental gender group set about the task of developing a practical tool in the form of guidelines1 consisting of a short introduction to the subject of gender and two pages of questions to be used at key moments during the project cycle management process.

This represents a first step towards ensuring the integration of this transversal issue but even these two pages may well be too long and complicated to ensure that busy managers use them. Conversely it was soon realised that more specific questions are needed for health and nutrition projects. At the moment it seems that the guidelines are a useful tool for an interested manager but will not necessarily be used by someone who does not already have an interest in gender.

Gender watchdogs and hats! Sometimes it requires as little as one person willing to act as ”gender watchdog” and ask the right questions at the right moment to keep the project team aware of the importance of viewing everything through a ”gender lens”. At the most basic level the ”watchdog” has only to ensure that the three or four relevant questions in the guidelines are asked (and answered!) at the appropriate moment. The watchdog concept however brings with it the danger of transferring the responsibility to one person when managers at all levels should be responsible for integrating a gender approach into their routine work.

This concept is a particularly practical way of ensuring that gender issues are included at key moments of the project cycle such as during planning workshops. To counteract the competing demands of other cross-cutting issues, ”hats” can be allocated to different members of the planning team. These hats can be interchangeable to emphasise the hierarchical rather than thematic responsibility for implementation of transversal issues.

Ensuring real participation in planning: The participation of both men and women in project planning is also important. As senior project and local partner staff are often in the majority male (even in mother and child health projects in which the majority of lower level staff in the field may be women), this will probably mean consciously inviting women of appropriate professional background, social status and confidence. The aim of this is not to ”be gender” as is so often jokingly said, but to include points of view which would otherwise not be heard and may be essential to the success of the project. This does not mean inviting a ”token” woman or women to justify decisions made by men. Nor does it mean, as an example reported from a health project in Burkina, electing women on to village committees to prepare the meal and clean the meeting room! Despite the difficulty in finding women in positions of responsibility, an effort needs to be made to invite suitable female representatives who should be encouraged to bring their unique point of view. This will call for particular sensitivity on the part of the moderator and may mean placing women who are in the minority together in one group where they have a better chance of expressing themselves rather than scattering them amongst different groups where their minority point of view is less likely to be voiced.

During a recent planning workshop for a Tdh nutrition project it was striking that, in spite a numerical majority of women, the discussions were dominated by a small number of men occupying higher positions in the social order. An attempt was made to allow the women to express their opinions by creating single sex working groups but in the plenary many of the women’s ideas were squashed by a minority of senior male doctors unused to having their authority questioned.

Whereas it is important to take into account the views of both men and women, gender inequities in health cannot be ignored. For example, reproductive ill-health affects women more than men and women therefore need to have their voices heard concerning their priorities with regards to health needs. This is one small contribution to reducing gender inequity in health and health care and ensuring that those with the greatest need receive their fair share of resources.

Participation Simulation: During a recent planning workshop, after conducting a general problem analysis, the Tdh resource person acting as moderator divided the group into several smaller groups to conduct the same exercise from the point of view of different groups within the target community, attempting to get inside the skin of specific groups with differing priorities. The result was of course several completely different analyses! Even though this was an artificial exercise, and in no way a substitute for real consultation of beneficiaries and partners, it brought home the importance of consulting different groups, men, women, girls, boys, elders, youth etc separately and the team left the workshop with new motivation for consulting the various members of the community in which they work.

Questions for Mainstreaming: If nothing else, then at least the three basic ”mainstreaming” questions2 need to be asked:

What is the ”gender situation” (this needs to be specific to the community in the immediate project area and should include as a minimum who does what and when, who controls resources and makes decisions, gender roles and needs).

How does this situation affect our project? (For instance, if fathers and mothers in law are influential in the health of children in the project area then activities must be planned to include them).

How does our project affect the gender situation? (are we increasing an already impossible workload on women by expecting mothers to travel long distances to attend baby clinics or leave the rest of their families while caring for a hospitalised malnourished child?).

