Gender Discrimination and its Impact on Health Equity
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Welcome to the 2015 issue of *Annals of Global Health Equity Foundation*. In keeping with our mission to advocate on behalf of all people who lack access to health education, preventive services and health care, Global Health Equity Foundation (GHEF) is proud to present this second issue in a series of compilations from our annual symposia.

GHEF’s goal is to become a principal source for knowledge on health equity. Our organization works to integrate research into advocacy and capacity-building projects for improving health equity. Toward these aims, we present our symposia papers and the insights of panels of experts. We do this gratis, for the benefit of any organization or individual who would like to take a proactive stance in improving health equity worldwide.

GHEF adopts a multi-disciplinary and a multi-level approach to problem solving. Specialists in a wide range of health-related fields work with everyone from the general public to health care professionals.

In Geneva in 2014, we addressed a pressing global crisis in health equity with our third international symposium titled, “Gender Discrimination and its Impact on Health Equity.” This symposium featured our expert faculty presenting problems, research and solutions in gender inequality and violence against women.

The topics presented in 2014 explored a wide range of issues, including:

- effects of gender inequality on health
- economic costs of violence against women and girls
- commodification of health and how it affects women’s health rights
- gender equity and the HIV pandemic
- how cultural and religious practices aimed at ensuring a woman’s virginity affect gender inequality
- lessons learned from mental health programs in England on gender mainstreaming

In this issue, we also include an article from One Heart Worldwide that highlights examples of how men have been motivated to ensure health equity for women in childbirth in Nepal.

GHEF is a non-profit organization that initially has been hosting and co-sponsoring projects in the United States since 2007, and in October 2012—expanding its international reach—has established and registered its headquarters in Geneva, Switzerland. GHEF launched its first international symposium that year, titled, “Global Health Equity in Times of Crisis.” The organization built on that success in 2013 with the second symposium, titled, “Chronic Diseases and the Equity Challenge.”

In 2014, GHEF published its first issue of *Annals of Global Health Equity Foundation*, which was a compilation of papers from the first two groundbreaking events. You may download the first issue of Annals at this link: http://ghef.org/ch/wp-content/uploads/sites/2/GHEFAnnalsWeb.pdf

Our 2015 Annals of Global Health Equity Foundation continues our commitment to release a publication after each symposium. We document the integrative thinking and knowledge of participants, and further GHEF’s international role as a primary source of knowledge on global health equity. The 2015 edition of Annals can be found at the following link: http://ghef.org/wp-content/uploads/2015/09/GHEFAnnalsWeb2015.pdf

The next step is action. We are working to put the knowledge gained from this third symposium into grassroots, community-oriented action toward achieving health equity for women and girls in a wide variety of environments. We invite you to enjoy this publication, and also to contact us with your insights into this global crisis, along with your suggestions for moving tangible solutions forward. Working together, we can build support for our efforts.
Looking to the future, GHEF plans to present its fourth symposium, titled, “Innovation and Equity in Health,” which will explore challenges related to the inequitable distribution of scientific, clinical and technological innovation in health.

In the health care field, innovation has traditionally been seen as invention and development of new technologies such as diagnostics, therapies, drugs, vaccines, or medical devices. Unfortunately, technological innovation brings little benefit unless it is intimately linked to social innovations. These include health system design and operation; product and service delivery; management of people and information; and embracing environmental, economic, political, cultural and social contexts that influence the broader determinants of health.

Our Innovation Symposium will present selected social innovations that emerged from three previous GHEF symposia and experience of applying them in various contexts, as well as those related to innovative technology solutions, including eHealth and communication technologies. We will also discuss enabling and constraining factors for the application of technology solutions to improve access to health care for poor and marginalized populations.

The Innovation Symposium will address relationships between innovation and equity in health:
• in what circumstances can innovation be effectively absorbed by health systems to create more equal access to health care
• how do different health systems promote and diffuse innovation
• is the quest for quality improvement linked with elimination of inequities
• what are the most effective approaches to increasing science, technology and innovation capabilities in low- and middle-income countries
• what are the most effective approaches to deliver improved access to services, and to lower inequity through application of innovation developed locally
• what approaches are effective in implementing innovative technology from outside the local or regional area

We would like to extend an invitation for you or your organization to support our “Innovation and Health Equity” Symposium. Your donation will help bring international expert faculty to Geneva to discuss challenges, and to develop capacity-building projects for nurturing innovation that results in greater health equity. To donate, visit ghef.org and click the yellow Donate button.

We thank you for your interest and support for Global Health Equity Foundation’s initiatives.

Sincerely,

Dr. Tayeb Al-Hafez, MD, FACP
Founder and President
Global Health Equity Foundation
Gender Discrimination and its Impact on Health Equity: a Framework for Discussion

Eduardo Missoni and Masuma Mamdani

Introduction

The Right to Health is affirmed in the Universal Declaration of Human Rights and is part of the World Health Organization’s core principles. The WHO global strategy of achieving Health for All is fundamentally directed towards achieving greater equity in health between and within populations. This implies that all groups (men, women, children, people with disabilities, the elderly, among others) have an equal opportunity to develop and maintain their health through fair and just access to resources for health. Equity in health is not the same as equality in health status. Inequality in health status among individuals and populations are to some extent inevitable. Whilst these may also be addressed, it is inequities (where they are avoidable) that we are addressing as a major challenge facing all societies.

Global dimensions of gender and health inequality

Globalization may have benefitted trade, movement of labor and improved communications; however, inequalities between and within countries have grown at an exponential rate over the past two decades.

Health inequalities not only persist between and within countries, but in many cases neoliberal globalization exacerbated inequalities in income and opportunities, and worsened poverty in the global South. Increasing inequities observed within low- and middle-income countries are of special concern. In most cases, these inequalities are a result of health problems attributable to the different social conditions in which people live and work—such as lower incomes, poor education, poor housing, and poor employment conditions—all of which are avoidable, unnecessary, and unjust (Whitehead, 1992). The consequences of health inequities are particularly dramatic in low- and middle-income countries (WHO, 2009). They also persist between women and men, in part because they are different biologically (in terms of their sex and reproductive health needs), (Payne, 2009), but also because of differences in the access to and control over resources in decision-making powers, as well as the roles and responsibilities that society assigns to them (Ministry of Foreign Affairs, Sweden, SIDA, 2009). Ethnicity, race and class are all factors core to gender discrimination where both poor men and women are affected by the fallout from globalization, but women much more so due to historical legacies of patriarchal laws and culture. Among migrant domestic workers, for example, men are treated badly with poor wages and often abysmal working conditions, but women are often physically abused as well as being paid badly. Patriarchal laws and culture create impunity at state level, which is replicated at the domestic level in the form of exclusion, violence and poverty (Pathirana, 2010).

U.N. Member states have committed themselves to reducing health and gender inequities through the several international legal obligations they are a signatory to (Ostlin et al., 2006), However, present status to some extent reflects the lack of effective implementation and follow-up of many of those commitments.

Gender International Conventions

Preceded by the 1979 Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the United Nations Declaration on the Elimination of Violence Against Women in 1993, and the International Conference on Population and Development (ICPD) in 1994, sustainable progress towards reducing gender inequality has been based in part on the UN charter for women’s empowerment with the Fourth World Conference on Women held in Beijing in...
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1995, which specifically addressed in its Platform for Action five strategic objectives in relation to Women and Health. These included women's access to appropriate, affordable and quality health care; preventive programmes that promote women's health; gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues; research and dissemination of information on women's health; and a need to increase resources for monitoring follow-up for women's health.

The Beijing Conference (1995) has been followed by five yearly reviews, the most recent (Beijing +15) in 2010. Furthermore, in 2000, the United Nations Millennium Declaration stated that "the equal rights and opportunities of women and men must be assured" and took a clear position that gender equality is both a right in itself and a key driver of development, and that women's rights, women's empowerment and gender equality are essential for a single Millennium Development Goal with core targets and benchmarks. Millennium Development Goal 3 ("promote gender equality and empower women") specifically addresses the gender issue, calling for an end to disparities between boys and girls at all levels of education. However, while only one of the MDGs is specifically about gender, addressing gender is of critical importance to every MDG. Indeed, the rules that regulate the behaviours and values of men and women in a given society and the status derived thereof have the potential to impact nearly every aspect of life (WHO, 2003).

There has been some achievement, especially a growing recognition of the widespread and profound implications of gender-based inequities in health following clear evidence on the magnitude and health consequences of gender-based violence. However, this growing awareness has not translated into actionable steps. Action by governments to bring national laws, policies and practices in line with the provisions of the ratified conventions has lagged behind, and countries still have a long way to go to achieve gender equity in all areas of health and well-being.

High-, low- and middle-income countries

While there are many commonalities in the health challenges facing women worldwide, there are also striking differences within and between countries, due to the varied conditions in which women live. (Sen et al., 2007)

Gender-based discrimination has increased particularly in low- and middle-income countries (LMICs) with poor women experiencing considerable hardship and poverty; this is reflected in poor access to services, insecure employment and a greater risk of violence within and outside of their homes.

In the main, at every age, compared to women in high-income countries, those in low-income countries are more likely to suffer from ill health and premature mortality, with girls and women living in wealthier households having lower levels of mortality and higher use of health-care services than those in the poorest households. The most striking difference between rich and poor countries is in maternal mortality: almost all (99 percent) of the 800 women who die every day due to largely preventable complications during pregnancy and childbirth—and the many more who suffer injuries, infection or disease—occur in developing countries. The poorest women worldwide continue to face special challenges throughout their lives (Mamdani and Bangser, 2004; ODI, 2014; Smithson, 2006; USAID, 2014; WHO, 2009).

Gender inequalities are an important dimension of wider inequalities in health and health care. Gender intersects with several other inequalities—economic, racial, cultural, and a number of other social markers—and together they contribute to the large differences in health status and the exclusion of some groups from health services (Sen et al., 2007).

Women may live longer than men because of both biological and behavioural differences, but spend more years living with a disability (Sen, 1996). Nutritional deficiencies can cause ill health in men, women and children. However, malnutrition and anemia are particularly marked in pregnant and lactating women and can be impacted on by household access to, and division of, resources (Sen, 1996).

High rates of morbidity and mortality among women from all countries are attributable to non-communicable diseases, violence injuries and mental health. In poorer countries where the incidence of communicable disease is still very high, the result is a dramatic double burden of diseases. Worldwide, the lives of many poor elderly women are not healthy ones. Many face increasing health problems as a result of their poor economic status earlier in life and also the cumulative risk factors they have experienced during their adolescence and adulthood (Sen, 2000). Additionally political and legal structures deny most women in LMICs any form of social protection in later life (SOROPTIMIST, 2011). Divorced, widowed and single women in developing countries, especially if belonging to lower and middle social classes, have few assets, which places them at risk of poverty and destitution. This is particularly applicable to countries where women are legally viewed as dependents of male kin, as is the case in much of the Middle East and North Africa (MENA) region.

Education is key to empowerment of girls and women

Girls' education is critically linked to women's empowerment and self-determination, improved health, social and economic status as well as positive health outcomes for the mother and the child. While access to primary education is expanding worldwide, girls are still less likely to continue into secondary and tertiary education. Disparities persist, between and within countries, and between men and women.
More men than women can read and have completed primary school in nearly every country surveyed. Levels of secondary education among women are far lower than primary education, where men in the 20-49 year age group more likely than women to have completed secondary school in 34 out of 40 countries. Women in North Africa, West Asia, and Europe are more likely to have completed secondary school than women in other regions (USAID, 2014).

Macroeconomic structural adjustment policies (SAPs) have led in many LMICs for girls to be taken out of education (namely secondary education, but also primary) so they can earn to support families with rising living costs, or they are married off early, as in India. WHO estimates there are 39,000 girl child marriages in India each day (WHO, 2013).

**Economic conditions and empowerment**

The majority of the women worldwide continue to earn less than men, and are less likely to have control over their earnings, to be paid in cash, and to receive any social benefits. Especially in developing countries, unpaid labor accounts for one-third of total global productivity. With regard to work, women undertake at least three roles: production labor to generate family income, a reproductive role to build the family, and community management to create community welfare (Vu Hong Giang, 2001).

Indeed, most women are concentrated in casual, low-skilled, unpaid or poorly remunerated, irregular employment. These jobs directly increase women’s exposure to ill health, such as environmental hazards and pesticide exposure and accidents among agricultural workers. Due to their informal nature these jobs provide little social protection from the employer and the state, further increasing the likelihood of lack of access to health care in the case of ill health (ODI, 2014; USAID, 2014; WHO, 2009).

In sub-Saharan Africa, women are especially overburdened with food-securing activities and primarily responsible for all food production, food preparation, food storage and food sale within the family, receiving only episodic help from the male members of their families. The vicious cycle of increasing work, lack of time, and lack of independent decision making for women who are responsible for food production and health of their families, has health and social consequences (Hyder et al., 2005).

Segmented labor markets reinforce existing patterns of poverty and social exclusion. (Mamdani, 2012) Also, poverty among older women remains among the most neglected policy areas, creating high levels of vulnerability and potential destitution. The ongoing global economic crisis continues to have consequences for poor women and their children (Sen, 2000).

**Gender-based violence including conflict zones**

Early marriage, gender-based violence, stigma, discrimination and other social norms that result in unsafe sexual practices make women and girls particularly vulnerable to HIV infection, and also influence their treatment-seeking behavior. Young girls, in particular the least educated and poorest with limited access to family planning or safe abortion services, face heightened risk of complications and death during pregnancy and childbirth (ODI, 2014; WHO, 2009).

Maternal deaths and pregnancy-related conditions cannot be eliminated without the empowerment of women. Maternal mortality is the number one cause of death for adolescents 15 to 19 years old and in many countries, sexual and reproductive health services tend to focus exclusively on married women and ignore the needs of adolescents and unmarried women.

With more than 1 in 3 women globally reported having experienced physical and/or sexual violence, violence against women is noted to be a major public health problem and human rights concern worldwide (WHO, LSHTM, SA-MRC, 2013). In countries such as Bangladesh, Bolivia, the Democratic Republic of the Congo, Rwanda, Uganda, and Zambia more than half of surveyed married women reported physical and/or sexual intimate partner violence (IPV) (USAID, 2014).

Women exposed to IPV are twice as likely to experience depression, almost twice as likely to have alcohol use disorders, 16 percent more likely to have a low birth weight baby and 1.5 times more likely to acquire HIV infection. The HIV pandemic is dependent on the systemic human right violations, such as gender inequality and violence against women, which render women at a disproportionate risk of infection. (USAID, 2014)

Some 42 percent of women who have experienced physical or sexual violence at the hand of a partner have experienced injuries as well. Around 38 percent of all murders of women globally were reported as being committed by their intimate partners (WHO, LSHTM, SA-MRC, 2013). Children of abused mothers are at greater risk for health and developmental problems (USAID, 2014).

In conflict zones, rape of women and children is increasingly used as a weapon of war. Because of the stigma, shame and the fear of incurring greater harm of reporting any form of abuse, we may never know the true extent of this problem (WHO, LSHTM, SA-MRC, 2013). However, the relation between gender and conflict goes well beyond gender-based violence. Conflicts exacerbate discrimination and women and girls pay the highest price. Recent conflicts in the MENA region (Iraq, Syria), for example, highlight widespread trafficking and girl marriage. These cases also highlight the dangers and risk women and girls face in refugee camps in all regions of conflict, where they often have to pay sexual favours to camp monitors to gain access to basic services (Rhen et al., 2002).
Notwithstanding the resolution on the elimination of female genital mutilation, adopted in December 2012 by the UN General Assembly, the practice of female genital mutilation (FGM) remains a problem for millions of women. More than 125 million girls and women alive today have been cut in the 29 countries in Africa and the Middle East where FGM is concentrated. In some countries FGM is very common, as in Guinea where prevalence has been reported up to 94 percent, and contributes to many negative health outcomes, including severe pain and bleeding, incontinence, complications with reproductive health and childbirth, and even death (UNICEF, 2013).

Gender equity and health systems

The 2008 World Health Report placed health equity as the central value for the renewal of primary health care and called for priority public health programmes to align with the associated principles and approaches (WHO, 2008). Inequities, defined as "Unfair and avoidable differences in health status" (WHO, 2008) are systematic, and affect particular groups of people. They take place across the social gradient, and differences in health are often more pronounced among the most vulnerable, those who have least access not only to health services but also to resources that contribute to good health (CSDH, 2008).

Women and children worldwide are among the most vulnerable. Focusing on their health is the gateway to improving the health of an entire population. However, the notion of gender-sensitive health services in many developing countries tends to have a narrow focus, reduced to providing sexual and reproductive services.

While both men and women suffer disadvantage in accessing health care all over the world, it is also about how in practical terms and through using resources in a gender-aware way can needed health services be delivered more equitably.

Despite awareness of gender discrimination in access to health care, changes are often not incorporated into service for prevention and health promotion for certain diseases or conditions. Recent research undertaken for the Department of Health in the UK (Wilkins et al., 2008) suggests, for example, that access to preventive services for chronic disease is flawed due to service organization based on social constructs of health and illness. For example, although both men and women suffer from the growing epidemic of obesity, women are more likely than men to receive help earlier. By contrast, heart disease is considered to be a "male disease" so there is greater recognition and support for men in health service provision. Whilst men are more likely to die in a sudden event, women's symptoms of heart disease will not be recognized until often it is too late. The study for the Department of Health (UK) showed that women experience different symptoms from men, although both are affected but women are referred much later to specialist care—sometimes too late. Similarly, while alcohol and substance abuse is twice as common in men in the UK, binge drinking is escalating among young women at a faster rate. Service organizations need to target resources fairly and effectively and not simply based on 'gender stereotypes' and cutting costs. In the long run, services that are adapted and rise above "stereotype" and gender constructs and constraints facing men and women in their work life and environment (e.g., opening hours of specialist clinics, health care facilities) can save both on suffering and on cost.

The concept of gender-mainstreaming remains ill understood. Though most appropriate, multi-sectoral responses are perhaps the most difficult to follow up on, and especially where systems are weak and stretched, initiatives remain isolated and uncoordinated.

Effective access to comprehensive programs and services is essential for meeting the sexual and reproductive health needs of men, women and young people. Provision of effective and accessible emergency obstetric services is particularly vital to prevent women from dying during childbirth. The uptake of sexual and reproductive health services is generally constrained by the extent of general health service provision and some of the challenges are specific to health systems—ranging from cost to the infrastructure that provides for patient privacy, availability of qualified and empathetic staff, needed medicines and supplies, functioning referral structures and emergency transport.

Global policy measures and challenges

Over recent decades the combination of factors such as prioritising debt repayment, the rising importance and leverage of multinational corporations, the weakened role of the nation state, a neoliberal ‘one size fits all’ approach to health sector reform, and a move toward technologically driven single-issue-vertical-programme-approach, has undermined health systems and comprehensive sexual and reproductive health services, in particular for those most in need (Fonn and Ravindran, 2011).

There is a growing tendency globally to see patients as consumers of health care and clients of health services. Partnerships are proposed to produce public goods—downplaying the importance of conflicting interests, and the ways in which those differences can be handled—can be especially harmful in relation to areas where injustice and social inequality are prominent, such as sexuality and reproduction. In addition, vertical programmes in reproductive health have ignored complexity through the adoption of a narrow definition of "maternal health" and the adoption of many quantitative indicators, largely inadequate for assessing the social equity dimension of reproductive health (Austtweg, 2011).

Maternal health services have been among the most affected by the decimation of the public health sector because of their sensitivity to the overall functioning of the health system.
Maternal death and disability remain the leading cause of healthy life-years lost for women of reproductive age in low-income countries (Unger et al., 2009).

But some countries have made considerable strides towards achieving universal access to RH services—Cambodia, Egypt, Nepal, Rwanda and Thailand, and more recently Bangladesh (USAID, 2014). But for many poor women, services remain inaccessible, unacceptable and costly (Mamdani and Bangser, 2004). Older persons, and older women in particular, face many obstacles, aside from physical and financial obstacles. Health workers are not respectful nor trained to deliver geriatric care. (UN, 2011)

In most LMICs fragile health systems will be affected by the dual burden of increasing non-communicable diseases and disabilities amongst older persons, as well as continuing to struggle with communicable diseases, particularly infectious diseases and other illnesses related to poverty (UN, 2011).

At every age, women in high-income countries live longer and are less likely to suffer from ill health and premature mortality than those in low-income countries.

Within countries, the health of girls and women is critically affected by social and economic factors. In almost all countries, girls and women living in wealthier households have lower levels of mortality and higher use of health-care services than those living in the poorest households.

Many high-income countries currently direct large proportions of their social and health budgets to care for the elderly. However, global and regional policies that encouraged privatization and cuts in public health funding both in low- and high-income countries have negatively impacted on women who are increasingly providing care for free within the home—the growing burden of unpaid care which poses a significant challenges to the mental and physical health of caretakers.

While there have been improvements in some areas, overall progress towards women's empowerment and gender equality is halting and inconsistent. The poorest women worldwide continue to face major challenges throughout their lives.

**The contribution of the GHEF symposium on “Gender Discrimination and its Impact on Health Equity”**

The development community is currently in the process of reviewing lessons learned and progress toward achievement of the millennium development goals with a view to accelerating progress before the 2015 MDG deadline. It is also set to elaborate the post-2015 development agenda, where gender equality is in the spotlight due to number of unaccomplished global actions (since Year 2000) related to gender discrimination and health. The challenges are particularly acute for many LMICs owing to ongoing policies of privatization and macro-economic adjustment which have reinforced both gender and class inequities. Clearly, as stated by the World Health Organization Director General, Margaret Chan: “The obstacles that stand in the way of better health for women are not primarily technical or medical in nature. They are social and political, and the two go together.” (Chan, 2009)

The GHEF Symposium on “Gender Discrimination and its Impact on Health Equity” specifically looked into these obstacles to better identify and map the impact of gender discrimination on health equity (notably) access to health services. These among other factors such as life course disadvantages—particularly in LMICs, which often lag behind in national policy measures to address the growing gaps and challenges of the effects of gender discrimination—will remain a priority for action.

**Conclusion**

Eliminating health inequities cannot be achieved merely through the provision of health services without discrimination, less so through selective approaches to disease control. Recognizing the root causes of gender inequities in health is a pre-requisite to designing appropriate responses. These imply a wider holistic and multi-sectorial approach capable of tackling the broader social, economic, political and environmental determinants of health and mainstreaming a human rights and non-discrimination approach capable of challenging the discriminating structures and policy making at national and global levels. Social construction of gender is shaped by a lifetime of ascribed gender roles that influence key decisions about education, career paths, working arrangements, social networks, family, and caregiving. The accumulation of these choices powerfully impact upon health and well-being throughout the life course in a multitude of ways and, in turn, are mirrored back into the wider society.

A vision and an approach are needed that go beyond the generic gender discourse, taking into account social, economic and political context and how women are affected by class, race, age, religion, and other socio-cultural factors. Existing social norms and socially constructed perceptions, together with inappropriately defined services, reinforce discrimination and inequalities between men and women. These need to be challenged to facilitate gender mainstreaming; and to advocate for inclusion of gender analysis in research towards identifying gender sensitive interventions that will improve the lives of both men and women. Ensuring community voice is captured in prioritizing, planning, and monitoring, and the delivery of quality health services, social services, and health promotion strategies is equally important in guaranteeing that the services meet the needs of those who are using them for both men and women. In low- and middle-income countries, it is increasingly recognized that the most effective interventions aimed at strengthening women’s and girls’ capacities are those with a focus on empowerment.
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1. Introduction

During the past decades women have achieved considerable progress regarding their health: Life expectancy has increased significantly since 1950, global maternal mortality has declined by about 45 percent between 1990 and 2013 and has fallen by as much as 49 percent in sub-Saharan Africa (World Health Organization, 2014).

International legal instruments playing a key role in these developments include the UN’s Universal Declaration of Human Rights (1948) and its rights to health and social security, Convention 102 on Social Security (Minimum Standards) of the International Labour Organization (ILO) and the Millennium Development Goals (2000). Most recently, the Social Protection Floors Recommendation 202 has highlighted the need for universal health coverage for all based on the criteria of non-discrimination and equity (ILO, 2012).

However, globally many women remain without health protection and access to needed health care. Although maternal mortality has significantly decreased in developing countries, the ratio of 230 maternal deaths per 100,000 live births is still 14 times higher than in developed countries (World Health Organization, 2014). Further, in many countries, women utilize less health care than men despite higher needs, such as in Ghana (Ghana Statistical Service, 2008) and Nigeria (Onah et al., 2014, p. 8). This situation causes unnecessary suffering and early death. It is related to the unaffordability of health care services and low levels of financial protection. The situation is worsened by socio-economic environments, societal practices and often gender-blind legislation that are not enabling equity in access to needed health care.

In order to address these issues and achieve equitable health coverage and access to needed care, it is necessary to tackle the root causes resulting in low coverage and access gaps both within and beyond the health sector. This paper identifies some of the key reasons for gaps in health protection and outlines cross-sectoral policies that have the potential to address these gaps. It is argued that equitable health protection for women requires inclusive and gender-sensitive legislation, effective levels of financial protection, the deployment of adequate numbers of (female) health workers, and a broader policy framework that addresses gender inequities through gender-sensitive social protection policies, labour market policies, as well as policies focusing on poverty alleviation and overall development.

