Gender Issues in Health Projects and Programmes

Report from AGRA East Meeting, 15–19 November 1993, The Philippines

T K Sundari Ravindran

An Oxfam Working Paper
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Preface

The AGRA East workshop on Gender issues in Health Projects and Programmes was held from 15 to 19 November 1993, at the University of Los Banos Campus. The workshop process and content was evolved by a core group comprising Eugenia Piza Lopez and Claudia Garcia Moreno from Oxfam headquarters, Galuh Wandita from Oxfam Indonesia, and two external consultants, Gert Ranjolabang from Centre for Women's Resources, Philippines, and T K Sundari Ravindran from India, co-editor of Reproductive Health Matters. The workshop was conceived as being participatory in approach, so that concepts would not only be acquired at the intellectual level, but the need for gender analysis, for example, felt and appreciated to the extent of becoming a commitment. For this, participants needed to go through experiential exercises that enabled them, in their role as development practitioners, to empathise with the situation of those on whose behalf they would be making decisions. All sessions were planned to be able to maximise participant input. The core group's role was essentially one of facilitation. Sessions consisted typically of a group or individual exercise which drew out what participants already knew, and built on these through the facilitator's specific inputs and discussion in the plenary.

The broad objectives of the workshop were to strengthen participants' understanding of the basic concepts and major issues in connection with gender and health. In the above process, they were collectively to develop tools for analysing gender and health issues in any given context, and for carrying these forward within each country programme. At the end of the four-day workshop, it was envisaged that the participants would be able to:

- analyse the major health issues and concerns faced by women
- identify gender and health issues within development programmes and projects
- address gender and health issues within partners' programmes and projects
- increase commitment on the part of development practitioners to gender and health issues.

This paper draws on the experience of the workshop to set out some of the major gender issues arising from considerations of health and health care provision.
Introduction

1.1 Women’s health in context

Health is not only a medical issue, confined to natural and biological factors which can be addressed by medical interventions. Rather, good health or illness are products, not only of biology, but of the social, cultural, economic and political environment in which we live and act. Health, thus, cannot be viewed in isolation from the context within which it is defined.

Good health is far more than just the absence of illness. Many factors affect our health, including how we live, what we do, the people with whom we choose to interact, and the nature of these relationships. Feeling unhealthy is not only associated with suffering from an infection or disease, but more often with feeling tired and overworked, being under stress, and living in a hostile atmosphere. Feeling healthy is closely associated with feeling relaxed, productive, and useful; being creative, living in healthy, active, and pleasant surroundings, and amidst supportive relationships with people whose company we enjoy.

Why should women's health demand a special focus? There is a perception that both sexes are equally vulnerable to disease, within a given context and setting. However, once we acknowledge that illness has a social dimension as well as a biological cause, it becomes imperative to address the impact of gender relations on health. Given the different social realities for men and women, their experiences of health and their health needs must also be different. Gender analysis shows that differences based on social and cultural relations ('gender'), exist between men and women that go far beyond the differences based on biology ('sex') (Oakley 1971).

Women have a vastly different status from men in every society: one of subordination. Women typically have less control over resources; the 'sexual division of labour', which is regarded by most societies as natural, burdens women with multiple demanding roles. Equally important is the fact that women and men undergo very different processes of socialisation; these give them such disparate social identities that they have different perceptions and definitions of good health and ill health. Consequently, not only do men and women have differing health needs, health problems, and access to health services, but also varying perceptions of health itself.

People's health problems are not only based on biology, but on structural factors, including socioeconomic status, and their own status as individuals within their households and communities. Both the cause of women's ill-health, and women's ability to obtain health care, are related to these factors. Some of the reasons why it is important to focus specifically on women's health needs are as follows:

- Women have special health needs because of their biological role as bearers of children.
- The sexual division of labour, which places multiple roles on women's shoulders, tends to make women more vulnerable to certain diseases than men.
- Certain conditions, such as sexually transmitted diseases, are more difficult to detect in women.
- Women may have greater difficulties in using health services.
- Women's specific health issues are neglected by health services.

1.2 Women’s life-cycle and their health

Traditional frameworks for the analysis of women's health tend to concentrate exclusively on the childbearing years, and, further, on problems directly related to pregnancy and childbirth, but women's health needs extend throughout their life cycle, and beyond their
reproductive role. Besides the special health needs related to reproduction and childbearing, women are also exposed to most of the health hazards that affect men. Reproductive health problems are compounded, or sometimes even caused, because of the heavy manual labour undertaken by rural poor women. Control over female sexuality dictates an early marriage for women, followed by early and frequent childbearing, often while shouldering an active productive role, and managing a household plagued by poor living conditions and chronic shortages.

Often, the roots of health problems which women experience later in life lie in their neglect in childhood. Discrimination against the female child starts early in many cultures: girl children are less welcome than a male 'heir'. The girl is socialised to accept her subordinate position, and is given fewer material and non-material resources than the boy. If the household is poor, this may mean undernourishment for the girl, less health care, and illiteracy. Early malnutrition causes stunting, leading to poor development of the girl's pelvic bones, and this considerably increases the risk of obstructed labour in pregnancy.

Women's productive roles may begin as early as four or five years old; girl children typically help at home from a very early age: cooking, cleaning, fetching water and fuel, and caring for younger children. This places them at risk of burns, and other accidents in the course of domestic work. By the time they are eight or nine years old, children in rural communities are often regular workers in the farm. They may be exposed to respiratory infections because of working in marshy and water-logged fields; and poisoning from pesticides and fertilisers is a growing problem. Another common health problem is infection by parasites such as hookworms. Infections may be contracted from animal bites, and there is a risk of accidents with equipment. Occupational health hazards associated with industry are burns, eye problems due to intricate work, lack of relaxation, exhaustion, poor posture and back problems. Sale of girls for prostitution exposes them to sexually transmitted diseases, including HIV/AIDS.

Girls who begin their productive and reproductive duties early will lack the opportunity to attend school. Girls are expected to adhere to sex-role stereotypes, as 'mother's helpers' and 'little ladies' in community gatherings, and may face more constraints on playing and having fun. This lack of relaxation or stimulation through learning also causes mental stress and fatigue. All in all, the workload of many female children throughout the world exposes them very young to continual and excessive physical stress, which will last throughout their lives into old age. In adolescence, young women continue the roles begun in childhood, only do more work than before. They carry out heavy agricultural work, and are exposed to respiratory and parasitic infections. These have implications for their health during pregnancy and following delivery: severe infection can lead to miscarriages.

As members of a community, there may be serious restrictions on women's sexual behaviour, which have consequences for their reproductive health. Girls and women are isolated during menstruation in some communities, making it difficult to maintain menstrual hygiene, and thus causing severe infections.

Productive work does not stop during pregnancy, and this places women at a higher risk of pregnancy-related complications, and maternal mortality. Farm-work performed knee-deep in water, and the consequent exposure to infection through micro-organisms, may result in urinary tract infections as well as gynaecological problems. Women often suffer from hyperacidity and gastritis, due to lack of time to eat or eating at irregular intervals. For women of childbearing age, repeated births, begun too young or continuing too late in a woman's life cycle, occurring too often or too soon after one another, add to the risk of maternal mortality. Births may be unsupervised by health personnel, and repeated abortions may have numerous health consequences such as anaemia, reproductive tract infections, pelvic inflammatory diseases, uterine prolapse, and urinary incontinence.

Societal norms that tacitly permit multiple sexual partners in men expose women who are their partners to the risk of sexually-transmitted diseases and HIV/AIDS. Women's subordination and powerlessness within conjugal relationships, and the acceptance by society of male violence as 'normal', has resulted in sexual and other violence within the family being a major health concern—both physical and psychological—for women. Repeated reproductive tract infections and exposure to the risk of sexually transmitted infections greatly increase women's risk of contracting cervical cancers, a major killer among women from developing countries.

