

OUTLOOK

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Feature Article

Gender Inequities and Women's Health

Women's health is affected not only by their biological differences from men, but also by gender-based social, cultural, and economic inequities. Gender inequities begin at birth when a preference for sons puts some baby girls at risk of infanticide.^{1,2} Girls in some societies receive less and worse food than boys, and less health care;¹ disparities in nutrition and health care often continue into adulthood. Girls face the possibility of female genital mutilation (FGM) in some cultures (see box, page 2). Many women throughout the world are at risk of sexual assault, forced marriage, poor obstetric care during pregnancy and childbirth, and the rigors of child care, household chores, and physical labor, all of which can present health risks.^{3,4}

These stresses contribute to women's psychological and physical problems, especially during their childbearing years.⁵ Women are at greater risk than men of depression and anxiety disorders.⁶ Battered women often suffer from alcohol and substance abuse, depression, and other problems.^{7,8} Sexually abused girls are more likely to engage in risky behaviors throughout life, including smoking, drinking, drug abuse, and risky sexual behavior, including commercial sex.^{7,9,10}

The significance of gender inequities for women's health was underscored at two United Nations conferences: the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 World Conference on Women in Beijing. These conferences recognized women's physical, emotional, and social well-being as a human right and as an essential element of sustainable development. The Beijing Conference also emphasized women's right to be protected from unwanted sex, abuse, and genital mutilation. This article discusses gender-based factors that impact women's health and evaluates how an understanding of these factors can help service providers improve women's health care.

Lack of Control Over Sexuality and Fertility

For many women sex is not voluntary, and they have little influence over contraceptive use and their fertility. Many girls are pressured into having sex at an early age. From 36 to 58 percent of rape victims are under the age of 16, and their assailants

Female Genital Mutilation

Female Genital Mutilation (FGM) is a dramatic example of how gender can affect health. It is estimated that at least two million girls are at risk of FGM each year in at least 26 African countries. Prevalence varies from 98 percent in Somalia to 5 percent in the Democratic Republic of the Congo (Zaire). The practice also is found among some groups in the Middle East and Asia, and in some immigrant populations in Western countries. African activists, governments, and the international community have worked to eradicate FGM since the 1970s. Efforts have increased since the ICPD and other recent conferences have encouraged more women's organizations, youth groups, and human rights activists to become involved.¹¹

FGM includes all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs. Type I involves removal of the clitoral hood with or without removal of part or all of the clitoris. Type II involves removal of the clitoris and part or all of the labia minora. Type III (infibulation) involves removal of part or all of the external genitalia and stitching and/or narrowing of the vaginal opening. The procedures are not reversible, and their effects last a lifetime. While health complications are more severe with Type III procedures, all types pose risks and can lead to death. Girls undergoing FGM can experience intense pain, hemorrhage, and shock. It can lead to infection, blocked menses, recurrent urinary tract infections, abscesses, and increased risk of maternal and child morbidity. FGM may enhance the spread of infections, including HIV, because the same unsterilized instruments often are used on several girls and because FGM-related scarring may increase the likelihood of virus exchange during intercourse.

Political and legal efforts to stop FGM are important, but successful eradication programs must always begin by learning more about how and why FGM is practiced. Even where it is illegal, such as in Burkina Faso, many adults may approve and continue the practice with their daughters.¹² Where FGM is common, older members of the community often are influential in deciding whether to perform the procedure on young girls,¹² for example, grandmothers, mothers-in-law, and circumcision providers.^{11,13}

Several community-based pilot interventions (such as in Egypt, Kenya, Senegal, and Uganda) are reducing the incidence of the practice on girls. These pilot interventions work because they: respect community values and traditions; understand the cultural basis of the practice; engage all segments of the community; inform the community about the harmful effects of FGM; and support decisions against the practice.

