

Some common stressors for African women

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Abstract

Stresses relating to education, reproductive and child health limit the development of girls and the well-being of women and their children in rural villages and poor urban areas across Africa. African girls are socialised to believe that they are less important and less intelligent than their brothers, and should do more work than them while at the same time deferring to male superiority, beliefs that are held by parents and teachers alike. Once girls reach maturity they are under social pressure to become sexually active at an early age although they do not have sufficient knowledge to make informed decisions about this important aspect of their lives. Strategies used to cope with these stressors range from traditional practices such as invocation of magic, through to using new information to solve or reduce the impact of previously intractable problems.

Keywords : *Africa; women; stress; education; reproductive health.*

Introduction

The general stressfulness of African life is widely reported in Western news media. For the approximately 80% of Africans who still live in rural areas and for the urban poor the struggle to meet survival needs is ongoing on a daily basis. In addition, cultural norms and belief systems mean that the lives of African women involve coping with some specific stressors related to their gender and roles in society.

This article outlines some sources of stress, and traditional responses to intra- and interpersonal stress. It describes ways in which traditional beliefs limit girls' access to education and women's access to the kinds of health services that ensure good reproductive outcomes. These two topics have been selected from among the many stresses that have a significant impact on the well-being of girls and women. They are both central to women's well-being in the modern world. It is important to note that relatively little psychological research has been done in Africa so that, although studies reported from one region or country seem likely to be true for women in many regions or countries, adequate data to state this with certainty are not often available.

Stress has been defined as a condition in which the individual perceives a discrepancy between the physical or psychological demands of a situation and their own biological, psychological or social systems (Lazarus & Folkman, 1984; Sarafino, 2002). Key aspects of life in which African women probably experience stress relate to the nature of their cultures and to the physical environment in which they live. Although various ethnic groups behave differently some cultural beliefs and practices are widespread across the continent. In general, African village women live in collectivist cultures where the survival and well-being of the kinship group is central to their values. Women in most African communities lead lives which are fairly separate from those of their sons and husbands. This is associated with strong social bonds with other women, with whom they spend the greater part of their time (Jackson & Abosi, 2006). In small villages this closeness is naturally the source of disputes and disagreements at times. Stress results because disharmony has a negative impact on the group cohesion that is important in collectivist cultures (Triandis, 1995).

Stress for women also arises in the context of their relationships with men, in particular from the widespread belief that men are superior to women and that they have rights that women cannot expect to attain. This long-established belief attributes power to men who are decision-makers in matters of importance, such as education and access to resources (Jackson & Abosi, 2006). In communities where this belief is still strong, women's roles are defined in relation to reproduction and nurturance with an emphasis on the female as sexual partner, mother, and provider for the children. Kisekka's (1990) study of gender differences in psychiatric illness concluded that two sources of stress for African women were traditional cultural values especially those concerned with reproductive behaviour, and changes associated with modernization. Because life is difficult and change is slow in the rural villages it seems likely that these stressors are still common. As in any community African women may also experience stress as a result of the socio-political situation in which they live. For poor women socio-political stressors include questions of how to meet

most basic needs for food and water, keeping safe from violence, and access to general health services. These stressors occur in addition to the specific stressors related to gender that are the focus of this report.

An association between stress and poverty has been reported (e.g., Catz, Gore-Felton & McClure, 2002) in the so-called northern hemisphere literature of the developed world. However, good social support when one is under stress has a mediating effect on the impact of the stressful event (Sarafino, 2002). This latter finding has been reported in Africa in studies of university students in South Africa (Pretorius, 1996) and professional women in Kenya (Kemoli, 1998). But the benefits of good social support may only influence responses to personal stress. Shulz et al. (2006) reported that poor African-American women who were concerned about broader sociopolitical aspects of life in their community (e.g., police responsiveness) did not obtain the same benefits from social support as women concerned about more personal matters. In South Africa Spangenberg and Pieterse (1995) similarly concluded that adverse sociopolitical events, whether recurring or continuous, were more strongly associated with psychological distress than were personal adverse events.

