
Being Born Female Is Dangerous for Your Health

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In this article, the author explores how gender inequity is manifested in poor reproductive and mental health outcomes, including unwanted pregnancy, unsafe abortion, maternal mortality, sexually transmitted infections, depression, and psychosomatic symptoms. Briefly described is a landmark 1994 United Nations conference emphasizing that gender inequity adversely affects women's reproductive health, particularly in developing countries, and the implementation of its recommendations is tracked. Although there is increased recognition of oppression's toll on women's physical and emotional health as well as their intellectual and social potential, progress toward equity goals is uneven and slow. Psychologists as a group play many roles—for example, in research, education, policy, law, communications, industry, international development, and private practice—through which they can make professional contributions to gender equity as a focus or underlying principle.

That sex and reproduction go beyond the biological and involve one's mental life in all its complexity is beyond dispute. Emotions, attitudes, beliefs, identity formation, and body image are inseparable components of sexual and reproductive behaviors and thoughts. Gender norms must be added to this list: Views on women's sexuality and women's behavior have always been filtered through this optic. Freud's pioneering work emphatically linked women's sexuality and mental health (Freud, 1923/1949), but restrictions on women's sexual and societal roles remained largely unquestioned by health professionals for several decades afterward.

Today's psychologists and other health professionals clearly see the interconnections among sexuality, gender norms, and mental health and in a far more nuanced way than did their earlier counterparts. In fact, the World Health Organization (WHO) defined reproductive health as "complete physical, mental and social well-being in all matters related to the reproductive system" (WHO, 1998a, p. 1). It defined sexual health as "a part of reproductive health that includes healthy sexual development, equitable and responsible relationships and sexual fulfillment, and freedom from illness, disease, disability, violence and other harmful practices related to sexuality" (WHO, 1998a, p. 1). Unfortunately, the actual reproductive and sexual health of millions of women around the world, particularly in developing countries, cannot be described by this ideal WHO definition.

Gender Norms

Sex is biological; gender is cultural. Gender norms refer to societal expectations for male and female behavior and roles and reflect the relative value of males and females. They prescribe the division of labor and responsibilities between males and females and accord different rights to them. Either intentionally or unintentionally, they create inequality between the sexes in power, autonomy, and well-being, typically to the disadvantage of females (K. Mason, 1995). Children are socialized into gender-defined behaviors and attitudes early in life.

Continued gender inequities are reflected in sexual relationships as children reach adolescence and adulthood. In poor countries characterized by strong male dominance, women usually have little control over their sexual lives; they are rarely allowed to choose at what age and whom to marry, when to have sex, how many children to have, and whether to use contraception or protection against sexually transmitted infections (STIs). Beliefs about what it means to be a man or a woman often encourage men to have multiple sexual partners and women to remain ignorant and passive about sexual matters, thus increasing both women's and men's risk of exposure to HIV and other STIs (Horizons Project, 2000). Writing about women's HIV risk factors, Wingood and DiClemente (2000) observed, "From a public health and psychological perspective, it is these gender-related inequities and disparities in expectations that generate the exposures, or acquired risks . . . that adversely influence women's health" (p. 540). Women internalize the norm that females are inferior to males, a norm reflected in high levels of female infanticide and feticide in some countries. In a recent analysis, it was concluded that gender discrimination, with its negative impact on women's reproductive health and other areas of life, is also accompanied by declines in women's mental well-being, notably by increases in depression (Astbury, 1999). In sum, gender inequities are frequently manifested by a variety of

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reproductive health outcomes, which are interwoven with mental health antecedents and outcomes.

Unexplained Gynecologic Symptoms

A report on South Asian women links their loss of reproductive and emotional well-being with their oppression by their husbands (Patel & Oomman, 1999). The authors described high rates of depression among women attending gynecologic clinics for vague, unexplained symptoms such as weakness and vaginal discharge, which are among the most commonly cited health problems of women in the region. The authors argued that such medically unexplained symptoms may be a somatic idiom for depression and psychological distress. One of the qualitative studies they cited illuminates the domestic context of poor women in Bombay who suffer from such complaints: "Women stay at home where their movements and behaviour are closely supervised . . . the majority of husbands drink heavily and regularly beat their wives . . . there is very little communication between partners around daily events" (Ramasubban & Singh, as quoted in Patel & Oomman, 1999, p. 33).

