Essential Readings

Compiled for

Short Course on

Gendered Research in Health

Baroda, March 6-18, 2006

Module 1

Introduction to Concepts and Tools in Gender, Rights, Development, and Health

Women's Health Training Research and Advocacy Cell
Women's Studies Research Centre

The Mahraja Sayajirao University of Baroda
Vadodara

Contents

Recommended Readings*

Session 1: Patriarchy

Manjrekar, N. and Shah, T. (2000). *Orientation Course in Women's Studies. Course Readings, Week 4.* Vadodara: Women's Studies Research Centre (WSRC).

Iyengar, K. (n.d.) *Review of Medical Textbooks of Obstetrics and Gynaecology.* Unpublished manuscript.

Komaromy, M., Bindman, A. B., Haber, R. J., and Sande, Merle, A. (1993, February 4). *Sexual Harrassment in Medical Training.* The New England Journal of Medicine, 328, pp. 322-326.

Sessions 2 and 3: What is Gender? Social Construction of Masculinity and Femininity

Geetha, V. (2002). *Understanding Gender.*Theorising Feminism Series. New Delhi: Stree.

Dixon-Woods, M. Regan, J., Robertson, N., Young, B., Cordle, C. (2002). *Teaching and Learning about Human Sexuality in Undergraduate Medical Education.* Medical Education, 36, pp. 432-440.

Guha, S. (1998). From Dais to Doctors: The Medicalisation of Childbirth in Colonial India. In L. Lingam (Ed.), Understanding Women's Health Issues – A Reader. New Delhi: Kali for Women, pp. 145-160.

Session 4: Locating Gender inequalities in Class and Caste

Oxaal, Z. and Baden, S. (1997, October). *Gender and Empowerment: Definitions, Approaches and Implications for Policy.* BRIDGE (development – gender), Report No 40. Brighton, UK: Institute of Development Studies, pp. 1-6.

Session 5: Concept of Development

Sen, G. and Grown, C. (1987). *Development Crises and Alternative Visions.* Chapter 1: Gender and Class in Development Experience. New York: Monthly Review Press, pp. 23-49.

Session 6: Health as a Development and Gender Issue

Health Canada. (2003). *Exploring Concepts of Gender and Health.* Ontario: Women's Health Bureau, Health Canada.

Courtenay, W. H. (2000). *Constructions of masculinity and their influence on men's well-being: a theory of gender and health.* Social Science and Medicine, 50, pp. 1385-1401.

Ballantyne, P. J. (1999). *The social determinants of health: A contribution to the analysis of gender differences in health and illness.* Scandinavian Journal of Public Health, 27, pp. 290-295.

Swaminathan, P. (2002). *Women, Work and Health. Issues for Consideration.* In R. Khanna, M. Shiva, and Gopalan, S. (Eds.), Towards Comprehensive Women's Health Programmes and Policy. Baroda: SAHAJ for WAH! pp. 442-459.

Sessions 7 and 8: What are Rights? Applying the Rights Approach to Health

Correa, S. and Petchesky, R. (1994, March). *Reproductive and Sexual Rights: A Feminist Perspective.* In G. Sen, A. Germain, and L. Chen (Eds.), Population Policies Reconsidered – Health, Empowerment and Rights. Harvard Series on Population and International Health, pp. 107-123.

Correa, S. (n.d.). *From Reproductive Health to Sexual Rights: Achievements and Future Challenges.*

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* *Note:* Readings are available with WOHTRAC and have been put on display. You may photocopy them at cost (60 paise per page). You are requested to fill the requisition form before 4.00 pm every day and the photocopies will be provided to you the following day in the morning.

Understanding Gender

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Kali for Women
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Although we have known the word gender in grammar, obviously it is being used differently now. Can you explain this new meaning ?

The word gender is now being used sociologically or as a conceptual category, and it has been given a very specific meaning. In its new incarnation **gender refers to the socio-cultural definition of man and woman, the way societies distinguish men and women and assign them social roles.** It is used as an analytical tool to understand social realities with regard to women and men.

The distinction between sex and gender was introduced to deal with the general tendency to attribute women's subordination to their anatomy. For ages it was believed that the different characteristics, roles and status accorded to women and men in society, are determined by biology (i.e., sex), that they are natural, and therefore not changeable.

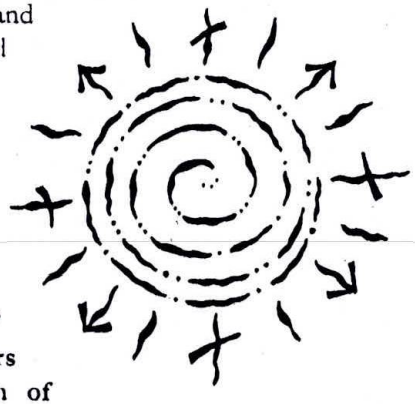
In a way women, and women's bodies, were and are held responsible for their subordinate status in society. Once this is accepted as natural, there is obviously no need to address the gender inequalities and injustice which exist in society.

The concept of gender enables us to state that sex is one thing, but gender is quite another.

Everyone is born male or female, and our sex can be determined simply by looking at our genitalia.

But every culture has its ways of valuing girls and boys and assigning them different roles, responses and attributes.
All the social and cultural "packaging" that is done for girls and boys from birth onwards is "gendering".

Each society slowly transforms a male or female into a man or a woman, into masculine and feminine, with different qualities, behaviour patterns, roles, responsibilities, rights and expectations. Unlike sex, which is biological, the gender identities of women and men are psychologically and socially — which means historically and culturally — determined.



Ann Oakley, who was among the first few feminist scholars to use this concept, says the following: **"'Gender' is a matter of culture, it refers to the social classification of men and women into 'masculine' and 'feminine'."** That people are male or female can usually be judged by referring to biological evidence. That they are masculine or feminine cannot be judged in the same way: the criteria are cultural, **differing with time and place. The constancy of sex must be admitted, but so also must the variability of gender."** [1] She concludes that **gender has no biological origin, that the connections between sex and gender are not really 'natural' at all.**

Let us see the main differences between these two terms.

SEX	GENDER
Sex is natural	Gender is socio-cultural and it is man-made.
Sex is biological. It refers to visible differences in genitalia and related differences in procreative function.	Gender is socio-cultural and it refers to masculine and feminine qualities, behaviour patterns, roles and responsibilities, etc.
Sex is constant, it remains the same everywhere.	Gender is variable, it changes from time to time, culture to culture, even family to family.
Sex is natural.	Gender can be changed.
Sex cannot be changed.	Gender is socio-cultural and it refers to masculine and feminine qualities, behaviour patterns, roles and responsibilities, etc.

How does one translate gender into South Asian languages ?

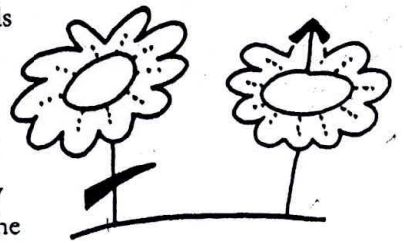
This is indeed a problem. While English has two different words — sex and gender – most South Asian languages have only one word – *"linga"* used for both sex and gender. To distinguish between them we have found two words to qualify *linga*. For sex we say *"praakritik linga"* or natural/biological sex, and for gender *"saamaajik linga"* or social sex. In fact this definition often works

better than "sex" and "gender" because the terms themselves contain the definition, and so no further explanations are required.

But isn't gender closely related to our sex ? Aren't the roles and behaviour assigned to women and men based on their sexual differences ?

Only to some extent. Because of their bodies women, but not all women, bear children, feed them and menstruate; but other than this there is nothing they do that men cannot do or that men can do and women cannot. Bearing children does not mean that only women can or should look after them. Men can just as well do the caring. So just having male or female bodies does not necessarily have to determine our characteristics, roles, or destinies.

But in reality it is quite difficult to establish what is natural and what is socially constructed, because as soon as a child is born families and society begin the process of gendering. In many South Asian cultures the birth of a son is celebrated, the birth of a daughter is bemoaned; sons are showered with love, respect, better food and better health care. Boys are encouraged to be tough and outgoing, girls are encouraged to be demure and home-bound. There is nothing in a girl's body which stops her from wearing shorts, or climbing trees or riding bicycles, and there is nothing in a boy's body which stops him from playing with dolls, looking after younger siblings or helping with cooking or cleaning the house. All these differences are gender differences and they are created by society. Proof of the fact that gender is a cultural and social attribute rather than a natural one, is that it keeps changing — over time, in different places and among different social groups. For example a middle class girl may be confined to the home or school while a tribal girl may roam around in the jungles freely, taking the animals for grazing, or climbing trees for fruits, leaves or branches. They are both girls but they develop very different capabilities, aspirations and dreams, inspite of the fact that their bodies are the same.



Similarly, in many families girls were traditionally not sent to school or allowed to go out of the house after they were 10 or 11, and were often married at puberty. But now things have changed. So too, the education, roles and responsibilities of men have changed, although perhaps not as much. This is what is meant when we say that gender is variable; it is or may be different in different families or communities and at different times in the same family.

Even our bodies can be shaped or changed by us, society or culture. We can change the size, shape and strength of our bodies through training, use, disuse, misuse or abuse. Obvious examples are bodies of male and female wrestlers, body-builders, athletes, dancers, yoga practitioners and so on.

Similarly, women's bodies are such that they can procreate, but we can now choose whether to have children, how many to have and at what intervals to have them. Reproduction is not inevitable in the same way for women as it is for female animals.

If a woman can cook,
so can a man,
because a woman doesn't cook with her womb!

What follows from this is that the different status women and men enjoy in society is indeed socially and culturally determined; it is man-made, nature has very little to do with it. It is gender not sex which has determined that, (almost) everywhere, women as a group are considered inferior to men. They enjoy fewer rights, control fewer resources, work longer hours than men but their work is

either undervalued, or underpaid. They face systemic violence at the hands of men and society; and they have little decision-making power in social, economic and political institutions.

> *"No social order in history has extended, distorted and used the natural difference between the sexes as brutally and systematically as ours. This order first transformed natural sex into a social artificial gender, made 'men' out of men, and 'women' out of women — in fact, turned 'men' into the 'human race' and women into simply a sex as such ... And finally, having created these differences, it declares them to be 'natural' again, in order to render them economically exploitable." Claudia von Werlhof* [2]

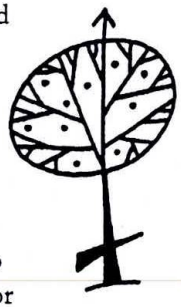
Every society prescribes different norms for girls and boys, women and men, which determine almost every aspect of their lives, and their futures. Let's just look at the more obvious ones.

Dress

Girls and boys, women and men dress differently in most societies. In some places this difference may be minimal, at others very stark. In some communities women are made to cover their bodies from top to toe, including their faces. The mode of dress can and does influence the mobility, sense of freedom and dignity of people.

Attributes

In most societies women are expected to have and perfect qualities such as gentleness, caring, nurturing and obedience; men are expected to be strong, self-confident, competitive and rational. Vasanth Kannabiran, an Indian feminist, once said in a gender training, "Rearing of children is supposed to be as natural, as inherent to a woman as giving birth to children. . . And it is not just in relation to the children we produce; it is assumed that love or



motherhood is sitting in me waiting to flow out like a stream to anybody who needs it. We become eternal mothers. So I mother my child, other people's children, my husband, my brothers, my sisters, my father who actually calls me 'my little mother' ! To everyone I become a mother by extension. You are expected to overflow with a motherly feeling towards the entire universe. And this is supposed to be natural ! Not work at all. It is something you do as easily as breathing, eating or sleeping." [3]

Roles and responsibilities

Men are considered to be the heads of households, bread-winners, owners and managers of property, and active in politics, religion, business and the professions. Women, on the other hand are expected and trained to bear and look after children, to nurse the infirm and old, do all household work, and so on. This determines their education or lack of it, preparation for employment, nature of employment, etc. However, the degree of differentiation between male and female roles varies widely. Sometimes the rules are merely preferential, and very little anxiety is shown by either sex over temporary role reversals.

> *"Cora du Bois reports that in Alor, although there are distinctions between the economic roles of the sexes, it is not thought unhealthy for anyone to take on the other sex's work — rather they are admired for possessing a supplementary skill. The women control the subsistence economy and the men occupy themselves with financial deals, but many men are passionate horticulturists and many women have financial skills. In some cultures, on the other hand, where horticulture is defined as a female pursuit, a proclivity for it in a man is regarded as proof of sexual deviation. In yet others, a special category may even be created for females who excel in pursuits assigned to both sexes." Ann Oakley* [4]

Other societies impose rigid sex roles. The Mundurucu Indians of Central Brazil, again according to Ann Oakley, are an example of a society in which the polarisation of sex roles and sex groupings has become a primary social element. The physical and social separation of the sexes is virtually complete: men and boys live in men's houses separate from females. Each sex group, (with the exception of small children) interacts only within itself, and antagonism between the two is shown on many ritual and other occasions. The sexual polarity pervades not only economic tasks and social roles, but the area of personality as well, where it takes the form of a concern with dominance and submission. Anxiety about people's ability to stay within the prescribed sex roles and personality types, and about the real and imaginary desire to transcend them, is expressed in many pieces of folklore and ritual." [5]

To the outsider, western societies seem to have very little gender differentiation, but as Ann Oakley points out, "In western societies today, sex *is* an organising principle of social structure, and despite popular belief to the contrary, it plays a great part in determining social roles. So it is not surprising to find that, as among the Mundurucu, a great deal of anxiety in western culture has its roots in the demands made by gender roles. Psychiatrists tell us that a great deal of our security as adults comes from staying within the boundaries of these roles — we must stay within them if mental health is to be preserved." [6]

Could some of these differences arise because girls and women are biologically weaker ?

Actually, biologically speaking men are the weaker sex and the Y chromosome (found only in men) is responsible for many handicaps.

A list given by Ashley Montagu in his book *The Natural Superiority of Women* contains 62 specific disorders due largely or wholly to sex-linked genes and found mostly in males. "About half of them are serious, and include haemophilia (failure of the blood-clotting mechanism), mistral stenosis (a heart deformity) and some forms of mental deficiency. . . At every stage of life, beginning with conception, more genetic males die than genetic females. More males than females are produced and the two facts of greater mortality and greater production seem to go hand in hand."

Although X and Y sperms appear to be produced in equal numbers, between 120 and 150 males are conceived to every 100 females. By the time of birth the ratio of males to females has dropped to about 106:100 in the US (whites only) and in Britain to about 98:100. More males than females are miscarried or stillborn, and more males than females die of birth trauma; 54% more males than females die of birth injuries and 18% more of congenital malformations.

"In fact the life expectation of the female at birth is almost universally higher than that of the male. In Britain, life expectation at birth is 74.8 years for females, but 68.1 for males; in China it is 65.6 and 61.3 respectively; in Brazil, 45.5 and 41.8. [7]

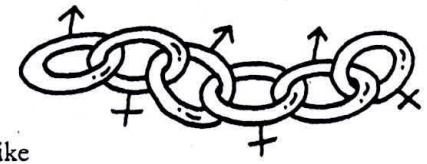
Ann Oakley provides ample data from research studies to show that men are much more susceptible to infectious diseases and mortality. According to her this susceptibility "has been directly connected with the difference in chromosomal make-up between male and female. Genes controlling the mechanisms by which the body withstands infection are transmitted via the X chromosome. . . the male's higher susceptibility has a distinct biochemical basis." [8]

In South Asia however the biological superiority of women has been overshadowed by the social and cultural inferiority imposed on them and today, in almost every area, women lag behind men.

> **Aristotle** *called the male principle active, and the female, passive. For him a female was a "mutilated male", someone who does not have a soul. In his view the biological inferiority of a woman also makes her inferior in her capacities, her ability to reason and therefore to make decisions. Because the male is superior and the female inferior, men are born to rule and women born to be ruled Aristotle said "The courage of a man is shown in commanding, of a woman in obeying."* [9]
>
> **Sigmund Freud** *stated that for women "anatomy is destiny". Freud's normal human was male, the female was a deviant human being, lacking a penis, and her entire psychology supposedly centred around the struggle to compensate for this deficiency.*
>
> *And here's what* **Mr.Darwin** *had to say about women:*
> *"Woman seems to differ from man in mental disposition, chiefly in her greater tenderness and less selfishness. . . It is generally admitted that with women the powers of intuition, or rapid perception, and perhaps of imitation, are more strongly marked than in men; but some, at least, of these faculties are characteristic of the lower races, and therefore of a past and lower state of civilisation."* [10]

Are you saying that biological differences between women and men are of no consequence at all ? That the fact that women produce children has nothing to do with the roles they are assigned in society ?

We are not denying that there are some biological differences between males and females, but the fact that gender roles vary so much between cultures shows that they cannot be based on or explained away by sex alone. We should remember a simple rule of science — **variables (gender roles) cannot be explained by constants (genitalia and chromosomes or sex).** If biology alone determined our roles, every woman in the world should be cooking, washing and sewing but this is clearly not the case because most professional cooks, launderers and tailors are men.



What we are saying is that neither sex nor nature is responsible for the unjustifiable inequalities that exist between women and men. Like the inequalities between castes, classes and races, these too are man made; they are historical constructs and therefore they can be questioned, challenged and changed. A woman may well have children but that should be no reason for her inferiority and subordination; nor should it determine her education, training or job opportunities. Why should having different bodies and different functions lead to inequality ? You do not have to be the same to be equal, to have equal rights and opportunities.

Maria Mies, a feminist activist and scholar writes in The Social Origins of the Sexual Division of Labour

"... male-ness and female-ness are not biological givens, but rather the result of a long historical process. In each historic epoch male-ness and female-ness are differently defined, the definition depending on the principal mode of production in those epochs. . . Therefore, men women develop a qualitatively different relationship to their own bodies. Thus in matristic societies, female-ness was interpreted as the social paradigm of all productivity, as the main active principle in the production of life. All women were defined as 'mothers'. But 'mothers' then had a different meaning. Under capitalist conditions all women are socially defined as housewives (all men as breadwinners), and motherhood has become part and parcel of this housewife-syndrome. The distinction between the earlier, matristic definition of female-ness and the modern one is that the latter has been emptied of all active, creative, productive (i.e. human) qualities."[11]

If this is so can you tell us how society turns males and females into masculine and feminine beings ?

This happens through a **process of socialisation or gendering;** an on-going process within families and society.

All of us know that a new-born baby is not only immediately classified by sex, it is also assigned a gender. We have already seen how in some cultures even the welcome given to a new-born child is different. This is followed by the difference with which they are addressed, handled, treated and clothed and, through this regulation, taught how they should behave to be part of the society they

are born into. This is called **socialisation.** The specific process of socialisation which teaches children their gender roles is also called **gendering** or **gender indoctrination.** Different social mechanisms teach children masculinity and femininity of personality and make them **internalise** behaviour, attitudes and roles.

According to Ruth Hartley, socialisation takes place through four processes, namely, manipulation, canalisation, verbal appellation and activity exposure, explained below. All four processes are normally differentiated by sex and all are features of the child's socialisation from birth on.[12]

By manipulation or moulding is meant **the way you handle a child.** It has been noted that boys are treated as strong, autonomous beings right from the beginning. In some cultures mothers fuss with the baby girl's hair, dress her in a feminine fashion and tell her how pretty she is. These physical experiences of early childhood are very important in shaping the self-perception of girls and boys.

The second process, **canalisation involves directing the attention of male and female children to objects or aspects of objects.** Examples of this are giving girls dolls or pots and pans to play with, and encouraging boys to play with guns, cars and aircraft. In working class homes in South Asia girls don't play with pots and pans, they are made to start cleaning **real** pots and pans, and **real** homes, looking after **real** babies while they are still very young; whereas boys are sent to school or made to work outside the home. Through this kind of differential treatment the interests of girls and boys are channellised differently and they develop different capabilities, attitudes, aspirations and dreams. Familiarity with certain objects directs their choices.

Verbal appellations are also different for boys and girls. For example, we often say, "Oh, how pretty you look" to girls and to a boy, "You are looking big and strong." Research studies show that such remarks construct the self-identity of girls and boys, men and women. Children learn to think of themselves as male or female and so to identify with other males or females. Family members constantly transmit aspects of gender role directly in the way they talk even to very young children, and they also convey the importance given to each child.

The last process is that of **activity exposure**. Both male and female children are exposed to traditional masculine and feminine activities from their very childhood. Girls are asked to help their mothers with household chores, boys to accompany their fathers outside. In communities where the sexes are segregated, girls and boys live in two distinct spaces and are exposed to very different activities. It is through these processes that children imbibe the meaning of masculine and feminine, and internalise them almost unconsciously.

If this process of socialisation is an on-going one then why is it that the debate between "nature" or "nurture" still continues ? Isn't it obvious that upbringing is responsible for differences between girls and boys ?

The amazing thing is that many of us are not always aware of what we are doing to our children. In fact we may believe we treat girls and boys differently because they are actually different. We may not accept that our daughters and sons develop differently because of the way schools, communities and we ourselves treat them.

Children also learn these roles without being aware of the fact that they are being moulded. If there were no differences between girls and boys, and **all** girls and **all** boys everywhere behaved more or less in the same way, one could argue that gender roles are based on sex, but as we have seen that is not the case.

Sanctions or disapproval against children and adults when they deviate from their gender roles is another very powerful way of making everyone conform to expected male-female behaviour. The most common form of sanction is **social ridicule.**

The worst case I have come across of a backlash against women who dared to deviate, is from in a village in Kerala. Three young women workers saw their male colleagues go into a local pub every day. One day they decided to do the same just for fun. That led to all kinds of men following them and approaching them for sexual favours. Because they had dared to walk into a place where "good" women do not enter, they were defined as "bad". The logic was "If you can walk into a pub, you should be available for sexual pleasure too." Not being able to deal with the social ridicule and harassment that followed two of the girls committed suicide.

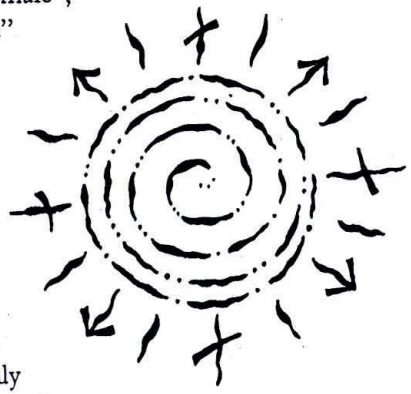
In addition to social sanctions there are also "economic sanctions" and, according to Ann Oakley, the severe problems confronting single women with children, and their economic difficulties are an index of society's disapproval of them. Often, families threaten or refuse to financially support children who deviate from set norms and practices.

Can you elaborate on this business of labelling certain characteristics and qualities as masculine, and others as feminine ?

Certain dualities have come to be defined as male or female when they need not necessarily be either. For example:

Body	Mind
Nature	Culture
Emotion	Reason
Subject	Object
Private	Public

With those on the left being "female", and the ones on the right, "male"



Not only have the two been ranged as polar opposite, a hierarchy has been created between them. Mind is supposed to be superior to body, and culture an improvement on and superior to nature. Those who are rational and objective are valued more highly than those who are subjective and emotional. Women are the bodies, almost like nature (they breed like animals); men are the minds, thinking, rational, acting beings who work on nature and transform "it" into culture. Men are therefore superior, over and above nature, they can do with nature what they please.

Not only do women belong to the left side of the above-mentioned dualities, the indigenous and poor are also categorised as such. This is why tribals, forest-dwellers, small peasants and fisherfolk can, like women, be treated with disregard by development planners. Their forests can be cut and lands taken over without their knowledge or consent. This is how millions of them become "development refugees" and end up in horrible slums in urban centres to eke out a living in the most dehumanising conditions.

At the global level, the third world or the South is considered Body, the first world, the Mind; third world is Nature, first world Culture;

third world is emotional and irrational and first world rational, scientific, modern.

It is important to understand these connections between gender and other hierarchies of class, caste, race, first world and third world, etc.

> *"Three hundred years of witch-hunting, running parallel with the colonisation of the world, were necessary to snatch from the women—as from Third World people—their power, their economy and their knowledge, and to socialise them into becoming what they are today: housewives and the 'underdeveloped'. The housewife— and with her the 'underdeveloped'—is the artificial product, resulting from unimaginably violent development, upon which our whole economy, law, state, science, art and politics, the family, private property and all modern institutions have been built. The Third World is the 'witch' of witch-hunting days and is the 'general-housewife', the 'world housewife' today including Third World men. The relation between husband and wife is repeated in the relation between the First and the Third World." Claudia von Werlhof* [13]

Not just qualities and characteristics, but even **spaces** are gendered. A pub, football stadium, street corner, tea-shop, paan shop, cinema hall can all become male spaces. Women normally go into them accompanied by some men. If they cannot help going into them alone they are expected to leave as fast as possible, if they do not wish to get into trouble. Under no circumstances should they consider lingering around like the men.

Similarly the kitchen or public well is almost entirely a female space. I am at a loss to find a social space that is exclusive to women.

They have no space for entertainment or work which is theirs alone. In Dhaka some women have started a weekly "*adda*" — a term generally used for a gathering of men where they chat, eat, drink, and enjoy themselves. Many men and some women objected to the use of the word "*adda*" by women because the very concept of "*adda*" was male — not "respectable" enough for women. Words and activities which are fine for "respectable" men are not considered good enough for "respectable" women. This is patriarchal logic.

Even within the home, a quiet room or space might be reserved for the man so that he is not disturbed by the rest of the household. It has been pointed out to me in workshops that household resources or items too, may be gendered. For example the larger glass, chair, or bed are reserved for the (male) head of the household. In working class homes the bicycle, radio, wrist-watch are all for men.

Isn't language also gendered ?

Indeed it is. Language is patriarchal and therefore carries and reflects gender biases and inequalities. Often men have a vocabulary of their own which women seldom use. The most obvious example of this is words of abuse with sexual connotations, commonly used by men. Although men use them without any hesitation, they are horrified if any woman does.

Our languages are also replete with proverbs and sayings which show women to be inferior to men; refer to them as being sinful, mean and quarrelsome. There is an oft-repeated couplet in Hindi which says a drum, an uneducated or low caste person and women, all deserve to be beaten. "A woman's heaven is in her husband's feet" is a proverb repeated all the time by some maulvis. In Bangla there is a saying, "Unlucky is the man whose cow dies. Lucky is the man whose wife dies."

Then there is the use of the masculine as the standard, the norm. 'Mankind', 'he' and 'his' are used even when the reference is to women. Words like chairman, newsman, sportsman, one-man-show and hundreds of others are commonly used for women in these roles — although this practice is now changing.

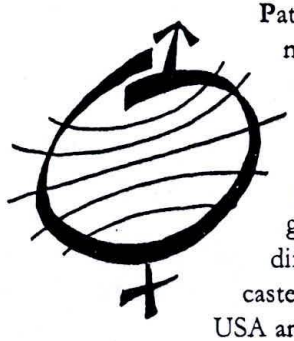
> *The language of social sciences, philosophy and other disciplines also continues to be patriarchal and ignores, marginalises or misrepresents women. The mode in which abstract thought is cast and the language in which it is expressed are so defined as to perpetuate women's marginality. We women have had to express ourselves through patriarchal thought as reflected in the very language we have had to use. It is a language in which we are submitted under the male pronoun and in which the generic term for "human" is "male". Women have had to use "dirty words" or "hidden words" to describe our own body experiences. The vilest insults in every language refer to parts of the female body or to female sexuality." Gerda Lerner*[14]

Another point worth mentioning here is that certain terms and roles in our languages **are gender ascriptive** (where gender is built in) like uncle-aunt, brother-sister, mother-father because they indicate the gender or sex of the person. But there are a host of others which are not gender ascriptive but it is assumed that they refer to a man or a woman. For example, secretary, nurse, kindergarten teacher are assumed to refer to women whereas boss, pilot, manager, politician, surgeon, or farmer refer to men. These assumptions only prove that public spaces and jobs continue to be dominated by men. Women are few and far between, especially in decision-making and managerial positions.

You have used the word patriarchy so often and have implied that patriarchy is the cause of gender inequalities and the subordination of women. Can you explain this term?

It is important to understand patriarchy in order to understand present-day relations between women and men. Gender relations are skewed because of the existence of patriarchy. In common parlance patriarchy means male domination; the word "patriarchy" literally means the rule of the father or the "patriarch", and was used originally to describe a specific type of "male dominated family"—the large household of the patriarch which included women, younger men, children, slaves and domestic servants, all under the rule of this dominant male. Now it is used more generally to refer to male domination, to the power relationships by which men dominate women, and to characterise a system whereby women are kept subordinate in a number of ways. In South Asia, for example it is called *pitrsatta* in Hindi, *pidarshahi* in Urdu and *pitritontro* in Bangla.

The subordination that women experience daily, regardless of the class we might belong to, takes various forms—discrimination, disregard, insult, control, exploitation, oppression, violence — within the family, at the place of work, and in society. The details may be different but the theme is the same.



Patriarchy is not the same everywhere. Its nature can be and is different in different classes in the same society; in different societies and in different periods in history. For example the experience of patriarchy was not the same in our grandmother's time as it is today; it is different for tribal women and for upper caste Hindu women; for the women in the USA and women in India. Each social system or

historical period throws up its own variations on how patriarchy functions and how social and cultural practices differ. The broad principles, however, remain the same i.e., men control most economic resources and all social, economic and political institutions.

Patriarchy is both a social structure and an ideology or a belief system according to which men are superior. Religions have played an important role in creating and perpetuating patriarchal ideology. They have spread notions of male superiority through stories like, Eve was created from Adam's rib; or man is created in the image of God, etc. Today, media and even educational institutions spread patriarchal ideology by showing men to be stronger in decision-making positions, and women as voracious consumers, dependent and jealous. Ideology plays an important role in perpetuating social systems and controlling people's minds. For example, by reducing women to bodies and objectifying them, media encourage violence against women. Ideology provides the justification for social behaviour and socio-economic structures.

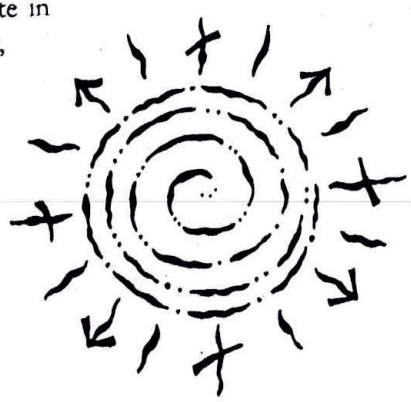
Normally the following areas of women's lives and societies can be said to be under patriarchal control.

Women's productive or labour power
Women's reproduction
Women's sexuality
Women's mobility
Property and other economic resources
Social, cultural and political institutions[15]

An analysis of the main institutions in society—the family, religion, law, political, educational and economic institutions, media, knowledge systems—demonstrates quite clearly that they are all patriarchal in nature, and are the pillars of a patriarchal structure. This well-knit and deep-rooted system makes patriarchy seem invincible; it also makes it seem natural.

Under patriarchy different kinds of **violence** may be used to control and subjugate women and such violence may even be considered legitimate. In fact, feminists believe that violence against women is not just pervasive, it is systemic in patriarchies.

All this does NOT imply that women are totally powerless or without rights, influence and resources under patriarchy. In fact, no unequal system can continue without the participation of the oppressed, some of whom derive some benefits from it. This is true of patriarchies as well. Women have risen to power, have occasionally been in control, have wrested benefits in greater or smaller measure. But all this does not change the fact that the **system** is male-dominated — women are merely accommodated in it in a variety of ways. To give a parallel example, in a capitalist economy workers play a very important role, they may even participate in management to some extent, but this does not mean they are ever in control. For a variety of complex reasons women also support and perpetuate patriarchy. Most of us have internalised its values and are not always free of patriarchal ideology.



In order to retain their privilege women continually renegotiate their bargaining power, so to speak, sometimes at the cost of other women. But it is important that we look at the overall system and analyze the reasons for this complicity. It is true that women often treat their sons better, deprive their daughters of education, restrict their freedom, mistreat daughters-in-law and so on. All this needs to be understood in the context of the respective power and position that men and women have in the family and in society. A rural woman explained this very well. She said "Men in our families are like the sun, they have a light of their own (they own resources, are mobile, have the freedom to take decisions, etc.) Women are like satellites, without any light of their own. They shine only if and when the sun's light touches them. This is why women have to constantly compete with each other for a bigger share of sunlight, because without this light there is no life."

The appropriate way to describe male control over women is **paternalistic dominance**. There is dominance but it is paternalistic because women are provided shelter, food and security vis-à-vis outsiders. Paternalistic dominance has oppressive aspects, but it also involves a set of mutual obligations and is frequently not perceived as oppressive. This is what makes it difficult to recognize and fight.

How liberating was national liberation?

Although national liberation movements ended the political control by colonial powers and introduced the principle of separation of legislative from judicial and punitive powers, women were not liberated from the rule of husbands, or fathers, in the household. Within the home men still retain consolidated and arbitrary powers to determine the rules, judge the performance, and punish their wives and children. Thus men have the capacity to :

- *demand sexual relations at any time;*
- *prevent their wives from practicing contraception;*
- *determine how wives and daughters could and should spend their time in domestic work, in education, leisure or cultural activities, and determine the terms on which they enter the public space for employment;*

- *exert punitive or corrective violence against women when they judge the rules infringed, and not be subject to legal retribution for this;*
- *use and dispose of wives' earned or inherited property; and*
- *buy and sell wives/daughters, or dispose of them to meet debts or to compensate for insult by other males.*

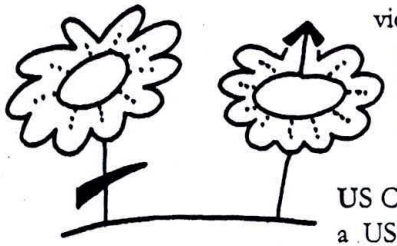
Many of these presumptions and behaviours are translated into relations with women in the outside community, the workplace and political spaces. [15]

Don't education and overall modernisation or development bring in equality between men andwomen?

Not necessarily. Very often education itself is patriarchal, it justifies, perpetuates or ignores inequalities between women and men. Any number of analyses of textbooks and children's literature have shown the gender bias in them, in favour of men. This bias continues in almost all academic disciplines and is one of the main battles being fought by the women's movement and women's studies practitioners, everywhere.

HISTORY is HIS STORY.
To get a complete picture of the world
we also need HER STORY

Even a cursory examination of societies like the UK and the USA which have had universal education for a long time and are supposed to be modern, industrialised and egalitarian, show that gender inequalities persist in them. Men are still considered heads of households inspite of the fact that both countries have large numbers of female-headed households. Over 50 per cent women in these societies experience physical violence at the hands of their husbands, and there is a high incidence of rape and physical



violence. Within the US, the Equal Remunerations Act has still to be passed, and abortion is a criminal offence in many states.

US Census Bureau figures show that a US working woman, just out of college, earns 75 per cent of the salary offered to the men she studied with — and the older she gets, the further behind she finds herself. An Associated Press analysis of census statistics released in 1991 found that at every educational level, women earned less than men with the same amount of schooling.

Ann Oakley provides statistics to show tha
t in all industrialised countries there is a marked differentiation by gender in most, if not all, occupations. One occupation in particular, that of a housewife, is exclusively feminine. She further states that within industry there is a great deal of differentiation by sex. Most women, usually between a third and two-thirds of all working women, are concentrated in textile and clothing manufacture, and in food processing.

On the whole males command the majority of jobs with high prestige, high skill and high income, and this is true throughout the industrialised world. Of all managers of large establishments tabulated for Britain in 1966, 87 per cent were men and 13 per cent women. Women make up three per cent of all barristers in the USA, four per cent in Great Britain and seven per cent in Sweden. A mere 0.06 per cent of all engineers are female in Britain, 0.07 per cent in the USA and 3.7 per cent in France. While women in the professions receive the same rates of pay as men, in other jobs they do not: thus skill, prestige, financial reward and gender are interrelated in a complex but consistent fashion. [17]

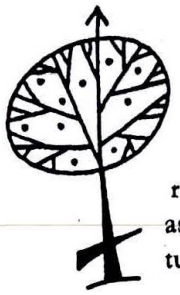
Vast differences persist in higher education, too. According to Ann Oakley, "It is at the highest levels of education that the disparity

is most marked. For every hundred people aged 20 to 24 in higher education in 1965, there were 6.6 females in the UK, 5.3 in Denmark, 2.3 in Switzerland and 15.2 in Bulgaria. While women made up about two-fifths of the intake of university students in Britain in 1967, women take less than a third of all final degrees and only about one-ninth of all higher degrees." These facts clearly reflect the situation in so called advanced nations that education is more important for a boy than it is for a girl. The subjects girls and boys study also reflect this disparity. In the United States in 1964, 46 per cent of masters' degrees in education were gained by women but only 10 per cent of these in science. Of all those studying medicine, dentistry and health in Britain in 1967, two-thirds were men.[18]

These statistics from industrialised countries, capitalist or socialist, indicate that gender hierarchies cannot be removed by education or development alone, **if no serious attempts are made to change patriarchal structures and attitudes.**

If gender determines the status and role of women and men, doesn't it also determine relationships between men and women ?

Indeed it does. If you assign different values to gold and silver you automatically determine the relationship between the two; so too, does society determine the relations between men and women. Relations based on gender are called **gender relations. "The term gender relations refers to the relations of power between women and men which are revealed in a range of practices, ideas, representations, including the division of labour, roles, and resources between women and men, and the ascribing to them of different abilities, attitudes, desires, personality traits, behavioural patterns and so on. Gender relations are both constituted by and help constitute these practices and ideologies in interaction with other structures of social hierarchy such as class, caste, and race. They may be seen as largely socially constructed (rather than biologically determined), and as variable over time and place."** [19]



Like gender, gender relations **are not the same in every society, nor historically static. They are dynamic,** and change over time. However, one can generalise and say that in most societies gender relations are not equitable.

This understanding challenges the assumption that, within households, relations between women and men are harmonious and without conflict. In fact, there is both co-operation and conflict, harmony and disharmony. In other words, there is **politics** in gender relations. Here the term "politics" refers to the fact of power play in any relationship. Because people are assigned differing amounts of power, authority and control (over other people, resources, decision-making), subtle or blatant power games or politics taking place between genders within the family, at the work-place and in society at large just as they do between castes, classes and races.

Theoretically gender hierarchy can mean the domination of either gender, but in practice it almost always means a hierarchy in which men dominate and women are dominated. A common aspect of gender relations across cultures and throughout recent history is the subordination of women to men. Gender relations therefore are **relations of dominance and subordination** with elements of co-operation, force and violence sustaining them. This is so because most societies are patriarchal or male dominated. One can also say, that in most societies, gender relations are patriarchal in nature, they follow the rules of patriarchy — an ideology and social system whereby men are considered superior to women, are dominant and control most resources and social institutions.

Not only does gender determine relations between women and men, it may also influence relations between men, and between women. In South Asia where gender hierarchies are particularly uneven, gender is a very strong organising factor. In North India for example, the social relations between the bridegroom's father and the bride's father are illustrative, with the former generally considered superior and worthy of greater respect. The bride's father is always considered to be in a lower, subservient position merely because he is the father of a girl.

Examples of gender often determining relations between two women are those between a mother-in-law and daughter-in-law (*saas-bahu*); between a woman and her brother's wife *(bhabhi)* or husband's sister (*nanad);* or relations between the two mothers-in-law. In all these, the women who are connected to the bridegroom automatically occupy a superior status to those who are related to the bride.

> *Thomas von Aquinas, an otherwise intelligent and god-fearing Christian leader who lived in Germany some three hundred years ago, said women are like weeds, they grow so fast because they are of little worth. (Men of course are the main crop, the cash crop in today's world !)*

To be considered equal to men women have to be twice as good as men. .....Fortunately that's not difficult....

What exactly do you mean by politics within the family and women's bargaining power being negotiated all the time ?

We have already seen that all members of a household do not have the same access to resources, services and

opportunities. Based on these inequalities, several social scientists see the family as a place of bargaining and contestation, where power is negotiated. The well-known economist, Amartya Sen, calls this a co-operation and conflict model. Bina Agarwal, a feminist economist, has developed this concept further, and according to her the household/family is a complex matrix of relationships in which there is ongoing negotiation, subject to constraints set by gender, age, type of relationship and "undisputed traditions". Gender interactions within the family as well as in the community, market and state contain elements of co-operation and conflict. Two parties agree to cooperate when such co-operation leaves them better off than non-co-operation.

Bina Agarwal maintains that a rural person's bargaining power will depend on his/her fall-back position, which in turn depends on five factors, in particular.

- private ownership and control over assets, especially arable land
- access to employment and other income-earning means
- access to communal resources such as village commons and forests
- access to traditional external social support systems
- access to support from the state or from NGOs

"These five factors impinge directly on a person's ability to fulfil subsistence needs outside the family. The premise here is that the greater a person's ability to physically survive outside the family, the greater would be her/his bargaining power (at least in relation to resource sharing for subsistence) within the family. Inequalities among family members in respect of these factors would place some members in a weaker bargaining position relative to theirs. Gender is one such basis of inequality, age another." [20]

To give just one example: women's income-earning capacity, when realised, places them in a stronger bargaining position vis-à-vis other members of the household, especially if their income is for the family's survival. Similarly, their access to or control over resources like land, money, or other assets reduces their dependent status, and enables them to negotiate a better status within the family.

How do our other identities like religion, caste and class affect gender and gender relations?

All of us have multiple identities. For example, in addition to being a woman, a person may be Hindu, middle class, upper or lower caste, married, etc. Gender interacts with the other identities, impacts and is impacted by social and economic factors, as well as by ethnicity, race, age and marital status. In society **all** women are not subordinate to **all** men. For instance, a rich woman because of her class affiliation, is in a position to dominate the men who work for her as domestic help. In this case a woman's **class** is more important than her **gender**. In other cases, a "lower" caste/class woman may be doubly exploited by an upper caste/class man. In some communities in India, for example, a lower caste bride is obliged to spend her first night as a married woman with the upper class landlord.

The existence of separate personal laws based on different religions also affects gender relations. Muslim Personal Law for example, allows polygamy and unilateral divorce for men; Christian Law does not recognise adultery by a man as cause for divorce; the Hindu Code does not allow adoption of children by parents of two different religions, and so on. And all religious laws favour men in matters relating to property rights and inheritance.