Social violence against women includes practices that are directly injurious to women's
health and lives, such as female infanticide, restricted mobility, and discrimination against widows. Ear piercing, tooth filing, and tattooing at puberty for beautification, are all part of the socialisation of young girls into norms of female beauty, and the acceptance of male control of female sexuality. An extreme manifestation of a male-dominated society is female genital mutilation, which denies women the right to sexual pleasure. Quite apart from this, female genital mutilation is the source of severe reproductive health problems, including severe pain during intercourse, and obstructed labour. Incest and sexual abuse in girls is not well researched, but, according to the limited data available, it seems to be widely prevalent. Female infanticide and foeticide, and childhood marriages are other problems to take note of. In addition, in situations of ethnic, racial and communal violence, and armed conflict, women are subjected to enormous mental and physical traumas, such as rape and sexual abuse, widowhood, and having to head the household all alone.

Towards the end of their lives, it is rarely possible for women living in poverty to retire and cease work. Towards the end of their reproductive span, women may suffer from a host of health problems related to menopause, such as excessive and irregular bleeding; hot flushes and mood changes owing to hormonal changes, and a feeling of vulnerability. A lifetime of deprivation and hard productive and reproductive labour, leaves women ailing from numerous problems such as arthritis, back problems, osteoporosis; and further deterioration of existing conditions such as prolapse of the uterus and bladder and urinary incontinence.

In many cultures older women have a greater say and role in the community, bringing greater confidence. However, older women are also more likely to be widows, dependent on others for their livelihood, which may mean greater vulnerability than ever before. It is not uncommon to find destitute old women in communities who do not even have two meals a day, nor health care, at a time when their need for such care is the greatest. In communities where resources are scarce, well-being of the elderly is usually a last priority, and that of old women without resources, least of all.

The consequence of biological vulnerability, and gender-based discrimination in a context of poverty, is ill health for women. When they feel ill, women seldom get health care promptly, because of lack of time and money; the socialisation which reinforces women's self-neglect; women's lack of decision-making power; and in many cultures, the restriction on their mobility, which makes it impossible for them to seek health care without the permission and accompaniment of male members of the household. For poor communities, there are yet another set of problems related to lack of transport facilities, and distance from a health facility, which, although affecting both sexes, have far-reaching consequences for women who have already lost much time before the decision to seek health care was taken.
2 Identifying women’s health needs: an analytical framework

2.1 Introduction

It can be seen from the above that, while biological factors and poverty or low socioeconomic status of the household are important factors influencing women’s health, they are not the only determinants of women’s health status. It is important to disentangle the consequences to women’s health of poverty on the one hand, and of intra-household inequities on the other. Women’s subordination to men, and their lack of power to take decisions governing their lives, largely determine women’s experience of ill-health and inability to obtain the health care which could help them.

Aspects of women’s lack of power can be seen in male control over female sexuality and reproduction; the compulsion upon women to bear a high number children; son preference; women’s multiple roles and heavy work load; their lack of control over resources; and their exclusion from decision-making. All these factors underlie and complicate common female health problems. Poverty only exacerbates the threat to women’s health which already exists due to gender-based discrimination.

The factors influencing women’s health (their socioeconomic situation, their biological needs, and sexual discrimination against them) are intertwined. Each of the factors impinges on the other. How do we go about initiating changes in this situation? The key to disentangling this complex web may lie in starting with women themselves; creating greater opportunities for them to interact, and to reflect on their situation; and facilitating their empowerment, to change their situation of oppression, as women, as poor people, and as members of a marginalised group or community. Factors affecting women’s health operate at individual, household, community, national and international level.

2.2 Household level factors

- Women’s resource base (their assets, skills, etc);
- women’s use of wider household resources, and their status in terms of autonomy, control over resources, power, and decision making authority;
- demographic variables such as age and parity.

Such factors influence women’s ‘illness burden’ (how frequently and seriously ill a woman is, and for how long), and, to a significant extent, women’s ‘health-seeking behaviour’ (any action a woman takes to regain good health when she falls ill). The ‘health outcome’, also known as a woman’s ‘health status’, is determined by the interaction of her illness burden and her health-seeking behaviour.

Health-seeking behaviour is strongly influenced by the community’s ‘health culture’, that is, the attitudes of the community to health and illness, and to fertility and its control, including beliefs about the aetiology of various health problems, traditional healing resources commonly used, and attitude to formal health services. Practices and beliefs surrounding menstruation, pregnancy, childbirth, and menopause would feature prominently among these.

Physical, economic, and social access to health services, and the prioritisation and quality of different aspects of health care provided, are other important influences on women’s health-seeking behaviour.

All factors at the household level are influenced by community level factors.
2.3 Community level factors

- Community structure: stratification, divisions, power distribution, resource-bases and resource distribution within the community;
- women's status within the community: authority, autonomy, participation in decision making, rights to use of and control over community resources;
- health services available to the community.

The first set of factors has to do with the number and amount of resources at a community's disposal, and their distribution across various social groups. The second set of factors deal with resource availability to women within each social group. An understanding of both first and second sets of factors is essential to an understanding of the consequences of being a woman who belongs to a very poor social group. These two sets of factors governing women's access to health care demand different strategies for action.

The nature of health services available to the community is related to the community's resources. For example, an urban community or a wealthy social group is likely to have better quality and more appropriate health care facilities available to it than would a poor or socially marginalised community.

2.4 National and international factors

The current process of transnationalisation of commerce and production, the growing interdependence of economies across the globe, and continuing inequality in the balance of power between countries of the North and South, significantly influence national economic policies and the performance of national economies. For instance, a slump in export prices of an agricultural commodity may result in a loss of jobs and intensification of poverty for a Southern community which depends principally on production of that commodity for export.

The indebtedness of Southern countries, and the Structural Adjustment Programmes (SAPS) which many countries have been compelled to embark upon, have resulted in massive cuts in social expenditure, including health expenditure, and in the destruction of small-scale economic ventures in many countries, which are now viewed as 'uncompetitive'. Agricultural subsidies, that helped populations to survive, have suffered, and many people have lost their usual means of survival and are increasingly forced to seek other livelihoods. All considerations have an impact on factors operating at the community level: many communities have found their resource base eroding, or experienced a redistribution of resources among particular social groups. These changes have had adverse effects on poor women in terms of resources and health services.

Two other factors at the macro-level influence the nature and quality of health services in a country: the transnational pharmaceutical industry, and the population-control establishment. While the former plays a significant role in influencing the proportion of health budgets spent on drugs, which could determine whether the country's health service has a rural, primary-health-care focus, or an urban, hospital focus, over the past three decades, international funding for population control programmes has significantly altered the focus of health services in many developing countries in favour of family planning services, at the cost of general health services.

National health service systems are thus greatly influenced by international economic and political forces, both directly, and through the influence of these external forces on the national economy. The nature of the national economy is also reflected in the health services, and determines whether these are state-funded and subsidised, marketed by the private sector as a service with a price, or a mix of the two. Health services also reflect state and cultural ideology: whether health care is considered a right of citizens, as a service which ought to be provided to them for welfare considerations, or as a commodity available in the market.

It should be emphasised that the framework given here for analysing factors affecting women's health status is not rigid, and women's situation is not pre-determined by any of these factors: given any situation, there are individual women who will break out of it. The framework should be seen simply as a tool which may enable an understanding of the causes of a certain situation, and an appreciation of the complexity of the factors which contribute to the situation.

Most health projects deal with factors at the community level, rather than considering household-level factors or scaling up to examine national policies and ideologies and their influence at community and household level. To be effective and to make an impact, health programmes need to work at all three levels,
addressing intra-household issues that affect health, and working at national level to affect policy.

2.5 Sexuality and reproductive health: making the connections

In addition to women's non-sex-specific health needs, they also have concerns relating to the female role in biological reproduction. These 'reproductive health needs' include those related to:

- pregnancy and delivery;
- fertility control;
- reproductive tract infections/sexually transmitted diseases, including HIV/AIDS;
- gynaecological disorders;
- cancers, particularly cervical and breast cancer;
- problems associated with pregnancy and delivery, for example, vesico-vaginal fistula and uterine prolapse;
- problems associated with menstruation;
- problems associated with menopause.

