Gender, Culture and Society

Chapter One

"Men have always been afraid that women could get along without them."

--Margaret Mead

"Women constitute one half of the world's population; they do two-thirds of the world's Work, they earn one tenth of the world's income and they own one hundredth of the world's property including land." United Nations (1979), *State of the World's Women.*

The Concept of Gender: An Overview

This course investigates the concepts of femininity and masculinity as they are defined by a society. Focusing on sociology, we will explore the multiple ways in which gender roles are assigned, manipulated, demonstrated, and reinforced. A specific culture and historical moment determines what is considered appropriate or expected behaviors and attitudes for males and females; there are few, if any, universal gender roles.

The goal of the course is to provide you with a better understanding of gender roles in a social context. Using principles of sociology, we will investigate gender expectations throughout the life course and in several social institutions, including the family, and education. You will also gain a better understanding of social theories as they attempt to explain gender differences.

Many contemporary gender theorists question whether there can be an "objective" or "value-free" social science. All individuals bring biases and agendas to both the perspectives they believe and the conclusions they draw. There can be multiple truths to any situation, and there are always exceptions to the rule. This course draws on several theoretical perspectives. It is up to you to decide which perspective you support.

By the end of the course, you will have knowledge from a variety of sources, and you will be able to strengthen and clarify your own opinions regarding gender roles in society.

Gender, ethnicity and class are interlocking categories of social experience that affect all aspects of human life; these elements can be seen as different axes of social structure, but individual

persons experience them simultaneously. Gender differences portrayed as unbridgeable and unchangeable; men and women are seen as polar opposites with innately different abilities and capacities. Underlying factors of gender difference in patriarchy assured men to feel root of dominance as more of physical than social; and socio-cultural disparities as secondary and consequences of the physical difference. They viewed themselves as initially superior in intelligence and ability than their opposite-women, whom with different physical characteristics**.** But the fundamental question here is whether the difference is innate i.e. natural or socially constructed realities reflecting interests of society regarding characteristics and positions of people.

In addition to age, gender is one of the universal dimensions on which status differences are based. Unlike sex, which is a biological concept, gender is a social construct specifying the socially and culturally prescribed roles that men and women are to follow. According to Gerda Lerner in *The Creation of Patriarchy*, gender is the "costume, a mask, a straitjacket in which men and women dance their unequal dance" (p.238). As Alan Wolfe observed in "The Gender Question" (*The New Republic*, June 6:27-34), "of all the ways that one group has systematically mistreated another, none is more deeply rooted than the way men have subordinated women. All other discriminations pale by contrast." Lerner argues that the subordination of women preceded all other subordinations and that to rid ourselves of all of those other "isms"-racism, classism, ageism, etc.-it is sexism that must first be eradicated.

In no known society have Women equaled men in terms of power. If current trends continue, modern democratic societies may become an exception to that rule, but full equality of the sexes remains to be accomplished. In some societies women have the right to be political leaders, but they don’t have the same probability of actually being a leader. Women have always had lower status than men, but the extent of the gap between the sexes varies across cultures and time (some arguing that it is inversely related to social evolution). In 1980, the United Nations summed up the burden of this inequality: Women, who comprise half the world's population, do two thirds of the world's work, earn one tenth of the world's income and own one hundredth of the world's property.

When we examine gender relations wife beating is common and accepted in different societies. There is an explicit view that men should and do dominate their wives. In fact, when men fail to dominate their wives, it is they, not the wives, who are the object of public scorn. As a result of these norms, women have little or no control over their marital and sexual lives. Indeed in most of these societies, wives are expected to show deference to their husbands, especially I the public. Such deference may take the form of wife walking several paces behind her husband or kneeling when she serves him food.

Generally speaking, the more modern the society in terms of industrialization and standard of living, the greater equality between the sexes and the fewer who support traditional definitions of sex roles. During the past decades, women breached the power structure. More women have more money and power and scope and legal recognition than we have ever had before; but in terms of how we feel about ourselves physically, we may actually be worse off than our unliberated grand mothers. Recent research consistently shows that inside the majority of the west's controlled, attractive, successful working women, there is a secret "under life" poisoning our freedom; infused with notions of beauty, it is a dark vein of self hatred, physical obsessions, terror of aging, and dread of lost control. It is no accident that so many potentially powerful women feel this way. We are in the midst of a violent backlash against feminism that uses images of female beauty as a political weapon against women's advancement: the beauty myth… . the beauty myth tells the story: The quality called "beauty" objectively and universally exists. Women must want to embody it and men must want to possess women who embody it.

"Female status certainly carries with it many disadvantages compared with that of males in various areas of social life, including employment opportunities, property ownership, income and so on. However, these inequalities associated with sex differences are not usefully thought of as components of stratification. This is because for the great majority of women the allocation of social and economic rewards is determined primarily by the position of their families and, in particular, that of the male head.

Although women today share certain status attributes in common, simply by virtue of their sex, their claims over resources are not primarily determined by their own occupation but, more

commonly, by that of their father or husbands. And if the wives and daughters of unskilled laborers have something in common with the wives and daughters of wealthy landowners, there can be no doubt that the differences in their overall situation are far more striking and significant. Only if the disabilities attaching to female status were felt to be so great as to override differences of a class kind would it be realistic to regard sex as an important dimension of stratification."

When it is sex differences and when is it gender differences?

Sex means biological differences between male and female and gender is socially and culturally defined differences between man and woman. Therefore sex differences refer only to those differences that can be attributed solely to biological differences and gender differences delineate those differences that exist between men and women.

While much of our focus is on the socially constructed differences between men and women, it is also important to note there are some clear physiological differences between the two sexes. In addition to different sex organs and sex chromosomes, the average male is 10 percent taller, 20 percent heavier, and 35 percent stronger in the upper body than the average female (some researchers believe that these physiological differences may have been influenced by social/cultural decisions in our evolutionary past. Even so, when measured against their own body size, rather than on an absolute scale (e.g., how much women can carry relative to their body size versus how much men can carry relative to their body size), indicates actual strength differences are minimal.

Women, for reasons still somewhat undetermined, tend to outlive men. Women's life expectancy in the U.S. is 79.8 years; men's is 74.4. Some believe this difference is due to the riskier lifestyles of men, especially earlier in life, combined with their typically their more physically stressing occupations.

Behaviorally, age of sitting, teething, and walking all occur at about the same time in men and women. However, men enter puberty on average two years later than do women. There are no significant differences in intelligence, happiness, or self-esteem between men and women. However, women are, statistically, twice as vulnerable to anxiety disorders and depression, but only one-third as vulnerable to suicide and one-fifth as vulnerable to alcoholism. Women attempt

suicide more often than men but have lower rates of "success", because their preferred methods do not involve firearms, unlike men. Women are also less likely to suffer hyperactivity or speech disorders as children or to display antisocial personalities as adults.[citation needed] Finally, women have slightly more olfactory receptors on average and are more easily re-aroused immediately after orgasm. Despite being widely accepted as true, there is no evidence to suggest innate differences in math ability between men and women. Any differences are the result of culture, not biology.

Social and Psychological Differences

As the previous section outlined, some gender differences are attributable to biology. However, there are number of gender differences that vary by society and/or culture, indicating they are social constructions. For example, in work group situations in the U.S., men tend to focus on the task at hand whereas women tend to focus more on personal relationships. Women in the U.S. also tend to express more empathy and emotion than do men in social situations. Both of these differences in behavior vary by culture and are therefore believed to be socially constructed. Two detailed examples of socially constructed gender differences are presented below: workforce differences and education.

Gender is the socially projected component of human sexuality. Perhaps the best way to understand gender is to understand it as a process of social presentation. Because gender roles are delineated by behavioral expectations and norms, once individuals know those expectations and norms, the individual can adopt behaviors that project the gender they wish to portray. One can think of gender like a role in a theatrical play - there are specific behaviors and norms associated with genders just like there are lines and movements associated with each character in a play. Adopting the behaviors and norms of a gender leads to the perception that someone belongs in that gender category. Gender roles are, unlike sex, mutable, meaning they can change. Gender is not, however, as simple as just choosing a role to play but is also influenced by parents, peers, culture, and society.

Some examples may help illustrate the distinction between gender and sex. Parents may socialize a biological boy (XY chromosomes) into a traditional masculine role, which includes traditional

gender characteristics like: independence, courage, and aggressiveness. Likewise, parents may socialize a biological female (XX chromosomes) into the traditional feminine role, including characteristics like: submissiveness, emotionality, and empathy. Assuming both children feel like their gender roles fit their identities, the masculine boy and feminine girl will behave in ways that reflect their genders. For instance, the boy may play with toy soldiers and join athletic teams. The girl, on the other hand, may play with dolls and bond with other girls in smaller groups.

Traditional Gender Characteristics

In studying gender sociologists are interested in the gender-role socialization that leads females and males to behave differently. Gender roles were defined as expectations regarding the proper behavior, attitudes, and activities of males and females. The application of traditional gender roles leads to many forms of differentiation between women and men. The following traits are traditionally used by people to define males and females. Consider the overall pattern that not only do we distinguish between the two sexes but also we define them in opposing terms.

Polarizing humanity in terms of gender is still widespread in societies of different countries.

Feminine Characteristics: submissive, dependent, emotional, receptive, intuitive, timid, passive, sensitive, sweet, and soft.

Masculine Characteristics: dominant, independent, rational, assertive, analytical, brave, active, insensitive, daring and tough.

However, gender is fluid and can change. This can be seen by continuing the above example. It is possible for the boy to decide later in life that he no longer wishes to portray himself as traditionally masculine. The boy may adopt some traditionally feminine characteristics and become androgynous, or may adopt a feminine character altogether. Either change would involve adopting the behaviors and norms that go along with the intended gender. The same is true for the girl, who may adopt masculine characteristics.

Gender implies more than how people think and act. The concept of gender stratification refers to a society's unequal distribution of wealth, power and privilege between the two sexes. In general societies allocate fewer valued resources to women than to men.

Chapter Two

"Beauty" ***is a currency system like the gold standard. Like any economy, it is determined by politics, and in modern age in the west it is the last, best belief system that keeps male dominance intact.*** **(Wolf 1992:9)**

2. Sociology of Gender

2.1 Introduction

Social analysis of gender emerged only in the 1970s. Sociologists differ in their views of gender stratification. The study of gender is an important means through which Sociology is being re-shaped. Sex identifies the *Biological* differences between Men and Women. Gender identifies the *Social and Cultural* differences / relations between Men and Women

Regarding gender, every society has distinct functions and responsibilities, assigned to men and women that is a gender based division of labour. In some societies, people say that gender roles are more rigid, and natural while in some other societies gender roles are fluid and dynamic. In some societies people claim that gender roles are natural due to the fact that women give birth. However, the patterns differ over the World. The patterns of gender based division of labor are so not universal. What is considered women's work in one society can be considered as men's work in another society. In Gujarat, India, women are responsible for collecting fuel wood, but in Bangladesh both men and women are responsible. Being a potter is a typical man's work in one society and a woman's in another. Hence one can say that these roles are not biologically determined but social and man-made ideology.

2.2 Sex and Gender

Sociologists make a distinction between sex and gender. Differentiating gender from sex allows social scientists to study influences in sexuality without confusing the social and psychological aspects with the biological and genetic aspects. Gender is a social construction; it is the perceived

or projected biological purposes, such that a person can only be female or male. If a social scientist were to continually talk about the social construction of sex, which biologists understand to be a genetic trait, this could lead to confusion.

Many species of living things are divided in to two or more categories called sex. These refer to complementary groups that combine genetic material in order to reproduce, a process called sexual reproduction. Typically a species will have two sexes: male and female. The female sex is defined as the one which produces the larger gamete (i.e. reproductive cell) and which bears the offspring. The categories of sex are, therefore, reflective of the reproductive functions that an individual is capable of performing at some point during its life cycle, and not the mating types, which can genetically be more than two. In mammals and many other species sex is determined by the sex chromosomes, called X and Y. for mammals, males have one of each (XY), while females have two of X chromosomes (XX). All individuals have at least one X chromosome. In humans sex is conventionally perceived as dichotomous state or identity for most biological purposes, such that a person can only be female or male.

In contemporary writings sex is treated with physiological endowment and gender with roles that are assigned, imposed through socialization. Gender is used as a primitive classification to denote the collective life such as procreation, family maintenance as well as tradition.

Sex differences are natural and gender differences have their sources in culture; that is gender is a basis for defining different contributions men and women make to culture. There are culturally accepted differences and behaviours one can find in gender in distinguished places and times, for e.g. tools, tasks, forms of speech, gestures, etc. These differences reflect the way to relate members of the opposite gender in the interest of cultural and collective life. The basis for making sense of collective life depended upon procreation, continuity of family, and tradition. Stonnel examined gender differences- men tend to follow political township boundary, whereas women seem to have certain people included in the community and draw according to what roads they live on.

Gender refers to the significance the society attaches to biological categories of female and male. Gender is evident throughout the social world, shaping how we think about ourselves, guiding our interaction with others, and influencing our work and family life. But gender involves much more than difference; it also signifies disparities in virtually all social resource. This inequality, which has historically favored males, is no simple matter of biological difference. Males and females do differ biologically, of course, but these variations are complex and inconsistent. Biologically, then, the sexes are distinguished in limited ways with neither one naturally superior nor the other inferior. Nevertheless, the deeply rooted cultural notion of male superiority may seem so natural that we assume it is the inevitable consequence of the sex itself. But society, much more than biology, is at work here, as several kinds of social research show.

2.3 Nature, Culture and Gender

Nature and culture defined by western societies. Culture is regulated by human thought and technology. Culture is universally valued hence it is superior to nature, where as nature is unregulated. Females are universally associated with nature therefore they are inferior and to be dominated. Male with culture and female with nature. Nature and culture, contrast between the sexes- the western thought. Nature is raw or wild whereas culture is cooked or tame. Female - male contrast is understood as nature -culture contrast. Procreative sex is to maintain societies. Sexuality is natural, but it becomes cultural with incest prohibitions and rules of marriage exogamy (Levi-Strauss, 1969, 30).

Many people think the fact that men seem concerned with getting rich while women appear preoccupied with remaining thin reflects some basic and innate differences between the sexes. But the different social experiences of women and men are the creation of society far more than biology. Consciously or unconsciously, we are likely to assume that flying a commercial plane is a man's job and the most parental duties are, in fact, maternal duties. Gender roles are evident not only In our work and behavior but in how we interact with others. We are constantly "doing gender" without realizing it. We socially construct our behavior so that male-female differences are either created or exaggerated. Gender is such a routine part of our everyday activities that we typically take it for granted and only take notice when someone deviates from the conventional behavior and expectations. Many societies have established social distinctions between females

and males that do not inevitably result from biological differences between the sexes (such as women's reproductive capabilities).

2.4 Sociology of Gender

Sociology of gender is a prominent subfield of sociology. Since 1950 an increasing part of the academic literature and of the public discourse uses *gender* for the perceived or projected (self-identified) masculinity or femininity of a person. The term was introduced by Money (1955): The term *gender role* is used to signify all those things that a person says or does to disclose himself or herself as having the status of boy or man, girl or woman, respectively. It includes, but is not restricted to, sexuality in the sense of eroticism."

Cross-cultural studies indicate that societies dominated by men are much more common than those in which women play the decisive roles. Sociologists have turned to all the major theoretical perspectives to understand how and why these social distinctions are established. Each approach focuses on culture, rather than biology, as the primary determinant of gender differences.

A person's gender is complex, encompassing countless characteristics of appearance, speech, movement and other factors not solely limited to biological sex. Societies tend to have binary gender systems in which everyone is categorized as male or femlae, but this is not universal. Some societies include a third gender role; for instance, the Native American Two-Spirit people and the Hijra of India. There is debate over to what extent gender is a social construct and to what extent it is a biological construct. At the extremes of these views you have social constructionism which suggests that it is entirely a social construct and essentialism which suggests that it's entirely a biological construct.

2.5 Need for Gender Studies

Sociologists call gender identity as ascribed status, one given at birth. Society shapes people's identities in three ways:

a) By presenting certain goals and selected values

b) By training the individuals to internalize and

c) By providing and justifying a self-evaluation that fits their position in society.

For many years research on stratification was 'gender blind'- it was written as though women did not exist, or as though, for purposes of analyzing divisions of power, wealth and prestige, women were unimportant and uninteresting. Yet gender is itself is one of the most profound examples of stratification. There are no societies in which men do not, in some aspects of social life, have more wealth, status and influence than women.

