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Gender Inequalities and Reproductive Health:
Changing Priorities in an Era of Social Transformation and Globalisation
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Introduction

Policy & Research Papers are primarily directed to policy makers at all levels. They should also be of interest to the educated public and to the academic community. The policy monographs give, in simple non-technical language, a synthetic overview of the main policy implications identified by the Committees and Working Groups. The contents are therefore strictly based on the papers and discussions of these seminars. For ease of reading no specific references to individual papers is given in the text. However the programme of the seminar and a listing of all the papers presented is given at the end of the monograph.

This policy monograph is based on the seminar on 'Gender Inequalities and Reproductive Health: Changing Priorities in an Era of Social Transformation and Globalisation' organised by the IUSSP Committee on Reproductive Health and the Population Studies Centre (NEPO) at the University of Campinas (UNICAMP), held in Campos do Jordão, Brazil, from 16-19 November 1998

Thinking Globally, Acting Locally

The concept of reproductive health, once a coin of uncertain value, is now common currency even in demographic circles. Although greeted with uncertainty if not suspicion by many participants in the International Conference on Population and Development (ICPD) held in Cairo in 1994, it has come to represent an integrated, multi-faceted, and holistic approach to talking about and dealing with a broad range of health needs and concerns among women and men throughout the life cycle. The definition introduced at Cairo that begins this way has been oft repeated:

'Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes' (ICPD 7.2).

But if the concept is to be manageable, not to say measurable, it must be broken down into some elementary components such as those suggested in Box 3. Each component is connected with the others in ways that are both difficult to untangle and highly contextual. The purpose of listing them separately here is to make an analytic distinction that highlights the need for specific programmes, research, and services addressing each area. Given the holistic nature of the reproductive health concept, however, it is understood that programmes and services are - or should be - linked in a synchronised and culturally responsive way.

This report is not about reproductive health per se, however, but rather, about how the reproductive health of individuals and groups in diverse circumstances is affected by a variety of social, economic, cultural and political forces. At the heart of these are the many inequalities that characterise relationships between women and men. Gender inequality can have a powerful influence on both women's and men's reproductive health. In turn, of course, reproductive processes and health problems can exacerbate gender inequalities in multiple ways.

BOX 3: WHAT IS REPRODUCTIVE HEALTH?

The capacity to determine the number and spacing of births through the use of safe, effective, and acceptable contraceptive methods;

The capacity to terminate an unwanted pregnancy safely, legally and affordably;

The capacity to conceive or to cause conception when a pregnancy is desired;

The capacity to carry a wanted pregnancy to term and to deliver a healthy baby under safe conditions, including the postpartum period;

The capacity to breastfeed and to ensure the health and wellbeing of the new-born;

Freedom from physical damage to the reproductive tract caused by childbirth, abortion or harmful traditional practices such as genital cutting;

Freedom from reproductive tract infections (RTIs), including cancers of the reproductive tract, sexually transmitted diseases (STDs) and HIV/AIDS;

Freedom from unwanted sexual relations and harmful or unwanted sexual practices, including violence and coercion within sexual relationships;

the capacity to enjoy and sustain sexual relations in a spirit of affection and partnership;

A basic understanding of sexual and reproductive processes of both sexes and how they change throughout the life cycle, including physical and emotional aspects;

Full access to appropriate and high quality reproductive health services.

Looking beyond the immediate relationships between gender inequality and reproductive health, one can ask more broadly how these relationships change under the impact of social transformation and globalisation. For example,

At the level of individuals and households, what are the linkages between changing patterns of intrahousehold power relations and women's ability to identify and address their reproductive health needs?

At the societal level, what is the impact on women's reproductive health needs and options of factors such as structural adjustment policies, changes in the nature of labour markets, and shifting family structures and relations, among other factors?

At the policy level, what assumptions and ideologies shape the ways in which reproductive health and rights are defined and decisions regarding service delivery are made? How are these changing at the national and international levels?

In the final analysis, actions relating to gender and other inequalities and to reproductive health services are meaningful primarily as they take place at the local level - at the level of communities, neighbourhoods, families, households, and individuals. But local action requires global thinking, that is, an understanding of how larger social, economic and political forces come to bear on local conditions and how these larger forces can themselves be manipulated by policies and programmes such as those articulated at Cairo.

The title of this report - 'Gender Inequalities and Reproductive Health: Changing Priorities in an Era of Social Transformation and Globalisation' - suggests an analytic framework for considering these questions and many others that logically follow. What do we mean by the key words and phrases in the title? How do the concepts connect, one with the other, at different levels of analysis and in different societies? What are the priorities for research and action in these turbulent times?

Gender Inequalities...

Research on the nature, causes and consequences of gender inequalities is far too extensive to summarise here. At best, we can select certain dimensions of such inequalities and examine briefly how they might influence, or be influenced by, men's and women's reproductive health. But gender inequalities interact with other bases of inequality as well. These include power and resource differences based on age, marital and family status; ethnicity, race and religion; and social class, place of residence and national identity, among others. The purpose

of this seminar was to examine not only the impact of gender inequalities on reproductive health but the impact of other inequalities as well.

Gender differences can 'cause' differences in reproductive health in a number of ways. Some paths are clear and direct; others diffuse and indirect.