2. Gender inequities: Observations on women’s health protection

Women are concerned by persistent inequalities with regard to many aspects: Within the group of women in a given country (e.g., by income level, age, education, labour market status, and place of residence) and beyond this group in comparison with men. Further inequalities can be observed across countries and at the global level. These inequalities are frequently mirrored by inadequate or non-existent health protection for women and the impact on their health status. Frequently, the accommodation of women’s needs in the health sector is ignored in:

- Legislation that is based on male-oriented labour market structures and income generation models and is thus gender-blind.
- Benefit packages that are insufficient in terms of scope, quality and costs such as co-payments and user fees and thus are inadequate and not affordable.
- Inaccessibility of care given the unavailability or absence of skilled health workers needed to provide services where women are living, e.g., in rural areas.

2.1. Legal health coverage barriers preventing women from accessing health care

Legislation is—among other issues—a result of societal norms and values. Consequently, in many countries, men are systematically empowered by legislation while women’s life cycles, income patterns and other aspects do not match the standardized rules and regulations. This is also often reflected in women’s rights to health as stipulated in national legislation or expressed in affiliation to a health system or scheme. As a result, gaps and deficits in the legal health
coverage of women can be observed both within countries and across countries: Even in a highly developed OECD country such as the United States, 1 in 5 women aged 18 to 64 was not covered in 2012 (Kaiser Family Foundation, 2014). Mostly concerned are the poor and near to poor who are most often informally employed, single mothers and young women. Inequities within the group of women are particularly visible as regards to the place of residence (Figure 1):

- In countries such as Egypt only around 10 percent of rural women are legally covered compared to about 25 percent of women in urban areas.
- In Morocco less than 2 percent of rural women compared to more than 40 percent of urban women are legally covered. In urban areas, women’s coverage rates even exceed those of men by more than 10 percentage points.

Besides being financially protected in times of ill health, effective maternity protection ensures income security for pregnant women and mothers of newborn children. The absence of income security during the final stages of pregnancy and after childbirth forces many women to return to work prematurely, thereby putting at risk their own health and that of their children. Effective maternity care prevents economic loss caused by reductions in productivity and earnings and promotes equality in employment and occupation. While most women in the informal sector suffer from income loss during maternity, about 40 percent of women in formal employment are covered by law under mandatory maternity cash benefit schemes; 48 percent if voluntary coverage (mainly for women in self-employment) is included (ILO, 2014).

Figure 2 (see next page) illustrates countries’ coverage rates for maternity cash benefits. However, a closer look shows that even in developed countries only 52 percent of female workers receive paid maternity leave at 100 percent of last earnings, as compared to 82 percent in the Middle East. In Africa, this is the case for 37 percent of female workers, while it is only 13 and 19 percent in Asia and Latin America respectively (Figure 3, next page). Hence, it is estimated that only 28 percent of women in employment worldwide are effectively protected through maternity cash benefits, which provide some income security during the final stages of pregnancy and after childbirth (ILO, 2014).
Figure 2: Legal coverage for maternity cash benefits: Women in employment protected by law for loss of income during maternity (percentages)

- 10% and under 10% (25 countries, 14.5%)
- 11-33% (27 countries, 15.7%)
- 34-66% (32 countries, 18.6%)
- 67-89% (31 countries, 18.0%)
- 90% and over (55 countries, 32.0%)
- Unpaid (2 countries, 1.2%)
- No data

Source: ILO 2014

Figure 3: Cash benefits during maternity and duration of leave, by region (percentages)

- Unpaid, paid less than 2/3 of earnings for 14 weeks, or paid for a period less than 14 weeks
- Paid at least 2/3 of earnings but less than 100% for at least 14 weeks
- Paid at least 14 weeks at 100% of earnings

Source: ILO 2010
2.2. Gender inequities in access to needed health care due to out-of-pocket payments

In many countries, women tend to provide more unpaid (family) work than men. This results in less formal employment, the exclusion from social health insurance schemes, and high out-of-pocket payments. As a result, the access to health care services for these women is severely restricted. But even if women are legally covered, ineffective enforcement and implementation of laws often lead to OOP for women-specific health care services. Moreover, the scope of the benefit package provided may be too limited, and/or co-payments, user fees and others costs associated with attending health care services are high. For example, in Nigeria a survey has shown that the most important reasons for women for not seeking care are drug costs and fees at the point of service delivery (Onah et al., 2014, p. 6). In India, the poorest households are heavily burdened by spending on maternal care. As a result, a substantial proportion of women reported cost as one of the main reasons for not using delivery care services (Mohanty/Srivastava, 2013, p. 248-249). In Kenya and Burkina Faso, 98 percent and 92.5 percent of surveyed women reported paying fees on basic facility-based maternity care. These fees can be high, amounting to more than US $18 as in Kenya, constituting an immense burden in a country with an average annual income of about $730, and a majority of the population earning less than $1 per day (World Bank, 2011). As can be seen in Figure 4, such costs can amount to as much as 35 percent of the monthly household income.

Thus, in all countries, the poorest suffer most from OOP and access to antenatal and delivery care reflects the huge differences among households from different income quintiles: A study of 65 countries indicated that over 85 percent of the wealthiest quintile of the population use antenatal and delivery assistance, but only 55 and 22 percent of the poorest population have access to antenatal and delivery care respectively (Houweling et al., 2007). In many countries, OOP are also used to get access to quality health care services. In India, delivery in a private health centre is usually of better quality. However, it is also three to four times more expensive than a public health centre and therefore only accessible for those who can afford it (Mohanty/Srivastava, 2013, p. 257).

Several studies provide further evidence for too limited benefit packages as well as hidden costs such as co-payments or under-the-table payments. As the following examples show, many women that are insured and thus should be protected against OOP still have to pay when receiving health care services:

- In Moldova, only 20 percent of women who attended antenatal care received full reimbursement either by a health insurance scheme or the government, while more than 50 percent of women did not receive any reimbursement (ILO, 2011).

- In India, for women insured with the SEWA scheme, 15 percent of hospital admissions resulted in catastrophic expenditures (OOP are equal to or exceed 40 percent of a household’s capacity to pay) even after reimbursement (Tangcharoensathien et al., 2011).

- Coverage for HIV treatment costs are often excluded from health protection benefit packages and covered by vertical programs. Such programmes often only cover costs of anti-retroviral (ARV) drugs, leaving costs of consultation, counselling, diagnosis and related costs to be paid out-of-pocket. Overall, such payments make up substantial proportions of total HIV expenditure, e.g., in Kenya (45 percent), the Republic of Zambia (30 percent) and to a comparably lesser extent in Ghana (9.4 percent) (Joint United Nations Programme on HIV/AIDS, 2010). In China, gaps in the scope of benefits translated into 1,200 and 340 percent of the annual income of rural and urban residents respectively (Moon et al., 2008). Since HIV/AIDS prevalence is higher for women than for men in most countries, women are often disproportionately affected by these costs (United States Agency for International Development, 2014).

- In Bangladesh, the free public maternity care involves hidden costs such as registration fees, purchase of drugs, food costs, tips, and transport costs, and was therefore unaffordable for poor women (Mohanty/Srivastava, 2013, p. 249).

- In Greece, there is a large black economy in the field of obstetric services; 74.4 percent of women who used public maternity services had to make under-the-table payments, which for the year 2009 were estimated at 848 Euros, corresponding approximately to the monthly net salary of an under-training physician (Kaitelidou et al., 2013, p. 28).

- In the United States, a survey shows that low-income women have to forgo, ship, or split medications because

![Figure 4: Cost for complicated deliveries in percent of monthly household income](source: Perkins et al. 2009)
they cannot afford them. Benefits are not comprehensive enough and insurance companies employ a variety of techniques to limit their expenses, such as co-payments, co-insurance, and restricting coverage to a certain number of prescriptions (Ranji et al., 2007, p. 364).

In times of crises and fiscal consolidation, gender inequities usually increase, as it was the case in several East and South European countries during the recent financial and economic crisis. The Council of Europe Commissioner for Human Rights reported that budget cuts in gender equality programmes, child-care services, parental and child benefits, services to victims of violence and legal aid particularly affected women (Council of Europe Commissioner for Human Rights, 2013).

2.3. The unavailability of acceptable health care services for women

The accessibility of health care implies the availability of a set of essential health care services, a health workforce to deliver these services, infrastructure allowing individuals to reach health facilities, and medical goods and products to provide care responding to needs. In the absence of one or more of these components, effective access to health care will not be achieved. Physicians, nurses and midwifery personnel are a prerequisite for the delivery of quality care services to women. However, the health workforce is experiencing a global crisis: it is much too small in numbers to deliver the services needed, unequally distributed and often lacking decent working conditions. The latter drives staff from developing countries, especially highly trained staff, to seek employment outside their home countries, leaving those who remain greatly demoralized (Exavery et al., 2013, p. 3). As a study in Tanzania shows, 50 percent of doctors and nurses are not satisfied with their jobs. Low wages, persistent unavailability of the necessary equipment for service delivery, and lack of participation in decision-making were among major reasons reported for their dissatisfaction (Exavery et al., 2013, p. 2).

Globally, the availability of health care is unevenly distributed among low-, middle- and high-income countries, as well as frequently within these countries (with rural and urban slum areas being disadvantaged). ILO estimates that the current shortage of health care workforce is 10.3 million (Figure 5).

Negative health outcomes for women such as high maternal mortality rates are often directly related to the unavailability of adequate health services and the non-existence of skilled health workers. In developing countries the proportion of skilled birth attendance has increased from 55 percent in 1990 to 66 percent in 2011. Still, in about 46 million of the 135 million live births in 2011, women delivered alone or with inadequate care (UN, 2013). This gap directly affects the health of women and, as can be seen in Figure 6 (opposite page), regions with the lowest proportion of births attended also have the highest maternal mortality rates.

Women living in rural areas are particularly affected by deficits in effective access to health care services. In many countries, a higher proportion of public resources is allocated to urban areas. This “urban bias,” where better-off interest groups in cities are better able to lobby the government to spend money on the services they want, while the poor in rural areas suffer from underinvestment in services, is a common problem (Class, 2013; Lakin, 2009). For example, China had a four times higher resource allocation to urban areas compared to rural areas (Scheil-Adlung/Kuhl, 2012).

While the most qualified health personnel are concentrated in centralized locations in urban areas, women living in rural areas often depend on underserved low-cost primary care facilities where specific services and drugs are not available (Onah et al., 2014, p. 6). This situation may be aggravated by the fact that for cultural and religious reasons, health care services in certain (often rural) areas may not be acceptable for women unless they are attended by a female doctor (Exavery et al., 2013, pp. 2-3). In Rwanda, Togo and Niger, the density of midwives in rural areas is close to 13, 14 and 16 times higher than in urban areas, where there are less than 0.3, 0.8 and 0.9 midwives per 100,000 population (Scheil-Adlung/Kuhl, 2012). The resulting difficulties in obtaining basic antenatal and maternity care also lead to lower skilled birth attendance rates: While in 2011, 84 percent of births received skilled attendance in urban areas, this figure was only 53 percent in rural areas (UN, 2013, p. 29). Geographical barriers associated with longer distances, insufficient road infrastructure and lack of transport as well as opportunity costs such as time and income losses prevent women in rural areas with low health worker densities from seeking care (Scheil-Adlung/Kuhl, 2012, p. 10). In India, more than 30 percent of women in rural areas reported geographical barriers to access health care, compared to less than 10 percent in urban areas. In Ghana, this was the case for 35 percent of women in rural areas and 16 percent of women in urban areas (Scheil-Adlung/Kuhl, 2012). These women may not get any health care at all or may be obliged to use expensive private health care facilities instead. In Tanzania,
long distances to health facilities were reported to be the main reason why 44 percent of women are unable to give birth in a health facility (Perkins et al., 2009).

3. Addressing gender inequities through the provision of effective access to health care

The overall objective of health protection policies is to achieve universal health coverage through an effective access to at least essential health care for all in need including maternity care and preventive services. To reduce gender inequities within and beyond the health sector, women need to be financially protected against the different kinds of expenditures incurred when accessing health care, such as payments for services received, transport costs and economic loss experienced due to reductions in earnings. Adequate legal coverage is crucial, but effective health protection for women may not be achieved as long as laws are not implemented and investments into the availability of health care services insufficient. Policies should focus on:

- Inclusive and gender-sensitive legislation that is meaningfully implemented to provide effective levels of financial protection for women.
- Provision of higher numbers of health workers in underserved areas to guarantee the availability of acceptable quality health care for women and their families.
- Improvement of the overall socio-economic environment through poverty reduction, education, and generation of income possibilities for women.

3.1. Providing effective levels of financial protection through inclusive legal health coverage

According to ILO Recommendation No. 202 (2012) concerning national floors of social protection, universal health coverage requires effective access to at least essential health care as defined at national level and also income replacement during periods of sickness, provided equally to all in need. Hence, in order to establish effective health protection and address gender inequities, inclusive and gender-sensitive legal health coverage is needed as a prerequisite for access. Gaps and deficits in legal health coverage due to political, legislative and administrative failures have to be addressed by applying a rights-based approach and ensuring that women’s needs are sufficiently taken into account and nobody is left out. Irrespective of the financing subsystem to which they belong, vulnerable population groups such as informally employed women in rural areas need to be legally covered in order to protect them from impoverishing OOP.

As to the scope of the benefit package and the level of financial protection, the aforementioned examples have shown that women are often excluded from health care services either because necessary treatments, prescription medicines or other important health care services are not covered or because cost-sharing through co-payments or extra fees is required. Hence, comprehensive benefit packages that include gender-specific services such as maternity care are necessary to financially protect women, as is the abolishment of any additional costs. Since minimal costs can act as barriers to access, women also need to be protected against economic losses from reductions in productivity and earnings, particularly during maternity.
Chapter: 2

Many countries have developed mixed financing mechanisms to generate stable revenues, large risk pools and reach out to vulnerable population groups. Regardless of which financing mechanisms are chosen to generate sufficient resources, minimizing OOP through pre-payments and risk pooling is crucial when addressing gender inequities in health protection. Taxes, contributions and premiums should thereby only be charged according to the capacity to pay. The shares of OOP and catastrophic health expenditure in percent of total health expenditure can thereby be used to assess the levels of affordability and financial protection in a given country (Scheil-Adlung/Bonnet, 2011). Recently, several countries in Africa, Asia and Latin America (e.g., Ghana, Mexico and Thailand) have embarked on approaches that involve government subsidization of contributions of those unable to pay as a means to reach out to the poor and informally employed. Such schemes may be considered when expanding health protection to informally employed women, particularly those living in rural and urban slum areas.

3.2. Increasing the availability of acceptable health care services through the deployment of adequate numbers of health workers

Due to higher health needs than men during the life course, significant gaps in the funding of health services affect women disproportionately and ultimately cause gender inequities. ILO estimates that currently $239 US per capita health expenditure (without OOP) are needed to provide quality health care services for all in need (ILO, 2014). Countries with per capita health expenditures below this threshold generally face financial deficits and exclude parts of their populations from accessing health care. The current financial deficit in low-income countries exceeds 90 percent of necessary expenditure to cover the costs of at least essential health care (ILO, 2014). Such gaps considerably reduce women’s access to health services. Hence, developing fiscal space to close such gaps in the respective countries must be a priority, e.g., through increasing tax revenues, introducing new sources of funding, and establishing a more accommodating macro-economic framework. Improvement in terms of quality and availability of health care services will encourage women to seek care in the public sector and protect them from incurring higher costs in the private sector, or from seeking no treatment at all (Onah et al., 2014, p. 9). In this context, the cost of women-specific services such as delivery in private health centres should be regulated to increase the availability of services and reduce OOP (Mohanty/Srivastava, 2013, p. 260).

The availability of acceptable quality care for women entails a sufficient number of skilled health workers for service delivery as well as adequate funds, e.g., for drugs and infrastructure. ILO estimates that 41.1 health workers per 10,000 population are necessary to provide at least essential services to all in need (ILO, 2014). In addition to the deployment of adequate numbers of health workers, decent working conditions need to be ensured. Against this background, the ILO Nursing Personnel Conventions 149 and 157 articulate the working conditions needed to address some of the problems many countries are facing. These include remuneration, career perspectives, education and training, as well as the adaptation of occupational safety and health regulations to nursing work. Particularly, the often close-to-poverty wages of health workers would need to be addressed if progress towards universal health coverage is to be achieved. Moreover, since women in more traditional areas would need or prefer female doctors, gender needs to be considered as a dimension in human resources planning to enhance health seeking behaviour and utilization of health services (Exavery et al., 2013, p. 8).

3.3. Tackling the causes for gender inequities beyond the health sector

As is the case with health protection, other social protection systems such as income support systems for the poor and unemployed, pension schemes for the elderly, allowances, education and housing often contribute to enhance gender inequities within society. This is particularly due to structural barriers of employment-based schemes that are based on the assumption of formal and long-term employment and the provision of wage-related benefits and are thus not appropriate for women who worked to be addressed if progress towards universal health coverage is to be achieved. Moreover, since women in more traditional areas would need or prefer female doctors, gender needs to be considered as a dimension in human resources planning to enhance health seeking behaviour and utilization of health services (Exavery et al., 2013, p. 8).

Finally, effective access to health care requires good governance of schemes and systems. Monitoring, feedback and participatory processes such as social and national dialogue can increase policy coherence, accountability and inclusiveness within a multi-stakeholder approach that addresses gender inequities within and beyond the health sector.
4. Conclusion

As defined by ILO Recommendation 202, universal coverage in health requires taking into account both legal health coverage and the effective enforcement and implementation of the laws in terms of availability, accessibility, acceptability and quality (AAAQ) (ILO, 2012). Only if these criteria are sufficiently taken into account, effective and equitable access can be provided. Even though women’s health has considerably improved during the past decades, gender inequities remain persistent across countries. The specific needs of women are often not reflected in national legislation or expressed in affiliation to a health system or scheme. Inequitable access to formal employment, the limited scope of benefit packages and the many cost-sharing requirements for women-specific health care services such as facility-based maternity care result in higher OOP for women with often impoverishing effects. In addition, many women, particularly those living in rural areas, are not able to access health care services due to the unavailability of health care facilities and the deficits in skilled health workers. Geographical barriers as well as opportunity costs such as time and income often prevent these women from seeking care elsewhere. Health protection policies aiming at reducing gender inequities need to financially protect women against expenditures incurred when accessing health care including transport costs and economic loss experienced due to reductions in earnings, particularly during maternity. A rights-based approach is required to address gaps and deficits in legal health coverage. This entails the provision of comprehensive benefit packages that include women-specific services as well as a meaningful reduction of formal and informal OOP. Furthermore, investments in the infrastructure and health workforce are needed and should take gender aspects into account in order to provide accessible and acceptable health care services for women. Health protection policies need to be part of a broader policy framework that tackles structural barriers of employment-based schemes and that ultimately aims to improve education and income opportunities for women (in the formal sector) through a coherent multi-sectorial approach.
References


Violence Against Women and Girls: Economic Costs and Health Impacts

Nata Duvvury, Patricia Carney and Aoife Callan

A fundamental marker of the degree of gender discrimination in any society is the prevalence of violence against women and girls. The Convention on the Elimination of All Forms of Discrimination, UN Declaration on Elimination of Violence Against Women, The Beijing Platform of Action, and the UN Secretary General’s 2006 Report on Violence Against Women have all repeatedly affirmed that the violence experienced by women and girls is an expression of gender inequality and discrimination and a fundamental human rights violation. Equally important is that violence has significant costs in terms of health and well-being, social and intergenerational stability and cohesion, and in terms of the economy. However, much of the research and discourse on violence against women has framed the issue as a rights violation and a public health issue. Attention to the economic implications of violence has been sparse and less clearly articulated.

We argue in this paper that the economic impacts are important to consider given the significant costs that families, communities and societies at large incur. We will consider the main impacts of violence on women’s and girls’ economic participation and their health status. We will review some of the key methodologies used, studies that have attempted to develop monetary estimates, and discuss some of the challenges involved, particularly around estimation of intangible costs. We suggest a framework for low- and middle-income countries and present the results of one study in Vietnam. We conclude with a discussion of the incompleteness of data information systems of health systems to track the response of the health system, raising questions about its accountability in fulfilling the right to health for all.

Section 1: Prevalence of violence against women and girls

Violence against women and girls is faced by women throughout the life course—from sex-selective abortion to infanticide to early marriage to partner violence to elder abuse—involving a wide variety of perpetrators, from intimate partners and family members, to strangers to institutional actors such as police, teachers and soldiers (UN, Secretary General, 2006). Among these multiple forms of violence, partner violence is the most pervasive form of gender based violence experienced by women and girls. A summary statistic commonly cited is that nearly one out of every three women globally has experienced psychological, physical or sexual partner violence during their lifetimes (Heise, Ellsberg and Gottemoller, 1999). In fact, a WHO meta analysis of studies on prevalence of physical and sexual violence by a partner suggests that at the global level, 30 percent of women have experienced physical and/or sexual violence by a partner (see Table 1 below). The evidence clearly indicates that intimate partner violence is a global phenomenon, that there is surprisingly little variation across regions, and it does not fall below 23 percent even in high-income countries.

Table 1: Lifetime prevalence of physical and/or sexual violence by an intimate partner among ever-partnered women

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Prevalence %</th>
<th>95% CI %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low- and middle-income regions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td>36.6</td>
<td>32.7 to 40.5</td>
</tr>
<tr>
<td>Americas</td>
<td>29.8</td>
<td>25.8 to 33.9</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>37</td>
<td>30.9 to 43.1</td>
</tr>
<tr>
<td>Europe</td>
<td>25.4</td>
<td>20.9 to 30.0</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>37.7</td>
<td>32.8 to 42.6</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>24.6</td>
<td>20.1 to 29.0</td>
</tr>
<tr>
<td>High income</td>
<td>23.2</td>
<td>20.2 to 26.2</td>
</tr>
<tr>
<td>Global</td>
<td>30.0</td>
<td>27.8 to 32.2</td>
</tr>
</tbody>
</table>

Source: WHO, 2013

In addition to violence in the home, women and girls experience physical and sexual violence in public places. There are a limited number of studies that have focused on collecting data from women and girls on their experiences of...
violence outside the home. The WHO meta-analysis of such studies found that non-partner sexual violence ranges from a low of 4.6 percent in Southeast Asia to about 12 percent in high-income countries.

Table 2: Lifetime prevalence of non-partner sexual violence by WHO region

<table>
<thead>
<tr>
<th>WHO region</th>
<th>Prevalence, % (a)</th>
<th>95% CI, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low- and middle-income regions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td>11.9</td>
<td>8.5 to 15.3</td>
</tr>
<tr>
<td>Americas</td>
<td>10.7</td>
<td>7.0 to 14.4</td>
</tr>
<tr>
<td>Eastern Mediterranean (b)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Europe</td>
<td>5.2</td>
<td>0.8 to 9.7</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>4.9</td>
<td>0.9 to 8.9</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>6.8</td>
<td>1.6 to 12.0</td>
</tr>
<tr>
<td>High income</td>
<td>12.6</td>
<td>8.9 to 16.2</td>
</tr>
</tbody>
</table>

Source (WHO, 2013)
CI = confidence interval
(a) Results adjusted for interviewer training, whether the study was national and whether response options were broad enough to allow for different categories of perpetrators or were limited to a single category of perpetrator.
(b) No data were found for countries in this region, therefore a prevalence estimate is not provided.

While regional estimates highlight violence against women and girls as a universal problem, it is a problem of extreme magnitude in less developed countries. A recent study in Uganda and Bangladesh reported that more than 80 percent and 94 percent of women surveyed respectively had experienced physical, sexual or psychological violence at some point in their marriage/intimate relationship (ICWR, 2009). Women and girls are at increased risk of violence in conflict, disaster and humanitarian contexts; several studies indicate a significant and substantial increase in partner violence following disasters persisting for several years past the event (Sety, 2012). Widespread rape has been documented in the Democratic Republic of the Congo, Bosnia and Rwanda, leaving a legacy of violence long after the conflict has ended. This level of violence affecting a significant proportion of women globally has enormous costs for women and girls, households, communities and societies at large. Researchers are beginning to unpack these costs, though much of this work has been done in high-income countries in Europe and North America. In terms of the Global South, the research thus far has been extremely limited given the complexity of methodologies of estimating costs. In this paper we discuss the results of a costing exercise undertaken in Vietnam, which is the first of its kind in the literature as it deployed a specific module on costing. The results suggest that violence has significant costs to the economy.

Section 2: Impacts of violence

Health Impacts

The health impacts of violence experienced by women and girls are multi-fold, ranging from fatalities to non-fatal injuries to chronic morbidity to poor mental health. Fatalities as a result of intimate partner violence (IPV) include deaths by homicide or suicide, and result in significant economic cost to society of premature mortality. Approximately 38 percent of all murdered women across 65 countries were killed by an intimate partner, compared to just 6 percent of men during the period 1982 to 2002 (WHO, 2013). Of the women experiencing abuse in the United States nearly 50 percent are physically injured by their partners (Sheridan and Nash, 2007). In the WHO (2013) meta-analysis, 41 percent of women who experienced IPV reported injuries. The resulting impacts of such non-fatal injuries include the well-documented increased health and social care utilization as well as possible ongoing physical and psychological impacts such as disfigurement, disability, chronic pain and stress.