Maternal Mortality and Morbidity

Women in developing countries suffer rates of pregnancy-related death and long-term morbidity many times higher than those of women in developed countries. A North American woman has only a 1 in 3,700 chance of dying from pregnancy-related causes, whereas an African woman's risk of dying is 1 in 16 and an Asian woman's risk is 1 in 65 (WHO, 1996). To be sure, poverty-related conditions combine with gender as contextual factors in maternal deaths in developing countries: women's underlying poor health, ignorance of the symptoms of obstetrical emergencies and resulting delays in seeking help, lack of access to affordable emergency obstetrical care, substandard services, and lack of needed medical supplies at the time of delivery (WHO, 1991).

However, gender-related factors also play an independent role. Women's greater poverty and their lack of power in families and communities means that they have little say over decisions that could save their lives. Even where low-cost transportation has been arranged by Safe Motherhood programs to increase access to emergency facilities, some husbands will not spend scarce household funds on their wives, although they would for themselves or their sons (Liljestrand & Gryboski, 2002). Women's greater rate of malnutrition contributes to maternal mortality through inadequate pelvic structure and severe anemia. Gender inequity contributes to this malnutrition: In a recent large-scale study, researchers found that men and boys have diets significantly higher in quality, that is, essential nutrients such as protein, than do women and girls (DeRose, Das, & Millman, 2000). The World Bank estimates that malnutrition affects 450 million women in developing countries, especially pregnant and lactating women; iron, iodine, and vitamin A deficiency are widespread (Tinker, Finn, & Epp, 2000).

For every woman who dies of maternal-related causes, millions more survive but suffer injuries and long-lasting

infections and disabilities, including ruptured uterus, pelvic inflammatory disease, and vesicovaginal fistula. WHO estimates this number at more than 15 million worldwide. The link between long-term health deficits and depression is well established—for the sufferers and their families (National Institutes of Health, 2000). Some experts declare that sufficient resources and political will could prevent almost all maternal mortality and morbidity in developing countries: It is because of the belief that women do not matter enough that they suffer and die (Rosenfield, 2001).

Family Planning

Family planning has reduced the maternal mortality rate in many countries simply by reducing the number of unintended pregnancies among all women of reproductive age. However, the number of unintended or poorly timed pregnancies is still large in poor countries and exposes women to the avoidable risk of death or long-term disabilities resulting from pregnancy, delivery, or unsafe abortion. Where women can practice it, contraception provides them the benefits of healthier spacing of pregnancies and increased autonomy to plan the number of children. Allowing an interval of two to three years between births decreases infant mortality significantly, clearly a benefit not only to the child but to the mother's mental health as well (Alan Guttmacher Institute, 1999).

The adoption of modern family planning by millions of poor couples in the developing world is one of the great success stories of the late 20th century. In developing countries, 56% of married women now use some means of contraception (vs. 74% in the developed world). Family planning is one of the major factors leading to a decrease in average family size in developing countries from more than 6 children in the mid-1960s to 3.2 children today (Population Reference Bureau, 2001). However, the family planning story is clouded by gender-related controversies. Some critics contend that millions of poor women have been targeted by government and donor programs in massive efforts to reduce global fertility rates while ignoring women's other reproductive health needs, such as help in combating reproductive tract infections and reducing HIV risks. The critics document abuses in some programs, from intense promotion of sterilization and intrauterine devices to outright coercion (Berer, 1993).

