Final Research Report: Assessing Women's Health Disparities with the Sagbado Neighborhood with SADA in Lomé, Togo

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ABSTRACT

Women's health has been identified by many international health organizations as a priority concern in the world. Because of sociocultural norms, women's health and development has suffered in the past. In this study, I worked in Lomé, Togo in West Africa, with a nonprofit organization, Synergie d'Actions pour un Developpement Approprié (SADA), to conduct an assessment evaluating the health needs of Togolese women. I developed surveys and single-person interviews to collect data on what types of health issues are affecting women of Togo. Data were collected from women between the ages of 18-44 years old, living in the Sagbado neighborhood of Lomé, and key informants, or those working in the domain of women's health like doctors, nurses, directors of nonprofit organizations, or certain government officials. The data identified seven categories of priority women's health needs and potential gender-bias in the health disparities of the population. This research opens up possibilities for relevant future intervention planning and implementation, focusing on the identified health issues.

INTRODUCTION

Biological and sociocultural factors contribute to the unequal treatment of individuals' health needs based on gender. These factors include, but are not limited to, unequal distribution of power in male/female relationships, social norms and hierarchies which decrease access to educational and professional development, unequal access to health care services, and increased potential for physical, sexual and emotional violence (WHO, 2015). Furthermore, there is evidence that women's higher susceptibility to disease than their male counterparts is intensified by governmental regulations which institutionalize the marginalization of women (Moore, 2008). "Inequality in women's and men's different health and education outcomes is still evident across and within countries, communities and households. Gender inequality in social services translates into fewer opportunities for women in particular and society as a whole" (UNDP African Human Development Report 2016, p. 3).

The United Nations (UN), World Health Organization (WHO), and other reputable global health organizations have cited women's health as a priority concern in numerous countries, and Lomé, Togo in northwestern Africa more than likely is no exception. In 2015, the inequality-adjusted Human Development Index (HDI) of Togo dropped 33.4% from its original rank due to the inequality in reproductive health, empowerment, and economic opportunities (UNDP Human Development Report 2015 Briefing Notes: Togo, 2015).

Millennium Development Goals (MDGs), strategic goals for improving conditions in developing countries, were established by the UN and provide data regarding the progress of many countries from 1990 to 2015. Togo was predicted not to reach 6 of the 8 MDGs by the 2015 deadline, two of which involve reducing maternal mortality rates and improving gender equality and women's empowerment. According to the MDGs Progress Snapshot of Togo, access to universal reproductive health services has remained low throughout the years, and the maternal mortality rate remains quite high, at 450 maternal deaths per 100,000 live births (United Nations, 2015). Maternal

mortality rates have been slowly declining, but lack of access to skilled nurses during birthing in rural conditions still poses a large threat to many women in Togo (Togo: WHO Statistical Profile, 2015).

When conducting initial research in Togo, I found that there was little information available on the women's health status in the country. The data available through international health organizations, like WHO or UN, indicated severe developmental and gender equality issues. When developing and implementing this research project, I hoped to gain a more comprehensive understanding of the state of women's health in Togo. This women's health needs assessment could lead to more appropriate health education and health promotion intervention programming to address the identified women's health needs in the community of Sagbado, Lomé, Togo.

The research process aimed to answer two research questions:

1. What are the perceived and actual health needs of adult women between the ages of 18-44 years in the Sagbado neighborhood of Lomé, Togo?

2. Do the identified priority health needs of the population indicate gender-based distinctions in the health needs of the community?

In creating this project, research questions and research materials were centered around one of the constructs from the Social Cognitive Theory (SCT), self-efficacy. The SCT aims to better understand what drives an individual's actions and to use that information in order to plan appropriate intervention. Self-efficacy refers to one's belief in their own capability to perform a task (Bandura, 1994). Self-efficacy is task-specific, according to its application in the SCT, meaning an individual's self-efficacy can change based on the particular task with which they are faced (Bandura, 1994).

I used the SCT, and my understanding of its various constructs, during the development of the two research questions, the two research questionnaires, and during the qualitative data analysis. The SCT will be especially useful in making pertinent recommendations for future programming based upon these research findings and in addressing self-efficacy of program participants. Self-efficacy is important when considering behavior change health education and promotion, because individuals generally do not implement changes in their lives without a certain level of self-efficacy regarding the behavior (WHO, 2012).