- **Biological differences:** In some respects, biology clearly is destiny. Only females are exposed to problems relating to menstruation, pregnancy, abortion, miscarriage, childbirth, and lactation. Most 'modern' contraceptive methods are designed for female bodies. Only women will experience breast or cervical cancer, pelvic inflammatory disease. Only men are at risk of prostate cancer, impotence as conventionally defined, problems related to vasectomies. Both sexes are at risk of transmitting and receiving STDs, including HIV/AIDS, although the probabilities and symptoms often differ. Both sexes can experience infertility. Clearly there is some overlap, but, by and large, girls and women are at risk of more varied and serious sexual and reproductive health problems than are boys and men.
- **Cultural/behavioural differences:** To the extent that females and males think and act differently as a consequence of their socialisation and of the gendered society in which they live, such differences will inevitably be played out in sexual and reproductive attitudes and behaviours. Indeed, in all societies, individuals are likely to experience intense social pressure to conform to accepted ideals of 'masculinity' and 'femininity'. Differences between males and females in the nature and timing of sexual experimentation, in age at first intercourse, in the number and characteristics of sexual partners, in age at marriage and in frequency of unprotected sex (among other behaviours) can result in sexual and reproductive health problems that are highly differentiated by gender. Sexual harassment and violence are also culturally constructed behaviours, as is risk-taking in general.
- **Resource differences:** Quite apart from those internalised ideologies of gender that everyone acquires, all societies are structured around hierarchical systems in which sex and age form the most fundamental organising features. Gender differences in access to and control over key material and social resources result not only in inequalities of health and wellbeing, particularly reproductive health, but also in inequalities in power, in knowledge, in the capacity to make independent decisions relating to sexual and reproductive decisions and to act on them in health seeking behaviour, and in the ability to pay for services. Thus, if biological predispositions form one basis for inequalities in reproductive health and cultural/behavioural differences another, the distribution of resources within the household, family, and community forms an additional layer of differentiation reflecting inequalities of gender.

... and Reproductive Health:

An analysis of the relationship between gender (and other) inequalities and reproductive health must look at factors that affect the distribution of reproductive health **problems** across individuals and groups; at factors affecting the distribution of reproductive health **services**; and at factors affecting people's **utilisation** of such services. Although interrelated, these are analytically distinct characteristics influencing sexual and reproductive health outcomes.

Inequalities in the distribution of reproductive health problems:

Because reproductive health is a subcategory of overall health, inequalities in reproductive health are logically related to inequalities in general health such as nutritional status and exposure to infectious disease. **Class-based** inequalities in general health result from poor living conditions and lack of information and resources, of course, but they may also be due to cultural/behavioural differences that place the poor at greater risk. **Gender-based** inequalities in health status, given that some derive from biological differences and others from cultural/behavioural and resource differences, cut across and interact with class inequalities in complex ways. Thus, a general health problem such as iron-deficiency anaemia, which is typically more common among women, among the poor and in rural areas, can result in highly class-specific patterns of reproductive morbidity and mortality among women.

It should be possible to map the distribution of reproductive health problems across individuals and groups through the use of sensitive survey instruments, analysis of records and observational techniques. Certainly one would expect to find a general correlation between indicators of reproductive health, such as maternal or infant morbidity and mortality, and indicators of overall health status. The purpose of selecting sexual and reproductive health **in particular** for study is not to suggest that it is unrelated to other health problems, but rather, to focus attention on the particular needs of girls and women that might otherwise be invisible. Measures of health status such as death and disability adjusted life years (DALYs) that do not take account of gender differences in the physical and social-psychological burden of illness from sexuality, reproduction and gender-based violence are particularly likely to trivialise women's real problems and concerns.

Inequalities in the distribution of reproductive health services:

Just as for reproductive health itself, reproductive health services are a subcategory of general health services and as such are logically interconnected with the structures and functions of the overall health system. The exception is when certain services are offered primarily through a single-purpose and separately funded vertical programme that is not otherwise integrated with the health sector. Interestingly, family planning programmes have taken this form in many countries, along with other single-purpose campaigns such as the eradication of smallpox. For this reason among others, the promotion of a comprehensive reproductive health approach at ICPD in Cairo has challenged the very structure of family planning policies and programmes in some countries and not just their methods of operation (Box 4).

To what extent are inequalities in reproductive health **problems** due to inequalities in the distribution of reproductive health **services**? Any attempt to map the distribution of services in a community or country would have to consider the following characteristics, among others:

- Inequalities in the distribution of primary, secondary, and tertiary-level facilities within the formal sector (public, private and NGO) for the diagnosis and treatment of general and reproductive health problems and the provision of services such as contraception, abortion, prenatal care, delivery, postnatal care, diagnosis and treatment of STDs and infertility, and counselling on male and female sexuality.
- Inequalities in the distribution across and within communities of organised outreach activities providing information and services relating to general health problems (e.g., nutrition, sanitation, vaccinations) and as well as to sexual and reproductive health.
- Inequalities in the distribution of non-formal providers of general and reproductive health information and services, such as midwives, herbalists, street vendors, traditional healers and spiritualists, among others.

The distribution, type, quality and price of general and reproductive health services in a country or region derive from a mix of public policies and resources (which are influenced by international donors), NGO activities and market forces. How responsive is the public sector to serving the health needs of the population? What priority is placed on health services compared with other investments and expenditures and, within health services, on some aspects (e.g., curative vs. preventive, maternal vs. child) compared with others? What is the role of NGOs and private enterprises in the reproductive health field? At what point have services been restructured to offer comprehensive reproductive health care? How is the community informed that these changes have taken place?