Although so much research in to social mobility has focused on men, in recent years more attention has begun to be paid to patterns of mobility among women. At a time when women are 'outperforming' boys in school and females are outnumbering males in higher education, it is tempting to conclude that long standing gender inequalities in society may be relaxing their hold.

Jessie Bernard is one among those who have made a remarkable contribution to the discipline of sociology with regard to gender. Bernard notes that past sociologists – even those critical of the statues quo- have historically paid little attention to women's lives. Karl Marx, for instance, all but ignored women in his writings.

A key reason for giving short shift to women, Bernard suggests, is that sociology like most other disciplines, developed largely under the control of men. She reveals how familiar issues and concepts have a built-I male bias. For instance, in their study of prestige attached to work, sociologists have long ignored housework, which has long been primarily the responsibility of women. In sum this example shows us the importance of insuring that our work addresses the lives of both females and males. Anything less is the study of just half of the society.

Feminism is the advocacy of social equality for the sexes, in opposition to patriarchy and sexism. The "first wave" of the feminist movement in US began in the 1840's as women opposed slavery drew parallels between the oppression of African- Americans and the oppression of women (Randall,1982). A group of women gathered in Seneca Falls, a village in New York, to discuss the social, civil, and religious rights of women. Led by Elizabeth Cady Stanton and Lucretia Mott, the group issued a "Declaration of Sentiments," modeled on the declaration of independence, proclaiming that "all men and women are created equal". Thus was born what was known throughout the latter half of the nineteenth century as "woman movement", an effort to end the

subordination of women. “Men, their rights and nothing more; women, their rights and nothing less.” was the motto. The primary objective of the early women’s movement was securing the right to vote, which was achieved in 1920. But, as other disadvantages persisted, a “second wave” of feminism arose in the 1960’s and continuous days.

Although there were many factions and conflicting points of view within the woman movement, two somewhat contradictory positions were widely shared:

1) There was no difference between men and women, and
2) Women possessed a superior moral nature from which the whole of society stood to gain.

Hence, many of those active in the movement combined the drive for women’s rights with a call for more general social reform and proposed that the one would result in the other. As Jane Frohock expressed this: “it is woman’s womanhood, her instinctive femininity, her highest morality that society needs to counteract the excess of masculinity that is everywhere to be found in our unjust and unequal laws” (Cott, 1987). Cott defines feminism as an ideology sprang from the woman movement having three essential features: 1) opposition to all forms of stratification based on gender, 2) belief that biology does not consign females to inferior status, 3) a sense of common experience and purpose among women to direct their efforts to bring about change.

At last, after a long silence, women took to the streets. In the two decades of radical action that followed the rebirth of feminism in the early 1970’s, western women gained legal and reproductive rights, pursued higher education, entered the trades and the professions, and overturned ancient and revered beliefs about their social role.

Why Sociologists Study Women?

- Women are singled out in society for differential treatment
- Women receive an unfairly small amount of society's rewards
- Women's opinion and social contributions are less valued

This has caused Sociologists to study about women who are the objects of racial or ethnic prejudice.

2.6 Importance of Sociology of Women

The Sociology of women as a branch of the scientific study of society where woman is the object is relatively new, although writings regarding this have existed from 1630s up to the present, women are considered to be more a objective thing rather than a subjective feeling. The study of Sociology of women relates to the study of social situation and social behaviours from the point of view of women. It is an investigation into the definition and role of women in any social situation. If they are present, what exactly they are doing and how they experience the situation in relation with others. What they contribute and what it means to them.

A generalizable conclusion arrived at is that women are present in most social situations, Where and when they are not present, it is not for lack of their ability or interest but because there have been deliberate efforts to exclude them. Where they are present, women have along with men actively created the situations. Women's roles in most social situations, although essential, have not been identical to those of men in those situations; for they have been less privileged and subordinate to men.

The history of woman's subordination is as old as the social world itself but writings regarding this have been steady because women as oppressed members have found their protests subject to suppression by male interest. Until 1960 the Sociology of women has remained on the margin of sociology, ignored by the central male formulators of the discipline. Marx and Engel's, for instance have only touched the subject from the male view point and Talcott Parsons has been conventional in his treatment of the subject.

From hunting stage of human evolution to the post industrial service stage, important activities outside the household those economically gainful are performed by males and women are denied. Males (male child) are considered to be a matter of special satisfaction. Son is often a source of economic and old age security. Daughters are denied. The fact that gender ideology "Man is the master" is followed in almost all societies. In all societies women's status is governed by similar ideas which are purely cultural and man made. This distinct ideology is based on certain stereotypes- which are part of the culture of s society.

2.7 Gender Identity

In sociology, **gender identity** describes the gender with which a person identifies (i.e, whether one perceives oneself to be a man, a woman, or describes oneself in some less conventional way), but can also be used to refer to the gender that other people attribute to the individual on the basis of what they know from gender role indications (clothing, hair style, etc.). Gender identity may be affected by a variety of social structures, including the person's ethnic group, employment status, religion or irriligion, and family.

2.7.1 Conceptual Origins

During the 1950s and '60s, psychologists began studying gender development in young children, partially in an effort to understand the origins of homosexuality (which was still viewed as a mental disorder at the time). In 1958, the Gender Identity Research Project was established at the UCLA Medical Centre for the study of intersexuals and transsexuals. Psychoanalyst Robert Stoller generalized many of the findings of the project in his book *Sex and Gender: on the Development of Masculinity and Femininity* (1968). He is also credited with introducing the term *gender identity* to the International Psychoanalytic Congress in 1963. Psycho-endocrinologist John Money was also instrumental in the development of early theories of gender identity. His work at John Hopkins Medical School 's Gender Identity Clinic (established in 1965) developed and popularized the interactionist theory of gender identity, which suggests that, up to a certain age, gender identity is relatively fluid and subject to constant negotiation. His book *Man and Woman, Boy and Girl* (1972) became widely used as a college textbook.

2.7.2 Gender- Identity - Below the surface

In the overwhelming majority of cases there is no difficulty determining sex and gender. The overwhelming majority of human beings are gendered, considered to be either men or women on the basis of their biological sex. Before the 20th century a person's sex would be determined entirely by the appearance of the genitalia, but as chromosomes and genes came to be understood, these were then used to help determine sex. Most often, men have male genitalia, one X and one Y chromosome; and women female genitalia and have two X chromosomes. However some have combinations of chromosomes, hormones, and genitalia that do not follow the typical definitions

of "men" and "women". Recent research suggests that one in every hundred individuals may have an atypical sex.

The most easily understood case in which it becomes necessary to distinguish between sex and gender is that in which the external genitalia are removed - when such a thing happens through accident or through deliberate intent, the lbido and the ability to express oneself in sexual activity are changed, but the individual does not for that reason cease to regard himself as a boy or a man. One such case is that of David Reimer, reported in *As Nature Made Him* by John Colapinto. It details the persistence of a male gender identity and the stubborn adherence to a male gender role of a person whose penis had been totally destroyed shortly after birth as the result of a botched circumcision, and who had subsequently been surgically reassigned by constructing female genitalia. So the term "gender identity" is broader than the sex of the individual as determined by examination of the external genitalia.

2.7.3 Formation of Gender Identity

The formation of a gender identity is a complex process that starts with conception, but which involves critical growth processes during gestation and even learning experiences after birth. There are points of differentiation all along the way, but language and tradition in most societies insist that every individual be categorized as either a man or a woman. When multiplicity is arbitrarily reduced to absolute dichotomy, conflicts are sure to result. The first question that people usually asks about a new born- "is it a boy or girl?"- looms so large because the answer involves far more than the infant's sex; it carries a great significance for the child's entire life.

Jessie Bernard suggests that the "pink world" of females contrasts sharply with the "blue world" of boys. In fact, the historical preference of boys among parents shows that gender is at work even before a child is born. In global perspective the preference for boys is greater where patriarchy is more pronounced.

When, for instance, the gender identity of a person makes him a man, but his genitals are female, he may experience what is called gender dysphoria, i.e., a deep unhappiness caused by his experience of himself as a man and his lack of male genitals.

Some research has been done that indicates that gender identity is fixed in early childhood and is thereafter static. This research has generally proceeded by asking transsexuals when they first realized that the gender role that society attempted to place upon them did not match the gender identity that they found in themselves and the gender role that they chose to live out. These studies estimate the age at which gender identity is formed at around 2-3. Such research may be problematical if it made no comparable attempt to discover when non-transsexual people became aware of their own gender identities and choice of gender roles.

Some critics question this research, claiming that the studies suffer from a sampling bias. The acquisition of hormone replacement therapy and sexual reassignment surgery is generally controlled by doctors. One of the questions some doctors ask to distinguish between "real" transsexuals and others is to ask them when they first felt identification with the opposite sex. The researchers may then be unintentionally eliminating some subjects from consideration when they try to determine a typical time of gender identity formation. There is also a possibility of reporting bias, since transsexuals may feel that must give the "correct" answers to such questions in order to increase the chances of obtaining hormones. Patrick Califa, author of *Sex Changes* and *Public Sex*, has indicated that this group has a clear awareness of what answers to give to survey questions in order to be considered eligible for hormone replacement therapy and/or sexual reassignment surgery:

"*None of the gender scientists seem to realize that they, themselves, are responsible for creating a situation where transsexual people must describe a fixed set of symptoms and recite a history that has been edited in clearly prescribed ways in order to get a doctor's approval for what should be their inalienable right*".

2.7.4 Problems- Gender Identity and Sex

Some people do not believe that their gender identity corresponds to their biological sex, namely transgender people, including trtanssexual people and many intersexed individuals as well. Consequently, complications arise when society insists that an individual adopt a manner of social expression (gender role) which is based on sex, that the individual feels is inconsistent with that person's gender identity.

One reason for such discordances in intersexed people is that some individuals have a chromosomal sex that has not been expressed in the external genitalia because of hormonal or other abnormal conditions during critical periods in gestation. Such a person may appear to others to be of one sex, but may recognize himself or herself as belonging to the other sex. The causes of transgenderism are less clear; it has been subject of much speculation, but no psychological theory has ever been proven to apply to even a significant minority of transgender individuals, and theories that assume a sex difference in the brain are relatively new and difficult to prove, because at the moment they require a destructive analysis of inner brain structures, which are quite small.

In recent decades it has become possible to surgically reassign sex. A person who experiences gender dysphoria may; then, these forms of medical intervention to have their physiological sex match their gender identity. Alternatively, some people who experience gender dysphoria retain the genitalia that they were born with (see transsexual for some of the possible reasons), but adopt a gender role that is consonant with what they perceive as their gender identity. There is an emerging vocabulary for those who defy traditional gender identity - see transgender and genderqueer.

2.7.4 Relationship to Gender Role

Just as socialization incorporates gender in to personal identity, so it teaches us to act in sex-linked ways. Gender roles or sex roles are the attitudes and activities that a culture links to each sex. Gender roles are the active expression of gender identity. In other words, in so far as our cultures define males as ambitious, and competitive, we expect them to engage in team sports and aspire to positions of leadership. To the extent that females are defined as deferential and emotional, we expect them to be good listeners and supportive observers. The related term, "gender role," has two meanings that in individual cases may be divergent:

First, people's gender roles are the totality of the ways by which they express their gender identities.

Second, people's gender roles may be defined as the kinds of activities that society determines to be appropriate for individuals possessing their kind of external genitalia.

There are probably as many shades and complexities of sexual identity and gender identity as there are human beings, and there are an equal number of ways of working those gender identities out in the intricacies of daily life. Societies, however, tend to assign some classes of social roles to "male" individuals, and some classes of social roles to "female" individuals (as society perceives their sexes). In some societies, there are other classes of social roles for, e.g., surgically neutered physiological male. Hijra (India), for example. Sometimes the connection between gender identity and gender role is unclear. The original oversimplification was that there are unambiguously male human beings and unambiguously female human beings, that they are clearly men and clearly women, and that they should behave in all important ways as women and men "naturally" behave. Investigations in biology and sociology have strongly supported the view that "*the sex between the ears is more important than the sex between the legs*", and the implication has been that people with masculine gender identities will truthfully give external representation of their gender identities by adopting gender roles that are appropriate to men, and, similarly, that people with feminine gender identities will adopt gender roles that are appropriate to women.

It may be very difficult to determine, however, whether a specific drag queen is someone who has a female gender identity and is learning a female gender role, or whether that person is someone with a male gender identity who enjoys mimicking a female gender role to entertain others, to taunt the more rigid members of his society, or for some other reason, such as to repudiate the value or validity of rigid gender roles. Some, such as RuPaul, refuse to be categorized.

Some famous people known for their cross-dressing or androgynous appearances in the 20th century include Brett Anderson, Gladys Bentley, David Bowie, Pete Burns, Eddie Izzard, Boy George, Norman Iceberg, K.D.Lang, Annie Lennox, Jaye Davidson, Marilyn Manson, Marlene

Dietrich, Mylene Farmer, Gackt, Grace Jones, Patrick Wolf, Marc Bolan, Brian Molko, Pat, Phranc, Prince, Susan Powter, Kate Bornstein, and Kristen McMenamy.

Chapter Three

3. Gender Issues

3.1 Introduction

As a consequence of the greater emphasis signaled on human rights over the past decades many UN summits in the 1990s sought to place issues of democracy, justice, and rights on the development agenda. In the context of this world wide process of democratic consolidation, many women's movements were born and sought to press for more equity between the sexes and address gender disparities. The term gender became popular in the 1990s as a replacement for "women and development'. Gender is a social construct that asserts that the expectations and the responsibilities of men and women are not always biologically determined. Advocates of this approach claim that gender more easily accommodates race, class, ethnicity and male- female power relationships.

Gender theory is applicable from the household to the international economy, but the most frequent applications of the theory are to the household and to employment. It was established that poverty exacerbates gender disparities and that gender imbalance in basic human rights, in resources and economic opportunities as well as in political participation hinder development.
In Africa home to over 410 million women, achieving sustainable economic growth depends on empowering them and promoting effectively their welfare and productivity so as to lift the continent itself out of poverty (ECA).

3.2 Role of Women: Genes and Biology

The question before us is how important are biological differences between men and women when it comes to determining social differences between the sexes? Is it true that "biology is destiny?

3.2.1 Heredity

Heredity is the Biological transmission of physical or mental characteristics from parents to children. The heredity characteristics transmitted from parents to child are carried through the genes; which carry the chromosomes found in the nucleus of our body cells. All Human beings have 23 pairs of chromosomes; one pair is called Sex chromosomes. Sex chromosomes determine the individual to be male or female. There are two types of sex chromosomes: X and Y. If an individual receives two X chromosomes, it becomes female; if an X and a Y pair up, the individual is a male.

Some very important differences are created by the sex chromosomes. They not only influence hormone production and sexual characteristics, but they also regulate the expression of certain hereditary traits such as disease, immunity to -diseases, aggressiveness, colour, height, weight, etc. Few males are born with an XYY chromosome pattern. Studies done among such males (Money and Ehrhardt, 1972) showed the evidence of more violent and aggressive behaviour. It is likely that Y chromosome produces a greater predisposition to aggressiveness; but does not always have to be so. This is because when biology does play a role, it does so, most often in connection with the socialization influences.

3.2.2 Anatomical Differences

The most obvious biological differences between men and women is their body structures-anatomy. There is also different distribution of fat and muscle by sex. Dr Barbara Edelstein (1977) suggests that the extra layer of fat under a woman's skin exists because females are designed to bear babies. The fat is needed to provide extra food and heat to the baby. Also men are found to be heavier and taller than women.

The anatomical differences are to a large extent supported by hormonal differences. Males and females produce the same hormones, except for the hormones produced by the sex glands. An important male sex hormone is testosterone, which is also produced in the females in very small amounts. There is some indication that testosterone is related to aggressiveness. Hormones that are present in large amounts in the female and in small amounts in the male are Estrogen and

Progesterone. Estrogen and Progesterone makes conception in the female possible. They are also responsible for the changes in emotional status of the female.

A socially significant effect of the anatomical difference is that it allows for differentiation by sex. Therefore the biological difference is important. It can also be important because the anatomical facts are credited or discredited for the use in society. In a society that places high value for thinness of women, the anatomical fact is discredited and women are socialized to control themselves.

