

Study Guide

WOMEN AND HEALTH

Code 9166

Units 1-9

Credit Hours: 3



**Department of Gender & Women Studies
Faculty of Social Sciences and Humanities
Allama Iqbal Open University, Islamabad**

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(Units 1-9)



**DEPARTMENT OF GENDER & WOMEN STUDIES
FAULTY OF SOCIAL SCIENCES AND HUMANITIES
ALLAMA IQBAL OPEN UNIVERSITY**

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1st Edition.....2023

Quantity.....1000

Layout :.....Naeem Akhtar

Printing Coordinator:.....Dr. Saramd Iqbal

Printer.....AIOU, Islamabad

Publisher..... AIOU, Islamabad

Course Team Members

Dean Faculty of Social
Sciences and Humanities

Prof. Dr. Abdul Aziz Sahir

In charge Department

Dr. Atifa Nasir

Course Development Coordinator

Dr. Atifa Nasir

Unit Writer

Dr. Atifa Nasir

2nd Revision

Dr. Atifa Nasir

Editor

Fazal karim

FOREWORD

Women represent the cornerstone of a family's overall health, ensuring they have access to quality care can also lead to improve health for children and families. The health of families and communities is no doubt, tied to the health of women. One famous slogan, “Healthy Women, Healthy World”, embodies the fact that as custodians of family health, women play a critical role in maintaining the health and overall well-being of their communities. However, because of the many roles that women play, they are too often focused on the healthcare of their spouse or children, while neglecting their own needs.

A woman's health does not refer not only to her physical condition, but also to her total well-being. It is not determined solely by biological factors, but also by the effects of workload, nutrition and stress. Some may argue that a woman's health is the most important today. As we know, the health of families and communities is tied to the health of women. The illness or death of a woman has serious and far-reaching consequences for the health of her children, family and even community.

Today, woman's health is taking on a higher position in society and people are realizing, while women have many of the same diseases as men, their symptoms and treatments may not always be identical.

This course introduces an overview of women's health including, productive and general health concerns. It also presents woman's health conditions in social, crisis and natural disasters where their health is compromised.

Vice Chancellor

INTRODUCTION OF THE COURSE

Dear Student

Welcome to the half-credit course **Women and Health (9166)** comprising nine units. The course, Women and Health (9166) is one of the BS in Women's Studies.

Woman's Health is an emergent issue in our society. Traditionally, health research and issues focused on men with results being generalized to women. There is a great need of recognition that woman's health has unique aspects that require distinct exploration, discussion and understanding.

The evolving woman's health field has begun to be shaped by a philosophy that recognizes the impact of woman's multiple roles in society on health and focuses on woman's health rather than just problems. Accordingly, this course has been prepared, keeping this philosophy in mind and following the four main perspectives:

- **A holistic perspective** that considers the multiple influences of biological, psychological, and social factors on woman's health and that embraces a wellness approach, rather than being problem-focused. Such a perspective focuses on women's assets, stressing their resiliency and positive factors that affect their health.
-
- **A lifespan perspective** that recognizes that women have different health and psychosocial needs as they encounter transitions across their lives and that the positive and negative effects of health and health behaviors are cumulative across a woman's life.
-
- **A social role perspective** that recognizes that women routinely perform multiple, overlapping social roles.
-
- **A women-centered / feminist perspective** that consider women's gender-specific experiences as normative and recognizes the diversity among women in their healthcare needs and access to adequate health resources.

This course will introduce you to a variety of women's health issues as well as the barriers faced by women striving to achieve a healthful lifestyle. This course is designed to support you in your personal exploration of attitudes, knowledge and values related to women's health. In recent years, the approach to woman's health has slowly moved away from one which viewed woman's health needs and the treatment of disease as no different from that of men with the exception of reproductive issues.

Besides, this course will take a broad perspective of women's health, examining medically defined illnesses, normal biological processes and social and political health issues unique to women. This course presents a feminist perspective on health and recognizes the social, cultural, and political paradigm which correlates with women's health status, the role of international and national agencies in promoting women's healthcare institutions as well as the influence of gender on health behavior.

OBJECTIVES OF THE COURSE

After completing this course, you should be able to:

- Define health from various perspectives which include human rights, social and feminist perspectives.
- Recognize the importance of the study of gender differences in health, androcentric, medical research bias, overgeneralization, and double standards on women's health from a personal and societal perspective.
- Identify women's requirements of healthcare as newly born, girl child adolescence, aging women, women with disabilities, and women in crisis.
- Recognize women's mental, emotional, psychological and reproductive health issues from a national and international perspective with special emphasis on South Asia.
- Analyze the impact of violence against women on health with reference to development.
- Demonstrate knowledge of women's various chronic diseases from social and cultural perspective along with their treatment and prevention.
- Discuss the political and social dimensions of health issues of women in crisis.
- Highlight the role and contribution of national and international agencies in the field of women's health.

HOW TO STUDY:

For studying material, you need to follow the given instructions.

- This study guide presents an overview. You are encouraged to study on your own by studying the suggested readings given under each topic for preparation of assignments/convince exams. Since BS Gender & Women Studies has be aimed to prepare a lot of social scientists and researchers in gender and women issues. Thereby, being a researcher, the more you will equip yourself by studying available online materials, the more you will be aptly fulfilling the role of a social scientist and researcher and will successfully complete your degrees.
- If you spend one hour daily studying your course, you will be able to complete your course in eighteen, 18 weeks.
- As soon as you are once assigned tutors, you start working on your assignments. Try to contact online on LMS Aghai Portal your tutors if you need to understand any topic or call GWS Faculty members (phone numbers are in your prospectus/on AIOU web) for guidance. Assignments are your personal

- notes, so always keep a copy with you before uploading it to your tutor.
- In the mid/quarter of your study period, a workshop will be arranged for you, which is a compulsory component of your study. This workshop gives you more clarity about topics. You interact with your peers and internal and external resource persons in the workshop. Therefore, avail yourself the best of information at the workshop and take notes of the lectures as well.
 - Extensively use the internet and Library (Provided by AIOU) for a better understanding of the topics.

Tutors Guidance:

In a distance learning system basically, the students must study on their own. However, the university appoints tutors for the guidance of students. The students are required to regularly attend contents these scheduled meetings. Most probably in this course, you will be assigned a correspondence tutor who not only evaluates your assignment but you are also encouraged you to be in contact with the tutors for guidance regarding the course as it is convenient for both of you.

Assessment and Evaluation

According to the university system your performance in the course will be evaluated through two modes that are:

- Home Assignments
- Final Examination
- You will be required to prepare two assignments for this course. The assignments are spread over course units. Each assignment is to be submitted by uploading online through the AGAHI portal for evaluation.
- The main objective of the assignments is to encourage you to study and appraise your performance. The tutor's assessment will guide you in the preparation for your next assignment.
- The marks obtained minimum 50% in each assignment add up to the final examination. The papers for final examinations are prepared, based on the complete course. For passing a course, one must pass both the components of the assessment and the final examination.

Wishing you Good Luck in your studies

Dr. Atifa Nasir
Course Development and Course Coordinator

CONTENTS

UNIT 1 Defining Health.....	13
Introduction	15
Objectives.....	15
1.1.Different Approaches To Health.....	16
1.1.1. Health as a Human Right Issue.....	16
1.1.2 Feminist View of Health.....	17
1.1.3 Social Understandings of Health	18
1.1.4. The Biomedical Approach	18
1.1.5. Current Approach to Gender and Health	20
1.2. Health and Development	21
1.3.Determinants of Health	22
1.3.1. Social Determinant of Women's Health.....	23
1.3.2. Physical Determinants of Health	23
1.3.3. Women-Specific Health Issues (Diseases)	24
1.4 Women's Health Movement (WHM)	24
1.5. Self-Assessment Questions	25
References	26
UNIT 2 Conditions of Women's Health.....	27
Introduction	29
Objectives:.....	29
2.1. Physical and Social Issues Faced by Girl Child.....	30
2.1.1. Nutrition Status of Girl Child	30
2.1.2. Son Preference	32
2.2. Adolescence	32
2.2.1. Factors that Affect Health of Adolescents	33
2.2.2. Adolescence Issues	35
2.2.3. Adolescent Needs (recognition, information, and counselling services).36	
2.4. Self-Assessment Questions.....	37
References	38
Unit 3 Womens and Mnetal/Psychological Health.....	39
Introduction	41
Objectives.....	41

3.1 Women and Mental Health	42
3.2. Feminist View of Mental Health.....	43
3.3 Mental Healthcare Provisions for Women.....	44
3.4 Women and Drugs	46
3.5 Why Women Abuse Substances?	47
3.5.1. Triggers for Drug Use in Women	44
3.5.2. Common Reasons Women Use Drugs.....	50
3.5.3. Alternatives to Drug Abuse in Women.....	52
3.6. Self-Assessment Questions.....	55
References	56
UNIT 4 Women and Reproductive Health.....	57
Introduction	59
Objectives.....	59
4.1 What is Reproductive Health?.....	60
4.2. Reproductive Health and Feminism	60
4.3 Reproductive Rights.....	61
4.4 Safe Motherhood	64
4.4.1 Pillars of Safe Motherhood	65
4.4.2 What is Continuum of Care?.....	66
4.5 Family Planing	68
4.5.2 Family Planning and Islam	68
4.5.3. Male as Partners in Family Planning	71
4.6 Biases in Healthcare System	71
4.7 STDs Infections and HIV/AIDS	74
4.8. Self-Assessment Questions.....	75
References	76
UNIT 5 Aging and Women;s Health	77
Introduction	79
Objectives.....	79
5.1 Ageing and Feminism.....	85
5.2.Physical And Mental Issues of Aging Women	81
5.3 Ageing Women and Healthcare System.....	85

5.4. Self-Assessment Questions.....	89
References	90
UNIT 6 Violence and Women’s Health	91
Introduction	93
Objectives.....	93
6.1 How Violence Against Women is Defined?	94
6.2 Types of Violence Against women	95
6.2.1 Psychological and Emotional Abuse	95
6.2.2. Social Abuse	95
6.2.3. Financial Abuse	95
6.2.4. Sexual Abuse	95
6.2.5. Physical Abuse.....	95
6.3 Other Forms of Violence Against women	96
6.3.1. Domestic Violence.....	97
6.3.2. Commercial Sex Workers and their Health	99
6.3.3. Prostitution and Feminism	100
6.3.4. Female Genital Mutilation (FGM).....	100
6.3.5 Female Infanticide	101
6.4. Selected Abortion	102
6.5. Self-Assessment Questions.....	103
References	104
UNIT 7 Health of Women with Disabilities.....	105
Introduction	107
Objectives.....	107
7.1 Why a Focus on Disable Women’s Health?.....	108
7.2 Definition and Models OF Disability	108
7.2.1 Medical model	109
7.2.2 The Social Model.....	109
7.2.3 Moral Model	110
7.2.4. Expert/ Professional model	110
7.2.5 Tragedy/Charity Model.....	110
7.3 Feminist View of Disability.....	110
7.4 Barriers to Health of Women with Disabilities.....	111

7.5. Self-Assessment Questions.....	113
References	114
UNIT 8 Health Issues of Women in Crises	115
Introduction	117
Objectives.....	117
8.1 Health Issues Refuge Women	118
8.2 Health Issues of Displaced Women.....	119
8.3 Health Issues of Women in Natural Disaster	120
8.4 Women in War and Conflict	121
8.5 Health of Women In Jails & Prisons	122
8.6 Self-Assessment Questions.....	123
References	124
UNIT.9 Role of National & International Institutions in Womens Healh	125
Introduction	127
Objective	127
9.1 Why We Need a National Women's Health Policy	128
9.2 Principles Underlying the Women's Health Policy.....	128
9. 3 Issues of Importance in Women's Health	129
9.4 Government of Pakistan and Women' Health	129
9.5 The United Nations (Un) and Women's Health.....	131
9.6 Non-Government Organizations (NGO's) and Women's Health.....	133
9.8 Self-Assessment Questions.....	135
References	136

UNIT 1

DEFINING HEALTH

Written by; Dr. Atifa Nasir
Revision by: Dr. Atifa Nasir

CONTENTS

Introduction.....	15
Objectives	15
1.1. Different Approaches to Health.....	16
1.2. Health and Development	21
1.3. Determinants of Health.....	22
1.4. Women's Health Movement (WHM).....	24
1.5. Self Assessment Questions.....	25
References.....	26

INTRODUCTION

This unit begins with the introduction of different perspectives on health focusing on social, feminist, and human perspectives with substantial issues that affect women's health in contemporary societies. Determinants of health and the significance of health as an indicator of development have also been discussed. This unit also explores women-specific health issues such as breast cancer, eating disorders, sleeping disorder and tuberculosis are argued with feminist insight. International Women's Health Movement (WHM) with its critique is also part of this unit.

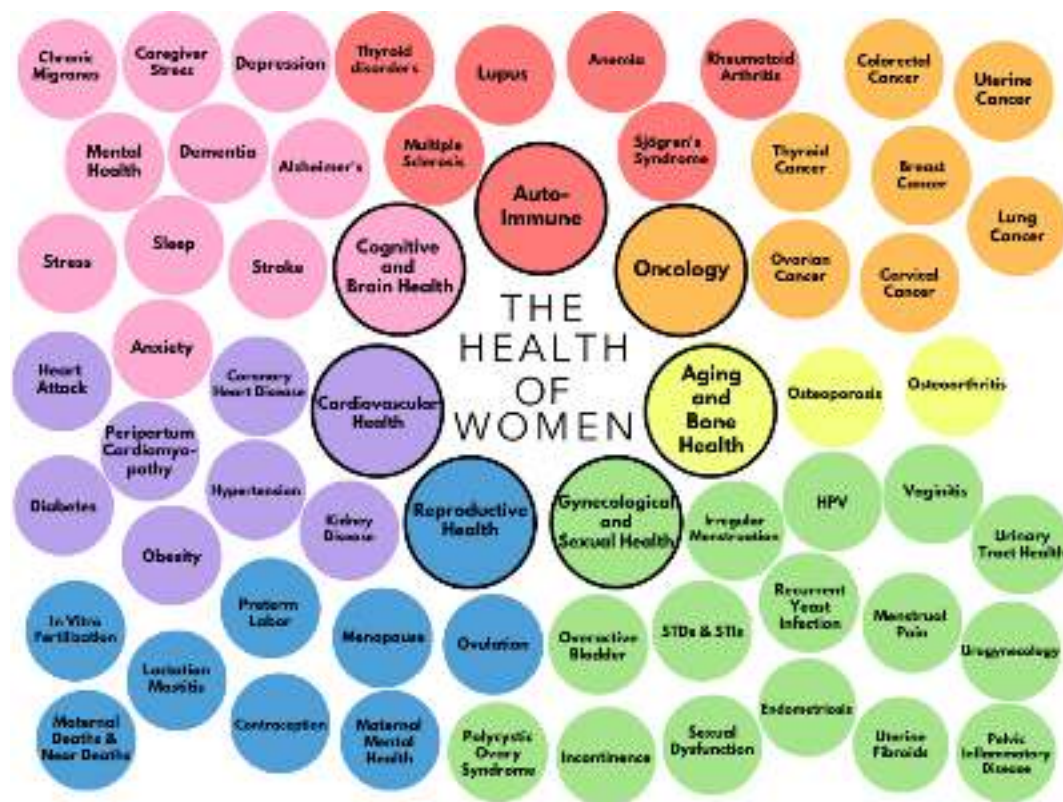
OBJECTIVES

After reading the unit, you will be able to:

- define health from various perspectives (human right, social and feminist)
- identify and discuss the linkage between women-specific health and development.
- identify the different determinants (social, physical) of health.
- describe women specific health issues (diseases)
- discuss Women Health Movement (WHM) and its critique on women health issues.

1.1. Different Approaches to Health

Women's health has been discussed with reference to many perspectives. It is imperative to investigate women's health from a different perspective for encompassing a comprehensive understanding of the health paradigm. In this section, we will look at health from various perspectives.



1.1.1. Health as a Human Right Issue

Health is one of the fundamental human rights and there are many important linkages between health and other human rights. Still, the focus on human rights within the health context is relatively recent. The right to health is an inclusive right. It can be understood as a right to the enjoyment of a variety of facilities, goods, services, and conditions necessary for the realization of the highest

attainable standard of health. The enjoyment of the right to health is linked to other human rights such as the right to food and education.

Key human rights principles such as participation, accountability, transparency, non-discrimination, empowerment, and local ownership related to health affect health policies and programs. In many ways human rights violations affect health for example:

- Human rights violations often have serious health consequences (e.g., violence against women and children, torture, female genital mutilation);
- Health programs can promote or violate human rights in the ways they are designed and implemented (e.g., rights to information, confidentiality, privacy, participation, equality of access, and non-discrimination);
- If human rights are respected, protected, and fulfilled, it can reduce people's vulnerability to ill health (right to food and nutrition, freedom from discrimination).

1.1.2 Feminist View of Health

The feminist view can be understood in contrast to the traditional view. The traditional view looks at the many ways in which women differ from men and concludes that these differences reflect some basic differences that far transcend reproductive capacities. The feminist perspective looks at the many similarities between sexes and concludes that women and men have equal potential for individual development. Feminists claim a vision of a world where all women freely make their own decisions regarding their bodies, reproduction, and sexuality and more over a world where all women can fulfill their own unique potential and live healthy whole lives.

Feminist health activism grew out of the women's liberation movement of the 1960s, which argued that ideas of female inferiority pervaded the gender-segregated healthcare system. In *The Feminist Mystique* (1963) Betty Freidan

assailed physicians who proscribed addictive tranquilizers to dissatisfied suburban housewives; protesters at the 1968 Miss America pageant rejected stereotypical notions of femininity; and other radical feminists organized "speak-outs" to break society's silence about abortion and rape. During the last 50 years, feminists have insisted that the ability to make their own decisions about their own bodies is a crucial foundation for achieving true equality for women.

In the 1980s there was a growth of feminist writing on health that began to identify differences in men's and women's health experiences and access to/use of care facilities and to offer theoretical explanations for these differences, covering the biological and social, which led on to further research projects Anne. 1999 Anne. 1999 attempting to prove/disprove hypotheses. In addition, in Africa, Asia, and Latin America, women began to initiate and undertake research and develop critiques of the failure of biomedicine to acknowledge and connect with indigenous notions of women's health. They aim to support women to achieve greater autonomy over their health/bodies and their work has not only recognized women's health issues but a broader range of questions that directly address the links between health experience and gender roles, for example, domestic and sexual violence and occupational health issues (Anne, 1999).