BOX 4: FROM CONTRACEPTIVE TARGETS TO REPRODUCTIVE HEALTH: CHANGING PRIORITIES AT THE NATIONAL, STATE AND LOCAL LEVELS

When a government adopts a radically new approach to service delivery in response to ICPD, people and programmes experience the impact at all levels, from the most centralised planning office to the most isolated health post. The challenges are enormous. In what ways must the health system be reorganised? What do service providers need to learn? What research is needed to make services more responsive to people's needs?

Leela Visaria addresses these questions and more in her analysis of the transformation in India of the national family planning programme from one based on contraceptive targets to one based on the integrated delivery of comprehensive reproductive health services.

Encouraged by Indian women's groups, participation in ICPD and the international donor community, among other sources, the Government of India decided to revamp its troubled family planning programme which had long been subject to charges of over-zealousness in the recruitment of acceptors and neglect of women's health needs. The new programme emphasises quality of care and women's overall reproductive health. Preliminary evidence from two states reveals some interesting findings:

- The temptation of planners and providers to continue setting contraceptive targets and to assess their performance according to these targets is very hard to overcome;
- Although services such as prenatal visits and immunisations are relatively easy to deliver, others such as treatment of gynaecological problems (e.g., genital discharge) and the termination of pregnancy (which is legal in India) pose problems because of a shortage of gynaecologists (paramedics are not yet trained in these areas);
- It is not yet clear how to assess community needs for sexual and reproductive health services that go beyond addressing the unmet need for family planning, or how to involve village level groups in programme implementation and evaluation;

- Service providers are overwhelmed by the extra paperwork that has accompanied new record-keeping systems (much of it unnecessary); and
- New concepts such as 'quality of care' and 'informed choice' need to be developed in ways that are understandable to planners and to workers at the grassroots level. Ultimately, they must form the basis for new indicators of service performance.

Political ideologies are likely to have a major impact on the distribution of reproductive health services. Among these are:

- Socialist or 'welfare-state' ideologies favouring the public-sector provision of social services that fulfil basic human needs such as health, education, housing and social security. States promoting such ideologies, such as China, Tanzania during the phase of African socialism, Cuba, and Sri Lanka tend to allocate a relatively high proportion of the national budget to health care and to try to reduce class inequalities in distribution and access. NGOs concerned with alleviating poverty and improving human welfare at the grassroots (e.g., the Grameen Bank and BRAC in Bangladesh) also try to extend services to marginalised population subgroups, especially women.
- 'Free-market' ideologies favouring the private provision of services or a mix in which private services predominate over the public sector. Under some conditions privatisation may reduce inequalities in distribution or access, e.g. by locating providers in previously under-served areas or offering services that the government does not provide; under other conditions it may exacerbate inequalities, e.g. by charging high fees for services or by draining skilled personnel from the public sector.
- Religious or nationalist fundamentalist ideologies can affect laws and policies by imposing limits on the range of reproductive health services and on eligibility, as in Indonesia or the Islamic Republic of Iran. Restrictions on abortion such as those currently in place in most Latin American countries are one clear example. Others include restrictions on 'artificial' methods of contraception or on sterilisation that are thought to violate religious injunctions or to slow the rate of population growth to unacceptably low levels. Inequalities in access result from the denial of family planning services to the unmarried and from requirements that married women must obtain their husband's consent, among other restrictions.
- Feminist ideologies expressed by rights- and health-oriented women's organisations typically aim at promoting the sexual and reproductive health and empowerment of girls and women through policy and programmatic means. This is the most explicit agenda for overcoming gender-based inequalities in access to information and services, although resources are often limited. Feminist NGOs in many countries also offer information and services to girls and women that may be otherwise denied them, such as safe abortion or counselling on sexuality and safe sexual practices for adolescents.
- Ideologies and resources of international donors (multilateral agencies, bilateral donors and foundations) can play an important role in the health sector, particularly in resource-poor countries dependent on outside assistance. In particular, they can affect the distribution and types of services offered, depending on the priorities of the funding agencies. Policies that favour the funding of vertical family planning programmes over integrated health services (or vice versa) are one example; others include funding for special campaigns such as Child Survival or Safe Motherhood. Currently, international agencies promoting the Cairo reproductive health agenda play a powerful role in shaping national health policies and programmes and in research.

Inequalities in the utilisation of services:

One could, with sufficient data, map the distribution of reproductive health problems within a population as well as the distribution of reproductive health services. These maps would reveal many sources and types of inequalities. But there is a third factor to consider, that is, inequalities in the **utilisation** of services given a particular distribution of health problems and service providers. Here again, multiple sources of inequality can affect utilisation. Some inhere in the nature of the services, some in the population (that is, the potential clientele) and some in the interaction between the two.

Factors affecting utilisation that are inherent in the **system** include the location and hours of operation of health providers, the quality and appropriateness of services, availability of personnel and medicines, confidentiality, waiting times, price, information relating to the services being offered and restrictions on client eligibility, among other factors.