3.3 The Sexual Division of Labor

Anthropologists Lionel Tiger and Robin Fox argue that compared to women, men are more aggressive and dominant. These characteristics are genetically based from differences between male and female hormones. The differences are due partly to the genetic inheritance from man's primate ancestors and partly due to a genetic adaptation to a hunting way of life. Males hunt which is an aggressive activity. Men are responsible for the protection of the band and for alliance or wars with other bands. Thus men monopolize positions of power. Tiger and Fox see dominance as a Sex-linked characteristic which explains how politics became the province of men from the ancestral time to the present.

According to them the natural family unit consists of mother and child. It does not matter how this unit is supported and protected. The close emotional bond between mother and child is a genetically based predisposition for both parties and particularly important for the welfare of the child.

George Peter Murdock sees biological differences between men and women as the basis of the sexual division of labour in society, and not the genetically based predispositions to adopt their particular roles. He suggests that the greater physical strength of men and the fact that women bear children, lead to gender roles out of sheer practicality. A sexual division of labour is the most effectual way of organizing society: Attempts to abolish gender roles and replace them with unisex roles will "go against nature"- Tiger and Fox.

3.4 Devaluation of Women in Industrial Society

One sound indicator of the global pattern of patriarchy is the extent to which house work- cleaning, cooking, and caring for children- is the province of women. In general members of industrial societies divide housework more evenly than people in the poor societies of the world do. But in no society on earth is housework shared equally. As Jessie Bernard (1981) points out, house work embodies a cultural contradiction: although everyone agrees housework is essential, it carries little reward or prestige.

With the onset of industrialization there has been a difference in the status and role of women, both in the early stages of industrialization and the modern industrial society. Thus the position of women in industrial society must be examined in relation to the particular society at a particular stage in its development.

a) Emergence of the Housewife Role: In pre-industrial Britain, the family was the basic unit of production. Marriage and family were essential to individuals for economic reasons since all members of the family were involved in production. Whatever the occupation, a household economy was prevalent. Agriculture and textiles were the main industries and women were indispensable to both as they had specific duties in both these industries whereas the men did other kinds of work required for it e.g.: In the production of cloth, the husband did the weaving while his wife spun and dyed the yarn. On the farm women were in charge of dairy produce.

During the early stage of industrialization the factory steadily replaced the family in economic production. Women were first employed in factories to do their traditional work in textiles. A series of factory acts began to take control of the employment situation restricting women to only certain kinds of work and defining their status as wage earners. When earlier in pre-industrial Britain when mothers involved in economic activity, children did the cooking, mending, washing, and child care at home: but in industrial Britain, they simply could not be trained for household work as their mothers went to factories. Their role in certain factory work too, was stopped by legislation and thereby the children became totally handicapped for their own survival. They became dependent fully on their parents requiring care and supervision. The role of child-care then fell on the women who became thus, the domesticated house-wife.

b) Women and the Labour Force: From the middle of 19th century to the beginning of 20th century there was a threat to women's employment. From 1841 to 1914 there was a tendency among the male workers to see women as a threat to their employment. In 1842 the Mines Act in Britain banned women being employed as miners. In 1851 for every four women one woman was employed (European Society). By 1911 there was only one in ten married women employed. Thus men used such economic, legal and ideological weapons to eliminate the competition of women in the labour force. According to Helen Hacker they even continued a ceaseless propaganda to return women to the home. However, despite the housewife role the number of employed females has been steadily increasing. However, they are not employed evenly throughout the occupational structure. Women are mostly concentrated in low paid, low status jobs. Women are less likely than men to have interesting work or opportunities for promotion. Women are employed mainly in unskilled and semi -skilled jobs. The wage differentials between the sexes are great.

As in the family, there is a sexual division of labour in the job market too. Often women's jobs are the extensions of their domestic role like caring for, waiting on, tidying and serving as in the case of nurses, waitresses, hostesses, secretaries, etc. Equality with men in the labour market requires either an abolition of the sexual division of labour or an upgrading of the so-called "women's-jobs". In 1947 women constituted 31% of the work force. Now it has come down to 22%. 24% are belonging to organized sector and 76% fall under agriculture. 2/3 of all work was done by women, but the remuneration they receive is 1/10 of that received by men. And property ownership was one hundredth (1/100). In the family - there is a sexual division of labour. Women's jobs are extension of their domestic role lime caring for, waiting on, tidying (maintaining neatness) and serving in the case of nurses, waitress, hostesses, secretaries, etc. In such a way women are devalued in the labour force. It is advocated that to maintain equality with men in the labour market requires: either an abolition of the sexual division of labour or there should follow an upgrading of the so-called women's jobs.

3.5 Women and Productive Role

Women in the home have a major impact on productivity. Their products are used daily in the home. In most of the societies women are responsible for the whole family maintenance (finance, savings, medical expenses, etc.). Women shoulders most of the responsibilities in the home including cooking, cleaning, and child care. Educating children is also one of a woman's jobs. Even during spare times, women often work - weaving carpets, making handicrafts, sewing cloths or doing other jobs which save money. In most of the societies men are bread winner but women often contribute by:

a) Working with their husband / father in farming, cattle raising,

b) By volunteering in orphanages, schools, or other institutions, and

c) By working as an independent member of society in an office, hospital or elsewhere.

While women work outside the home, they perform their duties in the home as well. There are many benefits when a woman takes care of her husband and children. The woman's temperament affects family relations and a happy home results in greater productivity on the man's part. Thus society benefits as well. A woman's love for her family is the glue that holds the members together and they cooperate with each other which also increase a society's productivity.

Productivity has two main aspects: Material and Spiritual. When the material productivity increases and when a community or a society has peace and spiritual progress is achieved.

2.5.1 Women's Role in Education

In any case, of course, women's position in education is denied. In cultural development both men and women are factors, causing the promotion of the human personality. The most effective tool for cultural development and better productivity is continuity in education.

2.5.2 Reproductive Role, Productive Role and Community Role*:*

Women were valued primarily as domestic laborers. Children were valued as economic assets. Because of urbanization and Industrial Revolution women could participate in paid labours that limit child care responsibilities. In 19th century women became aware of wealth, power and prestige were distributed according to statuses outside the family. Dissatisfaction over their

confinement to family roles formed the basis for early stages of the women's movements. The movements sought the goals- the right to vote, own property as well as equal access to higher education. In most societies both women and men are involved in Reproductive, Productive and Community Roles. But in time and place the nature and extent of their involvement in each activity reflects the gender based division of labor.

- ***Reproductive Role***

Reproductive role primarily involves into child bearing & rearing (weaning, toilet training, introduction of solid food, etc) and of course domestic tasks (washing, cleaning, cooking, mending, etc). Reproduction is women's biological capacity to give birth, it is often assumed that child rearing and household maintenance is also women's role.

- ***Productive Role***

Work done by both women and men for pay in cash and kind. It includes both Market production with exchange value and Subsistence / home production with actual use value. Informal economic activities carried out by women are often not considered productive- yet they contribute to society.

- ***Community Role***

Activities undertaken by both women and men at the community level as an extension of their reproductive role- to ensure collective consumption , such as fetching water, health care and education. One can see in the matter of social leadership/ membership role of women and men in the community. Men usually dominate in leadership and political roles, where as women usually perform service oriented or cultural activities. In all societies- women are very active, clever and compassionate towards their families and country. If they get a little more facilities, they will shoe that they are capable of producing the best products.

3.6 Theories Regarding Gender Roles

Theories of Gender Differences

Gender Socialization

Sociologists and other social scientists generally attribute many of the behavioral differences between genders to the socialization. Socialization is the process of transferring norms, values, beliefs, and behaviors to future group members. In gender socialization, the groups people join are the gender categories, males and females. Thus, gender socialization is the process of educating and instructing potential males and females as to the norms, behaviors, values, and beliefs of group membership. From birth until death, human feelings, thoughts and actions reflect social definitions of the sexes. Children quickly learn that their society defines females and males as different kinds of human beings, and they began to begin to apply gender standards to themselves. Gender is at work in our society's expectations for us and our aspirations for ourselves. We can see how different these visions are for the two sexes by noting that "becoming a woman" often involves bodily processes: starting to menstruate, losing virginity, or having a child. "Becoming a man" by contrast, is more likely to mean taking on significant responsibilities.

Preparations for gender socialization begin even before the birth of the child. One of the first questions people ask of expectant parents is the sex of the child. This is the beginning of a social categorization process that continues throughout life. Preparations for the birth often take the infant's sex into consideration (e.g., painting the room blue if the child is a boy, pink for a girl). Many of the gender differences just described are attributed to differences in socialization; though it is possible genetic and biological factors play some role. It is important to keep in mind that gender differences are a combination of social and biological forces; sometimes one or the other has a larger influence, but both play a role in dictating behavior. Research finds that gender differences in work and occupations begin with adolescents' first jobs:

- First jobs are significantly segregated by sex
- Girls work fewer hours per week than boys
- Girls earn less per hour than boys
- Hourly wages are higher in job types dominated by males

Researchers attribute these differences to gender socialization and differential opportunities for boys and girls. Another example of research finding differences in behavior between genders can

be seen in the differences in self-ratings of attractiveness. Using fifty-five Johns Hopkins University undergraduates (24 females), the authors had the students fill out questionnaires they designed as self-appraisals of attractiveness. The authors then used a panel to rate the attractiveness of the participants (an objective measure). The researchers found that women are fairly accurate in their assessments of their attractiveness but men are not. They explained their findings by discussing the salience of attractiveness for women, a characteristic learned through socialization: Attractiveness is a more important component of women's lives than men`s. This is seen in the disparity between men and women in the number of cosmetic surgeries they undergo. Of the 11.5 million cosmetic surgeries performed in 2005, women accounted for 85% to 90% of them. Because attractiveness is so important for women, they are more attuned to their actual attractiveness than are men.

Sociobiology

Socio-biologists and evolutionary psychologists argue that much of social life as we know it today has roots in human evolution and biology. According to these theories, some of the gender differences in behavior are attributable to differences in physiology. For instance, differences in sexuality and sex drives may be due to human evolution. Women, who physically invest more in the creation and bearing of children (through pregnancy), may have a greater propensity toward monogamous relationships as having a partner to help them improves the chances of their child's survival. Men, on the other hand, may be inclined less toward monogamy and more toward polygamous relationships as their investment in offspring can be (and often is) far smaller than that of women.

Evolutionary psychologists and socio-biologists use this theory to explain differences in sexual behavior, attitudes, and attractions between men and women: women tend to be attracted to men who can provide support (i.e., protection and resources) and prefer fewer sexual partners than do men; men, on the other hand, are attracted to fertile women (the symbols of which have change over time) and prefer more sexual partners

Structural Functionalism

In this perspective, which was developed in the 1940s and 1950s, genders are viewed as complementary - women take care of the home while men provide for the family. Much current research, especially after the women's movement of the 1960s and 1970s, criticizes this approach for supporting the status quo and condoning the oppression of women.

Conflict Theory

In contrast to the status quo supporting structural functionalist approach, social conflict theory argues that gender is best understood in terms of power relationships. Men's dominance of women is seen as an attempt to maintain power and privilege to the detriment of women. This approach is normative in that it prescribes changes to the power structure, advocating a balance of power between genders.

Biological Perspective

Theorists who propound the biological views state that there are some fundamental biological differences which distinguish women from men and which are also responsible for their secondary status in society.

- **Sex-based Function**

Since primitive days, men and women together have carried out innumerable life sustaining activities such as food gathering, hunting, and preservation of food, sewing of skins for clothing, child bearing and rearing. All these activities were shared by the men and women depending on their biological, physical and psychical differences between the men and women. Thus women due to their biological capacity to bear and feed children, were less mobile otherwise, and so took to additional domestic duties; whereas, the males were free of this function and also had greater macular strength that made them daring enough to go out hunting in the wild forests. They were able to seize their targets and bring them under control. These actions made them powerful in society until the present.

As life progresses, more and more varied kinds of activities are becoming necessary to sustain life. All the same, society continues to believe that women should take to the varied kinds of work

close to the kitchen and hearth because of her child bearing and rearing functions, while men should have the roles outside the home where they interact with other people because the only way to achieve power now is not by mere physical strength but by the achievement of power through interaction with public roles (Bird, 1979). This explains why the isolated house bound female role has been devalued and has less power.

Murdock (1949) suggests that biological differences such as the greater physical strength of men and the fact that women bear children, lead to a sex-based division of labour that is most efficient in organizing a society. In the other words, practical need dictated the kind of work to be divided between the male and female. The consequence was that the horizons of the woman thus became limited as a private one, whereas that of the male became a public one open to greater contact with the outside world and its inhabitants (Kessier 1976).

- **Characteristics:**

Universality: Murdock finds that sexual division of labour is present in all the societies and concludes that there are advantages in such a sexual division of labour which presumably account for its universality.

Complementary: According to Parsons, A woman plays an expressive role which means she provides warmth, security, and emotional support. A man spends his working day competing in an achievement oriented society which is an instrumental role leading to stress and anxiety. The expressive female can relieve his tension by providing weary breadwinner with love, understanding, and consideration. In this sense the expressive instrumental roles complements each other in an efficient family system.

Inequality: The physical differences between man and woman become the basis of building a system of role relationships. This includes the nurturing- that subordinated women; while the economic function of the male which was life sustaining defined as superior. When two human categories come together, each will try to impose its power upon the other. Unless both are able to

resist this imposition, one will prevail over the other and keep it in subjection. This has been occurring from time immemorial. The women have been less powerful.

Personality differences follow biological differences. Men are more aggressive and independent than women. Women on the other hand are more dependent, introvert and emotional. Man has taken advantage of this and subordinate women.

- **Criticisms**

Reed (1977) says that biological subordination is not the result of a predetermined biological function, and child bearing cannot be stated as her disability.

Simon de Beavoir states that this biological fact must be seen in the light of anthropological, economic, social and psychological context. The body alone cannot define a woman completely.

For Montague (1954) roles assigned to sexes are not determined wholly biologically but is largely cultural. The biological differences may provide the grounds for different social roles but need not be interpreted as the natural and ultimate connection between the two sexes.

Psychological Perspective

The psychoanalytical feminists mainly emphasize the emotional dynamics of personality the deeply buried emotions in the subconscious of the psyche and the importance of early childhood in the patterning of these emotions.

According to Sigmund Freud, women were second class human beings whose psychic (physical) nature fit them only for a lesser life than that experienced by men. Freud's theory of womanhood is centered on the masculine conviction that a woman is a castrated man with "penis-envy!". The whole feminine character or psychology of women, according to him is moulded by this anatomical difference. He mentions three major consequences of women's feminine character of psychology.

- The girl finds herself insignificant, and feels lost in relation to others, almost mortified, and represses a good part of her sexuality.

- The girl may not be willing to accept her inferiority- and therefore strives to achieve what she lacks. Then there develops what Freud calls the "masculine complex" of women.
- She tries to compensate the "lack" and wish to be attached to a boy.

These three state evidences different kinds of relationships between men and women, all having a truly male bias.

The psychoanalytic theorists see patriarchy as a system in which men subjugate women. This system is understood as being universal, pervading all social organization, durable over time and space and triumphantly maintained over challenge. In this system, all men work energetically to sustain it as it is, and women most often are fond to be actively working for their own subordination. They (women) rarely resist in this system.

❖ **Criticism**

The male bias in Freud's approach is his major weakness according to his critics Kete Millet (1973), Erich Fromm (1978) and Thompson (1973). Such a conviction would have hampered his understanding of the experience of woman in her feminine role. Freud would not have fully understood what women wanted to communicate through their rebellion. For Freud, woman's rebellion is an expression of their masculinity complex but it could well be that she is exercising her freedom. It never occurred to Freud, that the reference model of women need not be that of men. He believed that if one was free, he would tend to dominate others. Hence it was impossible for him to think that it was possible for women to live freely without having a tendency to dominate others. Thus it appears that the Freudian theory of women fits only into a culture where masculinity and feminity are defined in a particular way as described by him.

Liberal Feminism

The Liberal Feminist theory continues from the theories of gender inequality. These theories start from the identification of the sexual division of labour, the existence of separate spheres of social activity, such as the domestic and the public. The women being located in the former and the men in the later. Systematic socialization also takes place in such societies so that children can move into adult roles and sphere appropriate to their gender.

For the liberal feminists, distinction of the domestic sphere is nothing of particular value except that this sphere permits emotional openness. The domestic sphere is an under valued one associated demanding, mindless, unrecognized housework, child care and the emotional and practical service to adults. However the true rewards of social life such as money, power, status, freedom, opportunities for growth and self-worth are found and shared among those in the public sphere, namely the men. The system that restricts woman access to the public sphere is a system that burdens them with domestic responsibilities, isolating them in households and excusing their mates (men) from sharing of any of these domestic responsibilities.