Besides social support, the intrapersonal characteristic of resilience, and the use of problem-focused coping strategies also help individuals to maintain a sense of wellbeing during stressful times. Various studies (e.g., Grady, 2004; Lowe et al., 2003; Rafnsson, Jonsson & Windle 2006) suggest that women who use emotion-focused coping or avoidance/disengagement are more likely to react to stress with lowered sense of wellbeing and with depression. In African cultures, where there is generally an emphasis on moderation of emotional expression, use of explicit emotion-focused coping strategies may not be common. Information about a number of ethnic groups which shows that women report physical problems such as aches and pains as common reactions to stress (Jackson, 2006) suggests that this is a culturally normative way of coping. Admitting to physical problems may be a way of distancing oneself from psychological distress so to this extent it might be considered to be an emotion-focused coping response. Distancing may also be occurring when women report that "thinking too much" causes stress (Jackson, 2006) and that they take actions to avoid this. However, it has not been possible to find research about emotion-focused coping on the part of poor African women, or investigating their resilience.

Intra- and interpersonal difficulties

Interpersonal conflict is distressing, particularly in collectivist cultures where individuals cannot easily

leave the group and join another. In African cultures major disputes within the group were traditionally dealt with indirectly. Interpersonal disputes which could not easily be resolved by the immediate protagonists involved recourse to others in the community. Couples were offered or sought help from members of their extended family; parents, aunts and uncles might negotiate for resolution of conflict. Maintenance of a marriage was very important, because the marriage was not just between man and woman but formed a bond between families. This method of resolving conflict is still widely used today (Jackson & Abosi, 2006).

An African woman in dispute with another person might believe that the other is using witchcraft, curses or spells to bring harm. She might then seek help from a shaman who discovers whether harm has been sought by the accused, occurs because the complainant has broken a taboo, or failed to pay sufficient respect to ancestors who are now interfering in their lives (Jackson, 2006). It is not entirely clear how these coping strategies would be explained within the current Western psychological model. Probably, they should be described as problem-focused responses since these approaches to coping include the possibility that the stressed individual may expand the resources they use when stressed. The women who have been stressed by disharmony have taken active action (seeking help, offering restitution, paying increased respect to ancestors) to reduce stress and restore harmony.

Women in northern parts of Africa, who find their lives intolerably stressful, may come to believe that they are possessed by a zar spirit (Kahana, 1985; Jackson & Hagi, 2006). Possession by this spirit allows women to act in ways that are socially unacceptable in their ethnic group, demanding presents, swearing, dancing and shouting. All of these behaviours are culturally normative responses to stress in the societies in which they occur. Attribution of harm to an external source allows women to maintain the harmony within the group that has historically been essential for survival. Possession by zar spirits gives women power in cultures in which they have few rights and in which cultural demands for moderation of emotional expression prevent them from showing distress in more direct ways. Treatment involves giving the woman presents, accepting her behaviours and allowing her to join a group for people who are similarly afflicted, a kind of life-long therapy group in which she can express her needs. This way of coping with stress would appear to fit the category of emotion-focused coping. The afflicted person is not considered to be mad.

Limited access to education

Girls' access to education varies greatly from one African country to another and between regions within any one country but there are fewer girls than boys in schools except in the very few countries where education is accessible to all. For some girls, this lack of access to education occurs because parents are very poor and can only afford school fees for one child. The greater status of males means that a boy is chosen (Cammish & Brock, 1994; Lloyd, Mensch & Clark, 2000; Stephens, 2000; UNDP, 2006; UNICEF, 2000). School fees themselves may not be legal, in which instance teachers who corruptly require fees to be paid also contribute to the lack of schooling for girls (Carlson, 2000; Jeter, 2001). Research from Kenya and Malawi (Davison, 1993; Davison & Kanyuka, 1992) suggests that many parents and teachers believe girls are less intelligent than boys so will not benefit as much from education as their brothers. The girls and boys are acculturated to this belief and adhere to it themselves. African girls have been raised from birth to be submissive to men so asking and answering questions in a mixed class with a male teacher may be difficult for them. Because teacher expectations have long been known to influence learning outcomes (Good & Brophy, 1997) this in itself is one reason for lower attainment of some girls. Village parents may also believe that too much schooling reduces a girl's chances of marriage because, while in school, she misses out on the opportunity to learn the skills needed by village women (Stephens, 2000). Finally, religious beliefs may be a factor in deciding who goes to school, with Moslem girls less likely to begin school or complete education than their non-Moslem peers (Colclough, Rose, & Tembon, 1999; Lloyd et al., 2000).