MATERIALS AND METHODS

To complete this research project, I conducted in-person interviews accompanied by surveys, with key informants and community participants. These interviews aimed to discover and identify potential health needs of the population, women ages 18-44 years in the Sagbado neighborhood of Lomé. I interviewed key informants of women's health like doctors at local hospitals/clinics, government officials working in the domain of women's health, and directors of nonprofit organizations (NGOs) working with women's health. Key informant interviews provided great insight into the sociocultural factors which have the greatest effects on women's health in Togo. I also interviewed women between the ages of 18-44 years old, who live in the Sagbado neighborhood of Lomé. Interviews with community participants provided greater insight into the specific perceived and actual health needs of women in Sagbado.

During the implementation of the interviews, I was accompanied by two Togolese interns from the NGO with which I worked, Synergie d'Actions pour un Developpement Approprié (SADA), to aid in translation and notetaking. Because many Togolese women do not speak French fluently, it was necessary for my colleagues to translate questions into the native language, Ewé, take notes in French in the field, listen to the interview recordings afterwards, and further note any information previously missed in the translation. I then translated the notes from French into English. Key informant interviews were conducted entirely in French, so I was able to record more direct transcriptions. Because of the nature of language translation, it was difficult to create a verbatim transcription of each community participant interview. I instead created itemized lists of cited health concerns and responses to questions trying to quote most directly when possible, for each community participant interview.

Research Question 1 Methodology

I used two different questionnaires for key informant and community participant interviews; both featured questions addressing the perceived and actual health needs of Togolese women, perceived severity of the various health issues, questions about available health services, the accessibility and satisfaction of those health services. These questions were developed to answer the first of my research questions, "what are the actual and perceived needs of adult women in Sagbado in Lomé, Togo?" Additionally, these questions aimed to assess perceived susceptibility to various health issues for community participants. In many of the community participant interviews, the level of self-efficacy was perceivably low. I often noted that women cited external forces as the sources of their health problems, like the government or poverty. Many women did not report a need for health education programming, but rather a need for increased access to health care services and monetary support.

The questionnaire for community participants consisted of nine questions aiming to assess perceived and actual health needs of Togolese women and men, the perceived susceptibility of the population, access to and satisfaction with health care resources, and self-efficacy of the population. The interview questions for community participants were reworded twice after trials in the field, to ensure clarity during the interview process. Because of the nature of translation, some of the direct phrases originally translated from English did not translate clearly into French, resulting in a great deal of confusion for community participants. With the assistance of my two native Togolese colleagues, we reformed the language of a selection of questions to increase clarity and participant comprehension while keeping the original intent of the question. The translation of questions into the native language, Ewé, were also reworded to increase comprehension during the interview process.

The questionnaire for key informants included ten questions assessing perceived and actual health needs of Togolese women and men, perceived severity and susceptibility of Togolese men and women to various health issues. Questions for key informant interviews were only revised once while I was in-country, as there was a much higher comprehension of French in key informant interviews, in general, compared to the comprehension in community participant interviews. Comprehension of the interview questions after the revisions was noticeably higher compared with the original wording for key informant interviews.

Research Question 2 Methodology

The second research question was, "do the identified priority health needs of the population indicate gender-based distinctions in the health needs of the community?" Both questionnaires posed questions about perceived men's health issues, the perceived severity of men's health issues as compared to the severity of women's health, and questions about health care service accessibility. With these questions, it was possible to explore the potential gender-based distinctions in the health needs of the community.

In conducting qualitative research through interviewing, it is important to note that the researcher becomes the instrument collecting data. The researcher's facilitation of the interview sets the tone of the space and can affect how freely and comfortably the respondents share their experiences (Pezalla et al., 2012). In my efforts of being the best research instrument as possible, it was important during each interview to use the open-ended research questions, and use affirming but objective language. The often-sensitive nature of personal health information could have had an effect on the information that each participant was willing to disclose, so it was especially important throughout the study to create conditions that were perceived as non-judgmental and conducive to sharing. I listened participants share their stories with very little narrative on my part. When I did speak during interviews, it was to pose questions, to explain the questions further to increase comprehension, and the affirmative acknowledgement of the participants experiences. It was important to the research process that participants speak freely, with as little outside influence as possible.

Many research participants were very willing to discuss their perceptions of gender-based distinctions in community health needs. This may be in part due to the preliminary discussion of the confidentiality agreement and research design/objectives. Before each interview, I explained each document used in the research interviews, the objectives and research questions aligned with the project, and the legally binding confidentiality agreement which all participants signed. I relied on my Togolese colleagues for translation from French to Ewé, to lessen the

possibility for miscommunication. I asked that the participants pose any questions they might have had prior to beginning the interview so that they could feel more confident in their privacy and confidentiality. This procedure allowed for more open communication on a topic that could traditionally be difficult for some to speak about, like personal health and gender-based health disparities.