Culturally and in experience, there are two sides to a marriage namely, from the point of the man and from the point of woman. The cultural meaning of marriage rests on the predetermined idealized spheres of social activity; where as in experience the man's marriage is one in which he holds to the belief of being constrained and burdened and also having a right to domestic and emotional service by the wife. The wife's marriage culturally means the destiny and source of fulfillment while experientially it means powerlessness and dependence.

The liberal feminist sees sexism like racism to be the key forces that perpetuate such predetermined systems. It is the belief that one sex is innately superior to the other stands as an important ideological underpinning of patriarchy. Historically patriarchy has been supported by a belief in the innate superiority of males, who, therefore, legitimately, dominate females. Sexism is an ideology supporting male domination of females. Sexism-specially when institutionalized- has clear costs to women, who lose opportunities, stand at increased risk of poverty, and endure sexual violence. But a society as a whole also pays a high cost for maintaining sexism. Limiting the opportunities available to women ensures that the full talents and abilities of half the population will never be developed. Men too are hurt by sexism. Without denying that sexism confers on men a disproportionate share of wealth and power, this privilege comes at high cost/ price. Patriarchy compels men to relentlessly seek control- not only of women but of themselves and the entire world. The consequences include far higher rates of death from violence, accidents, stress, heart attacks, and other disease related with life style.

Over all, when human feelings, thoughts, and actions are rigidly scripted according to a culture's conceptions of gender, people can't develop and freely express the full range of their humanity. Society pressures males to be assertive, competitive and in control, a weighty burden for many to bear. Females are constrained to be submissive, dependent, and self effacing, regardless of their talents and distinctive personalities.

They maintain that societies with such systems must eliminate sexism by educating people to see the reasonableness. They also suggest introduction of equal economic opportunities, changes in family, school and mass media messages and attempts by all individuals to challenge sexism wherever they encounter it. For the liberals, the ideal arrangement is one in which each individual chooses the lifestyle most suitable to her or him. It appeals to the values of individualism, choice, freedom, and equality of opportunity.

Radical Feminism

The radical feminists see society as characterized by oppression between classes, castes, race, ethnic and religious, age and gender categories. Of all these, the fundamental structure of oppression is gender and the system of patriarchy.

- **Views on Social Organization**

Patriarchy was not only the first structure of domination and subordination, as Engels described, it continues to be the most pervasive and enduring system of inequality and the basic societal model for all domination. Through participation in patriarchy men learn how to hold other human beings in contempt to see them as non-human and to control them. Within patriarchy men see and women learn what subordination looks like. Patriarchy creates guilt and repression, manipulation and deception, all of which drive men and women to other forms of tyranny. Patriarchy to radical feminists is the least noticed and yet the most significant structure of social inequality.

- **The Gender Oppression**

Connected with this understanding of patriarchy is the violence practiced by men against women. Violence may not take the form of physical cruelty. It can be present in more complex practices of control in standards of- fashion and beauty, ideals of motherhood, chastity and heterosexuality

and exploitation in the work place (sexual harassment), household drudgery and unpaid or under paid wage work.

Violence here means the control that men exert in their own interests over the life chances, environments, actions, and perceptions of the women. According to radical feminists, men create and maintain patriarchy not only because they have the resources to do so, but because they have real interests in making women serve as tools. Men need women - as means for satisfying sexual desire, for production of children who satisfy practical and emotional needs of men, as labour force, as ornamental sign of their status and power, as source of emotional support, and as they reinforce in males' sense of significance.

❖ Strategies for Changes

Regarding the change required in such a social organization and the strategies for minimizing oppression, they suggest that patriarchy must be defeated by the reworking of women's consciousness, so that

(a) Each woman recognizes her own value and strength (b)
(b) Rejects patriarchal pressures that see them as weak and dependent
(c) Work in unity with other women, to establish a broad sisterhood of trust, support and appreciation.

What this sort of sisterhood in place, there may be two consequences:

(a) A critical confrontation with any facet of patriarchal domination whenever encountered and
(b) Women withdrawing into women-run business, household, communities, centers of artistic creativity, etc.

❖ Criticism

Radical feminism includes arguments by both the Marxian and psychoanalytical feminists about the reasons for women's subordination and yet moves beyond those theories. They support their thesis that patriarchy ultimately rest on the practice of violence against women (Barry, 1979, Griffin, 1978, Rich, 1976).

Socialist Feminism

These theorists have synthesized the Marxian feminist thought and the radical feminist thought; and this has resulted into two sub-varieties of socialist feminism. The first focuses exclusively on women's oppression and the knowledge on class oppression (from Marxian thought) and the other focuses on gender oppression (from radical feminism). The term most frequently used by the theorists of the first sub-variety to describe the system is capitalist patriarchy and the term most frequently used by theorists of the second sub- variety to describe the system is domination.

- **Characteristics**

The Focuses*:* An important characteristic of the socialist feminism is that it sets out to describe and explain all forms of social oppression using the knowledge of class and gender hierarchies as a base from which to explore systems of oppression centering not only on class and gender, but also on race, ethnicity, age, sexual preference and location within the hierarchy of nations.

First, as with all feminism, the oppression of women remains a primary topic of analysis. The theorists of domination give more elaborately the variations in that oppression.

Secondly, women's location and experience of the world serve as the essential point of domination. For they even explore how some women themselves oppressed, actively participate in the oppression of other women.

- **The Method**

The strategy of analysis used by the socialist feminists is Historical Materialism, a basic principle in Marxian social theory. It refers to the material conditions of human life, inclusive of activities and relationships that produce the patterns of human experience, personality, ideas and social arrangements. It is understood that these conditions also change over time because of the dynamics within them. History is a record of these changes in the material conditions of a group's life. Marxian typically used historical materialism to understand the economic dynamics of society i.e. ways in which goods of a type are created for and exchanged in the market. In this process, some become wealthy and other poor.

The socialist feminists who use historical materialism, on the other hand, go the economic dynamics of a group life and speak more broadly of the conditions that create and sustain human life i.e. the dynamics of

(a) The human body, its sexuality involvement in procreation and child bearing

(b) The home maintenance with its unpaid, invisible rounds of domestic tasks and

(c) Emotional sustenance. In all these life-sustaining activities, exploitative arrangements profit some and impoverish others.

- **Definition of Concept**

The concept of material conditions which according to Marxian assumption means human beings are producers of goods must therefore be redefined to mean that human beings are creators and sustainers of other human beings, as understood in socialist feminism.

- **Areas of Analysis**

To socialist feminism, motivation, ideas, social definition of situations, and knowledge. Ideology, the will to act in one's interest or in the interests of others, all deeply affect human personality, human action and the structures of domination. These aspects of human subjectivity are produced by social structures as powerful as those producing economic goods. Within the structures of human subjectivity are producing economic goods. Within the structure of human subjectivity are also exploitative arrangements that enrich and empower some and impoverish others. Analysis through historical materialism of the process that pattern human subjectivity is vital to the theory of domination.

Such an analysis develops a portrait of the social organisation in which the larger structures of economy, polity and ideology interact with the intimate micro processes of human reproduction, domesticity, sexually and subjectivity to sustain multi-dimensional system of domination. Thus the socialist feminist study the large scales systems of domination and also go deep into exploring the details of daily experiences of oppressed people.

- **Strategy for Change**

Their strategy for change rests in the elaborate process of analysis which leads to the discovery in which, they attempt to involve the oppressed groups they study with the hope that individuals and groups will earn small and large ways, to act in pursuit of their collective emancipation.

Chapter Four

4. Status of Women

4.1 Introduction

Any attempt to assess the status of women in a society should ideally start from the social framework. Social structure, cultural norms, and value systems are important determinants of women's roles and their position in society. They influence social expectation regarding behaviour of the two sexes. Social traditions are a major influence in shaping attitudes as well as behaviour patterns of human groups. Social structure can stimulate certain to ends of change, but at the same time it can also prove to be an impediment as their path- religion, family, and kinship, roles and cultural norms, delimiting the sphere of women's activities obstruct and the achievement of their full potential.

To examine the influence of religion in shaping and sustaining certain images of women, the forms social organisation that exerts the greatest pressure on women's roles and status namely descent and kinship systems, marriage, and family organizations. And also to examine some of the constraints on women because of the distinction between men's sphere and women's sphere such as those springing from division of work and seclusion and segregation of woman, and the Problems of adjustment that arise due to processes of social change.

4.2 Human Population

- **Fundamental of Growth**

The population of the world surged from 2.4 billion in 1950 to 6.1 billion 50 years later, because birth rates remained high at the same time that death rates began to fall. The number of children that a couple will have is determined by many factors, including health, religion, culture, economic status, and the ability to have the number they wish to have. Many of these factors relate to the status of women; the social, economic, and cultural circumstances of women in society and of individual women in different societies. Because these factors help determine the

number, spacing, and timing of births, women's choices (or lack thereof) regarding childbirth directly affect population growth.

- **Factors Affecting Family Size**

Biological, cultural, and socioeconomic conditions together determine the number of children that a woman will have. These conditions influence her exposure to intercourse and her ability to conceive a child, as well as the number of children she may wish to have. Some factors include age at marriage, use of family Planning methods, and breastfeeding. Many socioeconomic factors are also important influences on fertility. These factors are sometimes indirectly related. Education, urbanization, labor force participation, and infant mortality have a strong correlation with levels of fertility. But it is difficult to determine direct causation and one must be careful not to confuse causation with correlation. Some factors may be merely related to fertility rates, and other unknown factors may be the real cause of different levels of fertility among different women and different societies.

According to the Projection made by Central Statistical Authority (CSA, 1998) 50% of Ethiopia's population of 61.7 million are women. The number of women in childbearing age is estimated to be about 14 million i.e. 47% of the women and 24% of the total population.85% of Ethiopian people including women live in rural areas where social services are very limited.

- **Women's Age at First Marriage (years) and Family Size (TFR)**

Generally, the age at which a woman first marries is directly related to the number of children she will bear because it affects the length of time she will be at risk of becoming pregnant. Of course, unmarried women may also have children, but the vast majority of childbearing takes place within marriage throughout most of the world, which makes the age at marriage a valuable indicator of a woman's lifetime fertility. The total fertility rate or average births per woman for German women, who marry around age 24, are 1.3. Conversely, women in Chad, who marry earlier, average 7 children *(see chart, "Women's age at first marriage and family size,")*. Within countries, rural women tend to marry earlier than urban women and tend to have larger families. Access to contraception

is an important contributor to the differences in the fertility rates among countries, but culture and socioeconomics weigh heavily as well.

Women's access to education, health care, family planning, and employment all affect family size. Studies show that women who have completed primary school have fewer children than those with no education. Education is the key, because educated women are more likely to know what social, community, and health services, including family planning, are available and to have the confidence to use them. In addition, women with more education have more opportunities outside the home and can see the benefits of education for their children. Women who achieve a relatively high level of education are also more likely to enter the labor force before they marry or begin childbearing, and ultimately to have smaller families than women who marry in their teens. This trend is evident in almost every country where data are available. As the chart "Women's education and family size" shows, women with a secondary school education have substantially smaller families than women with less education.

Evidence shows that efforts to lower birth rates may depend on improving the status of women. Part of the Cairo Programme of Action, developed at the 1994 International Conference on Population and Development calls for universal access to education, employment opportunities for women, and an end to discrimination against women. Experiences in some countries have shown that fertility patterns can change in as little as a decade, and that voluntary policies and programs can be highly effective in encouraging the change.

The Commission on the Status on Women (CSW) is one of the first bodies established by the UN Economic and Social Council. Set up in 1946, it monitors the situation of women and promotes their rights in all societies around the world. It prepares recommendations and reports for the UN on any issue affecting women. In case of urgent problems, the Commission can press for immediate international action to prevent or alleviate violations of women's rights.

In other words, CSW is the global advocate for equality between women and men. The central part of CSW's work involves setting universal standards regarding equality between women and men

4.3 Gender and Health

WHO definition of Health*: health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*. Health is both an important factor in the achievement of status as well as an indictor of social status, particularly for women, whose health is conditioned to a great extent by social attitudes. The health status of women includes their mental and social condition as affected by prevailing norms and attitudes of society in addition to their biological and physiological problems**.**

Societies delineate women's roles partly according to their biological function and partly from prevailing attitudes regarding their physical and mental capacity. These social attitudes also influence the provisions and use of preventive and curative health care, including maternal care.

The cultural norms that particularly affect women's health are the attitude to marriage, age of marriage, the value attached to fertility and sex of the child, the practice of family organization and the ideal role demanded of the women by social conventions. They determine her place within the family, the degree of her access to medical care, education, nutrition, and other accessories of health.

The lower status of women is the result of her dependence and lower education and social position. Tradition idealizes her role as the mother, housewife, and the distributor of food. The young girls as they grow up are taught subservience and self-effacement. The process therefore starts at an early age and has very adverse consequences on women's health particularly at the time of pregnancy and childbirth.

In the developing countries, the other health problems of women- the higher maternal and infant mortality, maternal morbidity, lower expectation of life at birth, mal-nutrition, mental disorders, suicide rate and certain sex selective diseases are linked to their status and role in the society. Child bearing and rearing is still the dominant role assigned to most women in developing nations.

4.3.1 Why Gender and Health?

The distinct roles and behaviors of men and women in a given culture, dictated by that culture's gender norms and values, give rise to *gender differences*. Not all such differences between men and women imply inequity - for example, the fact that in many western societies, men generally wear trousers while women often wear skirts and dresses is a gender difference which does not, in itself, favor either group.

Gender norms and values, however, also give rise to *gender inequalities* - that is, differences between men and women which systematically empower one group to the detriment of the other. The fact that, throughout the world, women on average have lower cash incomes than men is an example of a gender inequality. Both gender differences and gender inequalities can give rise to inequities between men and women in health status and access to health care. For example:

- A woman cannot receive needed health services because norms in her community prevent her from traveling alone to a clinic.
- A teenage boy dies in an accident because of trying to live up to peers' expectations that young men should be "bold" risk-takers.
- A married woman contracts HIV because societal standards encourage her husband's promiscuity while simultaneously preventing her from insisting on condom use.
- A country's lung cancer mortality rate for men far outstrips the corresponding rate for women because smoking is considered an attractive marker of masculinity, while it is frowned upon as unfeminine in women.

In each of these cases, gender norms and values, and resulting behaviors, are negatively affecting health. In fact, the gender picture in a given time and place can be one of the major obstacles, sometimes the single most important obstacle - standing between men and women and the achievement of well-being.

The good news is that gender norms and values are not fixed. They evolve over time, vary substantially from place to place, and are subject to change. Thus, the poor health consequences resulting from gender differences and gender inequalities are not fixed, either. They can be changed.

The goals of the Gender and Women's Health Department are to increase health professionals' awareness of the role of gender norms, values, and inequality in perpetuating disease, disability, and death, and to promote societal change with a view to eliminating gender as a barrier to good health.

4.3.2 Health and Welfare

Health is an internationally recognized human right with far-reaching impacts: healthy people can take better care of themselves and their families, and are better able to contribute to the social, economic, and political progress of their countries. In fact, worldwide, some of the most dramatic development results have been achieved through interventions in health and nutrition.

The world has achieved unprecedented progress in health in just two generations: smallpox has been eradicated, polio is nearing extinction, child mortality rates have fallen dramatically, and one billion more people have access to clean drinking water.

- **The reality**

Despite the progress made in health and nutrition worldwide, the right to health remains unfulfilled for many, particularly the poorest and most marginalized populations in developing countries and countries in transition. There is disturbing evidence of widening gaps in health worldwide:

Today, nearly all child deaths occur in developing countries, almost half of them in Africa. Of the 20 countries in the world with the highest child mortality (probability of death under 5 years of age), 19 are in Africa, the exception being Afghanistan.

- Women in developing countries are more than 100 times more likely to die of pregnancy-related causes than their counterparts in industrialized countries;
- Twenty-five percent of the population in developing countries and countries in transition lack access to clean drinking water, and less than half have access to adequate sanitation;

- More than 350 million children and adults are suffering from malnutrition;
- The gap in life expectancy between the richest and poorest countries is more than 30 years;
- HIV/AIDS is eroding the health and development gains of the previous 50 years in many countries, leading to significant declines in life expectancy;
- Tuberculosis (TB) is the leading killer of people infected with HIV, and up to 50 percent of people with HIV or AIDS develop TB.