1.1.3 Social Understandings of Health

A social perspective of health is one that concentrates on improving the health well-being of the population and talks about the factors which influence health and well-being.

This view also draws on key social determinants that influence broadsides of health and illness within a population.

The World Health Organization has offered a definition of health that goes beyond the biomedical model and argues that health is 'A state of complete social, psychological and physical well-being and not merely the absence of disease'. Implicit within this

definition is the notion that health is not purely a physical phenomenon, but is influenced by socio-cultural, economic, and psychological factors.

There is a whole range of alternative understandings of health and illness that vary broadly from the understanding of health. Some have developed as indigenous systems over centuries e.g., acupuncture, whilst others have emerged more recently, partly in response to criticisms of the biomedical approach. One group of related analyses may be referred to as models of the social production of health and illness. These argue that health and illness are produced through social as much as biological processes and are products of the way in which society is organized.

1.1.4. The Biomedical Approach

The biomedical approach distinguishes between:

- Disease: a medical conception of physical pathology, indicated by a set of signs and symptoms
- Illness: a person's experience of ill health, indicated by a person's feeling of pain and discomfort.

The 18th and 19th centuries marked changes in the understanding of the 'natural world', and of the relationship between the individual, the environment, and disease. Research in the natural sciences was influenced by the work of scientists and engineers as they developed their understanding of mechanics, leading to the conception of the natural world in mechanistic terms. The focus was on the individual biological body as the site of disease pathology.

For example, the biomedical approach views women's problematic eating behavior and consequent weight loss/gain as the core issue and attempts to treat the symptom by physical means such as regular weight monitoring, bed rest, tube feeding and planned eating regimes, often reinforced by behavioral reward

systems. It does not necessarily seek to address underlying causes, but, arguably, does perform a vital role in keeping dangerously underweight women alive.

The biomedical manner of treating women's eating issues can miss the point of understanding them in context, i.e., as being expressions of social as well as individual dysfunction.

1.1.5. Current Approach to Gender and Health

Despite obvious differences between women and men, biologically, psychologically, and socially, the concept of viewing the totality of women's health as different from men's health was not fully applied practically. In the 1980s, students in most Western medical schools were taught that except for issues related directly to reproductive anatomy and function; women were medically identical to men. According to this belief system, medical research could be carried out on men and the results could simply be applied to women. Health policymakers and practitioners in the 1990s begin to recognize the importance and value of gender issues in the health field. Interpretations of gender analysis in the health fields have been varied but two main approaches have been identified.

- a women's health needs approach
- a gender equity approach (also known as a gender inequality approach)

A women's health needs approach is concerned with the implications for women of differences in the epidemiological profile between the sexes. This approach stresses that women's particular health needs have been neglected because of male-centered models of health and therefore argues for the need to address these needs in a way that views women and their lives holistically - that is, it addresses the full range of women's health problems, rather than just their reproductive health problems, and does this throughout their life cycle.

A gender equity approach is “concerned with the role of gender relations in the production of vulnerability to ill-health or disadvantage within health care systems”. So far it has focused particularly on the access to and utilization of formal health services. Equity’ can be distinguished from ‘equality’ in that while equality carries some notion of ‘sameness’, equity carries some notion of ‘fairness’. Therefore, while a focus on equality would argue that men and women should be treated exactly the same (that is, not discriminated against in the provision of health care explicitly on the basis of their sex), a focus on equity argues that men and women may have different needs and face different barriers to meeting those needs or having them met (World Health Organization, 2006).

Additionally, different needs and barriers may not lead to an equal disadvantage for both sexes. An equity approach, therefore, stresses that health policy must consider the different and inequitable needs of men and women in allocating resources for health promotion, prevention, and care.

1.2. Health and Development

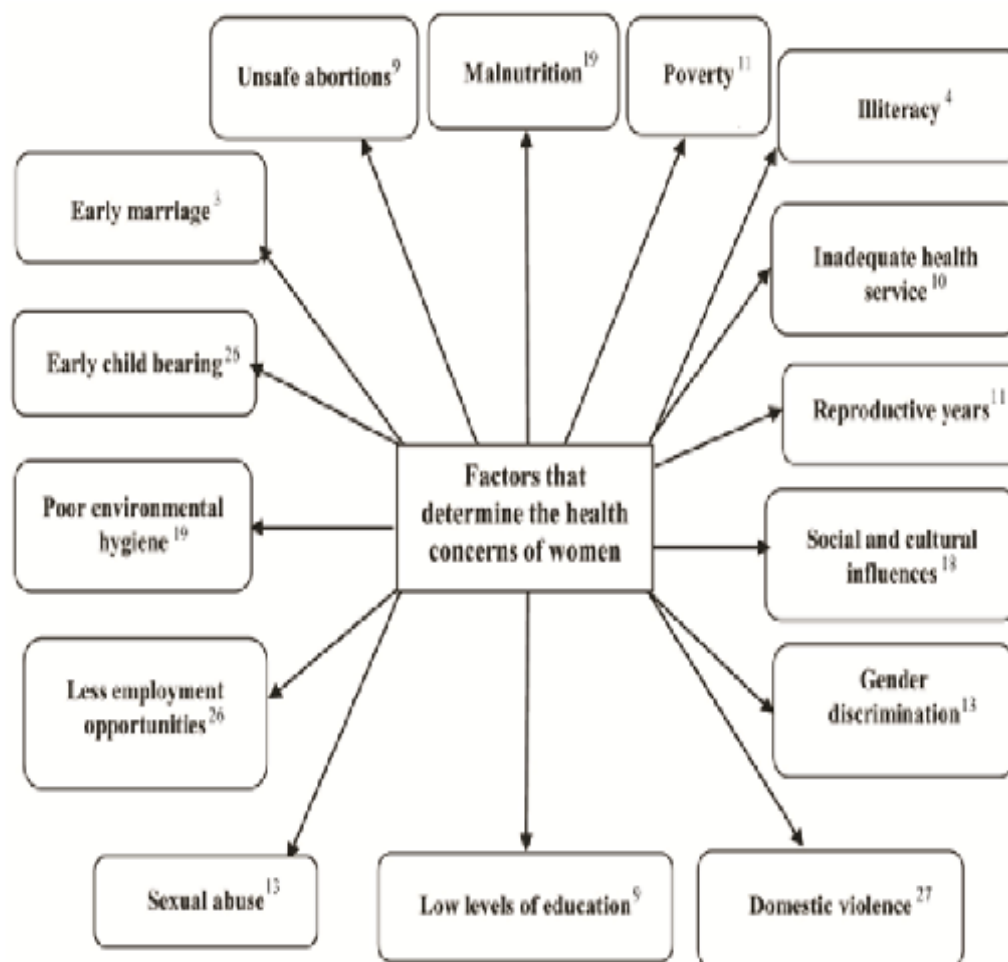
The role of health in development is an extremely important area of study both for social and behavioral sciences as these examine the relationship between health and development. Health may be used as an indicator of development in different parts of the world. It is well said that healthy people make a better nation, a better worker, make stronger economies and strong economies allow people to live and make good choices.

Empirical studies show that health improvement provides a signified boost to economic growth in developing countries. This leads to the view that health like education is a fundamental component of human capital and suggests the notion of health –led-growth. Better health leads to higher income and alternatively a wealthy nation (Scott-Dixon,2009).

Health system in countries all over the world faces economic challenges to meet in growing needs of the citizens' specially women who have specified health needs. The quality of health service delivery depends on availability and performance of qualified personal, and sufficient provision of medical facilities and drugs.

1.3. Determinants of Health

Health is strongly influenced by the underlying socio-economic and physical factors which play part as determinants of health. Owing to their importance in life they are being discussed below in detail.



1.3.1. Social Determinant of Women's Health

A person's health is influenced by the condition in which he/she lives. Social and economic conditions such as poverty, gender inequality, urbanization, social security population morbidity, unemployment, social exclusion, poor housing, health care system, education etc strongly influence health. They contribute in inequality in health which explains why people living in poverty die sooner and get sick more often than those living in more privileged conditions. Socioeconomic factors and women's status have influences on women's health. The burden of illness rests disproportionately on economically disadvantaged women and on those with low social status. The long-term effects of social disadvantage are apparent in the excesses of morbidity among women who are not either employed at the time of their children's birth or are women living in poor neighborhoods, and those living in households without modern amenities.

Research on the effects of socioeconomic disadvantage and women's status on women's health is important for policymakers in developing countries, where limited resources make it crucial to use existing maternal and child health care resources to the best advantage. The Indian subcontinent stands alone as an area in which women have a lower life expectancy at birth than men. The influences can be conceptualized as endemic stress that arises from social and physical environmental determinants of deprivation, inadequate resources, limited role opportunities, and oppressive cultural forces as there is a link between these factors and women's health status.

1.3.2. Physical Determinants of Health

The physical determinants of health are environment (which includes biological and chemical agents which attribute to the environment) water and sanitation. Physical determinants also include medical care, effective protection against

communicable diseases, safe sexuality, good reproductive health, increased awareness of healthy lifestyle, good eating habits, safer food, and health stress coping mechanisms.

1.3.3. Women-Specific Health Issues (Diseases)

The health issues that experience women are many and varied in their nature. They are not just about reproduction but women's overall health which affects health through relationships, work, culture, and society within which women live. In this part it is impossible to discuss all the health issues; therefore, a few of them are being discussed which will provide you an insight into the most common issues women face around the world. Some of them may include breast cancer, eating disorders, sleeping disorders, tuberculosis, cardiovascular diseases, etc.

1.4 Women's Health Movement (WHM)

The Women's Health Movement (WHM) emerged during the 1960s and the 1970s with the primary goal to improve health care for all women. Despite setbacks in the area of reproductive rights during the 1980s, the WHM made significant gains in women's health at the policy level during the 1980s and 1990s. The WHM became a powerful political force. The achievements of the movement in improving women's health during the 20th century were numerous and significant. Women formed self-help groups, influenced social policy through advocacy, and instituted new types of health delivery for women. Ultimately, the women's health movement changed medical practice, reshaped health care institutions, influenced health care policy, and improved the social status of women internally (Geary,1995).

The Women's Health Movement (WHM), which began in the early 1970s, has significantly influenced the lives and health care of women. A direct outgrowth of

dissatisfaction with paternalistic male dominance of women's health care, the WHM hoped to regain control over their bodies and medical decision-making by educating women to become knowledgeable about their health. Periodicals, particularly newsletters, have played a significant role in the empowerment process, by drawing together networks of women with common and often disease-oriented health interests.

1.5. Self-Assessment Questions

- Q.1. Discuss the link between health right and health. Discuss health from a human right perspective. How would you define the right to health?
- Q.2. The definitions of women 'health is in the process of definitional shift. Discuss it with socio- historical context of health.
- Q.3. Describe the social context of women's health.
- Q.4. Good health is prerequisite to human production and development process. How would you analyze this statement?
- Q.5. Define determinants of health in detail.
- Q.6. What are the main causes of morbidity and mortality in developing countries?
- Q.7. Discuss the social determinants of health in detail.
- Q.8. Discuss the most prevalent diseases in women.
- Q.9. Describe the historical dimension of women's health movement. How it dealt with women health issues?
- Q.10. Manisha Desai in her article "Gender, Health and Globalization: critical social movement perspective "argues this changing gender relation have affected the discourse of global health and has raised particular concerns of women 'health. Do you agree to her point of view?

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UNIT 2

**CONDITIONS OF
WOMEN'S HEALTH**

Written by; Dr. Atifa Nasir
Revision by: Dr. Atifa Nasir

CONTENTS

Introduction.....	29
Objectives:	29
2.1. Physical and Social Issues Faced by Girl Child	30
2.2. Adolescence	32
2.3. Self-Assessment Questions.....	37
References	38

INTRODUCTION

Every woman, man, youth and child have the human right to the highest attainable standard of physical and mental health, without discrimination of any kind. Enjoyment of the human right to health is vital to all aspects of a person's life and well-being. Even after conception, a female fetus starts facing discrimination and becomes the victim of malnutrition, if she is ever allowed to be born.

The continuing trend in the sex imbalance in Child Sex Ratio (CSR) against girls remains in most parts of the world, especially in South Asian countries as son preference which is described as cultural phenomenon. On arrival of adolescence, throughout her life this cycle of discrimination continues. The girl child faces physical, emotional and psychological disadvantages in every stage of life including stage of adolescent. Adolescent also comes hard on girls in terms of nutrition and emotional and psychological needs. Their needs are ignored, and their choices are very limited. This unit traces the social and cultural explanations of malnutrition of girls and son preference among many countries of the world and will provide a cross-cultural comparison of this phenomenon. This unit will also discuss adolescence in detail catering to its issues and services available especially for girls.

OBJECTIVES

After studying the unit, you will be able to:

1. discuss the physical and social issues faced by female newly born in relation to nutrition and son preference
2. define adolescence and identify the issues (physical, social, and emotional) of adolescent girls.
3. explain the needs (information and counseling services) of adolescence.

2.1. Physical and Social Issues Faced by Girl Child

2.1.1. Nutrition Status of Girl Child

Though malnutrition affects all segments of the population children appear to be more at risk than others, also the consequences of malnutrition appear to be more serious. In addition, culturally determined social behavior places the female child at a nutritional disadvantage. This belief has gained wide acceptance in many parts of the world. South Asia has the highest rates of child malnutrition in the world, twice as high as sub-Saharan Africa.

The one reason, according to top nutritionists, is the region's severe subjugation of women. This subjugation gives rise to a deadly cycle of malnutrition. A girl in India and Bangladesh is born underweight and malnourished. She is nursed less and fed less nutritious food than her brother. She is often denied health care and education. She is forced to work, even as a child. Her work burden increases significantly as she gets older even when she is pregnant. She is married and pregnant when she is young, often just a teenager. She is underweighting and malnourished when she gives birth to her children, who are born underweight and malnourished.

2.1.2. Son Preference

In most developing countries parents prefer sons over daughters. This is known as son preference. There has been a marked gap between the number of boys and girls, men, and women. This gap is the result of decisions made at the most local level and family. The birth of a son is welcomed with celebration as an asset, whereas that of a girl is seen as a liability, an impending economic drain. According to an Asian proverb, "bringing up girls is like watering the neighbor's garden".

The common wisdom is that the preference for sons is motivated by economic, religious, social and emotional desires and norms that favor males and make females less desirable: Parents expect sons but not daughters to provide financial and emotional care, especially in their old age; sons add to family wealth and property while daughters drain it through dowries; sons continue the family lineage while daughters are married away to another household; sons perform important religious roles; and sons defend or exercise the family's power while daughters have to be defended and protected, creating a perceived burden on the household. Son preference is a cultural phenomenon too, more marked in Asian societies and historically rooted in the patriarchal system. In certain countries in the Asian region, the phenomenon is less prevalent than in others. Son preference is stronger in countries where patriarchy and patrolling are more firmly rooted. Tribal societies, which are matrilineal societies, tended to be more gender egalitarian until the advent of settled agriculture (Wilson, 2007).

The psychological effect of son preference on women and the girl child is the internalization of the low value accorded by them by society. Scientific evidence of the deleterious effect of son preference on the health of female children is scarce, but abnormal sex ratios in infant and young child mortality rates, in nutritional status indicators and, even in population figures show that discriminatory practices are widespread and have serious repercussions. Geographically, there is often a close correspondence between the areas of strong son preference and of health disadvantages for females. Discrimination in the feeding and care of female infants and/or higher rates of morbidity and malnutrition has been reported in most of the countries where this phenomenon exists. For every growing girl who dies, there are many whose health and potential for growth and development are permanently impaired.

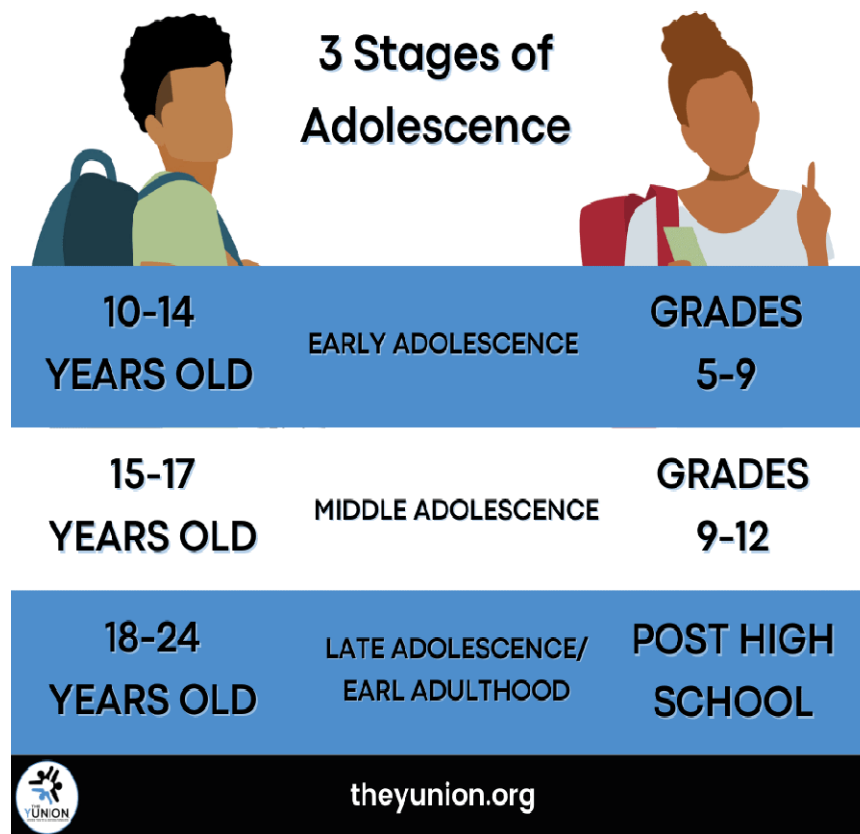
2.2. Adolescence



Adolescence, the transitional stage of development between childhood and adulthood, represents the period of time during which a person experiences a variety of biological changes and encounters a number of emotional issues. The ages which are considered to be part of adolescence vary by culture and range from preteens to nineteen years. According to the World Health Organization (WHO), adolescence covers the period of life between 10 and 20 years of age (Saxena, 2007). Adolescence is a specifically turbulent as well as a dynamic period of any person's life. Adolescence psychology addresses the issues associated with adolescence. A number of associations of psychologists across the world now recognize this phenomenon and requirement of a separate class of specialized psychologists to deal with the issues of adolescence.

