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Comparative Research Network, 2008

**Primary Health Care and Women in Cape Town (South Africa) and
Harare (Zimbabwe): A Comparative Study**

Annotated Bibliography

CODICE, 2009

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*Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A
Comparative Study*

Table of Contents

Introduction.....	3
Part I – Hard Copy Documents	4
Part II : Electronic Documents.....	7
2.1 Cape Town (South Africa)	7
2.2 Harare (Zimbabwe)	14
Part III : Background Document	21

Introduction

The Council for the Development of Social Science Research in Africa (CODESRIA) held from 14 to 16 October 2008 in Addis Ababa, Ethiopia, a methodological workshop gathering the Comparative Research Networks selected in 2008.

As a support to the researchers involved in the Comparative Research Networks, the CODESRIA Documentation and Information Centre (CODICE) has produced bibliographies on the various research themes. This bibliography has been generated for the Comparative Research Networks whose project proposal is **“Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study”**

Classified alphabetically by author or by title, the selected references are in English on the topics of Primary Health Care and Women in Cape Town and Harare and are grouped in two sections:

- ❖ Hard Copy Documents;
- ❖ Electronic Documents ;

The background Document is in the annex of this bibliography.

Specific bibliographic searches may also be done upon request from each participant of the Comparative Research Network.

We hope that this bibliography will be useful for the members of the Comparative Research Network, and suggestions for its improvement are welcome.

Part I – Hard Copy Documents

1. BAZILLI, Susan, ed.

Putting Women on the Agenda
Johannesburg: Ravan Press, 1991.- V-290p.

*/WOMEN'S PARTICIPATION/ /SOCIAL CHANGE/ /CONSTITUTIONS/ /CUSTOMARY LAW/ /FAMILY
LAW/ /TRADITION/ /CONTRACEPTION/ /ABORTION/ /REPRODUCTION/ /WORKPLACE/
/BOTSWANA/ /CANADA/ /NAMIBIA/ /SOUTH AFRICA/ /ZIMBABWE/ /SEXUAL HARASSMENT/
/GENDER RELATIONS/ /REPRODUCTIVE RIGHTS/*

2. BOERMA, Jean Ties; MGALLA, Zaida, ed.

Women and Infertility in Sub-Saharan Africa: a Multi-disciplinary Perspective
Amsterdam: Royal Tropical Institute, 2001.- 285p.

*/INFERTILITY/ /WOMEN/ /SEXUAL BEHAVIOUR/ /SEXUALLY TRANSMITTED DISEASES/ /HIV/
/AIDS/ /WOMEN'S HEALTH/ /FAMILY PLANNING/ /REPRODUCTIVE HEALTH//AFRICA SOUTH OF
SAHARA/ /ZIMBABWE/ /CENTRAL AFRICA/ /TANZANIA/ /GAMBIA//FEMALE INFERTILITY/*

3. BOOKER, Salih

We are your Children: the Kushanda Early Childhood Education and care Dissemination
Programme: Zimbabwe 1985-1993
The Hague: Bernard Van Leer Foundation.- 88p.

*/EARLY CHILDHOOD/ /PRESCHOOL EDUCATION/ /HEALTH EDUCATION/ /ADULT
EDUCATION//ZIMBABWE/*

4. CALDWELL, John C.; CALDWELL, Pat

The South African Fertility Decline / CALDWELL, John C.; CALDWELL, Pat
Population and Development Review. Vol. 19, No. 2, June 1994, p.225-262

*/FERTILITY DECLINE/ /FERTILITY RATE/ /FAMILY PLANNING/ /PROGRAMMES/ /DEMOGRAPHIC
ANALYSIS//SOUTH AFRICA/*

5. CHIZEMA, Givie

Disparities in the Supply and Consumption of Primary Health Care: a Case Study of
Murehwa Kubatana Rural District Council, Zimbabwe
Harare: University of Zimbabwe, December 1994.- xi-112p.
Dissertation, Master of Science, Rural and Urban Planning, University of Zimbabwe,
Faculty of Social Studies, Department of Rural and Urban Planning, 1994

*/PRIMARY HEALTH CARE/ /HEALTH FACILITIES/ /HEALTH SERVICES/ /HEALTH
PLANNING//ZIMBABWE/*

6. DENNERSTEIN, Lorraine, ed.

Women's Rights and Bioethics
Paris: UNESCO Publishing, 2001.- 215p.

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

/WOMEN'S RIGHTS/ /WOMEN'S HEALTH/ /BIOLOGY/ /ETHICS/ /LIFE CYCLE/ /EXCISION/ /REPRODUCTIVE HEALTH/ /MEN'S PARTICIPATION/ /GENDER ROLES/ /VIOLENCE AGAINST WOMEN/ /PROSTITUTION/ /OCCUPATIONAL HEALTH/ /BIOMEDICINE//SOUTH AFRICA/ /NORTH AFRICA/ /LATIN AMERICA/ /INDIA//BIOETHICS/ /FAMILY RELATIONS/

7. KALIPENI, Ezekiel; THIURI, Philip, ed.

Issues and Perspectives on Health Care in Contemporary Sub-Saharan Africa
Lewiston: The Edwin Melen Press, 1997.- x-419p.

/MEDICAL CARE/ /BASIC HEALTH/ /EPIDEMIOLOGY/ /CHILD MORTALITY/ /INFANT MORTALITY/ /WOMEN/ /GENDER RELATIONS/ /ETHNICITY/ /PREGNANCY/ /FAMILY PLANNING/ /HEALTH POLICY/ /AIDS/ /REFUGEES/ /WOMEN'S HEALTH/ /ACCESS TO HEALTH CARE//AFRICA SOUTH OF SAHARA/ /MALAWI/ /GHANA/ /NIGER/ /SOUTH AFRICA/ /ZIMBABWE/ /BOTSWANA/ /TANZANIA//AIDS PANDEMIC//SUB-SAHARAN AFRICA/

8. MACGREGOR, Jenny

Towards Human - Centred Development: Primary Health Care in Africa
Africa Insight. Vol. 21, No. 3, 1991, p.145-151

/PRIMARY HEALTH CARE/ /HEALTH/ /HEALTH POLICY//AFRICA/ /TANZANIA/ /ZIMBABWE/ /BOTSWANA/

9. MAFORAH, Fidelia

The Impact of Poverty on Health in Urbanising Communities
Journal of Social Development in Africa. Vol. 9, No. 2, 1994, p.87-98

/POVERTY/ /HEALTH/ /MATERNAL AND CHILD HEALTH/ /URBAN AREAS//SOUTH AFRICA/

10. OPOLOT, Samson Jamen, Ed.

Building Healthy Cities : improving the Health of Urban Migrants and the Urban Poor in Africa.
Washington: Woodrow Wilson International Center for Scholars, 2002.- ix-140p.

/HEALTH SERVICES/ /HEALTH SYSTEM/ /TOWNS/ /MATERNAL AND CHILD HEALTH/ /HEALTH FACILITIES/ /ACCESS TO HEALTH CARE/ /URBANIZATION/ /PUBLIC HEALTH//AFRICA/ /EAST AFRICA/ /TANZANIA/ /UGANDA/ /KENYA/ /SOUTH AFRICA//URBAN MIGRANTS/ /URBAN POOR/ /URBAN HEALTH/ /URBAN GOVERNANCE/

11. RAMJI, Shiraz

A Discussion Point: A Strategy for Primary Health Care for the Elderly in Zimbabwe
Journal of Social Development in Africa. Vol. 5, No. 2, 1990, p.45-59

/SOCIAL POLICY/ /LIVING CONDITIONS/ /AGED/ /PRIMARY HEALTH CARE//ZIMBABWE/

12. ROTHBLUM, Esther D.; COLE, Ellen, ed.

Women's Mental Health in Africa
London: Harrington Park Press, 1990.- 98p.