In most countries, despite affecting very large numbers of women, none of these problems have received the attention they deserve from health services. Not enough is known about these issues, and this makes the task of addressing them in health programmes difficult.

Central to understanding women's reproductive health problems is the need to address the issue of sexuality, its construction, and the unequal power relations between the sexes which are embodied in the way sexuality is manifested in men and women. Exploring notions of sexuality leads us on to understanding what lies behind reproductive health problems, and why they are so difficult to address. Lack of understanding and awareness of our bodies, and embarrassment about bodily functions, makes it difficult to know when something is wrong, and even more difficult to seek help for it.

It is important to make a distinction between sex and sexuality, and to emphasise that these are two different things. Sexuality is a sociocultural entity, but it also includes the biological aspect of conceiving and bearing children. Sexuality is constructed differently for men and women, irrespective of the cultural context from which we come. In fact, notions of male or female sexuality are bound up with the gender identity into which boys and girls are socialised; as such, sexuality is closely related to individual women's and men's definition of 'self'.

There is a direct relationship between sexual behaviour, women's powerlessness in sexual relationships, and problems related to sexual and reproductive health. The vast majority of women's reproductive health problems are related to the construction of male and female sexual identities and roles, and to control of women's bodies by others: men, the family and community, religion, and state. All these have laid down norms of behaviour, legislated in ways that affect women's sexual freedom, and so on. In this way the 'personal' is 'political'.

In all societies, there are ways in which women's sexuality is controlled, to enforce chastity outside marriage and fidelity within it, and thus ensure the paternity of children in patriarchal societies. Social norms are laid down as to how women can or cannot use their bodies. Many of these norms relate to women's dress codes, and to women covering or exposing their bodies.

Culture controls freedom to express sexual preference. Although human sexuality encompasses a number of preferences, discrimination against gay men and lesbian women is very common. Most societies assume universal heterosexuality, and controls, both legal and social, may exist to enforce this norm.

Norms concerning female sexuality in many countries dictate that women are uninterested in sex, or that they cannot enjoy it, while men are driven by passion. Women's sexuality and beauty is supposed to be for the sole purpose of pleasing their male partners, who 'own' them and their sexuality. In other countries, predominantly in the North, the situation is still more complex. There is an awareness of women's capacity, and sometimes of their right, to enjoy sex, but insufficient openness for women to say what sexual behaviour is pleasurable for them.

Sexual norms and behaviour are constructed by family, schools, and codes of appropriate behaviour by religion and by law. Irrespective of the differences in socio-cultural contexts, there is in general little open discussion about matters related to sex and sexuality. Peers and friends are the main source of information — and, often, of misinformation. We develop our sexual identities without understanding our bodies; learning about the oppressive side, without learning about the positive.
While gender identities and roles are derived from figures of authority, the role of other influences such as the mass media should not be underestimated. The mass media are very powerful in shaping images of what is considered to be beautiful, alluring or sexually attractive. In addition, peer pressure plays a significant role in adolescent sexual behaviour, which may actually challenge the norms of adult society.

In recent years, the spread of HIV/AIDS has brought gender issues in sexuality, previously the concern of sociologists and feminists, into consideration by the medical establishment. Since sexual relations between men and women are inherently unequal, women have little control or influence in negotiating sexual behaviour with their partners. Sexual behaviour and sexual health are thus closely linked.

Men are supposed to have the need for sexual activity and women the obligation to provide sexual services. It is a widely held view that men cannot be held responsible for their urges and actions. Being less able to negotiate appropriate sexual behaviour with their partners, women are vulnerable to reproductive health problems; but even so, they are held responsible for them.

Understanding sexuality is an important component of changing gender relations within the household and society, which create women's and men's differential access to resources including health care. In its turn, all social change affects sexuality, in the sense that sexuality is a mode of expressing power relations between the sexes. Social change may not bring about more egalitarian forms of expressing sexuality. It could deepen the gender divide, as is increasingly seen with the rise of fundamentalism in many societies.
3 Reproductive health care

3.1 Introduction

Reproductive health care should be comprehensive, providing:

- education on sexuality and hygiene;
- screening and treatment for reproductive tract infections, and gynaecological problems resulting from sexuality, age, multiple births, and birth trauma;
- counselling about sexuality, contraception, abortion, infertility, infection and disease;
- infertility prevention and treatment;
- information about and choices among contraceptive methods, with attention to contraceptivesafety;
- safe menstrual regulation, and abortion for contraceptive failure or non-use;
- prenatal care, supervised delivery, and postpartum care;
- infant and child health services.

It is vital that such health care should be high quality. This means treating clients with respect and compassion, and providing good follow-up- and after-care. Clients should be offered full information as to the most comprehensive range of health services available. They should be encouraged to continue use of health services, rather than the emphasis being placed on initial acceptance only (Germain, A and Ordway, J Population Control and Women's Health: Balancing the Scales, 1989:WHC in cooperation with Overseas Development Council).

Discussed below in some detail are a number of the most important reproductive health concerns.

3.2 Reproductive tract infections (RTIs)

RTIs, including HIV/AIDs, syphilis and gonorrhoea, are caused by infective agents including viruses, bacteria, and fungi. Some infections may be acquired as a result of medical procedures. RTIs are a frequent problem for poor women, yet they often go undiagnosed and untreated. There are multiple causative factors underlying RTIs, some of which are biological, but most are gender-related. All RTIs are preventable and most are curable. Despite this, they have not been accorded the priority they deserve.

Women's inability to negotiate condom use with men is a major issue in preventing the spread of RTIs and STDs. In particular, notions of female sexuality - as chaste within marriage, and dangerous and promiscuous outside it - have affected the policies which attempt to combat the spread of such diseases, as have norms of male sexuality which allow men to deny responsibility for their sexuality and fertility.

Messages regarding AIDS prevention tend to emphasise the importance of sexual fidelity between marital partners, without considering power relations in the private sphere, and the fact that the reason for HIV infection in many women is their inability to insist on safe sex practices with their partners, or to refuse unprotected sex. Programmes aimed at addressing reproductive health should base themselves on an understanding of issues of sexuality and sexual behaviour in the context in question.

Although women's and men's health is affected equally by HIV/AIDS, the discussion has tended to centre around male sufferers, while women are viewed mainly as transmitters of the virus, and as carers for men. Biologically, transmission from male to female is far more probable than from female to male. Socially, women are more susceptible to infection because they are not in a position to challenge male promiscuity or to demand safer sex. Frequently, women are exposed to infection as a consequence of sexual violence.

Social factors contributing to the spread of RTIs/STDs include:
• Economic forces: increase in commercial sex work or other forms of exchange of sex for money or support; family disruption through migration of male or female partner, or displacement through large-scale projects such as dam-building.

• Political factors: the shame and secrecy surrounding RTIs/STDs, and the low priority given to prevention and treatment, in terms of resource allocation.

• Technical factors: diagnosis is not always easy, and treatment can be expensive; lack of women-controlled technology for protection against contraction of virus.

The consequences of RTIs are serious for women and their babies. They include post-partum or post-abortion sepsis, pelvic inflammatory disease (PID), ectopic pregnancy (this increases by 60-100 per cent after PID), cervical cancer, foetal and prenatal death, infertility, with accompanying social rejection and emotional distress, (15-40 per cent of infertility in Asia is due to infection), chronic pain, and infection in infants.

Women often have no symptoms of RTIs. Many are perceived as being 'natural' or minor. However, chronic, low-grade reproductive tract infections greatly increase women’s susceptibility to more serious infections, including HIV/AIDS. Even when a problem is recognised, many women hesitate to seek health care, because of their socialisation which makes them view sex as a taboo subject. Matters are further complicated by the non-availability of treatment for RTIs as part of the regular Mother and Child Health (MCH) or Family Planning (FP) services.