RESULTS

During the in-field research experience, I was able to collect 92 community participant interviews and 34 key informant interviews. I transcribed these qualitative data from the interview recordings and notes, and coded them with seven health subject categories. I identified these seven categories as the most prominent themes in research participants' responses. Any data that did not fall into these categories were recorded in a miscellaneous category because they did not indicate statistical significance in an SPSS chi-squared test.

Table 1. Frequencies of Cited Women's Health Issues

Category of Health	**Community Participant Response Rate** (n=84)	**Key Informant Response Rate** (n=34)
Sexual/Maternal Health	36%	74%
Women's Rights/Autonomy	24%	62%
Environmental Health	52%	29%
Poverty/Access to Health Care	70%	65%
Malnutrition	66%	29%
Malaria	37%	24%
Hygiene/Sanitation	50%	32%

Narratives which aligned with the category of sexual/maternal health included access to contraceptives, access to attended births, untreated STIs, dangerous birthing conditions, lack of access to pre/post-natal consultations, unmet need for C-sections, and menstruation-related problems. Narratives which were categorized in the women's rights/autonomy category included domestic violence, financial dependence on men or husbands, unfair treatment from husband or other men, lack of access to education, sex work, no decision-making power in the home or community, or no autonomy. Narratives which were categorized as environmental health included litter, stagnant water, poor infrastructure, access to potable water, waste management problems, air pollution, water pollution, floods, and climate change. Malaria, malnutrition, poverty, and access to health care were all cited directly in narratives. Hygiene and sanitation problems were cited as problems of bodily and food hygiene, leading to infections. In response to the question "Do you think that your health is respected in your community" 83% of community participants responded "no," with 14% responding "yes," and 3% declining to respond.

In answering the second research question, I searched in the interview transcriptions for responses to the question posed: "what are the men's health issues you see in your community?" Additionally, I searched the

transcriptions of all interviews for men's health issues cited in response to other questions of the interview. I then recorded the frequency of the various men's health issues cited into a comprehensive list. The most commonly cited men's health issues during community participant and key informant interviews can be found in Table 2 below.

Many key informants and community participants cited 'ignorance' of men as disregard for the health of themselves and the health, safety, and security of their families. The majority of interviews cited more severity in women's health issues than in men's health issues, cited that men experienced no health issues at all, or that the only health issue men faced was the stress of being financially responsible for the family.

Table 2. Frequencies of Cited Men's Health Issues

Category	**Community Participant Response Rate** (n=84)	**Key Informants Response Rate** (n=34)
Poverty or work-related conditions	86%	32%
Infidelity or lack of respect for women	12%	35%
STIs/HIV	21%	21%
Sexual impotency	10%	0%

DISCUSSION AND CONCLUSIONS

Many community participants cited poverty as their only health issue by referring to it as their most severe health issue or the source of most or all of their health problems. Men's health issues cited during interviews greatly emphasized the financial stress which men undergo more than women, because they are culturally seen as the breadwinners in the family. This stress was described at "soucis" in French, translating indirectly as the psychological stress specific to one's socioeconomic status. Women lack the financial independence in the community so while men's health issues are greatly related to the need to earn money, women's health issues are related to the incapacity to hold or earn money. Even when Togolese woman are able to generate some of their own income, women do not inhabit all employment sectors, but rather remain mostly in the commerce sector of employment: selling vegetables, recycled clothing, or fabrics on the side of the road or the market. Other women in Togo work as dressmakers or hairstylists. Women in commerce comprised 82% of the community participants of the study. This limits the possibilities for Togolese women to generate enough financial independence to change their socioeconomic status and maintains their dependence on men. Certainly, there are women who work as doctors or teachers or government officials in Togo, but because of women's lack of access to education, these women are unfortunately exceptions to the norm.

This gender-based distinction in autonomy and financial independence is greatly reflected in the level of self-efficacy observed during community participant interviews. Additionally, this difference in financial independence is reflected in the difference of perceived severity between men's health and women's health issues during community participant interviews. Because women lack the financial independence of men, women consequently, have generally lower access to health care services, which can lead to an increased level of severity.

Sexual/maternal health was cited often in both community participant and key informant interviews. Sexually transmitted infections (STIs) were cited as both women's and men's health issues. Because polygamy is legal in Togo, husbands often have unprotected extramarital sexual relations, contract STIs, and in turn, transmit them to their spouses. Because women lack access to health care services, it is unlikely for a woman to be able to get herself tested regularly for STIs, leading to other possible complications like sterility or death.