"Adolescence" is also a modern cultural and social The time is identified with dramatic changes in the body, along with developments in a person's psychology

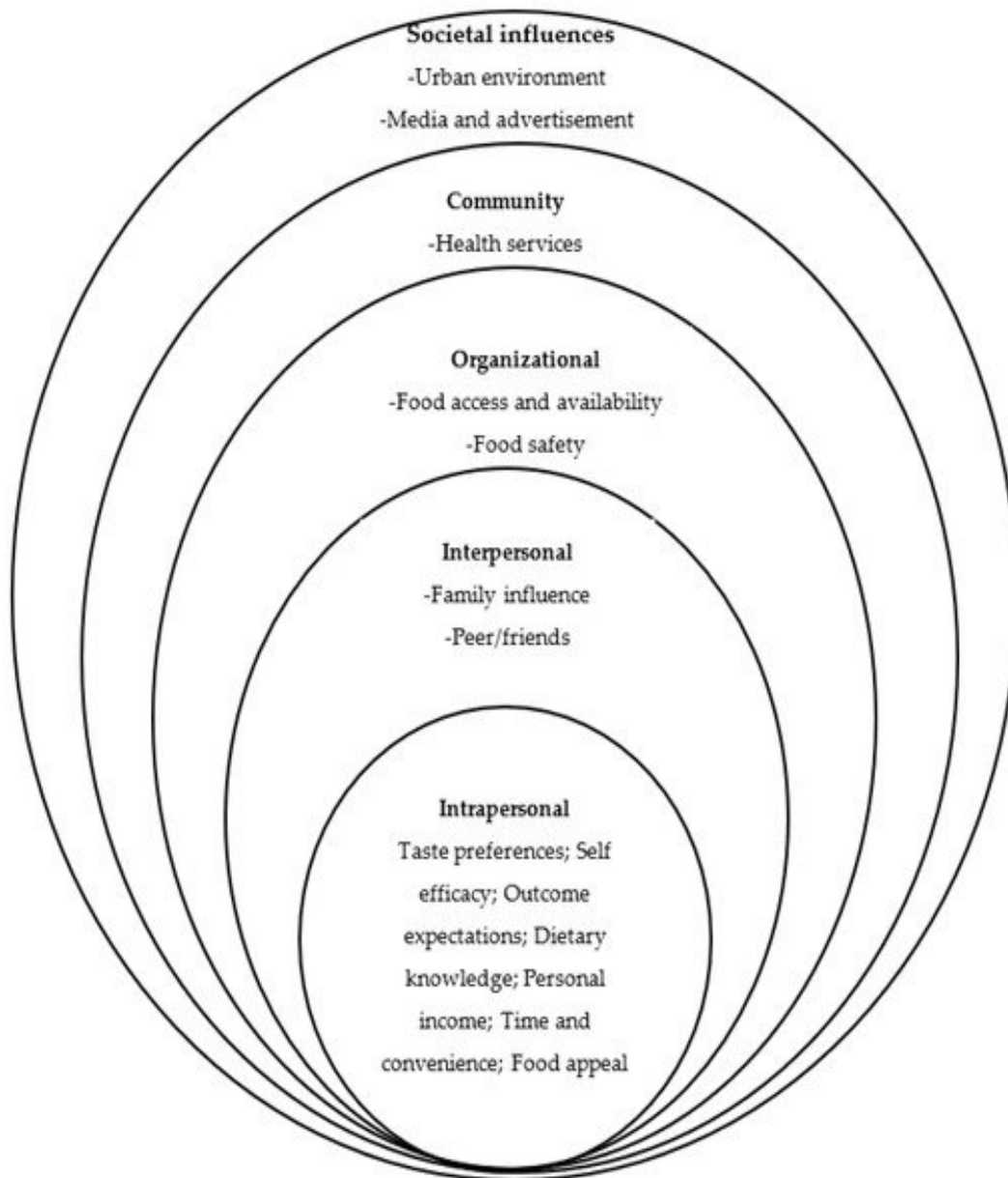
and academic career. It is also a time period to shape and consolidate healthy eating and lifestyle behaviours, thereby preventing or postponing the onset of nutrition-related chronic diseases in adulthood.



2.2.1. Factors that Affect Health of Adolescents

The health of adolescents is affected by a complex interplay of factors between the young person and their social environment. Their health is shaped by the parents and families, peers, neighborhoods, communities, schools, community organizations, faith, health care systems, media, employers and social norms, policies, and laws. These factors impact young people's sense of health and

wellbeing by affecting their withstand life stresses, their ability to transition in developmentally appropriate ways and their ability to make decision about health behaviors.



2.2.2. Adolescence Issues

These factors may include emotional and personality disorders, family pressures, genetic or biologic susceptibility, physical or sexual abuse, and a culture in which there is an overabundance of food and an obsession with thinness (Jackson, 2013). Eating disorders are generally associated with teen age girls are categorized as anorexia nervosa, bulimia nervosa, binge eating disorders, or not otherwise specified (NOS). Anorexia nervosa is a state of starvation that is caused by severe dieting. Bulimia nervosa describes a style of bingeing. It usually begins in early adolescence when young women attempt restrictive diets. When these diets fail, the adolescent reacts by binge eating and vomiting or taking laxatives, diet pills, drugs to reduce fluids, and excessive exercising (Sylwestrzak ,2015).

CHALLENGES DURING ADOLESCENCE

1. Attitudes and behavior toward sexuality and sexual relationships
2. Academic concerns
3. Group belongingness
4. Health and nutrition
5. Developing or Regaining Self-Esteem
6. Roles
7. Material Poverty
8. Parents Working Abroad
9. Career Choice
10. Relationships
11. Values and Beliefs
12. Other Challenges

Indicators of a need for intervention include behaviors, thoughts, or feelings that limit the youth's ability to maintain positive relationships, cope with the demands of home and school life, and continue healthy development. There is no clear dividing line between mental health, mental health problems, and serious emotional disturbances during this stage of life.

2.2.3. Adolescent Needs (recognition, information, and counselling services)

It has increasingly been recognized that adolescents form a specific group in society and have their own specific needs. Exploration and experimentation is the hall mark of this adolescent behavior, which often propel adolescents towards risk-taking and in girls case, to expose to unwanted pregnancies, STDs, substances abuse and unintended injuries. At the same times, adolescents often face constraints in seeking services including misperceptions about their own needs, fear of disclosure and service provider's negative attitudes. To overcome these constraints, there is need to develop specifically designed services for adolescents. Adolescent friendly services should be able to attract young people meet their needs with sensitivity and retain young clients for continuing care. Ideally, the holistic package of services must include reproductive health service, nutrition counselling, counselling to promote responsible behavior and prevent substance abuse and services such as immunization and life skills education.

2.4. Self-Assessment Questions

- Q.1. Discuss the girlchild with reference to right to health.
- Q.2. Discuss the reasons of son preference in Asia. Why is it still persist in South Asia?
- Q.3. Define adolescents. Why should one pay attention to health of adolescents?
- Q.4. What health problems do adolescents face? What kind of adolescent services meet the need of adolescent?
- Q.5. How would you define adolescent friendly health services?

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Unit 3

**WOMEN AND MENTAL /
PSYCHOLOGICAL HEALTH**

**Written by; Dr. Atifa Nasir
Revision by: Dr. Atifa Nasir**

CONTENTS

Introduction.....	41
Objectives	41
3.1. Women and Mental Health.....	42
3.2. Feminist View of Mental Health	43
3.3. Mental Health Care Provisions for Women	44
3.4. Women and Drugs	46
3.5. Why Women Abuse Substances?	47
3.6. Self Assessment Questions.....	55
References	56

INTRODUCTION

Women are integral to all aspects of society. However, the multiple roles that they fulfill in society render them at greater risk of experiencing mental problems than others in the community. Women bear the burden of responsibility associated with being wives, mothers and careers of other. Increasingly women become as an essential part of the labor force and in one-quarter to one third of households they are the prime sources of income (WHO, 1995) .In addition to the many pressures placed on women, they must contend with significant gender discrimination and associated factors of poverty, hunger malnutrition and overwork. An extreme but common expression of gender inequality is sexual and domestic violence perpetrated against women. These forms of socio-cultural violence contribute to the high prevalence of mental problems among women. (WHO, 1995). Mental illnesses affect women and men differently some disorders are more common in women, and some express themselves with different symptoms. Scientists are beginning to tease apart the contributions of various biological and psychosocial factors to mental health and mental illness in both women and men. In addition, researchers are currently studying the special problems of treatment for serious mental illness during pregnancy and the postpartum period. This unit explores various perspectives related to the mental and psychological health of women along with main issues related to it. Mental issues involving drug abuse is also part of this unit and discusses these issues in the women's health context.

OBJECTIVES

After reading the unit, you will be able to:

- explain the debates regarding mental health of the women from conventional and feminist perspectives.
- identify the factors, and issues that affect women's mental health.
- discuss mental and emotional health care provisions available for women.
- describe the effects of drugs on women's physical and mental health.

3.1 Women and Mental Health

Women's mental health cannot be understood in isolation from the social conditions of our lives. These conditions are characterized by social inequities (e.g., sexism, racism, ageism, and heterosexism) which influence the type of mental health problems women develop and impact on how those problems are understood and treated by health professionals and by the society (AMSHA, 2009). Women's experiences of mental health concerns link to social conditions and women's mental health. The definition of mental health used in the 1981 WHO report on the social dimensions of mental health, states that:

Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.'

Entrenched gender-based inequality represents one form of attack on women's right to achieve good mental health, gender-based violence is another. Both contribute to a tragic waste of human potential and illustrate the contention of the 1998 World Health Report's (WHO, 1998) that:

Women's health is inextricably linked to their status in society. It benefits from equality and suffers from discrimination.

3.2. Feminist View of Mental Health

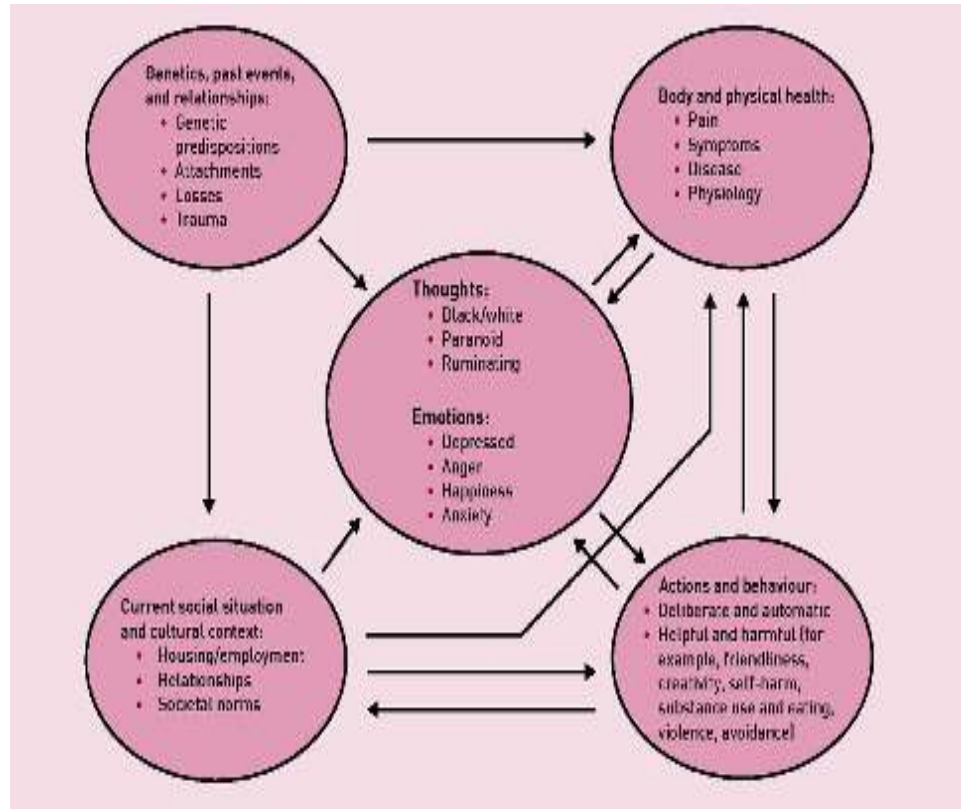


Figure: 3.1

Looking at mental health through a gender lens reveals that both physiological and social differences between women and men have an impact on mental health. Research on the connections between mental health status, biology and women's life cycle changes (e.g. menarche and menopause) and on clinical differences between women and men are providing important contributions to the understanding of gender and mental health.

Feminist scholarship on mental health has followed two lines of inquiry. The first, a social causation approach, examines the features of women's lives that enhance or undermine well-being. The social constructionist perspective involves critical

analyses of methodology and conceptions of mental health and illness. This body of literature suggests that the findings of gender differences in mental health focus on the sexism of psychiatry. Although these bodies of work have remained largely distinct and have been criticized as contradictory, both are important ingredients of a general feminist perspective on mental health. Feminist therapy is used as a model for a synthesis of approaches.

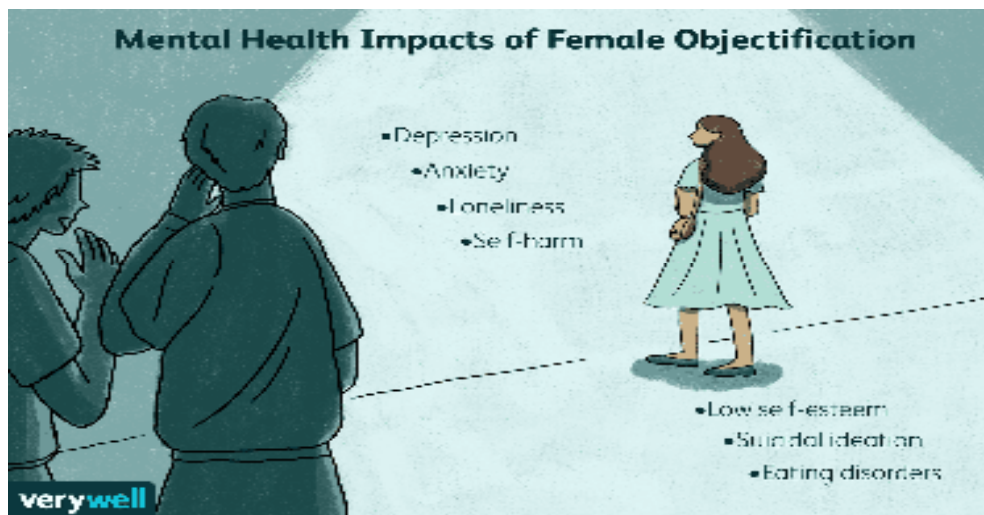


Figure: 3.2

Feminists say that psychological research data is often generalized from study samples that are too small to be statistically significant. Conclusions based on research conducted on males (such as in the area of personality or moral development) often aren't true of women, that the observed phenomenology of mental illnesses in men have been used to develop diagnostic criteria and treatment methods that are biased against women. Feminist arguments are that generalization from one too many (and vice versa) and from men to women (and vice versa) should be avoided (Robinson, 2021).

3.3 Mental Healthcare Provisions for Women

Even more than other areas of health and medicine, the mental health field is

plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial, and cultural diversity, age and gender. A key disparity often hinges on a person's financial status and financial barriers block off needed mental health care from too many people. Mental health services should provide a range of services to respond to individuals' diverse needs: social, therapeutic, and creative activities, self-help, practical support, medication, and psychological therapies. Key areas covered in this guidance are medication and psychological therapies. Women service users clearly say that they want more access to a range of 'talking therapies and less reliance on medication. In many under-served populations, women have a considerable mental health need. In spite of women's active involvement in a woman's health care movement, the mainline health care system continues to hold tight to its andocentric focus. If women are to be subjected to a health care system that employs sexist practices, the quality of life in their later years will continue to be jeopardized. (WHO, 1993; WHO, 1995).

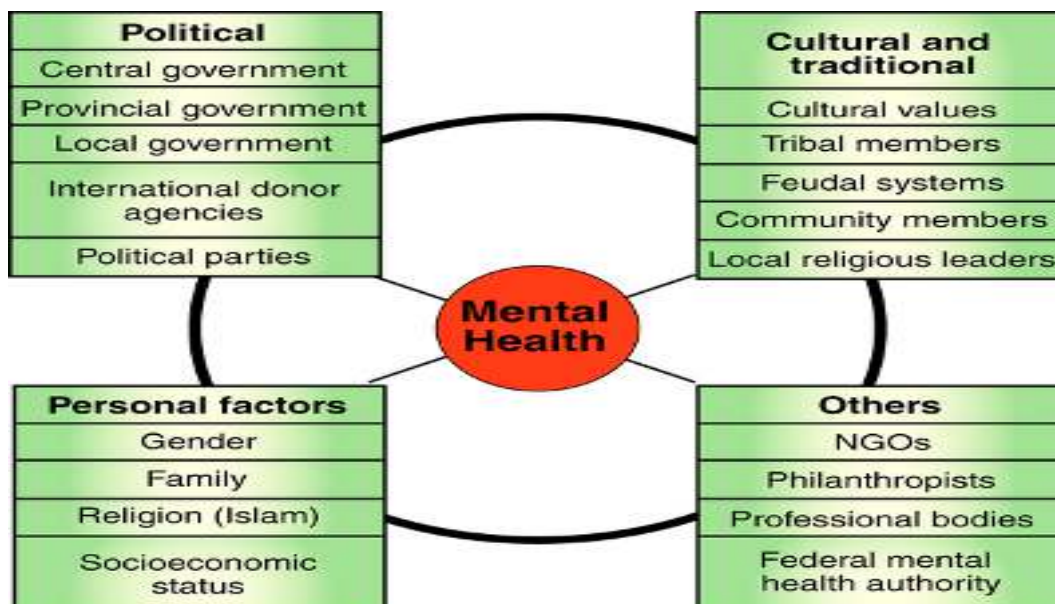


Figure: 3.3

3.4 Women and Drugs

People take drugs for a variety of reasons. Women do use and depend on drugs. Some women use drugs as a coping strategy during particularly stressful times in their lives. There are many kinds of drugs, with a variety of different effects. Opiates, stimulants, tranquilizers, etc, can all affect in different ways. Some drugs have side effects that alter appetites or bodily functions. Many women find that using drugs such as ecstasy (MDMA) or speed (amphetamines) can result in a loss of appetite and consequently weight loss. Women are more at risk from heatstroke than men because women have different water/fat ratio in their bodies. Although both women and men take drugs, because of their different chemical make-ups, each gender is affected differently by the drugs they take. In addition, women experience hormonal changes throughout their lives with puberty, menopause, and pregnancy. During each of these unique phases in a woman's life, she needs different medications to meet her body's needs.