Once at school, girls may receive less attention from teachers and spend more time away from class doing chores such as sweeping the yard or cleaning the toilets which are considered to be women's work (Davison & Kanyuka, 1992). This means that they experience less learning time during the school day. Girls who are menstruating stay away from school because they do not feel comfortable changing sanitary pads in unisex and/or dirty toilets (Colclough et al., 2000). In some schools boys who harass girls are not punished (Lloyd et al., 2000). After school girls do more chores than boys, so have less time for homework (Davison & Kanyuka, 1992). Overall, then, the learning and general school environment for girls is markedly worse for girls than it is for boys, making it difficult for girls to maintain motivation for learning, and to feel confident that their contributions in the classroom are valued by their teachers.

Adequate basic schooling almost certainly reduces stress on women who are married and have become mothers. Girls who have been to school for a minimum of 5 years have fewer children and these children are healthier than the children of non-schooled women (Palmer, 1993). This benefit to the children applies even if the woman's social class has not changed as a result of her education and appears to occur because the male head of the household takes more notice of an educated wife or daughter-in-law than he would if she had not been to school. Thus, the mother is given permission to seek medical help for any childhood illness earlier rather than later (Palmer, 1993). Treatments prescribed are also more likely to be administered correctly by a mother who can read the instructions. Schooled women are more likely to use simple home remedies, such as home-prepared oral rehydration mix used for treating diarrhoea, than women who have not been to school (Palmer, 1993). Women who have completed primary school are therefore potentially less stressed about their children's health even if their status within the family remains somewhat lower than that of their husband.

The stress of not being able to go to school or of not being treated as equal to boys in the class means that the stress is personal (Why can't I go to school? Does it mean I am stupid?) interpersonal (Why can you go to school when I can't?) and socio-political. The socio-political aspect has been widely recognised across Africa by teacher trainers and ministries of education. In most African countries these agencies have attempted to resolve the problem of gender differentiation in pupil treatment. But little may change. Harley, Barasa, Bertram, Mattson and Pillay (2000), for example, report the response of a male teacher who was asked if he believed in gender equality. The man, a union representative and knowledgeable about human rights, answered, "Never ever. As a man, I believe I am and will always be superior to a woman."

Reproductive and child health

For girls and women who have not had access to good education and who typically live in poverty on a continent with the highest rate of HIV infection in the world, sexual safety and reproductive health are elusive goals. The many causes for stress and problems in this aspect of life are outlined below.

1. Incorrect ideas about reproductive health and sexual activity. Lack of knowledge about the reproductive system, about sexual safety and disease may not necessarily be stressful in itself but the outcomes of such a lack of knowledge in terms of early pregnancy and sexual disease are obvious potential sources of stress. Unfortunately, these outcomes are very common among young African women (Adjahoto,

Houdonou, DeSouza, Tété & Baeta, 2000; Magnani et al., 2002). Without knowledge, and having been raised to be submissive to men, young women who are considering whether to become sexually active have to decide whether the pleasures of having a sexual relationship, which they acknowledge (Harrison, Zaba, & Kunene, 2001) outweigh the risks of sexually transmitted diseases (STD's), including HIV infection (an approach/avoidance decision). They must consider whether they will have sex even although they do not want to or risk losing their boyfriend as a consequence of a refusal (an avoidance/avoidance decision) or whether to have sex with a boy they find attractive or with a man who can give them money for food (an approach/approach decision). The process of making a decision in each of these instances is a stressful one (Sarafino, 2002).