In addition, studies across developing countries conclude that the health impacts of violence can be as significant as some of the leading causes of injury, with the impacts on reproductive health considered particularly significant (Morrison and Orlando, 2004). The stress and trauma of living with IPV during pregnancy has serious implications for maternal health, fetal development, birth weight and obstetric complications (Altarac and Strobino, 2002; Bacchus et al., 2004). The WHO meta-analysis indicates that women experiencing IPV had a 16-percent higher odds ratio of having a low-birth-weight baby (WHO, 2013).

Furthermore, a growing body of research recognizes that IPV heightens women’s vulnerability to HIV or STIs, with research beginning to shed light on the complexities of the relationship between IPV and ST/HIV infections (Garcia-Moreno and Watts, 2000; Campbell et al., 2008). While the prevalence of IPV and HIV infection among women varies globally, Campbell et al. (2008) infer that compared to men, women remain at an increased risk of both IPV and HIV and STIs. Sub-Saharan African studies undertaken in South Africa, Tanzania and Kenya found that HIV-positive women reported more lifetime partner violence than HIV-negative women (Campbell et al., 2008). However, the relationship is complex and causality is difficult to determine.

Economic impacts

The relationship between IPV and employment is complex. Employment is protective on one hand and likely to increase risk on the other hand. Several studies suggest that employed women are less likely to report experiencing violence than those who are unemployed (see Vyas and Watts, 2009; Villareal, 2007). It is equally true that women experiencing violence are more likely to work: two separate analyses of both the National Violence Against Women Survey and National Crimes Victimization Survey data for 2004 in the
United States indicated that women experiencing violence had a 10-percent higher employment level than non-abused women (Farmer and Tiefenthaler, 2004a; Farmer and Tiefenthaler, 2004b). This trend is confirmed in several studies in developing country contexts, including Latin America, Haiti and Zambia (Aguero, 2012, and Morrison and Orland, 2004). In Latin America, it was concluded that divorce was the mediating factor for the increased likelihood of being employed (Aguero, 2012). However other research has concluded the opposite—women experiencing violence are less likely to be employed (Meisel et al., 2003; Romero, et al., 2003). Many of these studies are cross-sectional and unable to establish causality. A recent randomized control trial of women in the flower industry in Ethiopia does suggest that employment opportunities for women may increase violence as men feel “threatened” by the autonomy earned by their wives (Hjort and Villanger 2012, cited in Aguero, 2012).

The complexity of the relationship between employment and violence may also be in part explained by the fact that there are both short-term and long-term ripple effects of violence. The few studies that have analyzed longitudinal data or panel data suggest long-term impacts on employment status, annual work hours, and job turnover (Tolman and Wang, 2005; Lindhorst et al., 2007; Staggs, et al., 2007; Crowne, et al., 2011). For example, a study of young women who had experienced violence in the late adolescent years found that these women were less likely to be employed four to five years later (Lindhorst et al., 2007). This pattern was confirmed by another study by Crowne et al. (2011) that women with children and experiencing physical violence had lower employment stability both concurrently (experienced violence in the past 12 months) and over the long term (experience of violence at time period 1 resulted in lower employment stability six years later). The authors conclude that, while IPV has a negative effect on employment stability, it has more of a medium-term effect than long-term; women reporting IPV prior to six years did not have increased employment instability. The authors conclude that depression is the key mediating factor accounting for 24 percent of the effect between IPV and long-term employment stability.

The pathway between violence and employment through trauma reflected in poorer mental health status is true not only for physical violence but also for sexual and psychological violence. Psychological violence and its impacts have been rarely explored, but one study in California suggests that psychological violence was a stronger predictor of unemployment than physical violence, largely through the effects of psychological violence on post-traumatic stress disorder (PTSD) (Kimerling et al., 2009). The role of trauma in labor market outcomes for sexual violence has also been explored. Sabia et al. (2013), using data on 8,273 young women from the US National Longitudinal Study of Adolescent to Adult Health (involving three repeated surveys between 1995 and 2008), conclude that sexual violence results in a 6.6-percent decline in labor force participation and 5.1 percent decline in wages. They suggest that between 18 percent and 31 percent of the association between sexual violence, labor force participation and wages, respectively, is explained by stress-related adverse psychological and physical consequences.

Section 3: Macro-costs of VAWG

The multitude of health and employment impacts of violence on women and girls suggest that these translate into significant macro-costs for societies across the globe given the high prevalence of violence. Many of these consequences of violence against women and girls can be classified into four distinct categories of costs—direct tangible, indirect tangible, direct intangible and indirect intangible. Direct costs are those incurred that are directly related to violence whilst indirect costs represent the "opportunity cost" of violence, i.e., the value of lost productivity. Tangible costs have a monetary value and intangible costs are non-monetary in nature.

Examples of each of the four types of costs are:

- **Direct tangible costs**—transport costs for getting to and from hospital; and expenditures on e.g., provision of medical care and other support services.
- **Indirect tangible costs**—the loss of earnings from both paid and unpaid work and includes loss of lifetime earnings resulting from mortality due to violence.
- **Direct intangible costs**—pain, suffering and emotional loss of a loved one through a violent death.
- **Indirect intangible costs**—negative psychological effects on children who witness violence.

Meta reviews of costing studies have identified several distinct approaches or methodologies to measure the costs of violence against women and girls (Duvvury, et al., 2004; Morrison and Orlando, 2004; Day et al., 2005; Willman, 2009). The key methodologies for cost estimation are:

1) **Direct accounting methodology**: This method estimates direct tangible costs. The accounting methodology is an approach used in most studies to establish the direct cost of service provision (Greaves, et al., 1995; Heiskanen and Piispa, 2002; Access Economics, 2004). The basic methodology involves estimating a unit cost for different services (p,) the utilization rate by women for each service (u), multiplying the two derived costs for service and aggregating the cost for all services. This same logic can be applied to estimate out-of-pocket expenditures of women for accessing services.

Advantages of the accounting methodology are that it is straightforward and less data-intensive than other methods. It is a useful approach to establish a quick and approximate...
estimate based on available data and simple assumptions. A limitation of this method, however, is that it requires data, which are often not available, particularly in low- and middle-income countries. Another limitation is that time frames may not be consistent when depending on unit costs from other studies. Further, it is not possible to capture long-term costs with this method, and it has the potential for double counting. In terms of double counting there may be overestimation if the full cost of services is applied rather than the proportion of service cost due to violence.

2) Human capital approach: This approach is used to measure indirect tangible costs due to IPV associated with lost time in the labour market, premature mortality and disability. The productivity loss due to IPV is most commonly calculated by multiplying the incidents of IPV that result in missed paid work by the average number of days missed per incident to yield an estimate of the total person days lost. The total person days lost is then multiplied by the mean daily wage rate to estimate the monetary value of lost productivity due to IPV (CDC, 2003). However, a more challenging task is to estimate the productivity loss of unpaid work, such as household tasks and caring for family members, due to IPV. To estimate this loss, studies have used time use surveys that ask individuals the amount of time they have spent on certain domestic tasks such as fetching water/firewood, and then multiplying this by the average market wage rate. For example, a study in Vietnam found that, on average, each woman lost almost $20.00 US per violent incident that resulted in days off paid work. By using the same average market wage rate, the value of domestic or unpaid work lost was valued at approximately $26.00 US per violent incident that resulted in days off domestic/household work (Duuvury et al., 2012).

To estimate the productivity loss due to premature mortality, studies have used information on incidence of fatalities due to violence, average age of death resulting from violence, average age at retirement and average wage rate. Using this method a study in Brazil found the loss to the overall economy resulting from fatalities due to interpersonal violence amounted to approximately $550 million US in 2007 (Butchart, et al., 2008).

A limitation of human capital or present value of lifetime earnings approach is the intensive data needed, including dedicated costing surveys that require adequate sample sizes and detailed data on average earnings by age, sex and occupation that may or may not be routinely or systematically collected.

3) Econometric approaches: Econometric methods, e.g., regression modelling and propensity score matching methods (PSM), can be used to estimate direct and indirect intangible costs. Studies have used regression modelling to estimate the impact of IPV on labour market outcomes such as labour force participation and women's earnings. Estimating the impact of IPV on women's earnings is, however, challenged because of women's "self-selection" into employment, i.e., that, independent of their experiences of violence, women who pursue paid work may be fundamentally different from women who choose not to pursue paid work—a difference that if not accounted for can yield biased estimates. To correct for this difference, studies have used reduced earnings equations. This involves first estimating the probability a woman is employed and then in the second stage, modelling women’s wages as a function of IPV and therefore, accounting for women’s self-selection into employment in the initial instance. This method was applied to data from a study in Managua, Nicaragua and found abused women's earnings were 46 percent lower than non-abused women's earnings (Morrison and Orlando, 1999).

A second econometric approach is propensity score matching (PSM), which can be used to establish the direct and indirect intangible costs due to violence against women and girls. The method uses probability models (e.g., logit or probit) to estimate for each woman her probability of experiencing violence (the propensity score). Each abused woman is then matched with a woman who has never been abused based on the degree of similarity in the estimated propensity score. Outcomes such as wages can then be compared between matched abused and not-abused women to establish an unbiased difference in outcome (effect-size) between the two groups (Vyas & Heise, 2014).

Using data from the Tanzania National Panel Survey, Vyas (2013) found that weekly income was 29 percent lower among currently abused women compared to women who had never been abused—a figure that rose to over 40 percent when considering severe abuse. In Haiti, Peru and Zambia, Morrison and Orlando (2004) found greater adverse outcomes among abused women on their sexual and reproductive health and their children's health. For example, in all three countries, a higher proportion of abused women had either contracted sexually transmitted infections or suffered from genital sores, and in Peru a higher proportion of abused women experienced complications during delivery. Children of abused women were more likely to suffer diarrhea (Peru) or anemia (Haiti).

4) Willingness-to-pay or -accept/contingent value methodology: This methodology has been used to estimate the direct intangible cost of long-term pain and suffering. The willingness-to-pay estimates are based on values that workers (or consumers) place on small risks of injury or death, whereas willingness-to-accept estimates are based on actual jury awards for identified individuals who were injured. The latter method has been used in high-income market economies with developed jurisprudence on damages in road accidents, medical malpractice, and so on. Walby (2004) applied the willingness-to-pay estimates determined by the UK Department of Transport in terms of reducing the risk of suffering injuries and fatalities from automobile accidents. She relied on work developed by Brand and Price (2000) to estimate the willingness-to-pay to avoid certain types of violent crimes. Essentially, she matched injuries and trauma from domestic violence including rape and stalking to the
common crimes listed by Brand and Price and applied their estimates of willingness-to-pay to estimate the monetary cost of pain and suffering due to domestic violence. Miller et al. (1996) used jury awards in civil litigation to determine the willingness to accept compensation for pain, suffering and loss of quality of life due to fatal and non-fatal outcomes.

The limitation of both willingness-to-pay and willingness-to-accept is that they require significant amounts of data collection and make assumptions regarding the similarity of duration and intensity of trauma from IPV and other violent crimes. Given the lack of willingness-to-pay or -accept surveys focused on IPV, studies using this methodology make assumptions about comparability of risk. Also, the application of the methodology is limited in many low- and middle-income countries because violence is often considered a socially accepted phenomenon and because market-based valuation of life, i.e., life and other types of health insurance, are undeveloped.

5) Disability adjusted life years (DALYs): This method, used in health economics, measures the years of life 'lost' due to death, disability and chronic morbidity—a way to measure direct intangible costs of pain, suffering and loss of quality of life as result of IPV or NPSV. It is particularly useful to establish the health burden of IPV relative to other health conditions such as heart conditions, cancer, etc. For example, a study in Mexico City indicated that IPV was the third most important source of DALYs for women (Lozano, 1999). A study in Australia suggested that, for women aged 15 to 44, IPV was a leading contributor to death, disability and morbidity (VicHealth, 2004).

An issue with DALYs, however, is the lack of any systematic method to translate them into monetary costs. For example, Access Economics (2004) used a method ascribing value to a statistical life and from this deriving the value of a life year and applying this to disability adjusted life years to convert DALYs into dollar terms. The limitation of this methodology is similar to the willingness-to-pay/accept compensation methodologies in that it is extremely data intensive and methodologically complex.

6) Gender Responsive Budgeting (GRB): This methodology can be used to estimate direct tangible costs of violence against women and girls. Some recent studies in the past five years have focused explicitly on assessing resource requirements for implementation of national laws or national action plans (UN Women, 2013). These studies have employed GRB, which involves assessing budgetary allocations to sectorial stakeholders in service delivery. The methodology involves a) mapping services that need to be provided as part of the legislation and policies in each country, b) identifying existing services currently being provided, c) identifying the services used by women through mapping their help seeking behaviour, d) identifying government allocations for programmes addressing violence against women and girls from national to local administrative authority and e) assessing the monetary flow to local services. The GRB methodology is particularly useful for estimating the cost of service provision in the absence of proper data with service providers on the ground, which could be the case in countries emerging from conflict.

Section 4: Framework for Global South

Despite the numerous methodologies, undertaking costing of IPV is particularly difficult in low- and middle-income countries due to social and economic reasons. Social norms of acceptability of IPV create a culture of silence on IPV, resulting in low disclosure, lack of services, minimal utilization of available services, and inadequate information systems (Duvvury, Grown and Redner, 2004). The economic structure of low- and middle-income countries also creates challenges for cost estimation. For example, the informal economy predominates economic activity, formal labour markets are less developed, and there is little value assigned to subsistence production. According to the International Labour Organization employment data, in developing and transitional economies, informal sector jobs comprise one-half to three-quarters of all non-agricultural employment. An implication of the dominance of the informal economy is that often the household is a site of both production and reproduction. The extent of informal and unpaid household production makes it difficult to assign appropriate and accurate values to lost and reduced output and productivity as a result of violence against women (Duvvury, et al, 2004).

A framework is needed to account for these differences. Existing cost studies have focused on aggregate costs building on costs of service provision. For low- and middle-income countries, determining national aggregate costs is highly problematic given both the lack of attention to IPV, lower level of service provision, and inadequate information systems. A better starting point for cost estimation is the household level given the centrality of the household as a site of production and reproduction. Focusing on losses at the household level would resonate with households, communities, and national policymakers because it would highlight the implications for poverty—a central concern of these economies—as well as the lack of a policy framework and information systems.

An operational framework relevant to low- and middle-income countries would therefore focus on the direct or imputed value of goods and services: (1) used to prevent and respond to IPV; and (2) that are lost by households, community-level entities, and businesses as a consequence of IPV. The community-level entities, or service providers, could be either government or non-government. Non-monetary costs such as behavioural impacts, health impacts, or inter-generational transmission of violence are not considered given the lack of applicability of existing methodologies to low- and middle-income countries. The specific costs included in the framework at the household level are out-of-pocket expenditures by the household for utilization of services, income loss due to missed work, and imputed value of missed
household work by members of the family. The framework utilizes the accounting and econometric methodologies to establish the magnitude of these specific costs.

Section 5: Vietnam Costing Study

Context

In Vietnam a costing study was undertaken in 2012 using the framework outlined in the previous section. Vietnam is a deeply patriarchal society with traditional outlook on gender relations, based on an interweaving of Confucian and Buddhist traditions. In both traditions women are perceived as the guardians of familial relationships with a primary duty to maintain harmony within the family (Vu Song Ha, 2002; Ghuman, 2005; Mia et. al., 2004; Rydstrom, 2006). Women often internalize norms to ‘save face’, are sexually available regardless of their own wishes, accept that men are naturally angry as they have ‘hot’ blood, and justify violence to ‘correct’ women’s behaviour. (GGSO, 2010)

The first national survey on domestic violence against women was implemented in 2009 with a nationally representative sample of 4,838 ever-partnered women of the ages of 18-60 (GGSO, 2010). More than half—58.3 percent—of the surveyed women reported experiencing at least one form of physical, sexual or psychological violence, with 27 percent experiencing at least one type in the last 12 months. The study confirmed that experience of violence cut across the main regions of Vietnam, rural/urban divide, educational level, socio-economic status and ethnicity.

Official data on the extent of domestic violence provides evidence of the severity of violence experienced by women within the family. Seventeen to 20 percent of murders between 1994 and 1997 were domestic violence-related murders, according to a study by the World Organisation Against Torture or Bourke-Martignoni (2001). A study by the Institute for Family and Gender Studies (IFGS) reported that between 1998 and 2000, the proportion of divorces granted that the courts due to domestic violence ranged from 52 to 63 percent of all cases (IFGS, 2008). Women need to have experienced repeated and severe physical violence for divorce to be granted, as violence by a partner is not an explicit ground for divorce per the Law on Marriage and Family. Moreover, the primary response to violence is compulsory conciliation, a long and complex process that is required before a divorce case can proceed in the court system. Given this context, the high number of divorce decrees due to domestic violence underscore that a significant proportion of women face extensive violence within marriage.

Methodology

The costing study in Vietnam involved a population-based survey of 1,053 women, aged 18 to 49 across seven sites (4 provinces and 3 central cities) that were identified from the GSO national study as regions/provinces with high levels of partner violence. Drawing on the support of the Women’s Union, specific district, communes and wards in each district, and households were identified. A random sample of 15 households classified as ‘rather harmony families’ and 15 households ‘known to have conflicts’ in each commune/ward was drawn using lists of households compiled by Women’s Union in the selected communes/ward in each district.2 A specific module was developed to explore in detail the costs incurred after a specific incident of violence focussing on direct monetary costs of out-of-pocket expenditures for accessing services and the indirect costs of missed paid days of work and missed time for household tasks. Additionally, to understand the costs at the community level, service providers in the selected provinces, districts, and commune/wards were interviewed for information on the resources spent to respond to and prevent violence. Representatives of primary health facilities, district hospitals, police stations, district courts and Women’s Union offices were interviewed. Specific questionnaires for each type of service provider were used to gather information on the number of female violence survivors accessing the service, the cost of time spent on providing support to the survivors, the time involved in referrals to other services, the expenses incurred for developing protocols and training staff, and the resources allocated for prevention programmes.

Using the accounting methodology, the direct and indirect costs for households were estimated for the sample and extrapolated to the population using the prevalence rate for any partner violence in the last 12 months given in the 2010 GSO study. The cost of service provision could not be estimated given the lack of data provided by service providers. Additionally, productivity loss for the economy was estimated using two-step OLS regression on earnings. The instrumental variable used was the number of quarrels, as it was expected that while this variable was related to violence it would have no relation to earnings.

Results

1. Prevalence

The results indicate a high prevalence of partner violence—63.7 percent of the surveyed women reported experiencing at least one behaviour of psychological, physical or sexual violence ever in their lifetimes and 39.3 percent reported experiencing at one behaviour in the past 12 months. These figures are higher than the overall prevalence reported by GSO of 58.2 percent for lifetime and 27 percent for past 12 months.3

2 As Vietnam has a national policy of ‘happy families’, Department of Family Welfare has encouraged Domestic Violence Prevention Committees to monitor families that are considered high risk or in conflict families. Families not at risk of violence are considered as rather harmony families.

3 The age range of women was different in the two studies—18-49 in this study compared to 18-60 in the GSO study. Moreover this study because of its focus on costs had two sampling frames of women likely to experience violence and those not where GSO selected randomly from a general sampling of women in the age range.
All types of violence—psychological, physical and sexual violence—were high in the past 12 months across rural and urban areas. Women also reported that the acts of violence were experienced multiple times involving multiple forms of violence. Nearly 35 percent of the sample reported experiencing all three types of violence in the last 12 months; 41.3 percent experienced two types (psychological and physical the majority).

In terms of relationship of violence with education, employment and wealth of the household, the results were complex. Overall violence (ever or current) did decline with education, employment and wealth as expected in the international literature. However, there was an interesting variation in terms of sexual violence, which showed no statistically significant relationship with any of the three variables. This potentially reflects the fundamental feature of sexual violence, as it is more hidden and ‘behind closed doors’ and rooted in male privilege.

2. Costs of Violence
Women who experienced violence in the past 12 months reported experiencing at total of 3,690 incidents. The average number of incidents per woman comes to 8.89 incidents in a year. Women gave detailed information on a total of 1,041 incidents in the past 12 months. For each type of cost, the actual costs were averaged across the number of incidents for which costs were reported.

Out-of-pocket expenditures for women were particularly high in terms of medical treatment after an incident of violence and replacement of property damaged as a result of violence. Women incurred an expenditure of approximately US $38 per incident to access healthcare including medicines, fees and transport in about 7 percent of incidents. Expenses for replacement of property were incurred more frequently with an average expense of $16 in about 15 percent of incidents reported. The physical devastation of violence in the home was visible, involving damage to furniture, broken utensils, broken phones, and damaged walls, but not widely recognized as cost. In line with the limited services available and the greater shame in reporting incidents of violence to formal institutions, only a very few incidents (less than 5 percent of the reported incidents) involved costs for reporting to police and formal courts. Interestingly, in nearly 7 percent of incidents women left home for some time and those who stayed in hotel accommodation (10 women) incurred an average cost of US $117 per incident. Weighted average cost across all incidents for the different types of costs came to $30 per incident. The overall out-of-pocket expenditure was approximately 21 percent of women’s monthly income.

The indirect costs were also significant. Women reported missing nearly 5.5 days of paid work per incident and about 33 hours of housework. This resulted in an average monetary cost of US $20 for paid work and US $26 for household work. Surprisingly, women reported that in 7 percent of the incidents men also missed work for about 6.5 days on an average amount to US $18 per incident.

4 The lower value of men’s missed work likely reflects the men who missed work were from a lower socio-economic status. This needs further probing.
3. Macro-costs

Using these basic costs per incident, the current prevalence rate provided by the GSO for physical and sexual violence (10.9 percent) and the incidence rate of 889 per thousand women the macro-cost for the economy was estimated. The indirect costs were significantly higher than the out-of-pocket expenditures. Together the overall costs to the household economy are significant and equivalent to about 1.41 per cent of GDP of Vietnam in 2010.

In addition to these costs, the analysis of productivity loss indicated that women facing violence earned 35 percent less than women not facing violence. This was quite similar to results of an earlier study in Chile and Nicaragua that indicated the gap in earning to be about 34 percent and 46 percent respectively (Morrison and Orlando, 2004). This earning loss is a way of measuring productivity loss as it encompasses the effects of employment instability, the loss of focus and concentration, and lower human capital accumulation, as discussed in the section on economic impacts. The earning loss of 35 percent in fact represents a significant productivity loss for the economy as a whole. Using the earnings gap, the prevalence of violence, and labour force participation rate of Vietnamese women, the projected cost comes to about 1.78 percent of Vietnam’s GDP in 2010.

This estimate is only partial as the direct costs of service provision have not been included nor the cost of suffering, pain and loss of quality of life. While the study did not attempt to estimate the indirect costs of pain and suffering, an attempt was made to capture direct cost of service provision. However, a key finding of the study was that most of the services do not have systematic records of violence cases, most of the service providers do not have a detailed idea of the costs involved in providing the service, and a majority had no idea of operational budgets for the facility.

### Implication and Conclusions

Costs of violence against women and girls are indeed quite significant for an economy of low- and middle-income countries. The results discussed in this paper demonstrate that costing is possible even in contexts with limited information through the use of surveys with women. However, there are also significant challenges involved in costing in developing country contexts. The first is the difficulty in establishing intangible costs of pain, suffering and loss of quality of life due to lack of adequate methodologies. Second is the lack of data to establish costs of service provision. Many service providers (particularly health and police) do not have proper information systems either because women do not report or, in the case of police, women are encouraged to negotiate the violence within the family itself. Additionally for many service providers it is difficult to differentiate what costs are involved as often the response to violence is integrated into ongoing work, making it difficult to disentangle the time devoted to partner violence. Another challenge is that the culture of under-the-table payments by service users disguises the actual costs.

### Table 3: Macro-estimate of Costs of Domestic Violence

<table>
<thead>
<tr>
<th>Unit Cost (000 VND)</th>
<th>Total Incidents</th>
<th>Total Costs (billion VND)</th>
<th>Percent of GDP (2010)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-pocket expenditure</td>
<td>600/incident</td>
<td>19812268</td>
<td>11887.3608</td>
</tr>
<tr>
<td>Lost earnings paid work (total)</td>
<td>888,219</td>
<td>19812268</td>
<td>13651.1793</td>
</tr>
<tr>
<td>Women</td>
<td>382.234</td>
<td>19812268</td>
<td>7572.9224</td>
</tr>
<tr>
<td>Men</td>
<td>305,985</td>
<td>19812268</td>
<td>6062.25688</td>
</tr>
<tr>
<td>Value of missed housework</td>
<td>501,525</td>
<td>19812268</td>
<td>10051.59</td>
</tr>
</tbody>
</table>

Source: Duvvury, et al. (2012)

(a) GSO (2012) National Accounts, Key Characteristics
involved in service provision. Finally, service provision is often based on volunteerism, with service providers incurring out-of-pocket expenditures to assist women and girls to access services (UN Women, 2013).