Comparative Research Network, 2008
*Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A
Comparative Study*

*/WOMEN/ /MENTAL HEALTH/ /AIDS/ /FAMILY PLANNING/ /MATERNAL AND CHILD HEALTH/
/MARRIED WOMEN/ /SEXUALITY/ /PSYCHOLOGY//AFRICA/ /SUDAN/ /UGANDA/ /EGYPT/
/ZIMBABWE//NIGERIA/*

13. THOMAS, Duncan; MALUCCIO, John

Contraceptive Choice, Fertility and Public Policy in Zimbabwe
Washington: the World Bank, 1995.- xi-43p.

*/CONTRACEPTIVES/ /FERTILITY/ /GOVERNMENT POLICY/ /FAMILY PLANNING/ /HEALTH
SERVICES/ /EDUCATION OF WOMEN/ /HOUSEHOLD INCOME/ /BIRTH
CONTROL//ZIMBABWE//CONTRACEPTIVES USE/*

Part II : Electronic Documents

2.1 Cape Town (South Africa)

1. ABRAHAMS, Naemah; JEWKES, Rachel; MVO, Zodumo

Indigenous Healing Practices and Self-Medication amongst Pregnant Women in Cape Town, South Africa

African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive.
Vol. 6, No. 2, Aug., 2002, p. 79-86

Abstract: This study was conducted in and around Cape Town, South Africa, at two primary obstetric facilities and in the antenatal clinics of two secondary hospitals. Findings show that majority of the Xhosa speaking women follow indigenous healing practices for both themselves and their babies because of the need to "strengthen" the womb against sorcery, to prevent childhood illnesses, and to treat symptoms they perceive that biomedical services would not be able to treat. Self-medication with non-prescribed drugs, herbs and Dutch remedies was common practice amongst the Afrikaans speaking women for both themselves and their babies. Herbs and Dutch remedies were mainly used to treat indigenous illness (baarwind) while non-prescribed over-the-counter drugs were used to treat minor ailments associated with pregnancy. There is, therefore, an urgent need to bridge the gap between orthodox and indigenous medical systems through reciprocal learning and by acknowledging each other's roles.

Source : Jstor

2. AMPOFO, Akosua Adomako; BEOKU-BETTS, Josephine; NJAMBI, Wairimu Ngaruiya; OSIRIM, Mary

Women's and Gender Studies in English-Speaking Sub-Saharan Africa: A Review of Research in the Social Sciences

Gender and Society. Vol. 18, No. 6, Dec., 2004, p. 685-714

Abstract: This article seeks to broaden understanding of issues and controversies addressed in social science research on women's and gender studies by researchers and activists based in English-speaking sub-Saharan Africa. The topics covered were selected from those ratified by African women in the Africa Platform for Action in 1995 as well as from current debates on the politics of identity. The common feminist issues the authors identified were health; gender-based violence; sexuality, education, globalization and work; and politics, the state, and nongovernmental organizations. In addition, the authors address theoretical and methodological trends. All four coauthors are feminist sociologists: One scholar is based in an African academic institution, two are Africans based in U.S. academic institutions, and one is an African American based in a U.S. academic institution.

Source: Jstor

3. ANDERSON, Kermyt G.; BEUTEL, Ann M.; MAUGHAN-BROWN, Brendan

HIV Risk Perceptions and First Sexual Intercourse among Youth in Cape Town, South Africa

International Family Planning Perspectives. Vol. 33, No. 3, Sep., 2007, p. 98-105

4. BALDWIN-RAGAVEN, Laurel; LONDON, Leslie; DE GRUCHY, Jeanelle
Learning From Our Apartheid Past: human rights challenges for health professionals in contemporary South Africa..

Ethnicity & Health. Vol. 5 Issue 3/4, 2000, p. 227-241

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

Abstract: Central to South Africa's democratic transformation have been attempts to understand how and why human rights abuses were common under apartheid. In testimony to the Truth and Reconciliation Commission evidence has emerged of a wide range of past complicity in human rights abuses by health professionals and their organisations. This has presented a major challenge to the health sector to develop ways to operationalise a commitment to human rights in the future. This paper argues that only after a process of self-reflection, both personal and institutional, which enables a thorough and accurate analysis of why things went so wrong, can the health sector effectively move forward. The authors' perspective draws on the submission to the TRC Health Sector Hearings by the Health and Human Rights Project in 1997, which provides a systemic and case-based analysis of the health sector's role in human rights abuses under apartheid. However, human rights responses have to take account of a changing national and global terrain in which human rights issues are no longer as morally absolute as previously encountered, and in which seemingly insuperable resource constraints, inimical economic policies, and the demobilisation of civil society, are serious obstacles. Moreover, the politics of transformation has generated expediencies that threaten to rewrite history in ways that fundamentally cheapen human rights. To address this contradiction, the authors propose a set of objectives that places accountability of health professionals in a human rights framework. These objectives are intended to give substance to the main tasks facing the health sector - to develop and infuse the capacity to recognise and integrate both the 'new' and traditional human rights dilemmas, and to effect personal and institutional transformation. A matrix is presented, linking these objectives to key role players in the health sector and identifying activities specific for each role player. As the health sector in South Africa grapples with the challenges framed in this model, key lessons for the international community may emerge that further our understanding of the complex relationship between health and human rights and how best to implement strategies for the attainment of human rights in health.

Source: Ebscohost

5. BENATAR, Solomon R.; RENSBURG, H. C. J. van
Health Care Services in a New South Africa
The Hastings Center Report. Vol. 25, No. 4, Jul. - Aug., 1995, p. 16-21

6. BENNETT, Trude
Reproductive Health in South Africa
Public Health Reports. Vol. 114, No. 1, Jan. - Feb., 1999, p. 88-90

7. CALDWELL, John C.; CALDWELL, Pat
The South African Fertility Decline
Population & Development Review. Vol. 19, Issue 2, Jun1993, p. 225-262

Abstract: Until recently, less has been known about demographic change in South Africa than in many other sub-Saharan African countries. This situation is now changing with the publication of analyses based on household fertility surveys. Each of the country's four "racial" groups is seen to have participated in demographic transitions albeit at distinctly different times. The fertility of black South Africans (numerically by far the largest of the four groups) began to decline in the early 1960s, and, with a current total fertility rate of 4.6, this decline represents the earliest and most advanced African fertility transition south of the Sahara. The decline has been assisted by a vigorous national family planning program, which helps to answer the question as to how African fertility might be affected if Asian-type family planning programs were implemented elsewhere in sub-Saharan Africa.

Source: Ebscohost

8. COOPER, Diane; MORRONI, Chelsea; ORNER, Phyllis; MOODLEY, Jennifer; HARRIES, Jane; CULLINGWORTH, Lee; HOFFMAN, Margaret
Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status
Reproductive Health Matters. Vol. 12, No. 24, Nov., 2004, p. 70-85

Abstract: The advent of democracy in South Africa in 1994 created a unique opportunity for new laws and policies to be passed. Today, a decade later, South African reproductive health policies and the laws that underwrite them are among the most progressive and comprehensive in the world in terms of the recognition that they give to human rights, including sexual and reproductive rights. This paper documents the changes in health policy and services that have occurred, focusing particularly on key areas of sexual and reproductive health: contraception, maternal health, termination of pregnancy, cervical and breast cancer, gender-based and sexual violence, HIV/AIDS and sexually transmitted infections and infertility. Despite important advances, significant changes in women's reproductive health status are difficult to discern, given the relatively short period of time and the multitude of complex factors that influence health, especially inequalities in socio-economic and gender status. Gaps remain in the implementation of reproductive health policies and in service delivery that need to be addressed in order for meaningful improvements in women's reproductive health status to be achieved. Civil society has played a major role in securing these legislative and policy changes, and health activist groups continue to pressure the government to introduce further changes in policy and service delivery, especially in the area of HIV/AIDS.