> *"Sexual exploitation mainly in the form of rape, is a means used by the ruling classes to discipline the exploited classes. In order to punish rebellious poor peasants and landless labourers, landlords and police are not satisfied with beating up men and burning their huts; in many cases they also rape their women. Why? Obviously, these rapes are not, as is often believed, a kind of safety valve for the repressed sexual urges of the rapists. In fact, these acts have nothing to do with sexuality as such, neither are the targets the women as such, but rather the men of the poor classes. Women are seen as the only property that the pauperised men still possess. The rape of their women teaches poor men the lesson that their status is one of absolute powerlessness and propertylessness. This sexual aggression on the part of landlords and police against poor women is a weapon with which to beat the men of the propertyless classes and to stabilise the existing or newly emerging power relations in the countryside. Class rule and the oppression of women are here closely interwoven. He who owns the land owns the women of the land." Maria Mies* [21]

Similarly there may be differences between people belonging to different races or ethnic groups. "Upper" caste women generally face more restrictions on their mobility than "lower" caste women because they have to preserve caste purity and superiority. Generally speaking, "upper" castes are much more male dominated or patriarchal because they are concerned about caste purity as well as patrimony or controlling property. This is why "upper" caste families impose restrictions of dress and mobility on their women, thereby controlling women's sexuality. Because "lower" castes have no purity to safeguard their women are not similarly restrained.

There is also a difference between the social, economic and political status of men and women belonging to different classes. Those of

the bourgeoisie or propertied classes have greater access to economic resources, education and information; they control social, economic and religious institutions in a way that people belonging to the working classes do not. There are differences between the roles, responsibilities and privileges of bourgeois women and working class women. Engels noted an important difference between bourgeois and working class women: the former in his analysis, does not work outside the family, she is totally dependent on her husband, she is property herself. Her only function is to produce heirs. The working class woman, on the other hand, has already broken her oppression by being a worker and hence attaining some economic independence.

Working class women also do not observe purdah or sex segregation, because they are obliged to enter public spaces to make a living. It has been observed that small farming households discourage their women from working outside the home when their economic condition improves. Women who remain within the household, being dependent, or in seclusion are considered a symbol of social status in many patriarchal societies.

Can you explain what is meant by the term "gender division of labour"?

Gender division of labour or sexual division of labour, refers to the **allocation of different roles, responsibilities, and tasks to women and men based on societal ideas of what men and women should do and are capable of doing**. Different tasks and responsibilities are assigned to girls and boys, women and men according to their sex-gender roles, and not necessarily **according to their individual preferences or capabilities**. All work/activities can be divided into three categories—productive, reproductive and community work/activities. Let us examine each of these for a "gender division of labour".

PRODUCTION refers to that activity which produces goods and services for consumption and trade. All work done in factories, offices and farms, falls into this category, and it is only these activities that are counted as economic and included in the Gross National Product of countries. Although both women and men are involved in productive activities the gender division of labour prevails. Men do jobs which are more skilled and better paid. Often women's productive activities are an extension of the work they do at home. In the agricultural sector, women's productive work is not reflected in economic accounting because it is considered an extension of their household work. Women's productive activities are given less importance and less value. Women are the last to be hired because of the patriarchal notion that men are the main breadwinners and are heads of households. Therefore, male employment is given greater emphasis and priority.

REPRODUCTION is of two kinds — **biological** and **social**. Biological reproduction refers to giving birth to new human beings, an activity which only women can perform. Social reproduction refers to all the caring and nurturing activities necessary to ensure human survival and maintenance. Reproductive activities, thus, are those activities which reproduce human labour. Caring of children, cooking, feeding, washing, cleaning, nursing and other household activities fall in this category. Although they are necessary for human survival they are neither considered work, nor an economic activity and hence are invisible, unrecognised and unpaid. Reproductive work is carried out mainly by women and girls across the world.

COMMUNITY work refers to all those activities necessary to run and organize community life. Governance, the organisation of and participation in social and cultural festivals, social services and

facilities like roads, schools, health care, etc. are all community activities. Both men and women participate in these but, again, according to prescribed norms which define "male" activities and "female" activities.

Gender division of labour, therefore, operates not only in reproductive activities within the household but in productive and community activities as well, most of which take place outside the household. The gender division of labour is now considered a key concept to understand how gender inequalities or asymmetries are kept in place and reconstituted.

In time this division leads to a gender division of skills. Men and women, boys and girls learn and master only those skills considered appropriate to their gender roles. Thus, different skills and aptitudes are created in women and men, girls and boys, and are then ascribed solely to one or the other.

Gender division of labour also leads to hierarchies and inequalities because men and women's labour is not valued or rewarded equally. Even now, equal pay for equal work is not the norm in most countries; housework is unpaid; and women are the first to be fired when recession hits the workplace.

The allocation of certain tasks to men and women in productive processes (specially in household production) also leads to issues of command and control over resources and the products of labour. Thus, because of a gender division of labour, men assume control over land; technology; credit; cash from the sale of products, and so on. Normally, women produce for subsistence and men for exchange or cash.

Like gender and gender relations, the gender division of labour is also not the same everywhere. It is specific to culture, location and time. To challenge the gender division of labour in society means challenging what being a "man" or a "woman" in a society entails.

Women's productive and reproductive work is generally not assigned much economic value. According to the UNDP Human Development Report of 1995 the invisible and unpaid work contributed by women, annually, is worth US $ 11 trillion.

"The husband has 'the queen of the commodities' i.e. money, in his pocket, but the wife is not paid for her work. The husband must give her only board and lodging, as he would also have to do for a slave. The housewife's working hours, conditions of work, holidays, leisure are not settled by contract; the marriage contract is not comparable to an employment contract. There is no right to strike, no sisterly organisation of housewives; they are instead , individualised and atomised. They enjoy no social security on the basis of their work as housewives, nor are they protected by law from the despotism and violence of their husbands. In the home nobody ensures the observance of human rights, hence they are a private affair, which allegedly do not concern the public even when there is no guarantee of physical safety.

The wife must serve, and above all, obey the husband; he can demand this in a court of law. In short the housewife is an unpaid worker, at the disposal of her husband, round the clock, all her life; even more, her whole person is at his disposal, including her sexuality and child-bearing capacity, her psyche and feelings, She is at the same time slave and serf who is compelled to do all the work that her husband and children need, including demonstrating love even when she does not feel any. Here one works out of love and love becomes work.

The situation may not always be intolerable, but it is impossible to predict that it will not become so." Claudia von Werlhof [22]

Irrespective of class or caste women do in the family what "shudras" or "menial" workers do in society. Within every household women are the "shudras" and men the "twice-born" or "upper castes". Women are the providers of services, even in bourgeois or upper caste households. Like the "shudras" therefore, women are considered "unclean", "impure", unfit for the superior pursuits of religion and spirituality, education, etc. Because menial jobs are not considered important or of much value, women's work is totally unpaid and unrecognised when performed at home, and underpaid when performed outside.

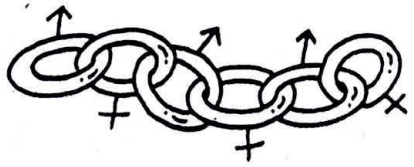
Women's work outside the home is often an extension of their work in the family. For example, a large number of women work as kindergarten and primary school teachers or nurses and airhostesses. Jobs which entail authority, power and control are considered men's jobs and jobs involving caring, nurturing, servicing are seen as women's jobs. **Women are subservient at home**, they continue to be subservient outside. **Men are in a position of power** and control at home, they continue to be in similar positions in the outside world. Men are better educated and better trained and they do not have to carry the double burden of work, so their professional graph rises much higher than that of women.

"Everything that women do must bear fruit and be gratis, like the air we breathe. This applies not only to producing and rearing children, but also to the sundry housework and wage labour, the emotional care bestowed on colleagues, the friendliness, submissiveness, being-always-at-others-disposal, healing-all-wounds, being sexually-usable, the-putting-everything-again-in-order, the sense of responsibility and self-sacrifice, frugality and unpretentiousness, the renunciation in favour of others, the putting-up-with and helping-out-in-all-matters, withdrawing-oneself and being-invisible and always-there, the passive being-available and the active 'pulling-the-cart-out-of-the-mud', the endurance and the discipline of a soldier. All this makes up the feminine work capacity." Claudia von Werlhof [23]

" When the Taliban leadership takes over in Afghanistan, the first instruction they issue is that men should wear skull caps and grow beards while women should cover themselves and remain indoors. Women are prohibited from working or using public baths. It is interesting to see the connection between a new political regime and the gender regime that comes into force and the way a gender division of labour is reinforced. The sexual division of labour therefore is not a structure in its own right. It is part of a system of production, consumption and distribution, which is structured by gender." Vasanth Kannabiran [24]

The gender division of labour is responsible for statistics like: globally, women hold only 14 per cent senior management positions (UNDP Human Development Report, 1995); the ratio between women's salaries and men's salaries in the US continues to be 3:5 and this has not changed in the last one hundred years. Seventy per cent of the world's poorest and illiterate people are women.

According to Maria Mies, we should no longer look at the sexual division of labor as a problem within the



family, but rather as a structural problem of society as a whole. The hierarchical division of labour between men and women and its dynamics form an integral part of dominant production relations, i.e., the class relations of a particular period and of society and the broader national and international division of labour.[25]

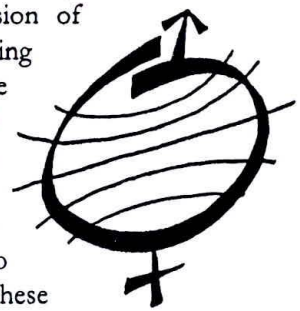
According to Joan Kelly, a feminist historian, we should look at property relations and women's relationship to work as the basic determinant of the sexual division of labour and sexual order. The more the domestic and public domains are differentiated, the more work and, hence, property are of two clearly distinguishable kinds. There is production for subsistence and production for exchange, and this is what influences the sexual division of labour.

But most people consider this gender division of labour natural. Because women give birth to children and breast-feed them, aren't they better equipped for caring and nurturing activities ?

Your use of the term "better equipped" is interesting. Women are indeed equipped with a uterus and a pair of breasts but they have no extra equipment for caring, cleaning or looking after; therefore it is not "natural" for them to be looking after everyone. And, let us not forget that men manage to sweep and clean and wash and cook when these activities are paid for, so the reasons for doing or not doing reproductive work cannot be biological or natural.

But because people want to believe that present gender relations and the gender division of labour are "natural", based on women's biology, they find it difficult to think beyond bodies. It's also very convenient to reduce everything to nature because then you don't need to question or challenge patriarchal privilege. You wash your hands off all responsibility. So often in gender workshops we have observed that men get extremely upset, agitated and belligerent

when we demonstrate that gender is socially constructed, that gender relations and the gender division of labour are not natural. They had a beginning and therefore can have an end. The challenge of feminism and the political work of the women's movement is to work towards an end to inequality based on biological difference. It is possible now — though still not common —to find examples in many societies where these so-called "natural " differences and division of labour have been changed.



Could some of this division of labour be the result of social conditioning because women are confined to the household and men deal with the outside world ?

This is an important but complex question, and it is not easy to provide a straightforward answer. First we need to understand the dichotomy between the private and public domains. Women are expected to remain in the private domain while men function in the public, while also controlling the private. Before the industrial revolution, however, this separation between the two was not so marked. Most production took place within the household and all members participated in it. Everyone was a "breadwinner". The household was the site of both reproduction and production. **There was co-operation and complementarity between men and women.** Women's skills, knowledge and their ability to reproduce the next generation were highly valued because they were indispensable for survival. In many ways this old order was **gynocentric** (woman-centred). Because of the important role women played in the household economy in colonial America the word "husband-woman" (the woman who managed, looked after, controlled or husbanded the affairs of the household) was commonly used.

The advent of the market economy and industrialisation dramatically upset the unity between private and public, the harmony between nature and human beings. Production was no longer a matter of subsistence alone — it was also intended for the market and for profit. Gradually production moved out of the household and into factories, commercial farms, and so on, and the market rather than nature became the controlling force in the lives of ordinary people.

The "economic man" moved out of the household and the "domestic woman" remained in it. Boys went to schools and universities to acquire knowledge and skills for operating in the outside world, while girls remained at home, acquiring skills for the "domestic" world.

> *"It was not only women's productive skills which gave her importance in the old order. She knew the herbs that healed, the songs to soothe a feverish child, the precautions to be taken during pregnancy. If she was exceptionally skilled, she became a midwife, herbal healer, or 'wise woman' whose fame might spread from house to house and village to village. And all women were expected to have learned, from their mothers and grandmothers, the skills of raising children, healing common illnesses, nursing the sick." Barbara Ehrenreich and Deidre English* [26]

What happened in Europe as a result of marketisation and industrialisation has also happened in South Asia. Here too, production moved out of the household, as did education. Earlier most people picked up knowledge and acquired their production skills in the household, and girls and boys both got educated at home in skills and activities which were necessary for survival.

Among tribals, forest dwellers and peasants living in remote areas of South Asia, even now production takes place largely within the household. Their economy is still primarily a subsistence economy; surplus production is exchanged with items not produced by the household, in the local market. Women and men share householding activities and there is little or no distinction between the public and private spheres. Compared to other classes and communities there is not much inequality between men and women either. Slowly these communities are also getting "integrated" into the market economy and becoming more "patriarchal" than they used to be.

> *"Because of changes in the mode of production the home ceases to be viewed as a centre of economic production and comes to be seen rather as a refuge from economic production, 'a haven from the heartless world', a 'utopian retreat from the city'. Reproduction remains in the family, production moves out. Household management loses its public character. It no longer concerns society. It becomes a private service and as Engels said, the wife becomes the head servant, excluded from participation in social production." Alison M.Jaggar* [27]

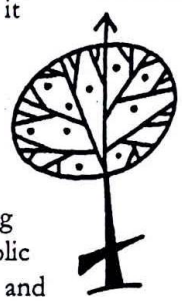
The distinction between the "public" and the "private" opens up new horizons and opportunities for men, but limits the place and functions of women. In a way, this is the end of the gynocentric order. Another consequence of the separation between the public and the private is the relative seclusion and isolation of women which follows. Women get excluded from society and separated from other women and men.

> *"The traditional productive skills of women — textile manufacture, garment manufacture, food*

processing — passed into the factory system. Women of the working class might follow their old labour into the new industrial world, but they would no longer command the productive process. They would forget the old skills. In time, even the quintessentially feminine activity of healing would be transformed into a commodity and swept into the Market. The home-made herbal tonic is replaced by the chemical products of multinational drug firms; midwives are replaced by surgeons." Barbara Ehrenreich and Deidre English [28]

But has this separation between "public" and "private" sharpened the inequalities between men and women ?

Yes it has. With the separation of the two, a hierarchy devel oped between them. The private or domestic sphere lost all economic, political and historical significance and became less and less important. That which does not enter the market is not considered "work", those who do not operate in it have no economic worth. Because women remained in the economically insignificant household, they lost their centrality, their value. Men's work became more important, the differences between women and men kept increasing, patriarchy became more powerful. From being gynocentric, households — and of course the public arena — became androcentric (male centred) and androcratic (male-ruled).



Gyne = Greek for woman
Andros = Greek for man
Gynecology = Science of psychological functions and diseases of women
Gynocentric = Woman-centred
Androcentric = Man-centred
Gynarchy = government by females
Gynocracy = women's rule
Androcracy = men's rule
Gynelatory = worship of women
Gynocide = killing of women
Gynophobia = aversion to or fear of women
Androgyny = presence of male and female characteristics in the same person

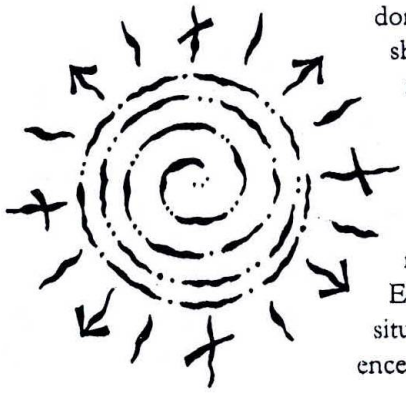
The basic **values** which govern the domestic and public spheres have also been sharply divided; in fact one can almost say they are **opposed** to each other. While in the private sphere love, caring, selflessness, understanding are appreciated, the public sphere requires and valorises competition, ambition, aggression, individualism. Women are expected to provide a haven for men at home, away from the ruthlessness of the market place.

Religion-based morality and values do not anymore have a place in economics, science or technology. Barbara Ehrenreich and Deirdre English have described this rupture very well: "This new ordering of the world is not to be imagined as a mere compartmentalisation along some neutral dividing line. The two spheres stand, in respect to the basic values, opposed to each other, and the line between them is charged with moral tension. In its most fundamental operations the market defies centuries of religious morality which (in principle, at least) exalted altruism and selflessness while it condemned covetousness and greed. In the Old Order commerce was tainted with dishonour, and lending money at interest was denounced as usury. But the market which imbibed the new order dismisses all moral categories with cold indifference. Profits can only be won by some at the price of poverty for others, and there is no room for human affection, generosity, or loyalty..."

From what you have said so far it seems that the greater the separation between the private and public spheres, the lower the status of women. Is this true ?

According to many feminist historians (and according to Engels), this seems to be the case. Women have a more equal status in societies where production takes place within the household and where there is little separation between the domestic and public spheres. But this private-public dichotomy is basically based on two different modes of production and economic systems in which women play very different roles. Therefore, in reality it is women's relationship to work and property which determines their status. Socialist feminists are of the opinion that women's secondary status in history can be traced to **economics**, inasmuch as women as a group have had a distinctive relation to production and property in almost all societies. The personal and psychological consequences of secondary status can be seen to flow from this special relationship to work.

According to Joan Kelly, "Although what constitutes 'domestic' and 'public' varies from culture to culture and lines of demarcation are differently drawn, a consistent pattern emerges when societies are placed on a scale where, at one end, familial and public activities are fairly merged and, at the other, domestic and public activities are sharply differentiated. Where familial activities coincide with public or social ones, the status of women is comparable or even superior to that of men. This pattern is very much in agreement with Engels' ideas, because in such situations the means of subsistence and production are commonly



held and a communal household is the focal point of both domestic and social life. It is in societies where production for exchange is slight and where private property and class inequality are not developed that sex inequalities are least evident. Women continue to be active producers all the way up the scale but they steadily lose control over property, products and themselves, as surplus increases, private property develops and the communal household becomes a private economic unit, a family (extended or nuclear) represented by a man. The family itself, the sphere of women's activities, is in turn subordinated to a broader social and public order governed by a state — which tends to be the domain of men. This is the general pattern presented by historical or civilised societies." [29]

Does this separation between private and public serve to conceal what happens inside the family, and make it difficult to challenge inequalities and conflicts within the household ?

Definitely. In fact it has been argued by many political thinkers (and their followers) that the State should have no say in the "private" realm. The home and relations between family members, it is argued, should be exempt from government regulation. Everything that happens within the four walls of the house is considered a personal matter and no outside intervention is encouraged. Glaring inequalities and grave assaults on women are thus allowed to continue. Wife-battering, marital rape, rape of girls by fathers or other male relations, mental and physical torture of girls and women, and general deprivation experienced by girls have, till recently, remained invisible, undiscussed and unchallenged.

The divide between the domestic and public spheres also creates problems for women who take up jobs outside the home. These demand from them independence, mobility, competitiveness and long hours of work; the family demands the opposite —

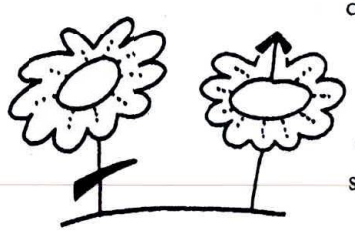
subservience, service, co-operation. Scores of working women have talked about these almost irreconcilable demands and the physical and emotional tensions and stress they lead to. The role of a good wife and an effective boss are difficult to combine. No such demand is made on men, to combine the role of a good husband and an effective boss.

Feminists have critiqued and challenged this strict division of the private and the public, because they believe it encourages male dominance and increases inequalities. It is to challenge this duality that the feminist movement coined and popularised the slogan, **"The personal is the political"**. It brought to the notice of the public the domestic sphere where women face different kinds of subjugation and oppression.

NO MORE SILENCE ABOUT DOMESTIC VIOLENCE !

Is there a difference between the different terms used for women's subordinate position — terms like oppression, exploitation, subordination ?

Although these terms are often used loosely and interchangeably, there are differences between them. But first I would like to point out that terms like gender oppression and gender subordination only state that there is oppression or subordination on the basis of gender. They do not specify which gender is oppressed or subordinated. Strictly speaking, gender oppression does not only actually mean women's oppression; although, because women are generally the ones who are subordinate, it is assumed that gender oppression and gender subordination refers to them.



The term **exploitation** is now normally used in a Marxian sense, and it means economic exploitation or extraction of surplus. Women's exploitation thus means that they are made to provide economic services at low or no rates at all, and the exploiters derive economic or material benefits from this exploitative relationship. **Oppression** is commonly used for women's subordinate position, or their domination by men. In general the term refers to a historical and structurally institutionalised system of rights whereby one group benefits at the expense of another. The term implies forceful subordination and it has been used to describe the subject conditions of individuals and of groups as in "class oppression", "caste oppression" or "racial oppression".

Subordination means being placed below or ranked in an inferior position to someone else, or being subject to the control or authority of another. The term "women's" subordination refers to the inferior position of women, their lack of access to resources and decision-making, etc., and to the patriarchal domination that women are subjected to in most societies.

Not all feminists find the term "oppression" appropriate. According to Gerda Lerner it "inadequately describes **paternalistic dominance**, which while it has oppressive aspects, also involves a set of mutual obligations and is frequently not perceived as oppressive. . .

". . . The word **'oppression'** focuses on a wrong; it is subjective in that it represents the consciousness of the subject group that they have been wronged. The word implies a power struggle; defeat resulting in the dominance of one group over the other. Women, more than any other group, have collaborated in their own subordination through their acceptance of the sex-gender system. They have internalised the values that subordinate them to such an extent that they voluntarily pass them on to their children. Some women have been 'oppressed' in one aspect of their lives by fathers or husbands, while they themselves have held power

over other women and men. Such complexities become invisible when the term 'oppression' is used to describe the condition of women as a group." [30]

Lerner feels that the use of "subordination of women" has distinct advantages. "Subordination does not have the connotation of evil intent on the part of the dominant; it allows for the possibility of collusion between him and the subordinate. It includes the possibility of voluntary acceptance of subordinate status in exchange for protection and privilege, a condition which characterises so much of the historical experience of women. I will use the term 'paternalistic dominance' for this relation. 'Subordination' encompasses other relations in addition to 'paternalistic dominance' and has the additional advantages over 'oppression' of being neutral as to the causes of subordination. The complex sex/gender relations of men and women over five millennia cannot be ascribed to a simple cause — the greed for power of men. It is therefore better to use fairly value-free terms in order to enable us to describe the various and varied sex/gender relations, which were constructed by both men and women in different times and different places." [31]

The term **deprivation** is sometimes used to express women's situation but it is inappropriate because it hides the existence of power relations. Deprivation is the observed absence of prerogatives and privileges. It focuses attention on that which is denied, not on those who do the denying. Deprivation can be caused by a single individual, groups of people, institutions, natural conditions and disasters, ill health and many other causes.

Since women's situation varies from society to society and at different times in history, one can use different terms to suit the situation one is describing.

Gender and Development

Why has gender become so important in development issues and debates?

Over the last 10-15 years gender and development has indeed been discussed a great deal. There have been scores of conferences, trainings and workshops on the subject. Women's, or gender, concerns were brought to bear on development issues when it started becoming clear that planned development efforts, which were meant to improve the lives of whole communities, were either not helping women, or were actually harming them in many ways. Around the end of the 1960s and early 1970s (mainly) women researchers in different parts of the world started pointing to the neglect of women in development planning. Similar things had been observed earlier about the lack of participation and further marginalisation of the poor in this process. Planners assumed that development programmes would automatically benefit all members of communities, but this assumption was found to be invalid almost everywhere. In the 1950s when the newly independent countries began planned development, their model was the west. It was thought that industrialisation and modern agriculture would usher in growth and development, and the focus was on industrialists, landowners, rich farmers and entrepreneurs. Governments of developing countries were "betting on the strong", assuming that the benefits of development would "trickle down" to the poor majorities, and gradually whole communities would prosper. Little attention was paid to the income-poor and to women. Women's contribution to the household and to the economy was neither recognised nor valued.

During the First United Nations' Decade, 1960-1970, it became clear that the benefits of development were not reaching the poor majority. There was evidence of underemployment, food shortages

and further polarisation between the rich and the poor. As a result of these findings and the pressure from below, the goals of development and the means for their achievement were re-examined during the Second Development Decade, 1970- 80. In countries like India and Bangladesh, NGOs working in rural areas pointed out the lack of participation by the poor and women in development programmes. This is when concepts like "people's participation", a "bottom-up approach", "redistribution with growth" and so on were debated, and the "basic-needs approach", accompanied by anti-poverty programmes, introduced.

In much the same way, it was discovered that even when a household benefits from development programmes, it does not follow that women in the household will benefit equally or benefit at all. Studies done from a feminist perspective — i.e., one which is guided by women's interests and concerns and aims to transform hierarchical gender relations and make them equal — in different parts of the world — provided data and evidence to show that gender-blind development plans had generally ignored women, their perspectives, needs and interests. This neglect meant that existing inequalities between women and men were not addressed, and second, women's action and potential contribution to and participation in the development process was ignored. Consequently, women were further marginalised and disempowered.

It was there for all to see that women were not given access to educational and training opportunities, technology did not liberate them from drudgery, and prejudice and misconceptions persisted.

Could you please give some examples to explain these points.

Almost everywhere in the world women have been farmers and producers of food. Despite this, our planners, decision-makers and communicators have persistently refused to recognise their contribution. The very language of these gentlemen (and

ladies) betrays their discriminatory perceptions. Thus while referring to farmers they invariably use masculine pronouns like "men" and "he".

Development programmes leading to marginalization of women

The result of these blinkers vis-à-vis women was, and still is, that in planning for agriculture and rural development, women have been neglected and further marginalised. Most training, information and credit for agriculture, horticulture and animal husbandry have been given to male farmers, inspite of the major contribution of women to these activities. Extension programmes have been run almost exclusively by men, for men. By contrast income generating activities for women have remained conventional: sewing, embroidery, *papad* and pickle making, which have generated little income but many myths about what is feminine and masculine.

Agricultural development has normally and almost entirely been "manned" by men, right from decision-making to implementation. For example the massive and expensive Training and Visit projects for agriculture extension in India, planned and funded by the World Bank in the 1980s, totally ignored or bypassed women. Similarly, a report on media support for big reforestation programmes in Nepal did not mention women even once. Women have not even been involved in projects related to reforestation, water supply, grain storage or other activities which are managed primarily by, and are of critical concern to them.

What is more, we find that most technology has been given to and is controlled by men, while women continue to do the more tedious, repetitive and back-breaking tasks. Commercialisation of agriculture has led to greater control of cash and family resources by men, even when, often, women do the work.

In the Eighties a review of eleven major rural development projects in Nepal showed that the productive roles of women were completely ignored because of distorted concepts of "housewife",

"head of household", and "economic" activity. In most of these projects, new farming technologies and machinery were made available only to men and applied only to male tasks, such as ploughing. When mechanisation was introduced for a female task such as husking or milling, it was transformed into men's work. This happened with the introduction of mechanised milling for high yielding rice varieties in Indonesia and Bangladesh. As a result, in one stroke large numbers of women were deprived of whatever little they were earning earlier.

Women have also been excluded from owning or controlling land, the most crucial productive resource in agricultural economies. An FAO study has pointed out that traditional systems of land tenure often allowed women to grow food for themselves, their children and extended families, without recourse to formal land ownership. Some land reform programmes, however, have given titles to land to individual men with the result that women may no longer have access to or control over it. At the same time the new owner may decide to sell rather than cultivate the land, taking it out of use for producing food for local consumption.

Because land deeds are made out in the names of men they become the legal heads of household. As such it is only they who are entitled to receive loans, participate in government schemes, become members of co-operatives, etc. This is so even in places like the hills of UP in India where most agricultural work is done by women because of male migration to the cities. It is the same story when it comes to training.

An analysis of many irrigation resettlement schemes like the Mahaveli Scheme in Sri Lanka, the Muda Scheme in Malaysia, and the Mwea Scheme in Kenya shows that they were planned with a nuclear family (a male head and a female housewife-helper) in mind, ignoring existing customary practices which gave women relative autonomy as producers in these communities.

Feminist researchers have pointed out that in the Mahaveli Scheme in Sri Lanka married women were not entitled to plots of land, and because the family was asked to name only one heir, this was usually the son. Thus, contrary to Sinhala customary law and practice of bilateral inheritance whereby both sons and daughters have a right to the family paddy land, and where married women too have independant and unalienable land ownership rights, in the scheme villages, wives were considered to be dependants. Again, because they were not given land titles, women had little access to agricultural extension information, institutional credit and co-operative membership. Thus women were marginalised and disempowered in new ways.

Extension trainings too, it has been found, neglected women, and cultural attitudes further discourage contact between women and male extension agents. For example, in one area of north - west Bangladesh, women traditionally selected seeds for planting. When a new variety of high yielding wheat was introduced the results were disappointing; it was found that women were choosing wrong seeds because the extension programme had been directed only at men.

Thus the experience of different parts of the world shows that women have been pushed out of mainstream agriculture in the name of "development". Earlier, men and women were equal partners in agriculture. Their knowledge, contribution, and participation in decision-making were more or less the same. Gradually, male farmers were singled out for attention by male " developers"; they got machines to lighten their burden and to increase efficiency; they were made members of co-operatives and development committees. Cash-crops delivered cash into the hands of men. Commercialisation of agriculture also marginalised women because markets, banks and trading centres are "public" spaces and thus beyond the reach of most women.

Other areas of economic activity provided similar insights. For example, in India it has been found that as a result of

mechanisation and modernisation women lost their jobs in the textile industry where they had been employed in large numbers. This economic marginalization has led to women's social marginalization and to a lowering of their status. This may be one reason why, for example, dowry, and female infanticide and foeticide in India have spread to areas and communities in which they did not exist earlier. This may also be one of the main reasons for the continuing decline in the female-male ratio in South Asia. Economic redundance seems to have lowered the chances of women's survival.

How would you characterise such a development paradigm from a feminist perspective ?

Many socialist feminist researchers have gathered enough evidence to show that monetisation and the commercialisation of production have led to the marginalization of women and the poor. Capital accumulation makes it possible for some people to accumulate more and more even as others lose control over land and other resources. The only thing they control is their labour power, but the value of their labour is not determined by them. In fact, Engels has said quite categorically that it was private property that led to the creation of class and gender hierarchies. According to him the need to control women came along with the emergence of private property. Male control over women's reproduction and sexuality made for the world historic defeat of the mother right. Further, the position of bourgeois women is much worse than that of working class women because bourgeois women themselves are property, they are merely the carriers and producers of heirs.

Economists Amartya Sen and Jean Drèze came to similar conclusions from their research on Female Male Ratios (FMR) in India.32 They show, first, how since 1901 the FMR for the whole of India has been going down systematically. Second, they show

that generally figures are higher among poor, illiterate working classes and castes.

In 1901 lower caste chamars in UP had an FMR of 986 compared with 937 for the state population as a whole. By 1981 the FMR was more or less the same among Scheduled Castes and Tribes and other castes This is because the SCs and STs of UP are today more like the 'higher' castes, which means they have also begun to practice the patriarchal neglect of women thereby reducing their chances of survival. In other words these figures prove that the patriarchal norms of higher castes are spreading to others.

This process, Sen and Drèze say, is particularly strong when the disadvantaged castes experience upward economic mobility. It is quite shocking and bewildering to be told by them, that higher levels of poverty tend to go with higher FMRs. It is in fact, plausible that the partnership aspect of gender relations is stronger in poorer households, where survival depends on effective co-operation, than among privileged households where women tend to have a more dependent and symbolic position.

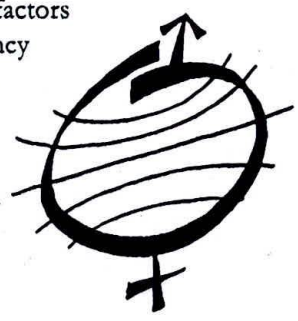
Veronika Bennholdt-Thomsen, a German feminist scholar presents a similar hypothesis. She writes that the appalling situation of the majority of Third World women is not a remnant of archaic systems of patriarchy, or a sign of backwardness and underdevelopment; on the contrary, it is a product of modern development. According to her, the housewife as we know her today, emerged in the First World during the 19th century. She is the result of a protracted historical process comparable with and closely related to that of proletariatization. Bennholdt-Thomsen terms this process 'domestication' or 'housewifisation' and she goes on to say that as soon as the modern money and commodity economy gains hold, women find themselves relegated to the unpaid or lowest paid spheres of work. In particular, women cease to be able to live autonomously with their children in a world which runs on the money to which they have such restricted access. Growing

propertylessness forces them to submit to dependence on men, and relations between men and women stop being co-operative. Based on these objective circumstances, they necessarily become hierarchical. She says since money and social esteem in modern society are closely related, those whose access to money is severely limited are also denied esteem. [33]

Maria Mies, who studied rural women in India in the '70s, writes: "The most brutal forms of violence and of sexist terror are to be found in areas where agriculture has been rapidly 'developed' in recent years, where new forms of wealth appeared, where cinemas, alcohol, television and other new consumer goods were introduced as indicators of 'modernisation'." [34]

These statistics and insights should make all those involved with "development" sit up and rethink. They remind us that economic progress by itself does not necessarily reduce gender inequalities. In fact, capitalist economic growth may actually lead to an intensification of gender bias. Punjab and Haryana, two of the most economically advanced states of India, with their FMRs of 882 and 865 respectively (as against the Indian average of 927), are good illustrations of this point.

Achieving greater gender equality involves a process of active social change which may have no obvious link with economic growth. A number of studies have shown that the extent of anti-female bias is substantially reduced by various factors that give women more voice and agency within the family. These are primarily education and the ability to earn an independent income through paid employment. The latter makes for women getting greater exposure, more respect, more bargaining power and better chances of survival. [35]



Have these researches and insights made any difference to development planning and programmes?

Yes, they have. Some planners and decision-makers realised that ignoring or neglecting women was harming not just women but entire communities and nations, because women, after all are half the human race. To influence member governments the United Nations organised a major global conference on Women and Development in 1975 in Mexico, declared 1975-85 to be the Decade of Women, and formulated declarations and plans of action which were endorsed by many member governments. Literally hundreds of other conferences and meetings were organised in different parts of the world to discuss how to integrate women into development. So, on the one hand there was pressure from below — i.e., the demands of the women's movement for equality, justice and development — and on the other there was pressure from above — i.e., global declarations, UN charters, and so on. The result was that many governments set up women's ministries, departments or commissions with the task of generating data and qualitative information on women, to monitor and evaluate the impact of development programmes on them, and to integrate women's concerns in development planning. Women's contribution to production and to society in general and their specific needs were now recognised and discussed. To some extent, the purdah of neglect and disregard was lifted and women became somewhat visible. Many governments agreed to provide annual reports to the UN Commission on the Status of Women on progress made by them towards gender equality.

However, as Saskia Wieringa points out, "Despite the attention paid to issues of women and development in the last decades, actual progress has been uneven and piecemeal, both under conditions of economic decline and of economic growth." In a United Nations Report of 1991, the Secretary General at that time, Perez de Cueller, noted that "It is clear from these data and

indicators that although there have been some improvements for women over the past twenty years, the majority still lag far behind men in power, wealth and opportunity. The HDR 1993 shows that women('the world's largest excluded group from development'), are frequently shut out from positions of power, are much less likely to be literate than men, and have many fewer job opportunities: in the (developing) countries for which relevant data are available the female human development index is only 60 per cent that of males." Some recent work has also stressed the link between the gender gap in development and violence against women. [36]

Have gender relations become more equal in South Asia ?

It is not easy to give a clear-cut answer to this question. The issue is complex and cannot be generalised for all societies or countries. In some ways women have definitely gained. Today they have more rights (right to vote or to inherit, for example); more opportunities (for education, training, jobs, travel); and more participation in political decision-making. There is also much greater awareness about women's oppression and the need to tackle it systematically. Women themselves are much more articulate and organised for change. But there are other ways in which women seem to be worse off.

In Sri Lanka, for instance, where the statistics for female life expectancy and literacy were quite impressive, the situation has deteriorated over the last 10-15 years. In India, Bangladesh and Pakistan the sex ratio continues to become more adverse for women. In 1901 the female-male ratio in undivided India was 975 women to 1000 men. In 1991 in Bangladesh it was 940, in India 927 and in Pakistan 910. Today 74 million women and girls are "missing" in South Asia. This means many more women and girls are being "killed" today than 90 years ago by patriarchal neglect, discrimination and violence. These figures prove that the situation of women and girls has been worsening inspite, or perhaps because

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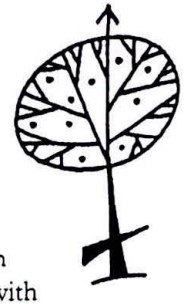
of, "development". In most of South Asia, while women are being provided with more opportunities, and there is more awareness and articulation of gender issues, we find a resurgence of patriarchies. Religious fanaticism of all kinds has meant more restrictions for women. In Pakistan, for example, progressive family laws have been replaced by the anti-women Hudood Ordinance; in Bangladesh, fundamentalists have been attacking emerging women's groups and NGOs working for the empowerment of women. Right-wing Hindu groups in India are busy reviving patriarchal role-models. Market fundamentalists are spreading pornography and demeaning images of women with incredible speed. Beauty contests, which had been discredited and more or less disappeared, are back with a vengeance along with globalisation and liberalisation. The incidence of violence against women has increased sharply. Economic hardships are leading to increasing discrimination against women. For example, in India, the practice of female infanticide has reached villages in South India where it had never existed; and dowry is being practised by communities which neither gave nor took dowry earlier. The figures with regard to women's participation in politics continue to be appalling, in spite of the fact that four of our seven South Asian countries have had women heads of state. No South Asian country has had more than a handful of women members of parliament since Independence.



Examining the changes in the patriarchal system in Britain, Sylvia Walby makes observations which seem to be applicable to South Asia as well. She says: "There have been changes both in the degree and form of patriarchy in Britain. It has seen a movement from a private to a public form of patriarchy over the last century. Private patriarchy is based upon household production as the main site of women's oppression. Public patriarchy is based principally in public sites such as employment and the state. The household does not cease to be a patriarchal structure in the public form but it is no longer the chief site. In private patriarchy expropriation of

women's labour takes place primarily by individual patriarchs, in public patriarchy it is collective."

On the question of whether there has been progress or regress in women's position, she says, "Patriarchy is not a historical constant. Modifications in gender relations over the last century or so have been interpreted variously as progress, regress and involving no overall change. Liberals typically define them as progress; Marxists as regress followed by stasis, and radical feminists as embracing no significant change."[37]

Earlier everyone talked of "women in development". How did this change to "gender and development"?

Initially most people talked about integrating women into development. This has been called the Women in Development (WID) approach, which aimed at meeting women's basic needs and making use of women's traditional skills and abilities for achieving the goals of development. However, it was found that WID policies and programmes did not address the subordination and oppression of women, nor did they question the anti-poor biases of development thinking and programmes.

It was in the '80s that the focus shifted from women to gender, and from welfare, basic needs and efficiency approaches to a women's empowerment approach, which seeks to address the patriarchal system at the root of women's subordination. It was argued that looking only at women is neither problem-free nor adequate. Focusing on women made it appear as if women were the problem, as if something was wrong with them, and that if that something was corrected, things would improve. Later it was pointed out that to improve women's condition and status and to make them partners in development, it was essential to understand the

causes of women's subordination; to examine the social system (patriarchy) which keeps women oppressed and subordinate. The concept of gender emphasised that the problem was not with women but with the socio-cultural definition given to women and men, which determined their rights and responsibilities, their work and spaces and so on. Women are what they are because of a social system, and it is the social system and its definition which need to be changed to improve women's status. Looking at gender requires looking at men as well, because women cannot be understood in isolation. It requires an examination of how gender is constructed and perpetuated in different societies, it means looking at gender relations, the gender division of labour and gender hierarchies. And, importantly, it requires looking at and addressing power in gender relations.

> *"The increasing recognition that development is not gender-neutral was accompanied by a conceptual shift from 'women' to 'gender'. The concept of gender emerged as a way of distinguishing biological difference and socially constructed inequality, while the concept of gender relations sought to shift attention away from looking at women and men as isolated categories to looking at the social relationships through which they were mutually constituted as unequal social categories. Gender relations are an aspect of broader social relations and, like all social relations, are constituted through rules, norms and practices by which resources are allocated, tasks and responsibilities are assigned, value is given and power is mobilised. Gender relations take account of the central issues of power and hierarchy within the family and society." Madhu Sarin*[38]

Although not all "gender experts" do so, we believe the following points need to be stressed when talking of gender and development.

Differences between men and women's achievements and participation are a result of socially constructed gender roles rather than of biological difference.

What needs scrutiny and change is not just women but gender-relations and gender divisions of labour.

Changing the condition, position and roles of women requires a corresponding change in the condition, position and roles of men. The two are inter-connected and there is a relationship of power between them.

To change women's position it is necessary to challenge patriarchal structures and ideologies.

Because of gender- subordination women continue to require special attention.

Gender relations and hierarchies cannot be studied in isolation. They have to be understood in the context of caste, class and race and north-south relations.

It is now widely recognised that women must be empowered and that the systems and ideologies which keep them subordinate, dismantled. Women must be equal partners in decision-making in all institutions and at all levels, and they must be subjects, not objects, or just beneficiaries of development policies and programmes.

These changes in the thinking on women and development have been analysed, categorised and labelled (mainly) by women researchers and academics.Approaches followed during the last three decades have been labelled WID, WAD and GAD. These labels try to capture trends which were set in motion from the ground up by millions of women and men all over the world who were dissatisfied with the treatment meted out to the majority of the world's population, and to nature, by insensitive analysts,

planners and policy makers. For the majority, their concern is not more "progress" but survival. In the '80s and the '90s Structural Adjustment Programmes, globalization and privatisation have further squeezed the poor who have lost even the little control they had over the natural resources on which they subsisted. Instead of the majority controlling the natural wealth of the world a handful of companies, motivated purely by profit and power, control and exploit it. In most countries of the world the poor are worse off today than they were in the '60s. So much for "planned development".

> *During the last two decades 1.6 billion people living in about 100 countries have experienced a decline in their per capita income.*
>
> *Growth can, and has become for many, jobless, voiceless, rootless and futureless. UNDP Human Development Report, 1996.*

People's organisations and movements (like the women's, environment, human rights and NGO movements) have been questioning development thinking, challenging hierarchies of caste, class, race and gender, and they have been trying to create alternative thinking and practices. One of these has been to reconceptualise women in development. Maxine Molyneux, a feminist researcher, pointed out that after the revolution in Nicaragua, efforts were made to meet women's practical gender needs but their strategic interests were not addressed. Hence although the condition of women changed, their position vis-à-vis men did not. Similar insights from different parts of the world led to the formulation of useful concepts like **condition, position, practical gender needs, strategic gender interests, subordination, empowerment, autonomy**, and so on.