In other words, in many low- and middle-income countries, inadequate budget for responding to violence undermines effective response to violence. But this situation of lack of funding/insufficient budget is not limited to the Global South. A recent study of health system response in Spain found "... it was not possible to get information regarding the budget allocated to IPV activities within the health system. This could be a sign of the fact that such programs face uncertain and poorly established funding channels within the health systems" (Goicolea, et al., 2013:15).

Inadequate budgetary resources for addressing violence has profound implications for the accountability of government and the key duty bearers within health, law enforcement and justice systems for ensuring women and girls' right to safety and right to health. Health equity requires not only conceptual understanding of the interaction between gender and health status, but also adequate allocation of resources. As long as health managers think along the following lines, "Every day I have 10 deaths due to cardiovascular diseases, so you can understand I am going to allocate very little money to gender based violence" (Goicolea, et al., 2013:7), there is little hope for ensuring the right to health for all is fulfilled and that gender inequity is addressed.
References


Eight out of ten of the world’s poorest countries are suffering or recently suffered from violent conflict. Poverty, political, and socioeconomic inequalities between groups serve as predisposing factors for conflict; whilst wars aggravate poverty, under-development and ill health, and work to the detriment of all groups.

The incidences of violent conflict have been on the rise since the 1950s, with most taking place within states. Despite a “cultural” dimension to these conflicts, including ethnic polarization and the fallout from boundaries set by former colonial powers that have divided culturally similar social groups, the underlying causes of violent conflict are most often economic ones. At the receiving end of most contemporary conflicts, however, are civilians; conflicts have shifted from fighting between conventional armies to intra-state action between disaffected groups. Political and socio-economic factors, including extreme poverty, economic stagnation, poor government, high unemployment and environmental degradation act as triggers for polarization and conflict. (Stewart, BMJ 2002).

Women and Girls

In most conflict zones the rape of women and children is increasingly used as a weapon of war. Because of stigma, shame and the fear of incurring greater harm of reporting any form of abuse, we may never know the true extent of this problem (WHO, 2013). But the relationship between gender and conflict goes well beyond gender-based violence.

Conflicts exacerbate discrimination such that women and girls often pay the highest price. Recent conflicts in the MENA region (Iraq, Syria), for example, highlight widespread trafficking, forced marriage and pregnancy, and prostitution. These cases also highlight the dangers and risk women and girls face in refugee camps, where it is reported they often have to pay sexual favors to camp monitors to gain access to basic services. Programs to support women in crisis regions are desperately needed to reduce its severe physical and mental health consequences. (Rhen and Sirleaf, 2002; UNHCR 2014).

Call for Attention to Boys & Men

The extent and impact of conflict on physical and mental health for boys and men remains a neglected issue. Despite being the main perpetrators of violence, men and boys can also be victims of brutality in conflict zones. Since the 1950s, conventional, symmetrical conflict (between armies) has been replaced by asymmetrical conflict (among separatist, rebel groups) that places civilians in the front line of violence. The frequent destruction of state function with the political collapse of governments (e.g. Afghanistan, Iraq, Libya, and now increasingly so, Syria) leads to a breakdown of the social and the “moral order,” in particular, the rule of law and an escalation of sexual violence. Perpetrators take advantage of the collapse of rules and sanctions and act with impunity. Some GBV actions include:

- Boys and men being abducted and forced to fight, including the use of child soldiers, who are often beaten into submission, given medication to survive battle or have to perform brutal initiation.
- Men and boys are raped where they resist or are degraded and humiliated by being forced to watch sexual abuse and rape of female members of their families.
- Men and boys can face high rates of psychological morbidity that remain undetected due to stigma and an almost total absence of support or rehabilitation services.
- Suicide rates among return combatants to the United States from several recent wars (notably Afghanistan and Iraq) are high; low- and middle-income country data are rarely collected. However, in the United States in 2010, for example, some 124 combatant fatalities were recorded from Afghanistan, vs. 154 suicides, mostly of young males (Partners for Peace, 2012).

Urgent efforts are needed to prevent conflict—supporting efforts towards conflict resolution through greater understanding of its triggers, and adopting a firm justice and rights-based approach.

References


The Ebola outbreak has taken its heavy toll on women. (Wolfe, 2014) Women form a disproportionate number of the people affected and killed by the virus, which has rapidly made its way—and its epidemiological turn—through the lorry tracks crossing countries in West Africa. Women account for 55 to 60 percent of victims (Hogan, 2014) who have died in the epidemic in Liberia, Guinea and Sierra Leone. But figures may actually be higher. Health teams in Liberia recently reported that women made up to 75 percent of victims who were infected or died.

Women are the caregivers, the ones who cook and serve food to the sick, clean them and wash their clothes. Most of the time, when there is a death in the family, it is the woman who prepares the funeral. This role is also extended to the medical field, where women are the traditional birth attendants, the nurses and the cleaners in the hospitals—where risk of exposure is high—but do not get the same support and protection as doctors, who are men in most cases. Pregnant women are also at high risk because of their increased contact with health services and health workers. Two of the three largest outbreaks of Ebola involved transmission of the virus in maternity settings, according to the World Health Organization (http://www.who.int/csr/disease/ebola/health-systems/en/).

Once again, Ebola shows the complex dynamic enveloping the health-disease-care process. While contracting infectious diseases is a function of the interaction of the biological and the social, the experience of the illness or disease is more socially determined (Hartigan and Tolhurst, 2002). Biological differences between the sexes do affect susceptibility to disease, but most often it is the social patterns attributed to the respective genders that contribute to the severity or physical consequence of the infection. Scientific literature and empiric evidence have demonstrated to what extent gender identities, norms, roles and relations have influenced and still influence women’s and men’s vulnerability to sexually transmitted infections (STIs) and HIV infection in different ways by shaping the negotiation of sexual relationships and practice. Norms of female sexual passivity and the social value attached to virginity make it difficult for young and unmarried women, for example, to seek information on how to protect themselves against STIs (UNAIDS, 2014). Gender roles may affect women’s willingness to even admit to ill health or seek care when it disrupts their domestic work. This is pretty much the case when they have no other social supports, or when they perceive that their value relies on their capacity to manage the household. Moreover, gender and poverty often combine to create multiple barriers to women’s health, and they have to face high opportunity costs when they fall ill, have to seek care, or have to care for someone else. In many countries, allocation of food, rest and health care within households and provision of appropriate public health infrastructure in communities are often biased against women (Sims and Butler, 2002).

The Ebola virus, for which effective vaccines and medicines do not exist despite its being known to the scientific community since the early 1970s, is a typical disease which has never attracted any particular attention by the global health community, both in the public, and even less in the private pharmaceutical, sectors. Why should it, after all? Ebola, like several other communicable pathologies, mostly affects patients with no purchasing power, living in low-income countries untapped by the market. These people are of no interest in the context of a globalised economy which has come to treat health as a business opportunity and medicines as commercial goods. Coherently with this economic paradigm, over the past 20 years, research and development (R&D) have been driven by a monopoly-based global patent system which stimulates innovation only where industry sees the opportunity for increasing sales and market share (Dentico, 2005). Health innovation is no exception. This is why, in the case of Ebola, the race for a new vaccine has only been recently galvanized by the powerful force of fear, the mobilization of the international donor community, and the prospect of an expanding market, now that the menacing virus has landed, and seeded a reasonable amount of panic, in the Western world. It remains to be seen, of course, if any of the Ebola research activity will be conducted on sex-specific aspects of the infection, focussed for example on women’s biological reproductive function, and specifically the fetus, and other female manifestations.
Something similar happened to eflornithine (http://en.wikipedia.org/wiki/Eflornithine), the so-called "resurrection drug" which treats sleeping sickness, a disease far more lethal and terrifying than its name suggests. Like Ebola, sleeping sickness is spread in a few countries of Africa by jewel-eyed tsetse flies that thrive in thickets along rivers where women and children usually go to collect water. Eflornithine was initially developed for cancer treatment in the late 1970s, but, while having little use in treating malignancies, it was found to be highly effective in treating sleeping sickness, especially its West African form (Trypanosoma brucei gambiense). The pharmaceutical company that manufactured the medicine then—Sanofi Aventis—abandoned its production in 1995, seeing no profit in selling it to poor African nations. But the drug made its own resurrection a few years later, not in Africa, but in the United States—a land free of tsetse flies but with 14 million women worried about unwanted facial hair. Another company—Gillette—resumed the provision of eflornithine, selling it in the form of a new depilatory cream registered by the FDA in 2000 to minimize female hirsutism. With its lavender-coloured logo resembling a graceful swan, and advertisements featuring young attractive models, eflornithine—under the name Vaniqa Cream—became another prescription drug marketing success.

The permanent syndrome of womanhood

Once upon a time, pharmaceutical companies promoted drugs to treat diseases, and the most successful ones were those with the brightest scientists searching for cures. A very good time it was. After the great transformation occurred in the past decades in the prescription drug industry, it is quite a different story. Today, the most profitable and powerful drug makers are those with the most creative and aggressive marketers who promote diseases to fit their drugs. Medicine advertisers have turned what were once ordinary life events—menopause, despair from a divorce, anxiety caused by a workaholic boss—into maladies that can be treated with a pill. After all, when patients are customers and health has become a commodity, the industry thrives when people believe they are ill. Prescription drug marketing permeates every corner of society in the United States (Peterson, 2008); doctors overprescribe drugs only to generate new problems for the patients with the pill's side effects (Bass, 2008). This model is being exported and promoted to other parts of the world, including emerging countries, as part of the neoliberal commodification that has dramatically transformed health from a universal human right to a global business opportunity. At the other polar end of the equation, health consumerism has taken its heavy toll on women, too.

While women have been systematically excluded from the construction of the knowledge base that constitutes Western medicine, Western medicine has often legitimized the association of disease and weakness with women's biological characteristics. Women's experiences of menstruation and menopause have been described as being processes of wasted production and signs of biological decay (Martin, 1990). These perceptions have traditionally paved the way for men's enduring control over women's bodies across countries and cultures, while fatally removing women's control and understanding from their own bodies. Also, they have sanctioned explicit or implicit discrimination against women's active participation in society. The phenomenon can indeed be traced historically to the treatment of women's nervous systems. Historians of medicine and anthropologists have documented how the diagnosis of hysteria provided women with a legitimate venue for their social frustrations. Nevertheless, the medicalization of women's bodies and social status also strengthened the perception that women were biologically weaker, and more vulnerable to invalidity. That is why women were discouraged from getting engaged in a wide range of activities on the basis of their delicate constitution and fragile nerves. The incursion of a discriminatory gender norms and practices into medical science, by the way, is not the monopoly of Western medicine, since it can be found in several traditional medical systems, too (Sen and Östlin, op cit.).

Today, women experience a different type of syndrome. Empirical evidence shows that globalization, as the result of policies aimed at deregulating and liberalising the economy, has produced disquieting consequences for people's health, and tremendous impact on health equity across the globe (Labonte and Schrecker, 2009). In particular, the big globalized pharmaceutical players have transformed patients into consumers and turned what were normal life events into maladies that can and must be treated with a pill. This cultural shift, driven by profit motives, has targeted women with skilful strategies, to the extent that women's hardly conquered health rights have come to be modelled by the medical definitions in mere demand-supply dialectics. It is not a surprise that the notion of "medicalization" was broached for the first time in the 1970s in the New England Journal of Medicine in relation to gynaecology (Blech, 2006). Looking at today's trends, women have been manipulated to serve industry's interests to such an extent, that health for them seems to have somewhat "disappeared:" Different waves of maladies come, one after the other, in between pregnancies. The years of menstrual cycle are followed by menopause, after which the hormone replacement therapy starts. One is almost induced to think that a woman's existence is in itself a disease. And this push towards pathologization can start at an ever earlier age in a woman's life today.

Evergreening of monopolies, profitable surgeries & other invasive interventions on women's bodies

Prozac, made by the company Eli Lilly, was the first of a new type of antidepressant called selective serotonin reuptake inhibitor (SSRI), mainly developed by researchers working outside the company. In the span of a few years, Prozac replaced other types of antidepressants because of its milder side effects. Prozac soon accounted for one quarter of Lilly's revenues, with annual sales of USD 2.6 billion (Angell, 2004), leading the path to the new craving for the drug blockbuster model. Prozac's patent protection expired in August 2001,
which means that has come to be sold in its generic version at about 80 percent less than its original cost. (When Prozac was getting close to the end of its exclusivity, Eli Lilly sued generic makers who hoped to enter the market.) But the company did not give up. With the ingenious intent of extending the life of Prozac and staying in the SSRI business, it patented a weekly dosage of Prozac. In a more sophisticated and audacious move, it renamed the drug Sarafem, coloured it pink and lavender, and got FDA approval to market it with three years’ exclusivity for a disease that does really exist, the premenstrual tension which most young women experience from time to time, now recognized as “premenstrual dysphoric disorder” (PMDD). Almost any bodily function or feeling can be tweaked with the help of a soothing pill. Lilly defines PMDD as particularly severe premenstrual symptoms, but understandably does not advertise the fact that the pill for it is Prozac in another colour and at a higher price. The problem is that the rising trend of prescriptions for antidepressants like Sarafem is not hitting adult women only, but potentially girls and teenagers exposed to the aggressive marketing campaigns (Peterson, 2008, op cit.).

Of course, a lot of money moves around women’s menstruations, including their suppression (Tsao, 2003). There are now products on the market that offer this option with an extended schedule for taking oral contraceptive pills to suppress menstruation. These pills are intended to change a woman’s menstrual cycle into a pattern to produce either a 12-week* (Seasonale) or just four periods a year (Seasonale and Seasonique), instead of a dozen. Menstrual suppression products are chemically identical to traditional oral contraceptive pills. The active tablets contain a combination of levonorgestrel and ethinyl estradiol. The difference lies in the way a woman takes the pills. The traditional oral contraceptive is taken for 21 days, followed by seven days of placebo pills. Seasonale and Seasonique are taken for 84 days consecutively, followed by seven days of placebo pills. Pharma manufacturers and health providers—men, in most cases—have different methods to present the advantages of how reducing the frequency of menstrual cycles helps improve women’s quality of life, and enhances their professional careers. “Menstruation is not a normal, healthy thing to happen,” (Rabin, 2004) claim some of these marketers, who insist that suppressing periods will increase school performance, reduce the risk of breast, endometrial and ovarian cancers and even extend fertility, ideas that remain unproven scientifically (https://nwhn.org/menstrual-suppression). They argue that it is unnatural for women to menstruate as many as 450 times on average during their lives. Women in the past had only around 200 periods. Pity that women in the past had more birth deliveries and their lives, simply, were shorter than today’s.

For all the progress in the women’s rights agenda, gynaecology remains under market siege. The removal of the uterus (hysterectomy) is the most commonly performed gynaecological surgical procedure. In the United States, 1 in 3 women can be expected to have a hysterectomy by age 60, and 1 in 5 women is doomed to get the same in the UK. In Germany the number of hysterectomies has been constant for many years, around 150,000, and according to national health experts only in 10 to 15 percent of cases these interventions are performed to fight serious or indeed lethal diseases like cancer. In most cases, these removals are pursued for benign conditions. Such rates being highest in the industrialized world has led to the major controversy that hysterectomies are being largely performed for unwarranted and unnecessary reasons, despite the significant adverse effects and surgical risks that these procedures may entail, including effects on sexual life and pelvic pains; the effects of a premature menopause, urinary incontinence and vaginal prolapse, adhesion formation and wound infection.

The same trend can be seen at birth delivery. The World Health Organization (WHO) has suggested that a caesarean delivery rate of 15 percent should be taken as a threshold that should not be exceeded (http://www.who.int/bulletin/volumes/91/12/13-117598/en/), but more than 10 years ago the British Medical Journal was launching its concern about the over-medicalization of childbirth (Johanson, 2002). Indeed, caesarean delivery rate—as a percentage of live births—has been rising globally (Souza, et al., 2004-2008), and in many countries rates have increased beyond the recommended level of 15 percent, almost doubling in the last decade, especially in high-income areas such as Australia, France, Germany, Italy, North America and the United Kingdom of Great Britain and Northern Ireland (UK). “Preserve your love channel, take a caesarean,” has been advertised for quite some time private health providers in the United States, to the extent that today, one out of three pregnant women with private insurance follows the pipe of that apparent emancipation. The caesarean fashion has developed its appeal elsewhere, and similar trends have also been documented in some of the emerging economies like China, India and Brazil, especially for births in private hospitals. In Rio de Janeiro, 85 women out of 100 resort to caesarean sections to preserve their vaginas (Bleich, 2006, op cit.). After all, the therapeutic alternative to the vaginal delivery is much more attractive, in a commodified system for health.

Conclusion

The way women have remained prey to epidemics in several parts of the world on the one hand, and become prey to health merchants on the other, often under the disguise of modernization and women’s rights, is insane. It is obviously their biological events that expose them more frequently to health injustices, including the global dynamics of the health business. Women see doctors more than men do. In addition, they are more inclined than men to a “one to one relation” with their physicians, who frequently happen to operate on behalf of pharma interests. That is how the reasons of gender emancipation are used to enhance the healthy business of modern Western medicine. But that is only one part of the story. In most cases, women are also the health carers of their families. When they are not neglected because they are too powerless or too poor, it is through women that drug marketers have easier access to other potential patients to colonize, including children and men of all ages. That is the paradox they often unknowingly live in. There is enough reason for a compelling debate in women’s circles worldwide.
References


Blech J., op. cit., p.158.


Petersen M., op cit., p. 93.


The aim of this paper is to use a case study of the global HIV pandemic to explore issues of gender equality and equity. However, we need to begin with some clarification of the concepts to be used to structure the discussion. The definition of “gender” is now well-rehearsed in policy debates, with the most useful version probably being that used by the World Health Organisation:

“The term ‘gender’ is used to define those characteristics of women and men that are socially constructed while sex refers to those that are biologically determined. People are born female or male but learn to be girls and boys and grow into women and men.” (WHO, 2002)

This provides an appropriate definition for our purposes here but requires one addition. The nature of HIV demands that we also pay attention to issues relating to sexual identities and practices. Hence we will need to discuss “gender” as it relates not just to heterosexual men but also to those who are homosexual or “same-sex identified.” As we shall see, these versions of masculine gender can have significant effects on health in general and HIV in particular.

This preliminary piece of “conceptual housekeeping” also needs to address the frequently confused issue of equity and equality. The health and wellbeing of individual women and men are shaped by the interaction between biological sex and social gender. As a result there are marked differences between the two. Some of these differences will be inequalities that result from the unfair, discriminatory and inequitable allocation of resources and can therefore potentially be remedied. However, others will be biological in origin and rarely amenable to change.

This means that attempts to promote gender equity in health should not be concerned with biological or genetic inequalities that cannot be corrected. Rather, the aim must be to meet the specific needs of both women and men through addressing avoidable inequalities that unfairly limit their access to the resources necessary for human flourishing. These will include health care itself as well as other basic necessities such as food and clean water, a safe working environment and supportive emotional relationships.

Gender equity will also necessitate a fairer allocation of status and power in both public and private domains. In what follows, we will explore the significance of these complex policy issues for the promotion of gender equity in the global HIV pandemic.

**Setting the scene**

As the potential for treatment of HIV increases, there has been a growing debate about issues relating to equality and equity. New forms of treatment are not equally available to all (UNAIDS Programme Coordinating Board, 2013), and a wide range of cultural, social and economic factors currently prevent this from being achieved (Doyal with Doyal, 2013).

The most obvious influences are socio-economic in origin, with major differences in access to treatment between rich and poor countries, and also within countries between those who are wealthy and those who are not.

But given the nature of HIV and its mode of dissemination there are additional factors at work, with stigma and discrimination playing a key role in promoting avoidable inequalities. This has been attributed to the association of HIV with infection, sex and death, but recent research has shown that there are many other factors shaping these discriminatory practices. Gender has rightly been identified as one of the key sources of inequality, but significant weaknesses still remain in related policy debates.

First, the focus has been almost entirely on women with the needs of their heterosexual partners being largely excluded from the agenda. Second, gender has too often been treated as an independent causal factor. But a particular woman or man will not be just HIV positive—they will also be rich or poor and black or white, they will come from a specific community in a particular part of the world, may or may not be employed and may or may not be a parent. It is their position

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1 These data focus only on inequalities in access to antiretroviral drugs (ARVs) which is of course a relatively narrow measure
2 When men have been included in policy debates the focus has been almost entirely on what they can do for women rather than the implications of their own gender for their own risk of HIV.
at the intersection of these (and other) social, economic and cultural formations that will interact with their biological characteristics to shape both their vulnerability to HIV and also the progression of their illness if they become infected.  

To add to this complexity we also need to acknowledge the relationships between gender and sexualities. In the case of women, same-sex preferences are likely to make little difference to their vulnerability to HIV.  

However, the situation is very different with respect to men, whose sexual identities and practices will be central to their risk of contracting HIV as well as affecting their lives if they become positive. Yet researchers and policy makers have rarely put gender and sexuality together within the same conceptual framework. Too many studies refer to samples of “men” without making any reference to their sexuality. This is especially true in the African region where heterosexuality is assumed to be the default category. Generalisations are made about characteristic “male” behaviours but there have been few attempts to explore the more subjective or experiential aspects of diverse heterosexual masculinities (Doyal et al., 2009). Hence there is only a sparse evidence base for the development of HIV services appropriate to the needs of this particular group.  

By contrast, the very high rates of HIV among men who have sex with men (MSM) as well as their continuing political and economic vulnerability, have meant that there is now a vast literature on HIV among MSM. Unlike the situation with their heterosexual counterparts, this has included extensive research relating to their sexual feelings and experiences. But it is rarely recognised that these men are also gendered. Hence much work remains to be done to explore the particular forms of “masculinity” associated with MSM and to compare them with those of heterosexual men.  

Given this complexity it is clear that the unproblematic use of the categories “men” and “women” will not be adequate for the achievement of an effective strategy for promoting greater equity in HIV services. Instead we will need to pay much more attention to the links between gender and sexuality as they are played out across a range of settings.  

Context and concepts  

The concepts of equity and equality provide the foundational principles for gender justice. Both terms are in widespread use in health policy but there is frequently a lack of clarity about their meaning. Indeed they are often used interchangeably, leading to confusion about what each implies in relation to desired outcomes and the strategies that will be needed to achieve them. In order to make sense of their implications in the context of HIV we need to begin by looking more closely at the differences between women and men and their relationship with wider social inequalities (Payne & Doyal, 2012).  

It is now widely accepted that the differences in the health of males and females can be attributed to two closely interlinked sets of influences: the biological and the social. We can begin with the biological. Variations in male and female reproductive capacities are clearly a major aspect of sex differences in biology. However, recent research has also identified a broader range of variations that include hormonal, genetic and metabolic variations between the sexes (Wizemann and Pardue, 2000).  

Life expectancy is one of the most commonly used indicators of these sex differences with (counter-intuitively perhaps) women now living longer than men in most countries in the world (Payne & Doyal, 2010). On the face of it this might mean (as men’s health advocates frequently argue) that men are not being treated fairly (Baker et al., 2014). However, it is now accepted that much of women’s potential for greater longevity has a strong genetic element rather than being socially created (Payne, 2006).  

On the other hand, women appear to suffer more ill health over a lifetime with higher rates of some infectious diseases such as malaria and sexually transmitted diseases as well as a number of non-communicable illnesses, particularly those associated with the autoimmune system. They also exhibit a wide range of reproductive health problems. By comparison, men are more vulnerable to developing early onset heart disease. Here too, there is a growing volume of research on how genetic influences shape differences between women and men (Payne, 2006).  

At the same time, of course, much of the variation in health between women and men results from the social construction of gender. Many aspects of daily life interact with biological influences in shaping differences in the exposure of women and men to potential harm and in their access to those resources needed for the promotion and maintenance of health. But thus far these issues have been explored mainly through a female lens.  

This concentration on women is not surprising given the serious structural disadvantages so many face. A wide range of gender inequalities has now been documented around the world with obvious implications for women’s health and wellbeing. Unequal access to education, higher levels of poverty, the high incidence of gender violence and the lack of social status have all been identified as potential obstacles to

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3 For an introduction to intersectionality and its relevance to HIV and gender see Doyal with Doyal (2013) pp55-57  
4 It is not impossible for bodily fluid to be exchanged during sex between women but very few cases have been identified (Deol and Heath Toby 2009). However they may of course be infected through sex with men as the “corrective” rapes reported from South Africa show with frightening clarity.  
5 The term MSM is widely used as generic term to describe those who engage in sexual acts with other men but makes no assumptions about their wider gender identity.

6 Of course, the degree of inequalities varies between societies but there are no societies in which women are the privileged gender.
women sustaining their health. Indeed it is the recognition of these harmful inequalities that has provided the foundation for extensive feminist campaigning over the past three decades.\(^7\)

In recent years these debates have gradually broadened to explore the links between (heterosexual) “maleness” and health (Courteney 2000, Connell & Messerschmidt 2005). We know, for example, that there is an association between masculinities and risk taking, with men being more likely than women to be involved in hazardous work (including the military), in car accidents and in dangerous sports. Similarly, many cultures sanction (or even require) further hazardous behaviour, such as cigarette smoking as well as frequent sexual relationships as demonstrations of “masculinity.”