Source : Jstor

9. COUGHLAN, Felicity J.
Primary health care organizations in South Africa: Some conceptual issues
South African Journal of Sociology. Vol. 26, Issue 1, Feb95,

Abstract: Discusses some conceptual difficulties associated with implementing primary health care in South Africa. Role of biomedicine; Role of the individual and the community; Appropriate personnel; Traditional healers; Paying the personnel and funding the health care system

Source: Ebscohost

10. DICKSON-TETTEH, Kim; PETTIFOR, Audrey; MOLEKO, Winnie
Working with Public Sector Clinics to Provide Adolescent-Friendly Services in South Africa
Reproductive Health Matters. Vol. 9, N°. 17, May, 2001, p. 160-169

Abstract: Health care facilities can play an important role for adolescents in preventing health problems, in promoting sexual and reproductive health and in shaping positive behaviours. Extensive research has established that South African public health facilities are failing to provide adolescent-friendly health services. The National Adolescent-Friendly Clinic Initiative (NAFCI) is an accreditation programme designed to improve the quality of adolescent health services at the primary care level and strengthen the public sector's ability to respond to adolescent health needs. The key objectives of the programme are to make health services more accessible and acceptable to adolescents, establish national standards and criteria for adolescent health care in clinics throughout the country, and build the capacity of health care workers to provide quality services. One of the indicators for success of NAFCI will be increased utilisation of public sector clinics by adolescents. NAFCI is an integral component of the largest, most innovative, public health programme ever launched in South Africa, loveLife. Achieving NAFCI accreditation involves clinic self-appraisals, quality improvements, external assessments and award of achievement stars. NAFCI is currently being piloted in ten government clinics in South Africa.

Source : Jstor

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

11. DI MCINTYRE; KLUGMAN, Barbara

The Human Face of Decentralisation and Integration of Health Services: Experience from South Africa
Reproductive Health Matters. Vol. 11, No. 21, May, 2003, p. 108-119

Abstract : This paper explores the processes of policy-making, budgeting and service implementation in three provinces of South Africa, drawing on interviews with health managers at different levels of government. It illustrates how the process of decentralisation creates disjunctures between the policy-making authority of higher levels of government and the implementation capacity of service provision levels. It also explores the complex dynamics between those responsible for specific policies, such as reproductive health policies, and those responsible for managing the integrated delivery of all policies, with their resultant contestations over authority and resources. The pace of change in South Africa and the enormous capacity it requires, both in relation to financial management and the technical skills needed for specific programmes, has created a sense of frustration and demoralisation. Whilst shortage of financial resources, particularly as reflected in shortage of staff, is frequently assumed to be the biggest constraint in this context, most managers identified other issues, particularly staff morale, as greater barriers to the delivery of high quality health services. The paper concludes that it is the complexity of experience and feelings described by health managers that may determine the extent and quality of service delivery. For this reason, both practice and research need to give greater attention to issues of power relations and personal experience of change.

Source : Jstor

12. FIDLER, Anne T. ; BERNSTEIN, Judith

Infertility: From a Personal to a Public Health Problem

Public Health Reports. Vol. 114, No. 6, Nov. - Dec., 1999, p. 494-511

Abstract: The Desire to Have Children is virtually universal, and the right to reproduce is recognized by the Supreme Court as a basic civil right. Whether driven by biology, emotional needs, or social pressure, at some point in their lives most adults seek to have a child, generally taking for granted that they will be able to do so by the usual biologic route whenever they choose. Infertility, or the inability to conceive a child, is a condition that affects millions of Americans each year and has a profound impact on a person's self-esteem, personal relationships, sense of value, and sense of purpose not to mention health and pocketbook.

Source: Jstor

13. GANGADHARAN, Lata; MAITRA, Pushkar.

Two Aspects of Fertility Behavior in South Africa..

Economic Development & Cultural Change. Vol. 50 Issue 1, Oct2001, 18 p.

Abstract: Analyzes the aspects of female fertility behavior in South Africa. Assessment on the effects of age on female fertility; Statistical details of conception and corresponding age variations; Differences of fertility patterns within the socioeconomic classes and races of.

Source: Ebscohost

14. GIBSON, Diana

Negotiating the New Health Care System in Cape Town, South Africa: Five Case Studies of the Acutely Chronically Ill

Medical Anthropology Quarterly, New Series. Vol. 15, No. 4, Dec., 2001, p. 515-532

Comparative Research Network, 2008

Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

Abstract: This article examines the experiences of chronically ill disadvantaged patients in a newly reformed health care system against a backdrop of inequalities still prevalent in the wider post apartheid socio-political economy of the Western Cape, South Africa. Patients negotiated a hierarchy of spaces at the national level of transformation and policy and at community-, secondary-, and tertiary-level facilities. The institutionalization of patients meant that expensive medical treatment was mobilized in accordance with different stages of illness and that certain services were available only to "qualifying" categories of diagnoses.

Source: Jstor

15. GILBERT, Leah

Sociology and the 'New Public Health' in South Africa..

South African Journal of Sociology. Vol. 26 Issue 4, , 1995, p. 115

Abstract: Explores the dimensions of the 'New Public Health' in general and in the South African context in particular. Sociology's role in public health research and training; Bio-medical and psycho-socio-environmental models of health and disease; Development of public health; History of public health in South Africa; Concepts and critique of the new public health; Training for public health..

Source: Ebscohost

16. GLUGMAN, Barbara; STEVENS, Marion; ARENDS, Katrina

Developing Women's Health Policy in South Africa from the Grassroots

Reproductive Health Matters. Vol. 3, No. 6, Nov., 1995, p. 122-131

Abstract: The Women's Health Conference in South Africa in December 1994 aimed to identify women's health needs and translate them into policy proposals. The process was inclusive and bottom up and cut across barriers of race, class and ideology. Prior to the conference, policy groups developed draft proposals on major areas of women's health, while provincial networking got input from the grassroots. The conference gave women space to talk about their experiences and finalise the proposals. Work on implementation has now begun; some proposals are being used by a number of provinces and by the Ministries of Health and Welfare and the Reconstruction and Development Programme's Gender Commission. In light of the proposal on abortion, the current abortion law is being reviewed by a Parliamentary Select Committee.

Source : Jstor

17. GORDON, Peter; ADAIKAN, P Ganesan; CHYE NG, Soon; CHETLEY, Andrew; GIRARDIN, Vincent; NARY, Gordon; SCHUKLENK, Udo; NUNES, Fred; DELPH, Yvette

If Men's Erections Are Going to Be Funded, Why Are Women Still Paying for Birth Control?