Existing approaches to providing health care for reproductive health problems are influenced by a perception of women as either 'good' (mothers, wives) or 'bad' (sex workers). Thus, while maternal health and family planning services focus only on pregnancy and fertility, STD services are directed towards commercial sex workers. AIDS programmes often operate as vertical programmes, isolated from other services, instead of being part of an integrated package of reproductive health services. Also, adolescents and older women are excluded from most programmes.

3.3 Maternal mortality

Maternal mortality is the leading cause of death among women of reproductive age in most of the developing world. In spite of the fact that official statistics do not record the full extent of the problem due to under-registration of deaths, it is the statistical indicator which shows the greatest disparity between developed and developing countries.

Worldwide, an estimated 500,000 women die as a result of pregnancy each year. The main causes of maternal mortality are haemorrhage, infection, abortion, and hypertensive disorders of pregnancy. Of these deaths, 99 per cent are in developing countries. Every time a woman in a poor Southern community becomes pregnant, the risk of her dying as a result of pregnancy and childbirth is 200 times higher than the risk for a woman in Western Europe. She is also exposed to the risk more often. Most of these deaths are preventable. In addition, many millions of women suffer from illnesses and chronic ill health as a consequence of repeated pregnancies and lack of maternity care. This maternal morbidity is almost always ignored.

<table>
<thead>
<tr>
<th>Fig. 1 Maternal mortality rates* in selected countries (per 100,000 live births)</th>
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</thead>
<tbody>
<tr>
<td>CAMBODIA (1981)</td>
</tr>
<tr>
<td>INDIA (1984)</td>
</tr>
<tr>
<td>INDONESIA (1987)</td>
</tr>
<tr>
<td>LEBANON (1971-82)</td>
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<tr>
<td>PHILIPPINES (1987)</td>
</tr>
<tr>
<td>SRI LANKA (1985)</td>
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<tr>
<td>VIETNAM (1989)</td>
</tr>
</tbody>
</table>

* Data from various studies, not national figures.
### Fig. 2 Percentage of maternal deaths due to various causes (1980-85)

<table>
<thead>
<tr>
<th>Study area</th>
<th>Haemorrhage</th>
<th>Infection</th>
<th>Toxaemia</th>
<th>Abortion</th>
<th>Obstructed labour/Uterine rupture</th>
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<td>14</td>
<td>16</td>
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<td>3</td>
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</tbody>
</table>

### Fig. 3 Causes of maternal death in selected countries

(Figures from various studies, not national figures)

<table>
<thead>
<tr>
<th>Country</th>
<th>(% of maternal deaths)</th>
<th>(% of maternal deaths)</th>
</tr>
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<tr>
<td>VIETNAM</td>
<td>(Hospital data)</td>
<td>PHILIPPINES</td>
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<td></td>
<td>Haemorrhage: 29</td>
<td>Postpartum haemorrhage: 31</td>
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<td>Sepsis: 16</td>
<td>Hypertensive disorders: 28</td>
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<td>RURAL INDIA</td>
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<td>Hypertensive disorders: 12</td>
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<td></td>
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<tr>
<td>INDONESIA</td>
<td>(% of all maternal deaths)</td>
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<td>(12 teaching hospitals)</td>
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<td>SRI LANKA</td>
<td>(% of maternal deaths)</td>
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Gender issues in health projects and programmes

The risk of maternal mortality is related to the woman's previous health and nutritional status, issues of gender discrimination, and access to health services. Maternal death often has a number of interlinked causes, which may start as early as birth or in early childhood. For example, a girl who is not fed properly during her early years will be stunted and therefore more likely to have obstructed labour. Also, a woman's risk of dying from infection and haemorrhage is increased considerably when she is malnourished. Adolescent pregnancy carries a higher risk due to the danger of incomplete development of the pelvis, and there is a higher prevalence of hypertensive disorders among young mothers. Frequent pregnancies also carry a higher risk of maternal and infant death.

Preventable or treatable infections like malaria and hepatitis can kill a pregnant woman. While trained attendants for home deliveries help to reduce the risks of giving birth, access to a secondary level of health care is essential when complications arise. Therefore, training programmes for Traditional Birth Attendants are not sufficient to reduce the maternal death rate.

3.4 Family planning

Different terms are used to refer to contraceptive services: 'family planning', 'birth control', 'fertility regulation'. Family planning is most commonly used to refer to provision of contraception. This provision may exclude adolescents or unmarried persons.

Women need safe and effective contraception and abortion services to ensure good health for themselves and their dependent children, and to enable them to exercise their reproductive rights. These, in their turn, are necessary for women to achieve empowerment. Social factors often constrain women's ability to choose to use contraception itself or which method they use, yet responsibility for regulating fertility tends to rest with women.

Many family planning programmes have been linked to population control policies which have demographic targets. However, it is important that family planning should not be confused, or conflated with, population control. The objective of providing contraceptive services is to enable women and men to decide freely on the number of children they want, and when they want these to be born. This basic objective needs to be recognised and respected by those planning policies and services. No form of coercion into using contraceptives to limit family size against the parents' wishes is acceptable, whether this coercion is implicit or explicit.

Access to contraceptive services is affected by a wide range of factors: social, cultural and religious, economic, geographic, women's own perceptions of the quality of services on offer, and the attitudes of health care providers.

The quality ofFP programmes tends to be poor: they have a tendency to focus on quantity (number of acceptors, number of contraceptives distributed) rather than to address individual women's needs. A model for quality of care includes an appropriate range of services, choice of methods, adequate information and counselling, technical competence, good interpersonal skills on the part of providers, and mechanisms to ensure continuity.

In addition to improving the quality of services, another important area in which FP programmes need to change is to shift their exclusive focus on married women, to include male methods of contraception, and the needs of single women and adolescents.

3.5 Abortion

Abortion is a major public health issue. There are an estimated 35 to 60 million induced abortions worldwide each year, according to the limited data available. Data on abortion are scant and unreliable, because abortion is illegal in many countries. When performed safely, it is a straightforward and uncomplicated procedure, but it is frequently performed in unsafe
Gender issues in health projects and programmes

Unsafe abortion is a major cause of maternal mortality, accounting for between 13 to 49 per cent of maternal deaths worldwide. Those who do not die can suffer from infection, haemorrhage, cervical lacerations, perforations of the uterus, or intoxication due to substances used. Infertility is a common consequence of unsafe abortion, and may have serious emotional and social consequences for women affected. Beyond the risks to their health of unsafe abortion, because of the way in which abortion is stigmatised and criminalised, women may be exposed to social pressures, including violence from their partners, and emotional trauma.

Most women do not make the decision to have an abortion lightly. Contrary to popular belief, it is not young, unmarried women, characterised as 'irresponsible', who have abortions most often. In many instances, it more likely to be middle-aged married women with several children to support who are compelled to undergo abortions because of economic pressures.

Besides posing serious health risks to women, unsafe abortions are also a major drain on medical resources. As much as 50 per cent of some maternity hospital budgets are spent on dealing with complications due to unsafe abortions. It is unquestionable that access to safe and effective contraception and sex education could prevent many unwanted pregnancies and abortions. Lack of male responsibility for contraception is a contributory factor. However, no contraceptive method has 100 per cent efficacy, even when women are able to use it and do so correctly, so abortion needs to be available as a back-up service.

The values and attitudes of public policymakers and health care providers affect the availability of abortion, which continues to be illegal or severely restricted in many countries. Abortion tends to be viewed as a political, rather than a health, issue, and the debate centres on ethics, morality, and religious beliefs, rather than on the health implications for women. Women's right to control their fertility without endangering their lives needs to be recognised, and should be reflected in national policy and legislation. It has been argued that underlying the fierce opposition to abortion is a fear of women's uncontrolled sexuality.

However, decriminalising abortion is a necessary but still an insufficient condition to ensure safe abortion for all women who need it. In several countries, including India and Zambia, abortion services are still neither safe nor easily available, despite being legal. Abortion needs to be affordable and easily available for women wherever they live, in addition to being legal.