> *Condition of women is their material state in terms of their nutritional level, health, access to*

basic needs, education, and this can be improved by providing food, health services, education, etc.

***Position** of women is their placement or status in society in relation to men. To assess the position we need to look at the social relations of gender or relations of power between women and men. To improve women's position the existing norms, structure and power relations between women and men have to be changed.*

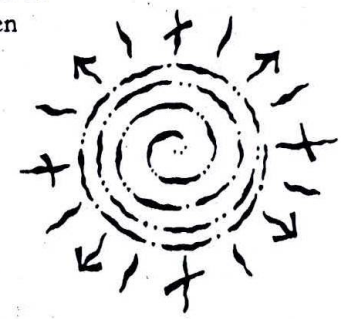
***Practical Gender Needs** (PGNs) are related to the condition of women. They are easily identifiable (food, clean water, medicines, housing) and they are related to the existing gender division of labour. For example women say they need water, fuel and fodder because it is they who look after their children, the household and domestic animals. Because fulfilling women's PGNs does not change the existing power relations no one feels threatened by activities and programmes aimed at meeting PGNs.*

***Stategic Gender Interests** (SGIs) are related to women's subordinate position in society and their desire to change the existing hierarchical gender relations and make them more equal. SGIs can be pursued by women organising, getting into decision-making positions, changing discriminatory practices, norms and rules in order to transform gender relations. Activities which promote women's SGIs are education, consciousness-raising, mobilising and organizing, developing leadership and management skills, etc. Such activities are often resisted because they challenge male domination and demand long-term changes in gender relations. But these categories are often very fluid. The condition of women can be changed in such a way*

that it leads to changes in their position and transforms gender relations.

Easier said than done! How do you actually change age-old ideas, attitudes and behaviour patterns? How do you redistribute power between women and men?

Indeed it is not easy to change all this, especially power relations. Organisations that are supposed to plan and bring about change are themselves very patriarchal, be they government departments or non-government organisations. Even women's organisations and women are not free of patriarchal thinking because they are products of the same culture. Massive changes are required in thinking, in organisational structures and policies, in planning and implementing development programmes, for real social change to take place.



Large numbers of women and men all over the world have made different kinds of efforts at different levels to change patriarchal thinking, attitudes, structures and organisations. To give just a few examples:

- School curricula have been analysed and made more gender sensitive.
- Patriarchal biases in media have been highlighted and laws, regulations and guidelines prepared to weed out sexism from media and make them reflect women's contribution, needs and aspirations.
- Laws have been scrutinised and made more gender sensitive.
- Women's studies centres have been instituted to prepare women

and men who can conduct gender sensitive research; to analyse social, economic and political issues from the perspective of women.

- Attempts have been made to make national censuses gender sensitive and obtain sex-differentiated data which would make it possible to prepare gender- transformative plans.
- Hundreds of workshops and trainings have been conducted for planners, managers, trainers, field-level workers, government and non-government, to help them understand gender disparities, sensitise them to gender issues, and instil a commitment to gender equality. Such workshops have also been conducted with police personnel, media persons, members of the judiciary, elected representatives of people and other public servants.
- Guidelines, check-lists, frameworks have been prepared to analyse plans and programmes to make them gender sensitive and gender transformative.
- Special units, cells, departments and commissions have been set up by NGOs, governments and the UN to plan and monitor progress towards equality. By 1985, 90 per cent of member countries had established an institutional body or system for promoting the status of women.
- Women's organisations have emerged in almost every country to work on a range of gender issues. Women's publishing, film-making, art , architecture, newspapers and magazines have flourished in many countries.

Some governments, UN organisations and NGOs have made special efforts to recruit women and train them for senior positions; and to make organisations, their policies, rules and work culture more women-friendly. Special gender indicators have been developed to measure the success of programmes aimed at women's empowerment and gender equality.

For making development more gender sensitive, government policies now increasingly emphasise qualitative inputs, focusing on inculcating self-confidence among women; generating awareness about their rights; and training them for economic activity and employment. Efforts to improve women's access to critical inputs and productive resources such as land, houses and trees through joint or individual titles have been expanded to include support through credit (or small scale capital), marketing, training in skills/ management and technology. Developing women's organisations is now accepted as an effective strategy for promoting women's empowerment.

The most well-known initiative of the Government of India to promote gender equality in the political sphere is the 73rd Amendment, reserving one-third of elected seats in local government for women. Through this measure, an estimated one million women could emerge as leaders at the grassroots level in rural areas alone, 75,000 of them being chairpersons. The Government of India has also drafted a national policy for the empowerment of women. Reservation of one-third seats for them, even in Parliament and state legislatures, is being debated.[39]

What exactly do gender sensitivity and gender sensitisation mean?

Different people mean different things by these words. The simple meaning of gender sensitivity is acknowledging that women are subordinated in most societies, and that this subordination is harmful not only for women and girls, but also for men and boys and the entire society. It means being aware of why men and women behave differently, and understanding their needs and concerns.

It also means understanding the implications and impact of different policies and programmes on women and men. In planning, gender sensitivity implies making plans which will not only not ignore and further marginalise women, but will take care of women's special needs and make efforts to involve and empower women. In short to transform gender relations.

According to feminist gender trainers, gender sensitivity means not only understanding but also challenging patriarchy and other interconnected hierarchies like those of caste, class, race and north-south. We believe gender sensitization is necessary at all levels in all organisations. Acknowledging the feminist slogan "Personal is Political", we believe gender sensitization begins with each one of us, our families and organisations. It requires not only an intellectual understanding of concepts like gender and patriarchy but using this understanding to transform our own ways of thinking and behaving. Understanding alone does not change social relations and social realities, what changes society is people's behaviour and actions. In other words gender sensitivity requires internalising our understanding and applying these insights to our behaviour. Transforming gender relations means demolishing the separation between theory and practice, personal and public, objective and subjective, rational and emotional. Gender sensitivity does not only mean "main (man) streaming" women, it means examining the mainstream from a feminist perspective. If it is patriarchal, unjust and unsustainable then women need to challenge and change it, instead of joining it.

Gender sensitivity also means acknowledging that ALL issues — economic, cultural, social or political — are women's issues because women represent half the human race.

Obviously, the opposite is also true: all the so-called women's issues (dowry, rape, pornography, female foeticide, infanticide, etc.) are

not just women's issues, they are social issues. It is unfortunate that for much too long only women and their organisations have been concerned with them. But it is heartening to see that some sensitive men are also taking up these issues now and starting groups like "Men Against Rape" or "Men Against Violence Against Women".

Gender sensitivity and gender justice definitely require women's equal participation in organisations and in decision-making processes but in addition they require a transformation in the practices and cultures of organisations. For example, while many NGOs are recruiting more women, their organisational culture continues to be male, and at times even hostile towards women. A careful scrutiny is therefore required in every organisation, of the language used, the jokes told, the songs sung, the comments passed on people's way of dressing, and so on.

Most NGOs expect their senior managers to work very long hours, to travel and work on weekends, etc. For women who have responsibilities at home it is not possible to live up to such expectations and hence to fill managerial positions. Therefore, instead of putting unnecessary pressure on women to put in longer hours of work, NGOs need to pressurise and encourage men to spend more time at home, and give more attention to their roles and responsibilities as parents, marriage partners and householders. Genuine changes in unjust gender relations can be brought about only through concrete changes in men's behaviour and activities. Men can understand, appreciate and help women only by sharing women's endless, repetitive and thankless work at home.

Gender sensitivity also requires understanding the situation of those women who have to combine their work at home with jobs outside. In addition to the double burden of work, women, specially those in management positions, face conflicting demands on their behaviour. A woman manager is expected to be tough,

cool, rational, competitive, in charge; but the same woman manager is expected to be submissive, caring, self-effacing as a wife and mother. Male managers face no such schizophrenic situations.

In the ultimate analysis being gender sensitive simply means being sensitive and caring; it means being against and opposing injustice and unfairness between men and women wherever it exists.

Has using the concept of gender contributed significantly to women's empowerment?

Concepts are basically analytical tools or theoretical constructs which help clarify our ideas and examine social reality in a more systematic way. They cannot by themselves change reality, although they may influence our perception of it and, in that sense, construct it. Gender is simply the concept that clarifies the fact that women and men are social categories or constructs, not merely biological categories.

However, some feminists think that this concept has theoretical problems. According to Maria Mies, the distinction between sex and gender follows the well known dualistic pattern of dividing "nature" from "culture". For women, she says, this division has had a long and disastrous tradition in western thought because women have been placed alongside nature ever since the rise of modern science. The duality between sex and gender is problematic because human sex and sexuality have never been purely biological affairs. Sex is as much a cultural and historical category as gender. By the dualistic splitting up of sex and gender, by treating the one as biological and the other as cultural, the door is again opened for those who want to treat the sexual difference between humans as a matter of our anatomy, or as matter.[40]

Others see the need to reconsider the political and philosophical significance of biology. According to them gender is in part determined by sex, therefore some aspects of sex are still politically

relevant. For example, certain features of women's biology may mean that occasionally their needs are different from those of men, most evidently, in the case of child-bearing.[41]

However, more problematic than these theoretical distinctions is the way the concept of gender is being used today.

What do you see as the problems with the "gender business" ?

Hardly a workshop, paper, article or speech on women today is made without using the term gender. The enthusiasm for it is so great but the understanding so little that it is being used when it shouldn't be or it is being misused and misinterpreted. For example, we have heard people say "gender-ratio" instead of sex-ratio and "gender-disaggregated" data instead of sex-disaggregated data .

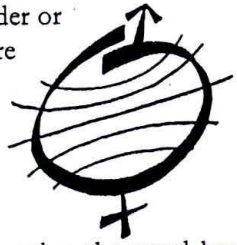
The main reason for this confusion and misuse is that most people have not really understood what this concept means.

An elderly social worker in a remote area of Bangladesh, when asked what type of work he was doing, said "Aami gender kori" (I do gender); I suppose what he meant was, he was working for women's development. Terms like women's empowerment, women's autonomy or women's development are being replaced with gender equity and equality, with each person free to interpret them the way they want. So much so that a senior development expert once said to me : "What is all this fuss about gender and gender sensitization. Everyone knows what gender is, just take off everybody's clothes and you will see gender." The poor chap had missed the point completely. He did not realise that our clothes tell us more about gender than our bare bodies !

What are the reasons for the sudden popularity of the term ?

Gender has been popularised because it allows us to talk about both women and men and obliges us to look at relations between them. However, many people who use the word gender continue to talk only about women, and work only ON, FOR or WITH women.

Many others prefer it because it is neutral, i.e., it refers to both women and men and hence may be less threatening. It does not antagonise men the way other terms like "women's empowerment" or "patriarchy" do. But for many feminists, this is precisely the problem with this term — its neutrality. Gender or gender relations say nothing about the nature of these relations. Gender inequality, for example, does not mean women are unequal or subordinate it merely means that there is inequality between the genders.



Maria Mies maintains that it is not surprising that the word has readily been adopted by all kinds of people who may not otherwise have much sympathy for feminism, and may even be hostile to it. If, instead of 'sexual violence' we talk of 'gender violence', the shock is absorbed by an abstract term, which removes the whole issue from the realm of political commitment to that of apparently objective discourse.

The word women's subordination, on the other hand, does say who is subordinated and marginalised, and who should be in focus. So too, women's empowerment is unambiguous.

The term "patriarchy" (which is, of course, no substitute for the word gender, but which is used less and less by the gender wallis and wallas) is also not neutral. It clearly and unambiguously characterises the nature of gender relations-i.e., that men are in control, that we live in a male-ordered world. The details and

particulars of the male world need to be studied carefully, but it is clear who is in power and how that power needs to be redistributed.

Because the term gender is neutral, it is creating a lot of confusion. Because people have not been told what it is, why it was introduced and how it should be used they use it to suit their own thinking on the subject. We have innumerable men saying " If it is a gender cell why is there a woman incharge ?" or "Why are there no men in gender workshops ?" or "Why are you talking of women's empowerment in a gender workshop ?" or "Why are there no male gender trainers ?" Suddenly everything has to be fifty-fifty to ensure men are not left out, and to prove we are talking of gender. Suddenly a lot of people (mainly, but not only men) are concerned about men being left behind or left out, men not being included in everything. Before much justice has been achieved for women, the threat of possible injustice against men is becoming a concern.

Thus we find that the term gender often obscures power relationships rather than illuminating them. And it is being seen as a sanitised, neutral category. For many gender experts, gender is now a specialisation. It has been taken out of the living, interconnected world. One can talk of gender in the context of a project without mentioning patriarchy, or understanding and challenging the root causes of gender subordination.

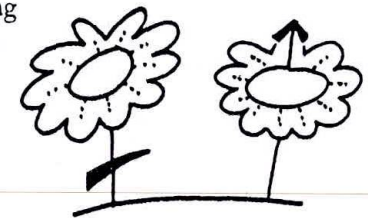
Gender is also fast becoming a thing you "do" to others, specifically to "target groups" or so-called beneficiaries. If not in theory then in practice, the concern is often with gender at the "grass roots" level. When gender is just a project-related concern it does not threaten anyone. It is quite acceptable, it can be mainstreamed, unlike struggles against patriarchy which call for dismantling oppressive structures, institutions, attitudes. This is definitely threatening.

This is not to deny the possibility of using gender politically, and many feminists use it that way. But there is the real possibility of

the concept being used totally apolitically. However since nothing is apolitical, it may end up being used to obscure the real issue, i.e., patriarchal subordination. Because of this many of us in South Asia have been very reluctant to use this concept and, even now, use it very cautiously and only along with other concepts like patriarchy.

Although, gender interventions in development programmes vary widely in their understanding and purpose, the objective of most so-called gender sensitisation modules used by official agencies and consultants/trainers for male [and also female] policy makers, planners and implementers is to look at gender relations in order to enhance the effectiveness of development programmes and policies; to involve women in development programmes in order to tap their "productive usefulness", to "invest" in women. Gender equality and gender justice may not be their primary aim. These experts seldom address the issue of power in gender relations. I have often heard the term gender being used only to describe the different roles and responsibilities of men and women, or the different access and control they have to resources and decision-making. Many gender trainers do not go beyond describing the situation, and even when they do analyse the reasons for gender inequalities, they do not necessarily challenge them. Quite often, they may even base their development interventions on an existing gender division of labour.

Many gender trainers and experts treat the whole issue of gender as a technical matter; treat it as if by using a few tools of gender analysis gender inequalities can be removed. Such trainings and interventions, we feel, are not only incapable of challenging gender inequalities, they are depoliticising the issues and making change more difficult.



Saskia Wieringa has pointed out how development planners are

searching for easy schedules, quantifiable targets and simplicity, while addressing enormously complex situations. Instead of demonstrating flexibility and a desire to appreciate complexity, they are trying to bend social realities to fit their narrow frameworks.[42]

Wieringa maintains that fundamental questions relating to women's gender interests are not being asked while planning development interventions. In the case of structural adjustment programmes, she argues, such questions include the following: Why does feminization of poverty occur ? Why is it that women have to do unpaid tasks such as the care of the young, the elderly and the sick ? Why are men not involved in these activities ? Why is it that so many men drop out of the families they helped to create ?

She continues, "There is a whole range of other relevant issues, such as the imbalance between the sexes in the distribution of food, luxury items and leisure time; the practice of invoking tradition to prevent women from moving into new areas of life, while men in the same circumstances are considered innovative; the lack of attention to issues of sustainability, environmental degradation and gender; the absence of women from the central positions in which political and economic decisions regarding their lives are being made; the tendency to view development as a mainly economic process, disregarding social aspects (even though a country's most vital resource is its people); the fact that sexual violence is rarely recognised as a legitimate development issue."[43]

Considering the kind of "mainstream" gender work being done in South Asia today, we also feel that instead of encouraging commitment, flexibility, ecological and interconnected ways of looking at social realities many "gender experts" are dishing out very simplistic tools, frameworks and exercises.

It is not gender per se but this neutralisation of women's issues by a large number of "gender experts" which is cause for concern. Discussions on women's issues are thus being robbed of their

struggle aspects and of their militancy. This is a problem for many other trainers who believe that the challenge to patriarchy needs to be strengthened, not diluted, patriarchy and patriarchal privilege are definitely NOT on the decline. In fact, with the growing importance of economic liberalisation, fundamentalism and conservatism, patriarchy is resurgent.

While socialist feminists and eco-feminists expose and challenge the present development paradigm itself as patriarchal and ecologically destructive, the attempt of many mainstream gender exercises is to increase women's opportunities for "empowerment" within the present system. The relationship between patriarchy, caste, class, race, the state, colonialism/imperialism and the environment are seldom explored because they are defined as "political" issues !! The assumption is that accepting these hierarchies is apolitical.

It is therefore important to challenge trends that have the potential for depoliticising our issues. We need more clarity, commitment and conviction in order to challenge patriarchy and hierarchies of caste, class, religions and ethnicity in South Asia, and to make for progressive social change. The distinctions between planners and implementers, thinkers and doers, experts and non-experts need to be minimised, and a much closer interaction and co-operation between gender planning, feminist theory and the women's movement needs to take place. Rather than fight shy of feminism, our programmes for women's empowerment need to be more clearly feminist.

According to you are there any issues which need to be given more attention ?

Yes, at last two issues need to be given more attention than they have been so far, namely —

- Women's access to and control over natural resources like land, water and forests. Much more concrete action needs to be taken at the level of policies and programmes to give women access and control over these resources.
- Sharing of household work by men and boys.

A major reason for the subordination, lack of autonomy and ill-health among women in South Asia is the extreme burden of household work. According to the UNDP Human Development Report the total value of unpaid work done by women, globally, is USD 11 trillion. Development projects have been trying to integrate women into development, use their "human resources" and "capital" in the service of global production; more recently, many people have been working towards increasing women's participation in governance at all levels. Yet most working class women are already on the verge of collapse due to overwork. Why do we hear so little about reducing women's household responsibilities? Most programmes end up increasing women's work and responsibilities in the name of "women's development" and "empowerment", but we have to accept that one reason why women are absent from public office and senior management positions is that they have more than full-time work at home. Women's roles as housewives and mothers forces them into subordinate positions in paid employment. Since reproduction and caring for children and families are not likely to disappear, it is necessary to start a. parallel movement of men towards family kitchens and homes. If we want women managers, politicians and civil society leaders then we need more men to be mothers, care-takers, nurses and cooks. Women can exercise autonomy over their bodies and lives only when the burden of reproductive work is reduced.

As Maria Mies says, "Men have to share the responsibility for the immediate production of life, for childcare, housework, the care of the sick and the old, the relationship work, all work so far subsumed under the term "housework". . . This would then immediately have the effect that men would have to spend more

time with children, cooking, cleaning, taking care of the sick, etc., and would have less time for their destructive production in industry, less time for their destructive research, less time for their destructive leisure-time activities, less time for their wars. Positively put, they would regain the autonomy and wholeness of their own bodies and minds, they would re-experience work as both a burden and enjoyment, and finally also develop a different scale of values altogether with regard to work. Only by doing this life-producing and life-preserving work themselves will they be able to develop a concept of work which transcends the exploitative, capitalist, patriarchal concept.

. . . The processes for the liberation of women and men are interrelated. It is not possible for women in our societies to break out of the cages of patriarchal relations, unless the men begin a movement in the same direction. A men's movement against patriarchy should not be motivated by benevolent paternalism, but by the desire to restore to themselves a sense of human dignity and respect. How can men respect themselves if they have no respect for women."[44]

Some people are of the opinion that "doing gender" requires working with women and men together, not working only with women, or men.

I have heard these views, but I do not agree. Gender and development does not mean you should not have separate groups of women and men, or conduct separate workshops for them, or even that you should have female and male trainers in every workshop. I believe our analysis should focus on the social construction of male and female identities and on gender relations. Such an analysis can be done in separate groups, if that is what the situation demands. In fact, in some communities it is necessary to have separate meetings with women to provide them with the space to talk and think freely, to develop bonds of solidarity and to

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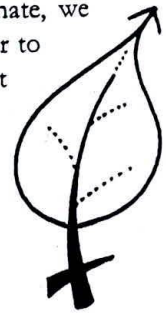
formulate common strategies. Similarly, it may be necessary to have separate meetings and workshops with men, again to allow frank discussions. Where women and men are comfortable in mixed groups, joint workshops and meetings can be held.

Again, focusing on gender does not mean we cannot speak of women or women's empowerment any more. As long as gender relations are hierarchical and women are subordinate, we need to strengthen women's empowerment in order to have gender equality. It is premature to think that men and women should be treated equally at all times even before gender equality has been achieved. Let us not forget that we started talking of gender only because inequalities between men and women persist.

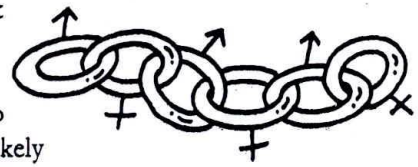


But surely the gender debate is not a women versus men debate ?

No, the issue of gender equality is not one of women versus men, nor is the conflict between all women and all men. It is between those who believe in and want equality and those who wish to maintain male domination. It is between belief systems and ideologies. All of us know that there are men and women in both these camps. There are those who accept and benefit from patriarchy and wish to retain the status quo, and those who wish to work for social change. Many men are today examining their rights and privileges, their roles and responsibilities. For the first time masculinity, male power, male sexuality, male knowledge systems, and male ordering of social relations are on the table for critical examination, and the examiners are both men and women.

Therefore it is both simplistic and incorrect to think that the fight for gender equality is a fight between women and men.

But there is no denying that there is also some conflict in the interests of men and women; as women begin to empower themselves it is likely that this conflict will be heightened, in the short term. But any struggle for equality will entail some polarisation before an equitable balance is achieved.



Why do gender-related issues evoke such an emotional, even hostile, response?

Maria Mies puts it well. She says most men and women try to avoid examining gender relations, because they are afraid that if they allow themselves to become aware of the true nature of the man-woman relationship in our societies then the family, the last island of peace and harmony in the brutal world of money-making, power games and greed, will be destroyed. Moreover, if they allow this issue to enter their consciousness, they will have to admit that they themselves, women and men, are not only victims (women) on one side and villains (men) on the other, but that they are also accomplices in the system of exploitation and oppression that binds women and men together. If they wish to come to a truly free human relationship, they will have to give up their complicity. This is not so only for men whose privileges are based on this system, but also for women whose material existence is bound up with it.

It is feminists who have dared to break the conspiracy of silence about the oppressive, unequal man-woman relationship and who want to change it. We believe that more and more people now realise that equality between men and women is essential for building just and peaceful relationships within families, and communities. Women and men everywhere have to join hands to achieve gender equality, and to create a world which is just and peaceful for all.

Does this imply that gender concerns in development go beyond integrating women into development ?

While some organisations only wish to add the "women's component" to the existing institutions and systems, we believe we need a radical transformation of patriarchal society, as well as of the notions and practices of development, to achieve genuine social change.

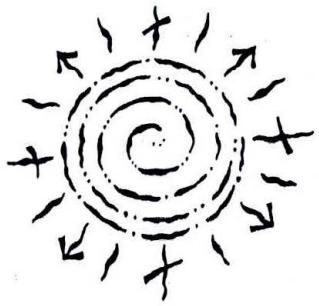
As we have already seen, development plans and projects can and do have many anti-women (and anti-poor) biases. Instead of simply integrating women into such plans and projects, we need to challenge and change them. There is enough evidence today to move that the present development paradigm with its emphasis on economic growth, pursuit of profit and individual interests has widened the gap between women and men, the rich and poor, and rich and poor countries. In addition it has led to ecological devastation. The UNDP Human Development Reports have provided statistics from all over the world which show that the present form of development has forced many people to become jobless, voiceless, ruthless, rootless and futureless (UNDP, Human Development Report 1996). Today 358 millionaires control more money than 2.5 billion poor people in the world. The budgets of some multinational corporations are larger than those of many national governments. This kind of polarisation and centralisation of power leads to greater tensions, conflict and violence.

A shift in development thinking will have to be accompanied by radical changes in our organisations, and in our social, economic and political systems. It will also require a major change of values — e.g. from self-assertion and competition to co-operation and social justice; from expansion to conservation; from material acquisition to inner growth. Engendering development paradigms and practices is one way of transforming development as we have known it, and making it more equitable and beneficial for all.

Achieving gender equality requires looking once again at the "masculine" and "feminine" characteristics and values (domination – subservience, competition – co-operation, self-assertion – giving in, exploitation – caring and nurturing) and seriously thinking :

- does or should development mean subordinating "feminine" characteristics and values and valourising "masculine" values and characteristics ?
- does gender and development mean having women enter the public arena and behaving like men?
- does the present polarised, conflict-ridden, ecologically devastated world require more competition or more co-operation ? More exploitation of nature or more caring and nurturing of nature ? In other words, does the present-day world need more "feminine" or "masculine" qualities ?

In fact we need to go a little further and ask whether it is correct to label values and characteristics as feminine and masculine at all? Aren't these values human values? Don't both men and women need and develop both "masculine" and "feminine" aspects ? Shouldn't women and men both be rational and emotional, self-assertive and sensitive to others, entrepreneurs and home-makers, public and domestic figures? If women are entering public spaces and assuming responsibilities in these spaces, shouldn't men enter the domestic space abd assume responsibilities for child care, nursing and home management?



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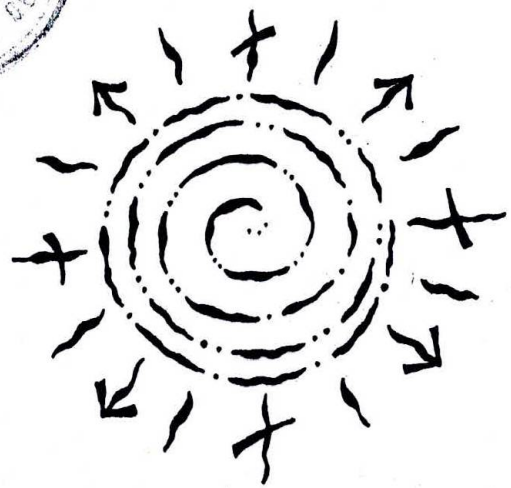
WOMEN'S PLACE IS IN THE HOUSE. THAT IS WHY THEY SHOULD BE IN BOTH HOUSES OF PARLIAMENT.

Gender equality requires each one of us, man and woman, to look into ourselves and overcome our negative "male" (being aggressive, domineering, competitive, self-centred) and "female" (being submissive, fearful, diffident) qualities. It also requires that all of us, girls and boys, men and women, nurture the positive male and female qualities. Each one of us needs to be strong and caring, fearless and sensitive, emotional and rational. We believe the present-day world, which is experiencing unprecedented and intolerable levels of violence and environmental degradation, can be healed only through the large-scale practice of qualities like caring and nurturing in the domestic and public spheres.

At yet another level, we need to question the separation between economics and ethics, politics and morality, science and religion. This separation has led to unethical economic pursuits, immoral political power and the irresponsible and destructive use of science. We believe value systems and ethics shouldn't be peripheral to economics, politics, science and technology but should constitute their very basis and driving force. We need holistic and ecological ways of thinking and being. For us all these concerns are part of our concern in engendering development. We believe gender and development issues cannot be treated in narrow and mechanistic ways. These debates cannot be limited to how many women, how many men, questions. In the context of our search for sustainability, gender and development debates have to discuss the transformation of the present gender, caste, class, race, north-south divisions of labour which are totally non-reciprocal and exploitative. We also have to raise basic questions about the goal of development and

the purpose of human life. The following issues demand greater attention than they are being given today in most gender discourses.

- Should the objective of human effort be the production of life and use value or merely production of things and profit ?
- Can human beings remain human if they are completely alienated from nature and organic matter ?
- Shouldn't communities be self-sufficient in satisfying their basic needs to avoid blackmail and exploitation ?
- Can sustainable communities and families be established without the autonomy of women over their own bodies and lives, without men sharing the responsibility for the immediate production of life, and all work so far subsumed under the term "housework" ?



References and Notes

1 Oakley, Ann. 1985. *Sex, Gender and Society.* England: Gower Publishing Company, p.16.

2 von Werlhof, Claudia. 1988 A. "The Proletarian is Dead : Long Live the Housewife", in Maria Mies, et al, *Women: The Last Colony.* New Delhi : Kali for Women, p.104.

3 Centre for World Solidarity. 1997. *Forging Links.* Hyderabad.

4 Oakley, A. op.cit., p.149.

5 Ibid., pp. 149-150.

6 Ibid., p. 150.

7 Oakley, A. op.cit., pp. 32-34.

8 Ibid., p. 36.

9 Ehrenreich, Barbara and Deirdre English. 1988. *For Her Own Good: 50 Years of the Experts' Advice to Women.* London: Pluto Press, p. 19.

10 Ibid., op.cit., p. 19.

11 Mies, Maria. 1988 A. "Social Origins of Sexual Divisions of Labour", in *Women: The Last Colony*, op.cit., p. 73.

12 Oakley, A. op.cit. pp. 174-175.

13 von Werlhof, C., op.cit., p. 177.

14 Lerner, Gerda. *The Majority Finds Its Past : Placing Women in History.* Oxford and New York: Oxford University Press, p. 232.

15 Bhasin, Kamla. 1993. What is Patriarchy ? New Delhi: Kali for Women.

16 Ashworth, Georgina.1996. *Gendered Governance: An Agenda for Change.* Gender in Development Monograph Series. New York: UNDP.

17 Oakley, A. op. cit, pp. 152-153.

18 Ibid., p. 156.

19 Agarwal, Bina. 1996. *A Field of One's Own. Gender and Land Rights in South Asia.* New Delhi: Cambridge University Press, p. 51.

20 Ibid., pp. 62-63.

21 Mies, Maria. 1988 B. "Class Struggles and Women's Struggles in Rural India", in *Women: The Last Colony*, op.cit., p. 138.

22 von Werlhof, C., op.cit., p. 175.

23 Ibid., p. 179.

24 Kannabiran, Vasanth. 1996. *Sharing the Fish-Head: The Philosophy and Practice of Gender Training in South Asia.* New Delhi: ASPBAE/FAO-NGO South Asia Programme, pp. 36-37.

25 Mies, M. 1988 A. op.cit., p. 71.

26 Ehrenreich, B. and D. English, op.cit., p. 8-9.

27 Jaggar, M.Alison. 1993. *Feminist Politics and Human Nature.* New Jersey: Rowman and Allenheld, pp. 144-145.

28 Ehrenreich, B. and D. English, op.cit., p. 11.

29 Kelly, Joan. 1984. *Women, History and Theory.* Chicago: University of Chicago Press, pp. 10-11.

30 Lerner, Gerda. 1986. *The Creation of Patriarchy.* Oxford and New York: Oxford University Press, p. 234.

31 Ibid., pp. 234-235.

32 Drèze, J. and A.Sen. 1995. *India: Economic Development and Social Opportunity.* New Delhi: Oxford University Press, pp. 140-175.

33 Bennholdt-Thomsen,V. 1988. "Why Do Housewives Continue to be Created ?" in Mies, et al, *Women: The Last Colony.* op.cit., pp. 160-161.

34 Mies. M. 1988 B. "On the Concept of Nature and Society in Capitalism", in *Women: The Last Colony,* p. 137.

35 Drèze, J. and Sen, A. 1995. op.cit., p. 199.

36 Wieringa, Saskia. 1994. "Women's Interests and Empowerment: Gender Planning Reconsidered." *Development and Change,* Volume 25, pp. 831-832.

37 Walby, Sylvia. 1990. *Theorising Patriarchy.* Oxford: Basil Blackwell, p. 63.

38 Sarin, Madhu. 1998. *"Who is Gaining ?"* Who is Losing ? New Delhi: Society for Promotion of Wastelands Development, p. 8.

39 Ibid., p. 8.

40 Mies.M. 1986, pp. 22-23.

41 For a discussion on this see Jaggar, A. op.cit., p.22.

42 Wieringa, S. op.cit., pp. 831-832.

43 Ibid., p. 832.

44 Mies, M. 1986. p. 23.

Ehrenreich, B. (1974). ***Gender and Objectivity in Medicine***. International Journal of Health Services, 4(4), pp. 617-623

GENDER AND OBJECTIVITY IN MEDICINE

Barbara Ehrenreich

Medicine in the United States has been an overwhelmingly male profession since the emergence of the modern medical profession in the late 19th century. Historically the exclusion of women from medical training was justified on the grounds that females are innately less capable of scientific objectivity than males. However, a brief examination of gynecological theory and practice advanced by male physicians over the last 100 years reveals that medical "science" has been and continues to be permeated with sex prejudices. The direction of the bias in the medical care of women has been to reinforce traditional social roles for women. In addition, nonobjectivity in the medical care of women has been directly detrimental to women's health. It is urged that medicine discard old prejudices and develop a firmer scientific basis.

I have been asked to speak on the subject of "Women and Medicine," but I am going to speak instead on a subject which is much less well understood, a subject which is so esoteric that it has only recently begun to be a subject of critical investigation—and that is the subject of *men* and medicine.

Men were not really very important in American medicine until well into the 19th century. Prior to that time, this country had, as had Europe, a tradition of female lay healing. The healing occupations were open to anyone with a claim to skill, and women entered those occupations in large numbers, serving both as midwives and as general practitioners. Many of these healers were probably illiterate women who relied on skills passed on from mother to daughter and shared among neighbors. Because they left few written records of their work, they remain anonymous in conventional medical histories, where they are usually mentioned only as a measure of the "backwardness" of early American medicine.

The 19th century was a time of great ferment in American medicine. There were dozens of medical sects, each with its own particular philosophy of healing—homeopaths, eclectics, botanists, Thomsonians—to name but a few. One sect is of particular interest, because, unlike most of the others, it was entirely male in composition. This sect had inherited from colonial times a somewhat mystical philosophy of healing called "allopathy" and an approach to healing that has been termed "heroic"—probably because of the heroism required of their patients. Bleeding (until the patient fainted or until the pulse ceased), blistering, and massive doses of calomel (a mercury-based laxative) were their principal techniques until the latter part of the 19th century, when surgery and opium were added. This particular sect held the messianic belief that they were the only true healers, a belief which they publicized through various verbal devices: They styled themselves as "regular" doctors, all others being termed "irregular," or, less politely,

This article, a seminar presentation at the Johns Hopkins University School of Hygiene and Public Health on April 4, 1974, is based largely on the book *Complaints and Disorders: The Sexual Politics of Sickness*, by Barbara Ehrenreich and Deirdre English, published by the Feminist Press, Old Westbury, New York, 1973.

"quacks." And when they formed their first national organization, in 1847, they named it *the* American Medical Association.

I would like to focus on this medical sect's theories of, and treatments of, female patients, especially as they evolved in the latter part of the 19th century. This is not merely a matter of historical curiosity, for it was this group of doctors (and I will henceforth accede to their claims and call them *the* doctors) that, shortly after the 19th century, did achieve a monopoly on healing and become *the* American medical profession.

Their overall view of women can be stated very briefly: women were sick. More precisely, all aspects and phases of female reproductivity—puberty, menstruation, pregnancy, menopause—were seen as dangerous crises requiring rest and close medical attention. Dr. W. C. Taylor, in his book *A Physician's Counsels to Women in Health and Disease* written in 1871 (1), gave a warning typical of his profession's public pronouncements:

> We cannot too emphatically urge the importance of regarding these monthly returns as periods of ill health, as days when the ordinary occupations are to be suspended or modified.... Long walks, dancing, shopping, riding, and parties should be avoided at this time of month invariably and under all circumstances.... Another reason why every woman should look upon herself as an invalid once a month, is that the monthly flow aggravates any existing affection of the womb and readily rekindles the expiring flames of disease.

I should qualify this by admitting that doctors did not believe that *all* women were sick. From the medical viewpoint, poor and working-class women were seen as extremely hardy, as evidenced by the fact that they were able to work 10 to 16 hours a day in factories and sweat shops and as household servants—whether they were pubescent, menstruating, pregnant, or menopausal. Of course, the truth was very different. As public health officials knew even then, the poor suffered much more than the rich from tuberculosis and other infectious diseases and from complications of childbirth—aggravated, no doubt, by malnutrition and overwork.

What is interesting, from a scientific viewpoint, is that the doctors postulated innate biologic differences between women of different social classes. Poor women were innately robust and in need of almost no medical care; affluent women were innately sickly and in need of almost constant medical attention. Now it is tempting to be cynical about a medical theory which postulates biologic differences on the basis of ability to pay for medical care, and I will not resist the temptation. The theory of the innate healthiness of the poor justified medical indifference to their problems; after all, they did not even have Medicaid to make their problems medically "interesting."

The theory of the innate sickness of affluent women served the economic interests of the doctors in two ways. First, it established middle- to upper-class women as a kind of "client caste" to the medical profession. Recall that in the late 19th century there was what the AMA called an "excess" of doctors, especially in the cities. A doctor could not count on having a very large clientele to himself, so it made sense to define those women patients he had as permanently, chronically sick. Second, the myth of female sickness helped to discredit women as healers. In the late 19th century, feminists were demanding female doctors for female patients, and women were literally beating on the doors of the "regular" medical schools. In his presidential address to the AMA in 1871, Dr. Alfred Stillé (2) was sufficiently moved by the feminist threat to state:

> Certain women seek to rival men in manly sports . . . and the strongminded ape them in all things, even in dress. In doing so they may command a sort of admiration such as all monstrous productions inspire, especially when they aim towards a higher type than their own.

On the whole, however, the medical defense against female doctors was less hysterical and more coolly "scientific": How could a woman—that is, a "lady"—perform a surgical operation if she were menstruating? How could she not help but faint at the sight of nudity in either sex?

The medical arguments against women in medicine, or, indeed, in any role outside the home, deserve a somewhat fuller explication, if only because they illustrate the depths of nonobjectivity which male medicine has achieved in its not-too-distant history. The basic physiologic theory entertained by American medical men was a sort of "conservation of energy" theory. The organs of the body were in competition for a fixed supply of energy; any one organ, or function, could only be developed at the expense of the others. As it applied to males, the theory was an injunction against overindulgence in sexual activities. If a man "spent his seed" too recklessly, he would sap the vital energies he needed for business, medicine, and other male pursuits.

The application of the theory to females was very different. It was established that intellectual activity would destroy a woman's reproductive powers. In his influential book *Sex in Education*, Dr. Edward Clarke (3) of Harvard University argued that higher education might literally cause women's uteruses to atrophy; this theory was extremely widespread. President Theodore Roosevelt believed it and foresaw in women's admissions to colleges the coming extinction of the white race. The following quote from Dr. R. R. Coleman, writing in 1889, illustrates the fervor with which 19th-century doctors expounded the gynecologic perils of education (4):

> Women beware, you are on the brink of destruction: You have hitherto been engaged in crushing your waists; now you are attempting to cultivate your mind: You have been merely dancing all night in the foul air of the ball-room; now you are beginning to spend your mornings in study. You have been incessantly stimulating your emotions with concerts and operas, with French plays and French novels; now you are exerting your understanding to learn Greek, and solve propositions in Euclid. Beware!! science pronounces that the woman who studies is lost.

It followed from the theory that one of the most common prescriptions for female patients was total abstinence from intellectual stimulation—reading, writing, and sometimes even conversation. As a young woman, Charlotte Perkins Gilman was confined to months of bed rest and isolation by one of America's most eminent gynecologists, Dr. S. Weir Mitchell. Fortunately, she recovered from this treatment to become one of the outstanding feminist theoreticians of her age.

Bed rest, however, was probably the least destructive therapy available. Doctors believed that all female ills stemmed ultimately from the uterus and ovaries. As Dr. M. E. Dirix (5) wrote in 1869,

> Thus, women are treated for diseases of the stomach, liver, kidneys, heart, lungs, etc.; yet, in most instances, these diseases will be found, on due investigation, to be, in reality, no diseases at all, but merely the sympathetic reactions or the symptoms of one disease, namely, a disease of the womb.

So, whatever a woman complained of—sore throat, indigestion, or "nerves"—she ran a good chance of being a victim of a medical assault on her reproductive and genital organs. Treatments ranged from the merely bizarre to the downright sadistic. Blisters and electric shocks were administered to the vulva as "counterirritants" for the basic problem in the uterus. Leeches were applied to the breasts (which were seen as sympathetically

connected to the womb), to the vulva, and even the cervix—notwithstanding their occasional disappearance into the uterus.

THE PRESENT DAY

Departing from the 19th century on that note, and reentering medicine in the present period, the subject assumes much greater significance. Today, 93 per cent of all medical doctors are male. Virtually all competition from other types of healers has been eliminated; the medical sect whose beliefs and activities in the 19th century I have described has achieved a total monopoly in the business of healing. In this context, the question of the role of men in medicine becomes an extremely pressing issue. We must ask, can medical men overcome the superstitions and "old husbands' tales" that have hindered the development of scientific medicine in the past? Are they capable of objectivity? I would not presume to give a final answer, but I would like to point out some of our reasons for doubt on this question.

When doctors make pronouncements on "female nature," we find them dominated by the superstitions and folklore of the past. I have made a brief survey of books written by doctors for lay women, and the message comes through strong and clear. Women are vain, silly, ignorant creatures, best suited for the "trivia" of homemaking under the firm guidance of husband and, of course, doctor. This is Dr. Bernard Cinberg's defense of his high fees in the introduction to his 1964 book *For Women Only* (6):

> Gynecologists' fees are high, at least their patients think so, but how do they compare with the price of a pair of shoes? Of a cocktail dress? If a patient would compile an honest accounting of the money she wastes annually on fripperies—include the beauty parlor, too, please—I'm certain that the cost of a semiannual gynecological checkup would assume its proper modest proportion.

Or we find that patriarch of American medicine, Morris Fishbein (7) advising a husband how to lure a recalcitrant wife in for a gynecological exam (*Ask the Doctor*, 1973): "Some women can be won over by a promise of a special treat—such as a long weekend at a resort or a new wardrobe. . . ." But if prejudice is thinly veiled in doctors' books for the public (at least those I have read), no effort is made to disguise it in the books doctors write for their fellow doctors. Pauline Bart and Diana Scully, sociologists and leading investigators of male medicine, have surveyed twenty recent gynecological textbooks printed over the last three decades. The following quote, from Dr. James Willson's *Obstetrics and Gynecology*, published in 1971, is typical of their findings on the medical view of "female nature": "The traits that compose the core of the female personality are feminine narcissism, masochism and passivity" (8).