The model of “hegemonic masculinity” described above has been important in highlighting the reality that being “male” may not be as “natural” as it seems and that it may hurt men as well as women. However, it is now acknowledged to be relatively simplistic and much more work is needed to explore the forms as well as the influence of “masculinities” in different settings (Connell & Messerschmidt, 2005). Without such clarification it will be difficult to develop strategies appropriate for mitigating the harmful effects of varying manifestations of masculinity in the context of particular health problems.

As part of this process it will be important to recognise that MSM also have gendered characteristics. It has too often been assumed that being a same-sex-identified man means being devoid of masculine characteristics and hence being either “feminine” or “ungendered.” Indeed the gender of individual MSM has often been assumed to be identified with whether they take the “receptive” or female position or the “insertive” or masculine position in sexual activity.\(^8\) However this is to confuse gender and sexuality. In reality, widespread homophobia means that many MSM have to live with what is effectively a stigmatised gender identity.

Hence, whatever their sexual orientation, men are no different from women in that they also experience health problems that can be related to both structural and internalised aspects of their gender. However, it is important to note that these factors cannot be analysed within the same framework used to analyse the potential health hazards facing women. While women are frequently damaged by the inequitable (and avoidable) distribution of resources, men are more likely to be damaged by their conformity to the social construction of potentially hazardous masculinities.

We can conclude from this review that both gender equity and gender equality are important issues in optimising health outcomes for both women and men. The most obvious policy priority must be the ending of gender discrimination in the allocation of resources or benefits. However, this will not be enough. Gender equity will also require us to recognise that women and men may have different needs that will need to be met if they are to have equal opportunities to flourish.

Some of the required policies will be relatively straightforward, but others will call for much more complex reshaping of intimate human behaviour, which may or may not be achievable. Thus, complex challenges will need to be faced, which we can now explore in more detail in the context of the global HIV pandemic.

Men and women in the HIV pandemic

In many parts of the world, infection with HIV is one of the most serious threats to the health of both women and men. In 2011 there were 2.5 million new infections and nearly 1.8 million deaths from AIDS, while around 34 million people were estimated to be living with HIV (UNAIDS 2012). The numbers of men and women affected is now broadly equal, though of course, the sex distribution has changed over time and between settings.

The earliest phase of the pandemic was concentrated among MSM in the rich countries (especially the United States). However, its rapid spread to other parts of the world involved a process of “feminisation.” In the Africa region (which currently contains about 70 percent of the world’s HIV-positive people) about 60 percent of those infected are now female, with young women at particular risk. Women also make up an increasing proportion of the positive population in some parts of Asia and Eastern Europe.

More than 15 million men are now living with HIV, but there is no definitive information on how many are heterosexual and how many are MSM, bisexual or transgender. However, we do know that the proportion varies between settings. In the United States, for example, around 76 percent of those living with HIV are males, of whom 69 percent are MSM. In the African region, on the other hand, the majority of infected men would define themselves as heterosexual.\(^7\) It is clearly of great importance that HIV infection is currently increasing among MSM in all countries (Beyrer, 2012).

Biology and HIV: identifying differences between the sexes

The human immunodeficiency virus (HIV) is transmitted through unprotected vaginal or anal intercourse, the use of infected blood or blood products, and injecting drug use with contaminated equipment, while a child may be directly

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\(^7\) These have of course been taken up by international organisations partly as a matter of principle but also in recognition that these inequalities can be damaging to the wider society.

\(^8\) This is not even an accurate representation of the sexual practices of MSM which have been found to be much more versatile (Lyons et al. 2013).

\(^9\) No precise figures are available and it would be difficult to know what they meant in the context of widespread homophobia. Indeed a recent report from international organisations talked of the “invisibilisation” of MSM in three settings (IGLHRC 2007)
infected by a positive mother during pregnancy or breast feeding. The proportion of infections transmitted through these different routes will vary markedly among settings and will shift over time. They also involve different degrees of risk. In well-resourced settings, the risk of transmission from a single act of heterosex is estimated to be around 0.04 percent for females to males and 0.8 percent for males to females (Baggaly et al., 2010). This derives mainly from the fact that potential infectious semen is left for some time on the woman's vaginal membranes, which may be highly permeable. This is especially dangerous in the presence of traumatic injury or existing genital infections (Abrahams et al., 2004; McNamara, 2003). Hence, women are at a greater risk than men from heterosex (Boily et al., 2009). However, the risk from anal sex is considerably greater than that from vaginal sex, making unprotected sex between men the most dangerous of all and highlighting again the significance of sexuality in exploring gender in the pandemic.

Once individuals are infected with HIV there is growing evidence that the course of the illness may be different in the two sexes. Much more research is needed to identify these variations, but it is generally agreed that for men, the first AIDS-defining or opportunistic illnesses are more likely to be cytomegalovirus, Kaposi sarcoma or oral hairy leukoplakia, while for women they are more likely to be oesophageal candidiasis or toxoplasmosis.

Not surprisingly, their reproductive biology will be a central factor shaping the lives of positive women. When it is untreated, HIV can pose a particular threat to those women who are pregnant. In sub-Saharan Africa, seropositive status is becoming increasingly important as a cause of maternal morbidity and mortality (Black et al., 2009). Since 1998, HIV has been the leading indirect cause of maternal deaths in South Africa, reversing a previous decline in mortality rates. One recent study in Johannesburg showed that HIV-positive pregnant women were around six times more likely to die than their negative counterparts (Black et al., 2009).

As we have seen, the significance of these biological differences is that they cannot be eliminated. However their effects can be mitigated both by the equitable and effective provision of health services and also by changes in sexual practices.

How social gender shapes vulnerability to HIV

The literature on gender and HIV has focussed mainly on the lives of women, analysing their greater vulnerability to HIV within the context of the wider analysis of social constructed gender inequalities. Much emphasis has rightly been placed on the degree to which many women have only limited autonomy in making decisions about their sexual lives. Too often their choices are restricted in relation to who they can have sex with, when, how frequently and in what ways. Refusal may not be an option, with young women in particular often being coerced into unprotected sex.

Data from the Asian region illustrates this with particular clarity. In 1990 women made up some 17 percent of the total HIV-positive population in India, but by 2007 this had doubled to 35 percent (UNAIDS, 2009). Most had only ever had sex with their husbands, whose own infection often resulted from extra-marital relationships with either male or female sex workers. Thus, gender inequalities in intimate relationships may combine with women’s greater biological vulnerability to increase their risk of contracting HIV.

The privileging of masculinity over femininity that exists in most communities will also place arbitrary limits on the access of the poorest women to the resources necessary for their own health and that of their family. For some, this will add to the pressures on them to have unsafe sex with their partners in order to avoid violence or loss of support. Others may have little option but to do sex work. In either case this will increase their risk of infection especially if they engage in transactional sex with men who pay more to avoid the use of a condom (Karim et al., 1995). Once women are infected, poverty may limit their access to health care and to the adequate nutrition and other resources necessary to ensure the effectiveness of treatment (Sia et al., 2013).

But if gender inequalities harm women and privilege men, how can masculinity be a risk factor for HIV? The answer lies in the fact that it is not the inequities associated with heterosexual relationships that lead men to harm their own health. Rather it is their internalisation of the societal expectation that one way for “real” men to “perform” their masculinity is through having frequent sex with multiple women. Similarly the widespread failure of these men to use condoms can be related to a model of heterosexuality that promotes risk-taking in pursuit of pleasure.

Similar points can be made with reference to gender and MSM (Ocampo, 2012). There is now a growing literature on the relationship between gay men and masculinities (Sanchez et al., 2009). Though empirical studies remain sparse, it is clear that there is great diversity between MSM. For many, “macho” models of masculinity are highly valued. In recent years what has been called “gay masculinity” has emerged among those men openly involved in same-sex identified gay communities and networks (Halkitis, 2004). This is centered around super-fitness and usually requires frequent sexual activity in what are often high-risk settings.

By contrast, the situation may be very different for the many millions of MSM who remain invisible for fear of stigma and discrimination. In the United States, for example, it is black African-American MSM who carry the biggest burden of infection. A number of factors account for this, including lack of knowledge, homelessness, unemployment and fear of being exposed for their sexual preferences (UNAIDS PCC, 2013).
These men face many challenges in a highly heteronormative environment, where they are forced to keep their sexual activities secret in order to sustain a gendered identity that is deemed acceptable. Similar examples can be drawn from parts of Asia, where it is not uncommon for apparently heterosexual men to have sex with other men (including male sex workers) while also getting married and creating families. Under these circumstances they are likely to find it especially difficult to protect themselves (and their partners) from infection.

### Sex, gender and HIV services

In most settings there are marked differences between women and men in access to HIV services. As the pandemic spread to the poorer parts of the world it was widely assumed that women would be missing out on treatment compared to men. However, recent studies have shown that it is usually (heterosexual) men who are less likely to access the care required to meet their needs (Muula et al., 2007; Antoniou et al., 2012).

This reflects in part the fact that most women are more likely to be tested in the context of pregnancy care. Indeed many women in the areas of highest prevalence are faced with the discovery that they are pregnant and positive at the same time. But it also reflects many men’s reluctance to acknowledge possible “weakness” or incapacity. Evidence from a number of countries now indicates that (heterosexual) men may be unwilling to test even when their female partners have been found to be positive (Skovdal et al., 2011). As a result, many are diagnosed at a late stage when their low CD4 count makes their prognosis significantly worse than that of females from the same community (CDC, 2013).

In the case of MSM a number of different patterns are evident. Those who have adequate resources and peer support may have better access to care than their heterosexual compatriots. However, those living with high levels of homophobia and poverty may face the greatest obstacles of all in accessing preventive or treatment services (UNAIDS PCC, 2013; IGHRC, 2007). As a result, MSM in lower-income countries are 19 times more likely than their heterosexual counterparts to contract HIV (Mburu et al., 2014; WHO, 2011). Once they have been diagnosed, both women and men show relatively high rates of drop-out from health services or non-adherence to medical protocols. Surprisingly perhaps, recent studies have shown that rates of retention in care are broadly similar in rich and poor countries at about 70 percent at 3 years (Fox and Rosen, 2010). However, there are marked variations among settings and between rich and poor countries (Mills et al., 2006: Nguyen et al., 2007).

Many of the reasons for this lack of adherence do not appear to be specifically gender-related, with fear of stigma and lack of knowledge and support being cited by all groups. However, a recent review of studies in the developed countries between 2000 and 2011 showed that women were more likely than men to drop out of HIV services (Puskas et al., 2011).

Among the reasons cited for this were the financial and time costs of travelling to service points, lack of confidentiality and the need to get permission from partners. Few studies have explored the experiences of men and hence, we do not know much about the particular barriers they face. Interestingly, however, a recent study from Tanzania reported that men feared marital disharmony and even abandonment by their wives if they were found to be positive and hence, assumed to be unfaithful (Herstad, 2010).

### Moving towards gender equity?

We have seen that the relationship between HIV and gender is more complicated than its representation in many equality policies. Men as well as women must be included in any strategy, since their masculinities as well as their sexual identities shape both their risk of contracting HIV and also their experiences of illness itself. Thus far, their inclusion has focussed mainly on the potential contribution of heterosexual men in reducing the risks of HIV to women and children, and this will clearly need to remain a central goal. However, the scope of policies for gender justice will need to be extended if men too are to optimise their potential for health. Moreover, these policies will need to be applied universally so that individuals are not unfairly handicapped by their socio-economic circumstances. We can begin to map out such a strategy beginning with the provision of equitable health services and then turning briefly to wider issues relating to socio-economic inequalities and to initiatives for gender transformation.

### Promoting equity in HIV care

If optimal HIV services are to be equally available to all, an appropriate knowledge base will be needed. As we saw earlier there are sex differences both in the modes of transmission and the development of HIV and AIDS in individuals. However, women have been under-represented so far in trials of antiretroviral drugs and this will need to change if appropriate and effective health care is to be equitably distributed (Stronks, et al., 2013).

For example, variations in CD4 counts between women and men will have particular significance for treatment decisions, but may not be properly understood. In order to learn more about these and other differences, clinical trials will need to include appropriate numbers of women and men. At the same time the social science research agenda will need to expand to fill some of the knowledge gaps on gender differences already signalled in the earlier part of this paper.

Moving on from the need for a more differentiated knowledge base we also need to examine the significance of different models of service delivery for different groups. It is now commonplace to argue that all health services should be “gender sensitive” and this will be especially important in the context of HIV. Hence, it will be important that the particular
needs and sensitivities of heterosexual women and men as well as MSM are mainstreamed into the delivery of all HIV care.

There has also been much discussion about the provision of specialist HIV services for some groups who are difficult to access. In the case of heterosexual men, for example, attempts have been made to provide services in what are assumed to be more convenient places, such as workplaces and barber shops. Attempts have also been made to set up single sex (heterosexual) male support groups to provide peer support for accessing testing and treatment services (Zaller et al., 2011; Antoniou et al., 2011). These reflect the fact that some heterosexual men will resist any attempt to include them in what they see as initiatives for women or gays.

Recent studies in the United States have gone further in identifying subgroups of mainly heterosexual men who face particular obstacles because of their involvement with the criminal justice system. Those incarcerated in prison, those who are substance abusers (especially injecting drug users), and those who are sex workers may all need special arrangements for linkage to comprehensive HIV services. In the case of injecting drug users, services to promote harm reduction will also be essential.

For those “gay” MSM who are “out” in a supportive community, there may well be easily accessible services tailored to meet their needs. However, these are usually confined to urban centres in the rich countries. But as we have seen by no means will all MSM be able to use such facilities. Even in the United States only about 50 percent of gay men are in receipt of antiretroviral drugs and only 42 percent have achieved viral suppression, with young African Americans facing the greatest difficulties. In many other parts of the world, specialist services for MSM would of course be impossible under current homophobic laws.

Turning to the needs of women, equity requires that they have easy access to HIV services where they are treated with respect and humanity. Recent evidence indicates that their care can be sub-optimal due to the demeaning attitudes so often directed towards poor women in particular. When this is combined with the moral opprobrium associated with a positive diagnosis, major constraints may be placed on the benefits women can receive from services.

This will be especially important in the context of the reproductive health services that are essential for meeting women’s special needs. We have already seen that women are at the greatest risk if they have untreated infections and other gynaecological problems. Hence it is important that they have easy access to services that can deal with these problems in appropriate ways.

From the perspective of prevention, reproductive health services can potentially play a part in the provision of biomedical- or female-controlled protection methods including the femidom and microbicides. However, these techniques are not yet widely available, leaving a “technology gap” between male and female prevention methods that urgently needs to be filled (Long, 2009; MacPhail et al., 2009; Kaler, 2004; Stein, 1990).

If women do become infected, their need for fertility control may be even greater than that of negative women. For many, fear for their own health will be a major barrier to pregnancy. While HIV does not appear to accelerate the progression of HIV it does make pregnancy itself more dangerous, with a recent study in Johannesburg showing that HIV-positive women were six times more likely to die from maternal causes than their negative counterparts (McCarthy et al., 2009; Black et al., 2009). At the same time, many positive women may feel that they cannot have a child because the child itself may be affected or because they may die before the child is grown. In this context reproductive health services relating to fertility control will potentially be of major importance. But evidence from around the world indicates that there are major gaps in this provision.

It is estimated that at least 215 million women around the world currently wish to avoid pregnancy but are not able to access contraception (UNFPA, 2010). We do not know how many of these are HIV-positive, but they clearly make up a significant subset of an already disadvantaged population (Leach-Lemens, 2010). A review of recent studies estimated that around 16,000 unintended (and potentially hazardous) pregnancies among HIV-positive women in sub-Saharan Africa could be avoided each year through appropriate birth control (Wilcher and Gates, 2009).

Many positive women who become pregnant unintentionally may decide to seek a termination. Again, we have very little information about the numbers who succeed in doing so. We do know that around 20 million women have unsafe abortions each year—most of them in low- or middle-income countries. It is not known how many of these are positive but studies from the United States carried out before the availability of antiretroviral treatment indicated that the numbers of abortions were very high. Moreover, there is evidence to suggest that termination may be especially dangerous for positive women if it is not carried out in a medical setting. This is because their immuno-compromised status gives them a greater likelihood of developing bacterial vaginosis, chlamydial cervicitis and anaemia.

Every year about 1.4 million positive women do continue with a pregnancy, the majority of them living in low-income countries (WHO, UNICEF AND UNAIDS, 2011). While little is known about their experiences, a growing number of qualitative studies are showing that many face major challenges to their emotional and physical wellbeing (Doyal with Doyal, 2014, ch. 7). All mothers worry about the health of their unborn babies, but this worry is greatly exacerbated for pregnant women who are HIV-positive.
those who know they may be infecting their own baby in utero. Moreover, many report discriminatory treatment by nurses in obstetric settings in particular (Jewkes et al., 1998). This lack of concern for positive mothers has been reflected in policy making over the years when the focus has been very firmly on the prevention of mother-to-child transmission, even when there may be no treatment available for the mother herself (International Treatment Preparedness Coalition, 2009).

We can see from this account that the provision of accessible and effective reproductive health services will be essential if avoidable inequities between positive women and men are to be removed. Moreover, experience has shown the necessity of integrating these services with HIV care and primary care as well as wider health and social support systems.

**Promoting wider social equality between women and men: challenges and contradictions**

It is clear that both gender inequalities and gender inequities play a part in limiting the potential of women and men to protect themselves from HIV and also to mitigate its effects should they become infected. Hence, we need to look beyond health policy to the wider social changes necessary to tackle these socially constructed realities.

As we have seen, there are obvious links among women's vulnerability to HIV and their relative poverty, their low social status and their vulnerability to gendered violence and other forms of abuse (Doyal, 1995; Payne, 2006). It is for this reason that the notion of the “empowerment” of women has been central to many national and international strategies to combat HIV. But again, we need to look very carefully at a concept that can have several different meanings.

In some contexts the term is used in the psychological sense of giving women greater capacity to optimise their autonomy in both public and private settings. This strategy is clearly important, and education in particular can play a major part in achieving it. However, an individualised approach of this kind will not be enough. Structural reforms will also be needed so that it will be essential to place HIV prevention and mitigation strategies within the framework of wider equal opportunities policies, anti-discrimination legislation and campaigns to end gender violence.

But what can we say about heterosexual men in this context? Empowering women through greater equality in the allocation of resources (including power and social status in particular) will clearly have an impact on men. Indeed it will, by definition, benefit women and lead to men losing out. If improvements in women's health necessitate their getting an increased share of available social resources, then men may have to get less, possibly leading to negative effects on their health.

This is likely to be especially problematic in settings where positive men are no longer able to work and hence, may already be losing their moral command over resources. Men on the edge of poverty for example, may be dragged down below subsistence if household income has to be shared more equally with their female partners. Will trade-offs of this kind be necessary within the context of scarce resources? If so, how do we measure the appropriate changes within the framework of promoting gender equity? And most importantly, how easy will it be to persuade enough men to relinquish their position of privilege? Hence, we are talking here not just about technical challenges but ultimately about gender politics.

Clearly the same challenges will not arise in the context of MSM. However, we need to acknowledge the very unequal circumstances of MSM themselves. While this is partly socio-economic, it is also linked to the legal status of homosexuality in different parts of the world. If all MSM are to have equal access to their basic human rights, reform will be needed in this legislation and of course in the discriminatory attitudes and practices in which it is embedded. This will not be easy to achieve but without it we cannot achieve a situation of gender equity that includes the group of men most affected by HIV.

Finally, we need to acknowledge what may be the most difficult challenge of all in achieving gender equity in the context of HIV. If many of the most important causal factors in the pandemic are to be tackled, major changes will be needed in some of the most fundamental aspects of human behaviour. As we have seen, aspects of male and female gender identities are central to the shaping of gender inequalities and gender inequities in the HIV pandemic. That is to say the behaviour of men may be increasing the hazards facing women as well as generating risks for themselves. Hence, policies will be required to enable them to transform fundamental aspects of their identities if they are to minimise the effects of HIV. But as we shall see, most aspects of gender and sexuality are deeply embedded in individual psyches (both male and female), making them difficult to change. This resistance will be reinforced by the location of many of these inequalities within the private space of the household or the even more private space of the bedroom.

This raises questions about how effective public policies can be in changing some of the most fundamental aspects of human behaviour. Initiatives attempting to achieve this are already underway in the form of what have been called “gender transformation” or “gender justice” strategies. Here the aim is to use a variety of methods to reshape masculinities in a direction that is healthier for both women and men. A degree of success is being achieved in some settings. However, it remains to be seen how far such relatively small initiatives can contribute to the massive task that faces us in promoting gender equity as part of the overall fight against HIV and AIDS.

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12 For an important example of such an initiative see Sonke Gender Justice based in South Africa.
References


Mainstreaming Gender Equity in Health: Possibilities and Pitfalls for Policy and Practice

Dr. Karen Newbigging

Introduction

Crossing organisational and global boundaries, gender inequality\(^1\) has been identified as "the greatest and most entrenched human rights concern plaguing societies worldwide, constituting a form of apartheid" (Chakrabarti, 2015). The concern with gender inequality is not new and has been the focus for activists for centuries (Spender, 1982), but the social and institutional forces that sustain it are woven into the warp and weft of everyday life, so much so that the power dynamic often remains unconscious (Lukes, 2005).

Campaigning by women’s organisations during the UN decade of women from 1976 to 1985 highlighted how women’s needs and interests were marginal to the mainstream economic and social development agenda and the need for clear institutional strategies to remedy this (Moser and Moser, 2005). As a consequence, gender mainstreaming was identified as a goal by the United Nations Fourth World Conference on Women in Beijing, in 1995, in order to bring women’s agenda from the margins into the mainstream across different policy areas, including health (United Nations, 2002).

In this paper I will explore mainstreaming as an intervention to improve gender equity in health. As a result of gender mainstreaming strategies, there is now considerable, albeit patchy, data on how gender inequalities in health reflect unequal access and control over material and non-material resources, unfair divisions of work, and possibilities for improving women’s life chances across the globe (WHO, 2008), I, therefore, start with an illustration of how the social processes that disadvantage women play out, and the implications in terms of health. Such examples contribute to building a rationale for gender mainstreaming. I then explore the concept of gender mainstreaming and the difficulties in its conceptualisation that have, arguably, influenced successful implementation. The evidence for the impact of gender mainstreaming on achieving gender equity in health is limited, but that which is available, including my own experience of leading a national programme to mainstream gender equity in mental health in England, points to the need for a more radical agenda.

The rationale for gender mainstreaming

Gender inequality is played out across all aspects of social life, from the representation of women in powerful positions, to their social and economic disadvantage and to theories of knowledge that privilege male experience as the standard, marginalising and homogenising women’s experience (Spender, 1980). These wider inequities have a direct bearing on health, as illustrated by the following example. Two young girls aged 14 and 15 in in the Budaun district of the large, poverty-stricken state of Uttar Pradesh India, were found hanged following a gang rape in May 2014. This shocking incident illuminates the nature of gender inequalities, particularly in respect of resources, recognition, and the gendered nature of sexual violence. The two young girls had gone out to go to the toilet in the fields, with open defecation in India a common practice reflecting the lack of toilets, both in people’s homes and public places. An inspection carried out by the High Court Committee in Delhi in 2007 noted that there were only 132 public toilets for women compared with 3,192 for men (i.e., under 5 percent)\(^2\). The general lack of toilets, worse for people living in poverty, differentially impacts on women, carries risks for their personal safety, and was clearly implicated in the death of these two young girls. According to reports of the incident,\(^3\) women from the girls’ village had highlighted the problems of public defecation for women, which included having to go out at times when no one is around because of embarrassment, further complicated by menstruation, with the attendant risk of gender-based violence.\(^4\) The women

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1. Gender inequality is widely used to refer to the condition of being unequal, and implicit in this is a sense of disadvantage and unfairness. In this paper I am using inequality as a more precise term, which includes a judgement that this inequality is unfair and unjust and differences in treatment of women and men are avoidable. Using the singular version is not to negate the multidimensional and intersectional nature of gender equity; indeed I lapse into the plural when I feel that this needs to be emphasised.


4. It is suggested from this account that 95 percent of cases of rape and molestation in India happen when girls and women go outside to the toilet. http://www.theguardian.com/global-development/2014/jun/01/girls-toilet-rape-murder-anger-embarrassment [accessed 181014].
reported that they had to structure their lives around going to the toilet and their concerns about the risks to personal safety apparently went unheard. Dismissal of women’s voices by those representing their interests perpetuates gender inequities and reinforces a dominant world view, constituting a form of epistemic injustice (Fricker, 2007). Concerns have also been drawn to the lack of vigour on the part of the police in investigating the girls’ murder and the low caste of the girls’ families identified as a possible cause, pointing to the complexities of gender intersecting with other forms of discrimination.

This example provides a powerful illustration of the social realities and consequences of gender inequities. In a health context, gendered power relations are reflected in girls being fed less, being more physically restricted, having lower access to educational opportunities including those relating to health promotion, women being vulnerable to intimate partner violence, carrying the greater burden for childcare and household tasks, and having poorer access to health care, including a variable say in decisions about their own health care (WHO, 2008), influenced by the extent of economic support from husbands and relatives and the gendered dynamics of intra-household bargaining (Tolhurst et al., 2008).