4.3.3 Health and Nutrition

4.3.4 Reproductive Health

In the last 20 years, real progress has been made in children's health around the world, but women's health has barely improved. What we take for granted in many countries — appropriate pre-natal care and safe deliveries — are not nearly as common in Africa, for example, where a woman's chances of dying from a pregnancy-related cause is one in 30.

Research shows that investing in the welfare of women is one of the fastest ways to improve living conditions for entire communities. Healthier, more active and educated women can contribute to the family income and raise stronger and more educated children. Empowering girls and women through better access to education, more economic and political participation in their communities, and health services geared toward reproductive health and fewer and safer pregnancies. Protecting women against violence is also becoming an increasingly important health and development issue.

❖ Safe Motherhood

Over half a million women die each year from pregnancy-related causes, almost all in developing countries. The most common causes of death are obstructed labour, haemorrhage and postpartum infection. If the mothers are too young or malnourished, they are at risk of obstructed labour, which more often than not ends with tragic results.

For many women, the decision to seek medical care is made too late and involves difficult and life-threatening journeys to seek assistance. In one district in India, nearly 70 per cent of women arriving at hospitals during a complicated pregnancy traveled by public bus and 19 per cent by animal-drawn carts. Around the world, over 18 million mothers are left with significant complications and permanent health problems. Proper pre-natal care, trained birth attendants, essential drugs and blood supplies and accessible emergency care can help.

According to the World Health Organization, universal access to high-quality family planning and information services is key to preventing pregnancies that are too early, too closely spaced, or too many. Experts believe that family planning practices would probably bring more benefits to more people at a lower cost than any other single health initiative.

❖ Women and Health

Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being their ability to participate in all areas of public and private life.

Everyone has the right to enjoy reproductive health, which is a basis for having healthy children, intimate relationships and happy families. Reproductive health encompasses key areas of the UNFPA vision – that every child is wanted, every birth is safe, every young person is free of HIV and every girl and woman is treated with dignity and respect.

But reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide. Impoverished women, especially those living in developing countries, suffer disproportionately from unintended pregnancies, maternal death and disability, sexually transmitted infections including HIV, gender-based violence and other problems related to their reproductive system and sexual behaviour. Because young people often face barriers in trying to get the information or care they need, adolescent reproductive health is another important focus *of UNFPA programming*.

The critical importance of reproductive health to development was recently acknowledged at the highest level. At the 2005 World Summit, world leaders agreed to integrate access to reproductive health into national strategies to attain the Millennium Development Goals. UNFPA is fully committed to mobilizing support and scaling up efforts to make reproductive health for all a reality by 2015.

Reproductive 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 so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.

❖ Maternal Mortality

Worldwide, more than 50 million women suffer from poor reproductive health and serious pregnancy-related illness and disability. And every year more than 500,000 women die from complications of pregnancy and childbirth. Most of the deaths occur in Asia, but the risk of dying is highest in Africa.

Women in high-fertility countries in Sub-Saharan Africa have a 1-in-16 lifetime risk of dying from maternal causes, compared with women in low-fertility countries in Europe, who have a 1-in-2,000 risk, and in North America, who have a 1-in-3,500 risk of dying. High maternal mortality rates in many countries are the result of inadequate reproductive health care for women and inadequately spaced births.

❖ Why do mothers die?

The high rates of maternal mortality throughout much of the developing world are the result of serious neglect of women's reproductive health, particularly for the poorest women, as well as ineffective interventions. In addition to contraception, women need access to a broad range of services. The primary means of preventing maternal deaths is to provide rapid access to emergency obstetrical care, including treatment of hemorrhages, infections, hypertension, and obstructed labor. It is also important to ensure that a midwife or doctor is present at every

delivery. In developing countries only about half of deliveries are attended by professional health staff. Even, where fertility rates are low, the timing and spacing of pregnancies, and the extent to which the births are wanted, warrant attention. Greater access to family planning can help reduce the maternal mortality rate by reducing the number of pregnancies. In addition to contraception, women need access to a broad range of services. Skilled attendants must be supported by the right environment. Life-saving interventions – such as antibiotics, surgery, and transportation to medical centers – are unavailable to many women, especially in rural areas. These women may lack the money for health care and transport, or they may simply lack their husbands' permission to seek care. The lifetime risk of maternal death is the risk of an individual woman dying from pregnancy or childbirth in her lifetime. A 1 in 3,000 lifetime risk represents a low risk of dying from pregnancy or childbirth, while a 1 in 100 lifetime risk is a high risk of dying.

4.3.5 Change in the proportion of attended birth in the last 10 years

All regions except for the Middle East and North Africa appear to fall short of achieving the 2015 target. Only 56% of women in developing countries give birth with the assistance of a trained midwife or doctor. In Latin America, where the share of births attended by skilled health personnel is high, maternal mortality is relatively low. But in Africa, where skilled attendants and health facilities are not available, it is very high.

❖ Child Mortality

More than 10 million children die each year in the developing world, the vast majority from causes preventable through a combination of good care, nutrition, and medical treatment. Mortality rates for children under five dropped by 15 percent since 1990, but the rates remain high in developing countries.

In developing countries, one child in 10 dies before its fifth birthday, compared with 1 in 143 in high-income countries. Child deaths have dropped rapidly in the past 25 years, but progress everywhere slowed in the 1990s, and a few countries have experienced increases in the same period. At current rates of progress, only a few countries are likely to achieve the Millennium Development Goal of reducing child mortality to one-third of their 1990 levels.

❖ Child mortality: gender and socioeconomic differences

Throughout the world, child mortality is higher in males than in females, with only a few exceptions. In China, India, Nepal and Pakistan, mortality in girls exceeds that of boys. This disparity is particularly noticeable in China, where girls have a 33% higher risk of dying than their male counterparts. These inequities are thought to arise from the preferential treatment of boys in family health care-seeking behaviour and in nutrition.

There is considerable variability in child mortality across different income groups within countries. Data collected by 106 demographic and health surveys in more than 60 countries show that children from poor households have a significantly higher risk of dying before the age of 5 years than the children of richer households. This is illustrated in using the results for three countries from different regions. The vertical axis represents the probability of dying in childhood (on a zero to one scale). The horizontal axis shows the information by "poor" and "non-poor". The identification of poor and non-poor populations uses a global scale based on an estimate of permanent income constructed from information on ownership of assets, availability of services and household characteristics. This approach has the advantage of allowing comparison of socioeconomic levels across countries. It implies that the individuals defined as poor in Bangladesh have the same economic status as the population defined as poor in Bolivia or Niger.

There are significant differences in child mortality risks by poverty status in all countries, although the size of the gap varies; the risk of dying in childhood is approximately 13 percentage points higher for the poor than for the non-poor in Niger but less than 3 percentage points higher in Bangladesh.

Child mortality rates among the poor are much higher in Africa than in any other region despite the same level of income used to define poverty. The probability of poor children in Africa dying is almost twice that of poor children in the Americas. Likewise, better-off children in Africa have double the probability of dying than their counterparts in the Americas. Moreover, better-off children in Africa have a higher mortality risk (16%) than poor children in the Americas, whose risk of death is 14%.

❖ **Child mortality is closely linked to poverty**

In 2002 the average under-five mortality rate was 121 deaths per 1,000 live births in low-income countries, 40 in lower-middle-income countries and 22 in upper-middle-income countries. In high-income countries, the rate was less than 7. For approximately 70 percent of the deaths before age five, the cause is a disease or a combination of diseases and malnutrition that would be preventable in a high-income country: acute respiratory infections, diarrhea, measles, and malaria.

❖ **Past trend and future progress needed to achieve under-five mortality target**

No region, except possibly Latin America and the Caribbean, is on track to achieve the target of reducing, by 2015, the under-five mortality rates by two thirds of their 1990 levels. Progress has been particularly slow in Sub-Saharan Africa, where civil disturbances and the HIV/AIDS epidemic have driven up rates of infant and child mortality in several countries. Just as child deaths are the result of many causes, reducing child mortality will require multiple, complementary interventions**.** Raising incomes will help. So will increasing public spending on health services. But more is needed. Access to safe water, better sanitation facilities, and improvements in education, especially for girls and mothers, are closely linked to reduced mortality. Also needed are roads to improve access to health facilities and modern forms of energy to reduce dependence on traditional fuels, which cause damaging indoor air pollution.

❖ Causes of death among children

In 2002, 48 countries had child mortality rates greater than 100 per 1,000 live births. 15 countries – 14 in Sub-Saharan Africa – had mortality rates of more than 200. A major factor contributing to child mortality is malnutrition, which weakens children and reduces their resistance to disease. Malnutrition plays a role in more than half of all child deaths.

❖ **Immunization is an essential component in reducing under 5 mortality rates:**

Among the childhood vaccine-preventable diseases measles is the leading cause of child mortality, over half a million deaths in 2000. Increased routine measles immunization to at least 90 per cent coverage in all countries combined with a ‘second opportunity’ for measles

vaccination either through a second dose in the routine immunization schedule or the supplemental immunization activities are the main strategies to reduce measles deaths.

❖ Surviving the first five years of life

Although approximately 10.5 million children under 5 years of age still die every year in the world, progress has been made since 1970, when the figure was more than 17 million. These reductions did not take place uniformly across time and regions, but the success stories in developing countries demonstrate clearly that low mortality levels are attainable in those settings. The effects of such achievements are not to be underestimated. If the whole world were able to share the current child mortality experience of Iceland (the lowest in the world in 2002), over 10 million child deaths could be prevented each year.

Today nearly all child deaths occur in developing countries, almost half of them in Africa. While some African countries have made considerable strides in reducing child mortality, the majority of African children live in countries where the survival gains of the past have been wiped out, largely as a result of the HIV/AIDS epidemic.

Across the world, children are at higher risk of dying if they are poor. The most impressive declines in child mortality have occurred in developed countries, and in low-mortality developing countries whose economic situation has improved. In contrast, the declines observed in countries with higher mortality have occurred at a slower rate, stagnated or even reversed. Owing to the overall gains in developing regions, the mortality gap between the developing and developed world has narrowed since 1970. However, because the better-off countries in developing regions are improving at a fast rate, and many of the poorer populations are losing ground, the disparity between the different developing regions is widening.

❖ Child mortality: global contrasts

Of the 20 countries in the world with the highest child mortality (probability of death under 5 years of age), 19 are in Africa, the exception being Afghanistan. A baby born in Sierra Leone is three and a half times more likely to die before its fifth birthday than a child born in India, and more than a hundred times more likely to die than a child born in Iceland or Singapore. Fifteen

countries, mainly European but including Japan and Singapore, had child mortality rates in 2002 of less than 5 per 1000 live births.

❖ Child survival improvements

The last three decades have witnessed considerable gains in child survival worldwide. Global child mortality decreased from 147 per 1000 live births in 1970 to about 80 per 1000 live births in 2002. The reduction in child mortality has been particularly compelling in certain countries of the Eastern Mediterranean and South-East Asia Regions and Latin America, while that of African countries was more modest. Gains in child survival have also occurred in rich industrialized nations, where levels of mortality were already low.

Although child mortality has fallen in most regions of the world, the gains were not consistent across time and regions. The greatest reductions in child mortality across the world occurred 20--30 years ago, though not in the African or the Western Pacific Regions, where the decline slowed down during the 1980s, nor in some eastern European countries, where mortality actually increased in the 1970s. Over the past decade, only countries of the South-East Asia Region and the higher mortality countries in Latin America have further accelerated their reduction in child mortality.

The most impressive gains in child survival over the past 30 years occurred in developing countries where child mortality was already relatively low, whereas countries with the highest rates had a less pronounced decline. Despite an overall decline in global child mortality over the past three decades, the gap between and within developing regions has widened.

Although the chances of child survival among less developed regions of the world are becoming increasingly disparate, the gaps in child mortality among affluent nations have been closing over the past 30 years, largely as a result of medico-technological advances, particularly in the area of neonatal survival.

In 16 countries (14 of which are in Africa) current levels of under-5 mortality are higher than those observed in 1990. In nine countries (eight of which are in Africa) current levels exceed even those observed over two decades ago. HIV/AIDS has played a large part in these reversals.

Analyses from the demographic and health surveys show that, while child mortality has increased in many of the African countries surveyed, the gap between poor and non-poor populations has remained constant over time in this setting. In contrast, there has been a widening of the mortality gap between poor and better-off groups in the Americas, where overall child mortality rates have fallen. This indicates that survival gains in many regions have benefited the better-off. The reduction in child mortality has been much slower in rural areas, where poor people are concentrated, than in urban areas (6). These analyses suggest that health interventions implemented in the past decade have not been effective in reaching poor people.

Losses in child survival in the countries described above are at odds with impressive gains in some African countries. Despite the ravages of the HIV/AIDS epidemic in Africa, eight countries in the region have reduced child mortality by more than 50% since 1970. Among these are Gabon, the Gambia and Ghana.

Overall, at least 169 countries, 112 of them developing countries, have shown a decline in child mortality since 1970. Oman has had the most striking reduction, from 242 per 1000 live births in 1970 to its current rate of 15 per 1000 live births, which is lower than that of many countries in Europe. Overall, the lower mortality countries of the Eastern Mediterranean Region experienced an impressive decline in child mortality, which has been accompanied by a reduction in the gap between countries' child mortality levels since 1970.

Child mortality has also declined substantially in the Americas. The most striking proportional reductions in mortality have been seen in Chile, Costa Rica and Cuba, where child mortality has decreased by over 80% since 1970. There have also been large absolute reductions in child mortality in Bolivia, Nicaragua and Peru. In contrast, Haitian child mortality rates are still 133 per 1000: almost double the mortality rate of Bolivia, the next highest country in the Americas.

An interesting pattern of child mortality trends has been observed in several eastern European countries. Here, child mortality initially increased or remained constant during the 1970s, only to

decline after 1980. This may to some extent be attributed to a more complete registration of child and infant deaths during that period. Interestingly, while adult mortality levels increased in the early 1990s, child mortality continued to decline. There is no other region where this particular pattern of mortality has occurred in such a systematic manner, and the reasons for the trend remain poorly understood.

❖ Causes of death in children

Infectious and parasitic diseases remain the major killers of children in the developing world, partly as a result of the HIV/AIDS epidemic. Although notable success has been achieved in certain areas (for example, polio), communicable diseases still represent seven out of the top 10 causes of child deaths, and account for about 60% of all child Many countries of the Eastern Mediterranean Region and in Latin America and Asia have partly shifted towards the cause-of-death pattern observed in developed countries. Here, conditions arising in the perinatal period, including birth asphyxia, birth trauma and low birth weight, have replaced infectious diseases as the leading cause of death and are now responsible for one-fifth to one-third of deaths. Such a shift in the cause-of-death pattern has not occurred in sub-Saharan Africa, where perinatal conditions rank in fourth place. Here, undernutrition, malaria, lower respiratory tract infections and diarrhoeal diseases continue to be among the leading causes of death in children, accounting for 45% of all deaths.

About 90% of all HIV/AIDS and malaria deaths in children in developing countries occur in sub-Saharan Africa, where 23% of the world's births and 42% of the world's child deaths are observed. The immense surge of HIV/AIDS mortality in children in recent years means that HIV/AIDS is now responsible for 332 000 child deaths in sub-Saharan Africa, nearly 8% of all child deaths in the region. Overall, the 10 leading causes represent 86% of all child deaths

4.3.6 The African crisis of child mortality

There are 14 countries in WHO's African Region in which child mortality has risen since reaching its lowest level in 1990. About 34% of the population under five years of age in sub-Saharan Africa is now exposed to this disturbing trend. Only two countries outside Africa observed similar setbacks in the same period -- countries that experienced armed conflict or economic sanctions.

Eight of the 14 countries are in southern Africa, which boasted some of the most notable gains in child survival during the 1970s and 1980s. Those promising gains have been wiped out in a mere decade.

The surge of HIV/AIDS is directly responsible for up to 60% of child deaths in Africa, as illustrated by the causes of child deaths in Botswana. The indirect effects of HIV/AIDS in adults contribute to the tragedy. Children who lose their mothers to HIV/AIDS are more likely to die than children with living mothers, irrespective of their own HIV status. The diversion of already stretched health resources away from child health programmes into care of people living with AIDS further compounds the situation, in the presence of increasing malaria mortality, civil unrest or social anarchy.