At the same time, over 120 million women say they wish to space or end childbearing but do not use contraception. This unmet need is due to many factors; surprisingly, geographical access is a relatively minor one (Westoff & Bankole, 1996). In fact, many women have access to contraception but fear side effects and health complications of contraception or are contraceptive dropouts—often because they were unprepared for troubling side effects. EngenderHealth, a leading international reproductive health organization, reported that

in many countries family planning workers are ill-equipped to talk with clients about such sensitive topics as sexuality and sexually transmitted infections, as well as ill-informed about side effects of contraceptive methods and what those side effects may mean for

the lives of women clients. (Harper, 1997, More Information Needed section, ¶ 2)

Researchers found that Albanian women of reproductive age participating in focus groups on reproductive health believed modern contraceptives were not only unsafe but toxic to women's health. The vocabulary the women used to describe their concerns about contraceptive safety was strong; they were not simply concerned about common side effects but "dangers," "threats to the organism," "damage to the women's health," and "destruction of the uterus" (Gorishti & Haffey, 1996, p. 11) that would render them infertile.

Although research shows that prior counseling on managing contraceptive side effects leads to higher method continuation, promotional programs interested primarily in fertility reduction frequently downplay side effects to increase acceptance of the promoted methods (Murphy & Steele, 2000). Other gender-related factors include rudeness of service providers to poor women, women's inability to pay for contraception, lack of confidentiality if clandestine use is necessary, and lack of access to sufficient education to dispel worries about safety. Some women are sequestered or forbidden to use family planning. Others are ambivalent about deviating from cultural norms regarding contraception and women's duty to bear children, especially male babies (Yinger, 1998).

Abortion

According to WHO estimates, 50 million abortions take place each year—ending 25% of all pregnancies worldwide. Of these, WHO considers 20 million unsafe; 95% of unsafe abortions occur in developing countries. Unsafe abortions kill almost 80,000 women each year and leave millions more to suffer extreme blood loss, infection, pain, damage to internal organs, and infertility. In Latin America, 21% of maternal deaths are due to unsafe abortion; worldwide, the figure is 13% (WHO, 1998b). Why such high figures in the era of contraception? Unwanted pregnancies occur because of nonuse of contraception, use of less effective methods, and incorrect or inconsistent use. As noted, women have many reasons for not using contraception, such as side effects, cost, disapproval by partner, or insufficient range of available methods to meet individual needs (including clandestine use of undetectable methods). Young, unmarried women, especially adolescents—who are often denied access to family planning services—are particularly likely not to use contraception or to use methods inconsistently or incorrectly (Alan Guttmacher Institute, 1997). Without protection, women with unequal power in sexual relationships are exposed not only to involuntary sex but to unwanted pregnancies carried to term or unsafe abortions (Heise, Moore, & Toubia, 1995).

For these reasons, millions of married and unmarried women still seek abortions. In a recent article, Berer (2000) documented the consequences of limited access to safe abortion in the developing world and argued strongly for making abortions safe and widely available as a matter of good public health policy and practice. The quality of

abortion services needs improvement as well, including counseling; providers often treat women with postabortion complications in a judgmental way but do not offer them contraceptive information (King, Billings, Friedman, & Benson, 1998). Abortion can be associated with emotional turmoil for some women, although the extent to which it is due to preexisting emotional problems, having an unwanted pregnancy in itself, or lack of support for the abortion decision is unclear. Attempts by antiabortion groups to relate abortion to subsequent depression and mental illness are not borne out by the few large-scale and reliable studies on the subject (Major et al., 2000; Russo & Dabul, 1997; Russo & Denious, 2001). In a review of these (developed-country) studies, Henry P. David (1999) pointed out that women experience the greatest anguish in the decision-making period before obtaining an abortion but that later, for the majority of women, the experience of regret is mild compared with their strong feelings of relief.