Such notions are not simply of academic interest. Unfortunately, they find their way into the actual practice of medicine as it relates to women. Just as 19th-century doctors traced all female ills to the erratic and diseased womb (or ovaries), today's doctors tend to trace our ills to the frivolous female brain. In our informal discussions and investigations of women's medical care, we have long noticed the doctors' tendency to diagnose our somatic complaints—nausea, chest pains, headache, or whatever—as mere psychosomatic problems, and to dismiss them with a pat on the head and a prescription for Librium. The drug companies encourage this tendency; for example, a recent ad for "Bellergal Spacetabs" (essentially a sedative) in the *Medical World News* (9), begins,

> When you see the same patient over and over with functional complaints . . . consider Bellergal Spacetabs. Most doctors have a number of patients who complain of *vague symptoms* such as menopausal disorders . . . premenstrual tension . . . palpitations . . . G.I. disorders . . . "nervous stomach" . . . recurrent throbbing headache. (Emphasis added, but the ellipses are in the original.)

The patient in the accompanying illustration is, of course, a woman.

The tendency of doctors to diagnose women's ills as psychosomatic may be lucrative for drug companies and doctors ("psychosomatic" diagnoses cut down on the time per visit yet ensure that there will be future visits, if only to renew the prescription), but they are definitely hazardous for women. I would recommend as required reading on this point the article "Alleged Psychogenic Disorders in Women: A Possible Manifestation of Sexual Prejudice," by K. Jean and R. John Lennane (10).

Some of the most flagrant examples of medical nonobjectivity have surfaced over the issue of the birth control pill. I will not detail the ugly story of the pill's development—from the first tests on Puerto Rican women (for efficacy only, not safety), to the virtually unmonitored "test" on 20 million North American women. Despite "side effects" ranging from depression to diabetes and death, the medical profession has campaigned relentlessly against publication and distribution of full FDA warnings on the pill. "If you tell a woman she's going to get a headache, she will," one doctor told a Congressional hearing on the pill (11). Medical journalist Barbara Seaman (12) (author of *Free and Female*) contrasts this massive medical indifference to women to the doctors' panicky reactions to the recent suggestion of possible harmful effects of vasectomy in mice!

But I am concerned here not with the merits of the pill, but with the quality of the doctors' reactions to the controversy. In his book for lay women, curiously entitled *On Being a Woman* (1971), Dr. W. Gifford-Jones (13) first reviews the evidence against the pill's safety and then makes the following statement, which must be a classic example of poor logic, anti-intellectualism, and just plain bad grammar:

> Furthermore, proving anything by statistics has always been a very risky game, for it's a well-known fact that you can prove almost anything you want by this method. In fact its [sic] been said there are three kinds of lies: lies, damned lies and statistics! Yet even assuming the figures are correct, it is also well to remember that all of our daily activities involve some risk. Look at the slaughter on our highways and the drownings in our lakes. These are major risks that are more common than the number of women [sic] who die while on the pill. . . . It's the old philosophy of "you pay your money and you take your chance."

I could continue. I could mention the frequently irrational and unjustified use of radical surgery—hysterectomies, for example—for women in this country. I could mention that branch of medicine called psychiatry, which, insofar as it deals with women, has been little more than a codification and systematizing of ancient male prejudices. But much of this would be, I trust, familiar, either from your own experience or from such recent books as Ellen Frankfort's *Vaginal Politics* (14) and Phyllis Chesler's *Women and Madness* (15). In summarizing, I would like to offer a tentative analysis of the issue of men and medicine.

SUMMARY

The medical view of women—especially of those women who today are demanding better, more rational medical care—is that women are hysterical, ignorant, and antiscientific. But men in medicine have been, and remain, in significant areas of their work, barbaric, superstitious, and antiscientific.

The question is, Why has this been so? I personally reject the obvious but facile biologic explanation. I see no reason to believe that male healers or men in general are innately superstitious and incapable of the objective practice of medicine. The view that some of us are coming to is that the kinds of nonobjectivity and superstition that medical men display when confronted by the female patient are not in any way random, as would be the case if mere ignorance were involved. Rather, the prevailing medical superstitions about women always show a remarkable conformity to the prevailing cultural mythology about the proper role of women.

In the late 19th century, the prevailing cultural norms held that genteel ladies of the so-called better classes were to be totally idle symbols of their husbands' wealth and achievements. The servants who waited on them and who "manned" the factories of our Industrial Revolution, were, of course, never supposed to be idle, but instead capable of ceaseless toil. The medical theory of the time supported and justified these roles. Genteel ladies were innately "sick"; working-class women were innately "healthy."

Today, with the demise of the servant class, even genteel women are expected to work—to manage their own households, to raise their own children, to nurture and entertain their husbands. Almost all women are expected, at some point in their lives, to hold down various jobs—volunteer work (for the rich); such well-supervised "professions" as nursing, teaching, and social work (for the middle class); clerical and less-skilled types of blue-collar work (for everyone else)—but definitely *not* leadership jobs for any of us. The medical mythology is entirely consistent with these roles. Women are seen as physically capable of working but mentally somewhat less than fully capable—as evidenced, among other things, by the widespread view that most women's medical complaints are basically due to "mental problems," i.e. they are psychosomatic.

The "scientific" stand on contraception has also changed conveniently to suit the times. Late 19th-century public policy was pro-natalist (for population growth, at least among the "better" classes), hence medical science found that contraception in any form was inherently injurious—potentially as "dangerous" as masturbation! Public policy today tends to be anti-natalist, or opposed to population growth. Thus, medicine can find almost no fault with any female contraceptive method that is effective, however unsafe.[1]

To conclude, medicine as practiced by an almost entirely male profession, on women, is in many respects not so much an objective "science" as it is a "scientific" disguise for the prevailing forms of male prejudice. This is why I feel that our demand must never be simply for "more" medical care for women. "More" is not enough when it can only mean more prejudice, more superstition, more barbarity. In framing visions of an alternative health care system, our demand must be for a totally new kind of medical care—care which reflects the physiologic and social needs of its recipients, rather than the biases of its practitioners.

Women, conscious of their own history of medical oppression, are taking the first steps: The gynecologic self-help movement, initially persecuted as a medically irresponsible "cult," has grown to international proportions, offering tens of thousands of women a revolutionary new concept of health and healing. Midwifery, long suppressed in the United States as "dirty" and "unscientific," is on the rise again, challenging the medical view of childbirth as a pathologic event. A new breed of self-assertive women is

[1] The Peronist government of Argentina provided a recent interesting case of medical flexibility by announcing in March a new policy of population growth. Contraceptives have been, for all practical purposes, banned. The government announcement said that the medical justification for this decision—the reasons why contraception is injurious—would be forthcoming.

entering the nursing schools, determined to be more than handmaidens to the dominant practitioners. There are more women in medical schools in the United States than ever before, and they are beginning to question—not just the barriers to their own advancement but the substance of what they are taught.

REFERENCES

1. Taylor, W. C. *A Physician's Counsels to Women in Health and Disease*, pp. 284-285. W. J. Holland and Co., Springfield, 1971.
2. Quoted in Shryock, R. H. *Medicine in America: Historial Essays*, p. 185. Johns Hopkins Press, Baltimore, 1966.
3. Clarke, E. H. *Sex in Education, or, a Fair Chance for the Girls*. James R. Osgood and Co., Boston, 1873. Reprint edition 1972 by Arno Press, Inc.
4. Quoted in Haller, J. S., and Haller, R. M. *The Physician and Sexuality in Victorian America*, p. 39. University of Illinois Press, Urbana, 1974.
5. Dirix, M. E. *Woman's Complete Guide to Health*, pp. 23-24. W. A. Townsend and Adams, New York, 1869.
6. Cinberg, B. *For Women Only*, p. xii. Dial Press, New York, 1964.
7. Fishbein, M. *Ask the Doctor*, p. 144. David McKay Co., New York, 1973.
8. Quoted in Scully, D., and Bart, P. A funny thing happened on my way to the orifice: Women in gynecology textbooks. *Am. J. Sociol.*, 78: 1045-1050, 1973.
9. *Medical World News*, March 8, 1974.
10. Lennane, K. and Lennane, R. Alleged psychogenic disorders in women: A possible manifestation of sexual prejudice. *N. Engl. J. Med.* 288: 288, 1973.
11. Women's liberation and the practice of medicine. *Medical World News*, June 22, 1973, p. 34.
12. Seaman, B. Personal communication.
13. Gifford-Jones, W. *On Being a Woman*, p. 69. Macmillan, New York, 1971.
14. Frankfort, E. *Vaginal Politics*. Quadrangle Press, New York, 1972.
15. Chesler, P. *Women and Madness*. Avon Books, New York, 1972.

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The 'Declining Significance' or the 'Changing Forms' of Patriarchy?

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INTRODUCTION

Is patriarchy in decline? Or has it merely changed form? Whether the development process decreases patriarchy is the question underlying this chapter. The answer to this question depends not only on the empirical evidence, which is being addressed in other chapters, but on the definition and theorization of 'patriarchy' itself. This chapter will address these theoretical questions on 'patriarchy' in the context of the trajectories of development and patriarchy.

The significance of gender relations in macro-historical trajectories of development is now widely recognized (Boserup, 1970; Elson and Pearson, 1981; Leacock and Safa, 1986; Jayawardena, 1986; Mitter, 1986; Moghadam, 1992; Sen, 1984, 1987). There is now a wealth of data on how gender relations have been changing, although the picture is still far from complete. The task of adequately theorizing these changes in gender relations at a macro-level necessitates adapting, refining, and building appropriate concepts. Existing concepts in other mainstream analyses typically insufficiently address the specificity of gender, leaving it as an empirical question rather than a theorized phenomenon. Many of the problems which have been identified with the use of the concept of patriarchy are related to contingent rather than necessary features of the concept. However, critics have frequently attempted to dismiss the concept of patriarchy for problems which they incorrectly suggest are intrinsic.

Many of the attempts at global understanding of development do not deal with the gender dimension (e.g. Wallerstein, 1974; Frank, 1967). There have been a few significant attempts within the development, historical, sociological, and women's studies literature to begin to make sense of global patterns of gender relations (Boserup, 1970; Kelly, 1984; Lerner, 1986; Mies, 1986).

The substantive question of whether the processes of development and of industrialization have increased or decreased gender inequality is highly contested. On the one hand, economic development was seen to go along with increased educational, economic, and political participation of women as part of the process of modernization. The suggestion that economic development emancipates women finds a wide resonance in the literature

on gender across the range of social science disciplines; across many and various conceptions of development, economic development, modernization, and industrialization; across time and space from contemporary Western changes to industrialization in the West to historical and contemporary changes in newly industrializing countries.

On the other hand there has been scepticism about the extent to which women have been able to control the proceeds of their waged labour, and concern about issues such as the conditions under which women work, about decreases in women's property rights, about increased sexual exploitation and effective political voice (Agarwal, 1988; Rogers, 1980; Brydon and Chant, 1989). The issue of a backlash is relevant to both newly industrializing countries (Afshar, 1989) and to the West (Faludi, 1992), and the possibility of reverse is historically clear (see Koonz, 1987 on Nazi Germany). Within Western feminist and gender theory the question of whether this century is seeing advances has often divided between theoretical perspectives. There has also been an awareness that language of progress and regress risks ethnocentric bias. Indeed so much so, that many would reject the question as inherently value laden.

My concern here is to examine the different ways in which the concept of patriarchy has been developed to address the diverse empirical issues. The concept of 'patriarchy' has a long, complicated, and contested history. I shall be arguing that in revised form the concept of patriarchy is indispensable. However, addressing the problems that have been raised about some of the ways the term has been used is essential. The first issues are those of definition.

THE DEFINITION OF 'PATRIARCHY'

The concept of patriarchy has been defined in a number of different ways, but usually with two similar core elements. Firstly, there is the core notion of gender inequality. Secondly, that there is a degree of systematicity, in that the different aspects of gender relations are connected in some way.

In order to take the debate forward it is necessary to consider the divergences in usage and to assess the merits of the different definitions. There are three main sources of divergence and debate.

First, whether the notion of gender inequality is expressed as men's domination over women, using the biological categories (e.g. Firestone, 1974), or whether the reference is to social structures and practices (e.g. Hartmann, 1979). If the definition refers only to biological categories, then the danger of biological reductionism is very strong. Since most analysts reject the notion that biology determines gender, it is important that the definition of patriarchy itself makes reference to the social dimension. However, it is important not to lose sight of the importance of the

biological signifier. My preferred definition of patriarchy as a system of social structures and practices in which men dominate, oppress, and exploit women, attempts to capture the middle ground here.

A second major issue is whether the definition of patriarchy is tied to the household or not. One strand of thought defines patriarchy in terms of men's domination over women through the household, often including a generational aspect in which the oldest man in a household dominates all household members including young men (Hartmann, 1979; Moghadam, 1992; Weber, 1947). Other writers have preferred not to tie the definition of patriarchy to any particular household form, and have left open the question as to the relationship of the household to gender inequality (Mies, 1986). Mies argues that we need to go beyond the old usage of the term 'patriarchy' which refers to the rule of the father, since, she argues, many other categories of men (for example, male bosses) are involved in the subordination of women. This is a key contested issue which will emerge crucially through the debates on changes in patriarchy which I shall discuss below. I shall argue that the household form of domination is a contingent, not necessary, part of patriarchy, and hence should not be included in its definition.

A third major divergence in the definition of patriarchy lies in the extent to which writers include a theory of patriarchy within the definition. For instance, Hartmann (1979) states that the chief way in which patriarchal control is maintained is through the appropriation of women's labour. Her definition of patriarchy thus includes a theoretical relationship in which labour is the base and other aspects of society constitute a superstructure. (However, the base–superstructure model is softened in later work by Hartmann.) Other theorists have variously suggested male violence (Brownmiller, 1976), sexuality (MacKinnon, 1989) and reproduction (Firestone, 1974), and various other areas as the basic structure. However, while MacKinnon sees sexuality as definitive of gender, not all the others find it necessary to build the base of patriarchy into its definition.

It is not theoretically useful to tie the concept of patriarchy to anything other than gender inequality. It is unnecessarily restricting, and at times highly misleading, to tie it to either a specific household form, or to a dominant structure, such as the economic. One of the major problems which stems from this is the difficulty of theorizing changes in gender relations. Yet it is vital to be able to do this. These issues are central to the debate on patriarchy and will be discussed in detail below.

SEPARATE OR FUSED SYSTEM

Since patriarchy both pre-dates and post-dates capitalism it cannot be derivative from it. Patriarchal relations exist in feudal societies (Middleton, 1981; Lie, this volume) and they existed in pre-1989 and post-1989 Eastern

Europe (Einhorn, 1993). That development of capitalism affected patriarchal relations is clearly the case, but a change in the form of patriarchy is not the same as its demise or creation.

There have been various ways of analysing the relationship between patriarchy and capitalism, depending on the degree and form of their engagement.

First, they can be considered to be so closely intertwined that they become not merely symbiotic, but fused into one system, Eisenstein (1979) took this position, arguing that patriarchy provides a system of control and law and order, while capitalism provides a system of economy, in the pursuit of profit. However, there are some logical problems here. If the two are fused into one system it is only one, yet Eisenstein does speak of their interrelationship as if they were two.

Second, patriarchy and capitalism can be regarded as analytically distinct (Hartmann, 1979; Mitchell, 1975). Writers differ in their mode of separation of patriarchy and capitalism. Some allocate different structures to the different systems, while others do not. Mitchell (1975) allocates the economic level to capitalism and the unconscious and culture to patriarchy. Hartmann (1979) sees patriarchal relations as crucially located in the expropriation of women's labour by men in the two key sites, the household and paid work. These two forms of appropriation reinforce each other, since women's disadvantaged position in paid work makes them vulnerable in negotiations over the domestic division of labour, while their position in the family disadvantages them in paid work. Thus she sees patriarchy and capitalism as ultimately mutually reinforcing systems, even if there are moments of tension.

Mies takes a mid-way position on the separation and integration of patriarchy and capitalism. She notes that patriarchy long pre-dated capitalism, and is usually in combination with another social system, for instance feudalism. Patriarchy and capitalism are seen as very closely connected, but ultimately capitalism is merely another form of patriarchy. Patriarchy, like capitalism, is a world system. Patriarchy is maintained by a series of structures and practices including the family, systematic violence, and the expropriation of women's labour. Mies uses the term 'capitalist-patriarchy' to refer to the current system which maintains women's oppression. Capitalism, for Mies, is the latest form that patriarchy takes. Thus she reverses the more conventional hierarchy between the two systems and argues that patriarchy pre-dates capitalism and has analytic priority. She resolves the dilemma of dual-systems theory, as to how systems of 'patriarchy' and 'capitalism' might interrelate, by theorizing capitalism as an expression of patriarchy.

Mies argues that the dependency of women in the industrialized countries is only possible because of the exploitation of women in non-industrialized countries. Mies argues that the domestication or, as she calls it, the housewifization of women in the metropolitan capitalist nations is dependent upon the exploitation of the Third World. The first stage is the process of forcible colonization and the development of the luxury trade. The second stage is the development of an internal colony, in which women are colonized by men in Europe. The relations within the industrialized countries is only half the account, the other is that in the colonies and ex-colonies.

Mies argues that there has been a shift in the international division of labour from the old one in which raw materials were exported from the colonies for processing in the industrialized world and then marketed world wide, to a new international division of labour. In the new division, industrial production is transferred to the developing countries, producing unemployment in the industrialized countries. It is women who are the new industrial producers in the Third World, and it is women who, Mies claims, are the consumers of these items in the First World. Women are the cheaper labour force in the Third World since their designation as dependent housewives enables them to be paid low wages. Women in the First World, fired from their jobs as a result of the transfer of industry, are the consumers.

The weakness in the account stems from problems in some of the supporting evidence and from theoretical silences—not unexpectedly, given the scope of the project. First, her argument that women in the First World are currently subject to housewifization following the transfer of industry to the Third World is empirically incorrect. Women are entering paid employment in greater proportions than ever before, despite having higher unemployment rates than men in almost all Western countries bar Britain (OECD, 1980). To be sympathetic one could note that this process is not complete, but nevertheless the direction of change is the opposite from that argued by Mies. Secondly, the nuclear family form was not unique to modern capitalism. Laslett (1977) and McFarland (1978) have shown that it is not unique and that it pre-dated the rise of capitalism, so could not have been caused by it. Even the more intensely domesticated version in which the women are not allowed to take outside employment is not unique to the Victorian middle classes since it can be found among Islamic societies, especially among their traditional urban middle and upper classes (also, this is changing). In short, Mies places too much explanatory emphasis upon changes in capitalism, despite her stated interest in a world system of patriarchy.

RELATIONS BETWEEN THE DIFFERENT ASPECTS OF PATRIARCHY

Many writers have argued that the concept of patriarchy has insuperable problems because it is inherently essentialist. There are considered to be

related problems of ahistoricism, reductionism, and inability to deal with cultural diversity (Barrett, 1980, though see Barrett, 1990; Rowbotham, 1981; Segal, 1987). This criticism has been levelled especially against the use of the concept of patriarchy by radical feminists, particularly those who have focused on the issues of reproduction, sexuality, and violence, such as Brownmiller (1976), Daly (1978), and Firestone (1974). Here the critique has argued that these accounts reduce women's oppression to one base and ultimately one which is biology, and hence that they are essentialist (see Segal, 1987).

Thus there are doubts as to whether 'patriarchy' is an appropriate term to grasp the complexity and diversity of patterns of gender relations (see Alcoff, 1988; Barrett and Phillips, 1992; Walby, 1992). There is an argument that the patterns of gender relations are too varied to justify attempts at grasping global patterns. This reaches its peak amongst writers of postmodernist tendency who have sometimes suggested that even the term 'woman', let alone 'patriarchy', can be inappropriately over-homogenous. One important dimension of this criticism has come from those who argue that cultural difference is insufficiently grasped by the term patriarchy, in that it tends to suggest that patriarchal relations are similar across ethnic groups (Carby, 1982; Hooks, 1984; Yuval-Davis and Anthias, 1989).

However, these problems only arise if patriarchy is conceptualized in the following ways. First, it is a problem if the definition refers to biological categories as the unit of analysis. As we have seen this is not the case in some definitions, though it is in others. Second, it is a problem if a simple base–superstructure model is used in which one dimension of social life determines all other aspects of gender relations. This is only true of certain usages of the concept. In those theories which have more complex internal models of patriarchy this problem need not occur. In these latter cases there is no simple reduction. If these two problems are avoided then there is no need for the concept and theory of patriarchy to be essentialist.

The solution to this problem is for the system of patriarchy to be conceptualized as being composed of several interrelated structures. At a lower level of abstraction, within each of these structures specific patriarchal practices can be identified which are less deeply sedimented. Structures are emergent properties of practices. Any specific empirical instance will embody the effects not only of patriarchal structures, but also of capitalism and racism (Walby, 1990).

I have argued that the system of patriarchy over the last 150 years in the UK should be considered to be composed of six structures: patriarchal relations in household work, patriarchal relations in paid work, a patriarchal state, male violence, patriarchal relations in sexuality, and patriarchal relations in cultural institutions.

Patriarchal relations in the household are my first structure. It is through these that women's household labour is expropriated by their husbands,

fathers, or cohabitees. The woman may receive her maintenance in exchange for her labour, especially when she is not also engaged in wage labour. Of course, the nature and extent of this work varies, especially, but not necessarily, with the wealth and income of the woman and her husband.

The second patriarchal structure within the economic level is that of patriarchal relations within paid work. A complex of forms of patriarchal closure within waged work excludes women from the better forms of work and segregates them into worse jobs which are deemed less skilled.

The state is patriarchal as well as being capitalist and racist. While being a site of struggle and not a monolithic entity, the state has a systematic bias towards patriarchal interests in its policies and actions.

Male violence constitutes a further structure, despite its apparently individualist and diverse form. It is behaviour routinely experienced by women from men, generating fear which has restrictive effects upon the actions of most women. Male violence against women is effectively condoned by the lack of state intervention against it except in extreme circumstances, although interpersonal violence is usually technically illegal.

Patriarchal relations in sexuality constitute a fifth structure. The sexual double standard, prostitution, and pornography are examples of practices here.

Patriarchal cultural institutions complete the array of structures. These are significant for the generation of a variety of gender-differentiated forms of subjectivity. This structure is composed of a set of institutions which create the representation of women within a patriarchal gaze in a variety of arenas, such as religion, education, and the media.

While this model was developed within the context of the last 150 years of UK history, with some modifications, the main features are globally relevant. These would include the reconceptualization of the boundary between the structures of patriarchal relations in paid work and in the household in the context of agricultural and peasant economies where such a boundary is not so clearly discernible.

CONCEPTUALIZING CHANGE

There are serious disagreements as to whether or not women's position has been improving with economic development. In the light of the foregoing discussion these can be divided into three types. First, there are disagreements over the same empirical issues. Second, there are disagreements over which empirical issues are important and how changes in different dimensions of women's lives are to be weighted in order to give an overall statement as to whether there has been an increase or decrease in gender inequality. Third, there is disagreement over how changes in gender relations are to be conceptualized.

An example of the first type of disagreement over empirical issues is over whether the workload of women in a particular society had decreased or increased. This is obviously made difficult if the statistics are inadequate, but more importantly there may be disagreements over what may be contained within the concept 'work': for instance, whether 'work' includes unpaid housework, or is restricted to work which enters the money economy. The work that women do in the domestic and informal sectors of the economy is notoriously undercounted in official statistics (see Thomas, 1992), in local understandings of what counts as significant work (Agarwal, 1988), as well as divergent views among development 'experts' (Rogers, 1980). Futher, there are very considerable differences in the extent to which women engage in housework, depending on class and income. But, none the less, this is more of an empirical than a theoretical question, even though the boundaries of such concepts are heavily theory laden.

The second type of disagreement is over the question of which aspects of women's lives count most towards an overall index of gender equity. Here there is profound disagreement. A key focus is over whether paid work intrinsically enhances a woman's emancipation. One aspect of this is the question of whether paid work is more or less alienating than work in the household. Can one aspect be balanced against another? For instance, some writers have argued that the development of commercialized sex in pornography and institutionalized prostitution is more likely with the development of a market economy; indeed some have argued that a sexual counter-revolution has historically been a feature of the backlash against women's gains in the political and economic arenas (e.g. Jeffreys, 1985; Millett, 1970; Faderman, 1981). (However, prostitution has long predated capitalism.) Whether or not there has been progress then depends upon the ranking of the significance of the different dimensions of women's lives.

EXPLAINING CHANGES

In many ways the question of whether paid employment liberates women is central to many of the debates about trajectories of development and patriarchy. The conceptual and theoretical underpinnings to the thesis that it does liberate women are interesting and all highly contested. First, there is the proposition that paid work is more advantageous to the woman than unpaid work. This often includes a second proposition, that women are able to control the wages they obtain in paid work. A third and related presumption is that the presumed advantages that a woman gains in employment increase the control she has in other areas of her life, such as the domestic division of labour, and in other social relations, such as access to political decision-making arenas.

There is thus an implicit, if not explicit, theory of patriarchy within this proposition that women benefit from increased paid employment. It presumes the connectedness of the different aspects of gender relations, that is, a degree of systematicity. It further presumes that these operate consistently in the same direction (rather than having an adverse impact).

Yet each of these propositions has been challenged, these challenges in turn drawing on implicit or explicit theories of gender relations.

Is paid work better than unpaid work? Much of the recent literature on 'race', ethnicity, and gender has queried this presumption. If the paid work that women do is terrible, as is often the case of those women in vulnerable positions, then it may be that domestic work is more fulfilling, allowing greater autonomy (Hooks, 1984).

Can women control the rewards from their work? Do they get paid themselves, or are their wages given to or controlled by dominant family men? There are a significant number of examples of men retaining control of the wages of women in their families (Mark-Lawson and Witz, 1990).

Standing (1989: 1090–1) has suggested that there are seven areas where the degree of control that women have over the rewards for paid work need to be considered, and advocates the collection of better data. First, control over self; for instance, as bonded labourers. Second, control over the hours of work, such as not working longer than they would wish. Third, control over the means of production. Fourth, control over raw materials. Fifth, control over output, such as whether the woman is allowed to sell her wares herself. Sixth, control over proceeds of output, especially over whether the woman worker controls the wages which are paid, or whether male kin or intermediaries prevent this. Seventh, control over labour reproduction, especially over the ability to renew and enhance their own skills.

Is there a positive relationship between changes in paid work and changes in other dimensions of women's lives? The conventional position implicitly presumes a base–superstructure model in which the economic base determines the superstructure of such things as political participation and sexual autonomy. Such base–superstructure models have been widely criticized when used in relation to class as well as in relation to gender, as oversimplifying complex causal interactions. Indeed some writers have argued that we should not exclude an inverse relationship: for instance, the backlash against women's successes in both first-wave and second-wave Western feminism in the arena of political and economic rights which took place at the sexual level (Jeffreys, 1985; Millett, 1977, Faderman, 1981; Faludi, 1992).

There is a question as to what are the circumstances under which paid work emancipates women. Historically in the West this has occurred at those moments when women have also been gaining political rights. When women won political citizenship as the result of the turn of the century

women's movement, this was used to ensure that waged work provided wider, not merely burdensome, opportunities for women (Walby, 1988).

The third and final question involves the very definition of patriarchy. If patriarchy is defined narrowly, then changes in some dimensions of gender inequality will be considered irrelevant, while changes in the element defined as key may be sufficient to justify a claim that patriarchy has ended. This is the problem with definitions of patriarchy which focus too narrowly on men's domination of women through the household, such as Mann (1986).

THE END OF PATRIARCHY?

Mann (1986) has argued that patriarchy no longer exists, although there is still gender inequality (presumably within the UK). This is because he defines a patriarchal society as 'one in which power is held by male heads of households' and where there is a 'clear separation between the "public" and the "private" spheres of life' (Mann, 1986: 41), and these conditions no longer hold. He suggests that there are three reasons for this: the erosion of the public/private boundary, employment trends, and the nation state's welfare interventions into the household/family (Mann, 1986: 55). Yet he is not suggesting that there is not gender inequality, indeed he suggests that it should be taken more seriously in that stratification should be regarded as gendered. Neither is he suggesting that there are not key 'stratification nuclei' (p. 56), nor that there are not significant commonalities by gender—'child-rearing unites almost all women' (p. 54).

In short, Mann is arguing that there is still a significant amount of gender inequality but, because it is not centrally determined by a male-dominated household, it is not patriarchy.

I think this is not a helpful theorization of the issues. The key element of a definition of patriarchy is that there is systematically structured gender inequality. Mann accepts that this is empirically the case, but denies the application of the concept. He does this because he has defined patriarchy as centrally linked to a male-dominated household. I think this is a mistake.

FORM AND DEGREE OF PATRIARCHY

The separation of the degree of patriarchy from its form is a crucially necessary theoretical development. On each dimension of gender relations it is often possible to specify the degree of inequality between the sexes, but much more difficult to do this at the level of the system as a whole because of the inherently value-laden decision as to the significance of different aspects of gender relations. For instance, it is possible to state

whether the gap in the hourly wage rates for men and women is greater or lesser. However, the relative balance of oppression in household work and paid work is a more problematic question.

It is possible for there to be a change in the form of patriarchy without a change in its degree and vice versa.

PUBLIC AND PRIVATE PATRIARCHY

There have been two major forms of patriarchy in the West over the last couple of centuries: public and private. They differ on a variety of levels: first, in terms of the relations between the structures, and second, in the institutional form of each structure. Further, they are differentiated by the main form of patriarchal strategy: exclusionary in private patriarchy and segregationist in public patriarchy. Private patriarchy is based upon household production, with a patriarch controlling women individually and directly in the relatively private sphere of the home. Public patriarchy is based on structures other than the household, although this may still be a significant patriarchal site. Rather, institutions conventionally regarded as part of the public domain are central in the maintenance of patriarchy.

In private patriarchy it is a man in his position as husband or father who is the direct oppressor and beneficiary, individually and directly, of the subordination of women. This does not mean that household production is the sole patriarchal structure. Indeed it is importantly maintained by the active exclusion of women from these public arenas by other structures. The exclusion of women from these other spheres could not be perpetuated without patriarchal activity at these levels.

Public patriarchy is a form in which women have access to both public and private arenas. They are not barred from the public arenas, but are none the less subordinated within them. The expropriation of women is performed more collectively than by individual patriarchs. The household may remain a site of patriarchal oppression, but is no longer the main place where women are present.

In each type of patriarchy the six structures are present, but the relationship between them and their relative significance is different. For instance, I am not arguing that in private patriarchy the only significant site is that of the household. In the different forms there are different relations between the structures to maintain the system of patriarchy.

In the private system of patriarchy the exploitation of women in the household is maintained by their non-admission to the public sphere. In a sense the term 'private' for this form of patriarchy might be misleading, in that it is the exclusion from the public which is the central causal mechanism. Patriarchal relations outside the household are crucial in shaping patriarchal relations within it. However, the effect is to make women's

54

experience of patriarchy privatized, and the immediate beneficiaries are also located there.

In the public form of patriarchy the exploitation of women takes place at all levels, but women are not formally excluded from any. In each institution women are disadvantaged.

The second aspect of the difference between private and public patriarchy is the institutional form of each of the structures. This is a movement from an individual to a more collective form of appropriation of women. There has also been a shift in patriarchal strategy from exclusionary to segregationist and subordinating.

In the context of the UK over the last 150 years the change within each structure has been as follows. Within paid work there was a shift from an exclusionary strategy to a segregationist one, which was a movement from attempting to exclude women from paid work to accepting their presence but confining them to jobs which were segregated from and graded lower than those of men. In the household there was reduction in the confinement of women to this sphere over a lifetime and a shift towards the state in the main locus of control over reproduction. The major cultural institutions ceased to exclude women, while subordinating women within them. Sexual controls over women significantly shifted from the specific control of the husband to that of a broader public arena; women were no longer excluded from sexual relations to the same extent, but subordinated within them. Women's exclusion from the state was replaced by their subordination within it. There are, of course, variations by class and ethnicity within the UK, in these changes.

The cause of this change was feminist activity at the turn of the century in the context of the increasing demand for female labour in an expanding capitalist economy.

EASTERN EUROPE

There are sub-systems within this: for instance, pre-1989 eastern Europe had a state-led form of public patriarchy, while the USA had a labour-market led form of public patriarchy, with Western Europe in between with its welfare state and female employment participation rates. However, as is becoming clear, it would be unwise to declare that women in Eastern Europe suffered a lesser degree of patriarchy than those in the West despite their greater participation in paid work, since the degree of inequality in the household and the size of the burden of household work appears to have been greater.

The current trajectory in Eastern Europe appears to be unhappily poised between a shift to a market-led form of public patriarchy, and a return to more private forms, as suggested by Moghadam's chapter in this volume.

It may be that a backlash against the exploitation of state-led public patriarchy will lead to a more private form of patriarchy. However, the economic shock treatment advocated by US economists may lead these countries simply into a market-led form of public patriarchy.

CONCLUSION

The concept of patriarchy is indispensable to the macro-level analysis of changes in gender relations. The concept needs to be developed in the light of the legitimate criticisms of some of the early formulations. In particular, the internal differentiation of structures within the system, and their various combinations into different forms of patriarchal system, is crucial if the concept is to be able to deal appropriately with historical, spatial, cultural, and ethnic diversity. Systematically interrelated forms of gender inequality do not stop when the household-based form of private patriarchy diminishes. Rather, we see new forms. The degree of patriarchy may change as well, but that is analytically separate from the issue of the form, even if, contingently, in Western history, there have been some changes in both simultaneously.

REFERENCES

AFSHAR, HALEH (1989), 'Women and Reproduction in Iran', in Nira Yuval-Davis and Floya Anthias (eds.), *Woman–Nation–State* (London: Macmillan).

AGARWAL, BINA (ed.) (1988), *Structures of Patriarchy: The State, the Community and the Household* (London: Zed Press).

ALCOFF, LINDA (1988), 'Cultural Feminism versus Post-Structuralism: The Identity Crisis in Feminist Theory', *Signs* (spring) 13/3: 405–36.

BARRETT, MICHÈLE (1990), *Women's Oppression Today*, 2nd edn. (London: Verso).

—— and Phillips, Anne (eds.) (1992), *Destabilizing Theory: Contemporary Feminist Debates* (Cambridge: Polity Press).

BOSERUP, ESTER (1970), *Women's Role in Economic Development* (London: Allen and Unwin).

BROWNMILLER, SUSAN (1976), *Against Our Will: Men, Women, and Rape* (Harmondsworth: Penguin).

BRYDON, LYNNE and CHANT, SYLVIA (1989), *Women in the Third World: Gender Issues in Rural and Urban Areas* (Aldershot: Edward Elgar).

CARBY, HAZEL (1982), 'White Woman Listen! Black Feminism and the Boundaries of Sisterhood', in Centre for Contemporary Cultural Studies, *The Empire Strikes Back* (London: Hutchinson).

DALY, MARY (1978), *Gyn/Ecology* (London: Women's Press).

EINHORN, BARBARA (1993), 'Democratization and Women's Movements in East

Central Europe: Concepts of Women's Rights', in V. M. Moghadam (ed.), *Democratic Reform and the Position of Women in Transitional Economies* (Oxford: Clarendon Press).

EISENSTEIN, ZILLAH (ed.) (1979), *Capitalist Patriarchy and the Case for Socialist Feminism* (New York: Monthly Review Press).

ELSON, DIANE and PEARSON, RUTH (1981), 'Nimble Fingers Make Cheap Workers: An Analysis of Women's Employment in Third World Export Manufacturing', *Feminist Review*, 7: 87–107.

FADERMAN, LILIAN (1981), *Surpassing the Love of Men: Romantic Friendship and Love Between Women from the Renaissance to the Present Day* (London: Junction Books).

FALUDI, SUSAN (1992), *Blacklash: The Undeclared War Against Women* (New York: Crown Publishers).

FIRESTONE, SHULAMITH (1974), *The Dialectic of Sex* (New York: Morrow).

FRANK, ANDRE GUNDER (1967), *Capitalism and Underdevelopment in Latin America* (New York: Monthly Review Press).

HARTMANN, HEIDI (1979), 'Capitalism, Patriarchy and Job Segregation by Sex', in Z. Eisenstein (ed.), *Capitalist Patriarchy* (New York: Monthly Review Press).

HOOKS, BELL (1984), *Feminist Theory: From Margin to Center* (Boston: South End Press).

JAYAWARDENA, KUMARI (1986), *Feminism and Nationalism in the Third World* (London: Zed Press).

JEFFREYS, SHEILA (1985), *The Spinster and Her Enemies: Feminism and Sexuality, 1880–1930* (London: Pandora).

KELLY, JOAN (1984), *Women, History and Theory* (Chicago: University of Chicago Press).

KOONZ, CLAUDIA (1987), *Mothers in the Fatherland* (London: Methuen).

LASLETT, PETER (1977), *Family Life and Illicit Love in Earlier Generations* (Cambridge: Cambridge University Press).

LEACOCK, ELEANOR and SAFA, HELEN (eds.) (1986), *Women's Work: Development and the Division of Labour by Gender* (South Hadley: Bergin and Garvey).

LERNER, GERDA (1986), *The Creation of Patriarchy* (New York: Oxford University Press).

MCFARLAND, ALAN (1978), *The Origins of English Individualism* (Oxford: Blackwell).

MACKINNON, CATHERINE (1989), *Towards a Feminist Theory of the State* (Cambridge, Mass.: Harvard University Press).

MANN, MICHAEL (1986), 'A Crisis in Stratification Theory? Persons, Households/Families/Lineages, Genders, Classes and Nations', in Rosemary Crompton and Michael Mann (eds.), *Gender and Stratification* (Cambridge: Polity Press).

MARK-LAWSON, JANE and WITZ, ANNE (1990), 'Familial Control or Patriarchal Domination? The Case of the Family System of Labour in Nineteenth Century Coal Mining', in Helen Corr and Lynn Jamieson (eds.), *Politics of Everyday Life: Continuity and Change in Work and the Family* (London: Macmillan).

MIDDLETON, CHRIS (1981), 'Peasants, Patriarchy and the Feudal Mode of Production in England', *Sociological Review*, 29/1: 105–54.

MIES, MARIA (1986), *Patriarchy and Accumulation on a World Scale: Women in the International Division of Labour* (London: Zed Books).

MILLETT, KATE (1977), *Sexual Politics* (London: Virago).

MITCHELL, JULIET (1975), *Psychoanalysis and Feminism* (Harmondsworth: Penguin).

MITTER, SWASTI (1986), *Common Fate, Common Bond: Women in the Global Economy* (London: Pluto Press).

MOGHADAM, VALENTINE (1992), 'Patriarchy and the Politics of Gender in Modernizing Societies: Iran, Pakistan and Afghanistan', *International Sociology*, 7/1 (March): 35–53.

OECD (1980), 'Women's Employment During the 1970s Recession', in A. H. Amsden (ed.), *The Economics of Women and Work* (Harmondsworth: Penguin).

ROGERS, BARBARA (1980), *The Domestication of Women: Discrimination in Developing Societies* (London: Tavistock).

ROWBOTHAM, SHEILA (1981), 'The Trouble with "Patriarchy"', in Feminist Anthology Collective (ed.), *No Turning Back* (London: Women's Press).

SEGAL, LYNNE (1987), *Is the Future Female? Troubled Thoughts on Contemporary Feminism* (London: Virago).

SEN, AMARTYA (1984), *Resources, Value and Development* (Oxford: Blackwell).

—— (1987), *On Ethics and Economics* (Oxford: Blackwell).

—— (1987), *The Standard of Living* (Cambridge: Cambridge University Press).

STANDING, GUY (1989), 'Global Feminization through Flexible Labour', *World Development*, 17/7: 1077–95.

THOMAS, JIM (1992), *The Informal Economy* (London: Macmillan).

WALBY, SYLVIA (1988), 'Gender Politics and Social Theory', *Sociology*, 22/2 (May): 215–32.

—— (1990), *Theorizing Patriarchy* (Oxford: Blackwell).

—— (1992), 'Post-Modernism: Theorizing Social Complexity', in Michèle Barrett and Anne Phillips (eds.), *Destabilizing Theory: Contemporary Feminist Debates* (Cambridge: Polity Press).

WALLERSTEIN, IMMANUEL (1974), *The Origins of the Modern Wold System* (New York: Cambridge University Press).

WEBER, MAX (1947), *The Theory of Economic and Social Organization* (New York: Free Press).

YUVAL-DAVIS, NIRA and ANTHIAS, FLOYA (eds.) (1989), *Woman–Nation–State* (London: Macmillan).

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'So you row, do you? You don't look like a rower.' An account of medical students' experience of sexism

Sandra Nicholson

Introduction Medicine has traditionally been considered a masculine pursuit and its undergraduate curriculum criticised as being inherently sexist. Overt sexism, though diminished, still occurs and students report offensive sexual remarks, unwanted sexual advances and unequal learning opportunities. Sexual discrimination also colludes with attitudes that promote the stereotyping of the roles of women both in medicine and in society itself. This study aimed to ascertain medical students' own experience of sexism during undergraduate training, their understanding of these events, what effects the events had on them and, specifically, how they coped.

Methods Twelve in-depth interviews, each focusing on a critical incident, with individual self-selecting Year 5 medical students took place. Initial qualitative analysis of transcripts produced themes that were further subsetted.

Results Students described situations where they felt their learning had been jeopardised. Male students reported frequent difficulties whilst attached to obstetric and gynaecology firms. Students commented that their gender did sometimes affect their relationships with teaching staff and that affirmation from their teachers was important. Female students coped well with their experiences of sexism, often supporting each other. Male students often felt resigned to being excluded from certain learning opportunities and this sometimes resulted in unresolved frustration.

Conclusions Developing a non-sexist undergraduate curriculum should be prioritised. Encouraging teaching staff to reflect on their attitudes to gender, approaches to teaching and providing support, such as mentoring, especially for female students frequently lacking appropriate role models, is advised.

Keywords education, medical, undergraduate/ *psychology; *sexism; adaptation, psychological; curriculum; attitude; Great Britain.

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Introduction

Criticism has been levelled at the nature of the medical curriculum, claiming that it is inherently sexist. In many curricula the '70 kg man' is taken as the norm and female values and anatomical diagrams are only displayed when dealing with reproductive systems. Medical education devotes less time to subjects such as domestic violence that are viewed as 'female'.[1,2]

Traditionally, medicine has been thought of as a male dominated arena. Until the 1970s, the numbers of female students starting undergraduate courses were well outweighed by their male colleagues.[3] Today, the numbers of female consultants and GP principals have risen significantly, but the majority of senior and academic posts are still filled by men, raising concerns that female students are without role models.[4] The current trend of disproportionate promotion in hospital specialities has also led some authors to conclude that this is due to direct or indirect discrimination.[5]

Sexism may be seen in open abuse or in more subtle collusion with attitudes and behaviours that promote the stereotyping of social roles. For example, it has been established that stereotypical expectations can adversely affect women's career opportunities, as is illustrated by the fact that more women enter specialities such as paediatrics rather than surgery.[6] It has been argued that women are being shepherded into specialities such as primary care, which have been traditionally perceived to be of lower status.[7] Typically, women, rather than men, are perceived to bear the brunt of sexism.[8] However, male students can suffer exclusion from skill development opportunities and negative attitudes in

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Key learning points

Sexism still exists in medical education and may be responsible for inequalities in students' learning opportunities, poor relationships with teaching staff and occasionally in much student distress.