Reproductive Health Matters. Vol. 6, No. 12, Nov., 1998, p. 150-162

18. LEWIS, Desirée; SALO, Elaine

Birth Control, Contraception and Women's Rights in SA: A Cape Town Case Study

Agenda. No. 17, 1993, p. 59-68

19. MCINTYRE, Di; KLUGMAN, Barbara

The Human Face of Decentralisation and Integration of Health Services: Experience from South Africa

Reproductive Health Matters. Vol. 11, No. 21, May, 2003, p. 108-119

Comparative Research Network, 2008

Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

Abstract : This paper explores the processes of policy-making, budgeting and service implementation in three provinces of South Africa, drawing on interviews with health managers at different levels of government. It illustrates how the process of decentralisation creates disjunctures between the policy-making authority of higher levels of government and the implementation capacity of service provision levels. It also explores the complex dynamics between those responsible for specific policies, such as reproductive health policies, and those responsible for managing the integrated delivery of all policies, with their resultant contestations over authority and resources. The pace of change in South Africa and the enormous capacity it requires, both in relation to financial management and the technical skills needed for specific programmes, has created a sense of frustration and demoralisation. Whilst shortage of financial resources, particularly as reflected in shortage of staff, is frequently assumed to be the biggest constraint in this context, most managers identified other issues, particularly staff morale, as greater barriers to the delivery of high quality health services. The paper concludes that it is the complexity of experience and feelings described by health managers that may determine the extent and quality of service delivery. For this reason, both practice and research need to give greater attention to issues of power relations and personal experience of change.

Source : Jstor

20. MEEKERS, Dominique.

The Effectiveness of Targeted Social Marketing to Promote Adolescent Reproductive Health: The Case of Soweto, South Africa

Journal of HIV/AIDS Prevention & Education for Adolescents & Children. Vol. 3 Issue 4, 2000, 20 p.

Abstract: Adolescents and young adults in South Africa increasingly face reproductive health problems, including unplanned pregnancy and exposure to infection with HIV and STDs. Hence, there is much interest in the effectiveness of policies and interventions that specifically address adolescent reproductive health. This study uses a quasi-experimental control group design to assess the effect of a targeted social marketing program on reproductive health beliefs and behavior among young women in Soweto. In response to adolescents' concerns, the intervention was developed with a focus on pregnancy prevention. The findings indicate that the intervention increased young women's awareness of the risk of pregnancy, awareness that condoms are effective for pregnancy and HIV/AIDS prevention, awareness that other contraceptives are effective for pregnancy prevention, discussions about contraception, and increased the percentage of women who have used condoms. These results suggest that the intervention was more effective in changing beliefs related to pregnancy prevention than those related to STD/HIV prevention, consistent with the program design. [ABSTRACT FROM Source: Ebscohost

21. MFONO, Zanele

Teenage Contraceptive Needs in Urban South Africa: A Case Study

International Family Planning Perspectives. Vol. 24, No. 4, Dec., 1998, p. 180-183

22. MULLAN, Fitzhugh; EPSTEIN, Leon

Community-Oriented Primary Care: New Relevance in a Changing World..

American Journal of Public Health. Vol. 92 Issue 11, Nov 2002, p. 1748-1755

Abstract: Since Its inception in rural, pre-apartheid South Africa, community-oriented primary care (COPC) has intrigued and informed public health and primary care leaders world-wide. COPC has influenced such programs as the US community health center movement, the general practice movement in the United Kingdom. and recent reforms in the public health system of South Africa. We provide a global overview of COPC, tracing its conceptual roots, reviewing its many manifestations, and exploring its future prospects as an organizational paradigm for the democratic organization of community health services. We examine the pitfalls and paradoxes of COPC and suggest its future utility COPC has Important values and methods to offer disparate but powerful movements in public health worldwide. - Source: Ebscohost

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

23. PAUW, Ilse; BRENER, Loren

'You Are Just Whores: You Can't Be Raped': Barriers to Safer Sex Practices among Women Street Sex Workers in Cape Town
Culture, Health & Sexuality. Vol. 5, No. 6, Nov. - Dec., 2003, p. 465-481

Abstract : This paper identifies barriers to HIV risk reduction among women street sex workers in Cape Town. To gain access to the study population, investigators undertook observational fieldwork for 9 months. This initial trust-building period allowed for the mutual identification of issues to guide the remainder of the research. Twenty-five individual interviews and four focus groups were then conducted. The following were identified as barriers to the uptake of risk reduction: the role of regular partners and 'special clients' in determining condom use; client resistance to condom use; accessibility of condoms and lubricants; client violence and forced unprotected sex; police violence and lack of protection; substance use among workers; access to health care services; inappropriate genital hygiene practices; inappropriate assessment by workers for sexually transmitted diseases in themselves and clients; and, the role of gatekeepers. Future interventions need to better understand the social context in which street-based sex workers are exposed to HIV risk. They need to be designed and implemented in partnership to develop sex workers' capacity to reduce the risk of HIV transmission among themselves, and their clients.

Source : Jstor

24. SANDERS, David; CHOPRA, Mickey

Key Challenges to Achieving Health for All in an Inequitable Society: The Case of South Africa
American Journal of Public Health. Vol. 96 Issue 1, 2006, p. 73-78

Abstract: The health inequalities in South Africa are rapidly worsening. Since 1994, the new democratic government has initiated a number of large-scale policies and programs with explicit pro-equity objectives that have improved access to health care and other social resources. However, these policies and programs have been constrained by macroeconomic policies that dictate fiscal restraint and give priority to technical rather than developmental considerations. We propose an approach to improving health for all that focuses on equity in the allocation of health resources. The implementation of pro-equity policies requires, in addition to technically efficacious interventions, both advocacy initiatives and communication with, and the involvement of, affected communities. The Cape Town Equity Gauge project is presented as one example of a response to the challenge of inequity.

Source: Ebscohost

25. SEEKOE, Eunice

Poverty and health in developing countries: a South African perspective..
Diversity in Health & Social Care. Vol. 4 Issue 3, 2007, p163-165, 3p.

Abstract: The article offers information on the role of the Growth Economic and Redistribution (GEAR) policy to bring about economic development in South Africa . It is stated that even after the end of apartheid in South Africa there was no improvement in the economic condition of the country. It was noticed that there was widespread illiteracy, poverty, poor health conditions, and unemployment. It is stated that the aim of GEAR was to improve the economic conditions in South Africa by offering facilities such as education, medical aid, and employment. GEAR also focused towards spreading knowledge about the human immunodeficiency virus (HIV) among the Africans.

Source: Ebscohost

26. MOULTRIE, Tom A.; TIMÆUS, Ian M.

The South African fertility decline: Evidence from two censuses and a Demographic and Health Survey

Population Studies. Vol. 57 Issue 3, Nov 2003, p. 265-283

Abstract: Inadequate data and apartheid policies have meant that, until recently, most demographers have not had the opportunity to investigate the level of, and trend in, the fertility of South African women. The 1996 South Africa Census and the 1998 Demographic and Health Survey provide the first widely available and nationally representative demographic data on South Africa since 1970. Using these data, this paper describes the South African fertility decline from 1955 to 1996. Having identified and adjusted for several errors in the 1996 Census data, the paper argues that total fertility at that time was 3.2 children per woman nationally, and 3.5 children per woman for African South Africans. These levels are lower than in any other sub-Saharan African country. We show also that fertility in South Africa has been falling since the 1960s. Thus, fertility transition predates the establishment of a family planning programme in the country in 1974.