Drug abuse is a patterned use of a substance (drug) in which the user consumes the substance in amounts or with methods neither approved nor supervised by medical professionals.

Women under the influence of drugs at similar or lower levels of use, develop more rapidly than men. Diseases like cirrhosis and hypertension, brain damage from alcohol abuse, lung cancer and respiratory diseases like emphysema and chronic bronchitis from smoking are common in women. Women are likelier to develop depression, anxiety and eating disorders which are closely linked to smoking and alcohol and drug abuse. Women who use sedatives, anti-anxiety drugs and hypnotics are almost twice as likely as men to become addicted to such drugs.

3.5 Why Women Abuse Substances?

Girls and young women are likelier than boys and young men to abuse substances in order to lose weight, relieve stress or boredom, improve their mood, reduce sexual inhibitions, self-medicate depression, and increase confidence.

Women are more likely than men to say their heavy drinking followed a crisis, such as miscarriage, divorce, or unemployment. Aging women are likelier than older men to self-medicate with alcohol and prescribed drugs in order to deal with loneliness, financial insecurity or loss of a spouse.

Traditionally, the stereotype of a drug user was predominantly male. The same was also true of the typical heart-attack sufferer. Either through evolution or more specific studies, both stereotypes have been overturned to reveal that women are just as likely as men to suffer heart attacks, and they're also just as likely to abuse substances.

Substance abuse among women is more prevalent than you might think. At least 15.8 million women used illicit drugs in 2013. That means 12.9% of all women tried an illegal drug at least once, or used prescription drugs improperly for recreational purposes, according to a study by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Until recently, gender differences in substance abuse habits were not recognized. But thanks to modern science, we now know that:

- Women become addicted to drugs after using smaller doses and for shorter periods of time than men.
- Women can be more sensitive to the effects of certain drugs because of sex hormones.

- Women who use drugs experience different changes in their brains than men do.
- A woman's menstrual cycle could affect her withdrawal symptoms and likelihood of relapse in addiction recovery.
- Women are more likely to experience anxiety or depression when using certain substances than men are.
- Women are more likely to die from an overdose of certain drugs than men are.
- Women can experience more physical effects from drug use than men.

Since more attention is now being paid to women's health, we have a deeper understanding of addiction in women, how it is initiated, what effects it has and, ultimately, how to help women overcome addiction.

3.5.1. Triggers for Drug Use in Women

Drug use is often triggered by emotional conditions, and women tend to experience more emotional extremes than men do.

The key triggers for drug use in women are:

- **Loneliness** — Women need social and emotional connections with other people to feel happy and fulfilled in their lives. Being alone or, worse, being in a crowd but feeling disconnected from everyone, is a sensation that can lead a woman to use drugs or to relapse in addiction recovery.
- **Stress** — Women tend to take on multiple projects at work and at home, leaving little or no energy for themselves. They are also likely to feel other people's emotions or worry about their problems. All of this adds up to a high level of daily stress, which is a big alcohol or drug abuse trigger.

- **Fatigue** — All that stress makes women feel tired. Instead of resting, we often do not give ourselves permission to take a break. This is a moment when the urge to use drugs could become strong.
- **Hunger** — Women tend to be more affected by public opinion than men, and they also diet more often. Instead of giving in to hunger by eating, many women use this condition as an occasion to chastise themselves for wanting to eat too much or choose the wrong foods. Some will turn to drugs to make the hungry feeling go away without consuming more calories.
- **Low self-esteem** — Drug use can be a form of subconscious self-abuse. Many women suffer from self-esteem issues. They feel bad about themselves, so they do not believe they are worthy of good care. Drug use may be a way of masking the emotional pain of low self-esteem, or it could be an attempt to fit in with the group.
- **Body image issues** — Women often use drugs to attempt to change the way they look. If they feel they are too fat, stimulants offer the false promise of easy weight loss. There are also other drugs that can be used to build extra muscle mass. When these approaches to changing one's body image do not work, which is likely, alcohol and still other drugs can be seen to soothe the emotional pain.

For many women, drug abuse starts as a way of taking control of something about themselves that they do not like. It's self-medication that's meant to make their lives better but, of course, it ends up having the opposite effect. There are no drugs to "fix" the way you look or feel about yourself. Drugs are not a substitute for friends or food or a relief from stress (Moos, 2006).

All these conditions can be changed with hard work and maybe some help. Focusing on the positive parts of your life and working to eliminate the negatives are two major steps in the life-long pursuit of happiness. Adding drugs or alcohol just compounds the negatives and makes this journey to happiness much more difficult.

3.5.2. Common Reasons Women Use Drugs

Studies across cultural lines and economic barriers show that women experience more pain than men around the world. Results were the same in developing countries as in developed countries. The results led to the conclusion that the difference in perception and tolerance of pain is physiological, not cultural. Throughout history, women have been told the pain is all in their minds. Apparently, it's just not that simple.

The painful conditions that women are more likely than men to experience include:

- Migraines
- Fibromyalgia
- Osteoarthritis
- Irritable bowel syndrome
- Back pain

1. Mental Illness

Mental illness is a common precursor to addiction. People who suffer from mental illness often struggle to relieve their emotional pain. Turning to drugs as a means of escape is not uncommon, but it accentuates their problems (Lerner,1988).

The high, or feeling of detachment and euphoria, achieved with drug use can be seen as a solution to the racing thoughts, fear, and anxiety that are associated with

some common mental illnesses. While under the influence, problems seem to melt away and you get a dose of happiness.

Meanwhile, the changes that take place in your brain from this drug use make it harder to treat the underlying mental illness. Drug abuse can cause mental illness in people who were previously healthy. As drugs alter your state of consciousness, they add to your emotional problems.

Women suffer from mental illness at an alarming rate. A recent SAMHSA study showed that 29 million women in America had been diagnosed with a mental illness in a one-year period. Some of those are chronic conditions, while others are only temporary. Of course, that does not account for the mental illnesses that go undiagnosed.

Some of the mental illnesses that are more common among women include:

- Suicide
- Eating disorders
- Post-traumatic stress disorder (PTSD)
- Depression
- Anxiety

2. Trauma

Nearly half of all Americans are exposed to at least one trauma in their lifetimes. Traumas include physical, sexual, or psychological abuse, accidents, natural disasters, domestic violence, and any other incident that is destructive in nature. Both the victims and the witnesses of trauma may develop emotional disorders, the most extreme of which is PTSD.

Trauma causes an emotional response that some people are not able to process. When those emotions get stuck in their brains, they play in an endless loop until they can make sense of the event. During this stuck phase, several symptoms can develop, including:

- Sleep pattern disturbances
- Irritability
- Paranoia
- Flashbacks
- Nightmares
- Loss of memory of the event
- Fear
- Anger

If untreated trauma symptoms can rise to the level of PTSD, which can become debilitating, interfering with daily activities and regular life events. Women are twice as likely as men to develop PTSD following a traumatic incident. They are also more likely to be the victim of a trauma, especially during childhood. Women who suffer from PTSD tend to experience the symptoms for a longer period than men do¹.

3.5.3. Alternatives to Drug Abuse in Women

Drugs may relieve pain, but that relief will not last for long. You will have to continue taking more and more substances to achieve that same relief in the future. Meanwhile, the changes to your brain from the drugs can become permanent. Opioids block pain messages in the central nervous system, but they

¹ <https://journeypureriver.com/substance-abuse-among-women/>

also slow heart rate and respiration. When combined with alcohol, another depressant, opioids are life-threatening. Overdose is a serious problem, especially when exceeding the doctor-recommended dosage.

Facing chronic pain, mental illness, trauma, or any other difficulty in life is a challenge. Here are some alternatives to self-medication that you could try:

- **Reduce stress** — Make some permanent changes in your lifestyle to reduce the amount of stress you're exposed to. If you're involved in an ongoing traumatic situation, get out as soon as you can. You cannot begin to heal from the trauma until it stops. Find a way to stop it so you can focus on healing.
- **Eliminate access** — Access is a key component to drug use. You cannot become addicted to a substance you do not take. Question the need for prescription drugs, and only take them as directed by your doctor. Dispose of the excess pills immediately so they will not be available for you or others in the future. Ask your doctor for alternative means of pain management if your condition is chronic. If you're taking prescription medication, do not drink alcohol. Compounding the effects of both drugs will lead to addiction much faster.
- **Call a friend** — When you experience emotional pain, it often helps to talk about it. Share your feelings with a trusted friend or family member. Connect with other people who have experienced trauma, either from the same accident you witnessed or from others. Talking through your feelings will help process them so they don't worsen.
- **Join a group** — There are support groups for everything, and they really help. Find a group of like-minded people, whether you're suffering from

chronic pain or recovering from an accident or violent act. Listening to how other people handle similar situations, and sharing your thoughts with them, will help reduce your anxiety and depression. Human connection is important for mental health.

- **See a counselor** — Mental illness is serious but treatable. With the right professional guidance, you can learn to eliminate your symptoms and live a happy, healthy life. Try to find a counselor who specializes in trauma recovery or women's mental health issues. She can help you understand the origins of your illness. In many cases, the illness can be completely cured with the right treatment (Center for Substance Abuse Treatment ,2014).

3.6. Self-Assessment Questions

- Q.1. Discuss in detail different perspectives on mental health. Discuss the feminist perspective of Psychology.
- Q.2. What are the mental disorders prevalent in women? Discuss.
- Q.3. What are the coping strategies which women apply in their daily lives?
- Q.4. How would you define eating disorders? Discuss them with reference to women.
- Q.5. What are the factors affecting mental health of women. Discuss in detail with examples.
- Q.6. What is drug abuse and substance abuse?
- Q.7. What are the different dimensions of substance abuse among women?
- Q.8. Discuss the use of alcohol and issues related to alcoholism among women.
- Q.9. Define depressant, antidepressant and anxiety drugs. What are their effects on women's lives?
- Q.10. Discuss in detail the gender biases in mental health area.
- Q.11. What are the traditional approaches to therapies and racial and cultural issues attached to it?
- Q.12. What is depression? Discuss its prevalence among women.
- Q.13. Discuss the contribution of feminist research in the medical science.

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UNIT 4

**WOMEN AND REPRODUCTIVE
HEALTH**

Written by; Dr. Atifa Nasir
Revision by: Dr. Atifa Nasir

CONTENTS

Introduction.....	59
Objectives	59
4.1 What is Reproductive Health?	60
4.2. Reproductive Health and Feminism	60
4.3 Reproductive Rights	61
4.4 Safe Motherhood	64
4.5 Family Planning.....	68
4.6 Biases in Healthcare System.....	71
4.7 STDs Infections and HIV/AIDS.....	74
4.8 Self Assessment Questions.....	75
References	76

INTRODUCTION

Major themes of feminism are woman's right to their own body, access to reproductive justice and reproductive health. It is desirable for women to make decisions about their own health and well-being. Access to information is integral to a woman's ability to make important decisions regarding her health. Many women face risks associated with pregnancy and childbirth, unintended pregnancy, sexually transmitted infections and HIV/AIDS and FMG. Women's reproductive health covers diseases and conditions that affect the female reproductive system which includes symptoms, diagnosis, treatment and prevention of women's reproductive health issues. This unit while keeping the feminist perspective deals and debates to those issues which cover the socio-cultural and economic perspectives of women 's reproductive health.

Many married women in the developing world face an unmet need for contraception. Family planning programs exist in almost every part of the world but their existence face couple of controversies in term of social, cultural and religious grounds. This unit discusses those controversies and looks at family planning from Islamic perspective.

In today's world, we often see the uneven distribution of healthcare that leaves many impoverished communities underserved. Economic, political and social factors all contribute to women's access to healthcare, both internationally and at home. This unit discusses all of those issues within feminist domain providing you an insight of the diverse themes.

OBJECTIVES

After reading the unit you will be able to

- define reproductive health and reproductive rights
- highlight the issues and debates about reproductive health in feminism.
- describe concerns related to concept of family planning with special reference to Islamic perspective of family planning.
- identify and describe Sexually Transmitted Diseases (STDs) and their effects on women' health.

4.1 What is Reproductive Health?

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 functions and processes. Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do.

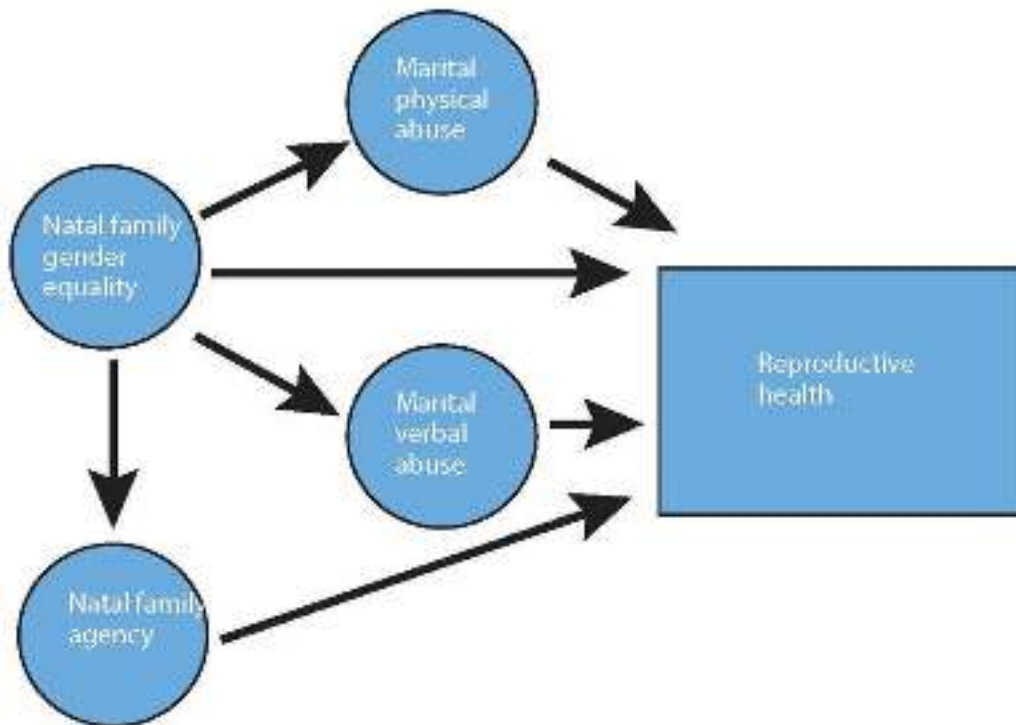


Figure: 4.1

4.2. Reproductive Health and Feminism

Being a woman has implications for health. Health needs of women can be broadly classified under four categories.

1. Women have specific health needs related to the sexual and reproductive function.
2. Women have an elaborate reproductive system that is vulnerable to dysfunction or disease, even before it is put to function or after it has been put out of function.
3. Women are subject to the same diseases of other body systems that can affect men. The disease patterns often differ from those of men because of genetic constitution, hormonal environment, or gender-evolved lifestyle behavior. Diseases of other body systems or their treatments may interact with conditions of the reproductive system or function.
4. Because women are women, they are subject to social diseases which impact on their physical, mental, or social health. Examples include female genital mutilation, sexual abuse, and domestic violence.

Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law/religion and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

4.3 Reproductive Rights

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do and the right to attain the highest standard of sexual and reproductive health. Women's

reproductive health and rights should not be adversely affected by their income level or geographical location, social policies, or laws.

Reproductive rights advocates demand a comprehensive movement that addresses women's reproductive health and choices. Reproductive health is a human right for all people throughout their life cycle. Reproductive health and rights are important ends in themselves, and women's reproductive health is inextricably linked to their reproductive rights. Women's reproductive capacity plays an important role in shaping their lives and health experiences. This integrated approach is about a woman's total reproductive health and its relationship to her living conditions and her daily experiences at work, school, home, and on the street. The goal is not to single out parts of a woman's body, but instead, see women's lives and experiences as a whole.

Reproductive justice is a framework that discusses how women's health, access to medical care and economic justice which are political issues may be connected in the minds of our elected leaders and reflected by their actions. Reproductive health is directly tied to the economic conditions in a woman's community, including environmental factors and experiences of women of color vis-à-vis race, class, and gender. For example, people who live where there is no market and limited access to fresh food suffer the health consequences.

The term "reproductive justice" emerged from the experiences of women of color. In the 1990s, the need for a more comprehensive reproductive choice was emphasized through reproductive health movement. This movement points out the need for measures that embraces and empowers all women, but with the understanding that there is a link between the economic means of women of color, where they live; go to school and worship and their sexual health and human rights. Organizations and activists addressing women's reproductive rights and

health, including Asian Communities for Reproductive Justice have set out to define and advance three main frameworks for addressing reproductive justice. Their analysis emphasizes the relationship of reproductive rights to human rights and economic justice.

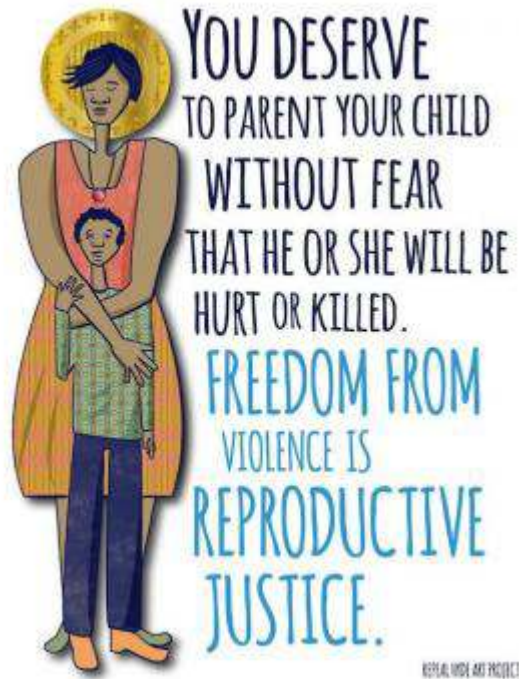


Figure: 4.2

The three frameworks are:

Reproductive Rights, encompass legal protections for women, such as the right to a legal abortion and the right to contraception and family.