Female students tended to cope better than male students, using coping strategies of social support and positive reappraisal. However, both sexes would benefit from formal and informal support structures, such as mentoring, to enhance their coping strategies.

Institutional strategies to combat sexism should be developed. Tutors should be encouraged to consider their own attitudes to gender and their approaches to developing and teaching a non-sexist curriculum.

Further research to gauge the size and importance of these issues needs to be undertaken.

certain predominantly female areas, such as obstetrics and gynaecology.

Unfortunately, despite repeated denouncements of medical student abuse, sexism and other forms of discrimination in the medical literature, such unacceptable occurrences still seem to be rife in medical education.[9] Overt sexism, though diminished in recent years, is still prevalent in medical education. In one study over half of students reported mistreatment during their studies and more women than men cited instances of public humiliation. Sexual harassment, in terms of offensive sexual remarks and/or unwanted sexual advances, is reported more frequently by female students.[6,10] In a letter to the Lancet it was proposed that male students were at a disadvantage during their final examinations as proportionately more male than female students fail.[10] Like their female peers, male students also face discrimination.

However, the full impact of sexism on the experience of both male and female students during their undergraduate training is not known. Students may well be negatively affected by learning in such environments to the extent that they then go on to develop attitudes that may prove harmful to the care of women patients.[11] Therefore, this paper describes the findings of a qualitative study of both male and female medical students, which aimed to ascertain students' own experiences of sexism during undergraduate training, their understanding of these events, what effects the events had on them and, specifically, how they coped.

Methods

A series of in-depth interviews were conducted between December 1998 and August 1999 with students in their fifth and final year of medical school. The principal function of these interviews was to explore students' experiences, perceptions and how they coped with negative learning experiences they had encountered during their medical education to date.[12] Students were informed that the information gained through the interviews would be used to monitor the quality of their undergraduate courses and to assist in making curriculum changes. Students were also informed that the interviews were part of a personal postgraduate degree dissertation being undertaken by the interviewer. All students completing a particular final year module were invited to give interviews verbally and by a written handout, which reinforced the nature of the interviews and their confidentiality and stated that information about negative learning experiences was being sought. Students who volunteered for the interviews were therefore self-selecting. No formal ethics committee approval was sought.

A critical incident technique was used during each interview. The student was encouraged to describe in detail any events that they considered to have been negative learning experiences. These then became the foci of the interview.[13] Many students mentioned gender issues in their descriptions of events and these were explored further. When a student did not raise such issues, the topic was introduced and if the student then wished to discuss this area, it was followed up.

A non-directive approach was used, where the interviewee was allowed to talk at length, in his or her own words, about what they considered the most important aspects of the described situation. An open interview framework was implemented in order to encourage students to describe events, uninterrupted, in their own language and time. This meant that each interview covered a list of issues, derived from informal discussions with students, rather than setting out specific questions.[14]

The number of completed interviews was limited because the interviewer did not want to extend the period of study into the subsequent academic year, when the successive cohort of final year students might possibly have had significantly different learning experiences. From the outset, the study was planned as a small qualitative project, which naturally had time and cost restraints.

The authenticity of the data was enhanced by having students explain events in their own words. It was also

58

important to consider the context of each event in order to maintain the validity of the data.

Following transcription of the recorded interviews, initial qualitative analysis categorised units of data according to emergent themes. Each theme was derived by searching for data that had similar meaning or was linked by a core concept. Common phrases and shared ideas in the transcripts helped to identify the themes. These themes with their associated data were entered into a matrix. All recorded data were referenced by their original interview source to facilitate further sub-analysis.[15]

Students of both sexes described situations where they considered their learning had been affected by their gender. These comments describing situations, events, relationships and student perceptions were categorised into the same theme. Further analysis of this reduced data was performed by coding or assigning meaning to units of data within this category. Data units bearing the same code were then grouped together. This clustering facilitated further analysis and conclusion formation.

In a cyclical process as later interviews were coded, the coding system was revised. It became apparent that some codes were important, with repeated themes, whereas other codes became obsolete. It was important that these concepts were tested out in subsequent interviews.[14] This also involved going back over some of the original transcripts to check for consistency in coding. Any obvious exceptions were followed up to enhance the robustness of the emerging coding system. Re-coding some of the earlier data ensured that the standard of internal consistency was high. This was important as the author was the only person completing the coding and therefore reliability was dependent on this internal consistency.

Attempts to collaborate or refute 'working' conclusions in later interviews and in the ongoing analysis were undertaken. This ensured that conclusions were not drawn[14] from isolated instances. However, due to the size of the study some incidents were only reported once, and where conclusions were deduced from these, attempts were made to confirm findings with other data sources. In particular, emerging theory was tested by comparing conclusions with the literature.

Results

Six female and six male students were interviewed. Ten of the 12 student interviews provided rich data describing negative learning experiences that included gender issues. Students' descriptions of other types of negative learning experiences and, in particular, how students cope with them form a further report.

The following categories were identified:

- learning opportunities;
- relationships with teaching staff;
- overt sexism, and
- coping strategies.

Learning opportunities

The most obvious source of sexism referred to students feeling they had been excluded from learning opportunities because of their sex.

> 'I found being a bloke was a write-off...because seeing births and stuff was impossible. I think it was more to do with my gender than anything else.' (Int. 2 pp.1 + 4)

The difficulty for male students of obtaining permission to witness births and examine patients in obstetrics and gynaecology featured repeatedly in student comments throughout the interviews. Male students' comments were collaborated by their female peers:

> 'I think being a boy's an issue if you're doing obs and gynae because you don't get to see anything.' (Int. 8 (female student) p.6)

No female student in the series of interviews described any incidents where they felt they had been deprived of skill development opportunities.

Relationships with teaching staff

Some students considered that although they were exposed to the same learning opportunities as each other, their treatment by, and the relationships they formed with, their teaching staff profoundly altered these experiences for individual students. Students therefore did perceive that their colleagues received preferential treatment based on their gender:

> '...with practical things I've had more or less the same experiences but I feel sometimes that the doctors tend to talk to the males in the group and not necessarily always the females. If I was male, I may have been referred to more often.' (Int. 1 p.8)

> 'We were the only two girls in the group and I don't know if it was any victimisation but we were noticeably criticised an awful lot more.' (Int. 3 p.1)

The above student thought that the reason for her perceived severe treatment was that she was one of two girls in a male-dominated group. It is noteworthy that their teacher was also female.

Data from study interviews confirms that affirmation was important for students of both sexes:

> 'She [the teacher] would never look at you when you were in the room and if you were too slow presenting a patient she would just go, "Oh, I haven't got time for this," and sort of walk out, and it just made you feel a bit hopeless. Well, it made me feel hopeless anyway.' (Int. 7 p.7).

Female students reported receiving more favourable treatment than their male peers in terms of opportunities to learn as a result of favourable relationships formed with teaching staff.

> 'I think it's [being a girl] helped in a lot of circumstances. It's definitely helped in obstetrics and gynaecology. It's been mostly cases where men have been excluded and we've been allowed to get in and do things. I tend to think the nurses are more sympathetic towards us.' (Int. 10 p.8)

Overt sexism

Rare instances of overt sexism were found in the study:

> 'So you row, do you? You don't look like a rower.' (Int. 7 p.11).

This student complained that she felt she had been treated differently from the boys on her firm who also needed some time off to play sport.

Coping strategies

When sexism occurred, the female students who participated in the study appeared quite capable of dealing with it effectively and of not allowing it to undermine their education. Female students tended to support each other:

> 'We used to laugh about it because it was just silly in the end, it was like we really couldn't do anything right.' (Int. 3 p.2).

Female students may cope by actively attempting to change or intervene in a teaching session where they perceive they are being neglected by their teachers or when they feel the teaching is being dominated by their male colleagues, as illustrated by another student's comment:

> 'I've butted in or tried to ask the question to get it to turn not necessarily my way, but to get me more involved.'(Int. 1 p.9).

Female students may also cope by deciding not to engage in the arena of sexism:

> 'The male surgeons have passed comments and you think, "Well, that's fine if you want to be like that...let's just get on with it." (Int. 10 p.9).

Unfortunately, the male students who participated in the study did not cope so well with being excluded from certain types of clinical teaching. They did not have effective coping strategies in place to attempt to achieve their goals of assessing female patients, but instead accepted not being able to see patients with passive resignation. However, there was also unresolved frustration, anger and a sense of injustice about these situations, which often generated an atmosphere of bitterness and disenchantment.

Discussion

The results are from a small qualitative study that gives an account of individual medical students' experienc of sexism. Although care was taken to minimise any bias, both in obtaining data and analysing it, thereby increasing the validity of the conclusions, this will not ensure generalisability. What the students said was true, but it was true for them, and pertinent to their own situations. Therefore caution should be exercised when drawing conclusions from such a small, focused study. However, the results do highlight some important points, which are powerful because of their face validity and natural context. Further research to gauge the size and importance of these issues needs to be undertaken.

A basic premise ensuring competency is that all students need exposure to a wide range of clinical cases to facilitate their learning of the basic history and examination skills. Undoubtedly, assuring male students access to female patients is a difficult and complex task. Obstetrics and gynaecology particularly demonstrate the interplay between supporting patient autonomy by ensuring appropriate informed consent gained before any student contact occurs, and facilitating adequate student experience necessary for their learning. A variety of gender issues amongst teaching staff, doctors, midwives and nurses also exert their forces onto a volatile situation. Research into patient acceptance of students in this field is scanty. A Californian study reported high levels of acceptance of both female and male students in an outpatient setting. Reasons stated for refusing student involvement included patient privacy and discomfort with the clinical examination.[16] To overcome these difficulties with the nature of the intimacy of the clinical

examination, other studies have reported their findings of replacing genuine patients with either simulated patients or students themselves.[17,18] However, both cases are fraught with ethical problems. Student opinion is clear that it is essential that both male and female students should have access to female patients and that the present unequal system that male students face is unacceptable. Contrary to the findings of this study, the literature also reports examples of female students suffering, such as the women in a surgery clerkship who reported fewer learning opportunities and less favourable staff attitudes than their male peers.[19]

When students considered their relationships with their teachers, who were usually male, they thought that teachers felt more comfortable talking with male students because that was more familiar to them. This hypothesis was generated to explain why male students may receive more teacher attention than female students and compares with other work in the area.[6] In the report *The Classroom Climate: A Chilly One For Women?* the authors identified some 30 ways in which postsecondary female students were treated differently to their male peers.[20] It is unsurprising, therefore, that this report concluded that women's academic development was likely to be affected.

However, other studies report that the majority of students find their learning environment to be gender-neutral.[21] This may be so for most students today in most fields, but even the present small study illustrates that this is not the case for some students in certain areas such as medicine. The literature discusses the lack of appropriate female role models and the open hostility some female senior doctors show to female medical students.[22] Unfortunately, what is not clear is why this should occur. There is some evidence that if a teacher experienced harsh treatment as a student herself, she may go on to abuse students in just the same way, isolating female students in particular in just the same way she was.[23] Certainly, female doctors graduating two decades ago encountered more difficulties than do today's female graduates. It may well be that in struggling to achieve and sustain a successful career in medicine, female doctors develop high expectations of their younger female successors and become antagonistic if they are disappointed.[24] Female students may also have expectations of their senior female colleagues in terms of support and empathy, and even positive discrimination. If these expectations are not fulfilled, female students may feel disheartened and let down.

Rienzi *et al.* reported that 10% of female and 2% of male graduates felt they had received negative treatment whilst at university because of their gender.[21] It has been speculated that the higher incidence of reports of such occurrences made by women is due to female students having higher regard for affirmation or shaming than their male peers.[25] The results reported indicate that both male and female students require appropriate feedback on their performance to reinforce correct methods and encourage further effective learning.

The fact that different studies report varying degrees of sexual harassment is probably a result of differences in how this term is defined. Follet *et al.* found that only 10% of students in their study were offended by behaviours that included sexist remarks or inappropriate humour.[8] In another study, 24·3% of female students reported that they had been subjected to personal sexist remarks. This meant that eight times as many women as men reported such events. Female students also reported a significantly higher rate of unwanted sexual advances by school personnel.[6] However, although instances of serious overt sexism are rare, this does not limit its effects. Many studies have now shown that student abuse can have a lasting detrimental effect on students. Following the most serious episodes, 16% of students reported that the effects of the experience would remain with them always.[26] Student abuse in general can not only affect students' academic progress, but also their personal lives, careers and, ultimately, patient care.[23,24] It has been reported that female residents more frequently use coping strategies of social support and positive reappraisal to deal with their experiences of educational sexism. However, it has been indicated that a more formal network of support groups should be instituted for female students.[22] Organisations promoting women in medicine, which students can join, exist in both the UK and the USA. However, although these organisations operate on both national and local levels, students may need a more personal approach directed at their individual learning environment. A recent study confirmed that female students actively participated in teaching, had good relationships with staff and fellow students and felt they benefited more from their educational experiences than their male colleagues.[27] The authors proposed that female students today are reaping the rewards of earlier reform and enhanced understanding of the educational needs of female students. However, this study was based on the experience of American university students, not necessarily studying medicine. Certainly the female students interviewed in the present study coped well with their experiences. Unfortunately, male students did not generally employ the same coping strategies of social support and reappraisal. They described losing out on learning opportunities and subsequently becoming dissatisfied. It is challenging to consider what we can

offer those male students who, in some clinical situations, are now operating in a women's arena.

The way forward

The preceding discussion has illustrated that the sexism experienced by a small number of medical students was complex with a multifactorial causation. Taking action as detailed below may help to ensure that all medical students are treated with respect and have equal learning opportunities.

Firstly, the personnel who teach students should be encouraged to consider their own attitudes to gender and their approaches to developing and teaching a non-sexist curriculum. This is a primary consideration because students mostly complained about the effects of sexism on their learning opportunities and their relationships with teaching staff, which obviously directly affects their learning opportunities. Reflection on one's own teaching practice rarely happens spontaneously and it is the responsibility of educators to ensure that teaching staff have access to appropriate training and are aware of these issues.

Secondly, it is essential that students, particularly women, are provided with appropriate role models. It is possible that female students do not see themselves as surgeons because they have not had the opportunity to observe women surgeons. Female students cannot witness first hand that it is possible to deal with the issues of 'role-strain' and balance family life with an academic career if there are not sufficient numbers of female academic staff. Some articles clearly advocate positive discrimination in promoting female staff until a gender balance is created.[4]

However, the situation will not be remedied by considering numbers alone, and the inclusion of strategies to provide mentorship for female students, who lack the equivalent of an 'old-boy network', is advised. Organisations such as Women in Medicine (UK) provide a forum for women with similar interests. Mentorship provides students, of both sexes, with career advice and personal and academic support.[4]

Some of the frustrating exclusions of male students from clinical situations may be prevented by reviewing how certain sensitive topics are taught. Pairing male students with female colleagues, ensuring female supervision and considering placing students in a more personal, community-learning environment may help ensure that they do not miss out on clinical teaching.

It is essential that students themselves combat sexism, especially in overt cases. Medical schools should operate a zero tolerance policy of sexism and all students should be aware of the procedures to follow in reporting serious incidents. These procedures should be confidential and seek to support the reporting students.

Future research will be necessary to evaluate whether any of the suggested recommendations to combat sexism are effective. It will also be imperative that an investigation into teachers' perspectives on the issues raised by the students is carried out, particularly as one of the main recommendations is to encourage some teachers to change their practice.

Conclusions

Sexism still exists in medical education today. The effects of such discrimination can be seen in unequal learning opportunities, students' relationships with teaching staff and occasionally in much student distress. Further study to assess the size of the problem, and ways of combating sexism, both on individual and institutional levels, should be undertaken.

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References

1 Phillips S. The social context of women's health: goals and objectives for medical education. *Can Med Assoc J* 1995;152:507–11.

2 Bickel J. Gender stereotypes and misconceptions: unresolved issues in physicians' professional development. *J Am Med Assoc* 1997;277:1405–7.

3 Braslow J, Heins M. Women in medical education. *N Engl J Med* 1981;304:1129–35.

4 Matorin A, Collins D, Abdulla A, Ruiz P. Women's advancement in medicine and academia: barriers and future perspectives. *Texas Med* 1997;93:60–4.

5 McManus I, Sproston K. Women in hospital medicine in the United Kingdom: glass ceiling, preference, prejudice or cohort effect? *J Epidemiol Community Health* 2000;54:10–6.

6 Bickel J, Ruffin A. Gender-associated differences in matriculating and graduating medical students. *Acad Med* 1995;70:552–9.

7 Showalter E, Kvaerner K, Aasland O, Botten G. Female medical leadership: cross sectional study. *BMJ* 1999;318: 91–4.

8 Follet C, Andberg W, Hendel D. Perceptions of the college environment by women and men students. *J College Student Dev* 1982;23:525–31.

9 Kassebaum D, Cutler E. On the culture of student abuse in medical school. *Acad Med* 1998;73:1149–58.

10 Acheson A. Do male medical students face prejudice? [Letter.] *Lancet* 1997;350:964.

11 Savage W, Tate P. Medical students' attitudes towards women: a sex linked variable? *Med Educ* 1983;17:159–64.

12 Nicholson S. What strategies do medical undergraduates adopt to cope with perceived 'negative learning experiences'? Dissertation MSc. Medical Education, University of Wales College of Medicine.

13 Dunn W, Hamilton D. The critical incident technique: a brief guide. *Med Teacher* 1986;8:207–15.

14 Hammersley M, Atkinson P. *Ethnography Principles in Practice.* London: Routledge; 1991.

15 Miles M, Hubermann A. *Qualitative Data Analysis: An Expanded Sourcebook.* London: Sage Publications; 1994.

16 Ching S, Gates E, Robertson P. Factors influencing obstetric and gynecologic patients' decisions toward medical student involvement in the outpatient setting. *Am J Obstetrics Gynaecol* 2000;182:1429–32.

17 Kleinman D, Hage M, Hoole A, Kowlowitz V. Pelvic examination and instruction and experience: a comparison of laywoman-trained and physician-trained students. *Acad Med* 1996;71:1239–4.

18 Abraham S. The effect of sexual experience on the attitudes of medical students to learning gynaecological examinations. *J Psychosomatic Obstetrics Gynaecol* 1996;17:15–20.

19 Calkins E, Arnold L, Willoughby T. Medical students' perceptions of stress: gender and ethnic considerations. *Acad Med* 1994;69:s22–s24.

20 Sandler B, Silverberg L, Hall R. *The Chilly Classroom Climate: A Guide to Improve the Education of Women.* Washington, DC: National Association for Women in Education; 1996.

21 Rienzi B, Allen M, Sarmiento Y, McMillin J. Alumni perception of the impact of gender on their university experience. *J College Student Dev* 1993;34:154–7.

22 Davidson V. Coping styles of women medical students. *J Med Education* 1978;53:902–7.

23 Kutcher S. Coping with the stresses of medical education. *Can Med Assoc J* 1984;130:373–4+381.

24 Rosenberg D, Silver H. Medical student abuse. An unnecessary and preventable cause of stress. *J Am Med Assoc* 1984;251:739–42.

25 Ingleton C. Gender and learning – does emotion make a difference. *Higher Education* 1995;30:323–335.

26 Wolf T, Elston R, Kissling G. Relationships of hassles, uplifts and life events to psychological well-being of freshman medical students. *J Behav Med* 1989;15:37–45.

27 Drew T, Work G. Gender-based differences in perception of experiences in higher education: gaining a broader perspective. *J Higher Education* 1998;69:542–55.

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63

It Goes Without Saying: Voices of Women Medical Students

Abstract

In *It Goes Without Saying; The Voices of Women Medical Students*, I have used the experiences of women in medical school to illustrate the gender biases that are present in undergraduate medical education. The collected experiences have been subdivided under eight themes, which include gender discrimination in the written and hidden curricula, as well as discriminatory behaviours on the part of some faculty members. I have also made recommendations for developing a gender-sensitive educational environment, and included further suggestions and resources from the relevant literature. This is followed by *Women as Patients and Medical Students: Common Themes*, which introduces some of the commonalities I observed between the concerns that women express as students of medicine and as recipients of medical care. The second piece is intended to illustrate that reducing the gender biases in our education will not only facilitate our experience as students but will also raise the standard of care we provide for women patients.

"It is imperative to avoid discrimination among students on the basis of the student's political or ethical ideas... (it goes without saying that discrimination on the basis of gender, religion or ethnic or social origin is absolutely antithetical to the academic ethic)."
Edward Shils in The Academic Ethic (1978)[1]

For the Gender and Medicine Project, I have collected quotations by women medical students, both from the existing literature and through direct solicitation from students currently attending medical school in Ontario. In the latter category, students were asked via e-mail for their thoughts and experiences relating to gender in their education. The respondents included the student participants in the Gender and Medicine Project. I identified eight themes that recurred among the student concerns and organized the quotations accordingly. Although the themes create some artificial divisions between experiences that are related in both obvious and complex ways, I think they generally accomplish my wish to outline core areas of concern. I have included my thoughts on each theme, and provided suggestions for implementing meaningful changes to the current system. However, I think the most powerful statements in this report are contained in the student voices, and that all medical educators should take the trouble to consider what we have expressed here.

1. The need for more women in academic medicine.

This complaint was particularly common among the sources I consulted. The observation that there are relatively few female professors and administrators in medical schools indicates that while women may now take for granted the right to practise medicine, they remain less likely than their male counterparts to gain power within the medical establishment. This notion is supported by a study performed in Finland, where women have been well represented in the medical profession for longer than in Canada. In the Finnish system, a gendered segregation of specialization and academic involvement persists, with women occupying fewer positions of influence than their numbers would predict.[2]

"...that's what I thought when I was in undergrad and didn't see any women profs. I thought, there must be something that stops women from doing this, either it's too hard to have children, there's sexism, you're actively discouraged from doing this. That's what the message is that I get from seeing so few women profs, that there are some barriers somewhere that makes it more uncomfortable for women to do this. And if there were more, I wouldn't feel that way and I would be more likely to consider it."[3]

"Often when a woman comes to the front of the class, people make the assumption – oh, she must be a dietician or a physiotherapist, or whatever else – or, she can't be a doctor, or we won't listen. Really, women instructors have to work extremely hard to grab the class' attention."[3]

"The lack of female faculty is particularly distressing during discussion group times, like patient-centered learning. Usually the advisors of this course have many stories to share, and quite frequently these stories have to do with things outside of medicine (i.e. lifestyle issues). This is an integral part of our education! Yet there is no female faculty to talk about the stresses of raising a family, maternity leave, role taking within relationships & dealing with others with traditional views of women." Student A[4]

"While we did have some professors who were women, the deans and those in charge of the courses and departments, for the most part, were men. The assistants in the

undergraduate office, the administrators of our clinical skills course, the librarians and the employees in the cafeteria, they were all women." Student B [4]

"One of the greatest weaknesses which I and many of my classmates see is a lack of female mentors and instructors. Having made it through two OSCEs now, I have yet to have a female evaluator. Classes are also predominantly taught by male instructors. More equitable exposure is found mainly in pathology, psychiatry, endocrinology and patient-centered learning." Student C [4]

"It felt really different to work with a woman surgeon – it was easier to see myself in her position. It made that field seem more possible." Student D [4]

The same Finnish study cited earlier reports that women are slowly increasing their presence in the areas of administration, teaching and research, raising the hope that medicine may be undergoing a gradual equalization.[2] Closer to home, we can look to the appointment of Dr. Carol Herbert as Dean of Medicine at the University of Western Ontario as a sign of progress. However, medical faculties need to be actively committed to promoting women and other underrepresented groups in order to expedite this process. Otherwise, experiences and numbers indicate that the current male-dominated structure will be inclined to maintain itself.[2,5,6,7,8,9] The importance of the effort to increase leadership by women in medicine should not be underestimated: "Recruitment, retention, and advancement of women faculty and administrators may be the most direct means to gender equity."[10] Specific recommendations for doing so are given by numerous authors.[11,12,13]

As we work for increased representation of women in the medical faculty, the situation for current students can be improved through mentoring initiatives between women physicians and students. The Federation of Medical Women of Canada and the Ontario Medical Association currently have mentorship programs. However, they are not advertised on their websites, and generally seem to maintain a low profile. Creating such programs on a per school basis may be more effective. The University of Ottawa has a program for the mentoring of junior women faculty, which includes an on-line Faculty Mentoring Handbook and an open invitation to use this resource.[14]

2. Gender-biases in the written curriculum.

The written curriculum of medical schools includes the presentation slides and lecture notes provided by professors, the contents of required and recommended textbooks, and the case studies used in small-group learning sessions. It is also reflected in course titles and organization. Importantly, it includes the evaluative components of all courses. Each of these aspects of medical education conveys views on gender – usually through subtle but pervasive patterns of emphasis and omission, and sometimes through blatantly sexist assertions.

"I was conscious because I was pregnant last year – another text that we use currently referred to a pregnant uterus as something like a 'tumorous mass'." [3]

"Why has all the research we learn about in pathophysiology only involved men subjects?" [15]

"Why are most drug trials, from which dosages, side effects and contraindications are established, conducted only on men?" [15]

"We did not study any breast anatomy at all. I would think this would be important for future doctors?! During sexual anatomy, the female was grazed over - a great way to reinforce the stereotype of the unknown, uninteresting, unimportant female sex drive. On the flip side, during pathology of reproduction the lectures focused on females (endometriosis, cervical cancer, etc) and no mention was made of male pathology. I would hope some male problems would be addressed (i.e. prostatic cancer)." Student A [4]

"In anatomy, we did not study the breast but we did study the inguinal canal in excruciatingly painful detail because 'it's so important clinically'. I guess breast cancer and feeding newborns are both less important than that ever-deadly global pandemic of inguinal hernias." Student B [4]

"Our book on plastic and reconstructive surgery has an illustrated page on breast enlargement surgery. The caption under the post-operative breasts says that 'After surgery, breasts appear fuller and more natural in tone and contour.' In other words,

regular, healthy women whose bodies don't conform to some current cultural ideal are unnatural and in need of medical intervention. I think it's shameful that this view would be expressed and sanctioned in our curriculum." Student D [4]

"Most of our problem-based learning cases were about men or boys." Student B [4]

"Looking at my classmates I can quickly recognise differences in age, height, weight, ethnicity, and sex. However a large proportion of our curriculum content has been set to a "normal" set of values and states based on evidence collected through clinical trials and basic science research. There needs to be a revolution in this practice where there is inclusion of 'differences' and an understanding that being different is the norm. For example, in a course such as physiology, all 'normal' values refer to a 70-kg white man, no mention of differences between sexes; differences between sizes; and even a lack in differences between ethnicities. For a multicultural society such as Canada this is unacceptable. A majority of our future patient population will not fit this 'normal' set of data." Student G [4]

As some of these concerns indicate, one major source of gender bias in the curriculum is the fact that medical research has long been conducted primarily on male subjects. Therefore, information such as the typical presentations of illnesses or the side-effect profiles of drugs, while generally presented in the curriculum as gender-neutral, have actually only been observed in men. In addition, the men in these studies have generally been white, so that different ethnic groups have also been systematically excluded from our medical knowledge. Now that the evidence-based medicine approach is being promoted as the golden standard for practise, we are at risk of further incorporating these injustices into the medical curriculum. It is essential that we demand "adding a 'diversity lens' to evidence-based medicine, one that widens the view to include sex, gender, race, religion, socio-economic status, sexual orientation and whatever other ways individuals may vary".[16] For more information on this subject please see the report on evidence-based medicine in this package.

Further biases are contained within the textbooks used by each particular school. Textbooks should be evaluated for their representations of gender; a tool for this evaluative process has been developed.[17] It would be practical for the evaluations to take

place centrally and to create a database of book critiques for all medical schools. Books that do not provide equitable gender representations should either be discontinued or modified with inserts that document the gender-biased aspects of their content. An in-class review of such an insert may provide students with a useful lesson in the critical evaluation of medical information. Naturally, the book publishers should be informed of the results of the reviews, and where applicable they should be urged to change the textbooks in order to make them acceptable for the curriculum.

A third source of bias lies in what professors choose to include and emphasize in their lecture notes and in case studies. This area may be improved with the gender issues workshops outlined in section 6. There are also practical guidelines for educators who are interested in eliminating gender-biased teaching materials and behaviours from medical school (Appendix C, Part i).[18,19]

3. Gender-biases in the 'hidden' curriculum.

In evaluating the medical curriculum, we cannot ignore the role of what has been termed the hidden curriculum: "The messenger's individual delivery style, subtle bias and choice of words or emphasis (...) cannot be assessed solely by examining the written curriculum. They are, however, central to the attitude students absorb in medical school and to the creation of an inclusive learning environment."[18]

"... a comment from a gynaecologist telling us that women with PID should automatically be considered promiscuous... the act of judging is certainly not the place of physicians (...) to call her promiscuous – to use that word (...) to use it in front of 80 impressionable young doctors-to-be who believe everything you say – I thought, it just felt wrong."[3]

"During classes, the language and tone generally represents females and diseases which females have as "atypical" or "abnormal" simply because they don't present in the same way as they do in males." Student C[4]

"In one lecture our anatomy professor pointed to an illustration of the perineum and called it that, then explained himself saying 'some women don't like it when you call this whole area the vagina'." Student D [4]

"A lack of understanding of the implications of what is being taught on women in society; a biochemistry professor talked at length on the benefits of eating a varied, healthy, self-prepared diet instead of supplements/prepared meals. Who's in charge of making most meals within families, and what kind of burden is this statement placing on them?" Student A [4]

"An ENT doctor showed us an image of a larynx covered with mucus and told our class that 'Otolaryngology is not for the fastidious – any more than gynaecology is'." Student D [4]

"It just felt really isolating. So much of medicine – the concepts – are male somehow. Like you don't really talk about the human aspects of things... you don't talk about illnesses in women's language, if you know what I mean... And I started to notice that – I don't know if I can explain it to you – sort of, the language used in notes is very static, very fixed – square. I don't have the words to describe it, and when I think how I would I describe it myself, it's a lot more flowing, more descriptive kind of language." [3]

"A female emergency physician teaching us about heart disease explained that 'Classically, women present atypically'." Student B [4]

Central to the hidden curriculum question is the issue of faculty attitudes and behaviours. This subject is common to several of the themes and will therefore be discussed cumulatively in section 6.

One theme that is apparent in these experiences is that women students find the social context of health insufficiently covered in the curriculum, both in its written and implicit forms. The current 'anatomicopathological'[20] approach to medicine seems to alienate not only students but also women patients. Alexandra Todd's work in particular illustrates that women's health care needs are frequently missed by physicians who conduct biomedically oriented interviews and do not raise or respond to psychosocial concerns.[21]

Susan Phillips has addressed this problem in her writing and created excellent goals and objectives for incorporating sensitivity to context, values and beliefs in their approach to patients (Appendix C, Part ii).[22]

4. Gender-biased treatment of students by faculty members.

Student complaints about being discriminated against by faculty on the basis of their gender are very common. This is one of the most powerful barriers against which women in medical school struggle. The behaviours undermine their educational experience and chances for advancement. At the same time they are subtle and transient enough that to document and challenge their occurrence remains difficult. Because the faculty members in question often do not perceive or acknowledge their own bias, they may resent complaints about behaviours that, although destructive, carry no harmful intent. In this problem I see the merging of two issues that are central to feminism: ingrained and unconsciously held gender stereotypes (see section 6) and the difficulties that women face in confronting such biases (see section 8).

"... say there are 8 people working with the physician, when it comes to things like putting the robe back on the patient, usually it's a woman singled out to do things like that... just kind of a different treatment. And then if you're talking about the different cranial nerves emerging from the brain stem, usually there's total eye contact with the other male people in the group, it's very subliminal."[3]

"When I raise my hand to answer a lecturer's question or even to ask a question during the discussion period, I've noticed it's not just me but, commonly, the women are called on much less frequently and even ignored."[15]

"I've noticed that the guys seem to get asked to help with a research project more often than the women residents. I'd really like to learn to do research; that's part of why I chose this residency program."[15]

"The male doctor I was working with made me face the wall during a genital exam of an adolescent. Although I understand the sensitive nature of the examination, as well as the patient's rights, the patient was never asked if he would prefer I leave the room

and the doctor simply assumed that it wasn't appropriate for me to be learning how to perform testicular examinations and that the patient would not want me to observe his genitalia. I found this situation extremely frustrating not only for myself, but also for the patient, since he was given the impression by the doctor that he should only be seen and examined by male physicians." Student C[4]

"The discussions also tended to be between the loudest, most outspoken people in the class because we were told to just jump right in and not raise our hands. This type of discussion seems to me to be better suited for the men in the class than for the women, or the quieter, politer men for that matter." Student B[4]

"I have heard many of my male classmates express feelings of inferiority and inadequate preparation with respect to pelvic and obstetrical examinations and gynaecological and obstetrical histories. Some male students expressed concern that they were not permitted to participate in these exercises during rural week at the end of first year, whereas their female colleagues were always involved." Student E[4]

In order to emancipate the present learning environment, education against gender stereotyping is essential. This is discussed in section 6.

The outlined experiences also indicate that gender bias in medicine can be held against men as well as women. This report is focused on the barriers that confront women in medicine; I will make no apologies for taking this view, as women remain relative newcomers within the male-dominated medical culture. However, the gender-sensitive learning environment that this project calls for includes the awareness and dismantling of male gender stereotypes. Rohan Maharaj and Yves Talbot have written a useful primer on men and gender issues as they relate to family medicine.[23]

5. Verbal and practical discouragement from entering certain specialties.

This section provides us with an idea of what causes women to be concentrated in relatively few specialties, which are generally considered to be of lower status in the medical hierarchy.

"It (surgery) is not really conducive if you're planning on having children. You KNOW you're going to be really stuck if you get pregnant during residency. You KNOW that taking maternity leave means you lag behind your classmates and you will not get good appointments. Whether it's overt or covert, you know that. It's definitely harder to be a woman in it than a man."[3]

" 'Well, you don't want to do that (Orthopaedic Surgery)... You want to go into Family Medicine, that way you can have kids – stay home – don't have to work 120 hours/week.' – and this was done in a condescending manner."[3]

" 'Well there are no female paediatric cardiologists.'... His attitude was that I couldn't do it simply because I was a woman – simply because no women have ever done it."[3]

"My training director was clearly frustrated when I told him I was 2 months pregnant and would take parental leave after delivery. He said I'd better expect my resident peers to be angry, and I should do whatever they wanted about making up my night and weekend coverage so they wouldn't leave because of me, and leave him without residents."[15]

"My faculty advisor warned me not to apply to such a competitive program after I told him it was my first choice. He said they usually just take one token woman and I probably wouldn't meet their standards despite my being in the top 10 % of my class."[15]

"While I do realize that the incidence of chromosomal abnormalities may go up with maternal age, and obviously the closer a woman is to menopause, the harder it will be to get pregnant, there are ways to get that message across without making women feel guilty about wanting to start a career." Student B[4]

"One male OB-GYN told us something to the effect of 'tell your female patients to never, ever plan on kids after 35'. An audible groan was heard from the females in our class. Did he realize he was talking to 56 women who were probably going to put off childbearing for some time? I realize the facts remain facts, yet he could have broached the topic with more sensitivity, instead of making half of the class question their choice of medicine as a career." Student A[4]

"Female classmates are often encouraged to enter family medicine so that they will have time to have babies. Other female classmates have been discouraged from specialties, such as surgery, because they will not have enough time to have a family. I think there is too much of an assumption that all women want to have children and that in order to do so, they must become family physicians. This sentiment is often echoed in cases (usually only the informal ones in class) where women are too frequently portrayed as home-makers and in only a maternal role." Student F[4]

"I would like to stay in hospital surgery, but I'm a bit family oriented so I'm not sure... I want to have the nice house, 2.4 children, and be happily married and all that, and I'm not sure how that works when you're a female surgeon."[7]

One clear theme that emerges from these experiences is the need for training and work schedules that allow for adequate parental leave. This issue is further explored in the Parental Leave section of the Gender and Medicine Project. The resentment of or discrimination against students and residents with children should also be actively challenged. Perhaps information sessions for program directors could clear up some common misunderstandings. For instance, contrary to the prevailing myth, women do not drop out of surgical residencies at a higher rate than men.[10]

The mentorship efforts suggested in section 1 will also be beneficial.

Another aspect of this problem is the stereotypical views of women's abilities and ambitions that lead some faculty members to make biased recommendations to their students. For further discussion of this question, please see section 6.

6. Women students are held to higher standards than their male colleagues.

While this complaint was not commonly voiced directly in the consulted sources, it struck me as important. For one thing, the same concern is implicit in section 5 on women and their specialty choices; when women are forced to overcome ingrained prejudice against their participation in certain specialties, they must work harder than others simply to be deemed competent. It is also reflected in section 4 on gender-biased

treatment, in the sense that women who are ignored by faculty during class discussions or rounds have to make additional efforts to receive the same level of instruction as their male counterparts. The finding has also been documented in quantitative terms. Janet Bickel writes that "an analysis of peer-reviewed scores for post-doctoral fellowship applications revealed that women applicants had to be 2.5 times more productive than the average man to receive the same competence score".[10] Besides being unjust, the pressure to exceed the already considerable demands of medical training can only be detrimental to the health of women medical students.

"...men just look incompetent for themselves, but when women fumble, they sort of give all other female students a bad name."[3]

The central issue that has emerged in this and the previous three sections is how to alter the stereotypical notions of gender that are inadvertently held by virtually anyone raised in the current culture. The question is both unworkable in scale and absolutely crucial to meaningful change. As a start, I have some suggestions to make. First, although the themes I have outlined focus on faculty behaviours, both faculty and students should be involved in gender education. It would be a mistake to exclude students from the process, because they contribute to the current learning environment, some of them will be faculty sooner or later, and all of them will be health care providers to gendered people. The subject should therefore be covered in the formal curriculum for students, and annual gender equity workshops should be provided for faculty.[15] In addition, the learning that takes place in such sessions should be reflective in nature. In other words, students and faculty should be asked to examine their own values and thoughts, rather than simply being provided with information. There is no doubt that medical students who are told that the eleven features of gender equity will be on the exam will memorize them, but such an approach will not alter beliefs, and that is the level of change that we should be pursuing. The goals and objectives composed by Susan Phillips will again be useful in this effort (Appendix C, Part ii).[22] I am also awaiting a translation of a Swedish paper entitled *Teaching future physicians about gender differences. Gender of the physician does matter!*, which should provide further ideas.[24] Perhaps the most compelling reason to make such changes is that they will ultimately result in better health care provision for all genders.[16]

7. Sexual transgressions ranging from harassment to assault.

Delese Wear writes on the subject of sexual misconduct: "What do these studies tell us? That verbal discrimination and the more flagrant forms of sexual harassment are remarkably widespread even in the prestigious profession of medicine, a profession dedicated to the care of human bodies and spirits, a profession dedicated to health-*seeking* behaviours. These studies tell us that leering, sexual innuendo and comments, jokes about sex or women in general, unwanted touching or other physical contact, and subtle or direct suggestions or threats for sex can thwart, diminish, or crush the spirit, confidence, and ambition of women at any age or level of professional attainment."[8]

"I said, 'now when I'm looking for the vas deferens, which is the tube that you cut during a vasectomy, where do I go?' And I was asking a male doctor, I mean, we were dissecting the male genitalia... He says, 'Well, you palpate the spermatic cord... you've probably done that, haven't you?' like meaning on a live person. I just looked at him 'Are you serious?' and just walked away. It was just so 'nudge, nudge, wink, wink, hey honey.'"[3]

"When the resident told me to go with him last Thursday night to the radiology department to look at our patient's x-rays, all of a sudden, as he was pointing out the patient's pneumonia, he put his hands on my neck 'to give me a massage,' he said, and then he started grabbing at me. At first, I was so shocked I didn't know what to do. Then I pulled away and ran back to the ward. He later said he was just kidding."[15]

"The attending and I were on our way to see a patient at the other hospital when he suddenly pushed me against the wall and started to kiss me. I had to really fight to get away."[15]

Women students should know exactly to whom they can report sexual misconduct during their training. Dickstein suggests appointing a faculty member responsible for gender issues on every clinical rotation.[15] This person should be identified during orientation, and examples should be given of reportable offences.[15] In addition to an unambiguous complaints procedure, on which I will elaborate in the following section, the consequences for misconduct should also be clear and substantial.

The experiences I came across in this area deal with faculty and residents as perpetrators, but it is important to be aware that "...a national survey on stress in residency revealed that the most common source of sexual harassment experienced by female residents (...) was patients' families."[15] Leah Dickstein writes that "this study indicates a clear need for public education, posted notices in hospitals and clinics, and visitors' passes containing clear rules of gender-fair behaviour".[15]

8. Trivialization or stigmatization of women students' concerns.

Perhaps the greatest concern that emerged for me during this project was the awareness that women's complaints may not be taken seriously, and may even be punished. Delese Wear reports on the subject of sexual harrassment that 'A woman can spend a good deal of emotional energy trying to figure out what she ought to do, how to handle her anger, and in the case of more subtle behaviours, wondering whether she even has cause to be uncomfortable.' *Wondering whether she even has cause to be uncomfortable.* Such self-doubt goes to the heart of the ancient oppression of women, when even in the face of slurs, suggestions, threats, and coercion, she asks: 'Did I do anything to provoke this behaviour?" [8] And this problem is not confined to incidents of sexual harrassment; it arises in most instances of gender discrimination, as the following quotations indicate.