Source: Ebscohost

27. VARGA, Christine A.

How Gender Roles Influence Sexual and Reproductive Health among South African Adolescents

Studies in Family Planning. Vol. 34, No. 3, Sep., 2003, p. 160-172

Abstract: Although the literature on Africa increasingly adopts a gendered approach to sexual and reproductive health issues, few studies have addressed adolescent pregnancy and parenthood in such a framework. This article examines links between gender ideology or gender roles and the social impact of adolescent childbearing in the lives of rural and urban adolescents in KwaZulu/Natal, South Africa. It employs a triangulated research methodology (focus-group discussions, narrative role playing and discussions, and questionnaires and in-depth interviews) to inform an analysis of adolescents' notions of male and female gender ideals. This analysis forms the basis for an exploration of the potential influence of adolescent childbearing on young peoples' lives and factors that shape their sexual and reproductive well-being. Results indicate that gender ideals are grounded in traits that reinforce poor sexual negotiation dynamics and behavioral double standards and that place adolescents at risk for early pregnancy and other sexual and reproductive health complications. Overall, adolescent parenthood is viewed negatively by participants of both sexes because it compromises personal, professional, and financial aspirations. Compared with its effect on boys, parenthood has a disproportionate (and highly negative) impact on girls that is directly linked to gender-based inequities. The article addresses the research and policy implications of these findings.

Source: Jstor

2.2 Harare (Zimbabwe)

28. BOOHENE, Esther; DOW, Thomas E.

Contraceptive Prevalence and Family Planning Program Effort in Zimbabwe

International Family Planning Perspectives. Vol. 13, N^o. 1, Mar., 1987, p. 1-7

29. CALDWELL, John C.; ORUBULOYE, I. O.; CALDWELL, Pat

Fertility Decline in Africa: A New Type of Transition?.

Population & Development Review. Vol. 18, Issue 2, Jun1992, p. 211-242

Abstract: A number of recent surveys show that fertility has begun to decline in Botswana, Zimbabwe, Kenya, and southern Nigeria. This study of an urban area in southwest Nigeria confirms a fertility decline and throws light on the erosion of traditional supports for high fertility. The authors conclude that the sub-

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

Saharan fertility transition is likely to differ during its early decades from the pattern established by the European and Asian transitions: the greatest demand for fertility control will come not from older women wishing to cease family building but from young married women who wish to maintain or lengthen traditional birth intervals even though the traditional mechanisms for achieving those ends are decaying. The onset of fertility decline is likely to be determined by the attainment of relatively low levels of infant and child mortality, substantial extension in female secondary education, an ample supply of contraceptives, and government leadership toward controlling family size.

Source: Ebscohost

30. CHIGUDU, Hope

Deepening our understanding of community-based participatory research: lessons from work around reproductive rights in Zimbabwe
Gender & Development. Vol. 15, Issue 2, Jul2007, p. 259-270, 12p.

Abstract: The Community Working Group on Health (CWGH) is an organisation that promotes community participation in health, especially in the area of HIV and AIDS and reproductive health. During the course of its work, it realised that there was a lack of community-generated information on which to base its activities. CWGH therefore initiated community-based participatory action research on various topics related to reproductive rights. The research, which was conducted by young people in their communities, provided a platform for provocative discussion in the community and contributed to the promotion of a community-based agenda for transformation in gender relations. The research provided an opportunity for the communities to reclaim their political space, stimulated exchange of information, and injected energy into the communities' lobbying initiatives.

Source: Ebscohost

31. DAVIES, Robert; DAVIES, Rob; SAUNDERS, David

Stabilisation Policies and the Effects on Child Health in Zimbabwe
Review of African Political Economy. N°. 38, Apr., 1987, p. 3-23

Abstract: The purpose of this article is to assess the likely impact of stabilisation policies on the health of children in Zimbabwe. It begins with a discussion of some of the general methodological issues involved in this kind of measurement before going on to outline Zimbabwe's recent stabilisation experiences. It considers how policies adopted have affected, first, general determinants of health status and, second, specific health sector inputs. Finally it attempts to assess the extent to which these factors have affected the health status of children.

Source: Jstor

32. FAWCUS, Susan; MBIZVO, Michael; Gunilla , LINDMARK; NYSTROM, Lennarth

A Community-based Investigation of Avoidable Factors for Maternal Mortality in Zimbabwe
Studies in Family Planning. Vol. 27, No. 6, Nov. - Dec., 1996, p. 319-327
Source : Jstor

33. FELDMAN, Rayah; MAPOSHERE, Caroline

Safer Sex and Reproductive Choice: Findings from "Positive Women: Voices and Choices" in Zimbabwe
Reproductive Health Matters. Vol. 11, No. 22, Nov., 2003, p. 162-173

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

Abstract: Positive Women: Voices and Choices was an advocacy-research project developed by the International Community of Women Living with HIV/AIDS to explore the impact of HIV/AIDS on women's sexual and reproductive lives, challenge the violation of their rights and advocate improvements in policy and services. The project in Zimbabwe, the first one in three countries, was carried out from 1998 to 2001. This article presents selected findings from the Zimbabwe research report. It shows that HIV-positive women were unaware they were at risk before an HIV diagnosis, and that gender norms and economic dependence on husbands/partners restricted women's ability to control their sexual and reproductive lives. Prejudices that HIV-positive women should not be sexually active or have children meant women did not disclose their status to health workers, making it difficult for their needs to be acknowledged or addressed. Condom use was considered inappropriate in marriage. Younger childless women wanted to become pregnant, often in spite of previous miscarriage and stillbirths. Women with several children wanted to avoid further pregnancies, and contraceptive and condom use increased markedly after HIV diagnosis, especially among those attending support groups. Safe abortion was almost entirely inaccessible, though technically the law would have permitted it. Better economic opportunities for women, and integrated pregnancy and delivery care, family planning, STI and HIV-related services are needed which take account of HIV-positive women's needs.

Source: Jstor

34. FRANCIS-CHIZORORO, Monica; NATSHALAGA, Neddy Rita

The Female Condom: Acceptability and Perception among Rural Women in Zimbabwe
African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive.
Vol. 7, No. 3, Dec., 2003, p. 101-116

Abstract: This study was conducted to generate data for developing an action plan for accessing the female condom through primary health care centres in Zimbabwe. It used both quantitative and qualitative methods to gather information from sexually active women and men on the perception and acceptability of the female condom among users in rural areas of Zimbabwe. The findings show that very few women had used the female condom prior to the survey. Several women (93%) liked the condom especially young women aged 20-39 years (83%), compared to older women aged 40 years and above (11%). Both women and men liked the dual role of contraception and protection against STIs including HIV/AIDS played by the female condom. Most women (98%) felt that it is important for women to have their own condom. However, both men and women pointed out that it will be difficult to introduce the female condom in married situations due to the stigma associated with condoms in general. Over 80% of women said they will have to seek permission from their partners to use the female condom. Women had problems with inserting the condom and were concerned with lubrication, size and appearance, and how to dispose of used condom. Regarding cost, 77% felt that the female condom is too expensive given that the male condom can be obtained free from health centres. The cost of the female condom could hinder its continued use and would encourage women, especially commercial sex workers, to re-use it. Respondents still require more information relating to side effects (45%), effectiveness in STIs prevention including HIV/AIDS (44%), proper use (43%) and cost (32%).