3.6 The population debate

During the past 30 years, population policies and programmes have affected the lives and health of women in developing countries and women from ethnic minorities in the North, in many significant ways. An understanding of the underlying political forces behind the formulation of population policies is important in any analysis of women's health concerns.

The population debate is very close to women's hearts, and to the issues of women's reproductive health and reproductive rights. Women are often caught between policies that may direct them towards bearing fewer children, and those (explicit or not) that may encourage them to have more children. In either case, meeting women's needs is not the main priority, and women's reproductive rights not respected.

There are big differences between a family planning programme that sets out to meet women's needs and respond to their concerns, and one whose main aim is reducing the population. The latter kind of programme is more concerned with achieving a target, and focuses on quantity (number of acceptors, number of contraceptives delivered) without much consideration for quality.

Over the past decades, the 'population question' has moved from the sidelines to the centre stage of issues commanding international attention. Even 40 years ago, there was no widespread anxiety about what came later to be termed the 'population problem'. There were no national family planning programmes; indeed, several countries, including some parts of the US, had laws against the distribution of birth-control devices, and information on them.

However, in some quarters the issue of birth control had gained significance much earlier, around the turn of the nineteenth century. In England, a decline in the birth rate dated from around 1877. Upper- and middle-class parents had strong economic motives to limit family size, due to the high cost of education, domestic servants, and other paraphernalia of the gentry. Contraceptive methods such as diaphragms, sheaths, and spermicide were already available
to the higher social classes. In 1877, the Malthusian League was formed, with the objective of bringing birth control within the reach of poorer mothers.

An organised birth-control movement emerged in the first and second decades of the present century. This was essentially a protest movement of women, stemming logically from the movement to achieve women's suffrage. In the 1960s, the rise of a mass, popular feminist movement again brought the issue of birth control to the forefront. One of the major demands of feminists at that time was women's right to readily available contraception and abortion. The feminist movement stressed women's right to make an informed and free choice of family-planning method, and fought medical control over women's reproductive choice. It spearheaded moves to make information readily available, and to set up women's clinics and help women to learn about their bodies, and about sexuality and fertility. The development of modern contraceptives greatly facilitated this process.

The history of birth control in the developing world is entirely different. While in the North the technology of birth control did not lead, but followed, social demand for it, in the South the process has been reversed. Population and population control have become key issues in Southern countries, and the concern is neither on planning families nor on women's emancipation.

The United States, through US Foundations, played a pioneering role in making 'population' an issue of international significance. The eugenicist movement was strong in America in the period between the First and Second World Wars. Political upheavals in China were interpreted as resulting from its overpopulation, while at the time of the US intervention in Korea, more people became convinced that excess population led to popular upsurges and provided a breeding ground for communism.

Another factor in the growth of the population-control movement was the growing feeling on the part of the US that aid to developing countries was failing to keep pace with population increases. Especially in the early 1960s, when US foreign assistance was cut due to its military involvements in South-East Asia and other regions, demands were made for better returns on foreign aid programmes.

By 1965, official endorsement for population control policies by government came in the form of Lyndon B Johnson's statement: 'Let us all in all our lands - including this land - face forthrightly the multiplying problems of our multiplying population, and seek the answers to this most profound challenge to the future of all the world. Let us act on the fact that five dollars invested in population control is worth a hundred dollars invested in economic growth.'

By 1966, the United States Agency for International Development (USAID) was funding official population control programmes in 25 countries. It was America which persuaded the United Nations (UN) to set up a Trust Fund for population activities; this was set up in 1967-68, with a third of its funds coming directly from USAID. This Fund was later to become the United Nations Family Planning Association (UNFPA).

Today, barely 25 years hence, 55 developing countries have adopted policies to reduce their populations; these countries account for 80 per cent of the developing world's population, and 60 per cent of the world population. The issue has been effectively 'sold' to Southern governments. No other sector of public spending, with the exception of defence, has experienced such high investments in money and manpower as international population-control programmes.

Critics of population-control policies have pointed out that population control is no panacea for problems of maldistribution and underdevelopment. Although depletion of resources is stated as a rationale for population control, few efforts are made to curb the maldistribution of wealth, or high consumption, in the developed world.

International trade continues to operate to the disadvantage of developing countries, and this is a major cause of poverty in the South. Population growth began to decline in the West as industrialisation created a demand for fewer and higher quality workers, child labour was banned, and the family bore the cost of educating, feeding, clothing, and sheltering children for a prolonged period; but this sequence of events has not yet occurred in the Third World. While, on the one hand, population has increased due to declining death rates, the birth rate has not fallen, partly because there has not been a demand for higher quality labour. A large reservoir of cheap labour has been created in the Third World, keeping wages low, while profits made from exploiting the material and human resources of developing countries have flowed, and continue to flow, to developed countries. It is an inherent contradiction of the international economy that the same forces
which propose population control also set the conditions for high fertility. No solution can be found for this anomaly, short of structural change.

For poor people, the ability to control births represents a major step forward only when it is combined with campaigns for equality on many fronts. Family planning has to become part of a popular cause that has self-determination as its basic principle. Otherwise, it represents yet another method of controlling the lives of women living in poverty. The manner in which the population debate is carried out is a clear manifestation of the violation of women's reproductive rights. Women who are directly affected by these policies have the least say in the matter, with decisions taken by the state, the church, international donors, and the medical community.

3.7 International population conferences

No discussion on the population debate would be complete without mention of the role of the many International Conferences on population and related issues, which have significantly influenced global population policies.

The most recent, the UN Conference on Population, Sustainable Development and Sustained Economic Growth (ICPD) was held in Cairo in September 1994. There have been two previous Population Conferences: in 1974 in Bucharest, the meeting became divided, roughly between North and South, with Northern countries promoting 'population control' for the South, while the South argued that 'development is the best contraceptive', and that poverty was not caused by population growth but by unequal distribution of resources. In Mexico in 1984, many Southern governments were beginning to show concern for rapid population growth in their own countries and wanted financial support for population policies and family planning programmes. The US did a turn-around in that meeting, introducing the 'Mexico City policy', which banned aid disbursement to programmes that had any connection with the provision of abortion.

The design of the ICPD of 1994 differed from these earlier meetings in many significant ways. For the first time, the conference focused on population and development. Following the United Nations Conference on Environment and Development in 1993 in Rio, non-governmental organisations (NGOs) experienced unprecedented access to the pre-Cairo discussions, meetings and documents. For the first time, women's NGOs were extremely well-organised, and able to articulate their demands clearly, and actively influence the content of the documents.

Women's organisations demanded that the focus shifted to a reproductive-health approach, which is based on respect of women's human rights. They asked for various issues to be addressed, including gender equity, women's empowerment, increased male responsibility, sexual rights, adolescent sexuality and fertility, and abortion. In addition, they requested that population be seen in the context of declining resources, debt, and SAPs. This last request was echoed by some organisations involved in population control. Constraints on the agenda of women's organisations came from several opposing forces, including fundamentalist religious leaders. Among others, the Vatican sought to promote 'family rights' over those of individuals, particularly women. Some environmentalist and neo-Malthusians were also opposed to the Cairo proponents of reproductive rights.

Progress at Cairo 1994

The following section was based on information provided by Claudia Garcia Moreno.)

Perhaps largely because of attention on the actions of extremists, there was a high level of global media coverage of the events at Cairo, which raised public awareness of the issues and gave legitimacy to new concepts. Despite the effort of groups opposed to the concept of women's reproductive rights, the Programme of Action which resulted from Cairo was on the whole a strong document, advocating action by different constituencies, including NGOs, in service provision of women's health facilities. The document achieved a shift in vision from reducing fertility to promoting 'sustainable development', based on the understanding of this concept reached in 1993 at the Rio Earth Summit. In particular, the document focused on gender, equality, equity, and the empowerment of women.