Reproductive Health emphasizes necessary reproductive services such as access to pap smears and pre-natal care.

Reproductive Justice recognizes that reproductive oppression is a result of the intersection of multiple oppressions and is inherently connected to the struggle for social justice and human rights. Women of low economic mean suffer consequences from the lack of access to complete health care (for example, the high rate of cervical cancers among women of color/ minority). Reproductive justice integrates reproductive rights which work with economic and social justice to provide activists and supporters a framework to connect different women issues and strengthen fight to end discrimination and advocate for justice for all women. Legal rights are just one part of a much larger picture. The women's rights movement embraces the model that fights for reproductive freedom as a human rights struggle and one that includes all matters of equality and social justice. The right to have or not to have children and the right to live in conditions that enable each woman to make optimal choices for her own life is a key to bring about true reproductive justice for all women.

4.4 Safe Motherhood

This is a term that covers a broad range of direct and indirect efforts to reduce deaths and disabilities resulting from pregnancy and childbirth. Direct efforts include those to ensure that every woman has access to a full range of high-quality, affordable sexual and reproductive health services, especially maternal care, and treatment of obstetric emergencies to reduce deaths and disability. (www.whiteribbonalliance-india.org/definitions.htm).

Once considered by feminists as the second-best option, motherhood is gradually gaining favor. In the 1960s and '70s women were urged to cast off the shackles of a homebound drudgery and to seek fulfillment in the workplace. But as increasing

numbers of career-minded women delayed or forwent having children, many found that success in the workplace provided only short-term satisfaction.

Reproductive health included issues such as family planning, safe motherhood, contraceptives, and the ability to control the spacing and timing of offspring. In simple words, reproductive health may be described as the comprehensive package that concerns the biological, physiological, and emotional health needs of women, given the social expectations of society. The totality of safe motherhood being a biological issue and the social expectations that women find themselves in which include their as a result of motherhood, the emotional pressures to conform to sexual relationships that they have little or no control over, the continuous state of their mental health, the desire for women to have full control of their sexuality when to have children, spacing between them are the issues related to motherhood.

More than 150 million women become pregnant in developing countries each year, and an estimated 650 000 of them die of pregnancy-related causes. This death rate is roughly equivalent to 4 jumbo jets each carrying 450 passengers crashing every day! This shows the horrible situation of maternal mortality. Conventional maternal and child health programs have focused primarily on infants and children, not their mothers, and the problems of pregnancy-related death and illness among women in developing countries have been neglected by the medical, obstetric, and public health communities, by international agencies and in particular by the governments of developing countries.

4.4.1 Pillars of Safe Motherhood

Motherhood can be made safe when some interventions are carried out. These are termed as pillars of safe motherhood. These pillars are essentials to achieve safe motherhood. Safe motherhood is founded on those elements.

The pillars that support safe motherhood are 1. family planning 2. Antenatal care 3. obstetric care 4. Post-natal care 5. Abortion care 6. STD/HIV control. This can be achieved when women's basic rights are granted and when primary health care is available for everyone.

A house will be strong, if its foundation is solid, and if the bricks we add one after another are strong enough. A seed must be planted in fertile land and when the seed sprouts, we need to water it and add the manure to make it strong and healthy and it will produce healthy seeds in the future. In the aforementioned scenario, there are many pits falls and the girl suffers a lot and she gives birth to a low birth weight child putting at more risk of infection. she got teenage marriage and subsequent pregnancy because of her family and the community, she couldn't have antenatal care because of her own ignorance, unavailability of health care providers. It was her good luck she survived the childbirth because of emergency obstetric care. Nonetheless, her health and health of the baby is still at risk due to lack of continuum of care.

4.4.2 What is Continuum of Care?

The concept of continuum of care is an approach to integrate the care that a woman should receive to have safe motherhood or safe childbirth. The "Continuum of Care" for reproductive, maternal, newborn and child health (RMNCH) include integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood. Families and communities, outpatient services, clinics, and other health facilities, should provide such care. The Continuum of Care is very important for the health of both women and the newborn child.

There are two dimensions of continuum of care:

1. Stages of the life cycle (Time) In simple language, this is continuous care that a woman should get in her lifetime at every stage of life from her own family, community, and health facilities.

2. Places where the care is provided

With respect to the place-of-care dimension of the continuum, MNCH interventions can be delivered:

- at a household and in a community – community level/home services.
- through outreach from first-level facilities (includes immunization, antenatal, and postnatal care delivered from/at village health posts) – first level/outreach services.
- at district hospitals or referral hospitals – referral level services (includes diagnostics, treatment, care, counseling, and rehabilitation).



Figure: 4.3

4.5 Family Planning

In recent decades, there have been tremendous advances in the development of safer and more effective contraceptives, and in the provision of affordable and accessible family planning services. Yet, still, millions of individuals and couples around the world are unable to plan their families as they wish. It is estimated that over 120 million couples do not use contraceptives, despite wanting to space or limit their childbearing. In addition, many women who use contraceptives nevertheless become pregnant. Other couples who want to have children are unable to conceive. (WHO, 1995) Family planning programs occupy an unusual place in the public policy arena. They exist in virtually every nation in the world, yet they continue to spark controversy in some quarters. Definitions of Family planning on the Web:

- A health service that helps couples decide whether to have children, and if so, when and how many.
- www.unesco.org/education/tlsf/theme_c/mod13/www.worldbank.org/depweb/english/modules/glossary.htm
- A system of limiting family size and the frequency of childbearing by the appropriate use of contraceptive techniques.
- (www.nrdc.org/reference/glossary/f.asp).
- The availability of family planning does more than enable women and men to limit family size. It safeguards individual health and rights, preserves resources, and improves the quality of life for individual women, their partners, and their children. Let's discuss the family planning program in three main headings.

4.5.1 Family Planning and Feminism

Feminism has keenly uncovered the sexual inequality in the fertility process. Sexuality of the fertility process is never a merely natural process. It is always a

natural-social process. Under the system of patriarchy, female sexuality and reproduction is dominated by two kinds of power: family (which represents the interest of male householder) and the state. State through its population policy sometimes encourages a limit, the state controls the fertility of the family according to the status of its resources at different times. These controls are upon the female. The benefits and cost of male and female in the process of fertility are imbalanced. Thus, feminists point out that it is inadequate to say simply that a decrease of the reproduction rate is beneficial to females. The costs and burdens on particular groups must be considered as standards when evaluating a policy. That is, when regulation of fertility is evaluated, a women's voice must be heard. Feminists believe that regulation of fertility is not an isolated, neutral and technical process. It is operated in a specific cultural and social environment, affected by certain values; it thus reflects a certain order of interest of the two sexes. If the cultural environment of male-centralism that sees the female as a mere tool of sexuality and reproduction of the male is not fundamentally changed, the stronger the state controls fertility, the greater the weakest group suffers.

Feminism is not only criticism; it is also constructionism. It is not merely a theory, but a movement whose premises are that women have equal rights with men including in the field of sexuality and reproduction. Reviewing fertility regulation in terms of feminists has recommended many points which effects on policy making, promoting changes in the regulation of fertility. In one sentence, feminism takes a unique role in pushing forward changes in values, goals, and the transformation of the control model of governmental fertility regulation.

4.5.2 Family Planning and Islam

One frequently cited barrier to the more widespread adoption of family planning in Moslem countries is religious opposition. Religions vary widely in their views

of the ethics of birth control. In Christianity, the Roman Catholic Church accepts only Natural Family Planning, while Protestants maintain a wide range of views from allowing none to lenient. Views in Judaism range from the stricter Orthodox sect to the more relaxed Reformed sect. Hindus may use both natural and artificial contraceptives. In Islam, contraceptives are allowed if they do not threaten health or lead to sterility, although their use is sometimes discouraged.

4.5.3. Male as Partners in Family Planning

- While past efforts to promote family planning and reproductive health have been largely directed at women, today there is growing recognition that men need to be more involved in these efforts. Men play a key role in preventing unplanned pregnancy and the transmission of sexually transmitted infections (STIs), including HIV, and often do not get the reproductive health information or services that they need. It is increasingly recognized that male involvement is critical for improving reproductive health outcomes for men and women alike.

There are some important points (Verhaeghen, 2011) which make men's partnership important in family planning which may include the followings:

1. Men have their own sexual and reproductive health concerns and needs which are not always met. The focus on male involvement only as a means to improve women's reproductive health may cause an oversight of men's own reproductive health needs. Due to their ascribed gender roles, men tend to have little knowledge about their own physiology and health including sexual and reproductive health.
2. Men's health status and behavior affect women's health and reproductive health. Involving them increases their awareness, acceptance and support of their partners' needs, choices and rights. It is important for men that they

- should “accept the major responsibility for the prevention of sexually transmitted diseases”.
3. Talking of female alone or male alone is not an adequate approach to reproductive health issues. Many of the decisions regarding reproductive health and family planning are made within a set of gender relations that affect them or their implementation. In addition, all methods of family planning and most methods of STDs and HIV prevention are traditionally labeled either as male-only or female-only methods. More attention should be paid to identifying to what extent each one of the methods requires co-operation and support of both sexes and its implications on the health and sexual relationship of both partners.
 4. Involving men gives the opportunity for increasing and communication on the issue of equality between men and women. The process of empowering men, regarding RH issues, will help them to be more sensitive to women’s needs and therefore more supportive of participating in efforts of enhancing women’s status (Smith, P& Taylor,C.2008).

4.6 Biases in Healthcare System

Explicit, overtly racist, sexist, and homophobic attitudes often underpin discriminatory actions. Implicit biases, by contrast, are attitudes and beliefs about race, ethnicity, age, ability, gender, or other characteristics that operate outside our conscious awareness and can be measured only indirectly (Paradies ,2014). For example, Some examples of how implicit bias plays out in health care include: Non-white patients receiving fewer cardiovascular interventions and fewer renal transplants. Black women are more likely to die after being diagnosed with breast cancer.

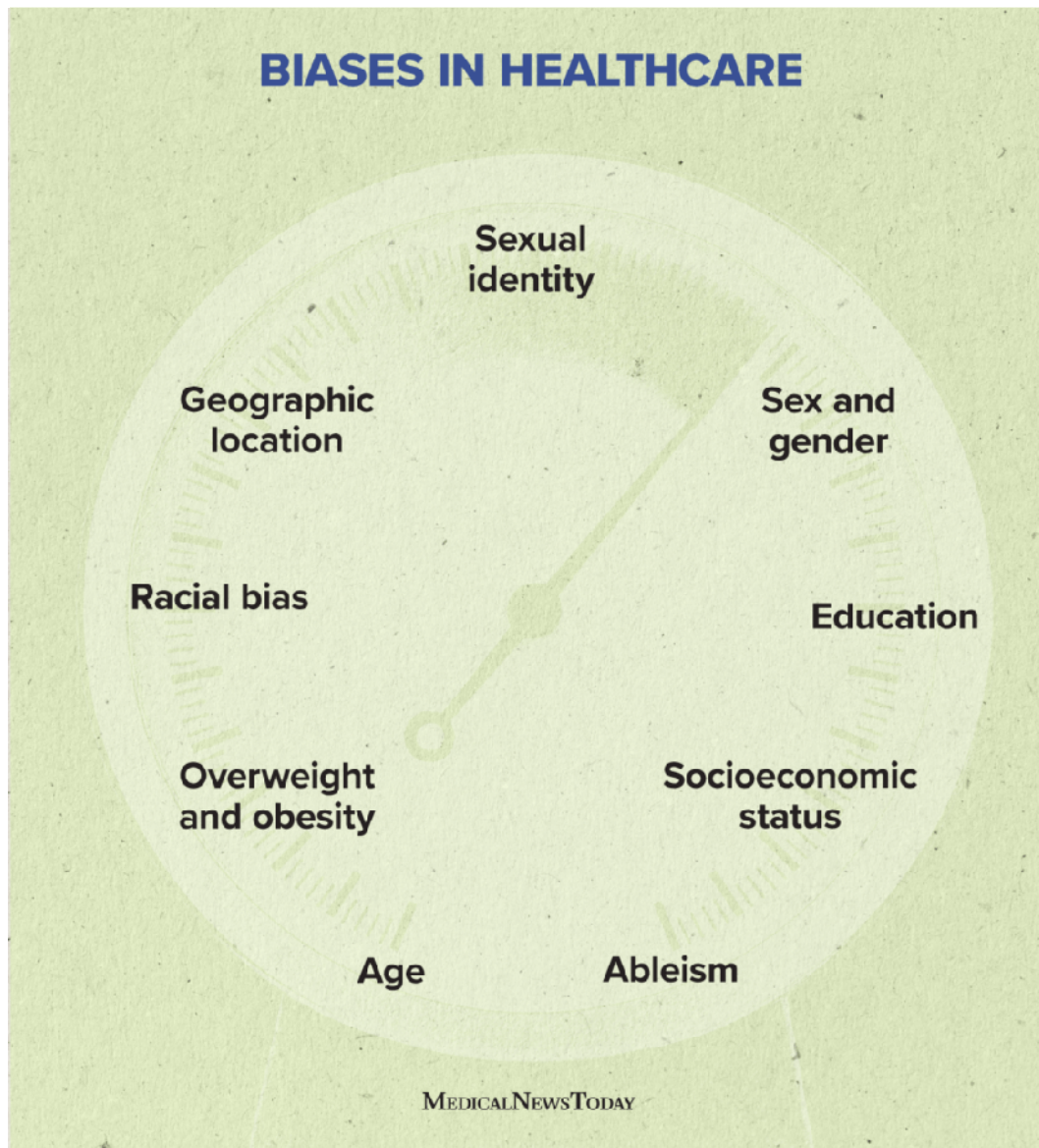


Figure: 4.4

When healthcare is biased, it means patients aren't always getting the care they need. Doctors may automatically attribute symptoms to an issue related to weight, race, or gender when, there are true underlying health problems that need to be addressed.

Gender inequalities in health are a consequence of the basic inequality between men and women in many societies. Despite the importance of socio-economic factors, women's health is also greatly affected by the extent and quality of health services available to them. Both non-governmental women's organizations and feminist health researchers have in recent years identified major gender inequalities in access to services and in the way men and women are treated by the health care system.

Firstly, although women are major health care users as well as providers, they are under-represented in decision-making in health care. Secondly, no justice is done in general to existing differences in the position and needs of women and men in defining the quality of health care, i.e., gender aspects.

Among women's organizations, there is general agreement that "gender-sensitive health care should be available, accessible, affordable, appropriate and acceptable". In addition, health care for women should be adequate and not depart from a male model of health and illness (Williams ,2010). There is a need to pay attention to inappropriate health care for women on the one hand, as illustrated by the increasing medicalization of women's reproductive life menstruation, menopause, pregnancy and childbirth and (in) fertility. On the other hand, gender bias in the management of serious, life-threatening diseases such as cardiovascular disease, lung cancer, and kidney failure, as a form of inadequate care must be considered serious threat to women's health .

Until recently, medical research has largely ignored many health issues important to women, and women have long been under-represented in medical research. In the past, research on women's health focused on diseases that affect fertility and reproduction, while many studies on other diseases focused on men. At present,

most women receive diagnoses and treatment based on what has worked for men. However, the efforts of women's health advocates and the unveiling of inequities in medical research have led to a broadened research agenda including many of the above-mentioned concerns.

4.6 STDs Infections and HIV/AIDS

STD" is a term applied to more than two dozen diseases that are transmitted primarily through anal, oral, or vaginal sex Sexually Transmitted Diseases (STDs) are health problem that affects women in specific ways due to their biological characteristics. Women are biologically more vulnerable to HIV infection. Some STDs may be asymptomatic in women, so they are unaware that they are infected. Untreated STDs increase the risk of infertility and contracting HIV. STDs are clearly a "women's health" issue. Women's experience of STDs is also affected by a number of factors such as gender roles, resources and perceptions and lack information about STDs etc.

4.8. Self-Assessment Questions

- Q.1 How would you define reproductive rights? Discuss the linkage between reproductive rights and reproductive justice.
- Q.2 What are the main criticisms on family planning program? Discuss in detail.
- Q.3 Describe the factors which control fertility among women in the world.
- Q.4 Women who are childless or decide not to have children, what kind of social process they face? Discuss within feminist perspective.
- Q.5 Discuss the impact of infertility on women and men.
- Q.6 Describe the reproduction technologies which are being used today. Analyze them through feminist lens.
- Q.7 Discuss in detail family planning in Islam.
- Q.8 Discuss the role of male in family planning. What are the benefits of male participation in family planning process?
- Q.9 What are STDs? Describe the different perspectives on STDs in detail.
- Q.10 Describe diverse perspectives on AIDS. What are the social concerns attached to it?
- Q.11 What are the immediate and proximate causes of maternal mortality?
- Q.12 Discuss the socioeconomic, cultural and political factors which affect pregnancy.

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UNIT 5

AGING AND WOMEN' S HEALTH

Written by; Dr. Atifa Nasir
Revision by: Dr. Atifa Nasir

CONTENTS

Introduction.....	79
Objectives	79
5.1 Ageing and Feminism.....	80
5.2 Physical and Mental Issues of Aging Women.....	81
5.3 Ageing Women and Health Care System.....	85
5.4 Self-Assessment Questions.....	89
References.....	90

INTRODUCTION

The problems related to ageing are to some extent socially constructed. The aging of the population in every region of world has a special impact on women, who live longer than men, suffer the double burden of gender and age discrimination and carry reproductive health problems with them into old age. Attention must be given to the social, political and economic context of health in which policies are developed and implemented. These contexts include dramatic demographic changes, reduced public resources, privatization and growing racial, class and gender inequities across the life span. This unit discusses the unique health needs of women as they grow older and move through menopause. This unit also explores the existing health care practices which limit the healthcare opportunities and choices of ageing women. It also outlines the challenges facing healthcare systems in developing countries, which have largely focused on women's childbearing years and examines potential interventions and services.