HIV/AIDS

About 42 million people worldwide are infected with HIV/AIDS, 70% of whom have contracted the virus through heterosexual sex. Another 10% occurs through sex between men, and the remainder is due to mother-to-child transmission, intravenous drug injection, and unsafe blood supply (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2002). Women, especially adolescent women, are vulnerable to HIV physiologically, psychologically, and socially. UNAIDS described the biological vulnerability in a report on women and AIDS in this way:

Research shows that the risk of becoming infected with HIV during unprotected vaginal intercourse is as much as 2–4 times higher for women than men. . . . As compared with men, women have a bigger surface area of mucosa exposed during intercourse to their partner's sexual secretions. . . . And semen infected with HIV typically contains a higher concentration of virus than a woman's sexual secretions. (UNAIDS, 1997, p. 3)

In male-dominated countries, where many women feel worthless without a boyfriend or husband, they frequently submit to unprotected sex even when they suspect infidelity, preferring the risk of AIDS over abandonment (N. Mason, 2001). Women's greater poverty and economic dependence on men reinforces the psychosocial reasons; poverty leads many young women to accept money from older sugar daddies or to become prostitutes. In addition to becoming infected herself, an HIV-positive pregnant woman often passes on the virus to her unborn child and faces the anguish of either watching her child die of AIDS or leaving the child an orphan. Women are also the main caregivers when family members become sick with AIDS. African women call this their "triple jeopardy" (Society of Women and AIDS in Africa, 1990). Moreover, an HIV-positive woman, already coping with a deadly disease and gender inequity on a daily basis, also adds discrimination and stigma to her burdens if her HIV status becomes known.

Violence Against Women

All over the world, women are subjected to violence from their intimate partners and to sexual violence from strang-

ers and acquaintances. A meta-analysis of research on intimate-partner violence found that globally, one third of women have been beaten, coerced into sex, and subjected to extreme emotional abuse (Heise, Ellsberg, & Gottemoeller, 1999). Incidence of violence experienced by women ranges from 10% to over 50% in various countries. Men who were abused or who witnessed marital violence in the home as children are more likely to abuse their partners as adults; frequent use of alcohol and drugs also increases this likelihood. Such violence has profound physical and mental health consequences (Russo, Koss, & Ramos, 2000). In addition to being a source of physical injuries, violence increases women's risk of chronic pain and disability, unintended pregnancy, adverse pregnancy outcomes, HIV and other STIs, substance abuse, and depression. Not only a risk factor for victimization, substance abuse may represent self-treatment for depression. The rate of substance abuse is elevated in women who have experienced violence but had no prior history of substance abuse (Heise et al., 1999).

The United States is not immune to violence against women. Every year, an estimated 1.5 million women in the United States are physically abused or raped by an intimate partner; in terms of lifetime occurrence, one third of women report being kicked, hit, choked, or otherwise harmed by their sexual partners. In addition, 27% of American women report childhood sexual abuse and 15% report having been raped at some time during their lives (Gazmarian et al., 2000).

Rape and other acts of violence against women are also common events in refugee camps in all parts of the world, with major posttraumatic stress sequelae (Mollica et al., 1993). A 1995 WHO position paper links domestic violence, as well as random rapes that occur in all societies and systematic rapes during wars and in refugee camps, to the same cause: the lower social status of women and the belief that women are the property of men. In the paper, it is noted that in addition to injuries, the risk of STIs, and unintended pregnancies, battered women have higher rates of depression, suicide, and other psychiatric morbidities than do women who are not battered. "When women's position in society is examined, it is clear that there are sufficient causes in current social arrangements to account for the surfeit of depression and anxiety experienced by women" (WHO, 1995, p. 2). Millions of women and girls are also subjected to violence and sexual abuse through sexual and other labor trafficking, female genital mutilation, early marriage, and honor killings, in which young women who have been raped or seen in the company of a nonrelative man are killed to avenge the "honor" of the family (Murphy, 2002). In spite of the major public health consequences of violence against women, health providers have been slow to address it—not recognizing the signs of it, not asking about it, and not knowing how to address it (Garcia-Moreno, 1999).

Cairo to the Rescue!