Among potential **users**, factors affecting utilisation include clients' awareness of service sources or individual providers, their decision-making capacity and physical mobility, their ability to pay for services and their

confidence in the provider's knowledge and skills. Many considerations may intervene between the problem and the solution, such as the following:

- Clients' fears of formal clinic or hospital settings is a common factor inhibiting their use even in some settings where the need is great and the facilities are close by. Such fears may relate simply to the unfamiliarity of the formal setting, in which women choose to give birth at home even when clinic services are available. In other cases they may be fuelled by rumours and suspicions, or by extreme distaste for the methods used, such as the examination of women's 'private parts' by male personnel.
- Power relationships and patterns of discrimination by age, sex or family status within the household will have an impact on patterns of use, depending on who makes decisions about health care and who pays. Values placed on female seclusion can prevent women from utilising services outside the home unless she is accompanied by a male relative. At the most extreme, women will be forbidden to leave the home even in cases of extreme emergency such as prolonged obstructed labour. The question of how women's decision-making power in the household translates into the ability to seek services outside the home is a crucial one for researchers and programme personnel (Box 5).
- The tendency of women to place their own health needs below those of their children and of other family members can result in unequal utilisation of services due to strongly internalised social norms. Research in Yunnan province of China showed that women gave highest priority to the needs of children, second to the elderly and third to themselves. This pattern fits with a fundamental devaluation of women that permeated all aspects of their lives. In Jordan and Sri Lanka, where virtually all women have frequent prenatal check-ups, few return to clinics for postnatal care during the days of maximum likelihood of infection or other problems following childbirth. Both women and formal providers contribute to this relative neglect of the 'M' in 'MCH.'

BOX 5: WHO GOES TO THE HEALTH CLINIC? THE DYNAMICS OF HOUSEHOLD DECISION MAKING

Even where low-cost health facilities are distributed throughout the population, few people may take advantage of them. In Egypt, for example, although 99 percent of the population has access to government health facilities, utilisation rates do not exceed 20 percent. Maha El-Adawy attributes this discrepancy to the poor quality of services. But decision-making processes within households and kin groups may also prevent many women from recognising and acting on their own sexual and reproductive health needs.

Evidence from papers presented in the seminar reveals that in some countries, such as Jordan and Sri Lanka, virtually all women utilise basic maternal and child health services, including frequent prenatal visits and hospital-based delivery. At the other end of the continuum, there are countries such as Mali where almost no women have access to trained providers in pregnancy and childbirth because such services are virtually non-existent in rural areas.

At both ends of this continuum, statistical models using indicators of household decision-making as predictors of service utilisation may appear to be weak simply because there is so little variation in the dependent variables to explain. Where there is greater variation in service utilisation, however, as in the number of prenatal visits or in the conditions under which babies are born (at home alone or with a family member, traditional midwife or trained midwife; in the presence of a nurse or doctor in a clinic), as is the case in Indonesia, indicators of women's decision-making power in the household are likely to be more useful.

How is women's decision-making power measured? These papers include a number of indicators, some universal and others tailored to a specific cultural context. At the individual level, researchers use the woman's age, education, labour force status, age at marriage, personal income, ownership of assets and ability to make decisions about various household resources and investments, both individually and relative to her husband. At the household level, the size, structure and membership of the household may be important; whether it is extended or nuclear; monogamous or polygamous; together with its social status, household income and assets owned. Some authors look to culturally-based kinship/lineage relations, including whether the woman is married to a cousin, whether she lives with or near her own kin group, whether brideprice or dowry was paid, whether endogamous or exogenous rules of marriage are followed and whether the family into which she has married is of higher, lower or equal status to her natal family. In Mali, researchers investigated the extent to which women's familial and non-familial social networks mediated the effects of gender inequalities on the frequency of reproductive failures such as miscarriage, stillbirth and infant or early childhood death.

- Perceptions of illness and its inevitability also influence the likelihood that a problem will be identified or acted upon. To the extent that 'female problems' such as difficult pregnancies and childbirth, excessive menstrual bleeding, genital discharge and pain during intercourse are identified as dirty and shameful or as a woman's inevitable lot in life rather than as treatable conditions, a culture of silence about such problems is likely to prevail (Box 6).

BOX 6: COMMUNICATING ABOUT SEXUALLY TRANSMITTED DISEASES

How do women negotiate with their husbands or stable partners regarding protection from and treatment for sexually transmitted diseases? Do partners tell each other about their experience of genital symptoms? Are there any differences between the male and female partners in communicating on reproductive illnesses? Does inter-spousal communication have any influence on the preventive and curative behaviours of couples? Studies from India and Uganda show how gender inequality inhibits both discussion and treatment.

In interviews with over 800 women and their husbands in five villages of southern India, Santhya and Dasvarma discovered that:

51 percent of the women said they experienced at least one genital symptom in the previous three months (the most common being a 'white vaginal discharge') and one-third of the men reported some symptom such as discharge, itching or genital sores.

One-third of the women experiencing symptoms said they informed their husbands (mostly in order to get treatment), but only one-fifth of the symptomatic men mentioned their condition to their wives.

Nearly half of symptomatic women and two-thirds of symptomatic men sought some form of treatment. The majority of women sought allopathic (western) medicines (although many tried herbal remedies) while men were more likely to treat themselves with herbs or by eating 'cooling' foods to treat 'excessive body heat' to which they attributed their symptoms.

Women who did not seek treatment reported reasons such as financial constraints, the need to inform their husbands if they were to go to a clinic and to ask their permission, acceptance of the condition as 'normal' and feelings of shame in presenting at the clinic.