Source : Jstor

35. GUILKEY, David K.; JAYNE, Susan

Fertility Transition in Zimbabwe: Determinants of Contraceptive Use and Method Choice
Population Studies. Vol. 51, No. 2, Jul., 1997, p. 173-189

36. HALL, Peter

Reproductive Health in Southern Africa: Report of a WHO Workshop
African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive.
Vol. 1, N°. 1, Mar., 1997, p. 97-99

37. HESSINI, Leila; BROOKMAN-AMISSAH, Eunice; CRANE, Barbara B.

Global Policy Change and Women's Access to Safe Abortion: The Impact of the World Health Organization's Guidance in Africa / Modification de la politique mondiale et l'accès par la femme à l'avortement sans danger: L'impact de conseil de l'Organisation mondiale de la santé en Afrique

African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive.
Vol. 10, No. 3, Dec., 2006, p. 14-27

Abstract: Along with governments from around the world, African leaders agreed at the International Conference on Population and Development (ICPD) in 1994 to address unsafe abortion as a major public health problem. At the five-year review of the ICPD, they decided further that health systems should make safe abortion services accessible for legal indications. Based on this mandate, the World Health Organization (WHO) developed norms and standards for quality abortion services, Safe Abortion: Technical and Policy Guidance for Health Systems, released in 2003. While abortion-related maternal mortality and morbidity remains very high in many African countries, stakeholders are increasingly using WHO recommendations in conjunction with other global and regional policy frameworks, including the African Union Protocol on the Rights of Women in Africa, to spur new action to address this persistent problem. Efforts include: reforming national laws and policies; preparing service-delivery guidelines and regulations; strengthening training programs; and expanding community outreach programs. This paper reviews progress and lessons learned while drawing attention to the fragility of the progress made thus far and the key challenges that remain in ensuring access to safe abortion care for all African women.

Source : Jstor

38. HOF, Caroline; RICHTERS, Annemiek

Exploring Intersections between Teenage Pregnancy and Gender Violence: Lessons from Zimbabwe

African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive.
Vol. 3, No. 1, May, 1999, pp. 51-65

Abstract: A qualitative study of teenage pregnancy was conducted over a period of three months in 1996 in Bulawayo, Zimbabwe. Interviews with teenage mothers and fathers gave reason to explore the various intersections between teenage pregnancy and gender violence. Gender violence is defined as acts of force or coercion directed at an individual woman and perpetuating female subordination. Teenage pregnancy and its relationship with gender violence are analysed against the background of the social and cultural conditions that promote, facilitate, or prevent violence against adolescent girls. It is argued that a much-needed improvement of adolescent sexual and reproductive health interventions should be based on the incorporation of new gender norms in all levels of society.

Source: Jstor

39. HOVE, Innocent; SIZIYA, Seter ; KATITO, Campbel; TSHIMANGA, Mafuta

Prevalence and Associated Factors for Non-Utilisation of Postnatal Care Services: Population-Based Study in Kuwadzana Peri-Urban Area, Zvimba District of Mashonaland West Province, Zimbabwe

African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive.
Vol. 3, No. 2, Oct., 1999, p. 25-32

Abstract: A cross-sectional study of 466 mothers and a case control study (31 cases and 99 controls) were conducted in a peri-urban town of Kuwadzana, Zimbabwe. The objectives were to determine the prevalence and associated factors for non-utilisation of postnatal care (PNC) services. A logistic regression

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

analysis was done in order to adjust for confounding factors. The prevalence of non-utilisation of PNC was 10.1% (95% CI 7.4, 12.8%). Respondents who belonged to the Apostolic religion and who had non-medical birth attendance during the last birth were 2.17 (95% CI 1.11, 6.62) and 5.30 (95% CI 1.90, 14.79) times more likely not to have utilised PNC services. Religion and birth attendance should be considered in interventions geared towards reducing the non-utilisation rate of PNC services.

Source : Jstor

40. MBIZVO, Elizabeth Mukuze; MSUYA, Sia; HUSSAIN, Akhtar; CHIRENJE, Mike; MBIZVO, Michael; SAM, Noel; STRAY-PEDERSEN, Babill

HIV and Sexually Transmitted Infections among Women Presenting at Urban Primary Health Care Clinics in Two Cities of sub-Saharan Africa

African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive. Vol. 9, N^o. 1, Apr., 2005, p. 88-98

Abstract: In a cross-sectional study, 786 consenting women from two cities in Africa, Harare and Moshi, attending primary health care clinics were interviewed, examined and tested for HIV and other sexually transmitted infections (STIs). The aim of the study was to assess and compare differences in the characteristics that may affect the prevalence of HIV/STIs among women in the two cities. Multivariate analysis was used to generate odds ratio. STIs and behaviour characteristics among this low risk group of women could not fully explain the higher HIV prevalence in Zimbabwe, 29.3% compared to 11.5% in Tanzania ($p < 0.01$). Interventions should target identified risk factors with particular attention to youths.

Source : Jstor

41. MCGREGOR JoAnn; RANGER, Terence

Displacement and Disease: Epidemics and Ideas about Malaria in Matabeleland, Zimbabwe, 1945-1996

Past & Present. N^o. 167, May, 2000, p. 203-237

42. MENSCH, Barbara; FISHER, Andrew; ASKEW, Ian; AJAYI, Ayorinde

Using Situation Analysis Data to Assess the Functioning of Family Planning Clinics in Nigeria, Tanzania, and Zimbabwe

Studies in Family Planning. Vol. 25, No. 1, Jan. - Feb., 1994, p. 18-31

Abstract : Situation analyses conducted in Nigeria, Tanzania, and Zimbabwe have revealed problems in the functioning of many of the subsystems of family planning service delivery, namely in supplies of commodities; in facilities and equipment; in staffing and training; in information, education, and communication; and in record keeping. Although a clear pattern of clinic use exists, in that only a few service-delivery points provide contraceptive services to the majority of new family planning acceptors in the three countries, an attempt to explain how clinics with more clients differ from those that are visited less frequently revealed only a weak association between subsystem functioning and use.

Source: Jstor

43. MEURSING, Karla; SIBINDI, Flora

Condoms, Family Planning and Living with HIV in Zimbabwe

Reproductive Health Matters. Vol. 3, No. 5, May, 1995, p. 56-67

Abstract: In the socio-cultural context of Zimbabwe, where men have both sexual freedom and power over women in relationships, the use of condoms and family planning remains subject to a man's willingness. Men's dislike of condoms remain a major barrier to HIV/STD prevention both before and after a positive HIV diagnosis. Openness about the diagnosis or even the suggestion to use condoms can provoke scorn and

Comparative Research Network, 2008

Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

rejection, making the likelihood of controlling HIV very slim indeed. De-stigmatisation of HIV and AIDS is essential to facilitate openness about the diagnosis and open the way for people to be able to protect their partners. These conclusions are based on a project of intensive counselling and support for 72 men and women age 9-55 with HIV.

Source : Jstor

44. PHILLIPS, Oliver

(Dis)Continuities of Custom in Zimbabwe and South Africa: The Implications for Gendered and Sexual Rights

Health and Human Rights. Vol. 7, No. 2, 2004, p. 82-113

Abstract: This article historicizes the legal regulation of sexuality and claims to sexual rights in South Africa and Zimbabwe, analyzing their implications. Focusing on the interaction of formal Constitutions and informal customary law in the differential development of agency and rights, it highlights the constancy of women's partial legal subjectivity alongside shifts in authority from lineage to nation-state. The tensions between the legal formalism of rights, and the historical authority of customary structures buttress the regulation of sex and the claims to sexual rights within these two countries, and they frame a discussion of how sexual-health programs and policies might better engage with the development of sexual agency.

Source: Jstor

45. RAY, Sunanda; BASSETT, Mary; MAPOSHERE, Caroline; MANANGAZIRA, Portia; NICOLETTE, Jo Dean; MACHEKANO, Roderick; MOYO, Josephine

Acceptability of the Female Condom in Zimbabwe: Positive but Male-Centred Responses
Reproductive Health Matters. Vol. 3, No. 5, May, 1995, p. 68-79

Abstract: An acceptability study of the female condom was carried out in Zimbabwe among sex workers (89), urban women attending a family planning clinic in Harare (84), and rural women (23). Their main reason for trying this new method was as protection from sexually transmitted infections, including HIV. Over 50 per cent of the women in all three groups said that they and their partners liked the condom very much and preferred it to the male condom. Less than 10 per cent did not like it. The main problems were with the inner ring and too much lubrication, but questions remain on sustainability, and cost is a major obstacle. Further, even though it did not interfere with the women's sexual pleasure, most of the reasons for liking the method were male-centred.