Abortion was represented at Cairo by a paragraph recommending governments to look into the issue as a public health priority. Warnings were given that governments should not misuse abortion procedures as a substitute for the provision of contraceptive services. The concepts of reproductive health and rights were questioned since the draft document included
'fertility regulation', which can be interpreted as early abortion. The concept of sexual rights was submerged in reproductive health. However, the resulting chapter on reproductive health and rights was regarded by many NGOs with a gender focus as reasonable.

There was considerable debate on the recommendations for resourcing the programme. Figures suggested represented 400 per cent of 1994 spending on reproductive health. However, Cairo was not a pledging Conference, so progress in such discussions was not binding. It is an open question at this moment as to how implementation will take place, and whether subsequent debates at the United Nations Women's Conference in Beijing in September 1995 will weaken the resolves of Cairo.

There may be many who question the relevance of ICPD and other international conferences for NGOs which are involved in development and women's issues. In many ways, UN processes seem far removed from the grassroots women and men with whom we aim to work. But although we know that what happens at such conferences does not make an immediate difference to what happens at country level, nevertheless the decisions that are made at that level do affect the formulation and implementation of national policies, and the allocation of resources by bilateral and multilateral donors and other UN agencies. For this reason, it is important for development and women's NGOs to be involved in shaping the outcome of international conferences; and to attempt to make the conclusions more sensitive to the needs of the ordinary woman and man.
4 Gender issues in primary health care

4.1 The primary health care approach

Most health projects at the micro-level have adopted the primary health care approach (PHC). The concept of PHC evolved in 1978 as part of the Alma-Ata Declaration, put forth by the World Health Organisation and UNICEF. This was a response to widespread dissatisfaction of people with their health services, as being expensive, inaccessible, and inappropriate.

Primary health care has been defined as essential health care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination.

As an approach, PHC is intended to be dramatically different from the earlier approach to health which stresses medical intervention. PHC is concerned not only with the poor health status of specific population groups, but with the indignity of health and health care being readily available to some, but denied to many.

The three main principles underlying the PHC concept are as follows: first, that health is an integral part of development. Second, the need is not so much to make further advances in medical technology as to reorientate the health system to make existing technology available to all. Finally, the PHC approach maintains that the conscious participation of people in the care for their own health is fundamental to the achievement of good health. In line with these principles, the PHC approach therefore calls for a move from hospital-based care alone, towards prevention of ill health, and making health services available at the community level, and emphasising ‘self-help’: what people can do for themselves.

Primary health care was conceived as comprising of eight essential elements:

- education, concerning prevailing health problems and methods of preventing and controlling them;
- promotion of adequate food supply and nutrition;
- adequate supply of safe water and sanitation;
- Maternal and child health care, including family planning;
- immunisation against the major infectious diseases;
- prevention and control of locally endemic diseases;
- appropriate treatment of common diseases and injuries;
- provision of essential drugs.

In its translation from theory to practice, the PHC approach has deviated considerably from its original intent. Experience has shown that many PHC projects act on the basis of false assumptions and premises. Typically, NGOs carrying out PHC projects arrive with a concept of a ready-made solution, instead of relying on community participation to determine their activities. In general, such projects have ignored class, gender, racial, ethnic, and other differences in their programme, treating the community as a homogenous entity.

Despite making significant advances by linking health and development and going beyond medical solutions to health problems, this approach to primary health care is largely insensitive to gender issues in health. This is despite the fact that PHC is supposedly concerned with inequities in health. The ways in which the sexual division of labour, and gender-based discrimination influence women’s health status is neither addressed nor understood. PHC does not recognise inequities within the household, nor go beyond viewing women as merely mothers and housewives. Consequently, it confines its vision of women’s health needs to
the realm of maternal and child health, where the focus is mainly on the child, with the mother seen as a vehicle for child health.

PHC also demands a great deal from women as providers of health care in the household, ignoring their multiple roles and time constraints. The approach focuses on educating mothers, and promoting health interventions at the household level which add further to women’s workload. It takes for granted women’s role as carers and health providers, while at the same time not acknowledging their knowledge about health care and healing, but imposing ideas from above.

When PHC projects employ women community health workers, they expect them to do voluntary work, while this is seldom the case when men are employed. Worse still, many messages regarding disease prevention have tended to ‘blame’ women’s lack of awareness and ignorance concerning their own, and their children’s, illnesses.

However, PHC is an important step forward from the earlier, bio-medical approach to the solution of health problems. The need is to make the approach to PHC more gender sensitive, rather than to negate the validity of the PHC approach itself. Addressing gender issues in through a PHC approach would mean:

• acknowledging and acting on the premise that the community is not a homogenous group but may be divided along lines of gender, class, ethnicity and caste;
• being aware of how gender roles affect women’s health needs and the variations in these across different social strata;
• Addressing problems faced by women as providers of health care within the formal health sectors, and as informal carers at home;
• recognising, valuing, and using women’s indigenous knowledge and skills in traditional medicine;
• changing the tendency in health education to ‘blame the victim’;
• planning in consultation with women, and respecting women’s knowledge of the community’s health needs.

4.2 Gender issues in access to health services

The use of health services may be seen as consisting of three main components:

Decision: recognising the need to seek health care, and deciding to seek care;
Contact: making contact with a source of health services delivery;
Care: obtaining adequate and appropriate care.

Women’s use of appropriate health services is constrained by barriers acting at each of these levels: first, in deciding that it is necessary to seek help for the health problem. Decision-making is affected by a woman’s power and self-esteem, as well as her level of knowledge. The woman may deny even to herself that a problem exists. Or she may not recognise the condition as abnormal. Even when a woman recognises that a problem exists, in the event of its being a gynaecological problem she may be too shy or embarrassed to seek outside help, and may prefer to tackle it at home, through home remedies. Even if a woman wants to seek medical help, she may be unable to do so since the decision to do so does not rest with her, but with her husband or elders in the family. She may be expected to cope by herself with any health problems she has, unless they are very serious. Because of this, women may hesitate to complain of ill health.

The second point at which women’s ability to obtain health care is constrained is in reaching a place of service delivery. Having decided to seek health care, a woman has now to overcome a series of other obstacles, such as distance from the health centre, and lack of time and money. There may be no-one to look after her children; the timings of the health centre, and the long queues, may mean losing a day’s work and wages. In many cultures, a woman may only travel if accompanied by a male family member, and therefore his convenience and interest become a determining factor.

Third, when she reaches a health facility after overcoming these barriers, a woman may still not receive appropriate or adequate health care. First of all, the health centre may not be in operation, because the doctor and nursing staff do not come regularly. If there are no female health staff in attendance, women may not express all their concerns to the male health staff. The services of the health facility may be limited to a narrow spectrum, with only MCH care aimed specifically at women. Reproductive health problems are many and varied, and women may not find either the facilities for screening, or personnel with appropriate skills. More often than not, women patients may be
Gender issues in health projects and programmes

sent back after superficial treatment of their symptoms. Lastly, even if a woman begins treatment, the opportunity cost of follow-up may be too high for her to continue with, and complete, the treatment.

Women's access to health care is thus a complex issue, going far beyond merely putting a health facility in place. The barriers to women receiving health care are caused by women's status at individual- and community-level, as well as by national policies. These individual and community-level barriers are composed of two elements: problems women face as a result of being poor, illiterate and powerless, due to factors including class, race or ethnicity; and problems arising from the fact that they are women in a patriarchal society which has inherent gender-based discrimination.

4.3 Integrating gender issues into health care

How would the preceding analysis of gender issues in health inform approaches to future programming for health care? It has been stated that health projects, including those that work on 'women's health', are often gender blind. The reasons for this may be traced to two major factors. First is a limited understanding of disease, as a purely biological phenomenon caused by the action of micro-organisms on the individual, or due to degeneration and wear and tear of the body; and consequently, of ill health as a purely medical issue amenable to technical solutions. The second major factor is a lack of gender analysis.