In Kenya, the women's organization Maendeleo Ya Wanwake Organization, in collaboration with PATH,

reduced the incidence of female genital mutilation by promoting alternate "coming-of-age" rituals. Thirty girls participated in the first alternative ceremony in August 1996. By December 1998, more than 1,000 girls had graduated to adulthood in four districts without undergoing FGM. This initiative became an entryway for educating girls about sexual and reproductive health, including relationships, STDs/HIV, and pregnancy prevention while supporting girls' education and community values.¹¹

In Uganda, the Sabinu Elders Association, in collaboration with the UNFPA-funded REACH project, has worked to improve the reproductive health of women and girls by eradicating FGM, promoting positive community values, and providing accessible reproductive health services since 1996. They focus on celebrating positive cultural values by retaining certain aspects of the FGM ceremony, like feasting and gift-giving. An annual "cultural day" was instituted to promote healthy traditions and dispel myths about harmful practices. Community seminars and workshops are held regularly, as are peer education activities and health worker training. The number of girls who have undergone FGM has dropped sharply since the beginning of the project, by as much as 40 to 90 percent depending upon the region.¹¹

Innovative, participatory, anti-FGM projects are making a difference in several countries. Increased financial and technical support for projects that build upon experience to date could lead to the eradication of the practice within the next 15 years—a long-term goal set by the World Health Organization.



Kenyan families celebrate girls' graduation into adulthood upon completion of a week-long "circumcision with words" training program.

frequently are relatives.^{8,10} Other girls are coerced into first having sex by adolescent boyfriends who want to prove their masculinity, and still others are tempted by presents and money offered by an older man (sometimes called a “sugar daddy”) looking for a young partner uninfected by sexually transmitted diseases (STDs).¹ Resulting pregnancies may force unmarried girls to drop out of school, marry prematurely, or even move onto the streets. For other young girls, intercourse follows an arranged marriage, often to a much older man.^{14,15} Whether married or not, young girls who become pregnant face higher risk of complications and death.¹⁵ (See *Outlook*, Volume 16, Special Issue.)

Married women also face constraints on sexual behavior and reproduction. In communities where having a large family leads to higher social status and where being childless is grounds for divorce or abandonment, women may feel pressured to have many, closely spaced children.¹ Gender roles often give men primary authority over sexual and reproductive health decisions—an authority that may be enforced by family pressure and threats of violence or divorce.^{1,7,8,16} Accepted standards of behavior may make it difficult for women to negotiate or even discuss sexual issues with their partners.⁷

Lack of control over their sexuality puts many women at risk of unwanted pregnancy and STDs, including HIV/AIDS.² For example, at one Bangkok rape crisis center, 10 percent of clients contracted an STD and over 15 percent became pregnant.⁸ Women who choose abortion risk life-threatening complications where the procedure is available only under unsafe conditions. While sex workers and victims of sexual violence have higher rates of unwanted pregnancies and infections than other women,⁷ social norms that condone or encourage men to have multiple sexual partners put married women at high STD risk as well. A study in Addis Ababa, Ethiopia, on the prevalence of STDs among sex workers and in married women showed that while rates were higher for sex workers (for example, 88 percent had gonorrhea and 78 percent had a chlamydial infection), women infected by their husbands also carried a large disease burden (40 percent had gonorrhea and 54 percent had a chlamydial infection).¹⁴

Violence Against Women

Physical injuries and other consequences from domestic violence are an obvious effect of gender inequities on women’s health. Studies around the world have found that from 20 to 50 percent of women have been abused by a male partner (see Table 1). In India and Peru battered

women constituted as much as one-quarter of female emergency room patients at selected hospitals;⁷ 18 percent of wives surveyed in urban Papua New Guinea had received hospital treatment for injuries inflicted by their husbands.⁸ Violence often continues during pregnancy and can endanger the fetus as well as the mother. Some studies show sharp increases in the risk of premature labor and miscarriage among battered women.^{7,9,10} Physical and sexual abuse also can lead to gynecological problems such as pelvic inflammatory disease (PID), chronic pelvic pain, and vaginal bleeding.⁹

“I work long hours. I get up earlier than he does. I have to get up, sweep the house, go fetch water, and then go to the fields. After work, I come back to cook and feed the animals. In the evening, I’m usually in bed first because each day is so tiring and hard. He goes out and visits, plays chess, and smokes.”
—rural Chinese woman³