Begin with Ourselves: In the Tdh nutrition capitalisation workshop for the Asia region it was also highlighted that, when trying to integrate a gender approach, we have to begin with ourselves. A country manager without a clear understanding of, and commitment to, a gender approach, will find it difficult to integrate this in practice, or rather will find it easy to let this slip to the bottom of the pile of priorities. Partners who are asked to use a gender approach will sooner or later ask for proof that we are practising what we preach in our own organisations. This forces us to examine our own assumptions but can be a threatening experience.

Practical examples from Terre des hommes Field Experience

In Nepal a psycho-social, rather than a technical approach was taken to a pilot nutrition project in Kathmandu3 with an emphasis on actively listening to mothers and treating their situation in a holistic way. This study concluded that the first and most important factor influencing the nutritional status of children in urban Kathmandou was the position of women within the family and society. This was ranked before food security, access to water and use of health services. It was therefore essential to make gender a central theme.

It also underlined the importance of the relation between the health promoter and the care giver and of listening before giving advice. This is often particularly difficult for health workers who owe much of their status to their ability to provide solutions. It was found that the attitude of the female health workers often reflected their own distress when faced with a seemingly hopeless situation. There was a tendency to concentrate on ”medical” information and practical services rather than psychological or social problems, often because they felt there was nothing they could do to ”solve” the psychosocial problems. At least by offering a medical solution they felt that they were doing something useful or at least legitimising their own role.

The study also reveals that female health workers confronted with a reminder of their own difficulties can react with empathy, but just as often recoil in fear and resentment. It is therefore not enough to try to change the habits of health workers without giving consideration to their own needs in relation to the role they are expected to fulfil.

Tdh Nepal chose not just to integrate a psycho-social approach but to specifically use it as a work method – not just looking at social conditions as separate but accepting them as an integral part of the health project.

In breastfeeding counselling training carried out in Guinea for health personnel from the West Africa region4, in addition to training in medical techniques, the emphasis was also on the approach used when counselling mothers. This involved making mothers feel at ease, showing empathy, reserving judgement, encouraging existing good practices, suggesting rather than ordering, and generally treating the mothers as people in their own right rather than mere tools for reaching their babies. This simple approach surprised even sceptical health workers who saw women, accustomed to being scolded for their poor health practices, open up to explain the reasons for their behaviour once they felt accepted by someone willing to listen to their real problems.

We haven’t yet found an ideal term for this approach ”active listening”, ”listen and learn” or ”psycho-social approach”. In practice it has many similarities with a gender approach and, like gender, this needs to be treated as a transversal issue.

Recommendations for Managers

Don’t take the integration of a gender approach for granted. Even a cross-cutting issue needs specific attention to ensure its implementation in practice. This will include the necessary budget and time allocation for training to ensure that all staff are not only aware of the issues involved but have also adopted them as their own and are competent in this area.

Thus the importance of training and of real appropriation at all levels. This training must include practical ideas and concrete ways of including them in the everyday life of a project.

Encourage field staff to reflect on their cultural knowledge and bridge the divide between personal and professional worlds with regard to gender issues.

Give teams permission to critically reflect on the way in which they are carrying out their activities and whether this is really the best way to achieve their objectives. This involves accepting the fact that the technical message alone is not enough - more emphasis needs to be put on how this message is shared.

Provide field managers with simple tools and ideas which can be integrated into existing systems and will not involve a large amount of additional work.

In order for these tools and ideas to be effective, they need to be situated in a context in which gender is seen as a mainstream institutional priority, permeating all decisions at all levels.

Although we still have a long way to go, Tdh is beginning to try to put these ideas into practice. As a result, health project staff in Burkina are already less likely to attribute difficulties in achieving project objectives to "ignorant mothers", and more likely to question their own approach to finding the most appropriate solution.

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1 Gender Guidelines: see www.tdh.ch (services download).
2 These questions are more usually associated with the mainstreaming of HIV/AIDS. See for example SDC documents for mainstreaming of HIV/AIDS.
3 Unreavelling Malnutrition. Challenges of a psychosocial approach. Barbara Weyermann.
4 Unicef 40 hour training for Breastfeeding Counsellors.

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