Deciding whether to have sexual intercourse may be stressful because it is one of life's transitions. It may be made more stressful because girls do not learn about their development from older female relatives at home as they did in the past (Courtois, Mullet & Malvy, 2001a). In some parts of Africa, neither girls nor boys value virginity today (Seboni, 1993) nor is sexual fidelity valued, especially among boys (Courtois et al., 2001a, 2001b; Nzioka, 2001) so deciding to remain a virgin excludes one from the peer group. Girls do not have good contraceptive knowledge as shown by Seboni (1993) in Botswana. This researcher reported that young women believed that intermittent use of the contraceptive pill protected them against pregnancy and also that even one sexual encounter would enhance their fertility in the future. In West Africa Adjahoto et al. (2000) found that many do not know when in the menstrual cycle they are most likely to be fertile. Girls believe some of many of the myths about what might happen if they begin to have a sexual relationship. In Botswana, for example, young girls are still generally cautioned about sexual intercourse and may be told that sex before marriage can be harmful. They may be told that if they have premarital sex they will emit worms from their vaginas (Seboni, 1993).

Girls may want to have a sexual relationship but fear disease. High rates of STD infection have been reported in a number of studies (e.g., Ahmed et al., 2001; Buvé et al., 2001). HIV infection rates are high in many countries, with higher rates among women (about 60% of cases are female) and the highest rates overall found in the countries of southern Africa (Asamoah-Odei, Calleja & Boerma, 2004). As elsewhere, boys pressure girls to have intercourse with them. Some young women yield to this pressure even though they might prefer to be having less sexual contact, and want intercourse to be taking place only within a longer term relationship (Harrison, Xaba & Kunene, 2001).

The combination of ignorance with high levels of sexual activity and poor contraceptive practice among adolescents results in a high rate of early pregnancy. In Botswana in the early 1990's 23.5 % of women became pregnant while still adolescent. In Kenya and Togo the rate of adolescent pregnancy was 21% with other African countries close behind (Network, 1993). In addition, older men frequently form liaisons with unmarried teenage girls who need the economic support that these men can provide (e.g., money to meet survival needs or to pay school fees, or buy soap or clothing). Many of these girls become pregnant while others contract HIV/AIDS from the older men who are already infected (Ball 1988; Hailonga, 1993; Seboni, 1993, 1996). Girls who become pregnant drop out of school, with consequent lack of choice about occupation and reduced capacity to contribute to the economic development of their country. These girls are at risk of falling into deep poverty with all its accompanying stresses.

Research reported by Machel (2001) has shown that middle class girls are less likely to have unsafe sex than working class girls. The benefit appears to arise from their willingness to challenge norms for sexual behaviour, greater assertiveness and financial independence from males. Working class girls, who are often very poor, are frequently much more dependent on male financial help and hence have less freedom to negotiate for safe sex.

2. Early marriage Traditionally women married men considerably older than themselves because a man had to show he was able to support his wife economically before he could marry. He also had to have enough worldly goods to be able to pay the "bride price" to his wife's family. Today, there is considerable diversity of opinion about the right age for marriage and this diversity of opinion can occur even within a country. In Botswana some girl children are forced into marriage as early as 12 with men much older than they are. Many other African traditional cultures allow the marriage of young girls at a very tender age of ten or thereabouts without considering the implications for the child and society. Legally, the minimum age for marriage differs from one country to another, but in many, for example Botswana, Mozambique, Zimbabwe and Swaziland, girls may marry when they are 12 or 14 and boys at 14 or 16 years (Stewart & Armstrong, 1990). This differential in age of marriage apparently reflects traditional beliefs that men should be older at marriage than women.

Early marriage can be stressful in Africa as marriage comes with many expectations and responsibilities. The man is expected to assist with the education and welfare of the wife's siblings and the parents and wife know this. On the other hand, the woman is also aware that she is accountable to the man if she is working. She

prepares the food and does other chores while the man watches television or talks to his friends. The man is the head of the family even when he is not in a position to provide for it and woman is to be seen and not heard.