Since the introduction of gender mainstreaming, data have been collected on many aspects of health and these inequities are described in relation to a wide range of health conditions – with the WHO providing factsheets, such as malaria, TB and AIDS and HIV prevention—as well as the different negative health consequences for women and men following disasters (See for example WHO 2002; 2003a; 2003b). The impact of gendered differences and gender inequities has consequences for health policy, promotion and delivery. For example, the findings from a longitudinal study of 4,505 women in a study of HIV prevention in Southern Africa indicated that intimate partner violence (IPV), emotional abuse and physical assaults were not only more common for the women in the sample but were also less likely to use condoms, thus increasing their (and their partner’s risk) of HIV (Kacanek et al., 2013). Kacanek et al (2013) conclude that interventions to prevent the use of IPV by men, and changing norms that condone men’s use of violence to exert power and control over women, are as important as interventions to promote condom use (Kacanek et al, 2013: 407).

Such examples provide the rationale for gender mainstreaming. They illuminate how “a one size fits all” approach to health policy and practice will perpetuate gender inequities. Thus, policies and programmes to improve gender equity for women in health require a nuanced and systemic understanding of the social realities of women’s lives, the social construction of gendered roles and associated power dynamics, and the impact of these inequities on women’s health and wellbeing.

Conceptualising gender mainstreaming

The widely cited definition of gender mainstreaming was developed by the UN Economic and Social Council (1997: 2):

“Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women’s as well as men’s concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality.”

Thus, gender mainstreaming is framed as a process to achieve the goal of gender equality and identifies a range of loci for action from policy though to programme level, with the aim of bringing gender-related knowledge into policy formulation and the process of design, provision and evaluation (Subrahmanian, 2004; UN, 2002). The intent behind gender mainstreaming is to promote system-wide action to embed gender equity into all policies and practices, based on the assumption that women and men are differentially affected by policies and that the mainstream (or ‘malestream’) reflects the dominant interests of men (Hanivsky, 2005). Although the UN definition refers to a process that is as relevant to men, gender mainstreaming is often interpreted as referring to women (Tolhurst et al., 2012), with more critical commentators arguing that it must call into question androcentric standards or roles (Meier and Celis, 2011; Squires, 2005).

The core features of gender mainstreaming that are commonly articulated were set out by the International Labour Organization (2002) as follows:

1. Leadership and accountability mechanisms for monitoring progress;
2. Identification of issues and problems across all area(s) of activity should be such that gender differences and disparities can be identified and their nature understood;
3. Assumptions that issues or problems are neutral from a gender-equality perspective should never be made;
4. Gender analysis, using sex-disaggregated data should always be carried out;
5. Clear political will and allocation of adequate resources for mainstreaming, including additional financial and human resources to translate the concept into practice; and
6. Efforts to broaden women’s equitable participation at all levels of decision-making.

Framed in this way, gender mainstreaming is positioning the state as an agent of transformative change for women (Subrahmaniaman, 2009), challenging the whole policy process, not just the policy delivery stage, through the long-term transformation of public policies (Liebert, 2002;
Stratigaki, 2005). Two types of mainstreaming have been distinguished, in a development context, with both required to achieve the necessary changes (Jahan, 1995). Institutional mainstreaming is focused on changing organisational dynamics, policies, structures, systems and procedures, whilst operational mainstreaming is concerned with the policies, programmes and projects that have a positive impact on the gender equity of women (Jahan, 1995; Ravindran and Kelkar-Khambete, 2007). Furthermore, there is a general agreement that mainstreaming does not negate the need for targeted, women-specific policies and programmes, positive legislation and affirmative action (International Labour Organization, 2002; Stratigaki, 2005).

Notwithstanding the evident implementation challenges, the concept of gender mainstreaming has great appeal and, indeed was widely welcomed when first introduced. There has subsequently been a number of critiques, many of which reflect the problems in translating gender mainstreaming into practice with Subrahmanian (2004: 89) commenting that gender mainstreaming is “a generator of myths that simplifies the complexity of gender and acts as a constraint on political action by feminists.” The experience of the impact of gender mainstreaming has also called the concept itself into question. These critiques have three main complexities: (1) the contested nature of the concept of gender with gender construed as part of a person rather than an ongoing process that reinforces or radically changes socially mediated constructions of gender (Porter and Sweetman, 2005). Thus, Bacchi and Eveline (2010: 87) argue that thinking of gender as a verb or a gerund (gendering) “we are more likely to capture how gender differentiation is continually ‘done’ through discursively-mediated institutional and organisational processes, including policymaking;” (2) prioritisation of gender as the axis of discrimination, reproducing a narrow male–female dichotomy, and overshadowing other forms of inequity6 homogenising women’s experience and not getting to grips with the complex power dynamics that constrain individual agency for women (Hanivsky, 2005; Porter and Sweetman, 2005; Subrahmanian, 2004); (3) the implicit model of change focuses on giving visibility to women, and their capacities and needs, and effectively deflects attention and effort away from the structural forces that shape gender inequity and the political nature of the change required (Subrahmanian, 2004). The consequences of this is confusion about what gender mainstreaming means and as a result, the adoption of gender mainstreaming by governments and development organisations has resulted in the mutation of feminist goals for gender equity into bureaucratic processes and a weakening of positive action (Subramanian, 2004). A review of development organisations, 10 years after the Beijing Platform for Action in 1995, identified that most had mainstreaming policies in place but that efforts at implementation were inconsistent, lacking coherent and integrated processes (Moser and Moser, 2005). One of the underlying tensions was the extent to which gender equity was an end in itself or whether it was a means to a wider end, particularly poverty reduction (Moser and Moser, 2005). Thus, gender mainstreaming became open to the charge of instrumentalism, not transformational as claimed. Critics have commented on the empty rhetoric of gender mainstreaming and observed that greater progress would have been made by the continued action of feminist activists (Payne, 2011). At the heart of the matter is the contention that gender mainstreaming has simplified gender relations and that gender mainstreaming has been introduced into contexts with multiple gender hierarchies, and where the embedded, social and cultural values remain unchallenged (Stratigaki, 2011): “just add women and stir” (Ravindran & Kelkar-Khambete, 2007). Accordingly, implementation has been reduced to achievable action, thus, placing the concept of gender mainstreaming rather than the social and political context, particularly gender power, under scrutiny. It remains a fact that women’s interests are often poorly represented because of their relatively weak political power in many countries and, therefore, the demand for change and equity is effectively muted.

The lack of progress on gender mainstreaming may also reflect inherent problems in the conceptualisation of the policy process as rational and linear; inexorably leading to the conclusion that implementation has failed, as noted by Pressman and Wildavsky’s (1973) seminal study of public policy implementation in the United States and argued by Bacchi and Eveline (2010: 87) that “we are more likely to capture how gender differentiation is continually ‘done’ through discursively-mediated institutional and organisational processes, including policymaking;” reflecting inherent problems in the conceptualisation of the policy process as rational and linear; inexorably leading to the conclusion that implementation has failed, as noted by Pressman and Wildavsky’s (1973) seminal study of public policy implementation in the United States and argued by Bacchi and Eveline (2010: 87) that “we are more likely to capture how gender differentiation is continually ‘done’ through discursively-mediated institutional and organisational processes, including policymaking;” reflecting inherent problems in the conceptualisation of the policy process as rational and linear; inexorably leading to the conclusion that implementation has failed, as noted by Pressman and Wildavsky’s (1973) seminal study of public policy implementation in the United States and argued by Bacchi and Eveline (2010: 87) that “we are more likely to capture how gender differentiation is continually ‘done’ through discursively-mediated institutional and organisational processes, including policymaking;” reflecting inherent problems in the conceptualisation of the policy process as rational and linear; inexorably leading to the conclusion that implementation has failed, as noted by Pressman and Wildavsky’s (1973) seminal study of public policy implementation in the United States and argued by Bacchi and Eveline (2010: 87) that “we are more likely to capture how gender differentiation is continually ‘done’ through discursively-mediated institutional and organisational processes, including policymaking;” reflecting inherent problems in the conceptualisation of the policy process as rational and linear; inexorably leading to the conclusion that implementation has failed, as noted by Pressman and Wildavsky’s (1973) seminal study of public policy implementation in the United States and argued by Bacchi and Eveline (2010: 87) that “we are more likely to capture how gender differentiation is continually ‘done’ through discursively-mediated institutional and organisational processes, including policymaking;” reflecting inherent problems in the conceptualisation of the policy process as rational and linear; inexorably leading to the conclusion that implementation has failed, as noted by Pressman and Wildavsky’s (1973) seminal study of public policy implementation in the United States and argued by Bacchi and Eveline (2010: 87) that “we are more likely to capture how gender differentiation is continually ‘done’ through discursively-mediated institutional and organisational processes, including policymaking;”

The adoption of gender mainstreaming by the World Health Organisation marked a shift from a focus on women’s health, based on an understanding that women’s health has both biological and social determinants to the gendered nature of health to promote better health for both men and women and equity and equality throughout the life course (Ravindran & Kelkar-Khambete, 2007; 2007). In their review, on behalf of the Women and Gender Equality Knowledge Network of the WHO Commission on Social Determinants, Ravindran & Kelkar-Khambete (2007) identify three challenges that gender mainstreaming in a health context has to contend with:

1. The attribution of gender differences to biology, such that biological functions become the dominant focus for health interventions and construed as sufficient.
2. Convincing key actors about the need for mainstreaming and sustaining a focus on different forms of gender inequities

How far have we come with mainstreaming gender in health?

The adoption of gender mainstreaming by the World Health Organisation marked a shift from a focus on women's health, based on an understanding that women's health has both biological and social determinants to the gendered nature of health to promote better health for both men and women and equity and equality throughout the life course (Ravindran & Kelkar-Khambete, 2007; 2007). In their review, on behalf of the Women and Gender Equality Knowledge Network of the WHO Commission on Social Determinants, Ravindran & Kelkar-Khambete (2007) identify three challenges that gender mainstreaming in a health context has to contend with:

1. The attribution of gender differences to biology, such that biological functions become the dominant focus for health interventions and construed as sufficient.
2. Convincing key actors about the need for mainstreaming and sustaining a focus on different forms of gender inequities

6 Including marginalising transgender identities.
when gender differences in mortality now indicate that women outlive men in most countries of the world.

3. The hegemony of a bio-medical approach in the health sector, in most countries, potentially jeopardising consideration of the social context of women's lives and the social determinants of gender inequities in health.

Reviewing the progress made in mainstreaming health policies, programmes, research, and training within health systems, Ravindran and Kelkar-Khambete (2008) found that whilst there was a wealth of descriptive accounts, there were few publications providing an insight into the processes or outcome of gender mainstreaming. They point to greater progress being made in operational mainstreaming (i.e., the development of specific programmes and interventions) as opposed to institutional mainstreaming (i.e., organisational structures and processes). Reflecting Moser and Mose's conclusions, Ravindran and Kelkar-Khambete observe that despite much activity in terms of institutional mainstreaming there is a widespread failure to make substantive changes. They conclude "these weaknesses in institutional mainstreaming of gender make it difficult, if not impossible, for operational mainstreaming to be large-scale or sustained over a long period" (Ravindran and Kelkar-Khambete, 2008: 137).

These challenges are illustrated by a recent assessment of gender mainstreaming in health care in Papua New Guinea, where women's and children's health status are among the worst in the world in a context of comparatively low levels of development, literacy, and political representation (Lamprell, Greenfield and Braithwaite, 2015). Health inequities are exacerbated by local traditional, cultural and political socioeconomic barriers, and despite government commitments to gender mainstreaming, there has been little progress in translating these into tangible gains because of a lack of political will to address entrenched gender roles, status and power relations (Lamprell et al., 2015). Lamprell et al. therefore, caution against the uncritical adoption of policies, formulated in the global north to widely differing contexts, such as Papua New Guinea. They argue that whilst having an inclusive conceptualisation of gender mainstreaming is necessary, it is not sufficient, as attention has to be paid to the specific context for the implementation of mainstreaming.

However, it is also evident that progress on gender mainstreaming in the global north is problematic. A recent analysis of health policies in Australia, using the Policy Scorecard on Gender Mainstreaming to assess government commitments to gender mainstreaming demonstrated an absence of gender analysis, gender-sensitive research, women's perspectives or gender goals in health policies, other than women's health policies (Keleher, 2013). These difficulties resonate with my own experience of leading a national programme for women's mental health and gender equality for a national body, part of the Department of Health, in England. Whilst this represented a significant opportunity to address the inequities impacting on women's mental health that had long been a case for concern and chimed well with the introduction of a legislative framework to promote gender equality (Newbigging & Paul, 2010), the reality was of limited institutional support for substantive changes, both in terms of operational and institutional mainstreaming. Modest gains were made in terms of general awareness raising, training and development of networks, but fundamental shifts in the design of the mental health system to address their concerns and better meet the needs of women were not achieved within the short timescale of this programme (Newbigging et al., 2010). The dominance of key leadership groups by men and androcentric norms of behaviour, covert and overt antagonism to feminism and both the wider goals of gender mainstreaming and specific initiatives being contested, all served as impediments to progressing the agenda.

Arguably, given the deeply entrenched nature of gender inequities, gender mainstreaming has had just a moment in time to demonstrate an impact. Furthermore, the conceptual ambiguity and operational difficulties appear to have overshadowed the need for robust evaluation of its impact. Clearly, the focus on gender inequity in health needs to be sustained, both in terms of working on women-specific health issues and ensuring that gender equity is considered within all aspects of health (Ravindran & Kelkar-Khambete, 2008). There is agreement that this requires both political will and leadership by women whilst empowering and enabling community level action (Moser & Moser, 2005; Ravindran & Kelkar-Khambete, 2008).

Conclusions: Gender mainstreaming - possibilities and pitfalls

There is a clear rationale for gender mainstreaming in terms of articulating and making visible the impact and nature of gender inequities, and holding governments and organisations to account. It has, however, attracted much criticism, for its inadequate conceptualisation, ineffective operationalisation and damage to the feminist project of achieving equity for women. Critiques to date point to the necessity for greater conceptual clarity, moving beyond narrow binary distinctions to systematically reflect a deeper understanding of intersectionality, which disrupt oppressive relations of power (D’hamoon, 2011). This clarity needs to include greater specificity both in terms of context and a coherent theory of change that includes specific goals, including how mainstreaming can impact on political, social and cultural barriers to gender inequities (Lamprell et al., 2015; Tolhurst et al., 2011). Integrating gender into existing policies runs the risk of reproducing and sustaining inequities, whilst locating gender equity within a broader focus on rights and social justice and a proactive agenda-setting approach, holds possibilities for greater advancement of gender equity in health (Jahan, 1995; Porter and Sweetman, 2005; Ravindran & Kelkar-Khambete, 2008). This is contingent on addressing the institutional barriers that perpetuate the marginalisation of women and sustaining the radical edge of the feminism, which seeks to disrupt orthodoxies of power and recast gender relations to achieve greater equity for women.
References


This article examines similarities and differences with respect to how men and women think about intimate partner violence, and how each sex responded to an intimate partner violence prevention campaign. The study analyzes qualitative data collected in campaign development and evaluation. Results analyzed using grounded theory indicate that male and female attitudes were significantly different both prior to and following exposure to the campaign. While women tended to perceive intimate partner violence as a symptom of patriarchal relations, men did not view abuse within a gender context. While men expressed substantial resentment of existing gender stereotypes, women did not express such feelings. Both men and women expressed victim blaming attitudes and ambivalence towards bystander intervention. The authors draw comparisons between these male and female reactions and offer some suggestions for future campaigns that foster agency among both perpetrators and survivors while confronting the structural barriers to enacting change.

Key words: social marketing, gender, health communication, and intimate partner violence

Introduction

A growing body of literature documents gender-specific outcomes of intimate partner violence (IPV) interventions, with recommendations for designing prevention and treatment efforts differently for men and women. This study analyzes qualitative comments gathered in the development and evaluation of a campaign designed to increase awareness of abuse. Previous research indicates widespread audience denial of the issue, so the intervention described here focused on increasing the public’s perception of IPV as a severe community problem (Henning, Jones & Holdford, 2005). Campaign evaluations, reported separately, indicated that women increased their awareness of community services, and disagreement with common IPV myths in response to the campaign. Men, however, moved towards greater acceptance of abuse-related societal myths that the campaign was attempting to debunk (e.g., ‘Violence has to be physical to count as abuse’) (see Table 1) (Keller, Wilkinson, & Otjen, 2010).

Further exploration of the qualitative data, presented in this paper, examines reasons why the campaign may have produced such different reactions in men and women and makes recommendations for future campaigns to minimize potential backlash reactions among target and tertiary audiences.

Literature review

Intimate partner violence is a serious social problem in the United States. The National Crime Victimization Survey from 2012 found that, while domestic violence overall has decreased since the 1990s, it still accounts for a significant portion of violent victimizations. Specifically, IPV accounts for 15 percent of all violent crime in the United States, and 76 percent of abuse survivors are female. It is not surprising, therefore, that the great majority of interventions aimed at prevention and treatment of IPV focus on violence by men against women (Wathen & MacMillan, 2003). Researchers estimate that 25 percent of all U.S. women will be beaten, coerced into sex or otherwise abused during their lifetimes (U.S. Centers for Disease Control and Prevention, 2010). Among women aged 15-44 worldwide, gender-based violence accounts for more death and illness than malaria, traffic injuries and cancer combined (Endabuse, 2003). Despite the high rates of abuse, financial support for prevention remains low. Public health funding represents less than two percent of the national budget, and spending for intimate partner violence prevention constitutes only a small portion of public health funding (Lankford, 2008).

Intimate partner violence interventions

Responses to intimate partner violence have focused, to date, primarily on intervention after the problem has been identified and harm has occurred (Gosselin, 2010). A particular challenge for those working in intimate partner violence prevention is finding strategies for informing both survivors and perpetrators about services available. Often, neither audience is reached until the issue has reached the legal system. There are, however, new IPV prevention approaches emerging that can serve as models for development of these strategies (Wolfe & Jaffe, 1999).
Social marketing campaigns are one such approach. They aim to reach both perpetrators and victims in order to educate individuals about the severity of abuse and the availability of services. Through public service announcements and advertisements, such campaigns typically provide information regarding warning signs of partner violence as well as community resources for victims and perpetrators.

A review of IPV prevention programs from 1991-2001 found that, of the few public education interventions conducted, most were either not systematically evaluated or not associated with effective outcomes (Wathen & MacMillan, 2004). One exception was a comprehensive public education campaign developed by the Family Violence Prevention Fund (FVPF) that included television advertisements delivering the message that there is no excuse for partner violence, and referrals to local services. Results of a telephone survey from 1994-1996 showed significant decreases in the number of people who said they: (1) did not know what to do about intimate partner violence; (2) did not believe it was necessary to report incidences of intimate partner violence; (3) felt that it was no one else's business when a husband beats his wife; and (4) believed that the media exaggerated the problem of intimate partner violence (Wolfe & Jaffe, 1999).

However, even effective social marketing campaigns are not without pitfalls. Because the campaigns use mass media to disseminate messages, they are necessarily impersonal. In addition, creators cannot control who receives the messages. Social marketers know these campaigns run the risk of eliciting unintended effects among both the intended and unintended audiences (Cho & Salmon, 2007).

Social reproduction

Health communication may also reinforce existing social distributions of knowledge, attitudes, and behaviors. For example, an evaluation of the television program, *All in the Family*, indicated that the program, designed to dispel ethnic biases, actually reinforced existing biases among some viewers (Vidmar & Rokeach, 1974). Social marketing campaigns can run the same risk.

Campaigns, via social norming, can render individuals vulnerable to shame and isolation. Social norms demand compliance and forge conformity. A person who is out of alignment with the implicit and explicit social expectations becomes even more vulnerable to shame and isolation in a campaign atmosphere (Piers & Singer, 1953). For those who are able to adapt themselves to majority social norms, normative messages may lead to a healthier lifestyle. Those who cannot or will not conform to the majority are marginalized; the attitudes of the non-marginalized toward the marginalized can become increasingly negative (Goffman, 1963). This potential minefield is an even larger problem in health communication related to intimate partner violence prevention, because it is a particularly sensitive and emotionally laden topic, in comparison with many other health behaviors. Historically, family violence was conceptualized as a private, individual issue and, though it is increasingly recognized as a social problem, it is still cloaked in secrecy (Carlson & Worden, 2005). Many offenders and victims feel ashamed and embarrassed and thus do not seek intervention. Intimate partner violence interventions that are public (such as social marketing campaigns) may aggravate feelings of fear, shame, and anxiety that surround this issue.

Gender & society

Additionally, IPV is closely linked to gender relations in our culture. Partner violence is at once both intensely personal and a reflection of patriarchal social structures. Beginning in the 1970s feminist theorists began to make the case that ‘wife battering’ is the result of gender oppression in patriarchal societies (Rhode, 1997). Advocates of the feminist sociopolitical position argue that intimate partner violence is one manifestation of a gender order in which male violence is normalized and legitimized and in which women are systematically marginalized and disempowered. In his oft-cited model of gender relations, Conneilt (1995) asserts that there are three primary structures of gender inequality: power relations, production relations and cathexis. Viewed through this lens, perpetration of abuse by men against women can be conceptualized as the interpersonal enactment of larger cultural forces. In particular, both men's physical power and their economic power, achieved through a gendered division of labor, combine with women's powerful emotional commitment to a cultural script about the importance of marriage and motherhood, and work to disempower individual women in unhealthy heterosexual relationships. Individual couples may enact these powerful gender scripts in their own relations, with domestic abuse as an outcome. Current studies apply this social structural model as they seek to explain the continued prevalence of male violence against women (Davies, et al., 2009; Doane & Varcoe, 2008; Wolfe & Jaffe, 1999.)

This gender relations paradigm has been adopted in IPV prevention strategies with mixed results. For example, the "Duluth Model" (the Duluth Domestic Abuse Intervention Project) sought to achieve 'attitude adjustment' among violent men, encouraging them to cultivate a more feminist, and therefore egalitarian, view of their relationships (Milner, 2004; Dutton & Sonkin, 2003). Critics argue that the Duluth model was ineffective in reducing intimate partner violence, citing a recidivism rate of 40 percent among program participants, compared with recidivism rates of 23 percent for those enrolled in traditional "anger management" treatment programs. Dutton and Sonkin (2003) conclude that relying on cultural scripts about gender in the treatment of male offenders can cause shame among clients and lead to "tendencies to externalize blame, reject feedback and experience chronic levels of high anger" (Dutton & Sonkin, 2003, p. 2). These critics assert that insisting that dominant gender ideology is at work in interpersonal violence can foster a backlash reaction among abusive men, undermining the goal of reducing partner violence.
Other critics argue that feminist explanations of domestic abuse erroneously assume that all perpetrators are male and all victims female. Milner (2004) acknowledges that applying a gender lens appropriately highlights the fact that intimate partner violence is a social problem rather than simply rooted in individual pathology, but makes the case that intervention strategies designed to “challenge” men about their adorn gender scripts further oppress women, who are theorized as passive and powerless to change, and fail to provide services for violent women. Similarly, Dutton and Nichols (2005) charge that the feminist approach has ignored female violence, trivialized the victimization of males and oversimplified a complex problem.

What little research has been conducted on the characteristics of survivors of intimate partner violence has focused on women and most frequently assumed that victims suffer from “battered woman syndrome,” in which they develop a pattern of behavior that psychologist Lenore Walker termed “learned helplessness” (Gosselin, 2010; Kirk & Ozakawa-Rey, 2007). Subscribers to this theory assert that battered women develop a sense of powerlessness that, combined with societal acceptance and victim blaming, undermines their belief in their ability to escape the abuse. This theory helps explain the cycle of abuse and provides an explanation for why battered women return to the abusive situation. While the approach recognizes the pattern of behavior that psychologist Lenore Walker termed “learned helplessness,” critics say that it continues to place the responsibility for ending abuse on the victims themselves as individual agents and advocates social-structural explanations of intimate partner violence (Kirk & Ozakawa-Rey, 2007).

Navigating the gender minefield in social marketing campaigns

Recognizing this gendered nature of IPV and the results of previous studies, the 2006 “Open Your Eyes” campaign implemented gender-specific messages and images in its efforts to increase awareness of the severity of abuse and the perceived response-efficacy of intimate partner violence hotlines. Because the campaign employed negative and emotionally charged ads that challenged men, it may have triggered an angry reaction among some men. By relying on gender stereotypes, based on the gender breakdown of reported abuse, the ads appear to have triggered a backlash reaction among men. Although women increased their awareness of services and understanding of common abuse-related myths, the male backlash reaction may have undermined the effectiveness of the campaign (Keller, Wilkinson & Otjen, 2010).

Recognizing this potential pitfall, a more recent campaign sought to direct its message only at men. Mbilinyi et al. (2008) developed a social marketing campaign designed to recruit non-adjudicated abusive men to a telephone intervention program. The researchers worked to create images that would not “arouse defensiveness in men who were ambivalent about making changes” (Mbilinyi et al., 2008, p. 346). They employed three primary strategies: they avoided a confrontational or blaming tone, emphasized the impact of intimate partner violence on children (i.e., portrayed men as “family guys”) and advertised that there was help available. While identifying shortcomings, the authors conclude that the campaign was a success, since they met their enrollment target and received positive feedback from the advertisements.