OBJECTIVES

After reading the unit, you will be able to:

- define ageing with reference to feminist perspective.
- debate the issues and concerns of ageing women.
- discuss the physical and mental disorders among ageing women.
- Analyze the problems and issues related to healthcare system and policies regarding ageing women.

5.1 Ageing and Feminism

To be old, female and poor is a triple jeopardy (Mondonna Harrington Meyer)

Aging is a constant, predictable process that involves growth and development of living organisms. Aging can't be avoided, but how fast we age varies from one person to another. How we age depends upon our genes, environmental influences, and lifestyle. Body changes associated with aging usually make us more vulnerable to various diseases, and to side effects and complications of medical treatment. Because the aging process slows our response time, it may take us longer to adjust to environmental changes. Aging can also be defined as a state of mind, which does not always keep pace with our chronological age. Attitude and how well we face the normal changes, challenges and opportunities of later life may best define our age.

Aging is largely culturally determined, and body emphasis can obscure that fact. It is crucial to consider bodies because old women's bodies are usually invisible. From a medical standpoint, ageing women's bodies are defined by illness and ailments, by unfixable problems. From the perspective of feminist gerontology, the obstacles to better health for women are not primarily biological but cultural. There is a criticism within feminist discourse (Samuels, 2008). Feminist scholars have given little attention either to ageing women or to aging. The oppression of women is discussed on the grounds of inequality and based on family, gender, race, religion, wealth, class, property and opportunities, but fail to address oppression on the basis of ageism. Feminist analysis of the absence of women in research highlights the long-standing notion of male being normal and women as the special or different. The male medical model equates male with being human. The impact of excluding women from clinical research hurts women in two ways: 1) it reduces access to new drugs and 2) it reduces knowledge about side effects on male -tested therapies. It is known that drug metabolism, dose-response

reaction and other clinical effects are different for women than men. How can testing of any drug or clinical procedure be founded if it excludes half the population? Studies show that women are at higher risk than men for medication side-effects due to the following factors:

- 1) smaller size
2. higher proportion of body fat to lean tissue; 2) higher consumption of medications. The patriarchal practices of medicine perpetuate this notion, as do the vast inadequacies in traditional ethics that do not include gender as an issue to consider. Nothing highlights the gender inequalities in women's health more than aging. Research on elderly women's psychological and biological processes is not adequate. Because women live longer than men and constitute two-thirds of those who are over 85, ageism may be only one part of the answer. Sexism may be the larger factor. It may be said that age, gender, and socioeconomic status are all factors that compound ageism.

5.2. Physical And Mental Issues of Aging Women

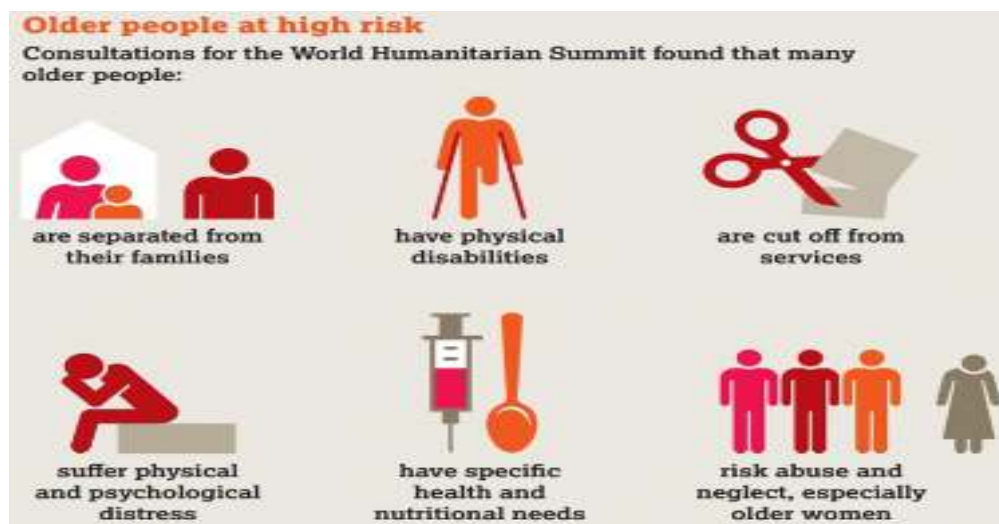


Figure: 5.1

The quality of life of many older women, particularly in the South Asia, leaves much to be desired. Ageing women form a forgotten group in the health and social policies of many governments (Krekula, 2007). Almost everywhere in the world, women outlive men, but their rights to inheritance and to pensions are not generally well provided for. Health care is often not geared to their needs. At the same time, older women fulfill important roles in society. They take care of younger children. Ageing women's health is affected by the social isolation that they experience, often due to the loss of a partner and health problems and disability related limitations.

Ageing women face lots of physical and mental issues which hinder their over all good health opportunities. Ageing women in developing countries endure extremes of poverty, insecurity through famine, disasters or warfare and often-minimal access to facilities. Many societies may also expect ageing women both to remain working and caring for their families while at the same time deny them a voice or social status. Some of the physical issues may include osteoporosis, menopause etc. Mental health issues of ageing women consist of depression etc. some of these mental and physical problems are discussed in detail in allied material.

Another overriding principle that will allow basic health determinants such as access to health care, food and safe water is the need to create an enabling environment in which ageing women can live. This enabling environment should be achieved by striking a balance between formal, informal and self-care. Ageing women experience more perceptual difficulties due to their longer lives. They often are required to care for a spouse. In spite of women's active involvement in

a woman's health care movement, the mainline health care system continues to hold tight to its andocentric focus.

Ageing women experience a high burden of chronic illness, disability and this burden is highest among socioeconomic ally disadvantaged and minority women. The consequences of a mismatch between the organization, delivery, and financing of health care for ageing women and their actual needs fall disproportionately on low-income and minority women. There is cause for optimism that by improving the quality of clinical preventive services and the management of common chronic conditions and geriatric syndromes it will be possible to improve functional health outcomes, prevent or postpone disability, and extend active life expectancy for all ageing women while making progress toward eliminating health disparities among the most disadvantaged.

The dramatic growth of the older population, especially among women and populations of color, has resulted in a corresponding increase in the number and diversity of multigenerational (three to five generation) families. Given these structural inequities and the wide range of practice and organizational settings involving multigenerational families, there is a need to learn the skills, knowledge, and values to analyze critique and advocate for policies and process that will support multigenerational families. Usually, current social, health, and long-term care policies are typically designed as categorical, age-based approaches that foster competition rather than conceptualizing public policy and responsibility across the generations. The problems related to ageing are to some extent socially constructed; therefore, attention must be given to the social, political, and economic context in which policies are developed and implemented.

These contexts include dramatic demographic changes, reduced public resources, privatization and growing racial, class and gender inequities across the life span.

A feminist and multicultural approach toward policy development builds upon such interdependence and recognizes the intersections of age, race and gender across a range of substantive areas, such as health and mental health, substance abuse, interpersonal violence and child welfare. For example, the growth of kinship care, especially (great) grandparents caring for grandchildren, reflects the intersections of race, class, age, and gender on policies that impact schools, child welfare, income maintenance, and aging.

There should be a life span approach toward policy development aims to prevent inequities and health disparities that increase across the life course, with ageing women of color forming the poorest and most functionally disabled group in our society (Arber,2003).

Attaining the goal of appropriate medical care for older women requires knowledge of the changes of aging, skills in recognition and treatment of disease, and an effort to other types of treatment may also result in complications, including significant morbidity and mortality. Women generally have less access to health care than men, while in fact they need more care during their life. From early age on, women are discriminated against in food, education and vaccination programmes. Women receive most of the care during and after pregnancy. By reaching older age, women are again confronted with inappropriate quality of care.

In many developing countries, there is for example a shortage of trained health workers who are specialized in elderly care. Geriatric complaints, such as sore

joints caused by overworking, bladder complaints and depression, are hardly recognized, let alone treated. Good hospital care is too expensive for many older people, and there are hardly any elderly homes. There is little access to affordable medicines. Also, people from fifty years onwards are excluded from AIDS education. As a consequence, there is still much misunderstanding in this age group concerning the disease. This is particularly distressing because AIDS has an enormous impact on the life of many elderly women; they are the ones taking care of their sick children and grandchildren.

Because elderly women often have no rights on possessions or retirement pay, they hardly have the means to provide for themselves. It used to be self-evident that their children would take care of them, but this is no longer the case. Many younger people move to the urban areas in search of a better life. The elderly stays behind alone. If women are to be subjected to a health care system that employs sexist and ageist practices, the quality of life in their later years will continue to be jeopardized.

5.3 Ageing Women and Healthcare System

Another overriding principle that will allow basic health determinants such as access to health care, food and safe water is the need to create an enabling environment in which ageing women can live(Karlsson, 2002).

This enabling environment should be achieved by striking a balance between formal, informal and self-care. Ageing women experience more perceptual difficulties due to their longer lives. They often are required to care for a spouse. Despite women's active involvement in a woman's health care movement, the mainline health care system continues to hold tight to its androcentric focus.



Figure: 5.2

Ageing women experience a high burden of chronic illness, disability and this burden is highest among socioeconomic ally disadvantaged and minority women. The consequences of a mismatch between the organization, delivery, and financing of health care for ageing women and their actual needs fall disproportionately on low-income and minority women. There is cause for optimism that by improving the quality of clinical preventive services and the management of common chronic conditions and geriatric syndromes it will be possible to improve functional health outcomes, prevent or postpone disability, and extend active life expectancy for all ageing women while making progress toward eliminating health disparities among the most disadvantaged.

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In many developing countries, there is for example a shortage of trained health workers who are specialized in elderly care. Geriatric complaints, such as sore joints caused by overworking, bladder complaints and depression, are hardly recognized, let alone treated. Good hospital care is too expensive for many older people, and there are hardly any elderly homes (Petry, 2003). There is little access to affordable medicines. Also, people from fifty years onwards are excluded from AIDS education. Consequently, there is still much misunderstanding in this age group concerning the disease. This is particularly distressing because AIDS has an enormous impact on the life of many elderly women; they are the ones taking care of their sick children and grandchildren.

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5.4. Self-Assessment Questions

- Q.1. Define the ageism and sexism? Are they interlinked? According to Igne Power Bell, what is double standard of Age? Discuss in detail.
- Q.2. Why feminist give little importance to issues of aging women? What are the factors behind this issue? Discuss in detail.
- Q.3. What are the stereotypes and myths related to menopause? Discuss.
- Q.4. Discuss the physical and mental issues of aging women.
- Q.5. Explain with examples. What are the issues of ageing women in South Asia? Describe in detail.
- Q.6. Discuss the issues related to health care system which affects ageing women.

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UNIT 6

**VIOLENCE AND WOMEN'S
HEALTH**

**Written by; Dr. Atifa Nasir
Revision by: Dr. Atifa Nasir**

CONTENTS

Introduction.....	93
Objectives	93
6.1 How Violence Against Women is Defined?	94
6.2 Types of Violence Against Women	95
6.3 Other Forms of Violence Against Women.....	96
6.4. Selected Abortion	102
6.5. Self-Assessment Questions.....	103
References.....	104

INTRODUCTION

Violence against women knows no geographical boundaries, no age limit, no class distinction, no race, and no cultural differences. Though differs widely in its nature, scale, and impact: From bullying and harassment at work to trafficking, rape, abuse and murder of women and girls. Although specific abusive acts can occur between any two people regardless of gender, those acts do not always have the same impact or meaning. In heterosexual relationships, the male perpetrator tends to have more power and control in the relationship and is usually physically stronger. Majority of the victims are women.

Regardless of the type, violent behavior is generally learned. In some cases, violence may result from a chemical imbalance, biological disorder, or mental illness. However, in the absence of a physical cause, much of violent behavior is learned. Whilst many women display remarkable resilience, the impacts on individuals and entire families can be devastating. There are also massive social and financial costs besides worst health consequences. This unit looks at violence against women from health perspective and explores various types and forms of violence and their impact on health of women.

OBJECTIVES

After reading the unit you will be able to:

- Define violence against women
- Describe different types of violence and its consequences on women's health
- Explain various forms of violence (such as prostitution, FMG, female infanticide, selected abortion etc) and the feminist debates within these issues.

6.1 How Violence Against Women is Defined?

In simple words, acts that result, or are likely to result, in physical, sexual and psychological harm or suffering to a woman, including threats of such an act, coercion or arbitrary deprivation of liberty whether occurring in public or private life. The United Nations has identified gender-based violence against women as a global health and development issue, and a host of policies, public education, and action programs aimed at reducing gender-based violence have been undertaken around the world (Fourth World Conference on Women, Platform for Action, 1995). The term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.

Definition

- *... the term "violence against women" is understood to mean any act of gender-based violence that is directed against a woman because she is a woman or that affects women disproportionately... It does not address gender-based violence suffered by men. The term "women" is used to cover females of all ages, including girls under the age of 18... manifested in a continuum of multiple, interrelated and sometimes recurring forms... physical, sexual and psychological/emotional violence and economic abuse and exploitation, experienced in a range of settings, from private to public, and in today's globalized world, transcending national boundaries.*

(UN Secretary General's Report on VAW, 2006, para 28 and 104)

Deep rooted beliefs and practices, gendered meanings and harms that constitute the micro inequalities of everyday life

6.2 Types of Violence Against women

Violence against Women (VAW) is not restricted to physical abuse. It has some other types too which are briefly discussed as under².

6.2.1 Psychological and Emotional Abuse

Threats, insults, and put-downs can be just as damaging as physical abuse because they endanger a woman's feelings of self-worth and her ability to control her own life.

6.2.2. Social Abuse

This form of abuse occurs most frequently in a domestic situation where a woman is kept totally dependent on her partner and isolated from the support of others.

6.2.3. Financial Abuse

A woman who is prevented from seeking employment, or who is not allowed to have a bank account or keep any of her income suffers financial abuse. Having no control of money keeps a woman totally dependent and at the whim of others, even for her basic needs.

6.2.4. Sexual Abuse

Being forced to do or watch something sexual without the woman's consent, or to have pain inflicted on a woman during a sexual act can constitute sexual abuse.

² Human Rights Committee, General Comment 31 (2004) on the nature of the general legal obligations imposed on States Parties, para. 8. 19 General Assembly resolution 57/214 (2002), para. 6; General Assembly resolution 61/173 (2006), para. 5(b); General Assembly resolution

6.2.5. Physical Abuse

Hitting, punching, slapping, biting, kicking, bruising, breaking bones, throwing things and using weapons are obvious examples of physical abuse. The denial of human needs, such as food, water, sleep and even shelter are also forms of physical abuse.

6.3 Other Forms of Violence Against women

Accordingly, violence against women encompasses but is not limited to the following:

- (a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation
- (b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution
- (c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs. From the final document of the Fourth United Nations World Conference on Women, 1995 describes violence against women about power and control. Some of these forms are discuss briefly as under.

6.3.1. Domestic Violence

Violence especially, domestic violence is acknowledged to be a serious social problem which affects individuals, families, communities, the workplace, and the economy(Catalano2010). Domestic violence is an abuse of power. It is when one partners usually a husband /boyfriend attempts to control and dominate the other, usually a wife/ girlfriend through violence, threat of violence, or by controlling the couple's finances and social life. Domestic violence occurs when a family member, partner, or ex-partner attempts to physically or psychologically dominate or harm the other.

According to WHO the Impact of violence against women affects the health status of women as Violence against women has serious consequences for their physical and mental health. Abused women are more likely to suffer from depression, anxiety, psychosomatic symptoms, eating problems, and sexual dysfunctions(Centers for Disease Control and Prevention,2013). Violence may affect the reproductive health of women through:

- the increase of sexual risk-taking among adolescents,
- the transmission of STDs, including HIV/AIDS,
- unplanned pregnancies,
- Various gynecological problems including chronic pelvic pain and painful intercourse.

Consequences such as HIV/AIDS or unplanned pregnancies may in themselves act as risk factors for further aggression, forming a cycle of abuse. Effects of violence may also be fatal because of intentional homicide, severe injury or suicide. Complications of pregnancy, including low weight gain, anemia, infections and first and second trimester bleeding are significantly higher for

abused women. Poor maternal health during pregnancy and lactating periods due to domestic violence may have consequences on the health of the child. Another way to understand why domestic violence a health issue is to look at the medical cost associated with domestic violence.

Violence against women puts undue burden on health care system as WHO describes that:

- 6 Studies from the United States, Zimbabwe and Nicaragua indicate that women who have been physically or sexually assaulted use health services more than women with no history of violence, thus increasing health care costs.
 - A U.S. study indicated that rape or assault is a stronger predictor of health care use than any other variable. The medical care costs of women who were raped or assaulted were 2.5 times higher than the costs of non-victims in the year that the study was carried out.

Violence against women is a significant public health issue in countries of both the industrialized and less developed world. Violence is a major factor in women's health and well-being (Semahegn,2015). The measurable health-related costs of violence against women in Canada exceed \$1.5 billion a year. These costs include short-term medical and dental treatment for injuries, long-term physical and psychological care, lost time at work and use of transition homes and crisis centers. Domestic violence also shows severe consequences on children's health. Children who witness domestic violence are more likely to exhibit behavioral and physical health problems including depression, anxiety, and violence towards peers. Thus, domestic violence is a health care issue. It has an immense impact on the healthcare system. Homicide and injury, mental illness, substance abuse, and repetition of violence across generations indicate the range of health problems related to domestic violence.

6.3.2. Commercial Sex Workers and their Health

Trafficked and prostituted women and girls have little redress against the abuse, violence, harassment, and humiliation to which they are subjected. Victims of prostitution often suffer severe health consequences ranging from injuries inflicted by beatings, rapes, and unwanted sex; psychological devastation, including trauma, depression, and suicide; HIV/AIDS and other sexually transmitted diseases; and alcohol and drug abuse induced by pimps or by the women's attempts to self-medicate. As stated by a prominent researcher" many of the chronic symptoms of women in prostitution are similar to the long-term physical consequences of torture. (Farley, 2004). All prostitution causes harm to women. Whether it is being sold by one's family to a brothel, or whether it is being sexually abused in one's family, running away from home and then being pimped by one's boyfriend, or whether one is in college and needs to pay for next semester's tuition and one works at a strip club behind glass where men never actually touch you all these forms of prostitution hurt the women in it. The commercial sex industry includes street prostitution, massage brothels, escort services, outcall services, strip clubs, phone sex, adult and child pornography, video and internet pornography, and prostitution tourism.