Some progress has been observed in the areas of diarrheal diseases and measles. While incidence is thought to have remained stable, mortality from diarrheal diseases has fallen from 2.5 million deaths in 1990 to about 1.6 million deaths in 2002, now accounting for 15% of all child deaths. There has also been a modest decline in deaths from measles, although more than half a million children under 5 years of age still succumb to the disease every year (8). Malaria causes around a million child deaths per year, of which 90% are children under 5 years of age. In this age group the disease accounts for nearly 11% of all deaths.

The overall number of child deaths in India has fallen from approximately 3.5 million in 1990 to approximately 2.3 million in 2002. This impressive decline is a result of a reduction in overall child mortality rates of about 30%, and a decline in total fertility rates of around 10%. The cause-of-death pattern has remained fairly stable, with the exception of perinatal conditions whose proportion has notably increased. There were some declines in the proportion of deaths from diarrhoeal diseases, measles and tetanus, which may be the result of increased use of oral rehydration therapy and improved coverage of routine vaccination, as well as intensive immunization campaigns.

A similar picture is emerging in China, where the number of child deaths has decreased by 30% since 1990, owing to a reduction in child mortality of 18% and a 6% decline in total fertility. As

in India, the most notable change in the cause-of-death pattern in China over the past decade is an increase in the proportion of perinatal deaths.

The challenge of reducing child mortality is widely recognized and effective interventions are available. The issue now is urgent implementation. The adult mortality challenges are more complex, as described in the next section.

4.3.7 Ethiopian Situation

The main cause of many of Ethiopia's health problems is the relative isolation of large segments of the population from the modern sector. Additionally, widespread illiteracy prevents the dissemination of information on modern health practices. A shortage of trained personnel and insufficient funding also hampers the equitable distribution of health services. Moreover, most health institutions were concentrated in urban centers prior to 1974 and were concerned with curative rather than preventive medicine.

Western medicine came to Ethiopia during the last quarter of the nineteenth century with the arrival of missionary doctors, nurses, and midwives. But there was little progress on measures to cope with the acute and endemic diseases that debilitated large segments of the population until the government established its Ministry of Public Health in 1948. The World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the United States Agency for International Development (AID) provided technical and financial assistance to eliminate the sources of health problems.

In addition to establishing hospitals, health centers, and outpatient clinics, the government initiated programs to train Ethiopian health care personnel so that they could supplement the private institutions that existed in a few major urban centers. The few government campaigns that exhorted the people to cooperate in the fight against disease and unhealthful living conditions were mainly directed at the urban population.

By the mid-1970s, the number of modern medical facilities had increased relatively slowly--particularly in rural areas, where at least 80 percent of the people still did not have access to techniques or services that would improve health conditions. Forty-six percent of the hospital beds were concentrated in Addis Ababa, Asmera, Dire Dawa, and Harer. In the absence of modern medical services, the rural population continued to rely on traditional folk medicine. According to official statistics, in 1983/84 there were 546 physicians in the country to serve a population of 42 million, a ratio of roughly one physician per 77,000 people, one of the worst ratios in the world. Less than 40 percent of the population was within reach of modern health services.

As in most developing countries in the early 1990s, Ethiopia's main health problems were communicable diseases caused by poor sanitation and malnutrition and exacerbated by the shortage of trained manpower and health facilities. Mortality and morbidity data were based primarily on health facility records, which may not reflect the real incidence of disease in the population. According to such records, the leading causes of hospital deaths were dysentery and gastroenteritis (11 percent), tuberculosis (11 percent), pneumonia (11 percent), malnutrition and anemia (7 percent), liver diseases including hepatitis (6 percent), tetanus (3 percent), and malaria (3 percent). The leading causes of outpatient morbidity in children under age five were upper respiratory illnesses, diarrhea, eye infections including trachoma, skin infections, malnutrition, and fevers. Nearly 60 percent of childhood morbidity was preventable. The leading causes of adult morbidity were dysentery and gastrointestinal infections, malaria, parasitic worms, skin and eye diseases, venereal diseases, rheumatism, malnutrition, fevers, upper respiratory tract infections, and tuberculosis. These diseases were endemic and quite widespread, reflecting the fact that Ethiopians had no access to modern health care.

Tuberculosis still affected much of the population despite efforts to immunize as many people as possible. Venereal diseases, particularly syphilis and gonorrhea, were prevalent in towns and cities, where prostitution contributed to the problem. The high prevalence of worms and other intestinal parasites indicated poor sanitary facilities and education and the fact that potable water was available to less than 14 percent of the population. Tapeworm infection was common because of the popular practice of eating raw or partially cooked meat.

Schistosomiasis, leprosy, and yellow fever were serious health hazards in certain regions of the country. Schistosomiasis, a disease caused by a parasite transmitted from snails to humans through the medium of water, occurred mainly in the northern part of the highlands, in the western lowlands, and Harerge. Leprosy was common in Harerge and Gojam and in areas bordering Sudan and Kenya. The incidence of typhoid, whooping cough, rabies, cholera, and other diseases had diminished in the 1970s because of school immunization programs, but serious outbreaks still plagued many rural areas. Frequent famine made health conditions even worse.

Smallpox has been stamped out in Ethiopia, the last outbreak having occurred among the nomadic population in the late 1970s. Malaria, which is endemic in 70 percent of the country, was once a scourge in areas below 1,500 meters elevation. Its threat had declined considerably as a result of government efforts supported by WHO and AID, but occasional seasonal outbreaks were common. The most recent occurrence was in 1989, and the outbreak was largely the result of heavy rain, unusually high temperatures, and the settling of peasants in new locations. There was also a report of a meningitis epidemic in southern and western Ethiopia in 1989, even though the government had taken preventive measures by vaccinating 1.6 million people. The logistics involved in reaching the 70 percent of Ethiopians who lived more than three days' walk from a health center with refrigerated vaccines and penicillin prevented the medical authorities from arresting the epidemic.

According to Ministry of Health, Ethiopia- infectious and communicable diseases related to malnutrition and poor living conditions are the major cause of morbidity and mortality. Low socio-economic development - resulted in low standard of living. Poor environmental conditions and inadequate social services contribute poor health status of Ethiopian people. Women are victims of the situation - the low status of women; high fertility, low literacy level and harmful traditional practices such as early marriage and female genital mutilation contribute significantly to the poor health situation of the women. Studies indicate that women in rural areas work to 13-17 hours; this is exacerbated by low health coverage of the country and by the distribution of health institutions mostly concentrated in urban areas particularly in Addis Ababa. Majority of the women in this country do not have the access to the basic health services; very few women receive basic maternal care, including prenatal delivery and postnatal care. Only 10.2% of the

total deliveries take place in health institution; 31.7% of pregnant women have received immunization against TT2 (MOH, 1998).

- **Availability of Health Related Indicators**

Potential Health Service Coverage (1997)	48.5%
Antenatal Care (1997)	30.4%
Postnatal Care (1997)	3.5%
Delivery Services (institutional- 1997)	10.2%
Women immunized (TT2, 1997)	
For Pregnant Women	31.7%
For Non-Pregnant Women	12.0%
Children Immunized (DPT3, 1996)	67%
Children immunized Measles (1996)	54%
Contraceptive Prevalence rate (1996)	9.8%

- **As per the 2001/02- the ratio of population to health personnel in Ethiopia**

Physician	28339
Nurse	5236
Health Assistance	8249
Environmental Health Workers	69228
Potential Health Service Coverage	51.8%
Child immunization Rate(DPT3)	51.5%
Maternal Immunization Rate	35.4%
(Pregnant& Non-Pregnant Women TT2)	
Antenatal Care coverage	34.11%
Postnatal Care coverage	7.12%
% of deliveries at health care facilities	10%

Access of safe water (1999)- Total- 33.2%, Rural- 24.7%, Urban-83.5%

Access to Sanitation(1999) -Total-16.9%, Rural-7.2%, Urban-74.1%

Utilized budget in health sector- 749.730 (in million Birr, 2000/01)

Per capita govt. expenditure -in Birr 11.5.

In general in Ethiopia maternal mortality and morbidity is very high. Complications related to pregnancy and child birth are the leading causes of mortality for women of reproductive age in the country. Hemorrhage, obstructed labour, infection, pregnancy induced hypertension, and complications of unsafe abortion are known to be the major causes of maternal mortality (Population reports, 1997).It is estimated that allover the world each year about half a million women die of pregnancy related causes; 99% of all maternal deaths occur in developing countries. In Ethiopia the maternal Mortality Rate is 560-850 per 100,000 live births (MOH, 1996).In Ethiopia as in many developing countries deaths due to complications of unsafe abortion becomes the major contributory factor for high maternal mortality. In the case of contraceptive prevalence, in Ethiopia though there is an increase, i.e., from 4% in 1990 to 9.8% in 1997 (CSA, 1993; MOH, 1998) still contraceptive prevalence rate is very low even comparing to the neighboring countries- the CPR is 33 in Kenya, 15 in Uganda, and 48 in Zimbabwe. The 1990 National Family and Fertility Survey indicate that about 52% of women in reproductive age and currently married are potential users of family planning methods either for limiting/ spacing child births.

- **Maternal Mortality in Selected Countries**

Countries	**MMR (Deaths per 100,000 live births)**		
Ethiopia	569-850	Japan	9
Kenya	650	USA	8
Uganda	1,200	Canada	4
Ghana	740		
Indonesia	650		
Sweden	5		

Source: Population Reference Bureau, 1997.

- **ETHIOPIA: High death rate from illegal abortions (www.irinnews.org)**

(This report does not necessarily reflect the views of the United Nations)

ADDIS ABABA, 28 Oct 2002 (IRIN) - More Ethiopian women die in hospital from illegal abortion complications than for almost any other medical reason, the World Health Organisation (WHO) told IRIN on Monday.

It estimates that some 70 percent of women, who are brought to hospital suffering from serious problems after back street abortions, will die. Research shows that for every 100, 000 women who have abortions in Ethiopia, 1, 209 women will die. Only tuberculosis kills more women in hospital. Abortions are illegal in Ethiopia, although back street operations are widespread. The majority of deaths occur in women aged between 16 and 20. The WHO does not advocate the legalization of abortion, but calls for better family planning to help avoid the need for abortions.

If you admit 10 criminal abortions, then seven may die; said Dr.Abonesh Haile mariam, programming officer for the WHO family health and population section in Ethiopia. In the whole country we are taking about thousands of deaths due to criminal abortions, she said. In terms of hospital fatalities it is one of the biggest causes of death. Problems caused by unsafe abortions are also having an impact on overstrained health services in the country, where health expenditure per person is just US $ 1.50. According to the Ethiopian Society of Obstetrician and Gynecologists (ESOG) treatment costs around 300 Ethiopian Birr (US $ 35).

4.3.8. Health Crisis in Africa (HIV/ AIDS)

- **Gender Analysis of HIV Transmission**

Gender analysis is crucial to understanding HIV/AIDS transmission in that it highlights the socially constructed aspects of male-female relations that underpin individual behaviour, as well as the gender-based rules, norms and laws governing the broader social and institutional context.

Here, three aspects are focused on:

- The immediate physiological factors in male-female sexual relations and other forms of transmission (based largely on medical research), and their links with socio-cultural issues;
- The socio-economic and socio-cultural motivations underlying sexual behaviour, which differ for women and men;
- Power as an aspect of gender relations, affecting the ways in which men and women can negotiate sexual relations, *inter alia*.

These aspects are all inter-related. But it is helpful to separate them out analytically in order to identity areas where current understandings are weak.

Many accounts of gender and AIDS have tended to define the issues in terms of women- specific vulnerabilities (whether physical or socio-economic) and to some extent this bias is reflected here. Others have questioned this "vulnerability" approach (e.g. Reid and Cohen, 1992), for its implicit suggestion that by addressing women's vulnerability, HIV/AIDS transmission can be reduced. At the same time, there is widespread recognition that unless men are addressed and included in AIDS prevention efforts, there is limited scope for reducing HIV/AIDS transmission (Mbizvo and Bassett, 1996). And it remains the case, even if decreasingly so, that the majority of persons living with HIV/AIDS and of AIDS deaths are men.

❖ **Physical Vulnerability**

It is widely agreed that women show a different pattern of vulnerability to HIV –infection to men. An early estimation by Anderson et al. (1991: 582)) assumed two-times greater probability of women contracting HIV from a man than vice versa. This is based on figures which show that men run an 11 percent risk of transmission from sexual intercourse with an infected partner, whereas the chance of being infected during intercourse is 20 percent for a woman. The likelihood of infection increases as the disease progresses and antigen concentrations rise.

Similarly, Webb (1997: 87) suggests that women are 1.5 times more likely to contract the HIV-virus from a man than vice versa due to their physical vulnerability, whereas UNAIDS (1997b) estimates that the risk is 2-4 times as high. This is due to the physiology of genital mucosa,

because infected male semen contains higher concentration of the virus; because female surface area is larger and because semen is in contact for a longer period with the female genital tract (Reid and Bailey, 1992; WHO et al. 1995).

The HIV – virus is transmitted through blood and sero-fluids as excreted during sexual intercourse, which makes it "sexually transmitted disease" (STD). The mean incubation period for adults' ranges between 8 to 10 years, independent of sex or risk-group, but dependent on age and geographical area, as drug treatment which may delay or even prevent the onset of HIV/AIDS is more available to patients in the North. Perinatally infected infants usually die within the first two years after delivery (Anderson et al. 1991: 582).

Young Women may be particularly vulnerable to HIV infection, for a variety of reasons:

- Young women have immature cervix with a thinner mucous membrane, which secrets lesser amounts of protectants against viral penetration, thus increasing the risk of infection;
- Women having sexual intercourse before the age of 17 are at higher risk of contracting other viral infections too;
- Rapid intercourse without sufficient expulsion of mucous increases risk of injury or mucous membranes. (This links to social issues, since younger women may be less likely to resist.);
- Unprotected anal intercourse increases risk. Younger women may be more likely to have anal intercourse as this is thought to preserve virginity.

It is difficult to separate the social and physiological causes, especially when young women who are at particular physical risk are exposed to sexual practices over which they have limited control due to social conditions. For social reasons, whereby women tend to have older male partners, the peak age of new infection for women is between 15 and 25 years, whereas men tend become to infected 5-10 years later (WHO et al. 1995: 5; Reid and Bailey 1992:2).This may be exacerbated by responses to the epidemic. As awareness of HIV increases, there is evidence that men shift towards younger partners who are deemed less likely to be infected, whereby the greater age difference increases the risk of transmission (Oppenheim-Mason 1994). In some societies, it has

been observed that people believe that they can be cured of AIDS by passing on the disease to others (Grundfest-Schopef 1991:756).

In other cases, men who are HIV positive specifically seek out younger partners ("virgins") in the belief that this may "cure" them.

Post-menopausal women also have particular physical susceptibilities that are often overlooked: *At this time*, a thinning of the mucosal lining occurs, which increases potential for infection; Post-menopausal women are not routinely monitored, or targeted through AIDS programmes, so that they are more likely to die of AIDS unnoticed. Among men, physical vulnerabilities also vary. The male entry point for infection is the delicates skin under the foreskin, but for the circumcised man this is reduced to the entrance to the urethra. Circumcised men seem to be relatively protected from infection with HIV and STDs (Reid and Bailey, 1992; Caldwell and Caldwell, 1994). Transmission rates may be greatly increased, in male to male sexual relations, for the partner who is being penetrated (Marcus, 1993a:9).

- **Mother-child transmission**

Mother-child transmission occurs through the placenta during pregnancy and through breast-feeding. It is estimated that the peri-natal transmission rate during pregnancy is 33 percent worldwide. Estimates vary by region of the transmission rate between mother and child, from around five percent in developed countries to an average of 25 to 35 percent or more in developing countries. In the North, the likelihood of transmission can be reduced through anti-viral drug-treatment (UNAIDS, 1998a), whereas the transmission rate in some developing countries is as high as 48 percent (WHO wt al. 1995:5). Breast-feeding may also contribute to mother-child transmission- increasing transmission by as much as one third to one half (UNAIDS 1998a: 8), depending on the duration*. This is a particular problem in developing countries where other options are often neither affordable nor safe, and where mothers are advised to breast-feed for up to two years. This route of transmission is of particular importance in Africa, where almost 90 percent of infected children live, but it is also a rising phenomenon in India and Southeast-Asia, linked to an increase in heterosexual transmission (UNAIDS, 1997).

Estimates on the rate of transmission are somewhat confusing. According to UNAIDS (1997c:3), the rate of mother-child transmission in industrialized countries without AZT-drug treatment and with low rates and duration of breast feeding is 15 to 25 percent, whereas in developing countries, the transmission rate was estimated to be around 25 to 45 percent, as the majority of mothers breast-feed for up to two years.