Fear of violence also prevents many women from refusing sex or raising the issue of contraception, leaving them vulnerable to unwanted pregnancy and STDs. In Bolivia, for example, among 300 family planning clients interviewed, 5 percent reported being physically abused and 15 percent verbally abused

because of contraceptive use.⁹ Some battered women may need a contraceptive method that they can use without their partner’s knowledge.¹⁷

Wife beating is tacitly accepted in many countries, and the police and courts rarely take action.¹⁵ Rape victims often face unsympathetic legal systems and social stigma so great that in parts of Asia and the Middle East they may be killed by their own families to restore family honor.⁹

A growing concern is the effect of organized violence against women during warfare. Globally, women and children represent 80 percent of the 13.2 million refugees and the 30 million people displaced within their country’s borders.⁷ These women are especially at risk of sexual violence and other forms of abuse, often used as a weapon against members of a particular race or ethnicity. In refugee camps in Tanzania, more than a quarter of the women aged 12 to 49 had been victims of sexual violence. In the

Table 1. Percentage of Women Who Report Ever Being Physically Abused by Their Husband or Partner

Country	Percentage
Cambodia (national)	16
Egypt (national)	36
Kenya (Kissi District)	42
Uganda (Masaka, Lira Districts)	41
Chile (Santiago)	26
Mexico (Guadalajara)	30
Nicaragua (Leon)	52
Canada (national)	29
New Zealand (five districts)	20
United States (national)	28

Source: WHO, 1997.¹⁶

Sex Workers

Millions of women worldwide exchange sex for money. Women and children may be sold into prostitution or may be forced to trade sex for money by the death of a spouse or other loss of income. In Thailand, it is estimated that there are as many as two million sex workers.²¹ Because of the nature of their work, they are at high risk for STDs and other reproductive health problems, yet sex workers tend to postpone seeking care for lack of affordable, acceptable services that will not discriminate against them.²⁰

Initially, health programs for sex workers focused on promoting condom use to reduce HIV/AIDS transmission, but these efforts proved effective only when they targeted brothel managers and clients as well as sex workers.²² One AIDS prevention program in Chiang Mai, Thailand, succeeded because brothel owners agreed to support and enforce a mandatory condom policy. This allowed sex workers to insist that clients wear condoms without putting their jobs, their incomes, or their safety at risk.²¹

Condom promotion efforts alone do not meet sex workers' broader needs, however. When the Lentera Project began serving female sex workers in Yogyakarta, Indonesia, in 1995, it quickly became clear that

former Yugoslavia, women and girls were imprisoned in "rape camps" and suffer ongoing physical and psychological scars from violence.¹⁸

Barriers to Health Services

Gender biases in health care systems adversely affect the health care provided for many women; for example:

- Providers may treat female patients disrespectfully.⁸
- Women may be offered less information and fewer treatment options than men.¹⁹
- Battered women may fear retaliation for seeking health care and their health care providers may be unsympathetic.⁷
- Sex workers are particularly reluctant to seek health services because of cost, the need to take time away from their work, and the social stigma of their profession (see box, this page).²⁰
- Religious or cultural restrictions prevent women from leaving their homes or communities or from receiving health care from male providers.^{3,15}

Women also are discouraged from seeking health care services because of cost and family spending priorities. In some parts of the world, families spend little money on

medicines and preventive care for women and girls, and delay seeking treatment for their health problems.^{1,3} For example, an Indian study found that only 8 percent of rural women had ever sought gynecological care, although 92 percent had one or more reproductive health problems, including reproductive tract infections, PID, genital prolapse, and urinary tract infections.²⁴

Developing Gender-Sensitive Services

Health care organizations cannot solve the social, economic, legal, and political inequities that restrict women's lives, but a gender perspective can help them improve services for women. Programs can begin with a gender analysis to better understand how gender issues affect health. They can also train providers to better meet their clients' needs, expand the range of services available to women in various situations, and lobby for social changes that would improve access to health services.

Gender analysis. Gender should be considered throughout the design, implementation, and evaluation of health programs.^{3,19} Managers must study the differences in women's and men's status, responsibilities, and access to resources in order to understand the realities of women's lives, including their health priorities and concerns.¹⁹ The results may challenge false assumptions on which current services are based, such as the belief that all women can negotiate terms of sexual encounters¹⁹ or that most women live in stable, monogamous relationships. The results also can identify the full range of women's health needs beyond reproductive issues, such as mental health and substance abuse.