Lack of access to family planning services and prenatal consultations were cited as women's health issues in both community participant and key informant interviews. Reasons cited for these difficulties in access were relationships between husband and wife and lack of resources to pay for such treatment. Because the husband is seen as the head of the family, as well as the financial breadwinner, it is he who decides whether or not the wife can seek family planning services or prenatal counseling. Because women lack financial independence, it is often impossible for them to seek out these services without their husband's agreement.

Many key informants who worked as sexual health care providers cited health issues arising from mal-prescription of contraceptives. When women are not permitted to openly use contraceptive measures under the authority of their husbands, but do not wish to become pregnant, they will take any measure possible to use contraceptives without their families knowing. This often means that they will use whichever kind of contraceptive measure they can find, even if there was insufficient consultation before prescription. Many instances of mal-prescription of contraceptive methods include situations where women are not able to discuss their health issues or history thoroughly with the doctor prescribing the medication. This communication is cut short, often by the need of these women to keep contraceptives a secret from their partners or other community members. Because of these socially-constructed issues with contraceptives, women do not often report to doctors any perceivable side-effects, like weight-gain, and they are not able to come in for check-ups, to screen for non-perceivable side-effects, like blood clots. Even after experiencing negative side effects, women in this situation will often continue the medication which can lead to greater health risks.

Maternal health in Togolese women is a highlighted issue in many groups: community research participants and key informants of this study, the Togolese government, and international health organizations like WHO or UN. In terms of maternal health, there were several themes which I was able to identify in these research findings. Overall, many research participants cited that maternal health conditions are not safe for most women in Togo, especially those women in rural communities. Research participants reported poverty-related issues in access to maternal health care, like assisted births and prenatal consultations.

Many key informants reported that the Togolese government recently passed a policy which would provide access to caesarian section births at a lowered price, 10,000 CFA, or about 20 US dollars. Many key informants identified this policy as movement toward increased access to maternal health care services, but also as insufficient for all women. Among other issues cited by key informants and community participants, the most common problems identified were: inability to raise the initial 10,000 CFA to receive care in time for their birth, inability to pay for prenatal or postnatal care, which is not covered in the policy which decreased the price of C-sections, and issues of proximity to health care service providers.

The unmet needs of women's health in Togo relate greatly to lack of autonomy, sexual health, and maternal health. The social climate of Togo prevents many women from achieving access to contraceptives. The resistance from their husbands, as well as the inability to pay for health care services contributes to this lack of access, which creates unhealthy and unsafe maternal health situations. Lack of access to contraceptives also contributes to transmission of STIs and HIV/AIDS, which pose a serious health issue to women who lack access to testing or treatment facilities.

Effective health education and health promotion programs based on the findings of this research project must address self-efficacy of the individual, and tailor it to the specific health topic of the program. Women's and maternal health programs focusing on prenatal consultations, assisted births, family planning services, preventive health services, STI testing and prevention, programs aiming to educate both men and women about women's health, and programs about local resources where women can receive health care resources at a reduced price, safely are all potentially effective programs. Any program implemented on the basis of these research findings should use self-efficacy as a key theoretical construct in the program planning, implementation and evaluation. Because participants showed a low level of self-efficacy during research interviews, potential future programming must

address the participants' self-efficacy for effective behavior change health education programming to occur.

LIMITATIONS

There are various limitations to this study and those of a similar nature. Firstly, the nature of translation may have unintentionally changed some of the data recorded from the interviews. The study relied on third-person translation, where the interview responses originally recorded in Ewé, were translated to French, and finally to English. This process could have affected the accuracy of some of the recorded data. I do not, however, feel that this potential for human error related to interpretation has drastically changed the research findings. Data was recorded and categorized into seven different subject areas, so in the event of a minor error in translation, the overall subject of the data would not likely have been changed. This use of frequency of categories helped in maintaining the integrity of the research data.

Secondly, my presence as a clear foreigner may have influenced the responses of certain research participants. Being a clear minority in Togo comes with its own array of experiences, and could have elicited unpredictable reactions from Togolese community participants, which might have affected what information they chose to share in the study. For example, many Togolese think that foreigners visiting their country, talking about women's health, are interested in giving the participants monetary support. This could have resulted in the participants' responses focusing more on their financial constraints than their other health issues. To the same effect, the two interns with whom I worked during the study were both men. Due to the sensitive nature of health, and the consistent socially constructed gender relations in Togo, the presence of two males posing questions to women during the study may have influenced what the participants chose to share. In order to combat these two limitations, SADA interns and I were sure to thoroughly explain the research objectives, the confidentiality agreement, and their rights as research participants. Participants were urged to offer all questions they had prior to the start of the research, to increase their level of comfortability in the research process.

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