Source : Jstor

46. ROBSON, Elsbeth

Invisible Carers: Young People in Zimbabwe's Home-Based Healthcare
Area. Vol. 32, No. 1, Mar., 2000, p. 59-69

Summary: Women and young people are disproportionately burdened by the restructuring of healthcare services. Home-based healthcare provision by children in Zimbabwe is investigated through qualitative interviews with young carers and key informants. The study suggests that young people (especially girls) become carers according to varied personal and household factors in the context of the AIDS pandemic, macro-economic decline and ESAP-weakened formal health services.

Source: Jstor

47. THOMAS, Duncan; MALUCCIO, John

Fertility, Contraceptive Choice, and Public Policy in Zimbabwe

The World Bank Economic Review. Vol. 10, No. 1, Jan., 1996, p. 189-222

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

Abstract: Zimbabwe has invested massively in public infrastructure since independence in 1980. The impact of these investments on demographic outcomes is examined using household survey data matched with two community level surveys. A woman's education is a powerful predictor of both fertility and contraceptive use. These relationships are far from linear and have changed shape in recent years. After controlling for household resources, both the availability and quality of health and family planning services have an important impact on the adoption of modern contraceptives. In particular, outreach programs such as mobile family planning clinics and community-based distributors (CBDs) have been especially successful. However, not all women are equally served by this infrastructure. For example, CBDs have a bigger impact on younger, better educated women, while mobile family planning clinics appear to have more success with older, less educated women.

Source: Jstor

48. Zimbabwe 1994: Results from the Demographic and Health Survey
Studies in Family Planning. Vol. 27, No. 1, Jan. - Feb., 1996, p. 52-56

Comparative Research Network, 2008
*Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A
Comparative Study*

Part III : Background Document

Background Document

Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

**Project Leaders: Prof. Diana Gibson (University of Western Cape)
Mr. Glen Ncube (University of Cape Town)**

Introduction

Delivering the eight basic elements of Primary Health Care (PHC) namely, health education, adequate nutrition, safe water and sanitation, mother/child care and family planning, immunization, prevention of local epidemics, treatment of common diseases and essential drugs supply, has had important implications for many urban women in sub-Saharan Africa since the Alma Ata Declaration on PHC in 1978. Yet, as primary health care is entering its second generation, these implications are still imperfectly known. The aim of this comparative study is to ascertain how the policies and delivery of PHC goals affect women in two neighbouring southern African countries. The reason for this focus originates in a WHO-sponsored report compiled by Helena Pizurki et al (1987), which argued;

“If WHO and its member states are to design and implement successfully a strategy whose cornerstone is primary health care and which aims at ‘Health for All by the Year 2000’, it is essential to concentrate on women as resources”

Adding its voice, the World Bank [1994], published its report reiterating that since many of the interventions that address women's health should be cost effective, PHC should therefore be seen as the product of choice. Ethel G. Martens (1995), an international public health scholar, further argued that PHC's stress on prevention, rather than cure, is a very important because it touches women's health more closely. In 1998, the WHO authoritatively said:

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

Voices of support for PHC have also come from other United Nations (UN) agencies. Pascal Allotey of the UN Division for the Advancement of Women [2005], further argued that, given the consensus reached at Alma Ata it will be appropriate to use PHC to solve women's sexual and reproductive health problems. PHC has thus been seen as having inbuilt strategies that promote the health of women and that of their families. Recently, the incumbent Director General of WHO, Margaret Chan (2007), called for renewed emphasis on PHC as an approach to boosting health systems, and as an underscore for the achievement of health-related Millenium Development Goals (MDGs).

Comparative Research Network, 2008
*Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A
Comparative Study*

PHC therefore seems to be the strategy that will dominate health delivery in the foreseeable future. Internationally recognized, it has been peddled as a revolutionary health care strategy because it de-emphasizes the vertically inclined biomedical approach in favour of a holistic approach that observes the linkage between health and underdevelopment, poverty, illiteracy etc. There has not been any particular challenge to the legitimacy of the strategy. The Alternative Health Sector Reform Theories that have mushroomed over the recent past do not challenge the core of PHC, but are frustrated with the failure of the public sector to meet its delivery obligations.

Our keen interest to investigate the implications of PHC for women has been enhanced by what some historians of health have said about the general complications encountered in the implementation of PHC since its enunciation. In separate studies Marcos Cueto (2007) and Glen Ncube (2007) observed that the general implementation of PHC unfortunately coincided with certain negative developments including the following:

1. Economic recession in the 1980s leading to poverty and increase poverty related diseases.
2. Fall in national health expenditures.
3. Low priority given to health as opposed to employment, etc.
4. Growth of anti-state sentiments spurred by a new belief in the power of the market to provide wealth and welfare.
5. Change in the ruling values on which PHC rested in the 1970s due to ideological shifts.
6. Contradictory economics of PHC: its emphasis on cost-effectiveness has spawned variegated interpretations.

In view of this, the outcomes for women could not be expected to have been any better particularly given the fact they often have to carry the burden of community care at a time when health systems in general are failing to cope. Low funding for primary care institutions – and by extension, community health care structures where women are the majority – has also had detrimental implications for them. There has often been lack of programme continuity as well, while gender stereotypes and other cultural barriers to women continue (Ncube 2007).

This project seeks funding to compare the experiences of women in two southern African cities namely, Cape Town (South Africa) and Harare (Zimbabwe) through a rigorous appraisal of their PHC programmes to ascertain how it makes assumptions about or reinforce the gendered dimension of community health care and the related responsibilities of women. Among other things, we hope to determine how the two cities are filtering the core value of PHC, i.e., the delivery of essential health care, easily accessible, affordable and accepted by the communities.

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

To do so we shall have the following goals:

1. To review international and national literature regarding quality Primary Health Care Services and its impact for women in the two countries.
2. To carry out a situation analysis in the form of case studies in three/four PHC facilities in each city regarding its PHC programmes.
3. To assess knowledge, attitudes and existing practices regarding PHC Services among service providers in the clinics.
4. To assess the gendered impact of PHC policy and provision for women.
5. To develop a mixed comparative methodology and analytical framework for research

Justification

1) Launched in 1978 as a joint operation by the World Health Organisation (WHO) and UNICEF, primary health care has become the world's most well-known and accepted strategy of health care. While the achievement of the goals of PHC and "health for all by 2000" was recognized as a world wide failure, the ascendancy of Margaret Chan as Director General of WHO in 2007, resuscitated global commitment to PHC. Independent empirically based scholarly feedback on this issue is therefore of urgent importance.

2) As rural to urban migration increases unabated, there is an ever more urgent need to continue expanding and improving health service delivery in urban areas. A comparative study will provide a launch pad for cities to compare experiences, share notes and import successful strategies while avoiding mistakes committed elsewhere. So, not only will a study of this nature be important to the international drivers of the policy, but also to the local implementers.

Major Research Gaps:

Coinciding with what seems to be the pinnacle of the information age and transnationalism, knowledge about PHC has expanded very fast across national and cultural boundaries. There is now an almost monotonous rendition of this subject in websites, national health policy documents and scholarly writings across the disciplinary divide. However, there is still a dearth in literature that approaches this subject from a comparative perspective and, which also looks more closely at its implications for women. This is where our project seeks to make its major contribution.

Comparative questions:

To make the collection of comparative data possible and to strengthen the analysis we have selected particular themes we will explore.