Managers need to assess how gender norms affect current health care services.¹⁹ For example, some key services may be unavailable to women, staff may be uncomfortable providing services to clients of the opposite sex, and there may be inequities in professional relationships between female and male staff members.

"I keep quiet. My husband is all I have. He brings us medicine when the children or I are sick, but I don't ever ask him for medicine. I am a woman."
—woman in rural Bangladesh⁸

Gender norms also affect how clients relate to their providers. In Bolivia, for example, women are socialized to be submissive and silent with men, and knowledge about sexuality is considered a sign of promiscuity. Therefore, many Bolivian women find it difficult, if not impossible, to talk openly with male health care providers about intimate sexual issues.²⁵

Gender training. Based on the results of a gender analysis, programs can educate managers and providers about the impact of gender issues on health. Gender training encourages reproductive health providers to:

- understand how social norms affect women's reproductive health;
- consistently treat female clients with respect;

- understand that female clients may not have control over reproductive health decisions;
- inquire about clients' sexual practices to help determine clients' reproductive health risks and needs;
- teach female clients how to negotiate sexual matters, offer to talk to their partners, or suggest a contraceptive method that can be used secretly; and
- look for signs of physical and sexual abuse, STDs, and FGM and encourage clients to discuss these issues.^{9,26}

In Bolivia, for example, the Women's Study Project is using research results to develop a manual on gender awareness for providers,²⁵ which introduces providers to the concept of gender, challenges personal values and gender stereotypes, and teaches them how to address gender issues as part of their work.¹⁹

Range of services. Reproductive health and family planning programs also can address the health impacts of gender by expanding the services offered and reaching out to clients they may have ignored in the past. Increasingly, programs are integrating STD and sexual health services with family planning (see article on Sexual Health, page 7) and reaching out to men. For example, at La Casa de la Mujer, a women's empowerment organization in Santa Cruz, Bolivia, health providers encourage a woman's partner to be present when she receives the results of exams that may reveal a sexually transmitted disease. Then, providers can specifically discuss how male behavior affects women's health.²⁷

In many developing countries, depression, anxiety, and other emotional disorders largely go unidentified even though sufferers often request treatment for related physical symptoms. Health care providers can be trained to identify and treat common psychological problems using simple tools, such as the screening checklists, information cards, and patient booklets developed by the World Health Organization (WHO).^{28,29} WHO's Nations for Mental Health program is helping health care providers, social workers, and religious leaders in several countries to develop strategies to detect and manage mental health problems.³⁰

Reproductive health care providers are in a unique position to help women experiencing violence. Women are far more likely to admit abuse to a sympathetic health care provider than to seek help from the police or the courts. While it is not yet clear which approaches work best, reproductive health organizations can work to meet the special needs of abused women by:

- displaying and distributing materials to raise awareness about domestic violence and rape;
- training providers how to counsel abused women;
- offering emergency contraception;

Changing Attitudes to Improve Health

The Society for Integrated Development in the Himalayas (SIDH), with assistance from PATH, has developed a training workshop to help men become more aware of how their attitudes and behavior toward women affect reproductive health. Although SIDH had been working with women's groups in the region for a number of years, many of the programs they had developed were not as successful as expected. Investigations into the reasons for these failures revealed that men's attitudes were an important factor, and that gender beliefs held by both men and women had a major impact on women's health.

The studies found that both sexes believed women should work hard and be deprived of food during pregnancy, that women's health care is only necessary under extreme circumstances, and that women have little information about issues that affect their health. Although both men and women expressed interest in family planning methods, the burden is often placed on the woman to obtain a method, and the responsibility for raising children belongs entirely to the woman.

The planners of the workshop used these findings to develop a curriculum aimed at changing the attitudes of participants. The four-day workshop focuses on challenging deeply held stereotypes about gender and sex by personalizing concepts, not just providing information, and by challenging participants to develop "Personal Work Plans" to help them integrate what they learned in the workshop into their daily lives. The focus is on changing the attitudes and behaviors of young people. Twelve workshops have been held in the region, with 250 participants. The most notable effect has been a change in the attitudes of married men, who more fully understand the experiences of their wives and daughters. Evaluation of the project is ongoing.