- **Co-infection patterns and other health-related factors**

Tuberculosis (TB)

Tb is a disease that coincides with HIV/AIDS. Both diseases speed up the progress of the other. It is thought that one third of the increase in TB incidence is attributable to HIV infection. TB is also the leading cause of death among people who are HIV-positive (WHO 1998b).

In comparison to men, women are more susceptible to developing TB once they are infected, especially when their immune system is weakened due to another prevalent infection, such as HIV, or when their nutritional status is deficient. Such a scenario gives rise to the concern that AIDS-related TB mortality will increase more rapidly for women than for men in the near future. Or, it may imply that AIDS-related mortality for women is concealed by their high death rate from TB, to a greater extent than for men.

Genital infection

Damage to the female genital tract will increase the risk for a woman of HIV infection through sexual intercourse with an infected man. Genital lesions, infections and inflammation may be linked to sexually transmitted diseases (STD), but can also occur as a result of lower reproductive tract infections which are due to other causes. Factors which contribute to the most common types of vaginal infections, virginities and cervicitis, include unfavorable hygienic conditions, trauma through insertion of foreign objects for contraception or abortion, or genital mutilation and its after effects (McNamara 1991; WHO et al. 1995).

Sexually Transmitted Diseases (STDs)

STDs can have two effects on the female genital tract, which increase the susceptibility of a woman to HIV/AIDS: a disruption on the epithelial mucosa and an increased local concentration

of lymphocytes, which are target cells for HIV (McNamara 1991). In many developing countries, syphilis and chancroid are the most common STDs which, apart from causing localized infection, result in a diminished overall health status through enteric infection. Treatment and programs related to STDs are mainly directed at people who are considered to be "at risk", such as sex workers. Nevertheless, it is thought that there is a high prevalence of STDs among "normal" (i.e. married, monogamous) women worldwide, and that infected women are often not aware of this (Elias, 1991). Gonorrhea and syphilis are symptomatic in 50-80 percent of women, while only 10 percent of affected men have no obvious symptoms (WHO et al. 1995:6). Social stigma may also prevent women, more than men, coming forward to have STDs treated (ibid: 11; Marcus, 1993a:6).

Nutrition

Major nutritional deficiencies, which particularly affect women in the South, are iron-deficiency-related anaemia and lack of Vitamin A. Both play a role in increasing the risk of contracting HIV/AIDS. Women with anaemia are more likely to require blood transfusion, especially after delivery, raising the possibility of infection through transfusion (WHO et al. 1995:11). Vitamin A plays a vital role in upholding the immune system and in keeping mucous membranes in function.

Maternal morbidity and mortality

HIV positive women who are pregnant are at greater risk of having spontaneous foetal abortions and stillbirths (Zaba and Gregson 1998) which poses an increased risk for maternal mortality. Data from Kigali suggests that HIV positive women, who give birth to living infants, experience a greater risk of postpartum haemorrhage and are more likely to give birth to a baby with birth weight below 2500g (Leory et al. 1997). In such cases the link between maternal mortality and HIV/AIDS are likely to go unnoticed.

Women whose immune systems are already under attack through full blown AIDS may be less likely to survive the complications of pregnancy, resulting in maternal death. Also, some drugs for the treatment of AIDS may be inappropriate for pregnant women. On the other hand, AZT reduces the chance of the baby becoming infected, and so is particularly important for pregnant women, although it is very expensive and not available to most women in developing countries.

HIV-infected blood is a major problem for women receiving blood transfusion as treatment for pregnancy complications. Women with known HIV/AIDS may be more inclined to seek illicit (and often unsafe) abortions, themselves a major cause of maternal death (13 percent death worldwide) (Oxzzl with Baden 1996).

Apart from the physical and health-related factors believed to contribute to vulnerability to HIV infection, a range of socio-economic and socio-cultural factors underlie sexual behaviour, and contribute to the likelihood of infection (UNAIDS, 1997b; WHO et al. 1995). A range of such factors which have been identified in the literature are listed below: these can be summarized as:

- Gender-differentiated awareness of issues of reproductive and sexual health;
- Gender ideology and norms around sexual behaviour;
- Differing motivations for sexual activity;
- Varying powers to negotiate around sex and other possible risks

Differential access to education, information regarding sexual health/ AIDS

- Women's relative lack of knowledge about own reproductive system
- Women's relative lack of awareness of health risks (including HIV infection) involved in sexual activity.

Gender –based norms surrounding sexual behavior

Women are often taught to leave initiative to men and or to behave in ways which "please men" (e.g. use of vaginal stimulants), whilst increasing risk to themselves;

Double standards: women are expected to limit their sexual relations, often to marriage or long-term partnerships. Men, meanwhile, are often encouraged to express their masculinity and increase their social status by having many partners/ lots of sexual experience, increasing their own risk of infection, but also that of their monogamous partner (Oppenheim-Mason 1994:221, Durrant 1994:9).

Women, in some societies, are expected to keep silent about and tolerate the sexual behaviour of their male partners (Cohen and Reid 1998, Oppenheim-Mason 1994:229);

As part of the marriage contract, women are often expected to meet male sexual "needs" and thus do not feel able to refuse sex, or unsafe sex. Where male sexual pleasure/ power is a dominant factor driving sexual elations, risks to the female partner are unlikely to be considered (Oppenheim-Mason 1994:227, Bond and Dover 1997).

There ahs been a tendency for women to be blamed as carriers of the virus as a result of public action against sex workers (Elias 1991:28, Abrahamsen 1997:177). This has contributed to a social stigma around HIV/AIDS, which brands women with AIDS as sexually "loose". This can have negative side effects by diminishing the attention to risks among married women and deflecting attention from other (male) actors.

Differing motivations for sexual activity:

Due to limited livelihood opportunities and various forms of gender discrimination and harassment, women adopt sexual "survival strategies", i.e. they may "sell their bodies at the work place, or at school, in order to gain access to resources, security, patronage or protection. This may be aggravated, where women loose their livelihoods as they become widows through AIDS (Durrant 1994:6).

Some women (and men) depend directly on sex for their livelihoods and thus are exposed to the risk of infection daily. High rates of infection have been among sex workers in a variety of contexts. However, in some cases, infection rates are falling due to the promotion of safe sex among sex workers and their clients.

Condoms are incompatible with pregnancy and where men or women desire children or where there is strong social pressure to demonstrate fertility, they may be reluctant to use them (Oppenheim-Mason 1994:227, Bond and Dover 1997).

Differential bargaining power

Women have difficulty in saying not to sex or to unprotected sex because of their economic and social dependence on male partners (Oppenheim-Mason 1994; Cohen and Reid 1998). Evidence suggests that it is often more difficult for women to insist on condom use in long-term sexual relationships than in casual or commercial ones (Bond and Dover 1997). This may be changing as a result of the HIV/AIDS epidemic and women may be able to gain support from e.g. family members to assert their right to refuse sex.

Women, especially young women, are particularly, thought not uniquely, at risk from sexual coercion and violence, including within marriage. Violent sex increases the risk of infection (McNamara 1991).

Impact of HIV/AIDS: Gender implications

Assessments of the impact of HIV/AIDS have focused on:

- Demographic impacts at the macro-level (e.g. UNAIDS, 1994) and
- Overall and Sectoral socio-economic impacts (e.g. Barnett 1992)

The social and economic impacts of AIDS are difficult to estimate, especially at national level. This is related to the complexity of the different factors influencing the supply and demand of productive resources, particularly labour. One specific difficulty in that the labour contributions of many individuals, and particularly of women, are not quantified in standard data collection and economic accounting systems.

At macroeconomic level, the World Bank (1997:33) concludes that the net impact of AIDS on gross domestic product (GDP) per capita will remain small, even where population growth rates are expected to fall. In societies where skill levels are generally low and unemployment rates high, it is easy to replace workers, who have left due to AIDS related illness or death. A recent

background paper by the US Bureau of the Census (Biggs and Shah 1996, cited by World Bank 1997:35) compared 992 African firms mainly employing low-skilled workers. It showed that turnover due to sickness and death comprised only a small percentage of overall turnovers and that it was eight times as difficult to replace professionals compared to unskilled workers. However, one identified negative impact, which is thought to result in a reduction of up to 0.5 percent in GDP per capita, is the fact that savings are more likely to be spent for health care of AIDS patients rather than for productive investments (World Bank 1997:34).

HIV/ADIS has important fertility implications, with consequences for individuals and households, but also, potentially, for overall population growth (Zaba and Gregson, 1998). This relates not just to reduce fertility among the HIV-positive population but also to indirect effects (due to behavioural changes) on the HIV –negative population. Evidence for the impact of HIV/AIDS on overall fertility (and consequently population growth) is currently limited and likely to be significant only where prevalence levels are high. Behavioural changes thought to be important in governing fertility reduction are increase in the age of start of sexual activity; decrease in remarriage following widowhood and separation; and increase in separation linked to reduced tolerance of infidelity (ibid: 20).

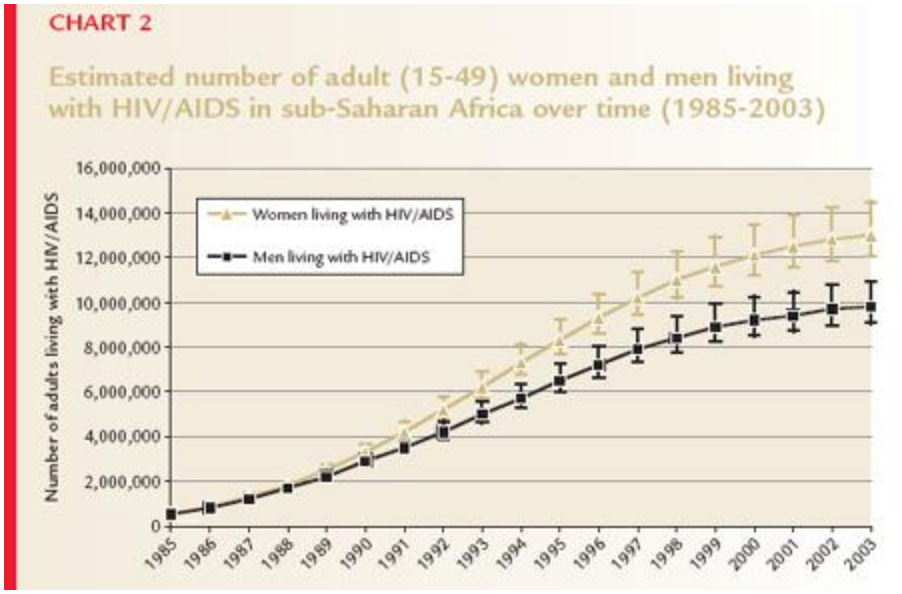
The Gender Dimensions of the HIV/AIDS Epidemic

Increasingly, HIV/AIDS is striking women. Today, more than 20 years into the epidemic, women account for nearly half the 40 million people living with HIV worldwide. In sub-Saharan Africa, young women aged 15 to 24 are more than three times as likely to be infected as young men.

Despite this alarming trend, women know less than men about how HIV/AIDS is transmitted and how to prevent infection. What little they do know is often rendered useless by the discrimination and violence they face, and their relative powerlessness to refuse sex or negotiate safe sex, especially in the context of marriage.

Reversing the spread of HIV/AIDS must address the critical role that gender relations plays in sexual and reproductive life, and how it affects HIV prevention. Indeed, the changing face of the

epidemic brings into sharp relief the gender and social inequalities that shape people's behaviours and limit their choices.



Source: UNAIDS/WHO estimates 2004

Gender Inequities are a Root Cause

Many HIV strategies assume an idealized world in which everyone is equal and free to make empowered choices, and can opt to abstain from sex, stay faithful to one's partner or use condoms consistently. In reality, women and girls face a range of HIV-related risk factors and vulnerabilities that men and boys do not any of which are embedded in the social relations and economic realities of their societies. These factors are not easily dislodged or altered, but until they are, efforts to contain and reverse the AIDS epidemic are unlikely to achieve sustained success.

In many places, male identity is very much linked to sexual performance: men feel pressured to have many sexual conquests to 'prove' their masculinity. Safer sex, which entails a reduction in the number of possible partners, avoiding one night stands and greater selectivity in sexual partnership may therefore be felt as a threat to masculinity. Young men, in particular, may feel pressured to take risks to assert their male identity.

Much sexual risk-taking by girls and young women is marked by unequal gender relations, and unequal access to resources, assets, income opportunities and social power. Far more must be done to ensure sustainable livelihoods for women and girls, particularly those living in female-headed households, if they are to be able to protect themselves against HIV infection and deal with its impact. Boosting women's economic opportunities and social power should be seen as part and parcel of potentially successful and sustainable AIDS strategies.

Overall, 35 percent of Africa's children are at higher risk of death than they were 10 years ago. Every hour, more than 500 African mothers lose a small child. In 2002, more than four million African children died. Those who live beyond childhood are confronted with adult death rates that exceed those of 30 years ago. In some African countries, life expectancy has been cut by 20 years, and life expectancy for men is less than 46 years. The main causes of death among children are diseases closely associated with poverty; diarrheal diseases; pneumonia and other lower respiratory tract conditions; and malaria.

HIV/AIDS, now the world's leading cause of death in adults aged 15 to 59 years, is killing almost 5000 men and women in this age group, and almost 1000 of their children, every 24 hours in sub-Saharan Africa. Since the mid-1980s, HIV has increased TB rates by as much as 500 percent in some countries of sub-Saharan Africa. TB causes up to 50 percent of AIDS deaths in Africa.

Acquired immune deficiency syndrome (AIDS) was a growing problem in Ethiopia. In 1985 the Ministry of Health reported the country's first AIDS case. In subsequent years, the government sponsored numerous AIDS studies and surveys. For example, in 1988 the country's AIDS Control and Prevention Office conducted a study in twenty-four towns and discovered that an average of 17 percent of the people in each town tested positive for the human immunodeficiency virus (HIV), the precursor of full-blown AIDS. A similar survey in Addis Ababa showed that 24 percent tested positive.

In 1990 the Surveillance and Research Coordination Department of the AIDS Control and Prevention Office, indicated that AIDS was spreading more rapidly in heavily traveled areas. According to the Ministry of Health, there were two AIDS patients in the country in 1986, seventeen in 1987, eighty-five in 1988, 188 in 1989, and 355 as of mid-1990. Despite this

dramatic growth rate, the number of reported AIDS cases in Ethiopia was lower than in many other African countries. However, the difference likely reflected the comparatively small amount of resources being devoted to the study of AIDS.

Evidences show that in Ethiopia particularly in the past few years HIV/AIDS is increasing rapidly. In 1997, it was estimated that about 2.5 million people were infected with HIV. Studies confirm that HIV infection is present in all the regions of the country particularly in urban areas. The prevalence of HIV among adults has increased from 3.2% in 1993 to 7.4% in 1997. The prevalence in urban areas is estimated to be much higher. In 1997 it was 21% in urban and 4.5% in rural.

People Living with HIV/AIDS

Adult (aged 15-49) (2001)	2,000,000
Children (2001)	200,000
AIDS Orphans (cumulative, 2001)	1,200,000
AIDS deaths (2000)	1,200,000

Awareness of HIV/AIDS (2000)

Women & Men have heard of AIDS

Women (aged 15-49)	84.7%
Men (15-49)	95.5%

Knowledge of ways of avoiding HIV/AIDS (2000)

Knows no way Female-31.5%, Male-8.1%

Knows one way Female-31.7%, Male-28.6%

Knows two or three waysFemale-36.8%, Male-63.3%

HIV/AIDS incidence was registered about 10% of the adult population between the ages of 20-49, women constitute 50%. Women's low economic status is one of the factors contribute to women's vulnerability to HIV/AIDS. *Women are forced to earn in living through commercial sex work; *Women are compelled to accept unwanted marriage arranged by parents. Apart from these, abduction, extra marital sex, low education, lack of access to information- expose women to

HIV/AIDS. And women take the burden of carrying for HIV/AIDS victims in their family. Girls and women are more vulnerable to HIV transmission than men.