Some important issues to be taken note of, when planning health projects and programmes are as follows:

- Women's health needs are different from those of men, not only because they are biologically different, but also because their social realities are different; the health risks they encounter are different, as also their health-seeking behaviour.
- Women are not only mothers and wives, but have multiple roles, as producers, reproducers and as members of patriarchal communities. This renders them more vulnerable to health risks than men. The disadvantages suffered in each role complicates any existing health condition. It is therefore not sufficient to provide the same kind of health care to both sexes even for health problems common to both, such as communicable diseases. Programmes have to be designed with an awareness of how the same health problem may affect women differently.
- Women's health needs extend throughout their life cycle, and beyond their reproductive roles. In addition to problems related to reproduction, women are also exposed to all the health problems that affect men. They therefore need far more than maternal health care. Surprisingly, even reproductive health problems have received very little attention in countries and programmes, including Oxfam-supported programmes. There is need for more research and better understanding of reproductive health issues so that these may be better addressed in future.

4.4 Working at different levels

i) Micro-level

We have seen how women's use of health services is constrained by barriers acting at various levels, and that these barriers exist because of the many disadvantages they suffer as women in a patriarchal society. Merely putting a health facility in place will not necessarily mean that women will be able to use it. Although factors affecting women's health operate at various levels - individual, household, community, national, and international - projects tend to focus on the community level, without unravelling intra-household relations, or 'scaling upwards' to make the connections between the experience of the grassroots and international policy formulation.

At the micro-level, interventions have to go beyond treating the household as the beneficiary, and start paying attention to intra-household inequities in resource allocation. Micro-level work aiming to help women to improve their health cannot confine itself merely to neatly packaged interventions addressing one or two 'health problems', since the issue is one of powerlessness to take care of oneself. Powerlessness both contributes to women's becoming ill and makes it difficult for them to seek health care. A starting point to address women's lack of power would be to create opportunities for women to challenge their oppression and change their situation, both as women and as members of a marginalised group or community.
Recently, micro-level interventions have begun to grapple with issues of sexuality: its construction, and the unequal power relations embodied in the way sexuality is manifested in men and women. Addressing sexuality is central to any work on women’s reproductive health, since nearly all reproductive health problems are related to the construction of male and female sexual identities and roles, and to male control over female sexuality.

Development workers sometimes have difficulties in addressing the issue of sexuality. One of the concerns of many NGO workers is that sexuality is private and personal, and its link to development is not clear to them. In addition, many workers who are sensitive to gender issues in their work are less so in their personal lives. The problem of linking development and sexuality is that it brings gender issues of male power and female subordination ‘closer to home’, challenging the way of life of many development workers and health providers.

Many health groups do not feel that their work includes issues related to sexuality and reproductive health. This may be because they have not addressed the issue of sexuality with members of the communities with which they work.

### ii Macro-level

At the level of national and international policy formulation and advocacy, work is needed to influence development policies to be gender sensitive, and especially to ensure that they do not lead to further deterioration of women’s situation. Economic and political decision-making has practical effects on women’s and men’s well-being, which may lead to ill health. Policies that negatively affect the health and well-being of people, such as those affecting food security, employment and wages, and social services, have to be challenged.
5 Addressing gender and health issues in NGO programmes

5.1 Working at the grassroots

Working at the grassroots level on gender and health issues essentially consists of attempting to equip women to meet their practical needs strategically; that is, in a manner which will allow them to increase their status in the community, as well as benefit them on a practical level in their day-to-day lives.

All work in this direction has to embrace some basic principles. Gender-sensitive health interventions should:

- start from women's own assessment of their needs;
- build on women's knowledge and skills and further enhance these;
- not in any way accentuate gender-based discrimination or dependency, but actively seek to redress these;
- contribute to women's ability to organise as a group, take leadership roles, articulate their demands, and seek both macro-level changes in policies and programmes, and changes in the way these are translated into action at the community level.

The effective grassroots work on gender and health which has been undertaken typically begins with awareness-raising, to help women to understand and exercise greater control over their bodies, and to enhance their self-confidence and self-image. The processes adopted are participatory. Awareness-raising usually begins by creating time and opportunity for women to reflect on the realities of their lives, articulate their feelings about their experiences as women, and move on to question why their lives are the way they are, and if they could actually be different.

Gender analysis of the realities of women's lives is thus the catalyst for a desire for change. Since gender-based socialisation defines women's destiny as based on their biology, the issue of sexuality and its social construction, and an understanding of the physiology of reproduction, are an integral part of gender analysis. Looking at reproductive health needs follows as a natural sequel to this.

When dealing with health issues, the focus is on revalidating what women already know, and at the same time, identifying gaps in knowledge. This is followed by acquisition of specific knowledge on the health issues identified. Medical knowledge is 'demystified', and made available to women, so that they have a better understanding of their health problems, and are able to negotiate more effectively for appropriate health care, with service providers.

Changing attitudes and health-seeking behaviour is a more difficult task than building knowledge and skills. The overall purpose is to encourage women to initiate self-treatment or seek medical help when ill, to actively seek antenatal and delivery care, and more importantly, to feel entitled to good health and care. It calls for an integrated process of making women more assertive and aware of their capabilities, as well as equipping them with leadership skills, such as articulating their thoughts clearly, speaking in public, facing up to authorities, and so on.

Since good health is an essential part of development, demanding the right to health leads on to demanding that basic needs of the community be met: that wages are high enough to ensure food security, that there is guarantee of employment, and so on. It also involves fighting against all forms of inequities, since these deny people good health and well-being. Working on gender issues in health is a logical component of any development programme, and not only of health-care programmes. Such work is also part of any consciousness-raising programme seeking to organise workers and marginalised groups, to demand their rights.

What difference would a gender sensitive approach to health and health care make to the nature of specific interventions? Given below are some illustrative examples. First, let us take the case of improving the nutritional status of
Gender issues in health projects and programmes

women and children. A gender-sensitive approach would not start with the assumption that the central problem is women's lack of knowledge about the nutritional value of foods. It would begin with an open dialogue with the women on what the problems are; these may be problems related to non-availability of food-stuff at affordable prices, lack of fuel, lack of time to make nutritious but elaborate preparations, or lack of energy due to chronic fatigue. Intervention may then focus on organising women and men to demand higher wages, or on making food processing easier, or making fuel readily available, or setting up community kitchens, instead of giving 'nutrition-talks' to women. Other approaches include alleviating women's work load, and thus reducing the energy they need to expend, while at the same time improving food intake.

Gender-sensitive approaches to family planning services would dramatically alter their content and focus. Instead of assuming that women's ignorance causes them to breed without control, family planning services would become a means of enabling women to regulate their fertility. Fertility awareness would form the core of the programme, and women would be given information on and access to a wide range of methods. Family planning services would be integrated with services for other reproductive health problems, and backed up with adequate follow-up as well as abortion services.

At the grassroots level, raising of gender-awareness, training and skill-development for self-help in health; leadership training; provision of specific services, and organising women are thus some of the important activities that would form part of a health programme which has a gender-perspective.

There are also examples of organisations working at a supra-local level, as well as those working at national levels, who have initiated activities and programmes addressing gender issues in health. In many instances, grassroots organisations actively participate in these programmes or benefit from them, so that these activities may also be counted as 'grassroots' interventions.

These include:

• publication of popular education material;
• provision of training-resources and support to grassroots groups;
• media and awareness campaigns, and popular workshops;

• campaigns on specific issues, for example, the campaign against maternal mortality and morbidity initiated by the Women's Global Network for Reproductive Rights, and the Latin American and Caribbean Women and Health Network;
• International Days of Action on specific women and health concerns;
• research on women's health problems, from a gender perspective, in collaboration with grassroots women and women's groups;
• advocacy and lobbying for specific changes in policy, such as those related to abortion laws in Mexico; foetal sex-determination tests in India; domestic violence in Malaysia; and the international initiative against population policies aimed solely at fertility reduction.

5.2 Issues for funding agencies working with partners

How would a donor agency go about raising gender issues in health with its partners? We shall start from the premise that most project partners would be willing to address gender issues, but are faced with genuine constraints. It is important for the field staff of donor agencies to carry out an analysis of these constraints, and the potential for change within partner agencies, and to work out systematic strategies for addressing these in ways suited to the requirements of different partners.