Young women who have not been prepared for this kind of life become stressed and demoralized and may behave in ways that do not enhance their own well-being as Seboni, Dambe and Abosi (1999) found in a study in Botswana. Problems arising in early marriage included girls competing with their husbands in misbehaving, for example, going to bars to drink, or fighting for the right to the money they earn from working while expecting the man to manage with the little money he gets from the cattle farm owned by most Tswana families. Separation of family due to transfers and other working conditions as well as lack of cooperation at home sometimes occur. Finally parents may advise their daughters to quit the marriage if they notice that the husband is not doing well.

Actual physical harm to the very young woman may occur if her reproductive organs are not fully developed at the time she begins to have intercourse. In a study in Nigeria, Ojanuga Onolemhmen and Ekwampu, (1999), for example, compared 50 women with vesicovaginal fistula (VVF, a condition in which tearing of the vagina results in an opening forming between the vagina and the bladder) with 50 women who did not have this condition. Women with VVF were smaller, less educated and of lower socioeconomic status than women without the condition. They had begun childbearing too early in life for safe delivery of an infant. Apart from health considerations, VVF also has social implications as the woman drips urine constantly and uncontrollably. She is commonly rejected by both her husband and her family unless she can have a repair operation. Another possible danger of early marriage that the young girl's pelvic region may not have fully developed, the resulting mal-proportion leading to difficulty in child delivery (Henrion, 2003)

In many cases early motherhood or marriage, end in difficulties and divorce. Parents on both sides interfere because the couples are considered too young to deal with marriage issues. According to customary law, reasons for choice of divorce differ for men and women. A man can divorce his wife for infidelity, barrenness, repeated adultery, sorcery and refusal to perform household chores and other forms of insubordination because she is legally a minor always. A woman on the other hand cannot divorce her husband on grounds of infidelity or cruelty unless it is excessive (Stewart & Armstrong 1990).

A study in Botswana by Seboni, Dambe and Abosi (1999) suggests that, in countries where all children get primary and at least some secondary schooling, education ideas about early sexual expression and early marriage may change. In their study of young adult

Botswana boys and girls they found that boys and girls both thought virginity was important and that 25 was considered the best age to have one's first sexual experience. Over 75% of the students said they would like to be married by the time they are 30 years old but only 15% of them wanted to be married by the time they were 25. The data suggest that the younger generation in Botswana no longer wish to marry early in life. Whether or not these young people lived by their ideals was not investigated.

3. Limited access to family planning. Many African women have large numbers of children. This may reflect traditional ideas or it may occur because women have limited access to modern family planning. Research reported by the Guttmacher Institute (2002) shows that good family planning can actually decrease the rate of infant mortality, by allowing women to control fertility when they are at risk because of youthfulness or older age. It also allows the 2 year space between births which was traditionally achieved by long periods of sexual abstinence after a birth, and which is associated with better child-bearing outcomes. The same study shows that only relatively few African women have access to modern contraceptives. The current US embargo on aid to family planning agencies that also provide abortions has greatly reduced the accessibility of contraception for millions of women. The same beliefs about sexuality that led to that embargo have been associated with an American belief that sexual abstinence until marriage and fidelity within marriage are the answers to the African AIDS epidemic. This claim is made despite the widely established awareness that sexual abstinence does not form part of modern African culture in many ethnic groups.

4. High rates of infant and maternal mortality The death of a child is very distressing and stressful for parents everywhere. In Africa infant mortality is generally high, with even higher rates of infant death for mothers in their teens and for mothers over 40 years (Guttmacher Institute, 2002). Some traditional health practices, such as coating the newly cut umbilical cord with oil, increase the risk of infant mortality (UNICEF, 2000). Together with the many other causes of infant death in poor African communities, the result is that one half of all African women in the age group 30-45 have experienced the death of an infant during his or her first year of life (Guttmacher Institute, 2002; UNDP 2006).