The workshop participants in Mussorie, India. The training helps young men understand women's experiences and how those experiences affect their health.

- helping women who want to use a contraceptive method without their partner's knowledge;
- offering STD, including HIV/AIDS, testing;
- recording evidence of violence for possible legal action;
- building a referral network for legal services, safe housing, and psychological counseling; and
- routinely screening clients for abuse when services at referral networks are in place.^{10,16,26}

A pilot project at the Asociación Civil de Planificación Familiar (PLAFAM) in Venezuela is implementing many of these steps in an effort to reduce the impact of violence in PLAFAM clients.⁹

Social change. Health care organizations can help raise community awareness of gender issues, especially the many ways in which gender roles and lack of power can affect women's health. Community outreach programs can promote discussions about standards of accepted sexual behavior for men and women, traditional beliefs about sex and reproduction, and women's right to control their own bodies. Reproductive health programs also can join with women's organizations that, in countries such as India and Malaysia, are advocating legal and police reforms to recognize the criminal nature of domestic abuse and rape, and to protect women from abusive husbands.⁵

Program and Policy Implications

Reproductive health programs must recognize the social realities that shape women's lives if they are to help female clients reach their reproductive goals and protect themselves from STDs. At a minimum, this requires training providers to understand how gender roles affect women's freedom of activity and to offer realistic advice about contraception, safer sex, and intimate relationships. Reproductive health providers are in an ideal position to identify frequently overlooked health problems such as physical abuse and depression. To meet these goals, programs can expand their own services to treat women with special needs, such as battered women and commercial sex workers, or they can help build a referral network of shelters, lawyers, psychologists, vocational schools, and other community agencies to serve these women.

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Sexual Health

Reproductive and sexual health encompasses freedom from fear of unwanted pregnancy, disease, and abuse, and from the shame and guilt that surrounds sexuality in many cultures.¹ The International Conference on Population and Development (ICPD) in Cairo expanded the definition of reproductive health to include a “satisfying and safe sex life,” a theme that was elaborated the following year at the 1995 World Conference on Women in Beijing.²

Yet sexual health, even as a goal, does not exist for many women. Many women have been socialized to feel shame and guilt about their sexuality, to be passive in sexual encounters, and never to discuss sexual matters with their partners.^{3,4,5} This lack of control can make the sexual act humiliating and depersonalizing.⁴ At the same time, women everywhere want to understand their own and their partner’s sexuality to improve their personal relationships. For example, counselors in Indonesia and elsewhere have found that many women enjoy sex but have a variety of questions and concerns about their and their partner’s sexual health⁶ (see box, this page).

Family planning can increase sexual satisfaction and improve the relationship between partners by freeing couples from fear of an unwanted pregnancy.^{2,4} Specific contraceptive methods may have less positive impacts on sexual satisfaction, however. For example, some women blame oral contraceptives for their lack of libido, while men frequently complain that condoms reduce their pleasure. While there has been little research on these issues, family planning clients often make decisions to adopt, continue, or switch contraceptive methods based on perceived impact on their sex lives.⁶ At one Brazilian clinic, half of family planning clients who had sexual problems blamed their contraceptive method; that proportion fell to five percent after the women attended sexuality education sessions.³

To a large extent, culture and society dictate patterns of sexual behavior.^{4,7} Beliefs about masculinity, femininity, and gender roles (see previous article), and the acceptability of various sexual practices determine whether a woman expects to enjoy sex, whether she can discuss sexual and contraceptive matters with her partner, whether she can control when and with whom she has sex, and whether she can use a method of contraception.⁴ In many countries, for example, multiple sex partners for men is widely accepted, which puts both women and men at increased risk of STDs.

The Role of Providers

Reproductive health providers need to help clients understand the link between sexual behavior and health.

Women Express Sexual Concerns

During individual and group family planning sessions, Indonesian women expressed a wide variety of concerns about sexual issues.