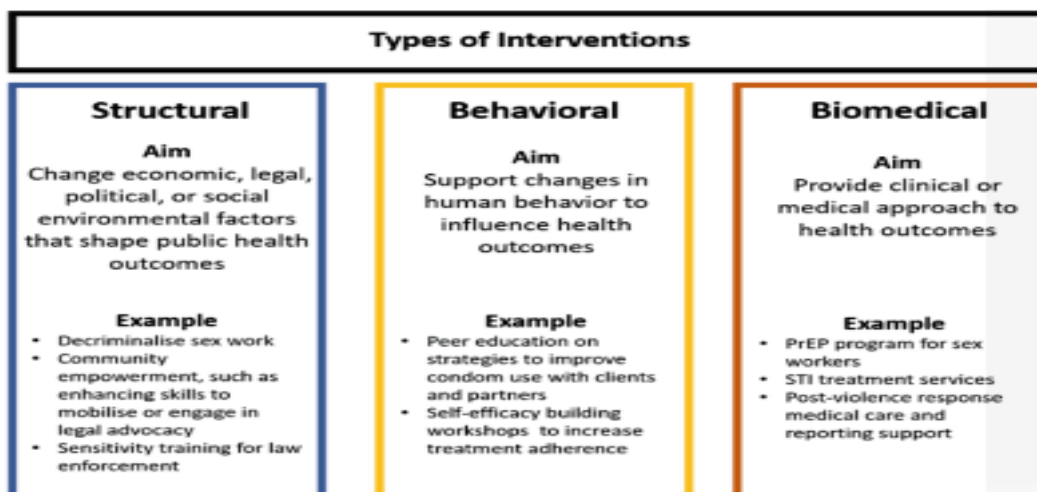


Figure: 6.1

6.3.3. Prostitution and Feminism

Since most prostitutes are women, prostitution is a significant issue in feminist thought and activism. Feminists who believe that prostitution is inherently exploitative, such as authors like Andrea Dworkin, herself an ex-prostitute, argued in the 1980s that commercial sex is a form of rape enforced by poverty (and often obvious violence by pimps). Some feminist rejects the idea that prostitution can be reformed. These feminists believe that the assumptions that women exist for men's sexual enjoyment, that all men "need" sex, or that the bodily integrity and sexual pleasure of women is irrelevant underlie the whole idea of prostitution, and make it an inherently exploitative, sexist practice. One feminist argument against Dworkin's position is that prostitution, in so far as it joins with the perception of an inherent 'need' on the part of men for sexual release, is exploiting men more than it exploits women.

Sex markets have been a concern to feminists because, historically, the “skin trade” has relied predominantly on female service providers and male consumers. Feminist theorists are divided on the question of whether markets in pornographic materials and sexual services pose a threat to women in all contexts. Some feminist theorists argue that when one is paid for sex, a person contracts to give away her freedom and sexuality. Others argue that selling sex harms women only because the work carries a stigma generated by double standards of sexual morality and negative attitudes to sex, which need to be challenged. The debate over sex commerce extends to a number of social practices, including pornography, prostitution, escort services, erotic dancing, and strip shows, etc. Feminist philosophers have primarily focused on the issues of pornography and prostitution and have subsumed the other practices under one of these broad categories.

6.3.4. Female Genital Mutilation (FGM)

FGM can neither be effectively understood nor addressed without consideration

of a complex of inter-related gender, cultural, migration, health and human rights issues. General feminist thought sees the practice of FGM as a means to exercise social control over women in societies which are highly patriarchal and patrilineal. There are a number of divergent feminist schools of thought that vary dramatically in their support of legislative intervention. Where the FGM-practicing community is in a minority, women are thought to be particularly vulnerable to psychological problems, caught as they are between the social norms of their own community and those of the majority culture. FGM not only physically but also emotionally and psychologically harms women.

6.3.5 Female Infanticide

Sex bias or son preference places the female child in a disadvantageous position from birth. In some communities, however, particularly in Asia, the practice of infanticide ensures that some female children have no life at all, violating the basic right to life laid down in article 6 of the Convention on the Rights of the Child. Selective abortion, foeticide and infanticide all occur because the female child is not valued by her culture, or because certain economic and legislative acts have ruled her life worthless. This is a systemic and more scientific form of violence against women.

In certain parts of India and Pakistan, women are still considered unnecessary evils. In the past, when victorious armies took their revenge on defeated communities, women were raped as part of the spoils of war. Subsequently, these communities resorted to killing their daughters at birth or when the enemy was advancing, to spare the female population and community from shame.

Modern techniques such as amniocentesis and ultrasound tests have given women greater power to detect the sex of their babies in time to abort. Illegal abortion, particularly of female fetuses, either self-inflicted or performed by unskilled birth attendants, under poor sanitary conditions has led to increased maternal mortality, particularly in South and South-East Asia.

6.4. Selected Abortion

Most abortions are caused because the pregnancy is unplanned and having a child causes a crisis for the woman. Therapeutic abortions result from a medical problem where allowing the pregnancy to continue to birth would endanger the woman's health. Selective abortions, which are a small fraction of all abortions, occur in those cases where a particular foetus is perceived as having undesirable characteristics. Selective abortion is also done when there are too many fetuses in a pregnancy.

These include cases where:

- the unborn child is a girl, and the parents, for cultural or other reasons, want a boy
- the foetus does not suit the parents in some other way
- the foetus is defective .

But this medical facility has been used against female fetus. In the last 20 years, international organizations and Asian nations have stepped up their efforts to eliminate sex-selective abortions, which have created a massive dearth of girls in many nations over the past years. One expert who spoke at the United Nations estimates that up to 200 million women and girls are missing worldwide because of sex-selective abortion and female infanticide. Feminists like to blame this rapidly-worsening situation on “patriarchy,” but that has been around for thousands of years and is less powerful today than ever before. What is new is the access to abortion in so many places. One school of thought blames feminist for this by saying that as it has long been a paramount goal of feminists: To grant the “right to control her own body” to each woman on Earth via unrestricted abortion. That, combined with falling prices for the ultrasound machines that can reveal an unborn child’s sex, has produced the disastrous situation that the Asian world is in now.

6.5. Self-Assessment Questions

- Q.1. Discuss in detail the rationales given by the abuser for violence against women (VAW).
- Q.2. Describe the forms of “women bettering” in detail.
- Q.3. Define the different forms of violence. What are the socio-cultural, historical and economical perspectives of violence against women?
- Q.4. Describe sexual harassment as a form of social control and its effects on women in workplaces.
- Q.5. Discuss violence against women as a global issue. Compare the role of government and NGOs in combating violence against women (VAW).
- Q.6. Describe the major health issues of women in sex industry.
- Q.7. Discuss the feminist approaches to prostitution and how these approaches may be useful in studying prostitution?
- Q.8. Critically analyze the causes of female infanticide and selected abortion. How can female infanticide be stopped from South Asia?
- Q.9. Farhat Moazzam in her article discusses the feminist discourse on female fetus. What are the different points of view she presented in the article? Discuss.

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UNIT 7

**HEALTH OF WOMEN WITH
DISABILITIES**

Written by; Dr. Atifa Nasir
Revision by: Dr. Atifa Nasir

CONTENTS

Introduction.....	107
Objectives	107
7.1 Why a Focus on Disable Women’s Health?.....	108
7.2 Definition and Models of Disability.....	108
7.3 Feminist View of Disability	110
7.4 Barriers to Health of Women With Disabilities	111
7.5. Self-Assessment Questions.....	113
References.....	114

INTRODUCTION

In recent years, women's health has emerged as a prominent public health priority. Research focused on women's health has led to valuable information about how and why certain diseases affect women disproportionately, predominantly, or differently than men. Yet despite the increased awareness of women's health, research to date has not adequately addressed the health concerns of women with disabilities. In general terms, disability refers to "limitations in physical or mental function, caused by one or more health conditions, in carrying out socially defined tasks or roles.

Disability rests on longstanding misconceptions and stereotypes about the disadvantages of impairment. Recent work from a wide variety of perspectives (e.g., feminist, liberal, and communitarian etc) suggest that there should be rethinking on the nature, concept and experience of disability with reference to women. Although there is a growing interest in women's health, however, research addressing the health of women with disabilities is a new and emerging field. In this unit an effort has been made to look at the health issues of women with disabilities with feminist perspective which focus on the women centered point of view instead of traditional approach to health issues. Attention has been given to health of women with disabilities regarding the healthcare system and well as biases in healthcare system. This unit also explores and highlights the areas which should be given immediate and special attention to the health needs of women with disabilities.

OBJECTIVES

After reading the unit, you will be able to:

- define disability with special reference to women.
- describe feminist view of disability.
- explain issues and barriers to healthcare with reference to women with disabilities.

7.1 Why a Focus on Disable Women's Health?

Women are more frequently affected by many of the conditions that cause disability. The most common causes are associated with chronic conditions such as back disorders, arthritis, heart disease, respiratory problems, and high blood pressure. Disabilities may also result from injuries or birth defects (Steele,2013).

There is a great need that women with disabilities in health may be given serious consideration. Experiences of exclusion, being devalued, of assumptions about incapacity, and the need for (often unwanted) help all intersect in a particularly powerful way for women with disabilities. Women with disabilities are the poorest of the poor around the world. In every sphere of life, women with disabilities in the developing world experience a triple bind: they are discriminated against because they are women, disable and from the developing world (Theis,2019) Many women are disabled due to the practice of female circumcision in parts of Africa, Asia, and the Middle East. Women are disabled with urinary and gynecological infections, fistulas that prevent walking and through trauma induced by the procedure.

In many developing countries, there are few educational opportunities for disabled girls. When there are opportunities for education, in special schools, boys usually receive them.

7.2 Definition and Models of Disability

Disability" is a broad term that encompasses a sizeable range of conditions and diseases. It refers generally to a limitation in physical or mental function caused by one or more health conditions (Almeida,2001). Disabilities are limitations in usual, daily activities due to chronic conditions and include physical and mental limitations arising from a variety of health conditions. The International

Classification of Functioning, Disability and Health (ICF), produced by the World Health Organization, distinguishes between body functions (physiological or psychological, e.g. vision) and body structures (anatomical parts, e.g. the eye and related structures). Impairment in bodily structure or function is defined as involving an anomaly, defect, loss or other significant deviation from certain generally accepted population standards, which may fluctuate over time. Some of these models are as under

7.2.1 Medical model

The medical model views disability as a problem of the person, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals. Management of the disability is aimed at cure or the individual's adjustment and behaviour change. Medical care is viewed as the main issue, and at the political level the principal response is that of modifying or reforming health care policy.

7.2.2 The Social Model

The social model of disability, on the other hand, sees the issue mainly as a socially created problem, and basically as a matter of the full integration of individuals into society. Disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment (Almeida,2001). Hence the management of the problem requires social action and it is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life. The issue is therefore an attitudinal or ideological one requiring social change, which at the political level becomes a question of human rights.

7.2.3 Moral Model

Moral model refers to the attitude that people are somehow morally responsible for their disability, including at one extreme as a result of bad actions of parents if congenital or as a result of practicing witchcraft. This attitude can be seen as unjust and causes unnecessary suffering.

7.2.4. Expert/ Professional model

The Expert/Professional Model has provided a traditional response to disability issues and can be seen as an offshoot of the Medical Model. Within its framework, professionals follow a process of identifying the impairment and its limitations (using the Medical Model) and taking the necessary action to improve the position of the disabled person. This has tended to produce a system in which an authoritarian, over-active service provider prescribes and acts for a passive client.

7.2.5 Tragedy/Charity Model

The Tragedy/ Charity Model depicts disabled people as victims of circumstance, deserving of pity. This and Medical Model are probably the ones most used by non-disabled people to define and explain disability. There are some other models of disability too such as the Social Adapted model, the Economic model, and Religious model etc. <http://en.wikipedia.org/wiki/Disability>

7.3 Feminist View of Disability

Looking at disability through the lens of a feminist and at feminism from a disability perspective enriches both feminism and disability studies with fresh insights. Women with disabilities experience a high incidence of abuse - physical,

emotional and sexual. This makes disability rights as a feminist issue (Sherwin, 1992). It is an issue that affects many women either personally or through friends or family.

Feminist Disability Studies begins with the assumption that disability is always inextricably linked to gender, race, sexuality, and social class. Issues explored within the formulations of the social model of disability have been subject to critical amendment by disabled women. Disabled women activists have, however, been equally critical of the failure of mainstream feminism to recognize the disability perspective.

Psychiatric disability is informed by trauma, marginalization, sexist norms, social inequalities, concepts of irrationality and normalcy, oppositional mind-body dualism and mainstream moral values. Drawing on feminist discussion of physical disability, feminist theory of psychiatric disability not only focuses on disabled women but also on the mind and moral consciousness. Like the women's movement, the disability movement is now experiencing internal debates about issues of commonality and difference. Recent critiques of the social model of disability have advocated a move towards a so-called feminist emphasis on the individual experiences of disability and impairment.

7.4 Barriers to Health of Women with Disabilities

Recent studies suggest that women with disabilities encounter many of the same health problems as women who are not disabled, yet they consistently report poorer health (Scully, 2008). The findings also identify disparities between women with and without disabilities on a number of leading health indicators. Barriers to health may include the following.

7.4.1 Physical Barrier.

Such as mammogram machines and scales that require a patient to stand, or exam tables that can't be lowered for wheelchair transfers. Women with mobility limitations may find it painful or physically impossible to position appropriately.

7.4.2 Communication Barriers.

For women with hearing or visual impairments, essential health information may not be available in a form they can access, including Braille, large print, audio recording or simplified language.

7.4.3 Attitudinal Barriers.

Disability training for providers and medical students is needed to reassess negative attitudes and faulty assumptions. Medical professionals often assume that women with significant disabilities are asexual and may fail to provide essential preventative care such as breast exams, mammograms, pap smears and screening for intimate partner violence.

7.4.4 Economic Barriers,

that play a significant role in preventing women with disabilities from accessing health care. Additionally, medical exams and routine procedures may take significantly more time for people with disabilities, but reimbursement does not compensate for the additional time, providing a financial disincentive to health providers.

7.4.5 Other Barriers,

such as the need for medical research related to this population and lack of transportation or childcare, among others. Transportation can be a major barrier in making and keeping appointments. Some of them may include policy barriers; lack of information about how disability affects health; limited finances; and insufficient personal assistance.

7.5. Self-Assessment Questions

- Q.1. Define Disability and different models of disability.
- Q.2. After the reading article of Rosemarie Thomson (Feminist Disabilities Studies). Discuss the feminist disabilities studies.
- Q.3. What is feminist philosophy of disability, care ethics and mental health? Discuss.
- Q.4. Discuss the obstacles faced by women with disabilities in healthcare services.
- Q.5. What are the barriers to healthcare services for women with disabilities and care? Discuss.

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UNIT 8

**HEALTH ISSUES OF WOMEN IN
CRISIS**

Written by; Dr. Atifa Nasir
Revision by: Dr. Atifa Nasir

CONTENTS

Introduction.....	117
Objectives	117
8.1. Health Issues of Refugee Women	118
8.2. Health Issues of Displaced Women.....	119
8.3. Health Issues of Women in Natural Disaster	120
8.4. Women in War and Conflict.....	121
8.5. Health of Women in Jails & Prisons	122
8.6. Self Assessment Questions	123
References.....	124

INTRODUCTION

According to UN Report, 2000, the world's refugee population of today is estimated at 12 to 15 million and the number of internally displaced persons (IDPs) at about 25 million. In the absence of many adult men, women have to shoulder extended responsibility for the elderly, the disabled and the children. During all phases of the refugee or displaced cycle or any other crises like these, women therefore represent a main resource for the survival and the wellbeing of the community. Their health and security are inherent part of the whole group. Refugees or displaced women and men share the same difficulties, but women face additional which are gender specific threats and problems. This unit explores the health specific issues of women who are facing crisis situations of various types. These may include the healthcare concerns options and availabilities of the health care system of refugee women, displaced women, women in drought, women in war and in imprisonment.

OBJECTIVES

After reading the unit, you will be able to:

- describe health issues of refugee women, displaced women, women in war, conflict and women in prison.
- explain the gendered nature of disaster and issues related to women in disaster.
- discuss the health needs and options of women living in crisis situations.

8.1 Health Issues Refugee Women

Refugee women face problems during resettlement in host countries that are often worse than those faced by voluntary migrants. Although these problems are generally thought to be related to previous traumatic experiences, this may not always be the case; there are many refugee women who may not have personally experienced torture or trauma but who nonetheless express needs that suggest a perception of profound marginalization from the mainstream society.

There are many spheres which needs attention in order to improve the status of refugee women's general health. Some of them may include general information regarding health, childbearing issues, health beliefs and practices, health focus - illness, stress and adaptation, etc.

Mental health problems are also present in refugees, especially among women. This is due to the traumatic events experienced by refugees, and women. Some women may have had pre-existing conditions which were triggered or worsened by the stress of what happened to them. Other women experience new onset conditions as a result of the stress of the homeland situation, trauma, flight, or relocation. Depression and anxiety disorders are seen very common among these women. In refugee women who have experienced physical or sexual torture, more often develop this disorder. In addition to traumatic occurrences, many women develop high levels of anxiety upon being separated from their families, which increases the chances of developing Post Traumatic Stress Disorder (PTSD)³.

Some studies have shown that the period of the greatest psychological strain for refugee women is the first year after their arrival in any place. The role changes a refugee woman undergoes and the lack of understanding she may have of the

³ UNHCR UNHC for. Figures at a Glance [Internet]. UNHCR. 2016 [cited 2016 Aug 30]. Available from: <http://www.unhcr.org/en-us/figures-at-a-glance.html>

system contribute to this. However, there is no time in a refugee's life when there is no risk of stress. Refugee women come from many different backgrounds and may find themselves in a setting completely unlike that which they are used to. Major psychosocial issues in resettlement may include housing, transportation, language, customs and protocols and use of technology etc.

8.2 Health Issues of Displaced Women

The often cited statistic says that 80 per cent of displaced populations are women and children. If mass displacement occurs whether due to conflict, famine, or other causes displaced populations, including women, are usually without any health care services. Families may become separated and women and girls may be at risk of gender-based and sexual violence from soldiers, border guards, bandits and others.