The Mbilinyi et al. study deserves praise for its efforts to avoid demonizing men and its success in recruiting untreated abusive men for interventions. However, in working to avoid arousing defensiveness in men, the campaign runs the risk of causing unintended consequences among women. Emphasizing the essential “good nature” of abusive men may inadvertently send the message to women that intimate partner violence is not a serious problem and that victims should consider staying with an abuser. Although the authors acknowledge that victims’ safety could be inadvertently compromised by targeting only perpetrators, they do not address the possibility of unintended consequences for victims.

Recent campaigns have appropriately recognized that reliance on gender stereotypes can result in unintended effects, but thus far no campaigns have managed to avoid the dual pitfalls of inadvertently demonizing men and reducing the perceived severity of abuse in victims and the larger public. The aim of this study is to analyze qualitative data gathered in the development and implementation of the 2006 “Open Your Eyes” campaign and to suggest social marketing approaches that recognize the structural constraints of gender relations but also identify spaces for agency on the part of both perpetrators and victims.

Methods

The qualitative portion of the project takes a phenomenological approach (Dreyfuss, 1982; Creswell, 2007) to understanding participants’ understanding of, and attitudes toward addressing, the problem of IPV in their communities. A combination of in-depth interviews and focus groups was conducted as part of the formative research for the campaign. Samples were drawn from two counties selected for campaign exposure, located near a small city (population 110,000) in a rural, mountainous section of the United States. Participants were recruited through case study sampling (Luborsky & Rubinstein, 1995).

The combined methods approach was used because one audience segment, survivors of IPV, wanted to remain confidential. In-depth interviews were conducted with six survivors (identifed as willing to share their stories). Four focus groups (n = 32) were conducted with members of the general public, separated by gender and recruited without regard to their IPV background, in order to ascertain common attitudes and perceptions about the issue and barriers to seeking help. The total interview sample involved 38 participants (26 women and 12 men).
Interview and focus group data were collected in two different waves: 1) for preliminary information before the campaign was developed; and 2) after the ads were designed, but before they were disseminated, to pre-test the ads. In the 1st wave, participants were asked to respond to general questions about intimate partner violence (e.g., "What is your definition of intimate partner violence? What types of women [or men] do you think get abused? Do you think any woman or man deserves abuse? Have you ever been in a situation where you wanted or tried to help? Do you feel intimate partner violence is a major problem [here]? Is intimate partner violence an issue to you personally?"). Both men and women were asked the same questions. In the 2nd wave, subjects were asked to respond to screenings of the campaign ads before they were launched (e.g., "What is the key message that you got from this ad? Would you take any action as a result of this ad? If so, what would you do? If you were involved in an IPV situation, would this ad be helpful? Why or why not? Do you identify with any of the characters in the ad? If so, who? Why? If not, why not?").

All interviews were conducted by undergraduate and graduate students at a local university. The in-depth interviews were conducted by conference call, to enable the subjects to preserve their confidentiality, and the focus groups were conducted on the university campus.

Data analysis was conducted independently by two researchers (a communications scholar with a background in health campaign design and evaluation, and a sociologist with a background in gender studies) using a grounded theory approach (see Berg, 2009 for a concise explanation of content analysis using grounded theory.) Using concepts gleaned from the literature cited above, analysis was focused on identifying content related to gender issues in intimate partner violence and intimate partner violence interventions. There were two very general areas of interest:

1. General perceptions about the prevalence and handling of intimate partner violence in the community.
2. Perceptions about the role of gender relations in intimate partner violence and prevention.

After careful reading of the transcripts, the researchers developed a "start list" of codes, as recommended by Miles and Huberman (1994). Other codes were developed as themes and issues emerged. After coding all transcripts within categories related to the themes under study, researchers compared code categories to ensure that the themes were consistent and valid, adding some and collapsing those that overlapped. These themes are discussed in the results section.

Qualitative data are rich with detail and provide a glimpse into the complexities of a social issue not possible with even the most robust quantitative survey instruments. However, there are limits to the method and how the results can be applied. First, while care was taken in this study to analyze the data as objectively as possible, some researcher bias always exists. This bias is reduced by clear definitions of concepts, careful data collection, transparency in analysis, and replication by two researchers, but it cannot be eliminated. Second, because the research method is qualitative, rather than quantitative, the findings cannot be generalized to any larger population. By definition, qualitative data are not statistically generalizable. However, Kvale (1996) distinguishes between statistical generalization and analytical generalization and makes the case that qualitative data can be applied to contexts beyond the individuals or groups under study, as a guide to what might occur in another situation. In this sense, the findings of this study may potentially be generalized, at least as a tool to guide the development of future intimate partner violence intervention programs.

**Results**

**General perceptions of intimate partner violence**

**Theme 1: Intimate partner violence is minimized or denied**

The preliminary interviews and focus groups provided information relevant to the gendered aspect of IPV and the perceived difficulty in effectively intervening to stop such violence. Both men and women indicated that IPV is not "taken seriously" by the culture in general and is not a topic that is openly discussed, even among friends. As one man put it, "It's not something that usually comes up...It brings the conversation down." Women abuse survivors added that law enforcement, hospital staff and emergency personnel sometimes ignore what they perceived to be obvious signs of domestic abuse. One survivor said that when she was hospitalized for her injuries she told conflicting stories, hoping the doctors and nurses would get suspicious and start investigating. No one asked any questions and she was released after two days.

Consistently, when asked how often they thought intimate partner violence occurs, participants stated that they believe it is common but often invisible. This finding confirms previous research and suggests that social marketing campaigns to raise awareness continue to be crucial.

In related comments, victims indicated denial of abusive situations, or minimizing the seriousness of the problem. All but one (five out of six) abuse survivors reported that they initially denied that their situation was abusive and that friends or family members also minimized the issue. One woman reported that she felt that she and her abuser "just had a passionate relationship" and that she "felt like she deserved" (the beatings). Another said she "ignored the weird feelings" she got from her abuser and a third explicitly stated that she had been in denial during the abuse, going to individual counseling and trying to save the relationship. Many victims reported that others around them also participated in this minimization or denial. One survivor stated that her abuser's parents would "tell her how to be a better wife" in order to reduce the beatings and another said that members of her church encouraged her to work harder to make the marriage work.
Non-victims also made statements that indicate denial. For most non-victim women, comments reflected the theme discussed above—the belief that IPV is a more serious problem than is generally acknowledged. Male respondents in one focus group, however, actually participated in minimizing the seriousness of the problem. In identifying types of abuse, three focus group subjects distinguished between a “disagreement” and verbal abuse and indicated some confusion over what would be defined as abuse. One man suggested that words could be considered abuse if the “screaming” was “a constant thing or demeaning” and another agreed, saying, “Yeah, if it’s always happening, I guess?”

Further, the men in this group minimized the seriousness of the issue by resorting to jokes and laughter when asked if there is any type of woman who “deserves abuse.” One man asked, “Are there any blondes in here?” and then added, “Maybe it’s their moms or something.” The others laughed in response. These responses may have simply been an attempt to lighten the mood around an uncomfortable topic, but the fact that such comments were amusing to the others indicates that intimate partner violence continues to be a topic that is not always taken seriously.

Theme 2: Victim blaming
A second theme that arose in the analysis was a tendency among respondents to blame victims of abuse. This theme is linked to the first in that blaming the victim is a method of minimizing the severity of the problem. This theme was far more common among male respondents than female. While it might be reasonable to expect survivors themselves (who were all women) to avoid victim blaming, this was true of non-victim women respondents, as well. Only one female participant made a victim blaming comment. Consistently, it was the male subjects who made comments coded as victim blaming.

Eight of the 12 men in the sample made victim blaming statements. Most common were statements asserting that, while no one “deserves” to be abused, some victims “provoked it.” Representative comments included: “Women who stay after their eyes are opened are now stupid victims, not innocent victims”; “I do not condone violence of any kind; however certain conditions may apply,” and, in a clearly gendered explanation:

“The woman wants to talk and talk and talk about it. And that drives a guy nuts after a while. Cuz there’s a point when it no longer goes through them; it just keeps hitting them in the head. And then they start to get a little frustrated, and the woman pushes it a little bit further, and what’s the guy gonna do? He’s either going to hit the wall or hit her, if it comes to that extent.”

Later in that same focus group, a second subject continued the gendered analysis, asserting that women might prevent abuse by dressing differently; “Maybe if you cover things up maybe that would be, would stop a lot of the sexual violence.” This finding, along gender lines itself, indicates that there continue to be gender stereotypes surrounding intimate partner violence and that victims continue to be blamed for abuse.

Perceptions of gender and gender relations

Theme 3: Intimate partner violence as a manifestation of patriarchal relations
One question that was asked of preliminary respondents was what factors lead victims of intimate partner violence to stay in abusive situations. Victims of abuse, all female, talked about a number of factors, but the most common reasons given were economic dependence and the belief that they needed to fulfill their marital and/or familial obligations. Non-victim women also cited these reasons for victims staying with abusers. Participants made statements like: “I have heard of husbunds threatening to cut off insurance benefits or inheritance money;” and “Sometimes it hurts the woman if the guy goes to jail, financially.” One survivor actually listed control of the money as evidence of domestic abuse. When asked what could be done to prevent domestic abuse, these women made suggestions like “Get your own money” and “eliminate poverty.”

These women also cited dominant gender roles as a barrier to women escaping abuse. They explicitly implicated “traditional” ideas about women’s roles as a causal factor in IPV. Ten women made comments coded as gender role explanations. These subjects frequently made comments about the expectation that women stay in their marriages and remain dedicated to their families. One survivor noted that she had been raised that “when you get married, you stay married, and try to work on it as long as you can.” Another, when asked how victims could be helped, replied, “Especially target the fundamentalists who believe that the woman should be subservient to the man.”

These issues were not mentioned by male respondents, who generally attributed victims’ unwillingness to leave abusive situations to their individual characteristics, like insecurity or a family history of abuse. This is a significant finding because only women—victims and non-victims alike—explained the helplessness of female victims using a gender lens. In citing economic dependence and cultural scripts about gender roles, women respondents confirmed Connell’s (1995) theory that patriarchal gender relations perpetuate intimate partner violence.

Theme 4: Gender backlash
Some respondents demonstrated a “backlash” response to stereotypical gender scripts in society, and the cultural framing of partner violence as abuse perpetrated by men against women. Though this was not exclusively a male phenomenon, men were more likely than women to express these sentiments. Two female respondents made the argument that men can be victims too, compared with seven men. These respondents reported that men are unfairly assumed to be the perpetrators. They also reported that men are almost exclusively penalized for abuse by the legal system. For example, one male focus group participant claimed that his ex-wife abused him and he defended himself, but that law enforcement assumed that he was the instigator.
and arrested him. Another member of that group stated that, “(In) a lot of states any domestic occurrence that happens, the man is the one that’s taken away. Cuz you’re more powerful than a woman.” In the pre-testing of the campaign ads, three men suggested that the designers ought to work to resist gender stereotypes in the ads. One participant suggested that an ad reverse roles and have a mother hit a boy (instead of a father). Another suggested that men need to be depicted as victims, too.

While women couched the issue of IPV in gender-specific ways and affirmed that patriarchal gender relations within interpersonal relationships can lead to abuse, men resisted gender attributions, asserting that both men and women are potential perpetrators and victims. In addition, men did not cite gender relations (either in the form of economic dependence or traditional gender roles) as a factor in why victims do not leave abusive situations.

**Suggestions for future campaigns**

Both men and women participated in pre-test focus groups. After viewing and reading potential ads, they provided feedback about which images and messages were effective and which needed improvement. Overall, respondents liked powerful imagery and messages that used “scare tactics” or other techniques to jolt viewers into paying attention. In particular, participants approved of ads that showed “real life” consequences of domestic abuse, like perpetrators being handcuffed and taken to jail (shown in one of the final campaign ads). Men, specifically, reacted to the depiction of perpetrators as male and made suggestions about “humanizing” the abusers depicted. They liked ads that did not demonize perpetrators as inherently “bad” people, but that illustrated that abusers learn their behaviors and are often frightened or panicked by the damage they inflict. In addition, they suggested that it was important that the ads depict efficacy in seeking help for perpetrators. These participants recommended that ads depict perpetrators calling hotlines and receiving assistance, to show that “people do get out” of the cycle of abuse (portrayed in another of the final campaign ads). They also warned that portraying men only as perpetrators might alienate men, who feel demonized as a group.

**Discussion**

These findings suggest that gender remains a salient aspect of both the prevalence and prevention of intimate partner violence. Men’s and women’s responses in focus groups and interviews differed significantly from each other, with women more likely to cite patriarchal gender relations as a factor in domestic abuse. Men, on the other hand, exhibited resistance to the gender stereotypes depicted in the ad campaign and in the larger culture. Both of the potential pitfalls of gender-specific social marketing campaigns are evident in the data reviewed in this study. While men may be alienated by stereotypical depictions of male abusers and female victims, appealing to men as “good guys” who just need a little help risks contributing to a culture that already minimizes and even denies the seriousness of intimate partner violence. One possible solution to this conundrum, as suggested by respondents, might be to continue to employ gender scripts in social marketing campaigns (depicting men primarily as perpetrators and women primarily as victims) but to show men in agentic roles—seeking help and improving their relationships, rather than demonizing them as members of a dominating, misogynistic fraternity of men.

The highly gendered nature of IPV will require careful tailoring of educational messages to address the unique needs of each sex, and, ideally subsets within each sex on the topic of abuse. Alienating men—or angering men—in an effort to increase public recognition of the prevalence and severity of abuse will risk backlash reactions, and may aggravate the very problem the intervention is trying to address, as highlighted by Girard’s (2009) study of men’s rights discourse in policy debates. On the other hand, interventions designed to sympathize with male abusers may unintentionally sanction public acceptance and denial of abuse, making it less likely or less easy for victims to leave abusive situations. Clearly, a careful balance is needed to simultaneously address the needs of victims, and the needs for public recognition of the severity of abuse, without alienating men. In order to increase male understanding of abuse, and engagement in prevention, positive messages are needed that role model preventive behavior. In order to increase female understanding of abuse, and increase victim support and self-efficacy to leave dangerous situations, the patriarchal context of abuse must be acknowledged and the structural constraints to action must be addressed. More work is needed to understand what types of messages will be effective among men, without dismissing or minimizing the problem, and what types of messages can be effective among women without alienating men.
### Table 1. Perceptions about intimate partner violence measured by survey

**On a scale of 1 to 5, one being strongly agree and five strongly disagree, please answer the following statements.**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimate partner violence should be settled within the family rather than involving the police or government officials.</td>
<td>5</td>
</tr>
<tr>
<td>Some people provoke abuse and deserve it.</td>
<td>3</td>
</tr>
<tr>
<td>There are no real victims of domestic abuse as we all have choices and can leave at any time.</td>
<td>2</td>
</tr>
<tr>
<td>Domestic abuse is a serious issue that our community should focus on preventing.</td>
<td>4</td>
</tr>
<tr>
<td>Physical, sexual, emotional, spiritual, and economic abuse are all forms of domestic abuse.</td>
<td>5</td>
</tr>
<tr>
<td>Domestic abuse is a serious crime and the abuser should go to jail.</td>
<td>3</td>
</tr>
<tr>
<td>I, or someone else in my family, is at risk of abuse.</td>
<td>2</td>
</tr>
</tbody>
</table>

### Table 2. Focus group results

<table>
<thead>
<tr>
<th>Themes</th>
<th>Example comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Minimization of abuse</td>
<td>“I know] a couple who was very active in their church where intimate partner violence was going on—She was afraid to say anything because they were leaders in the church and she thought everyone would look down on her for a divorce.” (female)</td>
</tr>
<tr>
<td>2. Victim blaming</td>
<td>“Women who stay after their eyes are opened are now stupid victims, not innocent victims.” (male)</td>
</tr>
<tr>
<td>3. Bystander helplessness</td>
<td>”At times [I think about intervening], but it’s one of those things where you step in, you don’t know what’s gonna happen back to you or whether you can stop it, or it might get worse for them when they get home.” (male)</td>
</tr>
<tr>
<td>4. Abuse as result of patriarchal relations</td>
<td>“By the time you get hit, your confidence has been worn down by emotional abuse so that you actually believe that it is your fault and that you have done something wrong, isolation is a huge factor.” (female)</td>
</tr>
<tr>
<td>5. Gender backlash</td>
<td>“I suggest you reverse the roles. Have the mother hit the boy…or have the man raise his hand to silence the boy when he starts to speak, ‘Daddy…’ and then freeze frame the father’s lifted hand.” (male)</td>
</tr>
<tr>
<td></td>
<td>“No one would take my son seriously, because women are never abusers, right? So he’s been victimized twice, by his wife and by the system.” (female)</td>
</tr>
</tbody>
</table>
Navigating the Gender Minefield: An IPV Prevention Campaign Sheds Light on Gender Gap

References


Report from the Field: The Network of Safety in Mountain Communities

Vincanne Adams, Sienna Craig, Arlene Samen, Surya Bhatta

"On our last visit to Baglung District, Nepal, we had to drive six hours from Kathmandu over a bumpy, winding dirt road, across rivers … you know, remote. When we finally got up to Tangram village in the mountains, the senior auxiliary health worker came out to meet us. He began to tell us about how the [One Heart World-Wide MCH] program was working. He knew all the statistics about who delivered and how many delivered, and all the progress they’d made. He said that as a leader in the community he established a no-home-births policy. ‘No women should deliver at home, and no one should deliver alone,’ he said. He went around to every household in the community and collected money and with that money he built a birthing center. This was probably also related to the fact that our organization had promised to supply the equipment for the center. Another man in the village donated his land for the building site. He was not even a wealthy man. Together the community built this space. It was one of the best I have ever seen: well constructed, clean, organized, en-suite bathroom, a separate room for intake and prenatal care, a room for labor and delivery, and a room for postpartum care. All of the decisions and effort that created this facility were initiated by the men in this community. Not just the raising of the money and setting the policy, but the community outreach as well. The district health officer was a man. The head of the hospital was a man. Most health post supervisors were men. The person who donated the land was a man. In many ways it is always men who are decision-makers about health care for women. So, of course, men will be the driving force for change."

This story, told by the director of a small NGO devoted to safe motherhood in Nepal’s Himalayan communities, offers some key insights about the challenges and achievements of working in mountain communities anywhere. One Heart World-wide began its program in the Baglung and Dolpa Districts of Nepal in 2010, after having successfully developed similar programs in the Tibet Autonomous Region, China, over the previous decade. Recognizing the particular obstacles facing women in remote mountain regions, OHW developed an approach called the "Network of Safety," which responds to these particular challenges. This report from the field offers a concise overview of how the Network of Safety works, and how it sometimes produces unexpected outcomes arising from the challenges of working in mountain communities.

In many ways, these outcomes, and the conditions that produce them, replicate the very same challenges faced by people living in mountain communities.

The list of challenges to safe motherhood in remote mountain communities is long, especially in regions that are at once geographically remote and socioeconomically disadvantaged. In many of the regions where OHW works, there are often no paved roads, little to no transport for emergencies, and minimal functioning government-supported health care infrastructure or resources (including essential drugs). Some communities where OHW works practice agro-pastoralism, such that members of households, including pregnant women, are “on the move” or in high-altitude pastures during the summer months. Extreme weather conditions add to the on-the-ground complexities of serving mountain communities, which are also marked, even in proximal regions of Nepal, by a great deal of cultural and sociolinguistic diversity: communities distinguished by the deep valley or a high mountain pass.

The Network of Safety approach used by OHW begins to address and overcome these challenges by providing a model for intervention that is flexible and that focuses on being responsive to the particular and unique needs of each community. The Network of Safety model emphasizes cultural respect, local, education and infrastructure. Education includes community and provider trainings that are aimed at mothers, husbands, health workers, and other community members, all the way to policy makers in the government. The aim here is to scale across,1 paving the way for systemic change in the whole system by starting small and working outward. OHW is also addressing key infrastructural gaps and obstacles to safe delivery by investing in the improvement in health facilities; this often involves partnering with government institutions. The Network of Safety attempts to surround the mother and her child with the kinds of resources and skills that are needed for health and safety, depicted schematically in this image.

The Network of Safety model deals specifically with problems of mountain communities in relation to access, diversity, and geography. Whenever OHW begins work in a new place, they begin by using ethnographic research methods to understand the specific histories, diverse experiences and challenges of that community. The OHW approach focuses on one community or catchment area at a time, trying to build a complete network in a small area, rather than trying

1 Adams, Craig, Samen 2015.
to scale up quickly or provide a single, vertical intervention across a vast region or population. In this, the aim is like that of Partners in Health’s Human Rights approach that devotes attention to multiple problem-solving tasks in one area before moving to another. Furthermore, OHW relies on local knowledge and resources to build from the ground up. This focus on local knowledge and resources helps ensure that programs that are built resonate with community needs and desires, and this helps to ensure their success. The community leader in the example above, for instance, became interested in working with OHW after the director introduced the project to a group of male health post directors. She asked the men about their involvement in safe deliveries, imagining how their lives would be different if their own mothers had died in childbirth. They then began to talk about how they recognized that they were part of the problem that women faced in not having safe deliveries. They therefore wanted to be part of the solution.

One of the advantages of the Network of Safety approach is that the model is nimble. Even if the needs of a neighboring community are quite different—in terms of infrastructure, culture or accessibility—the network can be adapted. This becomes important in mountain communities, where cultural, religious, and economic conditions can vary dramatically from one mountain or valley to the next. For instance, in Dolpa District, as one moves up in altitude, communities change from middle hill villages that are largely Hindu sedentary farmers to the higher elevation communities which are largely culturally Tibetan Buddhist pastoralists, farmers and traders. The attitudes toward delivery in these two communities share beliefs about the pollution of childbirth but in each community this belief plays out differently. Hindu beliefs about delivery require seclusion and keeping distance from men, but Buddhist beliefs focus on protecting families from the blood of childbirth but not necessarily keeping childbirth from the presence of men. Using the Network’s adaptive tactics may mean recruiting and training different key players in caregiving in each community and working with, rather than against, non-biomedical understandings of what makes a birth “safe.”

Similarly, villages in OHW catchment areas may have radically different profiles when it comes to existing health care infrastructure. In some areas, OHW interventions are often the only interventions and resources the villages have had, despite the fact that government health services should, theoretically, be available. Initially the network approach focuses on setting up personnel and facilities, and this often means obtaining commitments from the local, regional or national governments to provision the clinics and pay the skilled birth attendants who are initially trained by OHW. Often, however, the kinds of resources each village has, or has access to, are quite different, requiring distinct approaches to training and infrastructural support. Villages that have skilled birth attendants already, for instance, may need refresher training and support, whereas villages with no such health care workers will need recruitment, more training and ongoing support. The same is true for infrastructure in clinics, medicines, technologies and the financing for such resources. Each community may have different starting points, necessitating an ad-hoc approach to different kinds of investments in each place. Over time, the efforts of OHW can lead to further growth in primary care services. In Upper Dolpa, for instance, there were no health workers prior to the work of OHW, there are now health posts and health workers who provide not only family planning but

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2 Partners in Health Human Rights Approach https://donate.pih.org/page/s/declaration

also immunizations and general medical support and referral. Tailoring the project to the local community creates a sense of community ownership, which is vital to sustainability. This too helps people to gradually trust modern medical care, which never existed in past.

Problems of accessibility to health care and the provision of emergency evacuations in mountain regions are daunting at best for OHW teams. They can also be absolutely terrifying for the trained birth attendants who are given the job of keeping women alive in remote mountain communities. Often there is no option for emergency evacuation. Approaching these problems from the perspective of a Network of Safety means determining contingency plans for different cultural, geographic, and socioeconomic terrain, and for different sorts of medical emergencies. To this end, one of the education goals is to create channels of communication that allow birth attendants to reach out to people in the community to learn who has animals that can be used for transport or teams of men who can carry women. The team stresses the importance of sharing information about deliveries when they are in progress so that such resources can be mobilized. An important focus here is also on getting the community to recognize problems in delivery earlier, so that it is possible to get women to a skilled clinic in time. 4

Even with efforts to get women to clinics, timing can be a challenge. A OHW trained skilled birth attendant in one of the most remote high altitude villages of Dolpa District recalled a frightening incident in which she was called to help a mother who was part-way through her delivery of a stillborn. Faced with one of the most dreadful and difficult scenarios of her life, the birth attendant had to find a way to extract the dead baby with rudimentary instruments and without anesthesia. She saved the mother’s life but wonders to this day if she could have done more, and deals with the ongoing stress and anxiety over the thought of this happening again. Having to make such decisions about how to save lives is often radically different than being a healthcare worker in one of Nepal’s urban areas, let alone in a fully industrialized and well-resourced context. And yet, this birth attendant was not only able to act in ways that saved a mother’s life, but she was then given ultrasound training and use of a handheld ultrasound so that she could recognize complications sooner and refer and evacuate before this sort of event occurred again. This kind of tactic also helped bolster her sense of confidence in her work in the mountain village where she is based.