"That's a big issue for women right now. Because I'm in a very touchy point in my education – if I was an intern and already graduated it's a slightly different situation, but now, I would be more than likely to jeopardize my situation. It would be more harmful to me than to the person I was accusing, more than likely. And I would have a really hard time deciding it was worth it, unless it was so overwhelmingly awful... Because even if you are right, are justified, there's a stigma attached to complaining."[3]

"There's definitely still some sexist profs out there and the fact that nothing is done to silence them sends the message that it's not that important. It doesn't really matter. Even if it's offending you and making you uncomfortable, it's your problem, you should get over it because it doesn't really bother us..."[3]

"Jumping up and down in a class many times in a day to point out or speak out against this, which is what I thought my mission would be. I'll fail medical school, but I'll make some impact. No, you don't make any impact, except you wear yourself out..."[3]

"...and if you were to change the punch line from being 'woman' to being 'black' or even animal – 'dog' or 'horse'... people would be up in arms, they would not put up with it. But because the butt of the joke is a woman, everyone, including women laughed. And it breaks my heart to see women laugh like that, but I guess they laugh for the reasons they've laughed for years, because you're nervous about it and you don't want your colleagues to think you're a prude."[3]

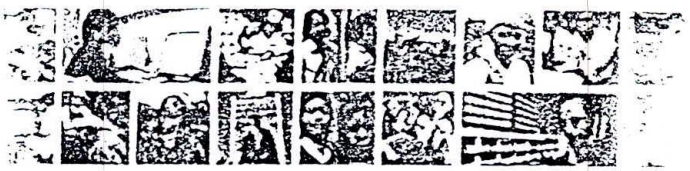
"What about gay women here? This would be the WORST place – how difficult – you can't even begin to imagine... Some of the comments... just so scary to me... 'Radical, lesbian, feminist' – that's exactly the words, exactly the words used to silence women."[3]

The reason that this area concerns me as much as it does is that I see student complaints as holding great potential for changing the current gender biases inherent in medical education. At the receiving end of any discriminatory behaviour is an individual student or group of students. We thus constitute the most sensitive detectors of what is currently wrong; what we perceive exceeds the capacity of any formal study or review process. And in my experience, medical students do not complain over incidents that may be considered trivial. We have other things to do, and generally bother to raise only the questions that leave us significantly troubled. The idea that such efforts for change should be met with ridicule or resistance is deplorable, both for the effect on the individual students and for the lost potential to improve the educational process. I am not suggesting that students are always right, but I am recommending that student complaints always be taken seriously. Faculty members should be educated in receptive responses to concerns specifically relating to gender and other equity issues. In addition, an independent counsel on gender should be present in every school to receive complaints that are either not being properly acknowledged by the faculty member in question or over which the student would prefer to remain anonymous.

I will conclude with an illustrative experience of my own. During my first year of medical school I approached our anatomy professor with a gender-related concern about the

course. We met in his office and he listened respectfully to my complaint, acknowledged the problem and offered to make a change in the course for the coming year. It took only that one short interaction to give me the sense that my response to my education matters, now and in the coming years – and I can also imagine how a dismissive reaction from this professor could have frustrated me into silence early on. We should not forget that although I have made several large-scale recommendations in this report, the small things we do as students and faculty can also change the system positively or negatively, according to what we choose.

Do Men Matter? New Horizons in Gender and Development. (2000, December). id21 Insights, Communicating Development Research Series, Issue 35.



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ID21 Home
Insights
Issue #35
Do men matter? New horizons in gender and development

Pillow talk: changing men's behaviour

Targeting men for a change

Breadwinners and homemakers? Children explore gender

Why men? Why now?

Men against marital violence: a Nicaraguan campaign

Boys behaving badly: challenging sexism in Namibia

Do weak states undermine masculinities?

Sites for Sore Eyes: online sources on men and masculinities

December 2000 Insights Issue #35

Back to Insights #35

Do men matter? New horizons in gender and development

Why do men not feature more in gender and development policy? The shift in emphasis from Women in Development (WID) to Gender and Development (GAD), from enumerating and redressing women's disadvantages to analysing the social relationships between men and women, has not led to a recognition within policy of the need to understand the position of women and men. Is there a need for an explicit focus on men in GAD?

With a few notable exceptions, men are rarely explicitly mentioned in gender policy documents. Where men do appear, they are generally seen as obstacles to women's development: men must surrender their positions of dominance for women to become empowered. The superiority of women as hard working, reliable, trustworthy, socially responsible, caring and co-operative is often asserted; whilst men on the other hand are frequently portrayed as lazy, violent, promiscuous and irresponsible drunkards.

Why then, focus on men? Emerging critiques of policy argue for special attention to be paid to men and masculinities in development, as follows:

- **Gender is relational:** it concerns the relationships between men and women which are subject to negotiation in private and public spheres. To focus on women only is inadequate: a better understanding of men's perceptions and positions and the scope for changing these, is essential. Exploring 'masculinities' inciudes focusing on socially constructed 'ways of being a man' rather than simply on their physical and sexual attributes. Biological essentialism is rejected in favour of an analysis of the social context within which gendered roles and relations are formed.

- **Equality and social justice:** gender concerns should not simply be viewed as instrumental in securing a more effective delivery of development. Instead, this critique recognises that men as well as women may be disadvantaged by social and economic structures and that they both have the right to live free from poverty and repression. Empowerment processes should also enable women and men to be liberated from the confines of gender stereotyped roles.

- **Gendered vulnerabilities:** evidence from several studies

suggests that while women in general may face greater social and economic disadvantages, men are not always the winners and that generalising about their situation risks overlooking gender-specific inequities and vulnerabilities, such as the damaging health effects of certain 'masculine' labour roles or social practices.

- **Crisis of masculinity:** it is suggested that changes in the economy, social structures, and household composition are resulting in 'crises of masculinity' in many parts of the world. The 'demasculinising' effects of poverty and of economic and social change may be eroding men's traditional roles as providers and limiting the availability of alternative, meaningful roles for men in families and communities. Men may consequently seek affirmation of their masculinity in other ways; through irresponsible sexual behaviour or domestic violence for example.

- **Strategic gendered partnerships:** there is a strong argument that if gender-equitable change is to be achieved in households, communities and organisations, then surely men are needed as allies and partners? This links to concerns about the need to mainstream gender issues in development policy to ensure that they are not sidelined or under-funded as 'women's issues'.

In this issue of Insights authors raise a variety of key issues relating to new ways of perceiving men in Gender and Development. The articles all explicitly or implicitly deal with 'crises of masculinity' but differ considerably in their analyses and suggested solutions. Common to all however is the need to locate the individual actions and beliefs of men and women within a wider framework of social, economic and political change.

The challenge, of connecting micro with macro analysis raises questions, reflected in Doyle's and Bujra's articles about the efficacy of projects in significantly affecting gendered power relations. They both question women-only projects, and the effectiveness of interventions which use gender as an entry point for instrumentally tackling development problems without facilitating wider empowerment or equality. As Doyle reports, women at a workshop on AIDS awareness in Vietnam requested that men be similarly targeted. However, when men did participate, they changed their behaviour in sexual relationships but not the way they fundamentally thought about gendered relations of power. Bujra's research in Tanzania and Zambia also asks whether AIDS awareness campaigns significantly affect gender balances power and suggests that what needs changing is not the behaviour of individual men and women but the relations between them.

Changing ideas about men's roles, varying cultural conceptions of masculinity, and the need to challenge dominant definitions of 'what it is to be a man', are all strong themes in reported experience of dealing with men and masculinities. This is well illustrated in Thomson's description of Save the Children's work with boys in the UK who struggle to cope with changing roles (with the 'crisis' of masculinity), the discrepancy between publicly-sanctioned gender roles and what actually happens in families, and the dynamic nature of gender relations. Indeed this dynamism echoes throughout these articles, several of which link difficulties men may experience with responsible partnering and parenting with changing expectations of employment and wider societal change.

Montoya focuses on a campaign in Nicaragua aimed at preventing men's domestic violence, emphasising the need to understand the fears and insecurities that men experience in their relationships with women. Interestingly,

Montoya links the increased tensions and conflicts in families to the environmental, economic and social devastation caused by Hurricane Mitch.

Smith's article on Oxfam projects supporting disadvantaged men in the UK highlights the problems associated with lack of employment and the stereotyping of alternative employment opportunities as 'women's work'. The changing shape of men's working lives and the ways in which policy interventions conceptualise gendered divisions of labour are key issues in studies of men and masculinities (see European Journal of Development Research, December 2000). For example, are different forms of work empowering or oppressing for men and women? How do gendered labour allocations impact upon health and wellbeing? Is it correct to assume that 'women do all the work' in developing countries? There is an urgent need to further investigate relations of power and domination in men's working lives.

Kandirikirira's and Dolan's articles explicitly link individual state action (or inaction) with the development of damaging forms of masculinity, expressed in violence. They differ significantly however in their suggested policy implications. Kandirikirira attributes the sexually violent and abusive relationships between boys and girls in Namibia (sanctioned or ignored by elders) to the policies of the previous apartheid state which systematically distorted the image of black people and restricted their opportunities. Participatory approaches have begun to help overcome this legacy as individual stakeholders become aware of their own responsibility and capacity to tackle injustice and inequitable relations. Dolan, by contrast, in analysing the prevalence of gender- related violence in Uganda, attributes this to the weakness of the state, to its incapacity to maintain the rule of law and to the threat to masculine identities that this constitutes. The developmental challenge, Dolan argues, is to hold states rather than individuals to account and to focus more widely on the political context in which masculinities are formed.

Men and masculinities is a relatively new area in gender and development. Ideas concerning policy implications are in their infancy. How can research, policy, and training contribute to the debate and complete the shift from WID to GAD so that the situation of women and men is better understood? Suggestions include:

- investigating the changing roles, needs and identities of men over lifecourses
- researching men's roles in families, the reproduction of gender inequities through work, and men's specific health vulnerabilities
- tracking and monitoring changes in gender relationships over time, in different cultural contexts, in association with programmes and policies
- developing positive role models for men and boys by influencing mass media images, establishing activities in schools, NGOs, religious and youth groups
- ensuring that legal frameworks supports gender equity, through regulating working hours, parental leave provision, improved maintenance and inheritance laws, for example
- improving gender training within development organisations to focus on gender and not women alone: for example by increasing the number of male gender trainers and improving gender analysis frameworks.

Pillow talk: changing men's behaviour

Can men change? Yes and no, suggests research by Care International in Vietnam. When men are equipped with the right kind of knowledge and skills they will improve their behaviour. However the deeper-rooted gendered inequalities that shape sexual encounters are more difficult to transform.

'Men In The Know', a Care International in Vietnam project, developed sexuality

training for men to promote safer sex within relationships and a trial of the training package with 2000 men. The focus on men arose from a previous course, 'Assertiveness Training Skills for Women for Protection from HIV/AIDS', during which the women expressed a desire for their partners to receive training in women's sexuality and safer sex in general. A participatory workshop focussed on two broad areas: a) imparting knowledge on the physiology of sex and b) challenging socio-cultural factors that shape sexual encounters.

A pilot component was also included, directed at men who visit sex workers, testing a new approach (social marketing) aiming to affect behavioural change through communication techniques commonly used in commercial marketing. The complexity and diversity of consumers is embraced by offering different groups of buyers similar products packaged in different ways. Similarly, CARE International in Vietnam tries to accept diversity by communicating safer sex messages in a variety of ways relevant to different groups of men. Key lessons include:

- Men are keen to learn how to change their behaviour, at least in the short term, to improve their own and their partners' sex lives.
- Levels of sexual knowledge, attitude and behaviour differ from one man to the next: multiple communication strategies are essential depending on the individual and the desired behaviour change.
- Change in sexual behaviour does not necessarily lead to change in substantive gender inequalities that shape sexual relationships.

Men responded very positively, pleased that they can now make responsible decisions. Partners were equally enthusiastic. Men still decide when and where sex will happen however, although as a result of the workshop, men are perhaps more considerate towards their partners.

Women's lives may have changed but this is largely because it is the men who have chosen to change: the basic power inequalities between men and women remain the same. The data below suggests that although the men taking part in the workshop have changed the way they think about sexual health, they have not changed the way they think about gender. Many men clearly want to improve their relationships and armed with the right knowledge and skills can become more understanding. What can policy makers do, given the gravity of the HIV epidemic?

- Acknowledge that men are willing to and can change.
- Include men in interventions, since the reality is that men have a disproportionate influence over sexual decision making.
- Adopt approaches such as social-marketing that address men's complexities and design interventions tailored to their diverse needs.
- Consider not only short-term health benefits, but longer term gendered inequalities that often facilitate unsafe sexual practices.

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Targeting men for a change

How can women fight against AIDS without the cooperation of men? A recent global shift towards the recognition that men are driving the AIDS epidemic raises two key challenges: to devise campaigns which treat men as individuals, and secondly to remember that what needs changing is not individual men and women but the relations between them.

Women in Tanzania and Zambia are actively addressing the HIV epidemic, according to recent research by the universities of Bradford and Leeds. Women are the main carers when people fall sick, for example, they support orphans and provide the backbone for most voluntary efforts to raise awareness and change behaviour.

Yet, almost everywhere women struggle with minimal support from men and inadequate resources. In some cases men even sabotage their efforts. Yet there are indications of minor shifts in male behaviour born out of a desire for self-preservation, that are nevertheless beneficial to women. Women are increasingly prepared, as men are beginning to realise, to challenge male dominance. Further findings indicate that men:

- still make key family decisions, appropriate the product of women's labour, expect to marry younger women and have extra-marital relationships
- have a high risk of contracting HIV from multiple partnering

Some changes are evident, however. Men:

- realise that their propensity to control women is undermined by women's increasing economic and social independence
- have begun talking about how to protect themselves from AIDS whilst still asserting male prerogatives
- often counsel younger men to control their sexual urges or to use condoms
- claim they are having safer sex with fewer partners - condom sales have risen dramatically.
- rethink gender roles when forced to care for the sick or orphans.

AIDS campaigns are now beginning to target men, but they are often confined to condom promotion and personal risk awareness. Campaigns tackle particular groups such as long-distance truck drivers or army personnel rather than men in general. They appeal to men's self-interest rather than challenging their power over women or promoting mutuality between the sexes.

How can men be encouraged to rethink gendered disparities? Challenges include:

- Targeting men in AIDS campaigns whilst still recognising women's need for support and resources.
- Finding ways to talk with men about sexuality and safety that link their self-interest to responsibility for their wives, partners and children (including those as yet unborn).
- Recognising that all sexually-active men may be at risk, rather than the minority who appear promiscuous.
- Persuading politicians and other men in the public eye to acknowledge the issue and to promote men's responsibility.

Why men? Why now?

Women are still the majority in the poorest groups, according to Oxfam's work on gender and poverty in the UK and internationally. But would working with men have a positive effect on the status of women? Would knowing more about how women and men are marginalised contribute significantly to gender equity?

Oxfam-supported projects looking at gender equity, poverty and men in the UK highlight the fact that links between men's attitudes, their roles, and employment need further investigation. Would UK policy makers do well to embrace the concept of gender taken from international development, thus avoiding a scattergun approach which problematises women or men separately and ignores the relations between them?

Three small-scale initiatives in England and Scotland, supported by Oxfam, work with men in community settings: support for teenage fathers on an isolated housing estate near Hull; shop-front drop-in community resource centre in Salford to help build the skills and confidence of long-term unemployed men and community health project participatory appraisal for residents of Glasgow's East End.

Men have very different attitudes towards participating in projects intended to address their problems. Further project findings include:

- The decline in full-time paid employment, especially for men, has left men unclear about their roles. Where do they fit in to what seems increasingly a woman's world?
- Project workers find it difficult to contact men and therefore to involve them in community projects.
- Young men and women have different everyday problems: territorial barriers imposed by gangs, for example, are very real for boys, but irrelevant for girls.
- In relation to parenting, boys concentrate on their role as a provider whereas girls have a more holistic and socialised view of parental responsibilities.
- Involving older unemployed men is difficult as their self-image is wedded to paid employment but younger men are more likely to take training if on offer.

How can men best be included in community projects? Project workers reported that:

- Advertising 'men's projects' can be counter-productive, but attracting men to recreational and technical activities, works.
- Recruiting local, male project workers, with 'street credibility' and known to men in the community also works. Yet, recruiting such men is not easy, perhaps because 'caring' work is low status and perceived as 'women's work'.

Contributor(s): Sue Smith

Do weak states undermine masculinities?

The study of socially-constructed masculinities and their relationship to violence reflects a healthy concern not to reduce the equation between men and violence to simple biological determinism. To suggest that violence is an inevitable outcome of social constructs of masculinity is also too static. Can flawed nurturing processes fully explain the capacity of individuals and indeed whole societies to shift between 'cultures of violence' and 'cultures of peace'? Or does the state, through its actions or inactions, shape those cultures and the responses of individuals within them?

Masculinities can not be used as a silver bullet to explain away a wide range of violent behaviour. The crucial question to answer is 'when do men become violent?', by examining the political and economic context of men's lives. Is violence the outcome of failed politics? If so, is stronger politics the answer? Such investigations would add enormously to debates about 'weak states' and 'complex political emergencies'.

Uganda is widely regarded as a model of the 'African Renaissance', yet eighteen months of field work by the Agency for Cooperation and Research in Development (ACORD) in northern Uganda suggests that whilst the form of the state in the north is strong its key function of citizen protection is weak. Most people have moved to 'protected villages' with a military presence, but rebels raid with impunity, seizing men, women, children, and properties at will. Men, therefore, live in conditions in which it is virtually impossible to fulfil 'masculine' roles as providers and protectors, husbands and fathers. The research also witnessed widespread human rights abuses committed by the state, through its armed forces and police, including rape, killings, extra-judicial executions.

Findings indicate that:

- State inaction in the face of human rights abuses had eroded men's self-respect, resulting in widespread feelings of fear, intimidation, humiliation, frustration and anger, often expressed in violence against self and the social sphere, in the forms of alcohol abuse, suicide attempts and domestic violence.
- The impossibility of seeking redress through formal channels prompts some men into passive or active resistance to the state further prolonging war.
- The threat to masculine roles and identities brought about by a weak state causes violence, rather than 'masculinities' per se.

Weak states are damaging, on the one hand demanding that individuals surrender their power to the state whilst on the other failing to keep its side of the bargain - providing protection. Men surrender the role of 'self-defence' to the state: if it is weak and fails them, the men suffer damaging consequences to their self-esteem and 'masculinity'.

The policy implications for NGO interventions in peace building are challenging: clearly, peace education aimed at tackling socialisation is not the solution. Further key policy implications include:

- NGOs need to question and understand the political and economic context which undermines what are mostly non-violent constructs of masculinity.
- The state's right to the monopoly of violence, political and human rights theory has it, derives from its capacity to protect its citizens, yet persistent inaction in the face of assaults on its people disqualifies the state from enjoying that monopoly.
- Holding the state to account rather than the individual, based on analysis of political context rather than social constructs, is a delicate but important area for 'apolitical' NGO involvement.

If men need help, it is to recover their dignity, their voice, and their 'masculinity'.

Men against marital violence: a Nicaraguan campaign

A third of women in Nicaragua has been assaulted by her male partner. What is being done to change men's violent attitudes and behaviour within the family? After Hurricane Mitch in 1998 domestic violence worsened. In response, Puntos de Encuentro and the Asociación de Hombres Contra la Violencia launched a campaign encouraging men to respect their partners, resolve conflicts peacefully and seek help to avoid domestic violence.

How do men behave within a relationship? What are their attitudes towards their female partners? An initial survey showed that many men in Nicaragua expect women to wait on them, to be passive, and dependent. Men also admitted to feeling threatened by the possibility of being dominated by women.

Do such fears and insecurities lead to conjugal violence? The study revealed, however, that men can have non-violent, positive relationships with women, despite growing up surrounded by aggression.

The devastation caused by Hurricane Mitch pushed men to violent behaviour as family tensions and frustrations increased in the face of disaster. Puntos de Encuentro, working closely with 250 other organisations, developed a massive campaign in 1999 targeting men in seven worst-hit cities. The campaign included national and local media ads over a five month period, posters, pamphlets,

educational materials, and training for activists, mostly men: men, research had shown, could best persuade other men to change. Central campaign messages were that:

- Men can avoid violent behaviour.
- Violence against women hinders reconstruction of community life and the entire country.

How successful was the strategy? Did it reach men? Did men listen? Pre- and post-campaign surveys of 2000 men each, and 660 women in the second survey revealed that:

- 60 percent of men surveyed knew about the campaign
- men exposed to the campaign felt that men can prevent violence more than those not exposed to it
- men exposed to the campaign felt that violence negatively affects community development more than those who were not exposed to it
- men with highly dominant attitudes towards their partners were positively affected by the campaign
- a third of men talked to their female partners about the campaign and almost two thirds talked to other men.

The first campaign ever aimed at men to tackle domestic violence in Central America has contributed significantly to raising awareness and changing men's attitudes and behaviour:

- Men are more aware of the problem of violence against women.
- Men are now more willing to be part of the solution.
- Campaigners are better prepared and equipped with educational tools, added experience, and good publicity to help build new relationships between men and women based on equity and respect.

Sites for Sore Eyes: Online sources on men and masculinities

Men and masculinities is a new area of interest but there is no shortage of websites dedicated to putting men back onto the gender agenda.

For information on men and masculinities in development, try out the University of Bradford Development and Project Planning Centre's new site (from January 2001), www.brad.ac.uk/acad/dppc/gender.html featuring papers from the recent Seminar Series, 'Men, Masculinities and Gender Relations In Development' from which many of the articles here were drawn.

UNDP's 'Men and Gender Equality' site, www.undp.org/gender/programmes/men/men_ge.html, UNFPA's www.unfpa.org/modules/intercenter/role4men/index.htm, and www.popcouncil.org/ppdb/men.html which has several downloadable research papers, are all excellent.

For on line resources on men and reproductive and sexual health, see UNFPA's excellent site: www.unfpa.org/swp/2000/english/contents.html. AVSC's 'Men As Partners' (MAP) initiative at www.avsc.org/avsc/emerging/map/index.html aims to involve men in and thus meet the needs of both partners. Family Health International (FHI), www.fhi.org/en/fp/fppubs/network/v18-3/index.html and PATH, www.path.org/programs/p-wom/men_in_rh.htm, both have useful information and publication links.

Two UNICEF reports examine men and children: 'The role of men in the lives of children', at www.unicef.org/reseval/pdfs/ROMfinal.pdf; and 'Men in Families' available at www.unicef.org/reseval/malesr.htm. The University of Minnesota's, www.cyfc.umn.edu/Fathernet/ examines fathers and fathering.

The Swedish Male Network, www.man-net.nu/engelsk/start.htm, focuses on Gender-based violence and features links to government fact sheets, presentations and publications on gender mainstreaming.

Two profeminist sites are run by men: www.profeminist.org/ which challenges patriarchy and hegemonic masculinity, and www.chebucto.ns.ca/CommunitySupport/Men4Change/index.htm or 'Men for Change', which promotes gender equality and an end to violence.

Two men's magazines are on the web: 'MenWeb' which celebrates masculinity and provides support to men at www.vix.com/menmag/menmag.html, and the radical 'Achilles Heel', www.achillesheel.freeuk.com/index.html.

Further links can be found at:

- www.rolstad.no/iasom/ www.vix.com/pub/men/index.html
- www.mensstudies.com/links.html
- www.qweb.kvinnoforum.se/papers/maleinvolv.html

Grieg, A. Kimmel, M., and Lang, J. (2000, May). ***Men, Masculinities and Development: Broadening ou Work towards Gender Equality***. Monograph # 10. UNDP/GIDP

MEN, MASCULINITIES AND DEVELOPMENT:
Broadening our work towards gender equality

By Alan Greig, Michael Kimmel and James Lang

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Table of Contents

Introduction

What do men, as a distinct group, have to do with the development process? Men play diverse roles in the economy, the community and the family. Men are husbands and fathers, brothers and sons. Across differences of class, race, ethnicity, sexuality, age and religion, one of the few commonalities that men share, as a 'distinct group', is their gender privilege. Men, like women, are affected by gender power structures that are interwoven with other hierarchical structures such as those based on race and class. Yet men, regardless of their positioning in other hierarchical structures, generally have a strategic common interest in defending and not challenging their gender privilege. As Connell states:

> *A gender order where men dominate women cannot avoid constituting men as an interest group concerned with defense, and women as an interest group concerned with change.* (Connell 1995)

The processes that confer privilege on one group and not another are often invisible to those upon whom that privilege is conferred. Thus, not having to think about race is one of the luxuries of being of a dominant race, just as not having to think about gender is one of the patriarchal dividends that men gain from their position in the gender order. Men tend not to think of themselves as 'gendered' beings, and this is one reason why policy makers and development practitioners, both men and women, often misunderstand or dismiss 'gender' as a women's issue.

Gender, as a determinant of social relations that legitimizes and sustains men's power over women, is inherently about relations between women and men, as well as relations among groups of women and among groups of men. Achieving gender equality is not possible without changes in men's lives as well as in women's. Efforts to incorporate a gender perspective into thinking about development requires more than a focus on women, however vital that might be; what is also needed is a focus on men.

Yet, significantly, men continue to be implicated rather than explicitly addressed in development programmes focusing on gender inequalities and the advancement of women. "In the gender and development literature men appear very little, often as hazy background figures" (White 1997). There is a growing recognition, however, of the need to define more precisely the relationship between men and 'engendered' development policy and practice, and examine questions of men's responsibility for women's disadvantage, as well as men's role in redressing gender inequalities.

This recognition is, in part, a consequence of the conceptual shift from the discourse of Women in Development (WID) to that of Gender and Development (GAD):

> *The GAD approach signals three departures from WID. First, the focus shifts from women to gender and the unequal power relations between women and men. Second, all social, political, and economic structures and development are re-examined from the perspective of gender differentials. Third, it is recognized that achieving gender equality requires transformative change.* (United Nations 1999, p. ix)

The purpose of this paper is to discuss men's possible relationships to this process of transformative change by exploring the meanings and uses of 'masculinity'. Discussions of masculinity provide a place in which men's involvement in producing and challenging inequalities and inequities in gender and other social relations can be investigated. Masculinity renders gender visible to and for men. Understanding the definitions and discourses surrounding masculinity can help in the analysis of how political, economic and cultural inequalities are produced and distributed not only between but also within the genders. Above all, an inquiry in to the 'politics of masculinity' offers an opportunity to rethink men's strategic interest in challenging the values and practices that create gender hierarchy.

Examining masculinity and the role it plays in the development process is not simply an analytical exercise, but has widespread implications for the effectiveness of programmes that seek to improve economic and social outcomes in virtually every country. "If development is not engendered, it is endangered" cautioned the 1997 Human Development Report. Gender equality is not only an end in itself, but also a necessary

means to achieving sustainable human development and the reduction of poverty. Signatories to the 1995 Copenhagen Declaration on Social Development recognized this when they committed themselves (in Commitment Five) to:

> *Promoting full respect for human dignity and to achieving equality and equity between women and men, and to recognizing and enhancing the participation and leadership roles of women in political, civil, economic, social, economic and cultural life, and in development* (United Nations 1995).

The nature and effects of gender inequalities worldwide have been well documented. In 1995, the Beijing Platform for Action listed the following critical areas of concern: the persistent and increasing burden of poverty on women; violence against women; inequality in economic structures and policies, in all forms of productive activities and in access to resources; inequality between men and women in the sharing of power and decision-making at all levels, and; gender inequalities in the management of natural resources and in safeguarding the environment (United Nations, 1995a).

Implicit in this listing is the identification of men and male-dominated institutions as the producers and beneficiaries of the gender order that disadvantages women in all spheres of life. This paper addresses questions that arise when men's contribution to gender equality goals is considered in the context of this prevailing global gender order:

- To what extent can men be involved in transforming the gender inequalities that currently privilege them?
- To what extent should gender programmes work with men, given the already scarce resources available for their existing work with women?
- What are the ways in which gender programmes can work with men in order to achieve their gender equality goals?
- How can a 'politics of masculinity' assist gender programmes to engage with men as potential agents of transformative change, without compromising current commitments to the advancement of women?

Across a range of development issues and institutions, there is an increasing interest in men as potential agents of change and not merely objects of blame. Commenting on the role of men in the HIV epidemic, Peter Piot, the Executive Director of UNAIDS, has stated that "[T]he time is ripe to start seeing men not as some kind of problem, but as part of the solution". The questions of "which men?" and "which solutions?" remain to be answered.

The Meanings of Masculinity

Discussions of masculinity provide a place in which to clarify these answers. But before turning to consider the usefulness of these discussions, it is important to look at the different meanings ascribed to the term 'masculinity' and the assumptions that prefigure, as well as the implications that ensue, from these meanings. Masculinity is a way to explain men – but there are different ideas captured with different terminology: biological determinism or essentialism, cultural or social constructionism and masculinity as a discourse of power.

Biological Destiny or Cultural Construction?

While both schools of thought believe that 'masculinity' is a useful tool to explain men, these polarized propositions diverge in their account of what determines men's masculinity: nature or nurture? As biological destiny, masculinity is used to refer to the innate qualities and properties of men that distinguish men from women. In this view, masculinity is men's nature, and as such helps to explain not only differences but also inequalities between men and women. Men's political, economic and cultural privileges arise from their 'masculine advantage', as variously reflected in genetic predisposition to aggression (in contrast to the passivity of femininity), physical strength (in contrast to the weakness of femininity) and sexual drives (in contrast to the sexual reserve of femininity).

The problem with biological determinism is the arbitrary nature of the fixing of men's 'essential' masculinity, which can range across a whole spectrum from men's innate physicality/animality to men's innate rationality. Feminist scholarship and practice has

long critiqued the political convenience of explaining gender inequality and hierarchy in terms of men's natural superiority. But development institutions and practitioners have been slower to take such biological determinist thinking about men and masculinity into account. As such, many have failed to grasp how the resurgence of such thinking has likely come in response to diverse threats to men's power posed by geo-political, economic and cultural changes, some of which have favored the advancement of women. For instance, writing of events in Serbia in the 1990s, Blagojevic (1999) notes that "[t]he political and economic changes endangered the male identity much more than the female". Consequently:

> *New prophets appeared on the scene offering various socio-biological arguments in support of the claim that men are inherently superior. One such was Tosevski, who proclaims Serbian masculinity to be superior to the western variety and advocates open promiscuity for males....The popularity which he enjoys, the pervasiveness of his ideas in public discourse, and the image of a "popular male mythology of Serbian masculinity" in his texts, together reveal how dramatic the problem of an emptied male identity in Serbian culture actually is.*

Resistance to the emerging global capitalist order has been similarly mobilized by appealing to biological determinist notions of masculinity. Scholars have pointed out the ways in which religious fundamentalism and ethnic nationalism use local cultural symbols to express regional resistance to incorporation by a larger, dominant power (see especially Jurgensmeyer 1995 and Barber 1995). These religious and ethnic expressions are often manifest as gender revolts, and include a virulent resurgence of domestic patriarchy (or militant misogyny); the problematization of global masculinities or neighboring masculinities (as in the former Yugoslavia); and the overt symbolic efforts to claim a distinct "manhood" along religious or ethnic lines to which others do not have access and which will restore manhood to the formerly privileged. In effect, masculinity becomes a rhetorical currency by which opposition to global integration, state centralization and increasing ethnic heterogeneity can be mobilized. In such cases, we expect to find ideas of traditional, local masculinities and their accompanying hierarchies reaffirmed. Typically, as Connell notes (1998: 17), "hardline masculine fundamentalism goes together with a marked anti-internationalism".

The political implications of the biological determinism that accompanies such fundamentalism have directed much attention toward other explanations of men and their masculinity. That gender is constituted in and by society and culture, rather than nature and biology, is of course a basic tenet of feminism, the women's movement and, subsequently, GAD policy and practice. But this understanding, at least in development institutions and practice, has usually been applied to programmes concerned with the advancement of women, and rarely to work with men. However, there is an increasing interest in 'gendering' men and this interest has centered on an exploration of cultural constructions of masculinity. This exploration still seeks to explain men and their behaviour in terms of their masculinity, but a masculinity which is defined as an embodiment of the cultural norms and social pressures that help to determine the roles, rights, responsibilities and relations that are available to and imposed upon men, in contrast to women.

Accounts of the cultural constructions of masculinity often conceive and describe it in metaphors of roles, performances and scripts. Such conceptions and metaphors give rise to a number of insights that are of use to development practitioners seeking to work with men toward gender equality goals. For example, separating men from their masculine roles creates a space within which their gender, and the process of their gendering, can become more visible to men themselves. Making men more conscious of gender as it affects their lives as well as those of women is a first step towards challenging gender inequalities.

The emphasis on the pressure that masculinity imposes on men to perform and conform to specific masculine roles (emotional and psychological as well as political and social) has highlighted the costs to men of current gender arrangements. Writing from an anti-sexist organization in Zimbabwe, Gokova (1998) notes that:

> *Men have not realized how much they pay in insisting on separate gender roles.... Men deny themselves the experience of being human, particularly in so far as their relationship with women is concerned. They miss important lessons of life*

derived from challenging relationships in which women play an equal role. Living the myth of male superiority has sometimes resulted in men suffering from stress, even early death, because of pressure to project an image that is not naturally theirs and that is not sustainable.

This concept of the pressure of masculinity, often linked to a notion of the fragility of masculine identity that requires constant performance, has proved fruitful in providing explanations of stereotypically problematic male behaviours, such as violence and sexual risk-taking. One programmatic consequence of this concept of the pressures of masculinity has been the attention given to addressing the sources of this pressure in processes of socialization. Working with the institutions (familial, educational, religious and cultural) that help to socialize boys into men creates an entry point for development practitioners concerned with increasing men's commitment to gender equality. Such work offers the possibility of reconstructing masculinity and creating new models and identities for men that will enable and encourage them to work towards gender equality, and therefore more effective models of development.

Defining masculinity in terms of its cultural construction offers ways to re-think men's relationship to gender in/equality. For some, this means displacing responsibility for women's oppression from men onto masculinity. There are dangers in this displacement, however, related to the extent to which cultural constructions of masculinity are regarded as determinants of men's actions in the world. Heise poses the question: "What is it about the construction of masculinity in different cultures that promotes aggressive sexual behaviour by men? (1997: 424)". She concludes that it is "men's insecurity about their masculinity that promotes abusive behaviour toward women (1997: 425)" and continues:

[T]he more I work on violence against women, the more I become convinced that the real way forward is to redefine what it means to be male. (1997: 426)

But the suggestion that men need a new definition of their masculinity in order to reduce or end male violence appears to prioritize questions of identity over questions of values. Clearly the two are related, in that the devaluing of women in most if not all

cultures is constitutive of "what it means to be male". But this gender hierarchy of value is interwoven with other hierarchies of value and structures of oppression (by sexuality, race and class for example). In this regard, it is not helpful to abstract a discussion of men's behaviour in terms of their masculine identity from a broader discussion of the values and practices that shape power relations not only between men and women, but also among men and among women.

Discourse(s) of Power

> *'Masculinity', to the extent that the term can be briefly defined at all, is simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture.*

The definition offered by Connell (1995: 71), though complex, is suggestive. It warns us that masculinity is not the property of men, and reminds us to be wary of using the terms 'men', 'male' and 'masculinity' interchangeably. Discourses of masculinity are available to, used by and imposed upon both men and women.

> *As a woman, I am a consumer of masculinities, but I am not more so than men are; and, like men, I as a woman am also a producer of masculinities and a performer of them.* (Sedgwick 1995: 13)

Understanding masculinity as discourse broadens the focus beyond men and the biological or cultural bases of their masculine nature or identity. The challenge confronting development practitioners concerned with men's relationship to gender equality is to place this relationship in the context of relations of power not only between but also within the genders. Addressing masculinity as discourse (by whom? for what purposes?) helps this placement by clarifying the values and practices that create such hierarchies of power. Misogyny, homophobia, racism and class/status-based discrimination are all implicated in a 'politics of masculinity' that is developed and deployed by men to claim power over women, and by some men to claim power over other men.

Discursive perspectives on masculinity are interested in the ways that it becomes a site for these claims and contests of power. Such perspectives pluralize masculinity into masculinities and note the way that subordinate masculinities emerge in resistance to the power claims of hegemonic masculinities.

Pluralizing masculinity into masculinities is more than a way to explain there are many ways to be a man. It is useful for understanding the connections between masculinities and the distribution and effects of power and resistance among the different forms of masculinity. This has significant implications for development work on men and gender equality. It suggests that such work should not be confined by a concern to work on masculinity in order to reform the male identity and offer men better ways of being a man, however useful such work may be to specific individuals. An understanding of the 'politics of masculinity' indicates that the values and practices (individual and institutional) that create gender inequality are also intimately involved in the creation of other hierarchies of oppression. Challenging these values and practices implies working with both women and men, at the policy and programme level, to mobilize constituencies for change in which gender equality goals are integral to movements and coalitions for social justice.

The Uses of Masculinity

This section turns to examine the uses of masculinity in relation to a number of critical development issues and themes. Discussion of these usages and their implications for men's relationship to engendered development practice and outcomes leads to a number of recommendations for development institutions, their policies and programmes.

Power and Patriarchy

The naturalizing of men's power is one of the main functions performed by discourses of masculinity. The masculine/feminine duality rests on and supports a whole set of dual associations that contrast the powerful male with the powerless female:

hard/soft, active/passive, productive/reproductive, warrior/nurturer. Such associations ease men's, and inhibit women's, access to and control over political, economic and cultural power. An effect of this 'natural' association between men and power is to render their gender invisible in the acquisition of such power.

One of the significant achievements of feminist scholarship has been to name the connections between men, gender and power and give them visible expression in the term 'patriarchy'. In both the public and domestic spheres, patriarchy refers to the institutionalization of men's power over women within the economy, the polity, the household and heterosexual relations.

Men's relationship to such patriarchal arrangements of power must be a critical area of concern to development programmes that seek to involve men in gender equality work. Irrespective of men's power vis-à-vis other men, it is clear that:

> *Men gain a dividend from patriarchy in terms of honour, prestige and the right to command. They also gain a material dividend.* (Connell 1995: 82)

But it is equally clear that men's 'patriarchal dividend' is mediated by economic class, social status, race, ethnicity, sexuality and age (to name some of the more salient modifiers). Patriarchy becomes a less useful concept when applied to questions of intra-gender equity and equality. Despite the dividend, most men remain disempowered in relation to the elites (composed of men and women) that wield political and economic power in societies and communities throughout the world. It is this experience of disempowerment that potentially connects some men and women across the patriarchal divide, and offers the possibility of linking a gender politics that challenges patriarchy with a wider politics of social transformation.

Production and Social Reproduction

But the barriers to this kind of transformative change, and especially men's involvement in it, are considerable. Many are rooted in gender relations in the spheres of production and social reproduction. Men continue to benefit from the fiction of the

separation between the spheres of production and social reproduction. Many women, in contrast to most men, do a double shift, working in both spheres. As Desai (1994) notes:

> *In the economic South, traditional gender relations inhibit men's involvement in the family, and women assume virtually all responsibilities for child care, regardless of their involvement in paid work.*

Industrialization and urbanization in developing countries has only served to increase the pressures on women to perform this double shift. The impact on gender inequalities is apparent in the way this burden of the double shift continues to restrict women's participation and progress in labour markets and the wage economy.

> *Efforts toward redistributing the burden of reproductive labour toward men within households or socializing the cost of child care or other types of caring labour are necessary for both reducing women's time poverty and helping them participate in labour markets more fully.* (Cagatay 1998: 13)

The report of the 1994 Cairo conference on population and development signaled recognition of the need for changes in men's lives for women's equality. One objective was:

> *To promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles.* (United Nations 1994)

But the politics of masculinity inhibits the social and policy changes that are required to "encourage and enable men" to renegotiate roles and redistribute burdens across the productive and reproductive spheres. The effects of such a politics are evident in the benefits that men draw from the cultural prohibitions on their involvement in social reproduction and the grounding of masculine identities in being the provider, the 'breadwinner'. These benefits are reinforced by macroeconomic development frameworks and poverty reduction strategies. Their 'male breadwinner bias', for example:

> *[C]onstructs the ownership of rights to make claims on the state for social benefits (access to services, cash transfers) around a norm of full-time, life-long working age participation in the market based labour force.* (Elson and Cagatay 2000: 18).

There is some evidence of limited change. Some cultural traditions actively encourage involved fatherhood, and others have proved amenable to change. A study of 700 new fathers in Jamaica found that 50% of the urban fathers reported significant involvement in family life such as cooking, cleaning and shopping. There, Fathers Incorporated works with men to promote more positive images of fathers and encourage community and family engagement (Brown and Chevannes 1993). Studies in Brazil have confirmed that younger men are far more flexible in their gender role expectations than older men (Barker 1996). There is also evidence of a backlash by men in situations where male authority is challenged, a backlash grounded in and justified by appeals to biological determinist notions of masculinity and their prescriptions of men's and women's 'proper' roles in the family. For example, "if men feel their authority is in jeopardy, they may attempt to tighten control over the women and girls around them, especially if it is perceived that female gains toward independence or equality mean a loss in their own entitlement as men" (UNICEF 1997: 23).

Dealing with this male backlash and challenging the male bias in economic, political and cultural practice will not be easy. As Elson (1991:15) writes:

> *Overcoming male bias is not simply a matter of persuasion, argument, and change in viewpoint in everyday attitudes, in theoretical reasoning and in policy process. It also requires changes in the deep structures of economic and social life, and collective action, not simply individual, action.*

The need to renegotiate an equitable division of labour (and its rewards) across both productive and social reproductive spheres requires structural and not merely individual change. This suggests that the emphasis given in cultural constructionist accounts of masculinity to the need to re-socialize men to perform caring and nurturing roles and to associate those roles with a new model of masculinity may be necessary but not sufficient to bring about the necessary change. Indeed, framing the problem purely in terms of

gender roles may distract attention from other basic issues such as economic class. Men and women in poor and marginalized communities in many ways lack the economic freedom to choose how they negotiate their distribution of productive and social reproductive tasks. Collective action at community and societal level is needed in order to create not only the cultural but also the economic conditions that can make this re-negotiation possible.

Poverty

Many governments, UNDP and a number of other development agencies have recognized the connections between gender equality, human rights and the reduction of poverty. As a component of a six-point action agenda for the eradication of poverty, The Human Development Report 1997 (UNDP 1997) states:

> *Gender equality needs to be part of each country's strategy for eradicating poverty, both as an end and as a means to eradicating other forms of human poverty. This means: focusing clearly on ending discrimination against girls in all aspects of health, education and upbringing .. starting with survival. Empowering women by ensuring equal rights and access to land, credit and job opportunities. Taking more action to end violence against women, the all-too-pervasive hidden side of human poverty. A creative commitment to gender equality will strengthen every area of action to reduce poverty .. because women can bring new energy, new insights and a new basis for organization. If development is not engendered, it is endangered. And if poverty reduction strategies fail to empower women, they will fail to empower society.*

Gender inequality is responsible for, and expressed in, the different articulations of the global 'feminization of poverty[1]'. Women represent approximately 70% of the 1.3 billion poor people in the world (Beneria and Bisnath 1996: 6). Compared with men, girls and women are most likely to be undernourished, and girls and women are most likely receiving less health care – out of approximately 900 million illiterate adults in the world – 2/3 are female (Cagatay 1998).