Leaving homes, property and community behind, renders women vulnerable to violence, disease and food scarcity, whether women flee willingly or unwillingly. Women are uprooted as a result of many different circumstances, including among other things, armed and other forms of conflict (international and internal) and foreign occupation; ethnic, religious, cultural and gender-based persecution; sexual violence, and economic necessity. Internally displaced women face additional dangers as they are often invisible to the international community within the borders of countries at war. Camps for refugees and the internally displaced have been criticized for not addressing women's needs and concerns in their design and procedure (Perera, 2013) Failure to account for women's security and health needs can make a camp dangerous and deadly, when it was intended to provide refuge.

Like refugee women, internally displaced women face the burdens of extreme poverty, changes in family and community structure and consequent family violence, and manipulation of culture. Amidst these struggles, the burdens of survival for themselves and their families also fall on women's shoulders. Women struggling to provide for their families without protection (legal or physical) and

often with little or no resources may turn to menial jobs or prostitution. When improvements are made in the general security situation of refugee life, sanitation, access to water, food and basic health facilities need to be addressed. Sexually transmitted diseases, above all AIDS, represent a major threat to women's physical security among many refugee and displaced populations. Women are often forced to walk or to be carried to distant health posts to receive proper medical and maternal care. This may have fatal consequences for pregnant women, especially those requiring birth attendants. Many women have aborted, miscarried, or been delivered of stillborn infants. Very few receive pre- and post-natal medical services. For decades they were largely ignored and forgotten, but together they comprise probably the world's largest group of vulnerable people (Perera,2013) A significant number of displaced women in South Darfur, Western Sudan, suffer from depression and experience suicidal thoughts because of largely unaddressed mental-health problems.

8.3 Health Issues of Women in Natural Disaster

When a natural disaster occurs, everyone suffers but women suffer the most. According to the international human rights group, Global Fund for Women (GFW) during and following catastrophes such as the 2004 Tsunami, women are more likely to experience rape or domestic violence but less likely to have their health needs met by relief groups and to be involved in decision making about reconstruction efforts (Lehmann,2002).

More women die than men as the direct and indirect result of natural disasters, according to research presented at the Royal Geographical Society's annual conference in London (2006). This effect is strongest in countries with very low social and economic rights for women. In contrast to those countries in which women in their everyday lives have almost equal rights as men, natural disasters kill men and women about equally. Physical differences between men and women

are unlikely to explain the result for example; women are often at an advantage in famines because they can cope better with food shortages due to their lower nutritional requirements and higher body fat. Social norms can provide some explanation. In many countries women are supposed to look after children, the elderly and their homes which hamper their own rescue efforts in almost all types of natural disasters. Yet, the most important reason why women are more vulnerable to the fatal impact of natural disasters is because of their lower social and economic status in many countries. With existing patterns of gender discrimination, boys are likely to receive preferential treatment in rescue efforts and both women and girls suffer more from the shortages of food and economic resources in the aftermath of disasters. Natural disasters are a tragedy in their own right but in countries with existing gender discrimination women are the worst hit. While most disasters cannot be prevented, policy makers, international and humanitarian organizations must develop better policies to address the special needs of women in the wake of large-scale natural disasters.

8.4 Women in War and Conflict

Neglecting reproductive health in the regions of conflict and emergencies has serious consequences, a report from the United Nations Population Fund (UNFPA) concludes. Unwanted pregnancies, preventable maternal and infant deaths, and the spread of sexually transmitted infections, including HIV/AIDS, can result in regions where populations are under stress and reproductive issues take a backseat to other problems (Marshall,2005).

Failure to provide for the reproductive needs of populations affected by crisis can also undermine an entire nation. Countless women and girls all over the world suffer the trauma of war as widows or orphans, perhaps displaced from their homes, sometimes detained. They are often separated from loved ones and become victims of violence and intimidation. For the most part they are civilians caught in the crossfire and show astonishing resourcefulness and resilience in

coping with the disintegration of their families, the loss of their home and their belongings and the destruction of their lives.

International humanitarian law, which grants general protection to all war victims, regardless of gender, provides extensive specific protection for women in war. If these rules were better observed, the suffering faced by women in war would be greatly reduced.

8.5 Health of Women in Jails & Prisons

Just because a woman has been deprived of her liberty does not mean she can be humiliated, abused or treated inhumanely. Yet around the world countless women in prisons and jails are being targeted for human rights violations because of their gender and because they are vulnerable. Many are at risk of torture, including rape and other forms of sexual violence. Many are denied health care that they desperately need. Many are singled out for cruel punishments, discriminated against, and treated as sub-human.

Since jails historically have held predominantly men, facilities and services have not been developed to meet the special needs of women in jail; women face a range of medical, psychological, educational, vocational and social problems in jails. The impact of imprisonment on the health of women is obvious. In a prison system primarily designed for men, women's health needs are often not addressed by prison policy, programs and procedures. As such, medical issues that relate to reproductive health and to the psychosocial issues that surround imprisonment of women are often overlooked. Many imprisoned women are survivors of physical and sexual abuser have greater risk for having high-risk pregnancies and for developing life-threatening illnesses such as HIV/AIDS, Hepatitis C and HPV/cervical cancer. Moreover, despite being imprisoned and presumably safe from harm, in multiple prisons women are victims of sexual abuse by prison staff at times during routine medical examinations.

In regards to mental health, imprisoned women may also have a higher prevalence of depression than imprisoned men. Other mental illnesses may include, major depression, schizophrenia, PTSD (post-traumatic stress disorder) and addiction disorders. Due in part to the high prevalence of mental health diseases in prisons and to the isolative and disempowering nature of imprisonment, death from suicide may occur in prison. The mental health of women prisoners is also affected by the hostile prison environment. This is especially expected given that many prisoners have been subjected to a lifetime of physical, mental and sexual abuse. With the continuation of abuses in prison including physical abuse and rape prison can begin to destroy people psychologically. Subsequent reports indicate that the problems continue, and may have worsened in many institutions. They include inadequate access to health services; failure to refer seriously ill inmates for treatment and delays in treatment or failure to deliver life-saving drugs for inmates with HIV/AIDS.

8.6 Self-Assessment Questions

1. Discuss the major health issues of refugee women in detail.
2. Explain the health problems of women who are displaced during war or famine or any other reason like this.
3. Discuss the health issues of women who face natural disaster.
4. In her article Patricia Hynes explain many factors which affect women's health in war-torn countries. Discuss them in detail.
5. What is meant by the concept of gendered nature of natural disaster? Explain.
6. Discuss how natural disaster affects women's health.
7. Violence against women as instrument of war. Comment
8. How war and women's health is interrelated? Discuss in detail.

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UNIT 9

**ROLE OF NATIONAL AND
INTERNATIONAL INSTITUTIONS
IN WOMEN'S HEALTH**

Written by; Dr. Atifa Nasir
Revision by: Dr. Atifa Nasir

CONTENTS

Introduction.....	127
Objectives	127
9.1 Why We Need a National Women's Health Policy	128
9.2 Principles Underlying the Women's Health Policy	128
9.3 Issues of Importance in Women's Health	129
9.4 Government of Pakistan and Women' Health.....	129
9.5 The United Nations (UN) and Women's Health	131
9.5 The United Nations (UN) and Women's Health	133
9.7 Self-Assessment Questions.....	135
References	136

INTRODUCTION

Women suffer countless disadvantages compared with men. Even after decades of progress, women make up two thirds of the world's 880 million illiterate adults and up to 70 percent of its poorest citizens. But health remains the cruelest of all inequities (WHO, 2002). Healthy women are the foundation of healthy families, which foster healthy prosperous societies. Experience shows that even small investments in women's health can pay large social dividends. It is very difficult to disentangle the social web of health violence, literacy, and fundamental rights. For the most part, it is impossible to raise health standards without addressing these issues because they are so intricately connected. A woman who is domestically oppressed does not learn to read and therefore cannot understand a product label or a prescription bottle. Reduced education, economic opportunity, control of resources and control of the size of the family have an immediate and profound effect on the health and development, both physical and emotional of women and their children. It is a frustratingly complicated cycle to break (WHO, 2002).. Women's health issues always get the main importance on the agenda of national, international and NGOs forum because of the above-mentioned facts. In this unit, we look at women's health through the work of these institutions in order to know how these institutions are dealing with women's health in their agendas. This unit will also explore there is still needs to be done in women's health as issue of high priority.

OBJECTIVES

After reading the unit you will be able to

- discuss the role and principle of health policy.
- analyze National Health Policy 2001 on women's Health.
- describe the role of UN in women health sector.
- define the role of NGOs in women health area

9.1 Why We Need a National Women's Health Policy

A national women's health policy is developed in order to recognize the position of women in the society and the way this affects their health status, their access to health services according to their needs. The formulation of any national women's health policy must provide a framework and planned strategy to improve the health of women and to meet their health care needs to the years ahead.

9.2 Principles Underlying the Women's Health Policy

The women's health policy is based on an understanding of health within a social context as emphasized by the World Health Organization and endorsed by the Pakistani Government. National policy 'Health for all' is a slogan which recognizes that: health is determined by a broad range of social, environmental, economic and biological factors; differences in health status and health outcomes are linked to gender, age, socioeconomic status, ethnicity, disability, location and environment; health promotion, disease prevention, equity of access to appropriate and affordable services, and strengthening the primary health care system are necessary along with high quality illness treatment services; and information, consultation and community development are important elements of the health process(Sen,2008).

Women's health policy must encompass all of a woman's lifespan, and reflect women's various roles in Pakistani society, not just their reproductive role. Women's health policy must aim to promote greater participation by women in decision-making about health services and health policy as both consumers and providers (WHO, 2002). Women's health policy must recognize women's rights, as healthcare consumers, to be treated with dignity in an environment that provides for privacy, informed consent, and confidentiality.

Women's health policy must acknowledge that informed decisions about health and health care require accessible information which is appropriately targeted for different socioeconomic, educational, and cultural groups. Women's health policy must be based on accurate data and research concerning women's health, women's views about health, and strategies that most effectively address women's health needs.

9.3 Issues of Importance in Women's Health

There are many health issues which play a special role in women health in any country's policy but some of the priority health issues for women may be identified as important for serious consideration at national and international level (Sen,2008).

These are reproductive health and sexuality; the health of ageing women; women's emotional and mental health; violence against women; occupational health and safety; the health needs of carers; and the health effects of sex role stereotyping. However, women's health concerns extend beyond specific health problems to include the structures that deliver health care (WHO, 2015).

The broad structural areas of the health system in which action is required to improve women's health have therefore been identified: improvements in health services for women; the provision of health information for women; research and data collection on women's health; women's participation in decision making in health and training of health care providers.

9.4 Government of Pakistan and Women's Health

From developmental point of view the term 'health' has quite different connotation from the one that is commonly perceived. It is much more than just health caring system. It encompasses economic, political, environmental, and

social conditions. In a complex society as is ours in the present modern era, things have got more interlinked and dependent on each other, making it both conceptually and practically impossible to look at such issues like health in isolation. A person can not be healthy if he is poor, unemployed, and illiterate, living in a politically unstable system or in a society where women are not empowered. Therefore, issues like poverty, unemployment, political instability, illiteracy, and women's incarceration are some of the issues which need to be properly tackled if health system in a given society is to be stated satisfactory. A national health policy is a document that is supposed to cover all these areas.

Dr. Talib Lashari (program coordinator/ advisor on National Health Policy) says that 'Pakistan still lacks an unambiguous health policy'.

The failure of successive national governments in Pakistan in developing any compact and comprehensive health policy is due to various factors, which other than the fragmented urban health services and problems related to public expenditure, also include "issues related to development projects like overlapping, gaps in planning and implementation, vertical programs, dependency of provinces on the federal government for funding which delays the projects; problems and imbalance in human resources; lack of regulation of private sector; problems with the planning process; issue of access; and poor community involvement.

Deploring the irrationality of the decision-making process regarding health policy in Pakistan, Dr. Talib says "This is due to three reasons: Health does not get priority in overall decision-making process, health expenditures hardly differ from previous budget; within the health sector, there is no proper use of minimal resources and decision-making takes place in isolated manner without including all stakeholders i.e., legislatures and civil society etc. Lack of continuity of policies, lack of community participation, lack of government initiatives to bring

the private health sector in the mainstream of health care, lack of good governance and ‘lack of necessary skills and interest on the part of some of the stakeholders which include public representative; and NGOs’, are some of the other factors which contribute negatively in that whole saga.

Dr. Talib concludes with much emphasis by laying much emphasis on the decentralization of health policy process. Looking at the history of health initiatives taken by different governments in Pakistan, it is not difficult to understand that the theory of centralization of health policy has not proved successful in achieving the targets. Especially after the introduction of Devolution Plan’ in 2001 in the country, it seems appropriate to decentralize the whole process and involve districts directly in the implementation of health initiatives while residing policy formulation with the federal government.

No development is possible without improving health of a nation. The development is defined as a process which is supposed to contribute in raising the life standards of people((Sen,2008). Development further depends on economic, political and social conditions and unless these are improved the analysis of societal health will be counted below the graph.

9.5 The United Nations (Un) and Women’s Health

Nearly seventeen years ago in Sept. 1994, the United Nations International Conference on Population and Development (ICPD) convened in Cairo, Egypt to reach a consensus on a Programme of Action. Prior to ICPD, often called the Cairo Consensus or Cairo Accord, the global focus at that time was on demographic targets and quotas as the way to slow population growth and further economic development. This landmark conference was unique as it was the first to address the following important issues all in one forum: population and

sustainable development; reproductive health and family planning; gender equality and empowerment of women; health, morbidity, and mortality of women and resource mobilization for economic development (W HO, 2015).

The Cairo accord, many countries have been able to translate the commitments they made at Cairo into successful policies and programs. So, in some parts of the world, progress has been quite visible. In Sri Lanka, absolute levels of mortality among girls are lower than in other South Asian countries; Follow-up activities to the ICPD have included the Fourth World Conference on Women in 1995, the ICPD +5 in 1999, and the Fourth World Conference on Women 5 in 2000.

Beijing, the 4th World Conference on Women went beyond the ICPD platform by identifying 12 critical areas of action specific to women, some being: women and poverty, the health of women, armed conflict and women, the economies and women, the environment and woman's roles in decision-making, not only family decision-making but the role of women in politics. With regard to women's health, incorporated directly into the 4th World Conference plan of action was the following language, "Good health is essential to leading a productive and fulfilling life and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment." The Fifth Asian and Pacific Population Conference was held in Bangkok in 2002. This region unequivocally reaffirmed its commitment to ICPD and ICPD +5. This was a stunning victory for women's health advocates in the face of formidable obstacles, notably the United States delegation under a new administration with a mandate to roll back ICPD.

The UN Population Fund organized three thematic high-level roundtables in the framework of the 10-year review. One is the Global Consultation on HIV/AIDS and Reproductive Health in the New Millennium: Getting Priorities Straight. This

round table brought together global leaders from both the reproductive health and HIV/AIDS fields to reach consensus on a set of actions that need to be taken to ensure more effective integration and linkage between policies and programmes that address HIV/AIDS and those that address reproductive health (WHO, 2015).

The UN Population Fund organized a two-day Roundtable on Promoting Reproductive Health and Rights: Reducing Poverty, with high-level policy-makers, experts and selected social and opinion leaders. Globally, women's health issues have attained higher international visibility and renewed political. There is no doubt that UN takes women's health issue on its front agenda but there is still much more to do internationally by using UN forums.

9.6 Non-Government Organizations (NGO's) and Women's Health

Non-governmental organizations (NGOs) historically have played a significant role in the provision of health services in many countries of the world around particularly in rural areas. In this context NGOs are defined as private agencies usually operating on a not-for-profit basis that are affiliated with community organizations, religious entities, or international charitable and/or aid organizations (Marmot,2005). During the past two decade of a growing burden and shrinking resource base in the public sector, the private sector and primarily NGOs have expanded their role in service delivery too.

NGOs are increasingly visible and diverse from small grassroots NGOs to multi-million-dollar budgets giants, such as CARE or Human Rights Watch, largely funded by governments. As these examples suggest, today's information age has been marked by the growing role of non-governmental organizations (NGOs) on the international stage. Many NGOs claim to act as a global conscience, representing broad public interests beyond the purview of individual states. They

develop new norms by directly pressing governments and businesses to change policies and indirectly by altering public perceptions of what governments and firms should do. NGOs do not have coercive hard power but they act as pressure group with the ability to get the desirable outcomes through attraction rather than compulsion.

Adequate health care services are essential for women's health. To meet basic needs, they must be able to respond to women as well as men in society. Non-governmental organizations (NGOs) play a particular role in hearing healthcare needs, interpreting them to other players including healthcare institutions, and delivering services (Marmot,2005). A greater appreciation of NGOs' current and potential roles can help to contribute to the provision of appropriate health care services to women and people who are in minorities (old persons, religious minorities, ethnic minorities etc).

9.8 Self-Assessment Questions

- Q.1. Discuss in detail Millennium Development Goals (MDGs) of health.
- Q.2. Explain the prerequisite of MDGs for equitable health system.
- Q.3. Discuss the link between health and development. How does it affect women's health?
- Q.4. Describe in detail the strategies which deal in improving the effectiveness of aid for health.
- Q.5. Identify and discuss the challenges tracking progress and measures of achieving health MDGs
- Q.6. Mariana Haslegrave in her article discusses the role of NGOs in promoting gender approach to health care. Critically analyze her points, while keeping Pakistani situation in mind.
- Q.7. What are the key features of National Health Policy of Pakistan 2001? Critically analyze and give your comments on the key areas which are related to women's health.
- Q.8. Do you agree that NGOs play a vital role in opinion building among people? Discuss in detail with examples.
- Q.9. What are the different roles any NGO can play, while promoting women's health. Critically analyze the role of NGOs working in Pakistan in relation to women health. Do you agree what they are doing? Justify your answer with examples.
- Q.10. Describe in detail the strategies which deal in improving the effectiveness of aid for health.
- Q.11. Identify and discuss the challenges tracking progress and measures of achieving health MDGs.

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Department of Gender & Women Studies
Faculty of Social Sciences and Humanities
Allama Iqbal Open University, Islamabad