The Network of Safety approach often takes the OHW team in unexpected directions that pose new challenges, and ones that are often unique to a given village, or moment in time. We see this quality as resonating with the very qualities of the communities where OHW works. That is, in mountain communities people have learned to adapt to demanding environments, to survive and even thrive in some of Earth’s most uncompromising locales. People who are used to facing these challenges are often quite receptive toward working with an organization whose mission and approach endeavors to embrace this sense of adaptability. We see these qualities of adaptability and improvisation as well as tight-knit senses of mutual aid and social support, as they arouse as valuable and instructive for the kind of work that is involved in keeping women alive and improving their chances for survival in mountain regions.

Returning to the story at the beginning of this essay, we note that the Network of Safety interventions often produced unpredictable windfalls as side-effects of the focus on delivering women. When OHW began its work in Baglung District, the team anticipated meeting resistance from the men, given what was known about the isolation of women, and the traditional profile of rural uneducated communities, the cultural suspicion of and fear of the blood of childbirth that had prevented women from being cared for during delivery. 5 In fact, the opposite seemed to occur: Not only did the men end up taking an active part in the decision-making about safe motherhood, but they became active contributors to the programs that OHW helped to launch.

As other literature suggests, the needs of delivering women in the most mountain regions are overlooked simply because the challenges they face are so much more extreme than those in easily accessible communities. Indeed, many large NGOs and government aid organizations simply give up on making these communities a target because their challenges are too huge. Instead, they focus on those places where they can get more impact for their investment, and these are often in more accessible places that have roads, a well-established (even if minimal) health care infrastructure and access to resources. Even though it is daunting, and even though many organizations are unwilling to face these challenges, we would argue that with the right approach the provision of high quality maternal and child health care in mountain communities can be accomplished.

5 See the Nepal Safer Motherhood Project http://www.nsmp.org/pregnancy_childbirth_nepal/index.html

One Heart World-Wide’s mission is to decrease maternal and neonatal mortality and morbidity in remote rural areas. Its lifesaving skills programs were initially established in the late 1990s in the Tibetan Autonomous Region. During its time in Tibet, One Heart World-Wide experienced a number of significant successes in collaboration with the Lhasa Prefecture Health Bureau and the Women’s Federation. Over the last ten years, the organization was able to decrease unattended home births from 85 percent to 20 percent, mostly by ensuring the presence of a skilled attendant at delivery. In 2008, in the two counties where One Heart World-Wide was working, the Lhasa Prefecture Health Bureau reported no maternal deaths and newborn death rates dropped from 10 percent to 5 percent since the start of the One Heart World-Wide project.

One Heart World-Wide is also now responding to the devastating magnitude 7.8 earthquake that occurred in Nepal on April 25, 2015.
Introduction

Girls suffer many forms of discrimination that have adverse effects on their health, but none are more discriminatory or more damaging than those practices that are aimed at ensuring a girl’s virginity on marriage.

In many cultures and religions it is literally a matter of life or death that a bride is a virgin on marriage and many traditions and practices ensure that she will have had no sexual experience before her wedding night. Two of these discriminatory practices have particularly far-reaching consequences for a girl’s health—child marriage and female genital mutilation. They are both extremely common.

Child marriage is defined as marriage before the age of 18—before the girl is old enough physically and mentally to cope with a resulting pregnancy or mature enough psychologically to handle the relationship with her husband and his family (ICRW, n.d.). If a girl is married before or on reaching puberty she will have less opportunity, or desire, for pre-marital sexual experiences.

The main purpose of female genital mutilation (FGM), defined as “procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons” (WHO, 2014) is to ensure a girl remains a virgin until her marriage and to deprive her of sexual satisfaction afterwards so she will not be tempted to be unfaithful to her husband.

The scale of these forms of discrimination

Many more girls living in low- and middle-income countries (LMICs) suffer child marriage and FGM than their counterparts who live in richer countries (WHO, 2014).

There are approximately one billion girls in the world today (U.S. Census Bureau, 2010). It is estimated that 1 in 3 of these girls are married before the age of 18, and 1 in 9 before the age of 15, but this may be an underestimate as many marriages are not registered. If current trends continue, in the next 10 years a further 100 million more girls will be married before they reach the age of 18. Early marriage is particularly common in South Asia, sub-Saharan Africa and parts of Latin America. In certain countries in sub-Saharan Africa many girls are married before they reach 15 years old (ICRW, n.d.).

Across the world from 100 to 140 million women have endured FGM, and about three million more girls are being ‘cut’ every year. FGM is widely practised in Africa, the Middle East and Southern Asia; in Africa alone over 90 million girls and women have had some form of FGM. In seven countries almost every girl is ‘cut’ (WHO, 2014). There are significant numbers of girls and women who have undergone FGM in developed countries where they have settled after emigration.

Despite increasing international disapproval of both these practices it would be optimistic to imagine that the situation will improve, as almost all the estimated growth in global population will be in LMICs, where the percentage of young people reaching puberty is high and these practices are most prevalent (UNFPA, n.d.).

The consequences of child marriage and FGM on girls’ health

Sex within marriage is usually not negotiable even if the girl has not reached puberty and as soon as she begins to menstruate she will face pressure from her husband to become pregnant. The majority of sexually active girls between the ages of 15-19 in the developing world are married (Bruce, 2007).

Amhara is a rural region of Ethiopia with a population of about 19 million people where it is estimated that half of all girls are married before the age of 15. A study carried out by the Population Council found: only 5% of girls knew their husband before the wedding, only 15% knew they were going to be married before it happened, only 20% consented to the marriage, 81% said their first experience of sex was forced and against their will (up to 90% of those married under the age of 10), and 69% had their first sexual experience before they started to menstruate (Erulkar et al, 2004).
A girl’s husband and his family will want and expect pregnancy to follow shortly after marriage and 90% of first births below the age of 18 are to married girls (Interagency Youth Working Group, 2005). In Niger, 52% of girls have given birth before they reach the age of 16, and a quarter of all girls in sub-Saharan Africa have had a child by the age of 18 (UNICEF, 1994).

Maternal mortality is responsible for over 300,000 deaths each year (WHO, 2014) and is the main cause of death for 15- to 19-year-olds in the developing world (UNFPA, 2004). Around 70,000 teenage mothers die each year from unsafe abortions (PLAN, 2007). Mothers under the age of 15 are five times more likely to die in childbirth than those in their 20s (UNFPA, 2004). In a survey in 2007 one in six mothers died in childbirth in Afghanistan and Sierra Leone (UNICEF, 2007). It is such a concern that its reduction was made Millennium Development Goal 5, Target A: “to reduce by three-quarters by 2015 the maternal mortality rate.” In the latest report on the achievement of the Goals, the “maternal mortality rate has dropped by 45% between 1990 and 2013” but “in developing regions (it) is still 14 times higher than in the developed regions” (UN, 2014).

One common consequence of childbirth in very young mothers is the condition of obstetric fistula. One million girls and women, largely in the poor regions of sub-Saharan Africa and South Asia, suffer from obstetric fistula—with only two percent receiving any treatment (Fistula Foundation, n.d.). As a result of the damage caused by prolonged labour (which may last days) faeces or urine flow unchecked out of the vagina and, apart from the medical consequences, the girl is usually ostracised because she is perceived to be unclean.

The younger the bride, the greater the age difference is likely to be between her and her husband. In South Asia the average gap is five years; in sub-Saharan Africa the average gap is six years (UNICEF, 2007). However, in Guinea if the bride is younger than 18 years old there is an average age gap of 14 years (Bruce, 2007). As a consequence, the older husband is likely to be sexually experienced and have had several partners who may or may not be prostitutes—raising the likelihood that he will pass on sexually transmitted diseases to his wife. In areas where HIV is prevalent this puts him at risk of infecting his wife with HIV. Studies show that married girls are more than 10% more likely to be HIV positive than unmarried girls in the same area. In one area of Kenya, 33% of married girls aged 15 to 19 were HIV positive compared to 22% of unmarried girls (Bruce, 2007). These young wives do not have the power to negotiate abstinence or the use of condoms with their husbands, and indeed to do so could put them at risk of a violent response.

Domestic violence is another common consequence of child marriage. According to a WHO study of domestic violence in a range of countries and urban/rural settings, the incidence experienced at the hands of an intimate partner ranged from 15% of women in a Japanese city to 71% of women in rural Ethiopia (WHO, 2005). Domestic violence includes, at its most extreme, murder and severe physical violence, but also includes slaps, insults, isolation and humiliation, which generally go unreported, even though the psychological trauma can sometimes be as damaging as physical abuse. It is difficult to establish the scale of the problem as it is estimated that only a third of such cases are reported but the wider the gap between the ages of the husband and wife, the greater the likelihood of violence, both active and passive.

Apart from the obvious results of physical and sexual violence, young wives often live in a climate of fear that effectively stunts their development and prevents them from protecting themselves against HIV or pregnancy or acquiring any economic independence.

In the Middle East, Asia and Africa, polygamy is still practised where Islamic traditions are strong or where traditional religions and customs allow a man to have several wives (Seagar, 2005). Polygamous marriage is particularly challenging for a child bride as she will become part of a family which not only has a dominant mother-in-law but also more senior wives. If she is very young then she is likely to be treated as a sexual and domestic slave and she will have little power within the household and minimal influence over her husband’s decisions.

Female genital mutilation results in many physical health problems, sexual difficulties, depression and psychological damage. In the short term it causes the loss of blood, pain and shock, and if carried out under unclean conditions there is the risk of acute infections, made worse by the application of traditional poultices such as dung and earth. Later on there can be abscesses and scarring, and infections that can lead to tetanus, gangrene, urinary tract infections and infertility. The WHO carried out a study that showed that women who had undergone FGM were much more likely to have a caesarean delivery and have babies that died before or just after birth (WHO, 2001).

With infibulation the passing of urine can be obstructed as can the menstrual flow, leading to infection and inflammation. Infibulated women have to be opened up before they can have intercourse with their husbands and childbirth is particularly gruesome as they have to be opened up to deliver their babies, often tearing apart scars, leading to severe haemorrhaging. They may be infibulated again afterwards.

If the girl is living in a more liberal society, the traditional reasons for her mutilation are even harder to explain and understand.

CAUSES OF DISCRIMINATION

There are still many societies where men use their power to discriminate against women and to control them. In these communities they hold all the economic power and their domination is reinforced by their religion and culture.
Over 80% of the world’s population profess to belong to a religious faith (Adherents, 2003), many of whose conservative and fundamentalist sects legitimise discrimination against girls. It is not only on an individual level where religious doctrines have a damaging effect on the health of girls; faith groups have a disproportionate influence on policy-making, especially on issues concerning sexual and reproductive health.

Some cultures and traditions allow for a wide diversity but some are extraordinarily prescriptive. FGM is an entrenched ritual even though no religion has texts that insist on it. Where FGM is practised, girls of certain ethnic groups will have a high incidence irrespective of their religion and almost all girls, both Muslim and Christian, in Egypt, Eritrea and Mali are subjected to FGM (WHO, 2014). Although FGM is common in several strongly Islamic states there is considerable divergence of religious opinion as to whether it is forbidden or obligatory. Mothers are often strong advocates for FGM in certain cultures and insist on ‘cutting’ their daughters because otherwise they would not find husbands and would be considered ‘unclean’ by their communities. It is not only women from traditional and rural communities who strongly support continuing this custom. Many women persist in cutting their daughters as part their motherly duties even when they are living in a developed country.

Poverty increases the pressure on families to marry their daughters early, even if it is not one of the customs of the community. Marrying a daughter to an older man who can afford to keep her ensures her survival or gives her a better life—materially at least (ICRW, n.d.). Added to this, the shortage of marriageable women in some areas means that men are seeking brides from outside their communities, or even their countries, and are prepared to pay for them – a tempting proposition for some very poor families in rural Egypt (PLAN, 2007).

**Pro-equity policies: how effective?**

Sixty-six years after the Universal Declaration of Human Rights we still do not have effective global institutions with the courage to challenge the vested interests of male-dominated societies, even though there are many pro-equity policies agreed by the majority of the world’s states.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979) S(a) states, “Parties shall take all appropriate measures to modify social and cultural patterns to eliminate prejudices of customary and all other practices which refer to inferiority of women.” (UN, 1979) This Convention was supposed to come into force in 1981. It has been supported by 186 states (with the shameful exceptions of Qatar, Tonga, Iran, Sudan, Nauru, Palau and Somalia) and is one of the world’s most ratified treaties (PLAN, 2007). It stipulates that, “Countries who have ratified or acceded to the Convention are legally bound to put its provisions into practice. They are also committed to submit national reports, at least every four years, on measures they have taken to comply with their treaty obligations” (UN, 1979)

In the 1994 International Conference on Population and Development, FGM was specifically recognised as a form of extreme violence against women and steps to end its practice were included in its Programme for Action.

The African Charter on the Rights and Welfare of the Child has been signed and ratified by 39 African countries and was to come into force in 1999. This specifies that the “marriage or betrothal of girls and boys shall be prohibited and the minimum age for marriage shall be specified as 18” (ACERWC, 2014) and yet early marriage is extremely common in many countries in Africa.

In 1995 the UN’s Fourth World Conference on Women agreed on a Platform for Action—an extremely impressive blueprint for improving the situation for women and girls. Sadly, as with its predecessors, much of its Platform has not been implemented.

The Millennium Development Goals were agreed to in 2000 and the achievement of these targets would immensely improve the lives of girls and women. However, only Goal 2—“achieve universal primary education,” Goal 3—“eliminate disparity between girls and boys in primary and secondary education,” and Goal 5—“reduce maternal mortality rates and achieve universal access to reproductive health,” even tangentially address the abuses of child marriage and FGM. According to the UN’s latest summary update these ambitious targets are not likely to be achieved by 2015 (UN, 2014).

As a result of all these international conventions most countries have national legislation protecting the rights of girls but they are not implemented.

Most countries specify the minimum age of marriage (although at least 38 states do not) but it is a highly complex situation, with many countries specifying a civil minimum (which can be as young as 12 years) but accepting that religious, customary and traditional laws allow marriage at younger ages. Different minimum ages of marriage for boys and girls are found in at least 44 countries (Save the Children, 2011). But often marriages are not registered, so the law cannot be invoked and similarly many births are not registered, so the age of the girl cannot be established. In many countries even where the laws are clear, governments rarely contend with their religious or traditional communities to enforce them. Even if laws were enforced, this could only be done once the marriage had been arranged or taken place and this could cause even more problems for the new “wife.”

Despite international concern and efforts to stop FGM, it still continues and “action to bring about any substantial change has been slow or superficial” (OHCHR, 1994). In almost half the countries where FGM is common it is illegal but the law is widely ignored. In practice, making FGM illegal may actually make the situation worse as the practice often continues in secret and
therefore under more unhygienic conditions. Egypt, for example, made FGM illegal in 1997 but it was only banned in 2007 after a girl died under anaesthetic while undergoing FGM. In a study in 2000, there had been prosecutions in only four countries where FGM is endemic (Rahman and Toubia, 2000).

There are discrepancies between a government’s intentions, as exemplified by its legislation, and its inability or unwillingness to tackle the religious communities and traditional customs that perpetuate the denial of the rights of girls. However difficult, governments must be held to account for the commitments they have made to various Platforms for Action and enforce their own legislation. Governments can be successful—FGM was declared illegal in Burkina Faso and the law was forcibly applied with fines and prison sentences, alongside public information campaigns, and now the majority of women have turned against this practice (UNICEF, 2005).

States in both the developed and developing world generally abdicate their responsibility at the door of the family home yet much of the discrimination meted out to girls is often perpetuated by her own families.

Religious leaders must speak out against harmful customs that are not part of their religious doctrines.

It is not a coincidence that the greatest discrimination against girls takes place in LMICs where poverty is a major factor. Any success in alleviating poverty would have a significant impact on the implementation of pro-equity policies.

Ethical questions surrounding identity, beliefs and value systems give rise to an undermining ambivalence over the implementation of pro-equity policies. Should communities have the right to perpetuate customs that are seen to be an integral part of their identity, even if these same customs infringe on the rights of a large percentage of their population? Does cultural ‘sensitivity’ absolve the international community from saying that discriminatory practices are wrong? Should states or international agencies actively promote their views on human rights in countries where local values are very different? Where governments are unwilling or unable to support the human rights of all their population including girls, should donor governments, aid and development agencies put pressure on them through the refocusing of aid or by withholding it? Where does tolerance end and action against the abuse of human rights begin? A powerful response to these questions was outlined by Dame Rosalyn Higgins (President of the International Court of Justice, 2005-2009) “It is sometimes suggested that there can be no fully universal concept of human rights for it is necessary to take into account the diverse cultures and political systems of the world. In my view this is a point advanced mostly by states and by liberal scholars anxious not to impose a Western view of things on others. It is rarely advanced by the oppressed who are only too anxious to benefit from perceived universal standards.” (Booth, 2007)

Knowledge gaps

There is no universal registration of births and marriages. This would be immensely useful in countering early marriage.

Research on married women usually includes girl brides without any distinction as to their different circumstances, so the plight of these young women is largely unknown. Social and health research has generally grouped all married women together regardless of a wife’s age or the conditions surrounding her marriage. Studies and policies aimed at girls generally look at unmarried girls and usually only those who are in school. The millions of girls who are married before the age of 18 simply disappear from the statistics, making it almost impossible to devise useful policies and programmes for them (UNICEF, 2005).

Capacity-building opportunities: Empowerment of girls by girls and women themselves

It is very difficult to change deeply entrenched religious and societal beliefs and practices from the outside—they need to change from within. In general, legislation and top-down projects have failed, even when they have been focussed on the health risks to the girl; it is the girls and women themselves who need to be empowered to change their circumstances.

There is convincing evidence that the education of girls, even if it is superficial and brief, has an enormously empowering effect on girls. Yet despite the emphasis put on this in MDG 2, not all girls attend school and, despite MDG 3, Target A, fewer girls than boys go to school and for shorter periods (UN, 2014).

For some, continuing girls’ education has been seen as the answer to combating early marriage. Statistics show that girls who stay longer in school marry later, but there is disagreement over whether more years spent in education is a cause of later marriage or if delayed marriage and longer schooling go together for other reasons.

There are programmes that provide girls and their families with quite modest financial incentives to stay on at school and these do result in later marriage. In Haryana state in India a small sum of money is put into a saving account for a girl. If she is unmarried at 18 she can take the money and its interest.

In rural Kenya, in the Saka project run by the Kenya Girl Guides Association girls are given a goat if they stay on in school. Knowledge gaps

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Non-formal education has been defined as “an organised educational activity outside an established formal system that is intended to serve an identifiable learning clientele with identifiable learning objectives” (Chief Executives, 1999). These educational programmes give girls the self-confidence and skills so they can change their own circumstances for themselves. There are several well-established global organisations—the Guides, Scouts, YMCA and YWCA— that
reach over a hundred million young people each year. For over a hundred years they have been providing programmes that have changed the lives of young people, yet still their contribution is not truly recognised by those who have not directly experienced their benefits for themselves.

Non-formal education programmes develop girls’ self-confidence, leadership and independence. Groups are often female-only, providing safe places where girls can find support, information and help in confidence, which is especially important when dealing with sexual and reproductive issues. In many developing countries the local Guide Association also teaches skills such as dress-making, bread-making and crafts so that girls can become more economically independent and have some negotiating power within their families. Non-formal education is also a vehicle for changing the attitudes of boys and men. Without such a change, “attempts at the full development of women will only result in conflict and disappointment” (Chief Executives, 2001).

Role models can inspire and demonstrate a different way of life from that of the older women in a girl’s community, opening up horizons and raising expectations. Girls can be very effective both as advocates and executors when they are determined to change their own circumstances, as can be seen by the participation of young women in many global forums and, more recently, by Malala Yousafzai and her education campaign.

The role of the media will become increasingly important as technology reaches out to communities that have previously been isolated. In many LMICs the radio is a powerful way of transmitting positive messages and in changing attitudes. Many girls and young women, even in strictly traditional households, have access to the internet—a fact not always known by their parents—and to friendships with girls from different backgrounds and to worlds which are very different from their own.

Community-based projects that focus on empowering women and girls, and packages that include child marriage and FGM alongside the reduction of poverty and equal access to education, have had some success. Campaigns that raise awareness within communities of the health risks and the need to protect women and children’s rights have also been successful.

**Conclusion**

Discrimination against girls and women is so endemic in many societies it can seem as though it will only be reduced if the world was simply a better place—a world with access to health services for all, good universal education and without poverty or war. However, in a world without infinite resources, priorities have to be identified. Formal education for girls is essential and accepted as a priority, but prioritising non-formal education also has great potential for the empowerment of girls. It is cost-effective—even small amounts of funding going directly to local organisations run by women and girls can make a huge difference, and can be tailored to the needs of particular communities. Girls who have experienced non-formal educational programmes have become convincing advocates for change, locally and in global forums. They have gone on to become leaders in their communities, and many government ministers, and other influential and successful women have learnt their leadership skills in such groups (Lever, 2010).
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Presenter & Co-Author Biographies

Vincenne Adams, Co-primary Investigator, One Heart World-wide.

Tayeb Al-Hafez, MD, practicing physician and healthcare strategist. He is President and Founder of Global Health Equity Foundation.

Thorsten Behrendt, Health Specialist, Social Security Department, International Labour Organisation.

Surya Bhatta, Program Director, One Heart World-wide.

Aoife Callan, PhD, HEOR Manager, Novartis Dublin Business Solution Centre, Global Business Services.

Patricia Carney, B.Comm., M.Econ.,Sc., Ph.D, research fellow at the Irish Centre for Social Gerontology at National University of Ireland, Galway.

Sienna Craig, Medical Advisory Board Member, One Heart World-Wide

Nicoletta Dentico, Co-Director of Health Innovation in Practice and former coordinator of the Democratizing Global Health Coalition, and founder of Se Non Ora Quando.

Lesley Doyal, Emeritus Professor of Health and Social Care at the School for Policy Studies, University of Bristol.

Nata Duvvury, Co-Director, Global Women’s Studies and Leader of the Gender and Public Policy Cluster in the Whitaker Institute at the National University of Ireland, Galway.

Dr. Joy C. Honea, Department of Sociology, Montana State University Billings.

Dr. Sarah Keller, Professor, Department of Communications and Theater, Montana State University, Billings.

Lesley Lever, author and former CEO of the World Association of Guides and Girl Scouts (UK).

Masuma Mandami, Chief Research Scientist and Policy Analyst, Ifakara Health Institute, Tanzania.

Anjali Menezes, Consultant, International Labour Organisation.


Dr. Karen Newbigging, Senior Lecturer at the Health Services Management Centre at University of Birmingham, UK.

Arlene Samen, Founder and President, One Heart World-wide.

Dr. Xenia Scheil-Adlung, Health Policy Coordinator in the Social Security Department of the International Labour Organization.

Dr. Kasturi Sen, Wolfson College (CR) University of Oxford, UK.
The Global Health Equity Foundation (GHEF) attends to this global health equity crisis by advocating on behalf of people who lack access to health education, preventive services and healthcare.

We believe that a comprehensive, inter-disciplinary approach can provide an optimal solution to this crisis. The Foundation shares expertise and seeks to translate basic knowledge of the causes and consequences of health inequities into practical and innovative solutions. Global Health Equity Foundation integrates its research into advocacy and capacity-building projects for improving health equity worldwide.

GHEF’s three strategic activity areas—research, capacity building and advocacy—are part of a value chain through which we promote and support improvements in health equity. Through these strategies GHEF inspires and empowers capacity building at multiple levels—local to global—and provides tools with which to advocate for increased equity in health. The strategies also serve to communicate the need for reorienting global, national and local systems and practice toward building more healthy and equitable societies.

What We Do

Inequities in health state are deeply rooted in the determinants of health, including the social, economic, political and environmental factors. GHEF aspires to becoming a primary source for knowledge and action on health equity.

The Foundation embeds its research into advocacy and capacity-building projects for improved health equity worldwide. Since 2007, the Foundation has hosted and co-sponsored projects in the United States as a 501(c) (3) organization. In October 2012, GHEF opened its headquarters in Geneva, Switzerland as a registered non-profit organization and extended its networks to other regions, including the UK, mainland Europe, and to public health practitioners in Syria.

Our Approach

GHEF is dedicated to research, advocacy and capacity-building as strategic approaches for raising awareness, building and sharing knowledge, reducing gradients and gaps in health equity toward promoting the advancement of civil society.

Our Core Principles

- Acknowledging the merits of independent solutions
- Respecting people’s culture and context
- Acting with openness and transparency
- Sharing capabilities and competencies neutrally
- Achieving lasting positive change

Our Mission

- Contribute toward tangible improvements in global health equity.
- Explore opportunities and challenges faced by communities through research.
- Inform public opinion about the right to health
- Support capacity-building projects premised on practical knowledge

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The Right to Health is affirmed in the Universal Declaration of Human Rights and is part of the World Health Organization's core principles. The WHO global strategy of achieving Health for All is fundamentally directed towards achieving greater equity in health between and within populations. This implies that all groups (men, women, children, people with disabilities, the elderly, among others) have an equal opportunity to develop and maintain their health through fair and just access to resources for health. Equity in health is not the same as equality in health status. Inequality in health status among individuals and populations are to some extent inevitable. Whilst these may also be addressed, it is inequities (where they are avoidable) that we are addressing as a major challenge facing all societies.