[1] The concept of 'feminization of poverty' can refer to a variety ideas including either one or a combination of the following: women compared to men have a higher incidence of poverty; women's poverty is more severe than men's, and/or, over time, the incidence of poverty among women is increasing compared to men. (Cagatay 1998: 3)

Discourses of masculinity help to shape the power relations underpinning gendered and inequitable division of labour and access to resources. Households, communities, markets and states are interconnected sites of cooperation and conflict over the control and allocation of resources, and discourses of masculinity are used to legitimize some men's stronger bargaining position vis a vis women and other men. The differentiation of men's work from women's work, the differential remuneration that men and women receive for the same work, the exclusion of women from positions of power within the economy, and the omission of the reproductive sphere in macro-economic planning can all be linked to discourses of masculinity that privilege the male over the female.

In addition, although they appear to be gender-neutral, the institutional arrangements of global society are very much gendered. The marketplace, multinational corporations, transnational geopolitical institutions and their attendant ideological principles (economic rationality, liberal individualism) express a gendered logic. The "increasingly unregulated power of transnational corporations places strategic power in the hands of particular groups of men," while the language of globalization remains gender neutral so that "the 'individual' of neo-liberal theory has in general the attributes and interests of a male entrepreneur" (Connell 1998: 15).

Feminist economics and other approaches to engendering economic planning and policy making at all levels can make more use of 'masculinity' as a discursive framework within which to mark men as gendered beings and to expose the constructed and political nature of their privilege in the economic sphere. Equally, an understanding of the politics of masculinity can help to link broader dimensions of human poverty (such as freedom, self-perception, and violence) to the distribution of political, economic and cultural power between and within the genders. This suggests the need to work at the community level, with women's and men's differing but shared experiences of poverty, to develop collective action and advocacy for the sustainable reduction of human poverty.

Governance

Redressing gender inequities in the distribution and impacts of poverty is connected to questions of gender inequalities in systems and structures of governance. Development institutions, among many others, are conscious of the connections between women's economic empowerment and political enfranchisement. Increasing attention is being given to identifying and challenging the barriers that prevent women from participating fully in the political process, with the aim of creating a critical mass of women in positions of governance at all levels.

In describing the inception of the Panchayat Raj Institutions (PRI) system in India, by which the Indian constitution was amended in order to mandate the reservation of seats for women in local government, Devaki Jain (1996) notes:

> *Women's empowerment challenges traditional ideas of male authority and supremacy. It is unsurprising, then, that PRI has been opposed by some men. Ratanprabha Chive (Ratna) is the sarpanch (head) of the seven halets (hamlets) that comprise the Ghera Purandar Panchayat. Ratna was beaten up as soon as she assumed office by her rival who could not accept the fact that a female had outwitted him.*

The reluctance of men to cede power to women in institutions of governance has been evident too in the marginalizing of women within movements for national liberation. McClintock (1997:109) has noted the ways in which the nationalism of such movements is masculinized, and the effects this has on silencing the gender politics of such political transformations.

> *Male nationalists have condemned feminism as divisive, bidding women hold their tongues until after the revolution. Yet feminism is a political response to gender conflict, not its cause. To insist on silence about gender conflict when it already exists is to cover, and thereby ratify, women's disempowerment...If nationalism is not transformed by an analysis of gender power, the nation-state will remain a repository of male hopes, male aspirations, and male privilege.*

Similarly, the politics of masculinity in anti-colonial struggles mimics the use made of discourses of masculinity to claim and maintain colonial power. Thus, for

example, colonial administrations often problematized the masculinity of the colonized. In British India, Bengali men were perceived as weak and effeminate, though Pathas and Sikhs were perceived as hypermasculine – violent and uncontrolled (see Sinha 1995). Similar distinctions were made in South Africa between Hottentots and Zulus, and in North America between Navaho or Algonquin on the one hand, Sioux, Apache and Cheyenne on the other (see Connell 1998: 14). In many colonial situations, the colonized men were called "boys" by the colonizers (see Shire 1994).

Securing the entry of a sufficient number of women into positions of political power and influence will help to make gender visible as a key governance issue and will challenge the masculinizing of power that has been alluded to already. But questions of representation remain, given the possibly divergent interests of different groups of women in a given society. The uses of masculinity in claiming and resisting power over local, national and global governance suggest that the entry of more women into positions of power within these structures may be a necessary but not sufficient condition for gender-equitable sustainable human development. More fundamentally, there is a need to challenge the series of exclusions (by gender, race, class, sexuality, ethnicity, age and able-bodiedness) on which such power is based and which are embodied by discourses of masculinity and their hierarchizing of not only inter- but also intra-gender difference.

Violence and Conflict

Men's violence is a key determinant of the inequities and inequalities of gender relations, both disempowering and impoverishing women. Violence is a fundamental dimension of human poverty. Yet, men's 'natural aggression' is often invoked as a defining characteristic of an essential gender difference and as an explanation for the gendered hierarchical arrangements in the political and economic lives of richer and poorer countries alike.

Understanding development as freedom and as a right means recognizing that men's violence restricts women and children's development by curtailing their freedoms and restricting their rights. This understanding also means recognizing the various

pressures placed upon men that may result in violent reactions and well as the need for men to take responsibility for their actions.

> *It is important to give simultaneous recognition to the centrality of individual freedom and to the force of social influences on the extent and reach of individual freedom. To counter the problems that we face, we have to see individual freedom as a social commitment. (Sen 1999)*

Heise (1997: 414) reports on a summary of twenty studies from a wide variety of countries that 'document that one-quarter to over half of women in many countries of the world report having been physically abused by a present or former partner'. She concludes that '[t]he most endemic form of violence against women is wife abuse, or more accurately, abuse of women by intimate male partners (Heise 1997: 414)'. In terms of sexual health and reproductive rights, such abuse diminishes women's capacity to express and enjoy their sexuality and to control fertility, while increasing their risks of pregnancy complications and of acquiring sexually transmitted infections.

By moving from biological determinist to cultural constructionist accounts of masculinity, a number of men's anti-violence programmes have been able to work with violent men to help them understand the ways that structural pressures, cultural messages and/or parenting practices, have contributed to their socialization into violence. Deconstructing their violence in this way has helped some men to change.

Violence prevention and intervention[2] programmes are numerous worldwide. United Nations entities including UNIFEM, UNICEF, UNDP and UNFPA have launched and supported a significant number of violence prevention campaigns and projects over the past decade, some of which involve men, and the UN General Assembly passed the Declaration on the Elimination of Violence Against Women (resolution 48/104).

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[2] Prevention refers to stopping violence before it starts – initiatives that, for example, address socialization processes, use public awareness strategies or methodologies such as peer education. Intervention refers to work with those who commit acts of violence.

In many countries, civil society organizations and profeminist men's groups work alongside women's shelters to confront men's violence. Over 100 men's groups in the United States – including Men Overcoming Violence (MOVE) in San Francisco, St. Louis's Rape and Violence End Now (RAVEN), the Massachusetts-based Men's Resource Center, upstate New York's Volunteer Counseling Service, and Boston's EMERGE – actively work to end men's violence against women. Other U.S.-based groups, such as MVP Strategies, have developed training materials for men and women in high school and universities, corporations, law enforcement agencies and military services. Similar programmes exist throughout the world. The Men Against Abuse and Violence, based in Mumbai, India is a volunteer organization whose focus is to end domestic violence. In Mexico, CORIAC holds workshops to reduce men's violence against women while in Nicaragua, CANTERA develops training and resource materials for working with men on issues of domestic violence, using popular education methodologies. The International White Ribbon Campaigns (WRC) invite men to wear white ribbons for one week – usually commencing November 25, the International Day for the Eradication of Violence Against Women – symbolizing their opposition to men's violence against women, to overcome complacency, to develop local responses to support battered women and to challenge men's violence. Wearing a white ribbon is a means to break that silence and encourage self- reflection. Today, WRC has been successfully launched in more than a dozen countries in Africa, Asia, Latin America, and in the United States and Australia.

Beyond the public awareness and therapeutic value of such interventions, it is also important to explore the political opportunities of deconstructing the connections between men, masculinity and violence. In describing a project that works on male violence in Nicaragua, Montoya (1999) stresses the importance of contextualizing such violence in history and culture:

> *Violence in couple relationships is a problem of power and control. [...]It is maintained by the social structures of oppression in which we live – based, among others, on gender, class, age, and race inequalities. A national history of wars and a culture of settling conflict through force also maintain it. Colonialism and imperialism have had a role in intensifying this violence.*

Implicit in this quote too is a connecting of different types of violence; the interpersonal violence in couple relationships is placed in the context of the structural violence of inequalities based on gender, class, age and race. It is also located in a culture that 'naturalizes' violence, rendering it 'normal' (in itself, an act of violence against those who have come to accept violence) and a history of wars, colonialism and imperialism.

Placing men's violence in a historical and cultural context helps overcome the naturalizing of men's violence, or what might be called the 'masculinizing of violence'. Indeed, it points out the role that discourses of masculinity play in exploiting what is claimed to be men's 'natural' aggression and militarism for specific political purposes. Enloe (1990) notes the way that public power continues to be used to construct gender in such a way as to militarize a society and mobilize its 'fighting' men. Blagojevic (1999) comments on the mythology of a dominant Serbian masculinity that became popular in Serbia in the 1990s in order to compensate for men's reactions to the war:

> *The behaviour of many men during this last war was neither "manly" nor "macho", and, contrary to the popular media image of the Serbs as warriors, they did not generally support the war. They too found themselves to be, in many ways, victims of patriarchal megalomania and the madness of civil war.*

Men's and women's relationship to violence is usually more complex than gendered accounts of perpetrators (male) and victims (female) suggests. This is not to deny the material reality of women's suffering at the hands of men and that women are at far greater risk of being the victims of acts of violence committed by men than vice versa. But questions of responsibility become more complicated when such gender-based interpersonal violence is contextualized within structures, cultures and histories of violence that both men and women have produced and reproduced. To address these, it may be useful to look not merely at the violence of men but at the violence that lies at the heart of masculinity's hierarchizing of difference and the misogyny, homophobia and racism that are embedded in discourses of masculinity. In this sense, a development response to the connections between men, masculinity and violence should not only

health promotion work with men, especially in the area of sexual health. For example, a recent report from UNAIDS (2000):

> *[C]hallenges harmful concepts of masculinity and contends that changing many commonly held attitudes and behaviours, including the way adult men look on risk and sexuality and how boys are socialized to become men, must be part of the effort to curb the AIDS epidemic. Broadly speaking, men are expected to be physically strong, emotionally robust, daring and virile, the report says. Some of these expectations translate into attitudes and behaviours that endanger the health and well-being of men and their sexual partners with the advent of AIDS.*

HIV prevention work, with both straight and gay men and looking at both homosexual and heterosexual transmission, has addressed HIV-risk taking behaviour as a facet or demonstration of masculine identity. Deconstructing the need for this demonstration and highlighting the pressures on men to 'perform' their masculinity through risk-taking have created a space for men to be more conscious of the reasons for and consequences of their own sexual behaviour.

Focusing on risk as the mediating term between masculinity and poor public health, however, threatens to decontextualize gender from issues of sexuality and power relations more generally. Pleasure and desire are less often identified as mediating terms, and yet the power and privilege of men in their relations with women often translates into a sense of entitlement to express their desire and seek pleasure in their heterosexual relations with women. Arguably, it is men's assertion of their entitlement to pleasure, and the demonstration of power that underpins this assertion, that help to explain the effects of masculinity on sexual health.

Pleasure and power are also important concepts for understanding the nature and health outcomes of sex between men. Parker's work in Brazil on the desires, practices and identities of men who have sex with men offers many valuable insights (Parker 1998). Clearly, the notion of risk-taking sexual behaviour as proof of masculinity is inadequate in contexts where men's choice of active and passive positions in anal sex both reflects and recasts the gendering of sexual and social roles that see men as

dominant and women as submissive. Parker also notes the way that men play with masculine-feminine 'boundaries' and also, in their transition in to gay identities, demarcate a gay masculinity that both confronts and reinforces more orthodox arrangements of power in terms of gender and sexuality.

The connections between health and gender inequality are most urgently expressed by the HIV epidemic. "The HIV epidemic is driven by men," commented Calle Almedal, a senior official with UNAIDS (cited in Foreman 1999: viii). Of the estimated 30 million people infected with HIV, about 17 million are men (Foreman 1999: 172). Ana Luisa Liguori, head of the MacArthur Foundations programs in Mexico points out that if there is a positive side to the AIDS crisis it is that "it provides proof that the very unequal relationship between men and women in poor countries is a danger for the human race" (cited in Foreman 1999: 62).

Given that male sexuality, and the cultural, economic and political contexts that shape its expression, is the main HIV risk factor for many women, efforts to integrate men into HIV prevention programmes are urgently required.

> *"Involving men more fully in HIV prevention work is essential if rates of HIV transmission are to be reduced. While such a move may not be universally popular, it seems necessary if we are to ensure that men take on greater responsibility for their own sexual and reproductive health, and that of their partners and families"* (Rivers and Aggleton: 1999: 18).

Successful HIV risk reduction programs have targeted men's behaviour in such diverse countries as Thailand, Great Britain, Australia and Senegal. In the Caribbean, the Gender Socialization and Life Skills Education project works with younger men to control HIV and reduce teen pregnancy and violence. In the Dominican Republic, a collection of NGOs have promoted the Avancemos ("Let's Move Ahead") programme to promote condom use among clients of sex workers. In Zimbabwe, teaching of life skills and

responsibility issues has been incorporated into primary school curriculum by using HIV as an entry point.

Perhaps the most successful HIV risk-reduction programme has been in Uganda, where the rate of new infections of HIV has moved from being one of the highest in Africa to one of the lowest. Life Skills Education programs are run in every school, and *Straight Talk,* a magazine on sexual issues targeted to a young audience, is distributed free as a monthly insert in the country's state-owned daily newspaper. Significantly, these socialization approaches have been combined with efforts to mobilize community action on some of the social and cultural determinants of HIV vulnerability. Training programmes, such as *Stepping Stones*, have been used to initiate a dialogue between women and men at the community level on issues of gender and sexuality.

Development institutions can build on these examples if they recognize that involving men in work on gender equality and health must look beyond programmes targeted at men's behaviour. There is a need to initiate dialogues between women and men about the structures of inequality that determine the distribution of morbidity and mortality, and the role that the politics of masculinity plays in maintaining such structures.

The Workplace and Organizations

> *Changes in mainstream policies and resource allocations must reflect the interests and views of women as well as men. This mainstreaming strategy emphasizes systematic attention to gender equality issues and the experience of women in organizational practices, policies and programmes.* (UNDP 1998: ii)

Gender biases at the institutional level are deeply embedded in organizational cultures and practices, management systems and bureaucratic structures. 'Gender mainstreaming' is one method of overcoming institutional biases and involves not only a recognition of the gender implications of development programming and resource allocation, but also challenges an organization to reflect on the gendered processes that exist in its own operational structures.

UNDP, with an overriding mandate of poverty reduction, recognizes that sustainable poverty reduction requires gender equality. Consequently, through gender mainstreaming programmes and its men's initiatives, UNDP is taking steps in a self-reflective process meant to identify barriers to a more gender equitable working environment. In general, these types of self-reflective exercises may also identify other forms of inequitable power relations that are not based solely upon gender, such as those based upon class and race.

During a gender mainstreaming workshop in February 1999, a group of male UNDP staff was encouraged to discuss the role of men as advocates for gender equality and the advancement of women. This group soon evolved into the UN Men's Group for Gender Equality, which has identified a number of barriers to a more gender equitable organization:

- The organizational culture. There are barriers embedded in the organization such as sexism, male/female staff ratios, hierarchical structures in decision-making, and prevailing attitudes that hold gender to be a 'women's issue'.

- The lack of ample opportunity and/or spaces for men to discuss gender equality with other men and women.

- The limited number of men participating in mainstreaming efforts. For example, the mainstreaming workshop had a six-to-one female-to-male participation ratio.

The UN Men's Group for Gender Equality subsequently disseminated a statement called "Gender Mainstreaming: A Men's Perspective" that outlined what it believes to be issues behind these barriers:

> *(1) Fear: Men are often fearful when first presented with a gender mainstreaming agenda. The advancement of women may be perceived as a threat to men's personal and professional status. This may be buttressed by anxiety*

about ridicule or compromised masculinity if one is widely perceived as an advocate of women's equality.

(2) Lack of experience: Men recruited by UNDP, and a majority of those already working for the organization, do not have experience – whether academic or professional – on related gender issues. Concurrently, it is frequently women who are recruited or appointed to handle gender concerns, regardless of their expertise. Therefore, any meaningful dialogue on gender equality and the role of men and women in gender mainstreaming could be viewed as disunited from a common agenda.

(3) Organizational culture: UNDP's organizational culture is a product of accumulated legacies, which can maintain a partition between men and women. There is an absence of incentive structures for staff to view gender equality as integral.

In its current capacity, the UN Men's Group for Gender Equality sponsors panels and seminars, and also facilitates a web site and electronic discussion list. By creating spaces for dialogue about gender issues, the institutional barriers to gender equality and possible solutions, the group seeks model how men can become involved in gender mainstreaming.

Practically, gender mainstreaming requires that gender be brought into the center of discussions about development, and not marginalized as a 'women's issue'. Organizations need not only to take a 'gendered lens' to its mission and practice; gender mainstreaming also requires internal organizational self-examination, and investigating the assumptions and criteria for administrative decision-making and human resource policies.

Men must be integrated fully in discussions regarding gender mainstreaming, lest their attitudes provide the chief obstacle to women's equality, organizationally and politically. Senior staff and managers can encourage and provide incentives for the promotion of gender equality. When the organizations charged with facilitating development adopt an effective inward/outward looking gender mainstreaming policy,

they can begin to fulfill their commitments to gender equality, poverty alleviation and human rights.

Conclusions and Next Steps

Thinking about masculinities and men's roles in working towards gender equality is relatively new in the development field. This paper has presented a review of the meanings and uses of masculinity to catalyze thinking around these issues – to inspire new conversations and debate – and to offer a conceptual backdrop for practitioners engaged in work with men. To carry this work forward, continued efforts should be made to publicize and advocate for the importance of men's responsibilities and roles in work towards gender equality in international fora, local and national policy debates, and development programming. Making masculinities visible and men more conscious of gender as it affects their lives and those of women is a first step towards challenging gender inequalities.

Beyond the broadening and deepening of conversations concerning men, masculinity and gender equality, a second step in this undertaking is the facilitation of programming efforts. UN agencies and the UN Men's Group for Gender Equality can help practitioners talk to each other about conceptual starting points, assumptions and practical methodologies to be used on the ground. The clearinghouse of resources and methodological tools on the Men's Group web site (http://www.undp.org/gender/programmes/men/men_ge.html) can be expanded and linked with other such efforts. Through data collection efforts, context-specific information can be compiled and shared concerning gender norms and attitudes, community assets, socialization processes, and good practices that are replicable across geographical and ideological settings.

The conclusion of the 1995 Human Development Report articulated a vision of transformation:

One of the defining moments of the 20th century has been the relentless struggle for gender equality. . . When this struggle finally succeeds – as it must – it will mark a great milestone in human progress. And along the way it will change most of today's premises for social, economic and political life. Let us hope that the success of that struggle will be one of the defining moments of the 21st century, because gender equality will enable both women and men to live lives of greater freedom and integrity.

To achieve this vision, numerous actors (men and women, communities, civil society organizations, development agencies and governments) should carry out transformative work at multiple points of entry in the development process. Some of this work is ongoing, but can be optimized with greater connections to actors at different levels, and a clearer understanding of the discourses of masculinity.

What follows are some suggested areas to help practitioners think about these issues more broadly and to identify spaces for intervention.

- Gender mainstreaming and institutional cultures. To start, gender mainstreaming means taking gender out of its enclave of "women's work" and embedding it in a sustainable human development and human rights agenda supported by both men and women. Many organizations have some gender-specific policies in place, ranging from resource allocation and policies against sexual harassment, to hiring practices and maternal and paternal leave. However less apparent structures that perpetuate discrimination such as the 'blocks' of institutional cultures can be targeted for change. Initiatives such gender mainstreaming capacity building programmes and men's discussions groups can create spaces for consciousness raising and self-reflection that ultimately lead to stronger, more effective and equitable organizations.

- Policymaking. Beyond institutional policies, discussions around gender equality and discourses of masculinity can be brought to the table in local, regional and national

policy debates. Such perspectives can deepen the understanding of the social content and outcomes of policies and highlight the need to coordinate the different levels of policy. For example, surveys measuring the social and economic costs of domestic violence can influence the design of more integrated policy frameworks at the local level (among communities, schools, law enforcement agencies and health care providers) as well as national level social, economic and labour policies.

- Focusing on socialization and youth. The family, educational systems and religious institutions play key roles in gender socialization, and can also act as agents of transformation. In the family, increased involvement by fathers can have powerful effects on both boys' and girls' socialization. In schools, attention to empowering girls and efforts to pay attention to the ways in which male socialization steers boys away from intellectual pursuits are vital steps. In religious institutions, spiritual leaders can act as role models who value compassion and community building over more constraining gender roles.

- Addressing issues of class and other modifiers of inequality. Understanding different forms of inequality may help build bridges between men and women who recognize and are affected by similar patterns of disempowerment. Although gender can be a fundamental vehicle for determining power relations, gender works in conjunction with other power structures, such as those based upon differences in ethnicity, class and race. When we ask "What's in it for men?" it becomes clear that gender equality is part of a broader social justice agenda that will benefit most men materially and all men psychologically/spiritually. Reflections on class and race, for example, also can be helpful in the context of the advancement of women by raising question such as "which women are we talking about"?

- Sexuality. It is difficult to think about gender inequality without also talking about sexuality, and the sex-gender system that mandates gender relations be grounded in a specified sexual relation (i.e., heterosexual relations). Being able to recognize diverse expressions of sexuality disrupts traditional views of the sex-gender system, and may

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References

Barber, B., 1994, **Macdonald's and Jihad**, New York: Simon and Schuster

Barker, G., 1996 'The Misunderstood Gender: Male Involvement in the Family and Reproductive and Sexual health in Latin America and the Caribbean', **Report to the John D. and Catherine T. MacArthur Foundation Population Program**, New York: MacArthur Foundation

Beneria, L. and Bisnath, S., 1996, 'Gender and Poverty: An Analysis for Action', **Gender in Development Monograph Series Number 2**, New York, UNDP

Brown, J.P. and Chevannes, B., 1993, **Report on the Contribution of Men to the family: A Jamaican Pilot Study**, Caribbean Child Development Centre, Kingston: University of the West Indies

Blagojevic, M., 1999, **Personal communication**

Cagatay, N., 1998 'Gender and Poverty', **Social Development and Poverty Elimination Division Working Paper 5**, New York: UNDP

Connell, R.W., 1998, 'Masculinities and Globalization', in **Men and Masculinities**, Volume 1, Number 1

Connell, R.W., 1995, **Masculinities**, Cambridge: Polity

Connell, R. W., 1987, **Gender and Power**, Stanford: Stanford University Press

Courtenay, W. H., 1998 'College Men's Health: An Overview and a Call to Action' in **Journal of American College Health**, Volume 46, Number 6

Desai, S., 1994, 'Women's Burdens: Easing the Structural Constraints' in A. Sen, A. Germain and L. Chen (Editors), **Population Policies Reconsidered: Health, Empowerment and Rights**, Boston: Harvard School of Public Health

Elson, D., 1991, (Editor) **Male Bias in the Development Process**, Manchester: Manchester University Press

Elson, D. and Cagatay, N., 2000, **The Social Content of Macroeconomic Policies**, forthcoming in **July 2000 Special Issue of World Development "Growth, Trade, Finance and Gender Inequality"**

Enloe, C., 1990, **Bananas, Beaches and Bases: Making Feminist Sense of International Politics**, Berkeley: University of California Press

Foreman, M., 1999, (Editor) **AIDS and Men: Taking Risks or Taking Responsibility**, London: Zed Books

Gokova J.K. 1998 'Challenging men to reject gender stereotypes' in **AIDS/STD Health Promotion Exchange**, Number 2

Heise, L.L., 1997, 'Violence, Sexuality and Women's Lives' in R.N. Lancaster and M. di Leonardo (Editors), **The Gender Sexuality Reader: Culture, History, Political Economy**, New York and London: Routledge: 411-34

Jain, D., 1996, 'Panchayat Raj: Women Changing Governance', **Gender in Development Monograph Series Number 5**, New York: UNDP

Jurgensmeyer, M., 1995, **The New Cold War? Religious Nationalism Confronts the Secular State**, Berkeley: University of California Press

McClintock, A., 1997, '"No Longer in a Future Heaven": Gender, Race and Nationalism' in A. McClintock, A. Mufti and E. Shohat (Editors) **Dangerous Liaisons: Gender, Nation and Postcolonial Perspectives**, Minneapolis: University of Minnesota Press

Meursing, K. and Sibindi, S., 1995, 'Condoms, Family Planning and Living with HIV in Zimbabwe' in **Reproductive Health Matters**, Volume 5

Montoya, O., 1999, **Personal communication**

Parker, R.G. 1998, **Beneath the Equator: Cultures of Desire, Male Homosexuality, and Emerging Gay Communities in Brazil**, New York: Routledge

Rivers, K. and Aggleton, P., 1999, **Men and the HIV Epidemic**, New York: UNDP HIV and Development Programme

Sedgwick, E.K., 1995, 'Gosh, Boy George, You Must Be Awfully Secure in Your Masculinity' in M. Berger, B. Wallis and S. Watson (Editors) **Constructing Masculinity**, New York and London: Routledge

Sen, A., 1999, **Development as Freedom**, New York: Knopf

Shire, C., 1994, 'Men Don't Go to the Moon: Language, Space and Masculinities in Zimbabwe' in A. Cornwall and N. Lindisfarne (Editors), **Dislocating Masculinity: Comparative Ethnographies**, New York: Routledge

Sinha, M., 1995, **Colonial Masculinity: The Manly Englishman and the Effeminate Bengali in the Late Nineteenth Century**, Manchester: Manchester University Press

UNAIDS. 2000, **Men and AIDS – a Gendered Approach: 2000 World AIDS Campaign**, Geneva: UNAIDS

UNDP. 1998, **Building Capacity for Gender Mainstreaming: UNDP's Experience**, New York: UNDP

UNDP. 1997, **The Human Development Report**, New York: Oxford University Press

UNDP. 1995, **The Human Development Report**, New York: Oxford University Press

UNICEF. 1997, **Role of Men in the Lives of Children: A Study of How Improving Knowledge About Men in Families Helps Strengthen Programming for Children and Women**, New York: UNICEF

United Nations. 1999, **World Survey on the Role of Women in Development**, New York: United Nations

United Nations. 1995, **Declaration and Programme of Action of the World Summit for Social Development**, New York: United Nations

United Nations. 1995a, **The Beijing Declaration and Platform for Action,** New York: United Nations

United Nations. 1994, **Report of the International Conference on Population and Development, Cairo, 5-13 September 1994**, New York: United Nations

White, S.C., 1997, 'Men, masculinities and the politics of development' in C. Sweetman (Editor), **Men and Masculinity**, UK and Ireland: Oxfam: 14-23

Ray, R. (2000). ***Masculinity, Femininity and Servitude: Domestic Workers in Calcutta in the Late Twentieth Century***. Feminist Studies, Fall 2000.

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MASCULINITY, FEMININITY AND SERVITUDE: DOMESTIC WORKERS IN CALCUTTA IN THE LATE TWENTIETH CENTURY.

Author/s: Raka Ray

In a memorable scene in Aparajito, the second film of Satyajit Ray's Apu Trilogy, the destitute Brahmin widow Sarbajaya watches her son learn to serve. She has recently obtained work as a cook in the household of a rich Brahmin, where her employers are considerate and inconsiderate in the manner of feudal lords. In this scene, she observes from the top of the stairs as the master of the house sends for her son Apu to light his pipe and tells him to pluck gray hairs from his head, rewarding him with a tip. In the next scene we see Sarbajaya and her son on a train, having left the job behind.

Sarbajaya's reaction is entirely different from that recorded by V. Tellis-Nayak in his study of Indian domestic servants, who reports primarily resignation and a surprising lack of stigma attached to the job. [1] Sarbajaya's face as she looks upon the scene makes it dear that nothing could be worse than watching one's son become a servant. I say "son" here deliberately because it is not clear that Sarbajaya's reaction would be quite as strong in the case of a daughter. Indeed, in the first film of the trilogy. Pather Panchali, the daughter Durga (who dies at the end of the film) is shown at the service of her little brother, looking after him, feeding him, and ultimately being responsible for his well-being. Durga was born to serve, in one way or another, but not Apu, the Brahmin son. The scene described above is as much a powerful comment on mother love and gender expectations as it is about the extreme and peculiarly gendered stigma attached to the identity "domestic servant" in India.

How do we understand the humanity of a group of people who get paid to do tasks that no one wants to do? This is a question that lies at the heart of scholarship on domestic servants. Some argue that the humanity of servants develops in a distorted way because of both the nature and the conditions of this work. Servants are reduced to a state of "perpetual infantilism," which leads to extreme hopelessness, and to a corresponding lack of resistance. [2] Others have written movingly about the everyday ways in which domestic workers resist degradation. Both sets of authors, however, see domestic workers primarily through the lens of the power and authority that inhere in relations between the employer and employee. [3]

In recent studies of the working class in India, several scholars have argued that ideologies and practices of gender, caste, and religion both shape the contours of the workplace and the trajectory of class identities. [4] As Gillian Hart and Karin Kapadia have argued elsewhere, an analysis of the meanings and relations of gender is necessary to better understand class consciousness. [5] In this article, I explore not the social identities underlying worker identities but how work and the way work is constructed feed into gender identities. In other words, I argue that relations between worker and employer are refracted through the lens of gender and are used by the workers to build and reflect upon their gendered selves. My argument stems from the realization that the fulfillment of gendered expectations framed every conversation I had with domestic servants in Calcutta. This article then, is about how domestic servants in India negotiate their identities as women and men and about how they evaluate their embodiment of those identities. It explores the way female and male servants imagine and articulate their lives as gendered beings, given that they perform, on a daily basis, the most undesirable tasks of society.

I turn first to the structure of paid domestic work in India and then discuss notions of class, masculinity, and femininity in the city of Calcutta (where the research was conducted), situating these ideas within the distinctive caste and gendered class culture of Calcutta's middle, or bhadralok, classes. Thus I explore the gendered ideology of those who employ servants in Calcutta. For this distinctive class, the bhadralok, hegemonic masculinity is defined by the absence of menial labor and the presence of education and cultural capital. There is in addition an idealized notion of independence, though few bhadralok achieve it. [6] Idealized femininity, on the other hand, involves being protected and staying at home. it is virtually impossible for those who do paid domestic work to achieve respected masculinity or femininity when their very definitions seemed designed to exclude them.

The final sections of the article explore how, under these conditions, domestic servants try to define their masculinity and femininity against their employers and how they accept, reject, embrace, and modify the way others see them as women and as men. I argue that female and male domestic workers seek, on the one hand, to appropriate bhadralok ideals and to deny their employers the monopoly of being bhadralok. On the other hand, they redefine what it means to be a good man or a good woman, bringing these definitions closer to the lives they lead. The study of both sides of the domestic work relationship allows me to explore the dialectic of employer and employee gender ideologies, to examine how employers build ideas of bhadralok femininity and masculinity precisely by excluding servants, as well as to show how servants fight that exclusion with varying degrees of success.

The data for this paper are drawn from a larger study of sixty interviews (thirty employers and thirty workers) conducted in 1998 and 1999. Fifteen of the workers lived in the homes of their employers. Because live-in work heightens the question of workers' femininity or masculinity, I focus my inquiry on them. [7]

PAID DOMESTIC WORK IN INDIA

Because paid domestic workers in the West, Latin America, and East Asia are primarily female, domestic service has appeared to be synonymous with women's work in most research. [8] Yet precisely because the "domestic" is seen as a distinctively female realm, the presence of men questions the taken-for-grantedness of the gendered separation of spheres. [9] Domestic servants in India have historically been both female and male, but women and children have begun to dominate the ranks of this occupation in India, which reflects both the secular trend toward more female labor force employment and the worsening of economic inequality. [10] The 1971 census showed that there were 675,878 domestic servants in India, of whom only 251,479 were women. A decade later, the picture was quite different, with the 1981 Census of India reporting that there were at least 807,410 people who worked as domestic workers in India, evenly divided between 402,387 men and 405,023 women. [11]

This article focuses on Calcutta rather than on India as a whole. A focus on one region enables a more grounded reading of the practices of domestic servitude. Calcutta is an ideal site for the investigation of femininity and masculinity in domestic servants for several reasons. First, the region of West Bengal, in which Calcutta is situated, has a rich and elaborate feudal tradition. Second, the 1981 Census shows that the sheer numbers of domestic servants, at 149,100, are far greater in West Bengal than in other more populous states. Finally, the transition from primarily male to primarily female domestic workers has happened relatively recently in Calcutta, rendering the issue more salient in Calcutta than in other cities where male servants are increasingly invisible. [12]

According to economists, the increasing numbers of female servants in Calcutta are due to their expulsion from agriculture and organized sectors of industry (such as jute) and the partition of Bengal, which made refugees out of women who had not previously had to work outside the home. As employment alternatives closed for women, they expanded for men, so that the numbers of women domestic workers slowly increased, while the numbers of men decreased. [13] At the same time, the trend toward smaller apartments and families caused employers to think of women as safer servants around their daughters than men. [14] As in other dual-sex occupations, men have the higher status within the ranks of servants and command higher wages. These changes mean that female domestic servants are becoming the norm, with the more expensive male workers being out of reach for most middle-class families today. Yet

employers still think male servants are better, even though they no longer can afford nor perhaps would hire a male ser vant today. At the same time, as it becomes clear that many men have other options than domestic servitude, those who remain in this profession must explain it to themselves and to others.

BHADRALOK SOCIETY

The femininity and masculinity of servants is judged both by employers and the servants themselves against a complex backdrop of class deprivation, normative ideas of what it means to be female and male, and the actual practice of doing domestic work. Femininity and masculinity are not simply cultural ideal-types, but they are also created through practice; and it is through practice that they are weighed, judged, and transformed. Although there are many ways of being masculine, there is at every moment a masculinity of the powerful, which Robert W. Connell terms "hegemonic masculinity." Hegemonic masculinity is historically, culturally, and materially specific, as are the masculinities of those excluded from the masterful configuration. [15] Although Connell focuses on men of the metropole, how do we best understand hegemonic masculinity in Calcutta, especially the masculinity of men who have few cultural or economic resources? I examine first the particular construction of hegemonic masculinity and hegemoni c gender ideology in Calcutta, before turning to the way employers and employees understand subaltern masculinities and femininities.

Bengali society today is dominated by the values of the bhadralok (which literally means respectable man or gentleman), most of whom belong to the three upper castes. As civil servants, teachers, doctors, lawyers, and descendants of absentee landlords, the bhadralok, who came into being in the late nineteenth century, were the first products of English education and the first to intellectually challenge British authority over Indians. [16] Bhadralok stand in opposition to both those who own the means of production (landlords and industrialists) and workers. They place a high value on men of letters, high culture, and the intellect. Bhadralok are opposed to either chhotolok or gariblok, who are poor or not "civilized." They do not do manual labor, although they are associated with skilled and clerical work. [17] Their values have exercised considerable influence on gender and class relations in contemporary Bengal, and they have done so, as Sumanta Banerjee has shown in his study of elite and popular culture in nineteenth- century Calcutta, at the expense of lower-caste popular values. [18]

The bhadralok are also defined by a distinctive masculinity. [19] These men were not warriors and yet were instrumental in the creation of a nationalist project about the place of women and men in the world. [20] Their gender ideology was primarily one of respectability. For the bhadralok--the gentle-man-this means not doing menial labor, being educated, having independence of means, and maintaining a genteel and cultured life. Hegemonic masculinity in Bengal has little to do with strength and virility.

For the bhadramahila--the gentle-woman--respectability is also defined by the absence of menial labor. In addition, a bhadramahila is protected, culturally refined, and responsible for the inner life of the family. [21] The bhadramahila's respectability comes not from independence but the luxury of its opposite. Bhadramahila have lajja--shame and modesty--attributes closely connected with virtue and respectability. As Himani Banerjee articulates it, "to be civilized is to have a sense of shame." [22] It is the uncivilized woman (the poor woman or the low-caste woman) who does not have shame, is not protected, is sexually powerful and immoral, and is therefore a threat to the moral fabric of society.

Today's bhadramahila have to work outside the home (although women's labor force participation in Calcutta is exceedingly low, at 7.04 percent), but they are supposed to work in genteel professions such as teaching? [23] Even when women do work, the assumption that the home is her real world is inviolable, as is the ideology of female dependence upon male kin. [24]

The employers of domestic workers with whom I spoke were all clearly bhadralok, while the employees, by definition, were not. Indeed, from the 1880s onwards, the ability to hire servants became a mark of bhadralok status. [25] Given this society, how do we understand the relationship between hegemonic and subaltern femininities and masculinities?

EMPLOYERS ON THE MANHOOD AND WOMANHOOD OF DOMESTICS

If you look at the skill content required in cooking--it is much higher than in say, washing the dishes. Any old person can wash the dishes. The male psyche calls for a more skilled job. (Male employer, age thirty)

I prefer male servants. But it's difficult to get them nowadays because they can get jobs elsewhere. You see, men, if they work for eight hours in a factory, they are free after that. If they work for me, they are not free. They are, after all, always at my beck and call. (Female employer, age seventy)

In Calcutta, both women and men work as domestic servants, but they are not interchangeable. Men are the preferred workers but are increasingly hard to come by. In the imagination of employers, men are by nature less willing to do work that requires them to be at one's beck arid call and are now discovering they don't have to be. Although this is considered an occupation with few skills, men are thought to possess more of the skills that the occupation requires. They are also thought to need skilled work more than women do. Their nature dictates that they be independent or swadhin, and social structure provides them more opportunities to be so. [26] Women, by contrast, are thought to be more accustomed to having to obey. They have access to fewer alternative opportunities, and although they are less desired, they are increasingly found in service jobs where they are on call for their employers and cannot return home at the end of the day.

The middle- and upper-middle-class employers we interviewed in Calcutta consistently revealed a preference for male servants, even though they were not quite as clear about their reasons for this preference. [27] Yet not all male servants were the same, and employers frequently contrasted the male servants of today with the male servants of yesterday. One spoke of the old family retainer who was fiercely protective of them. "He brought us up. He was our ayah and our nanny. He would not steal a penny. We knew he had a wife somewhere and some children, but he only visited them once a year and never wanted to extend his visit. He was intensely loyal, and his life was with us. My brothers took the place of his children." Visible here is a crucial attribute of the male servants of the past--unswerving loyalty and a willingness to put their employers' families above their own. Today's employees think only of their own families. A certain subservient loyalty, then, is the mark of "good" subaltern masculinity.

Yet how do people reconcile male servant preference with a highly sex-segregated society like India's? Male servants walk in and out of bedrooms, handle women's clothes, and are present at intimate moments when other men could not be. We asked one elderly conservative woman, who preferred male servants, how she felt about men servants touching her clothes. Her response was immediate. "Doesn't bother me; I'm perfectly happy. A servant isn't really a man; a servant is a servant." We asked her whether it struck her as odd that her male servant did work that her husband would never do or think it possible for men to do. She answered that "the male servant is doing this for money. My husband doesn't think he has to do the work. He earns money and gives it to me--his wife. As far as he is concerned, either I will do the work or hire someone to do it. It's up to me."

Although the male servant appears to embody a less valued masculinity by virtue of performing such menial and heavy labor, he is not always emasculated. Nobody wants a male servant in the house when there is a young daughter at home. In days past, male servants could serve employers with young daughters because women in the extended or joint families acted as guardians and buffers. In today's nuclear families, however, the threat of the male servant is larger, precisely from the belief that he is not bhadralok. The fear of being alone in the house with a male servant, articulated by one widow, stems from her understanding of men of a lower class as having a brute strength, which employers otherwise want for heavy work. [28] Thus the male servant is sometimes more than a man and often less. Ultimately, the masculinity of male servants coexists uneasily with the bhadra femininity and masculinity of his employers.

With smaller families and apartment living has grown an increased acceptance of and even preference for women servants. Male servants may be status enhancing, but women are cheaper and more trustworthy. Employers have complex emotions about hiring women and girls. The

fear of women's sexuality is such that there is an increasing drive to recruit young prepubescent girls from the village and to send them back when they reach puberty. Uppermost in all employers' minds when they hire a young woman is the risk of her potential sexuality, because unprotected women are perceived as sexually dangerous and therefore not respectable.

Issues of respectability and protection loom large in the hiring of women servants. In many families, the husbands rarely speak to the female servants, and the female servants seldom speak directly to them. The idea that women should be respected and respectable does not fit well with the hiring of female domestics. One man, who refuses to hire women servants, recalls a moment of extreme embarrassment in his youth when he was riding the bus. Calcutta buses have several seats reserved for "ladies." When there aren't enough women in the bus, those seats are occupied by men, who vacate the seat when a woman comes aboard. On one such occasion, this young man was sitting in the "ladies" seat and vacated the seat when a woman come on board, without glancing up at her face. After she sat down, they both realized to their mutual embarrassment that he had given up his seat for the servant of the house. Confusingly, the notice on the bus, "reserved for ladies," both does and does not apply to her.

No matter their present, often tentative, class location, the bhadralok have been weaned on feudal tales and have nostalgic fantasies of servants of the past. [29] They consistently contrast today's male servants with male servants as they used to be-selfless and loyal, like fathers to them. Today's male servants are failures precisely because they have alternate aspirations and identities. They do women's work because they need the money, yet they are still men who do heavy work and are potential sexual predators. If male servants possessed bhadralok masculinity, they could not be good servants. It is precisely because they will serve and do menial work that the bhadralok can afford their masculinity.

Women servants are certainly women, but they are dangerous and endangered precisely because they are not protected, as a bhadramahila should be. Women servants complicate life for the bhadralok, for how is he to treat them? And yet, if female servants were not considered different, to whom would the bhadralok contrast his women? A female servant conscious of bhadramahila propriety would be of little use to her employers. Because she cannot afford propriety and protection, the bhadramahila can.