However, before we begin to examine the potential for change in partners' organisations, we have to look at our own organisations as well. Strengthening the capabilities and commitment of the country teams of donor agencies would therefore be the starting point for such an exercise. Questions that field offices may ask themselves in this respect are:

• Is the NGO gender-aware, and committed to gender and development work?
• Do decision-makers in the NGO office provide support to work on gender issues?
• Is there a lead person in the team, or is work on gender issues viewed as everyone's responsibility? Do men take up gender issues?
• Is the style of work in the office conducive to 'empowerment' of women in the office, and women's leadership?

When assessing the potential for change in a partner organisation, the factors to be taken into
account include any constraints on and resistance to addressing gender issues; the reasons why these constraints or resistance exist; and any opportunities for addressing gender issues within and outside partner's organisations. Any action taken by the donor agencies to address the resistance should be assessed, and if there has been any follow-up to this. Finally, the implications for programme and resource requirements should be noted.

i. Reasons for resistance and constraints

There are many genuine constraints that partners may face in introducing gender issues in health programmes; there may also be resistance to the idea of 'engendering' health for a variety of reasons. Constraints include having a small number of staff who already have a great deal to do, so that adding on one more responsibility may be difficult. Even when there are staff available, there may be some reluctance to take up the issue, because personnel do not understand the concepts or lack the skills required. In particular, finding women with the required qualifications and leadership skills may be difficult, because the nature of jobs in NGOs are usually demanding, do not assure job security, and are not desk-based.

At times, the reasons why gender issues are not taken up have to do more with the organisation's structure and style of functioning than with either ideological differences or practical difficulties. It may be that the organisation does not have a clear direction or sustained strategy, and supports projects in an ad hoc manner. It may have a top-down structure, with the management taking all the decisions, leaving other staff with a very low morale, and without initiative or willingness to bring about changes. Alternatively, workers with a gender perspective may not have the authority to implement changes.

However, it may be easier to address such problems than to find solutions to constraints and resistance arising from ideological differences. NGOs that are dominated by male staff in decision-making positions who are gender-blind may dismiss the entire notion of looking at gender issues as not important. Women's NGOs which are driven by a welfarist approach and are not aware of or sympathetic to gender analysis may claim that gender issues are being dealt with, merely because the NGO works with women. Working for 'women's health' is not the same as addressing gender issues in health. The first limits itself to meeting women's practical need alone, while the second does so in a way that would empower women and address gender-based inequalities.

Yet another source of ideological resistance is from those who believe that inequality caused by class is the basic injustice to be addressed, and that dealing with gender issues could cause divisions and disunity within disadvantaged classes. For others, the resistance is based on accusations of cultural imperialism: 'gender' is seen as a fad brought in by funding agencies, and promoted by those influenced by 'Western' feminism. There is refusal to recognise both its relevance for developing countries, and the indigenous resistance to male domination which can be found among women at all levels and in all regions.

ii. Opportunities within and outside partners' organisations.

Among opportunities that would facilitate the integration of gender concerns in health programmes, the willingness of partners, especially men, to undergo gender awareness training would be a major factor. Organisations with an extensive network of women staff would also be at an advantage, since these would form the core group for initiating and pressuring for organisational changes. Donor agencies' interest in the issue, and their willingness to support it, would help to translate the intention to change into action. If there is a strong women's movement in the country, this would make available skilled personnel with a gender perspective, who could help with training and research. A supportive national political climate would be a major asset, in that ideas and concepts for gender-sensitive programming would be welcomed and supported rather than resisted and discredited. All these are opportunities that the donor agencies should look for, in their attempt to help partners to integrate gender issues in health programmes.

iii. Addressing resistance and using opportunities

Possible action that could be taken vis-à-vis development partners includes making opportunities available for gender-awareness training to staff of the organisation, and in case of resistance, negotiating with the organisation to agree to this. This may be a long and protracted process, and pose some difficult questions in terms of respecting partners' autonomy and being non-directive as a donor agency. The approach to take may be one of advocacy, or
'selling' the idea. In doing this, the resources available within the women's movements of the respective countries should be used, rather than external consultants.

Increasing the number of women staff in the organisation may create a more supportive climate for gender-sensitive programming. In order to facilitate the recruitment of women staff, donor agencies could suggest policies such as in-service training and skill-development, so that lack of training does not exclude women from being recruited. Other policies, such as flexi-time work schedules, may also be adopted. In the case of choice of new partners, a set of criteria may be evolved to evaluate their gender sensitivity, and funding decisions taken on the basis of the partners' potential for implementing gender-sensitive programmes.

The efforts of donor agencies in gender sensitisation of their partners may not always be successful. At times, it intensifies conflict between gender-aware field workers and the middle management, causing an impasse. Worse still is the scenario where lip service is paid to changes in programme content, resulting in an increase in gender-blind women's activities to satisfy donor requirements.

iv Implications for programmes and resources
Initiating activities to help partners to integrate gender issues in work on health programmes would, needless to say, place additional demands on the country teams of donor agencies, who have been entrusted with this task. To begin with, the country teams have to equip themselves with a clearer understanding of the issues involved, and evolve explicit policy positions. This may be achieved through staff training, discussions with other donor agencies similarly engaged, and exposure visits to projects and programmes that have integrated gender issues in health programmes. After this exercise, the team may set itself specific objectives in relation to making the health programmes of partners more gender-sensitive, with time lines and measurable outcome.

The next step would be to evolve clear criteria, guidelines, and indicators for assessing the gender sensitivity of health projects as well as partner organisations. Once this is done, a plan to raise awareness of gender issues systematically and strategically with partners may be evolved and implemented. The guidelines and criteria evolved have to be disseminated to the partners, so that they know what the expectations are. Partners may need help and assistance in identifying training sources and advisers within their countries, who would help them to effect the programmatic changes planned.

Even after such a process has been initiated, there is need for continuous dialogue about gender issues within teams relating to projects and programmes, and continued training and research support to country teams to strengthen their interventions with partners. As far as new partners are concerned, gender sensitivity should be a determining factor in the decision whether or not to support programmes. In addition, a mechanism for regular monitoring of the progress made in achieving the objectives initially set, needs to be in place.

In order to be able to do all this, donor agencies would need to commit a far greater proportion of staff time for working on gender issues, as well as finances to implement changes. Other resource needs would be in terms of expertise in training and analysis of gender issues in health, and in monitoring health programmes for their gender sensitivity.
Appendix

Questions for assessing the gender sensitivity of health projects

Given below are questions developed for assessing the gender sensitivity of health programmes, which may prove useful for initiating the process of 'engendering' health programmes:

1. What are women's gender-specific health needs in the programme area? What attempt has been made to gain a detailed knowledge of those needs?

2. How far do girls receive differential treatment in the project area? How does the project address these issues?

3. What are the existing constraints on women's time? Does the project reduce women's workload? Does the project load all the responsibility for improved health on women rather than also involving men?

4. Has the project understood the informal local methods used by women (and men) to safeguard physical and mental well-being?

5. Is the project clear that women are not a homogenous group, but are divided along class, caste, religious, ethnic lines? Is it clear that the project will benefit poorer, more marginalised women?

6. Can women in practice make productive use of health facilities, and services, taking into account their workload, daily, and seasonal peaks in activities, financial resources, and lack of mobility and decision-making power? How does the project address these constraints?

7. What kind of quality of care is provided by the health services?

8. Will the project increase women's involvement in decision making within their households and wider community?

9. Will it increase women's ability to act collectively, and organise within the community?

10. Will it improve women's access to, and control over services and infra-structural facilities?

11. What impact will the project have on the relationships between women and men?

Source: Mosse, Julia Cleves, Gender and Health: Comments arising from NGO proposals and reports, Paper prepared for the JFS/NGO workshop on gender and development, July 1993.