Only 6 percent of women and 11 percent of men perceived their genital symptoms as due to sexual activity. Thus, sexual abstinence or condoms were not considered as possible preventive measures. Although women sometimes used non-verbal means for avoiding sex when they didn't want it, they were reluctant to talk about it with their husbands for fear of abuse, abandonment or being considered a bad wife.

In a study of 1,750 married women and their stable partners in two districts of Uganda reported by Wolff and Blanc, one of which (Masaka) represents an epicentre of the AIDS epidemic and of a campaign to encourage awareness and prevention,

Virtually everyone interviewed in the high-AIDS district of Masaka knew someone who had died from AIDS, but only two-thirds of the men and one-third of the women believed that they themselves were at risk.

Although virtually all male and female respondents in Masaka had heard of condoms, only half knew that condoms can prevent AIDS and only one in ten among the latter group had ever used a condom with their current partner.

Although more than two-thirds of male and female respondents in Masaka agreed it was acceptable for an unmarried women to ask her partner to use a condom, only one-quarter thought it was acceptable for a married woman to do so. The symbolism of sexual looseness associated with condom use motivated many respondents to actively oppose the use of condoms within marriage.

More than two-thirds of male and female respondents agreed that a married woman can refuse to have sex if her partner has HIV-AIDS. However, about one-third of the men and one-quarter of the women believe that a woman cannot refuse sexual relations with her husband even under these conditions.

Finally, factors inherent in the providers and in the population of potential users can interact to create a complex pattern of under-utilisation of health services in general or of particular types of services.

- Inequalities between providers and potential clients in language, religion, race or social status, especially when providers express disdain for their clients or when clients are made to feel ignorant, can create a chilling environment for service delivery. Examples abound in the seminar research papers and elsewhere of women who complain that they have been ignored, mocked or patronised by health care personnel who consider themselves superior in every way to the clients they are expected to serve.
- The best 'fit' between client and provider depends in large part on cultural definitions of causality and treatment. Even if a reproductive health problem such as female infertility or male impotence is recognised, it may not lead to the conclusion that 'modern' medical treatment is appropriate. Rather, potential clients may turn to more familiar treatments from spiritualists, herbalists or distributors of quack medicines to attempt to correct the perceived imbalances that are identified as having caused the condition.

Changing Priorities...

The elements of the analytic framework outlined above raise a number of possibilities for research and action that are directly related to the goals of improving overall levels of reproductive health in the population and reducing inequalities based on gender, class and other bases of social differentiation.

The key word here, however, is 'changing.' Of course one could develop a set of priorities for policies and programmes relating to gender inequality on the one hand, and to reproductive health on the other. Indeed, such priorities have been set out in a number of publications by independent scholars, international agencies, international and regional conferences, private foundations, NGOs and research and policy institutes, including the IUSSP. Often, however, planners who are expected to act on these priorities find themselves perched on a slippery slope of political, economic and social uncertainty. National and local fortunes rise and decline. Health and other social sector budgets vanish. Policies are adopted, abandoned, implemented, ignored. Political factions form and reform. The idea of setting priorities is based on the assumption that an active civil society can effectively represent its own interests, that reasonable economic and political stability will prevail, that rational long-term planning is feasible, and that donors will maintain interest in their own initiatives after the initial enthusiasm subsides. The papers presented in this seminar suggest that this is not always the case.

Nevertheless, a number of programme- and policy-related research questions can be posed as tools for advancing gender equality and reproductive health. For example:

- At the national level, how can the elements of existing health and family planning programmes be disaggregated and reaggregated to form a recognisable reproductive health programme that serves women's needs for information and services, including especially the needs of adolescents? What kind of research is needed in order to assist governmental and private health care providers to deliver a realistic and sustainable sexual and reproductive health care package? (Box 7)

BOX 7: WHERE DOES REPRODUCTIVE HEALTH FIT IN HEALTH SECTOR REFORM?

As the winds of newly defined policies of international agencies and donors blow through the corridors of national health ministries, administrators are expected to transform the structures and priorities of current systems to adapt to new expectations or conditions of funding. Initiatives follow initiatives. Primary Health Care; Maternal and Child Health; Family Planning; Child Survival; Safe Motherhood; Health Sector Reform; Reproductive Health. Some initiatives demand greater integration; others, such as Oral Rehydration Therapy, are distinct vertical programmes commanding separate funding. With each new initiative, planners struggle to redefine their mission.

In response to the priorities of the World Bank, USAID and the European Union, among other donors, Egypt (along with many other countries) has undertaken a Health Sector Reform Programme that required considerable reorganisation of the health system. The challenge posed to planners by donors such as USAID, UNFPA and the international NGOs in promoting a Reproductive Health Agenda is where does this new initiative fit?

Maha El-Adawy analyses some of the organisational difficulties of the Egyptian health sector in the face of this new initiative. The Ministry of Health and Population is divided into three main sectors: preventive and primary health care, curative care and population (which has targets for contraceptive acceptance, reduction of unmet need for family planning and lower fertility rates). According to El-Adawy, 'This organisational layout scatters the reproductive health activities among all three departments resulting in poor co-ordination of the reproductive health package'. Moreover, a major policy issue that must be resolved is the 'complete dissociation' between the Reproductive Health agenda and the Health Sector Reform agenda in the Ministry of Health and Population.