Maternal mortality is very high in some parts of Africa (UNICEF, 2000). Many of these deaths are preventable with only little increase in knowledge about birthing procedures. In Mali, for example, Grey, Baudouy, Martin, Bang and Cash (1990) taught traditional birth attendants some basic rules about hygiene, particularly the need to keep the umbilicus clean, to prevent infant death from tetanus. They

provided the birth attendants with a rubber mat onto which the infant might be born, instead of just lying on the ground. Palmer (1993) in a similar study in Cameroon, taught traditional birth attendants some of the indicators that might suggest they need to advise the mother to go to a clinic or hospital for the birth (e.g., first birth, bleeding heavily during an earlier birth, probable multiple birth) so that women's chances of survival were improved.

Mortality of children under 5 years is also very high in Africa. The uptake of vaccination programmes for common diseases of childhood varies from one country to another partly because only a few countries in Africa provide these vaccinations free of cost (UNICEF, 2000). Some that don't have been directed by funding agencies such as the World Bank or the International Monetary Fund to charge fees as part of economic restructuring packages when loans are being sought for national development. Fears about the reasons behind vaccination campaigns may also limit participation. A recent example related to the WHO poliomyelitis eradication program in Nigeria. Religious leaders in Kano, in the north of the country, persuaded people in their community not to be vaccinated because, they said, the vaccination affect fertility (Raufu, 2004). This problem has been sorted out, but in the meantime the poliomyelitis virus with DNA showing it had originated in Nigeria has spread as far as Indonesia and other countries where the disease had previously been eradicated.

5. Incorrect ideas about food and feeding practices which increase the risk of child illness. Having "Change in health of a family member" is one of the items that are rated as a high source of stress in the Holmes and Rahe (1967) Social Readjustment Rating Scale (SRRS) and having a sick child obviously fits in this category. Illness may be more likely, and mothers more stressed as a result, in communities where women who do not breast feed during the first few days after the birth because they believe that colostrum is harmful to the infant. This means that the infant does not receive the vital antibodies which would have offered some initial protection from disease. (Bassett, 2000).

Children may miss out on the protein, vitamins and trace elements they need for growth and health if their mother believes that a the child who has had plenty of the starchy basic food cannot be hungry (Cassidy, 1980; Zeitlin, 1996). Men and adult sons may be fed before women and children. Men get most of the meat and children get starchy foods (Sigman, Neumann, Jansen & Bwibo, 1989; Zeitlin, 1996). Food restriction may also be used as a punishment by some mothers when children are already not getting the number of kilojoules they need for optimal growth and development of brain, bones and organs (Nsamenang, 1993; Zeitlin, 1996).

Conclusion

This article has described just two of the many potential stressors that African women face every day. It supports Kisekko's (1990) finding that stresses abound in the area of reproductive health and that girls and women are missing out on the advantages of modernity in the form of education. It also suggests that traditional ways of coping with some stressors remain effective tools in some circumstances. Strategies used include planful problem-solving, seeking social support, and distancing, a mix of emotion-focused and problem-focused approaches to stress. However, the combination of limited resources, low status, lack of control over such resources as do exist, and lack of education mean that many African women need help to learn new ways of solving the problems they face.

Research in other areas of health, for example, eradication of guinea worm infection (McLellan, 2003) and changes in methods of obtaining water (Practical Action, 2006) have shown that women respond well to new information and quickly learn skills that will help them solve stressful recurrent problems relating to survival. But they, and the men in their communities, need to be able to take advantage of modern knowledge in social areas relating to male-female relationships and for this to happen many need better access to the services Westerners take for granted - adequate education and good health provision.

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Research Profiles

Kathy Jackson is an experienced teacher, child psychologist and university lecturer. She was educated at the University of Canterbury and at Victoria University Wellington in New Zealand and completed her PhD at Victoria University of Technology, in Melbourne, Australia. For her PhD she investigated the emotional development of children from four ethnic groups. She has taught psychology and educational psychology at Monash University in Melbourne, and at the University of Malawi and University of Botswana. Her recent research and writing has focused on the development of children in African and on folk theories about mental health of refugees from Africa, the Middle East and Asia who have settled in New Zealand. She is currently working as a consultant, teaching courses in cross-cultural communication for Auckland University

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