- A. *What are the current policies concerning PHC as it applies to clinics in the two countries?*

Although the WHO has guidelines for PHC, it relates to what is needed and cannot ascertain how countries implement such policies. By comparing PHC policies in the two countries we will be able to gain an understanding of areas of strength and

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

weakness, differences and similarities in emphasis in two neighbouring countries. Policies are essentially instruments of governance which not only make certain normative claims, for example about women as a resource for health care, but also reinforce them through implementation and application. At this level a comparison between two countries will highlight, for example, culturally informed and gendered metaphors and ideas and its implication for women (Shore and Wright, 1997).

B. *To what extent can clinics conform to the country's PHC policy, or what actually happens at clinic level?*

Because policies have to be implemented they are never neutral, but operate in the working of power. The ways in which PHC policy is implemented at local clinic level can have ambiguous outcomes for women and can reconfigure gender inequalities (Ncube 2007). It is therefore important to establish what PHC services are offered at clinic level, how staff understand and implement the policy, what the strengths and problems are. By comparing clinics in two countries we aim to enhance the understanding of contextual and general factors that play a role in policy implementation.

C. *How is PHC perceived by the clients?*

Studies on PHC inevitably focus on the staff and services components, yet little attention is given to how the users themselves make sense of it. We will establish how clients perceive the gendered impact of the PHC approach in particular contexts.

D. *What is the gender impact of PHC for clients?*

Although many generalizations are made about the influence of the PHC approach on women's work as health care providers, no context-specific and comparative studies have been done.

E. *What are the main problems related to PHC as perceived by:*

- i)** local government,
- ii)** local service providers;
- iii)** clients at local clinics?

By focusing on the three levels we will be able to compare how the processes of implementation of policy can be constrained by issues at each of these levels in particular contexts.

F. *What historical factors are at play in the implementation of PHC (as it affects women)?*

We understand that the past has so much to do with the present. On the basis of this logic, we would consider the historical factors in each context to see how they interact with the newer forces, and the implications of this for PHC. PHC as a

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

strategy is relatively new, but health care delivery structures have a long history of existence.

Research methods

To enhance the validity of the research, methods will be triangulated. Mixed methodology will be used, involving both quantitative and qualitative tools, while providing an empirical understanding of context specific processes (Lambert 2002). For the different comparative questions a mix of methods will be used which will underscore each other and will allow different entry points into the same issue, thereby making comparison possible.

The tools used for the different levels will be as follows:

A. Current PHC policies:

Tools: Review of policies; content analysis of documents to establish similarities and differences; Development of a survey questionnaire from the context analysis to use for B

B. PHC policy implementation in individual clinics and its impact for women.

Tools: Survey questionnaire of all different aspects of PHC standards and norms as set out in policy.

C. Client perception of PHC.

Tools: **i.** Focus Group discussion with male and female clients – a set of semi-structured questions will be developed from the FGD discussions.

i.i. Semi-structured interviews with male and female clients

D. Impact of PHC for women.

Tools. **i.** Focus group discussions with female clients to develop set of questions for semi-structured interviews concerning women's experiences of PHC

ii Semi-structured interviews with female clients

iii. Survey questionnaire of women's health care tasks in the community.

iv. Because we cannot follow women into the community within the time made available for the project 20 women selected from each clinic will be given a disposable camera. These women will attend a workshop in which they will be taught how to use it, as well as be given guidelines as to the kinds of photographs we wish them to take. Each woman will be asked to follow a main theme, namely "women's work in community health care". They will be requested to return their photographs at a specific date. After the photographs had been developed, each woman will be interviewed about the meaning of the photograph. The photographs and related texts will be interpreted using constant comparative analysis. Each woman will receive a new disposable camera for her own use and one photograph of herself will be given to her. Because this method raises the visibility of the research, we will also have an exhibition of the photographs with the texts at each clinic.

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

E. Main problems for women in PHC provision

i. Local Government

Tools: Key informant interviews with 4 co-ordinators of PHC programmes

ii. Clinic staff:

Tools; Key informant interviews with staff in charge of clinic subdivisions, e.g. nursing, medical, pharmacy, auxiliary services.

Semi-structured interviews with PHC staff

iii. Clients.

Tools: i FGD with mixed group

ii. FGD with female group about specific gender related problems with PHC approach

iii. Semi-structured interviews with X male clients and X female clients

F. Historical factors

Tools: **i.** A review of archival documents that relate to women, health and the urban context;

ii. Oral history exercise to re-capture some long term experiences

The problems of comparative research and analysis

By using both comparative quantitative and qualitative research methods the study will make more comprehensive descriptions, understandings of attitudes, experiences and behaviour related to PHC across two southern African countries possible. The use of qualitative methods can also be utilised to explore the formulation of future hypotheses (Mangen, 1999). The two countries selected reflect key differences in social, economic and political contexts, all issues which makes comparison easier..

At the same time the very comparative nature of the study is a challenge for data collection and analysis in a meaningful way. Data has to be evaluated and interpreted across different historical, cultural, socio-political and economic contexts. For this purpose particular information has to be collected, while the methods must fit the purpose, be explicit and clear (Oxley, 2001). It will also mean that systematic comparative analysis of data needs to be done. To do so the research team will have to develop codes, themes and categories continuously and in conjunction with each other. A file system will be kept to ensure that the meaning and use of codes remain consistent and to also make an audit of coding decisions possible (Hewitt-Taylor, 2001). Through comparative analysis, patterns can be established in the data sets and premises established from which conceptual categories are developed (Glaser and Strauss, 1967)

Six levels of data will therefore be collected by the study:

- Quantitative information at institutional, local facility and client level;
- Information on policy and institutional arrangements in each country
- Institutional arrangements at PHC level in each of four selected clinics at city level .
- Detailed qualitative data on clinic staff experiences and problems experienced.
- Detailed qualitative data on individual client experiences and problems experienced.
- Photographic material and related texts of women's health work.

Comparative Research Network, 2008
Primary Health Care and Women in Cape Town (South Africa) and Harare (Zimbabwe): A Comparative Study

The research will be very labour intensive because it uses a mixture of quantitative and qualitative measures. To ensure reliability, questionnaires will be personally administered.

The research sites

Three community health clinics will be selected in sub-economic areas in Cape Town and in Harare as sites for the study. At least one of each of the clinics will be selected because it provides services to an informal settlement, thus making it possible to get access to recent migrants into the cities.

On the Cape Peninsula clinics will be selected in Site C, Masiphumelele and Phillipi. In Harare, clinics will be selected in Epworth, Hatcliffe and Mbare All of these suburbs provide services to a mix of people in permanent and informal settlement settings and we will thus be able to find respondents who have more recently come from rural areas as well as others who have been settled in the area for a long time.

Data Collection shall be done by the research team with the support of selected research students in Zimbabwe and South Africa.

Research plan

1. Policy Review, contact with Department of Health, City Health authorities and clinic staff; Investigation of contextual differences/similarities through desk research: August – Sept 2008, obtain ethical clearance from universities and permission from various authorities for research.

2. *Preparation for field work* – Methodological Workshop on “How to overcome problems of comparative Research”, which include different contexts, different data sets etc. – October 2008

3. *Field Work and constant comparative analysis*: November 2008– November 2009

4. *Review Workshop* – June 2008.

5. *Finalisation of Data Analysis*: December 2008 – January 2009

6. *Finalisation of Reports* – February 2009.

Expected Outputs

1. Training in comparative research methodology and comparative analysis
-Training documents for training workshop.
2. Student Research reports
3. Articles: two country specific articles published in a national level journal
One joint article published in an international journal
4. Finished work to be published as a book.