Lest this seem like an unrelieved litany of misery, there is good news. The 1994 United Nations–sponsored Interna-

tional Conference on Population and Development (ICPD) held in Cairo, Egypt, and the United Nations Fourth World Conference on Women held in Beijing, China, the following year were milestones in recognizing women's unequal status and generating practical remedies. At the ICPD meeting in Cairo, participants criticized the population-control paradigm through which donors and governments have spent billions of dollars on programs whose sole purpose is to get women to use modern contraceptives. The ICPD Program of Action, agreed to by 180 nations, called for client-centered, rights-based, integrated services that meet a broad range of women's reproductive health needs. It also called for programs to address gender inequity, rape, intimate-partner violence, sexual and labor trafficking, and harmful traditional practices (Germain & Kyte, 1995). At the meeting in Beijing, participants reconfirmed ICPD's stands on reproductive health and rights and also called for educational, economic, social, political, and legal equity for women in all spheres of life (Mehra, Esim, & Sims, 2000).

Since the Cairo and Beijing conferences, a great deal of attention has been paid to the issues outlined above, and reforms are under way in many countries. Although there was initial resistance by some traditional donors and others who feared that the new integrated approach would dilute the demographic effectiveness of family planning, professionals working in population have increasingly embraced the Cairo agenda (Murphy & Merrick, 1996). For example, the World Bank has adopted the reproductive health approach in its large population loans to poor countries, notably India and Bangladesh, and has played a leadership role in the Safe Motherhood movement (World Bank, 1998). The United Nations Population Fund has sponsored regional conferences to promote the Cairo approach and emphasizes gender inequity and the need to address it in its publications (United Nations Population Fund, 2000). WHO strongly supports the Cairo agenda. The International Planned Parenthood Association, the largest global network of nongovernmental family-planning facilities, has made concerted efforts to address sexuality, gender, and violence issues in its services. The Office of Population and Reproductive Health of the U.S. Agency for International Development, although slow to adopt the Cairo approach at first, has subsequently formed an active gender working group and increasingly designs large-scale programs that integrate family planning with HIV/AIDS prevention, maternal health, and gender issues, such as the ReproSalud Project in Peru (Rogow, 2000). Thousands of nongovernmental organizations in the developed and developing world are engaged in advocacy and/or direct implementation of the ICPD Program of Action (Catino, 1999).

Conclusion and Recommendations

How much progress has been made in the struggle to protect and promote women's reproductive and mental health and rights? Reviewing the positive activities above, one could certainly take heart. However, assessments five years and more after the Cairo and Beijing conferences note that the glass is still more than half empty. Sofia Gruskin, of Harvard's Bagnoud Center for Health and

Human Rights, wrote, “while there have been some successes at the global, regional and national levels, full translations of these concepts into reality have been few and far between” (Gruskin, 2000, p. 4). Another assessment of progress observed that lack of consensus on gender concepts and strategies, limited data, and inadequate funding have hampered efforts to integrate a gender perspective into health and development efforts (Reproductive Health Outlook, 2000), and political controversy over what is meant by reproductive health continues unabated. Moreover, the ICPD Program of Action is a 20-year plan; it will take considerable time to see significant and sustained change, particularly in countries where there is extreme gender inequity.

Further, international donors need to increase their spending in this area and to put pressure on governments to fully implement the ICPD program. Better measures of women’s contributions to their societies and of the losses incurred by women’s poor health are also needed (AbouZhar & Vaughn, 2000), as are clear and measurable indicators of success in implementing the ICPD Program of Action. Recommended at this point, most of all, is renewed understanding of and commitment to gender equity by all actors in the field of reproductive health and mental health, including psychologists. Vigilance is required to ensure that WHO’s “complete physical, mental and social well-being” definition of reproductive health is reflected in the health reforms being undertaken in most developing countries and that those reforms do not undermine implementation of the ICPD Program of Action (Merrick, 2000). The world is finally waking up to the oppression of women and the terrible toll such oppression takes on their physical and emotional health, as well as on their chances to realize their intellectual and social potential. It is time for the human rights, public health, and mental health communities to make improving women’s lives a common cause. Psychologists working internationally or in the United States play many roles—for example, in research, education, policy, law, communications, industry, international development, and private practice—through which they can make professional contributions to gender equity as a focus or principle.

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