The age profile of reported AIDS cases from hospitals in the country indicate that - 90% of the cases among adults between the ages 20-49 (MOH, 1998).Number of male and female is estimated to be about the same. It is stated that the mode of HIV transmission is mainly through sexual contact. The majority 87% of HIV infection is due to the practice of multiple partner sexual contact. When examining the age distribution at young ages the number of infected females is much higher where as at older ages than umber of males infected is higher. Social and economic disadvantage that women face make them vulnerable to sexually transmitted infections including HIV/AIDS. Women's low literacy level and economic status make them more victims to the situation. Furthermore women are also biologically more vulnerable to HIV infection than men. The female reproductive tract is more susceptible to infection with HIV/AIDS and this is particularly higher in young girls. Adult HIV Prevalence in Ethiopia is - 1984- 0.0%, 1989- 1.0%, 1993- 3.2%, 1997- 7.4% (MOH, 1998). In general among other factors the high prevalence of sexually transmitted diseases such as gonorrhea and syphilis and the incidence of multiple concurrent sex partners are believed to be among the factors which contribute to the high level of HIV in the sub Saharan Africa.

Starting in 1975, the formulation of a new health policy emphasizing disease prevention and control, rural health services, and promotion of community involvement and self-reliance in health activities. In 1983 the government drew up a ten-year health perspective plan that was incorporated into the ten-year economic development plan launched in September 1984. The goal of this plan was the provision of health services to 80 percent of the population by 1993/94.

The regime decentralized health care administration to the local level in keeping with its objective of community involvement in health matters. Regional Ministry of Health offices gave assistance in technical matters, but peasant associations and kebeles had considerable autonomy in educating people on health matters and in constructing health facilities in outlying areas. Starting in 1981, a hierarchy of community health services, health stations, health centers, rural hospitals, regional hospitals, and central referral hospitals were supposed to provide health care. By the late 1980s, however, these facilities were available to only a small fraction of the country's population.

At the bottom of the health-care pyramid was the community health service, designed to give every 1,000 people access to a community health agent, someone with three months of training in environmental sanitation and the treatment of simple diseases. In addition to the community health agent, there was a traditional birth attendant, with one month of training in prenatal and postnatal care and safe delivery practices. As of 1988, only about a quarter of the population was being served by a community health agent or a traditional birth attendant. Both categories were made up of volunteers chosen by the community and were supported by health assistants.

Health assistants were full-time Ministry of Health workers with eighteen months of training, based at health stations ultimately to be provided at the rate of one health station per 10,000 population. Each health station was ultimately to be staffed by three health assistants. Ten health stations were supervised by one health center, which was designed to provide services for a 100,000-person segment of the population. The Regional Health Department supervised health centers. Rural hospitals with an average of seventy-five beds and general regional hospitals with 100 to 250 beds provided referral services for health centers. The six central referral hospitals were organized to provide care in all important specialties, train health professionals, and conduct research. There were a few specialized hospitals for leprosy and tuberculosis, but overall the lack of funds meant emphasis on building health centers and health stations rather than hospitals.

Trained medical personnel were also in short supply. As noted previously, the ratio of citizens to physicians was one of the worst in the world. Of 4,000 positions for nurses, only half were filled, and half of all health stations were staffed by only one health assistant instead of the planned three. There were two medical schools--in Addis Ababa and Gonder--and one school of pharmacy, all managed by Addis Ababa University. The Gonder medical school also trained nurses and sanitation and laboratory technicians. The Ministry of Health ran three nursing schools and eleven schools for health assistants. Missionaries also ran two such schools. The regime increased the number of nurses to 385 and health assistants to 650 annually, but the health budget could not support this many new graduates. The quality of graduates had also not kept pace with the quantity of graduates.

Since 1974 there have been modest improvements in national expenditures on public health. Between 1970 and 1975, the government spent about 5 percent of its total budget on health

programs. From 1975 to 1978, annual expenditures varied between 5.5 and 6.6 percent of outlays, and for the 1982-88 period total expenditures on the Ministry of Health were about 4 percent of total government expenditures. This was a low figure but comparable to that for other low-income African countries. Moreover, much of the real increases of 7 to 8 percent in the health budget went to salaries.

A number of countries were generous in helping Ethiopia meet its health care needs. Cuba, the Soviet Union, and a number of East European countries provided medical assistance. In early 1980, nearly 300 Cuban medical technicians, including more than 100 physicians, supported local efforts to resolve public health problems. Western aid for long-term development of Ethiopia's health sector was modest, averaging about US$10 million annually, the lowest per capita assistance in sub-Saharan Africa. The main Western donors included Italy and Sweden. International organizations, namely UNICEF, WHO, and the United Nations Population Fund, also extended assistance.

The international vision

The Millennium Development Goals (MDGs), adopted by the United Nations in 2000, provide an opportunity for concerted action to improve human well-being by 2015. They place health at the heart of development. They represent commitments by governments throughout the world to do more to reduce poverty and hunger and to tackle ill-health, gender inequality, lack of education, poor access to clean water, and environmental degradation. Three of the eight MDGs are directly health-related—reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases—and all of the others MDGs have important effects on health.

Despite progress in some cases, many developing countries are not currently on track to achieve their health-related MDG objectives. In order to meet the MDGs globally by 2015, both developed and developing countries will have to strengthen their commitments.

The Millennium Development Goals (MDGs), adopted at the Millennium Summit of the United Nations in September 2000, call for a dramatic reduction in poverty and marked improvements in the health of the poor. Meeting these goals is feasible but far from assured. Success in achieving the MDGs will require a seriousness of purpose, a political resolve in countries, and an adequate

flow of resources from high-income to low-income countries on a sustained and well-targeted basis.

The importance of the MDGs in health is, in one sense, self-evident. Improving the health and longevity of the poor is an end in itself, a fundamental goal of economic development. But it is also a means to achieving the other development goals relating to poverty reduction. The linkages of health to poverty reduction and to long-term economic growth are powerful, much stronger than is generally understood. The burden of disease in some low-income regions, especially sub-Saharan Africa, stands as a stark barrier to economic growth and therefore must be addressed frontally and centrally in any comprehensive development strategy. The AIDS pandemic represents a unique challenge of unprecedented urgency and intensity. This single epidemic can undermine Africa's development over the next generation, and may cause tens of millions of deaths in India, China, and other developing countries unless addressed by greatly increased efforts.

The feasibility of meeting the MDGs in the low-income countries is widely misjudged. On the one side of the debate are those who believe that the health goals will take care of themselves, as a fairly automatic by-product of economic growth. With the mortality rates of children under 5 in the least-developed countries standing at 159 per 1,000 births, compared with 6 per 1,000 births in the high-income countries. They take the view that it's just a matter of time before the mortality rates in the low-income world will converge with those of the rich countries. This is false for two reasons.

First, the disease burden itself will slow the economic growth that is presumed to solve the health problems; second, economic growth is indeed important, but is very far from enough. Health indicators vary widely for the same income level. The evidence suggests that 73 countries are far behind in meeting the MDGs for infant mortality, and 66 are far behind for meeting the MDGs for child mortality. The disease burden can be brought down in line with the MDGs only if there is a concerted, global strategy of increasing the access of the world's poor to essential health services.

Domestic Violence:

Protecting Women against Violence

Protection against violence is becoming an increasingly important health issue. According to UNICEF, a quarter of the world's women are abused in their homes. Women and girls are at greater risk of violence from members of their own households than from strangers. At least one in five women suffers rape or attempted rape in their lifetimes.

Family Violence against women

Family violence is a large-scale social problem that affects sizable segments of the population on a regular basis. Women, children of both sexes, and elderly persons of both sexes bear the greatest brunt. The abuse of women by their partners is an endemic form of family violence. The manifestations of family violence include physical, psychological, and sexual abuse. According to studies conducted in Latin American between one-fourth and more than one half of women report have been abused by their partners.

The Multiple Links between Violence against Women and HIV

Violence against women is both a cause and consequence of HIV/AIDS. Research has confirmed a strong correlation between sexual and other forms of abuse against women and women's chances of being HIV-infected. Male (or female) condoms are irrelevant when a woman is being beaten and raped. Moreover, forced vaginal penetration increases the likelihood of HIV transmission. In addition, the fear of violence prevents many women from asking their partners to use condoms, accessing HIV information, and from getting tested and seeking treatment, even when they strongly suspect they have been infected. Many women are in danger of being beaten, abandoned or thrown out of their homes if the HIV-positive status is known. If HIV-prevention activities are to succeed, they need to occur alongside other efforts that address and reduce violence against women and girls.

Violence Against Women: Around the world, as many as one in every three women has been beaten, coerced into sex, or abused in some other way ?most often by someone she knows, including by her husband or another male family member; one woman in four has been abused during pregnancy.

"Violence against women both violates and impairs or nullifies the enjoyment by women is one of their human rights and fundamental freedoms. In all societies, to a greater or lesser degree, women and girls are subjected to physical, sexual and psychological abuse that cuts across lines of income, class and culture." (*Beijing Declaration and Platform for Action, paragraph 112)*

Gender-based violence both reflects and reinforces inequities between men and women and compromises the health, dignity, security and autonomy of its victims. It encompasses a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls and several harmful traditional practices. Any one of these abuses can leave deep psychological scars, damage the health of women and girls in general, including their reproductive and sexual health, and in some instances, results in death.

Violence against women has been called "the most pervasive yet least recognized human right abuse in the world." Accordingly, the Vienna Human Rights Conference and the Fourth World Conference on Women gave priority to this issue, which jeopardizes women's lives, bodies, psychological integrity and freedom. Violence may have profound effects – direct and indirect – on a woman's reproductive health, including:

- Unwanted pregnancies and restricted access to family planning information and contraceptives
- Unsafe abortion or injuries sustained during a legal abortion after an unwanted pregnancy
- Complications from frequent, high-risk pregnancies and lack of follow-up care
- Sexually transmitted infections, including HIV/AIDS
- Persistent gynecological problems, and Psychological problems

Gender-based violence also serves – by intention or effect – to perpetuate male power and control. It is sustained by a culture of silence and denial of the seriousness of the health consequences of abuse. In addition to the harm they exact on the individual level, these consequences also exact a social toll and place a heavy and unnecessary burden on health services.

UNFPA recognizes that violence against women is inextricably linked to gender-based inequalities. When women and girls are expected to be generally subservient, their behaviour in relation to their health, including reproductive health, is negatively affected at all stages of the life cycle.

UNFPA puts every effort into breaking the silence and ensuring that the voices of women are heard. At the same time, the Fund works to change the paradigm of masculinity that allows for the resolution of conflict through violence. One strategy is to engage men policy makers, parents and young boys — in discourse about the dynamics and consequences of violence. As the chart below shows, women may face different forms of violence at different stages of their lives

Violence at Home

Most domestic violence involves male anger directed against their women partners. This gender difference appears to be rooted in the way boys and men are socialized -- biological factors do not seem to account for the dramatic differences in behaviour in this regard between men and women.

Pregnant women are particularly vulnerable to gender-based violence. Some husbands become more violent during the wife's pregnancy, even kicking or hitting their wives in the belly. These women run twice the risk of miscarriage and four times the risk of having a low birth-weight baby.

Cross-cultural studies of wife abuse have found that nearly a fifth of peasant and small-scale societies are essentially free of family violence. The existence of such cultures proves that male violence against women is not the inevitable result of male biology or sexuality, but more a matter of how society views masculinity.

Gender and Violence

Studies of very young boys and girls show only that although boys may have a lower tolerance for frustration and a tendency towards rough-and-tumble play, these tendencies are dwarfed by the importance of male socialization and peer pressure into gender roles

The prevalence of domestic violence in a given society, therefore, is the result of tacit acceptance by that society. The way men view themselves as men, and the way they view women, will determine whether they use violence or coercion against women.

UNFPA recognizes that ending gender-based violence will mean changing cultural concepts about masculinity, and that process must actively engage men, whether they are policy makers, parents, spouses or young boys.

Sexual Assault

The majority of sexual assault victims are young. Women in positions of abject dependence on male authorities are also particularly subject to unwanted sexual coercion. Rape in time of war is still common. It has been extensively documented in recent civil conflicts, and has been used systematically as an instrument of torture or ethnic domination.

Now, with precedents set at the International Criminal Tribunal for Rwanda, in Tanzania, and the International Criminal Tribunal for the Former Yugoslavia, at The Hague, for mass rape, other acts such as sexual assault, sexual slavery, forced prostitution, forced sterilization, forced abortion, and forced pregnancy may qualify as crimes of torture, crimes against humanity, and even some as crimes of genocide.

UNFPA Responds

Because gender-based violence is sustained by silence, women's voices must be heard. UNFPA puts every effort into enabling women to speak out against gender-based violence, and to get help when they are victims of it. The Fund is also committed to keeping gender-based violence in the spotlight as a major health and human rights concern.

UNFPA advocates for legislative reform and enforcement of laws for the promotion and the protection of women's rights to reproductive health choices and informed consent, including promotion of women's awareness of laws , regulations and policies that affect their rights and responsibilities in family life. The Fund promotes zero tolerance of all forms of violence against

women and works for the eradication of traditional practices that are harmful to women's reproductive and sexual health, such as rituals associated with puberty.

Sixteen Days of Activism: Sixteen Days of Hope

Gender-based violence is one of the most pervasive of human rights abuses. It covers a range of injustices from gender abuse to systematic rape and from pre-birth sex selection to female genital mutilation. In 2005, UNFPA took part in a worldwide campaign, 16 Days of Activism Against Gender Violence, that began on 25 November, the International Day for the Elimination of Violence Against Women, and ended 10 December with International Human Rights Day. Find out more about the campaign as well as 16 ways that UNFPA addresses gender-based violence.

As part of its work to counter gender-based violence, UNFPA has supported training of medical professionals, to make them more sensitive towards women who may have experienced violence and to meet their health needs. Pilot interventions have been tested in 10 countries Cape Verde, Ecuador, Guatemala, Lebanon, Lithuania, Mozambique, Nepal, Romania, Russia and Sri Lanka.

Following consultations with health providers and clients, all women were screened for abuse in some pilot projects. Possible victims have been offered legal, medical and psychological support, and medical referrals when necessary. Attention has been paid to involving communities, and to creating support networks for gender-based violence victims that include both police and health-care providers, along with counseling services.

UNFPA has also held workshops for health providers on recognizing the effects of gender-based violence on women's health, and on how to detect and prevent abuse and assist victims. These have stressed the need for confidentiality and monitoring.

Based on this experience, UNFPA has produced a manual, A Practical Approach to Gender-based Violence, which has been translated into seven languages.

- Additional strategies the Fund employs to address gender-based violence include:
- Ensuring that emergency contraception is available for victims of sexual violence

- Strengthening advocacy on gender-based violence in all country programme, in conjunction with other United Nations partners and NGOs
- Advocating for women with parliamentarians and women's national networks
- Integrating messages on the prevention of gender-based violence into information, education and communication projects
- Conducting more research on gender-based violence

Harmful Practices against Women: ***Taking a Stand against Practices That Harm Women***

Throughout the world, practices that undermine the well-being of women endure. But like slavery and foot-binding, they constitute egregious violations of basic human rights.

- At least **130 million women** have been forced to undergo **female genital mutilation/cutting**. Another **2 million** are **at risk each year** from this degrading and dangerous practice.
- Killings in the name of **'honour'** take the lives of thousands of young women every year, mainly in Western Asia, North Africa and parts of South Asia.
- At least **60 million girls** who would otherwise be expected to be alive are **'missing'** from various populations as a result of **sex-selective abortions** or **neglect**.

In most industrialized societies, although gender based violence is officially condemned, it persists, implicitly sanctioned by messages in mass media.

In some developing countries, practices that subjugate and harm women such as wife-beating, killings in the name of honour, female genital mutilation/cutting and dowry deaths ?are condoned as being part of the natural order of things. Throughout much of Asia, a preference for male children results in the neglect and sometimes infanticide of girls, or their elimination by abortion in places where prenatal tests are available to determine the sex of the fetus.

Forced early marriage of young girls or adolescents is another practice that can cause lifelong psychological as well as physical problems, especially those resulting from early childbearing.

And as conflicts among ethnic groups rage, women and girls have increasingly become pawns of war, and face rape and forced pregnancies. FGM/FGC, coerced sex and early marriage are also factors in the spread of HIV to women.

Eradicating long-standing traditional practices does not happen overnight. One way to begin, though, is by information and advocacy that raises public awareness and changes the climate of public opinion.

"Consensus-building around social issues is extremely difficult, because it touches the identity of nations, communities and individuals. Discussion of social questions polarizes viewpoints and may seem to widen the gap between cultures. But in the end, the overriding social purpose concentrates our minds and enables us to bridge all cultural gaps got because we want to go home with an agreed form of words, but because all of us, each in our own way, want to save people's lives." **(*UNFPA Executive Director Thoraya Ahmed Obaid)***

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