The shift from family planning to reproductive health in Egypt will require major organisational changes, retraining and a redistribution of funding and other resources across programmes. Reproductive health services will have to be integrated into the basic benefit package (BBP) of primary health care services undertaken by the Health Sector Reform. How is this to be accomplished and funded? At what cost to the goals of the family planning programme? What happens when donor interest slackens? With reproductive health priorities being set primarily by donor agencies in collaboration with the Ministry, how can the interests of Egyptian women - the major stakeholders in the process of agenda-setting - be incorporated into the planning process? What steps will need to be taken to overcome broad-based cultural barriers to the utilisation of reproductive health services?

- How can the needs of populations and population subgroups for sexual and reproductive health care be accurately assessed at the national and local levels? How do the self-perceived needs of particular subgroups, including women of different socio-economic classes and at different stages in the life cycle, correspond to the availability of services? What major gaps remain to be filled, such as the need for safe abortion services, for postnatal maternal care, or for programmes to reduce sexual violence?
- In what ways is the distribution of reproductive health services according to location, type, price, staffing, and overall quality influenced by gendered assumptions or ideologies at the national or local level about the health needs and priorities of the population being served? In what ways may these assumptions work to the disadvantage of girls and women, for example, the assumption that unmarried girls are not sexually active, that married women are not at risk of STDs or that post-menopausal women are not in need of services?
- How can the quality of reproductive health care in the public and private sector be assessed at the national level and under different local conditions and expectations? What indicators of quality are most useful and most understandable to programme managers and providers? How can record keeping be simplified and the ongoing evaluation of quality be incorporated into administrative decisions?
- How do the staffing patterns of hospitals, clinics, or health posts affect the likelihood that girls and women will seek information about and treatment for particular sexual or reproductive health problems, especially sensitive ones? What difference does it make in particular contexts if providers are male or female, medical doctors or paramedics, or of similar or different social backgrounds to the clients they serve?
- What training is needed for sexual and reproductive health care providers in the formal sector and in outreach programmes that will improve their effectiveness as health workers as well as raising their consciousness about patterns of gender discrimination in their own programmes and in the communities, families and individuals they serve?
- What methods can be developed for learning about and incorporating women's own priorities into programme planning, implementation and evaluation at the local and national levels? How can the interests of women of particular social groups best be represented and protected?
- What policies are in place, or need to be put in place, at the national and local levels to reduce gender inequalities, in particular those that result in the denial of women's sexual and reproductive rights? What research is needed to identify the ways in which particular manifestations of gender inequality such as sexual abuse and violence impede girls' and women's exercise of their rights, including their access to services?
- How can gender-based behavioural/cultural patterns that place girls and women at greater risk of sexual and reproductive health problems such as unwanted sexual relations, unwanted pregnancies, or STDs be modified through initiatives such as sexuality education or other IEC (information, education, communication) campaigns? In particular, how could such initiatives help girls and women understand that many of the conditions they experience are not natural or shameful but are treatable health problems?
- How do gender differences in the acquisition of resources such as knowledge, power, prestige and money influence women's capacity to negotiate their own sexual and reproductive health? How could programmes aimed at the empowerment of girls and women through schooling, vocational training, credit schemes and the expansion of employment and political opportunities (among other means) help to create a sense of entitlement to sexual and reproductive health and to high quality services?
- What legal changes are needed to provide support for the exercise of women's sexual and reproductive rights, such as the decriminalisation of abortion, the abolition of harmful practices such as female genital cutting, or the revision of laws relating to sexual harassment, rape and domestic violence?
- In all of these areas, what are the key elements of social transformation and globalisation that are affecting gender inequalities and reproductive health (considered as health problems, health services, and service utilisation), and in what ways?

in an Era of Social Transformation...

The macro processes of social transformation and globalisation could of course be conceptualised in many ways. For the purposes of this report we select certain elements that have been addressed in the seminar research papers or would logically be expected to have a major impact on gender (and other) inequalities, on reproductive health, and on the connections between them.

With regard to the forces of social transformation, for example, a number of key processes could be identified, such as:

- **Processes of secularisation** involving a shift in personal world view from one in which the individual is viewed as subjected to larger forces, such as religious doctrines or fate, to one in which the individual is viewed as an autonomous being. Belief in the ideas of personal freedom of choice and the exercise of

individual rights are reflected in new patterns of family formation, attitudes toward fertility regulation, and greater tolerance of diversity. Transitions such as these can affect all dimensions of gender inequality and sexual and reproductive health, including attitudes regarding the conditions under which abortions should be legalised (as in Argentina) and the provision of other services.

- **Changing relationships between the generations**, particularly the emergence of sexually active youth cultures and the relative empowerment (or at least rebellion and defiance) of young people of both sexes with respect to their elders and to traditional authority in general. With extended periods of education and delayed marriage, middle-class urban adolescents and young unmarried adults become increasingly independent of parental control and, as in Utomo's analysis of the Indonesian situation, create new demands on sexual and reproductive health services (Box 8).
- **Population movements** relating to urbanisation, internal and international migration (both temporary and permanent), and refugee status. Of particular concern here are the movements of populations across international borders to situations in which they may be significantly disadvantaged in access to information and services due to their nationality or refugee status, to their economic condition, and/or to their possible minority ethnic, religious or linguistic status. As shown in the Botswana study, migration is likely to affect the nature and degree of gender inequality (depending on the type and duration of the move); create new reproductive health problems (intensified concern with infertility, for example, and the spread of STDs including HIV/AIDS); and affect access to services.