- “Will vasectomy decrease male libido? If yes, I won’t let my husband do it!”
- “Can we have intercourse during menstruation? I feel an increasing desire during that period.”
- “My husband has been experiencing premature ejaculation lately. It’s driving me mad and making me frustrated. How can this be cured?”
- “Lately I have seen sores around my husband’s penis; his semen has a yellowish color and sometimes it smells bad. His condition has made me reluctant to have sex with him. Is that a sign of infection or sexually transmitted disease?”
- “Now I’m forty-one; our three children are grown up; I feel old and it doesn’t seem right to be having sex as often as when we were young, but my husband is as eager as before and complains about my passive behavior lately. Do you have any medicines or herbs to arouse me?”⁶

Women and men need basic knowledge about human sexuality and their bodies, including how sexual practices contribute to their risk of contracting an STD or having an unplanned pregnancy. They need support and advice about discussing sexual issues with their partners and in addressing problems such as pain during intercourse, diminished libido, and premature ejaculation.

Meeting these goals requires a broader and more personal approach to counseling clients. Providers must be prepared to discuss a client’s sexual life, including current and previous partners, sexual practices, STD risks, sexual satisfaction, and client control over her or his sexual life.^{4,8} An upcoming issue of *Outlook* will discuss strategies for helping providers communicate with clients about these issues.

Despite concerns that these matters are too private to discuss, many women in developing countries are willing and eager to talk about their sexual experiences and concerns in a safe and sympathetic environment.^{3,6,8} Privacy and confidentiality are essential, and providers must be respectful, supportive, and, above all, nonjudgmental.^{5,9} Some reproductive health programs have developed self-assessment techniques to help clients address the most sensitive issues. For example, clients can assess their risk of contracting HIV by answering questions posed by a computer program or reading a list of questions in a waiting room rather than discussing this difficult topic with a provider.^{9,10}

Changing providers' attitudes and strengthening their skills is the greatest challenge for many programs.^{6,8,11} Providers typically share deeply held values with the community, for example frowning on sexual activity by unmarried teenage girls or condemning homosexuality. When family planning clinics in Brazil, Honduras, and Jamaica integrated HIV/AIDS prevention into their services, helping providers clarify their personal values regarding sexual behavior was a key element in the training. Staff also learned about STDs, HIV/AIDS, sexual development, sexuality, and the effects of different contraceptive methods on sexual satisfaction. With training and experience, providers learned how to discuss sexual topics without feeling uncomfortable and how to encourage clients to speak about sensitive topics, such as sexual abuse, homosexuality, and infidelity.⁸

Group education sessions on sexual issues are a good complement to individual counseling because they offer social and moral support. The Family Planning Clinic at the University of Campinas in Brazil holds group sessions to help women understand their sexual desires and responses, overcome feelings of guilt, and talk to their partners.³ Women attending group sessions sponsored by Sociedade Civil Bem-Estar Familiar no Brasil (BEMFAM) learn to be more assertive and to negotiate effectively with their partners about sex.⁸

Conclusion

Health care providers, family planning counselors, and program planners can play a vital role in improving the sexual health of their clients. Understanding client concerns about family planning methods, helping clients

to understand their bodies and how behavior affects their health and that of their partners, providing a safe and supportive environment to address client concerns, overcoming personal biases, and understanding cultural pressures on men and women regarding sexual behavior are all vital to meeting the goal of a "satisfying and safe sex life" for all people.

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The writer for this issue was Adrienne Kols, and production assistance was provided by NanCee Sautbine.

In addition to selected members of *Outlook's* Advisory Board, the following individuals reviewed this issue: Dr. C. Garcia-Moreno and Dr. A. Mohamud. *Outlook* appreciates their comments and suggestions.

Outlook is published by PATH in English and French, and is available in Chinese, Spanish, Portuguese, and Russian. *Outlook* features news on reproductive health products and drug regulatory decisions of interest to developing country readers. *Outlook* is made possible in part by a grant from the United Nations Population Fund. Content or opinions expressed in *Outlook* are not necessarily those of *Outlook's* funders, individual members of the *Outlook* Advisory Board, or PATH.

PATH is a nonprofit, international organization dedicated to improving health, especially the health of women and children. *Outlook* is sent at no cost to readers in developing countries; subscriptions to interested individuals in developed countries are US\$40 per year. Please make checks payable to PATH.

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