BOX 8: EMERGING YOUTH CULTURES AND THE CHANGING NEED FOR SERVICES

In Indonesia, as in many countries, young people between the ages of 15 and 25 are experiencing a rapid and bewildering change of values, attitudes and behaviour toward their parents, their peers and the opposite sex. In the context of rising age at marriage and increasing educational attainment, the lifestyles of middle-class urban youth are becoming more Westernised. Popular media promote consumerism and individual freedom. Premarital sex, pregnancy, abortion and STDs are on the rise.

Iwu Utomo reports that the ideology of the Indonesian state - which is expressed as an 'idealised morality' that emphasises conservative religious family values - stands in the way of official acknowledgement of these changes. By law, the national family planning programme is intended for married couples only. Some clinics affiliated with the International Planned Parenthood Federation also deny contraceptive and menstrual regulation services to unmarried women. As a consequence, young people in need of contraception, abortion or treatment for STDs turn to private sources if they can afford it, to informal providers, or to no one at all.

Utomo concludes that reproductive health policies and programmes related to young people should receive top priority in national planning. The government needs to take a more pragmatic view of the serious nature of unplanned pregnancies, unsafe abortion and the risk of HIV/AIDS and other STDs among young women and men. Programmes should include high-quality sexuality education in the schools as well as access to sexual and reproductive health counselling and services for in-school and out-of-school adolescents and unmarried adults.

- **Changing structures of opportunity** in the formal and informal labour markets, in schooling, in marriage markets and in political structures and processes, as they affect particular age/sex and socio-economic groups. In some countries girls and women are making significant gains in education, thus reducing gender inequalities in access to schooling, while in others old patterns of discrimination continue or even worsen under the impact of economic crises or of fundamentalist regimes. Transformations in the demand for labour in local, national and international markets incorporate some subgroups into the labour process and expel others. The distribution of resources across and within groups is fundamentally affected, which in turn can affect the distribution of reproductive health problems and access to services.
- **Social/political movements** attempting to transform national ideologies and policies, such as religious fundamentalist movements, ethnic or nationalist movements, the women's movement and movements for the expansion and protection of universal human rights. To the extent that such movements incorporate an agenda relating to the role of women in the family and in society - as all of them do - and to the extent that they manage to influence public policy or private behaviour, the results will be played out in the areas of gender inequality, sexual and reproductive health and access to services.

... and Globalisation

It will become immediately apparent from the previous list of (selected) social transformations at the community and national levels that the processes identified are all connected with globalisation. The notion of a world economic system in which the furthest geographical reaches are subject to capitalist penetration and Western individualism is of course not new, but the technological speed and ideological weight of the current global economic and political movements do suggest that an irreversible sea change is underway. Inevitably, the process has caused a backlash - sometimes a violent one - in those countries that are suffering the most from its economic and social consequences. Nationalist and religious fundamentalist movements are one response. As Carlos Lista points out in his study of ideology and the abortion controversy in Argentina, the re-emergence of religion in the world-wide political arena is associated with resistance to the overwhelming 'globalising impact of secular capitalism' that threatens traditional values, the authority of elites and national boundaries.

Again, the best we can do here is to select particular elements of the process for scrutiny as they affect both gender (and other) inequalities and reproductive health. If we include those aspects of globalisation that are related to the policy work of United Nations international conferences such as ICPD at Cairo and the Fourth World Conference on Women in Beijing; to international agencies such as the International Monetary Fund (IMF), the World Health Organisation (WHO) and the United Nations Fund for Population Activities (UNFPA); and to bilateral donors and private foundations, then the list becomes quite an interesting one with many conflicting elements. Consider the consequences of the following:

- The globalisation of capitalist **markets** involving the free flow across national boundaries of capital, labour, goods and services.
- The globalisation of **communication**, including the spread and homogenisation of information and entertainment through the multinational capitalist mass media.
- The globalisation of **economic and political policies** under the guise of neo-liberal reforms that include structural adjustment policies, privatisation and 'democratisation,' as imposed by international lending institutions (Box 9).

BOX 9: REPRODUCTIVE HEALTH SERVICES AND GLOBAL ECONOMIC CRISIS: THE IMPACT OF STRUCTURAL ADJUSTMENT POLICIES

For many countries, especially those of sub-Saharan Africa, the ICPD initiative on reproductive health could not have hit at a worse time. Structural adjustment policies (SAPs) imposed by the IMF and other lending institutions in the 1980s required that governments adopt severe economic austerity measures. For many, these came at a time of economic crisis resulting from falling world prices for basic export commodities such as coffee and cacao and from currency devaluations. The health sector in many countries experienced shortages of medicines, declining quality of services, and rising costs; clients were now expected to pay fees for services they had previously received free.

In Côte d'Ivoire, Cameroon, Nigeria and Tanzania, as in many other countries, the rising costs and declining quality of health services occurred amidst widespread impoverishment, political conflict, drought and famine, population displacement, an HIV/AIDS crisis of epidemic proportions (often combined with other STDs), continued high birth rates and low levels of contraceptive use and high levels of maternal and infant mortality. If basic maternal and child health services and family planning could not reach the large majority of the population, how were governments to meet the expectations of ICPD?

Planners have struggled to design the new policies, but some observers believe that they are likely to have as little impact on health as the old ones. 'Beaucoup de recommandations, peu de réalisations,' writes Joseph-Pierre Timnou of the not untypical situation in Cameroon. Indeed, the prospect of making significant improvements in the social sector in general appears dim. In addition, as Agnes Adjmagbo notes in her study of the Côte d'Ivoire, prevailing gender inequalities in access to and control over key resources - already a factor in inhibiting women's access to services - have intensified in some areas due to worsening economic conditions.

Have SAPs affected people's utilisation of health services? Evidence from these papers suggests that in the face of higher costs and declining quality of public health services, clients are turning back to traditional means of diagnosis and treatment, including spiritual healers, chemists and drug peddlers and home cures. Without longitudinal data, however, and without knowing what would happen in the absence of SAPs, it is difficult to draw strict conclusions as to causality. Nor is it easy to draw out the implications for particular dimensions of sexual and reproductive health. Nevertheless, one policy conclusion is clear. As I. O. Orubuloye says of Nigeria, what is needed to prevent further emiseration is 'adjustment with a human face'.

- The globalisation of **population, health, gender, human rights, and family planning policies** as promoted by international agencies, by the agreements reached in international conferences and by various donor agencies.

It is not possible to spell out all of the lines of possible causality that this list implies. The impact of globalisation is felt in both developed and developing countries, among the rich and the poor. Fault lines of traditional class divisions shift as resources are redistributed across and within nations. Access to information and technology is a key to the new global economy. Capital becomes increasingly disassociated from conventional investments; as a free-floating element, it transcends borders with the tap of a computer key in quantities impossible to imagine. At the same time, as costs rise and public resources fall, governments struggle to maintain at least minimal levels of expenditure in the health sector and in other areas that serve the public good.

For many countries, then, the global economic crisis in combination with the requirements of structural adjustment policies and the impoverishment of growing segments of their population places an insurmountable barrier between their aspirations and what they are capable of achieving. As the demand for services rises, resources fall and economic inequalities intensify. The analysis of gender inequalities and reproductive health must be placed in this context. What is feasible? What is achievable? What policies, what programmes can be put in place? What research can guide us? Where does the greatest good inhere: in raising overall levels of reproductive health or in reducing inequalities? What ethical standards shape the decisions that are made? What interventions are most needed to minimise the effects of social inequalities on health outcomes?

Seminar on Gender Inequalities and Reproductive Health: Changing Priorities in an Era of Social Transformation and Globalisation

List of papers presented at the seminar on 'Gender Inequalities and Reproductive Health: Changing Priorities in an Era of Social Transformation and Globalisation' organised by the IUSSP Committee on Reproductive Health and the Population Studies Centre (NEPO) at the University of Campinas (UNICAMP), held in Campos do Jordão, Brazil, from 16-19 November 1998.

Session 1: Reproductive Health: Global and Country Perspectives

- Brief Considerations on Population Issues during this Century by Elza Berquó
- From Contraceptive Targets to Reproductive Health Services: Evolution of India's Policies and Programmes by Leela Visaria
- Family Planning and State Ideology: The Case of Islamic Republic of Iran by Amir H. Mehryar and Nazy Roudi
- Reproductive Health: Does it have a Place in a Health Sector Reform Agenda? by Maha El-Adawy

Session 2: Reproductive Health: Household Dynamics and Gender

- Individuals, Households and Kin Groups as Determinants of Access to Reproductive Health Services: The Case of Jordan by Jon Pedersen
- Women's Social Networks and Reproductive Health Outcomes in Mali by Alayne M. Adams, Sangeetha Madhavan and Dominique Simon
- Spousal Communication on Reproductive Illness: A Case Study of Rural Women in Southern India by K.G. and G.L. Dasvarma
- Bargaining Power within Couples and Reproductive Health Care Use in Indonesia by Kathleen BEEGLE, Elizabeth Frankenberg and Thomas Duncan
- The Role of Gender Balance in Decision-making on Condom Use in High and Low Risk Settings in Uganda by Brent Wolff and Ann K. Blanc

Session 3: Reproductive Health and Gender: Demographic Implications

- Gender Inequalities and Perception of Health in Northern Botswana: Some Implications for the Study of Fertility in Southern Africa by Rebecca Upton
- Impact of Credit-plus Paradigm of Development on Gender Inequality, Women's Empowerment and Reproductive Behaviour in Rural Bangladesh by Firoz Kamal
- Biomedical Facts and Social Constructs: the Relative Attention Paid to Pregnancy and Postpartum Period in Sri Lanka by Indralal W. De Silva

Session 4: Gender Ideologies and Reproductive Health Services

- Uneasy to Take Health for Women by Jie Zhao
- Reproductive Health Services: A Case Study of Indonesian Youth by Iwu Utomo
- Attribution of Control and the Abortion Controversy: Different Sides, the Same Struggle by Carlos Alberto Lista

Session 5: Reproductive Health: Structural Transformations and Health Care Systems in Africa

- Women's Health Treatment under Adjustment in Nigeria by I.O. Orubuloye
- Atteindre les Objectifs de la Santé de la Reproduction: un Défi Difficile pour les Pays Africains: Analyse du Contexte Camerounais by Joseph-Pierre Timnou
- Gender Inequalities and Reproductive Health in the Changing Socio-economic Context of Rural Africa: Qualitative Evidence from Côte d'Ivoire by Agnès Adjagbo
- Women's Reproductive Health Strategies During the Era of Structural Adjustment: A Case Study of Adapting Medical Systems in Kigoma, Tanzania by Sheryl Mccurdy

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