SUBALTERN CONSCIOUSNESS

The women and men who work as domestic servants are constantly faced with expectations based on hegemonic bhadralok readings of their femininity or masculinity. My interviews with them consistently reveal that their work is the experiential world around which they construct gender. How does hegemony work

in this context? Does it effectively reproduce social inequalities? Or does it fail to penetrate the daily culture of the dominated classes? [30] Karin Kapadia argues that "untouchable" women do not accept upper-caste interpretations of their identity, while Kalpana Ram shows how Mukkuvar fishermen are able to use their relationship to the sea to carve out alternative identities for themselves. [31] Paul Willis, on the other hand, claims that social inequality reproduces itself despite and through resistance. [32] I argue that female and male servants idealize and seek to attain some part of bhadralok gender ideology but not the whole of it. They modify it such that they can consider themselves to have achiev ed a desired femininity and masculinity, but they do not resist bhadralok gender ideology wholesale. Bhadralok constructions of domesticity and gender act as a powerful master discourse for these domestic servants.

Based on my interviews with servants, I isolate several core themes that servants articulate in evaluating their own gender identities. For male servants, the lack of swadhinata, or autonomy, underpins their sense of failure as men. Yet others counteract this sense of failure with their ability to sacrifice themselves in order to fulfill their responsibilities toward their families. For women, their inability to be protected marks their failure to be bhadramahila. Yet some assert their humanity and right to be loved and acknowledged in the face of this lack of protection. Although employers judge the masculinity of male servants in terms of their lack of swadhinata (which causes their servility) and their female servants because they are not protected, the servants instead foreground the concepts of male responsibility and female relationality as alternative ideologies which legitimate their masculinity or femininity.

In what follows, I present thematic stories from my respondents, highlighting one life story for each theme in order to enable readers to understand each worker's choices and constraints in full context. This use of life histories provides depth and context to the interaction of individual agency and social structure which other methodologies do not illuminate as well. [33]

SUBALTERN FEMININITIES

As studies of working-class women in Bengal have shown, a woman who does not work in a genteel occupation is potentially either a victim or a loose woman. [34] Given these choices, women domestic servants long for protection, actively seek it, or explain their misfortunes as due to its lack. Yet, protection is not the only thing they seek, the only standard by which they live. Despite, or perhaps because of, a life in which they have been less loved and nurtured than their brothers, and married off young, some women assert the right to live a more loved life, to be recognized and appreciated, even at the cost of protection. [35] This desire for satisfying relationships, often construed as sexual licentiousness on the part of their bhadralok employers, may lead them to step outside the protection they otherwise hold so dear.

In search of protection. Although many young women in India migrate to the city in search of autonomy from their families, the search for protection seemed stronger than the search for autonomy in the women I interviewed. [36] These women struggled to survive in a world that they saw as particularly hostile to unprotected women. Respectability was a powerful source of protection, and yet respectability was itself premised on already having protection. Thus, some women's pursuit of protection was relentless.

Mitali was born in Naihati and came to Calcutta to seek work after her father died of snakebite when she was eight years old. Her mother died when she was an infant. As an eight-year-old girl, she survived by living on the railroad tracks gathering and selling the coal that fell off the trains that thundered by. An extremely attractive woman today, she realized early that because her parents were not there to protect her, she had to find a husband who would. Thus as a child, she says, she had two desires. The first was to see many films, and the second was to make sure she found a husband. The narrative of her life follows a search for protection.

She accepted her first job as a domestic servant simply because it offered her a roof, even though they paid her pennies a day As Mitali learned some skills, she left that household, for a series of jobs. As she went from house to house, husbands and young boys frequently tried to molest her--"they kept getting under my mosquito net," she says euphemistically. Finally, she convinced a woman employer to let her sleep on her kitchen floor, while continuing to work for other families. She recalls with appreciation her employer's anxiety when she returned late from a film one night. The relief that somebody was looking out for her more than compensated for her employer's wrath.

One particular story poignantly reveals what it means to be an unprotected poor woman in urban India. Mitali worked part-time in several houses, sweeping and mopping in one house, cooking in another. Her daily journey from one employer to the next took her past a street corner where a goonda (thug) hung out. This man, she says, wanted her for himself and threatened to kidnap her if she did not go to him willingly. She worried about it incessantly. What should she do? "I thought I should maybe give up working in that house so I didn't have to pass him, but I needed the money, so I couldn't stop." Then however, she began wearing sindur on her head (the vermilion mark that is the most overt Hindu sign that a woman is married), in order to protect herself, and the plan worked. The man stopped harassing her immediately, because she was now under some other man's protection. The very success of this plan, however, worried her. "I thought, if people see me with sindur, they will think I am already married and then how will I really get married? I had no parents to marry me off, so I was already worried about that, and I was really anxious now." It was this anxiety that prompted her finally to give up the job in the house to which she could not travel without encountering the thug.

Subsequently, Mitall worked for an older woman who became very fond of her. She called this old lady "Ma" or "mother" and confesses that she frequently lied to her and went to the movies, much as a daughter would. "I earned 200 rupees, and I thought 'good! 100 for the movies and 100 to be saved for my marriage.'" But when she finally fell in love with a local night watchman, she turned to Ma for help. "I told Ma I have liked this boy, but how do I know he won't take advantage of me and then abandon me?" The employer sent for the man and ensured that he agreed to marry her. She then accompanied them to the court to make sure the marriage was legalized. Mitali had effectively called upon precapitalist modes of loyalty and employer responsibility in order to enforce a contract that would guarantee her protection. Now that she has a son, she still works for Ma. She wishes she didn't have to keep working and her husband weren't so poor, but she considers that she has achieved what she had to, given her circumstan ces. "No one after all wants to make a living working in people's houses. But that is fate. I was so worried that no one would marry me because my parents were dead, but that worked out."

What strikes one about Mitali's story is the single-mindedness with which she sought protection. If protection is ideally associated with passivity, a being-done-to rather than a doing, it takes on a whole new meaning here. The protection that Mitali sought was symbolic and institutional. She understood that being unprotected implied sexual availability and that this had little to do with her desires. She also understood that the only way for a woman to be considered respectable was to appear to be protected and that although a woman's body is never really safe, it must, at least be symbolically guarded.

Marriage is a formal system of protection, and parents are often eager to marry their daughters off when they feel incapable of protecting them further. When a young girl has no parents, her relatives are especially anxious to get her married. Thus Sonali (forty-five), whose parents died when she was one year old, was married when she was eleven, becoming her husband's third wife. She left her husband's home as soon as she could and has been working for the same employer for the past twenty years. There are no alternative protections available for Sonali. Thus she stays with her employers despite their exploitation of her, their refusal to give her new clothes, and the sharp tongue of her mistress.

The failure of patriarchal protection is not limited to parents. Many women work as live-ins despite being married because they wish to escape the violence of their husbands. Rama, who is fifty-six, works to support her five grandchildren, left in her care by her daughter's death. Although her daughter was clearly burned to death by her husband, Rama spoke of it as suicide. When I challenged her, she told me that she couldn't afford to point a finger at her son-in-law, for who would look after the children if he were in prison? If there was ever a reminder that the ideal of husbandly protection is often not a reality, this surely is it.

Husbands and families can't always protect them, so women workers have learned to protect themselves. They try to remain indoors as much as possible, and they strictly police their own behavior and the behavior of their daughters. Women domestic workers live in a cultural world where the respected and respectable, protected and protectable bhadramahila is the ideal. Yet, their world is filled with rea' .nd mythic predators--from their employers to their own husbands. Often orphaned young, unable to find a husband or married off to strangers, the workers I spoke with desperately hold on to respectability under circumstances and occupations that are calculated to rob them of it. Protection for these women is not only a cultural ideal but a very real need as well. In search of recognition. Lakshmi (age forty) was born in Calcutta and is relatively new to domestic work, having done it for only the past seven years. She is married and thus technically has protection, but in her eyes, her marriage violates what sh e considers to be an essential principle of humanity--the right to be loved. Although Lakshmi knew that I was interested in her life as a domestic worker, she did not wait for me to ask the first question. As soon as we sat down she initiated the conversation by talking to me about her marriage. "I married by choice" were her first words. "I married by choice despite resistance from my family. My uncles and aunts asked me repeatedly, 'Lakshmi, are you sure, are you absolutely sure,' but I said I was." Her parents had died when she was young, and she was raised by affectionate and well-meaning relatives. However, her life was not easy after marriage. Her husband sold goods out of a roadside stall, and they could not make ends meet. Once she became pregnant, she started to cook for a family but could not sustain it because of her pregnancy. She tried her hand at several other jobs--piece-rate sewing, making and selling dung patties, and so on. That was still not enough to sustain her sansar (family, or world). As babies were born, she continued to try various ways to make ends meet. She initiated a move which

helped her husband's store, by buying cooking oil at wholesale prices and selling it retail. She recalls with pride how she was so scared to get on a bus that she would clutch her husband's shirt as they got on and off the bus. Now, however, she has figured out which the best places are and can manage to bring back 100 liters of oil on her own.

But even as she talks with pride about her new confidence and abilities, she returns continually to her relationship with her husband and to her realization that he never loved her as she thought he did. She repeats the questions her relatives asked her twenty years ago--"Are you sure, Lakshmi? Are you absolutely sure?"--to emphasize to me just how wrong she had been. For the love he had, she has now concluded, was for the dowry he thought she would bring. She suspects that he felt cheated when she came to him empty-handed. What else can explain her inability to win his love or his refusal to give her the adhikar (right) to make demands on him. He always wants her subordinated (parajito, or defeated) to him. "So for these few years now, I have been doing this ayah work," she says. it is as if this work she does is a result of his not loving her.

Lakshmi returns repeatedly to the subject of her husband's failure to love and appreciate her, his jealousy and possessiveness, and his will to dominate. The issue that brings tears to her eyes is that he has never given her a sari, not even for the religious festivals.

A lady gave me a watch the other day. She said her husband had given it to her and that he had given her another watch before that. Do you know, he also buys all her saris for her! When she told me that, I went home and cried that night and thought: "How fortunate she is, to have the love of her husband, a husband who loves enough to buy her these things." Had my husband bought me so much as a blouse-piece, I would be the happiest woman.

"What do you want from your future?" I ask. She is silent for a moment, and then says, "Just some love. There is much I did not understand when I was younger. One can't live without love. Just like a plant or a tree, one withers and dies. There is a man who loves me now and does a lot for me, but he is not my husband." She looks away and then turns to me again. "But tell me this, am I wrong to accept love from someone else when my husband has refused it to me for so long? If a thief steals, are you going to beat him up or find out what the circumstances were that led him to commit this act?"

What she means by "love" is many things. Love represents, on the one hand, a fulfillment of all that is missing; and on the other, it represents responsibility, recognition, and appreciation. It is her husband's failure to give her recognition that leaves her feeling unfulfilled. It is the absence of his "confirming response" as Jessica Benjamin would say, and the absence of his acknowledgment that she is important to him or affects him, that Lakshmi finds unbearable. [37] Because he has never shown her that she matters to him, he has lost the right to keep her. The minute her duties toward her daughters are fulfilled (i.e., they are married), she says, she will leave her husband. She will move into the home of her employer's daughter and work as a live-in. If her husband gives her no love, at least her employer and her family do. She does not expect the same sort of love from her husband as from an employer. However, her employers love her as employers can, while her husband does not love her as husbands co uld or should. [38] Lakshmi will, in other words, give up a culturally accepted form of protection, under these conditions.

Economic logic would not predict a move from live-out to live-in work. Most servants want nothing more than to be able to move out of their employers' homes and out from their power twenty-four hours a day; however, Lakshmi's search for a satisfying relationship propels her in a different direction. Her employer appreciates her and her abilities, but her husband does not.

When she asked me whether I thought she was wrong to accept love from a man who was not her husband, she was asking me to understand the conditions under which she had come to this decision. She had come to a moral position based on her husband's failure to give her the affection and recognition which should have been her right. It was important to Lakshmi that I think of her decision in that light and not think of her as a woman committing adultery. She seeks to give her decision respectability by assuring me that the man who loves her has "no dirty-ness in him"--he does not simply want sex from her, and he has given her two blouses for her saris. She recognizes and has every intention of fulfilling her responsibility toward her children, but she no longer recognizes her obligation toward her husband. She is willing to defy

his patriarchal authority, but she will do so by opting for a benevolent paternalistic or maternalistic relationship with her employer. Here domestic service provides Lakshmi with the op portunity to trade protections--a failed one for one that just might work. It could be argued that Lakshmi's actions were in fact an assertion of an alternative, non-bhadramahila morality, but I suggest that her deliberate desexualization of her relationship with her lover indicates that she is in fact steeped in that morality.

Lakshmi is not alone in emphasizing her employer's affection for her. The search for a decent, caring relationship is often uppermost in women servants' minds, and when they don't find it with their husbands, some turn to their employers, often pulling their female employers into their lives. Pushpa recalled her first employers with great fondness: "I was fortunate when I worked for them. I was so young and irresponsible, but they were a good and loving family." Many of these women have been denied parental love and often the love of a husband. They long therefore not just for a romantic love but also for the parentlike figure that they never had.

And yet, the failure to win one's husband's love is a bitter pill to swallow. "What does it matter what work I do when my own husband does not love me," says one woman. And another says: "I don't like this work. What will it take for me to be free from this life? If my husband were better, then life would be tolerable. I don't get love from anybody-not parents and not my husband. And now my children resent me because I am not there for them." In many of these women's stories, the hostile encounters they describe with their employers have much less emotion in them than the encounters with those who are supposed to love them. In their already deprived lives, they are unwilling to give up the right to be loved.

Manisha Ray has documented the way that upper-middle-class Bengali women are almost schooled in romantic fantasy and expectation, taught to daydream about the men they will one day marry (often a stranger they barely know). [39] These fantasies are not restricted to women of the upper classes. Indeed, through novels, folktales, folk songs, television, and flints, Indian women of all classes are steeped in a culture of longing. [40] These desires do not belong simply to the realm of unattainable fantasy for poor women. Lakshmi, for one, has transformed the desire to be loved into a source of strength. She has made it her right, transformed it into a requirement for humanity, and can therefore use the violation of this right as a justification for her subsequent actions. She uses her employment as a lever to enable her to leave her marriage, just as Mitali used her employment to enter it. If Mitali pursued protection because she had never had it, Lakshini can walk away from it because the protection of marriag e costs too much for her.

SUBALTERN MASCULINITIES

If the essence of domestic service is subservience, if it is less about the completion of tasks than about being at the beck and call of the employer, then it is also a job that runs counter to hegemonic ideas of masculinity, both bhadralok and other. [41] There is a clear awareness on the part of male domestics that this is a bad job. Given the recent transition to a majority female occupation, there is also regret among some m the older generation of male servants that the job is being progressively de-skilled and is therefore even less desirable for men than it previously was. [42] Further, those men who work as domestics today have failed to find a better job when popular opinion maintains that men can easily find less demeaning jobs. Given the increasing association of women with this already low-prestige occupation, how do male domestics manage their gender identity? How do they negotiate their daily presence in a space that is demarcated for women?

When the ideal is bhadralok society, male domestic workers--men who work as cooks, factotums, and sweepers-have failed to be men on several counts. Bhadralok are men of culture and education, and they do white-collar jobs. If they are successful, they are professionals and if unsuccessful, clerks, but bhadralok never work with their hands. Because of the caste system, many forms of menial labor are steadfastly associated with servitude. In addition, bhadralok have jobs which allow them to be patriarchs of their homes at the end of the work day. For live-in male domestics, this is not a possibility. So it is that in the domestic workers' eyes, what prevents them from being men of the bhadralok classes is both that they do menial work and that they do dependent (paradhin), not independent (swadhin), work. Finally, bhadralok earn enough to support an establishment, so their wives can remain protected and not have to work.

These are standards few working-class men can live up to. Factory work, which meets two out of the three criteria, is the prized working-class job, but it is not easy to find. There are many informal-sector jobs that allow men to be more swadhin, but they do not provide security. There is no other job that fails to meet the first two criteria as profoundly as domestic service, and thus the men engaged in this work are often bitter and frustrated with themselves.

Most men who work as domestic servants cannot afford to have wives who do not work. However, some men redefine masculinity such that even if a man is not the sole support of his family, he is a good man if he is financially responsible. It is a masculinity of duty, both filial and paternal, a masculinity that resists the image of the failed and ineffective man. By being financially responsible for the family, by being, in other words, a "good family man," these men defy the images that the bhadralok have of the chhotolok class. Unlike the good subaltern of the past, these men do not put their employers' families first; they swear undying loyalty not to the families of their employers, but to their own.

Swadhin versus Paradhin work.

We are not free, and therefore we are not men.

Arun

Arun is the oldest domestic servant in his apartment building. Although he has worked with the same family for over twenty years as their cook, they pay him little, and he has little affection for his employers. When, fresh from interviewing women domestic workers, I ask him if his employers are fond of him, he shrugs. "Sure, but not enough to give me more money or new clothes, or even money for medicines when I am sick!"

Arun was the youngest son of eight children, born in the district of Medinipur to poor farmers who had a little land themselves but had to farm other people's land to make ends meet. Because he was the youngest, he was at least able to study until the fourth grade. Just as Lakshini was more interested in talking to me about her marriage than her work, Arun wanted to tell me about his childhood and adolescence, when his life was really worth living. Arun told me about life in the village (which he left when he was fourteen) and about the time he was a soldier in the underground struggle for Indian independence. His tired eyes and lined face brightened as he described his participation in the resistance against the British, the cooperation of the neighboring villagers together, and the conch-shell alarm blowing when British soldiers came looking for them. After several years of guerilla warfare, his father, increasingly afraid for his son's safety, helped him escape to Calcutta where he joined his older brothe r. Arun's summary of the next fifty years of his life is an account of his failure to keep a succession of jobs through lack of skill, illness, or sheer bad luck. Finally, he began work as a cook. Today, twenty-six years later, he still works for the same family.

I suppose I am OK here. I say sometimes that I will leave. They [the employers] say, where will you go, you have no other skills? Do what you can here. Arid they are right. As I grow older, they will forgive me if I do less than acceptable work. But who else will forgive me? Sometimes, if I forget to put salt in the food, they still eat it. Others wont let me get away with it.

He believes, as his employers have repeatedly told him, that he does not have the ability to find a less demeaning job. His lack of skill keeps him dependent, and his dependence on this particular family has grown in the years he has been with them. He knows that his mind and body have slowed down. Thus, today, he dare not leave. Arun's narration of his participation in the struggle for Indian independence contrasts particularly with his assessment of the lack of freedom in his later life. He realizes that his sons are not going to support him when he can no longer work.

My sons are useless. They will give me nothing. So I have decided what will happen to me when I am old. I will kill myself. I have lived my life with my head bowed, but I will not bow my head at the end of my life. I have lived paradhin, but I will take some sleeping pills and that will be the end of it.

Arun can hope only to die like a man--freely and independently.

Hegemonic masculinity is unkind to those who fail to pass muster. Almost without exception the men with whom I spoke blamed themselves for not attaining the status of an independent man. The word paradhin is usually applied to subjected peoples (as India was paradhin under the British). There was no male domestic servant who did not use this word, which confirms the degree of subservience and lack of control this work implies. There seems, at least on this ground, to be agreement between employer and male servant about the nature of this work and its effect on men. This is not a job for adult and independent men, because they have to ask permission to go out for an hour and are often closely monitored and ultimately because they are dependent on the employer's charity and whims. One man told me how he had served his former employer well and was stunned when he was left with nothing when his employer moved to another city, his expectations of feudal relations of servitude betrayed.

Raghu, a young servant in his thirties who originally came to Calcutta as an adventure, has been working as a domestic for several years now. Although he didn't think doing domestic work was a problem when he was single, he believes this work should not be done after one is married. Yet this presents a no-win situation. On the one hand, a man doesn't want to look paradhin to his wife. On the other hand, he needs security more once he has a family. His job is paradhin, but it seems secure; he struggles to maintain his self-respect while doing it. For example, he refuses to accept old clothes from his employer and so maintains some semblance of being swadhin.

Because the key to the swadhin bhadralok world is education, the men voice regret at not achieving enough education to have a clerical job. Achin, whose father frequently abandoned his family for months at a time, speaks bitterly about begging his father to allow him and his brother to go to school, and about his refusal to do so. Shibu, who has two daughters, constantly worries about their future, and considers himself weak because his wife has to work.

There is shame involved in not being independent as well as not being able to support one's family. Some male servants regret that their wives have to work, and some lie to their in-laws about their employment. Achin's in-laws, for example, do not know that their daughter works outside the home and they think he is a chauffeur--a job that has more dignity and more independence. Chauffeurs (or drivers, as they are called in India) occupy an intermediary space between paradhin and swadhin work. They are skilled, and they work outside the home. He knows that his daughter tells her friends that he is a chauffeur as well. He is embarrassed, but he understands his daughter's need to tell her friends her father does more bhadra (civilized) work than he does.

On responsibility and sacrifice. Not all male servants accept that they are less than men because they do paradhin work and because their wives work. Rather than accepting failure by the standards of upper-caste Bengali bhadralok masculinity, Kamal, and others like him, actively counter the disparagement of their work and life by redefining the notion of a good man.

About forty years of age, Kamal has been working for the same family for over twenty years. When his male employer died, the widow became increasingly dependent on him. Today, he says, he does everything from washing dishes to bank-related errands. His wife works part-time for the same family. He earns well compared with the other male domestics I spoke with, and his employer helps his daughter with her homework in her apartment. He appeared both confident and resigned and spoke calmly about the decisions he had made about his life. "What does it matter what work I do as long as I can carry out my responsibilities to my family? There is no good work or bad work, just well-paid work and badly paid work." Here he effectively bypasses the caste system and the bhadralok disparagement of menial labor. What matters is not the substance of the work but whether it enables one to put food on the table. Kamal thus sees himself as the worker of capitalism, the contractual worker.

When I asked him what troubled him most about his life, he quickly responded that he didn't feel troubled. Many think "there is no dignity in this work." I don't have that attitude at all. If I can do it well and earn enough to support my family, then I am willing to do anything.... I don't

agree that there is a difference between this work and others. Some feel revulsion (ghenna) that a man should do "domestic work" but not me. People think sweeping, mopping, and washing dishes are women's work. But why shouldn't all people do everything? I find that 99 out of 100 people feel ghenna, but I am not like this.

Well aware that the image of men doing women's work stirs feelings of revulsion in many people, he steadfastly refuses to participate in a culture of shame. Instead, he has made the idea of supporting his family central to his sense of self.

Kamal knows full well that his is not swadhin work and that he is dependent on his employer. However, he has schooled himself to react not as a man who is being made to serve but as a man who has a responsibility toward his family who depend on him, and who therefore controls traditionally male reflexes. Many male servants spoke wistfully about their desire to be drivers, and regretted their continued domestic work, but Kamal was firm about his choices. As a father, he feels that his daughter is safer in the apartment building where he works than she would be in the slum in which they would otherwise live. Without delusion and with some resignation, Kamal has thought carefully about his life circumstances. He is socially ambitious but knows that the most likely candidate to escape this life is not himself or his wife, but their daughter. He urges her to be serious about her studies and scrapes together money for her dance lessons. He compares himself with other fathers in the building and knows that he is a better father than most, despite his financial constraints. Employers in the apartment building talk about his daughter with some admiration, and he sees in their eyes an expectation that she will make it. That is Kamal's source of pride. He is a good man because he has succeeded in being a good father. Indeed, by a sleight of hand, he manages to conflate fatherhood with manhood.

For several male domestics, the feeling of pride comes from having done their duty. By doing paradhin work, they have ensured that nobody else in their family ever will again. Dipu says: "I have been working since I was twelve not as swadhin, but in other's houses. Naturally I have had to take the employers' wrath. I told my sons that as long as I am alive, they can study and then could get [white-collar jobs]. They want it and I want it for them. I do not want that my son should work in your house." His sons are in college, his brothers work in the local government offices, and his daughter is married. He was able to pay for funeral ceremonies after his father died, and he sends money home to his mother.

Thus the admirable man sacrifices his masculinity in order to ensure the survival of his charges. Although the warrior who sacrifices his life so his people may live is considered a man and a hero, one who lives to ensure that his people survive is commonly not. But Kamal, Dipu, and others like them consider what they have done heroic. They have swallowed their pride and the shame of their paradhin work so that their families will not tread that path. Unlike the male servants of the past, they sacrifice their lives not for their employers' families but for their own.

CONCLUSION

The women and men whose life stories appear here often work twelve- to sixteen-hour days, cooking and cleaning, sweeping and mopping, dusting twice a day to remove the layers of dust that cover every item of furniture in the tropics, running errands, polishing silver, grinding spices, washing clothes by hand, wringing them out to dry, and taking care of other people's children while praying that their own will be spared this life. They are the workers that the lives of the middle classes are built on, yet they are the workers that no one wants to be.

I have argued in this article that domestic workers judge themselves by the extent to which they have achieved or failed to achieve hegemonic gender norms. Domestic work in Calcutta, and indeed, in India, is individualized, unorganized, and made familial. Unions are either not interested in organizing these workers or give up after initial attempts, because the dispersed workplaces make collective action difficult. This is particularly true of those who do live-in work. Given this, and the extreme stigmatization of this occupation, it is not surprising that these domestic workers minimize their identities as workers and instead think of themselves as women and men, mothers and fathers, wives and husbands, daughters and sons. These are not, however, the only alternate identities that domestic servants can choose. In other parts of India, where there are powerful political parties and organizations representing lower castes (such as in the state of Bihar), domestic workers could make their caste identities primary. In Calcutta, however, domestic workers, by and large, lack caste or class representation.

I have also argued that although the workers do focus on gendered identities, it would be a mistake to romanticize these constructions as resistance, for they do not invent the content of these identities as they please. Their identities are constituted through their class location, the work they do, and their particular relationship to a domestic space, which is also their place of work. Unlike the Mukkuvar fishermen and women, or factory workers, live-in domestic workers have little autonomous space outside bhadralok culture. [43] Unlike part-time workers, they have no homes to which to return at the end of the day. They are therefore materially and discursively constrained within a universe that is not of their own making.

Yet, if there is a common thread between Mitali's, Lakshmi's and Kamal's narratives, it lies in the way in which they represent themselves. None has had the chance to tell "their story" before this, and they are not interested in a story of victimhood, although it is against that backdrop that they want others to understand their tales. They want their agency, their ability to exercise choice in the midst of lives usually bereft of choice, to be appreciated. As I return to my question then, I choose neither structure nor agency but, rather, end with partial failures, defeats, and victories.

Bhadralok society can idealize particular notions of femininity and masculinity precisely because the subaltern classes cannot attain them; however, live-in domestic workers struggle with these ideals and try to fit their lives within them. Regardless of whether they ultimately accept or reject the bhadralok evaluation of themselves, they judge their lives by the very ideals which were designed to be out of their reach. Yet they also reach out to ideas culled from popular discourse and classic myth--ideas of love and responsibility. They hold on to ideas about womanhood and manhood that allow them hope and pride, which bhadralok ideology does not do. And in this process, female and male domestic workers are simultaneously defeated by and partially victorious over hegemonic gender ideologies.

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NOTES

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(1.) V. Tellis-Nayak, "Power and Solidarity: Clientage in Domestic Service," Current Anthropology 24 (February 1983): 67-74.

(2.) Anna Rubbo and Michael Taussig, "Up Off Their Knees: Servanthood in South-West Columbia," Latin American Perspectives 39 (fall 1983): 2-23.

(3.) See, for example, Julia Wrigley, Other People's Children (New York: Basic Books, 1995); Bonnie Thornton Dill, Across the Boundaries of Race and Class: An Exploration of Work and Family among Black Female Domestic Servants (New York: Garland, 1994); Carole Turbin, "Domestic Service Revisited: Private Household Workers and Employers in a Shifting Economic Environment," International Labor and Working Class History 47 (spring 1995): 91-100; Mary Romero, Maid in the U.S.A (New York: Routledge, 1992); Judith Rollins, Between Women: Domestics and Their Employers (Philadelphia: Temple University Press, 1985); Pierette Hondagneu-Sotelo and Cristina Riegos, "Sin Organizacion, No Hay Solucion: Latina Domestic Workers and Non-Traditional Labor Organizing," Latino Studies Journal 8 (fall 1997): 54-83. Evelyn Nakano Glenn's Issei, Nissei War Bride: Three Generations of Japanese American Women in Domestic Service (Philadelphia: Temple University Press, 1986) is a powerful exception. More recently, Pierette HondagneuSo telo and Ernestine Avila address the ways in which migrant domestic workers try to mother their children from afar. See "I'm Here,

but I'm There': The Meanings of Latina Transnational Motherhood," Gender and Society 11 (October 1997): 548-71.

(4.) See, for example, Dipesh Chakrabarty, Rethinking Working-Class History: Bengal, 1890-1940 (Princeton: Princeton University Press, 1989); Leela Fernandes, Producing Workers: The Politics of Gender, Class, and Culture in the Calcutta Jute Mills (Philadelphia: University of Pennsylvania Press, 1997); and Samita Sen, Women and Labour in Late Colonial India: The Bengal Jute Industry (Cambridge: Cambridge University Press, 1999).

(5.) Gillian Hart, "Engendering Everyday Resistance: Gender, Patronage, and Production Politics in Rural Java," Journal of Peasant Studies 19 (October 1991): 93-121; and Karin Kapadia, Siva and Her Sisters: Gender, Caste, and Class in Rural South India (Boulder: Westview Press, 1995).

(6.) In the late nineteenth century in Colonial Bengal, the Bengali elite lost their power over their land and had to turn increasingly to professional, administrative, and clerical employment. See Mrinalini Sinha, Colonial Masculinity: The 'Manly Englishman' and the 'Effeminate Bengali' in the Late Nineteenth Century (Manchester and New York: Manchester University Press, 1995); and Sumit Sarkar, Writing Social History (Delhi: Oxford University Press, 1997).

(7.) Of the fifteen servants, eight are women and seven are men. They are all first-generation domestic workers, who came to Calcutta from the rural areas of Bengal either because their land could not sustain them or, in the case of the women, because they were married. Most are lower castes, two are Brahmin (a married couple), and one man is Christian. Three women are separated from their husbands, one is widowed, and the others are married. All the men are married, although two do not live with their wives. They range in age from thirty to sixty-six and have been working between seven and thirty years.

The employers are primarily upper middle class, upper caste, and Bengali. They live in old bungalows and apartment buildings and work in the corporate world and the professions. The youngest employer was thirty and the oldest, eighty. All of them grew up with servants, and none has been without servants for a long stretch of time. All interviews were open-ended conversations. The interviews with employers were conducted jointly by Seemin Qayum (from the University of London) and myself and lasted from one to four hours, with the average being two and a half hours.

I interviewed live-in workers at the sites they chose, usually their "quarters" in the apartment buildings of their employers. It was more difficult to interview the workers than employers for several reasons. Because they are live-in workers, they are constantly at the beck and call of their employers and have little time to spare. Most workers have between one and three hours off in the afternoon. This is the time they use to shower, eat their lunch, sleep, or do their own errands. They were rarely free at night before 10 p.m. Thus, I often started conversations in the afternoon and completed them at night. Worker interviews were conducted in Bengali.

Why would domestic servants agree to speak with me, since I am clearly of the employer class? There is no simple answer to this question. I entered the "field" with the help of a domestic servant I have known and talked with for many years. He introduced me to my first three interviewees who, in turn, led me to others. Because I was recommended to them by people they trusted, were they initially more open to me? Or was it the substance of the questions that convinced them that I was safe? Perhaps it is the intensity of their desire to speak and the lack of opportunity to do so that made the barriers fall. Although most interviews with employees started out slowly, soon I could barely keep up with note taking, as the workers, especially the women, spilled out their life stories. One woman said that my intentions were good, but the people who really needed to read my book (such as her employer) would not. "You see," she said, "They probably think 'Why would anyone write a book about those people?' Such people have no conscience. Can you really reach them?"

(8.) See, for example, Lesley Gill, Precarious Dependencies: Gender, Class, and Domestic Service in Bolivia (New York: Columbia University Press, 1994); Elsa Chaney and Mary Garcia Castro, Muchachas No More: Household Workers in Latin America and the Caribbean

(Philadelphia: Temple University Press, 1989); Christine B.N. Chin, "Walls of Silence and Late-Twentieth Century Representations of the Foreign Female Domestic Worker: The Case of Filipina and Indonesian Female Servants in Malaysia," International Migration Review 31 (summer 1997): 353-85. Indeed, despite the fact that their own data show that there are many thousands of male domestic servants in India, a study sponsored by the Catholic Bishops' Conference of India (CBCI) declares: "In Indian tradition, females are most often involved in domestic chores" and claims that in most cases employers prefer female servants because of the idea that women are more "submissive, polite, and loyal" (CECI, 1980, 31).

(9.) Domestic servants have historically been male in Africa. See Karen Hansen, African Encounters with Domesticity (New Brunswick, N.J.: Rutgers University Press, 1992).

(10.) As Ruth Milkman and her colleagues have persuasively argued, "a crucial determinant of the extent of employment in paid domestic labor in a given location is the degree of economic inequality there." See Ruth Milkman, Ellen Reese, and Benita Roth, "The Macrosociology of Paid Domestic Labor," forthcoming in Work and Occupations 25 (November 1998): 453-510.

(11.) See the Census of India, 1971 and 1981, Series 1, India, Part III-B (iii) General Economic Tables, 1981. However, this is a vastly undercounted number because the census includes only maids and other house cleaners (category 531) but not cooks, ayahs (nannies), or any other category of domestic worker. In addition to women and men, this class comprises thousands of children, both girls and boys, who work as domestic servants, whom the Census leaves out. According to a study commissioned by the CBCI, 16.65 percent of the domestic servants interviewed were under the age of fifteen. See Catholic Bishops' Conference of India, A National Socio-Economic Survey of Domestic Workers (Madras: Catholic Bishops' Conference of India Commission for Labour, 1980), 36.

(12.) Census of India, 1981, Tamil Nadu Series 20, part III A&B (ii); Census of India, 1981, Maharashtra, Series 12, part III A&B (iii); Census of India, 1981, Uttar Pradesh, Series 22, part III A&B (v); Census of India, 1981, West Bengal, Series 23, part III A&B (ii).

(13.) Nirmala Banerjee, Women Workers in the Unorganized Sector: The Calcutta Experience (Hyderabad, India: Sangam Books, 1985); and Bela Bandopadhyay, interview with author, Calcutta, 22 Jan 1998.

(14.) Gautam Bhadra, interview with author, 7 Jan. 1998.

(15.) Robert W. Connell, Masculinities (Berkeley and Los Angeles: University of California Press, 1995).

(16.) Sarkar, 170.

(17.) For other writings on the bhadralok, see Sumanta Banerjee, The Parlour and the Streets: Elite and Popular Culture in Nineteenth-Century Calcutta (Calcutta: Seagull Books, 1989); and Rabindra Ray, The Naxalites and Their Ideology (Delhi: Oxford University Press, 1988).

(18.) Banerjee, Parlour and the Streets.

(19.) Perhaps because they resisted the British through the intellect rather than the sword, the bhadralok were defined by the British as effete, the opposite of both the British gentleman and the loyal Pathan warriors. This charge of effeminacy applied specifically to the Bengali elite and not to Bengali workers or peasants. See Sinha, 16. The British wondered at these "soft-bodied little people" who could nonetheless compete successfully against the British in the civil service exams and become the salaried workers, professionals, and civil servants that form the core of the Bengali postcolonial elite. See John Rosselli, "The Self-Image of Effeteness: Physical Education and Nationalism in Nineteenth-Century Bengal," Past and Present 86 (February 1980): 121-48.

(20.) Partha Chatterjee, "Nationalist Resolution of the Woman Question," in Recasting Women: Essays in Indian Colonial History, ed. Kumkum Sangari and Sudesh Vaid (Delhi: Kali for

Women, 1989), 233-53.

(21.) Chatterjee.

(22.) Himani Banerjee, "Attired in Virtue: The Discourse on Shame (lajja) and Clothing of the Bhadramahila in Colonial Bengal," in From the Seams of History, ed. Bharati Ray (Delhi: Oxford University Press, 1995), 81.

(23.) Census of India, 1991, Series I, Provisional Population Tables.

(24.) Hilary Standing, Dependence and Autonomy: Women's Employment and the Family in India (London and Princeton: Princeton University Press, 1984).

(25.) Ibid.; and Meredith Borthwick, The Changing Role of Women in Bengal, 1849-1905 (New York: Routledge, 1991). For a fascinating study of the advice given to middle-class women hiring servants at the turn of the century, see Swapna Banerjee, "Exploring the World of Domestic Manuals: Bengali Middle-Class Women and Servants in Colonial Calcutta," in Sagar: South Asia Graduate Research Journal 3, no. 1 (1996).

(26.) Swadhinata here refers to a specific relationship to work. It is not so much the fact that one works for someone else that prevents one from being swadhin. People who work in offices do work for someone else. But, rather, it is the fact of having to be on call all day and be unable to go home at the end of the day, which makes one paradhin (unfree). While both employers and servants use this word, the servants use it repeatedly, as we shall see.

(27.) Hansen reports a similar dynamic in Zambia. In Janet Bujra's study of Tanzania, only two out of the sixty employers interviewed thought women were better servants. See Janet Bujra, "Men at Work in the Tanzanian Home: How Did They Ever Learn?" in African Encounters with Domesticity, 242-65.

(28.) Bengali landlords, for example, frequently used lower-caste men to fight off rivals and frighten tenants. See Roselli.

(29.) I am grateful to the anonymous reviewer who reminded me of this point.

(30.) James Scott, Weapons of the Weak (New Haven: Yale University Press, 1995).

(31.) Kapadia; Kalpana Ram, Mukkuvar Women: Gender, Hegemony, and Capitalist Transformation in a South Indian Fishing Community (Delhi: Kali for Women, 1992).

(32.) Paul Willis, Learning to Labour (1977; Aldershot, England: Gower, 1981).

(33.) See, for example, Luisa Passerini, Autobiographies of a Generation: Italy, 2968 (Hanover, N.H.: Wesleyan University Press, 1996); and Barbara Laslett and Barrie Thorne, eds., Feminist Sociology: Life Histories of a Movement (New Brunswick, N.J.: Rutgers University Press, 1997).

(34.) Fernandes; and Standing.

(35.) Psychologist Sudhir Kakar concludes, following his interviews with two working-class women in Delhi, that despite their many hardships, there is nothing to dim the luminosity of their romantic longings." See Sudhir Kakar, The Indian Psyche (Delhi: Viking India/Penguin, 1996), 71. I would argue that it is not just romantic love to which they cling but rather to the idea of being acknowledged, recognized, and appreciated.

(36.) The literature on domestic workers in Latin America emphasizes young women's desire for autonomy as well. See Elisabeth Jelin, "Migration and Labor Force Participation of Latin American Women: The Domestic Servants in the Cities," Signs 3 (spring 1977): 129-41.

(37.) Jessica Benjamin, Like Subjects, Love Objects: Essays on Recognition and Sexual Difference (New Haven: Yale University Press, 1995), 33.

(38.) Lakshmi uses the same Bengali word bhalobasha to refer to the affections of her employer and husband.

(39.) Manisha Roy, Bengali Women (Chicago and London: University of Chicago Press, 1972).

(40.) See, for example, Hum Aapke Hai Kaun? (Who am I to you?) and Dilwale Dulhaniya Le Jayenge (The gallant one will win the bride), two of the most popular Hindi films in recent years.

(41.) Rubbo and Taussig.

(42.) See also Hansen.

(43.) Ram.

Fausto-Sterling, A. (1997). ***How to Build a Man.*** In R. N. Lancaster and M. di Leonardo (Eds.), The Gender/Sexuality Reader. New York: Routledge, pp. 244-248

16 How to Build a Man

Anne Fausto-Sterling

How does one become a man? Although poets, novelists, and playwrights long past answered with discussions of morality and honor, these days scholars deliberate the same question using a metaphor—that of social construction. In the current intellectual fashion, men are made, not born. We construct masculinity through social discourse, that array of happenings that covers everything from music videos, poetry, and rap lyrics to sports, beer commercials, and psychotherapy. But underlying all of this clever carpentry is the sneaking suspicion that one must start with a blueprint—or, to stretch the metaphor yet a bit more, that buildings must have foundations. Within the soul of even the most die-hard constructionist lurks a doubt. It is called the body.

In contrast, biological and medical scientists feel quite certain about their world. For them, the body tells the truth. (Never mind that postmodern scholarship has questioned the very meaning of the word "truth.") My task in this essay is to consider the truths that biologists extract from bodies, human and otherwise, to examine scientific accounts—some might even say constructions—of masculinity. To do this, I will treat the scientific/medical literature as yet another set of texts open to scholarly analysis and interpretation.

What are little boys made of? While the nursery rhyme suggests "snips and snails, and puppy-dogs tails," during the past seventy years, medical scientists have built a rather more concrete and certainly less fanciful account. Perhaps the single most influential voice during this period has been that of psychologist John Money. Since at least the 1920s, embryologists have understood that during fetal development a single embryonic primordium—the indifferent fetal gonad—can give rise to either an ovary or a testis. In a similar fashion, both male and female external genitalia arise from a single set of structures. Only the internal sex organs—uteri, fallopian tubes, prostates, sperm transport ducts—arise during embryonic development from separate sets of

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structures. In the 1950s, Money extended these embryological understandings into the realm of psychological development. As he saw it, all humans start on the same road, but the path rapidly begins to fork. Potential males take a series of turns in one direction, potential females in another. In real time, the road begins at fertilization and ends during late adolescence. If all goes as it should, then there are two, and only two, possible destinations—male and female.

But, of course, all does not always go as it should. Money identified the various forks in the road by studying individuals who took one or more wrong turns. From them, he derived a map of the normal. This is, in fact, one of the very interesting things about biological investigators. They use the infrequent to illuminate the common. The former they call abnormal, the latter normal. Often, as is the case for Money and others in the medical world, the abnormal requires management. In the examples I will discuss, management means conversion to the normal. Thus, we have a profound irony. Biologists and physicians use natural biological variation to define normality. Armed with this description, they set out to eliminate the natural variation that gave them their definitions in the first place.[1]

How does all this apply to the construction of masculinity? Money lists ten road signs directing a person along the path to male or female. In most cases these indicators are clear, but, as in any large city these days, graffiti sometimes makes them hard to read and the traveler ends up taking a wrong turn. The first sign is *chromosomal sex,* the presence of an X or a Y chromosome. The second is *gonadal sex*: when there is no graffiti, the Y or the X instructs the fetal gonad to develop into a testis or an ovary. *Fetal hormonal sex* marks the third fork: the embryonic testis must make hormones that influence events to come—particularly the fourth *(internal morphologic sex)*, fifth *(external morphologic sex),* and sixth *(brain sex)* branches in the road. All of these, but especially the external morphologic sex at birth, illuminate the road sign for step number seven, *sex of assignment and rearing.* Finally, to become either a true male or a true female in John Money's world, one must produce the right hormones at puberty *(pubertal hormonal sex),* acquire and express a consistent *gender identity and role*, and, to complete the picture, be able to reproduce in the appropriate fashion *(procreative sex).*[2]

Many medical texts reproduce this neat little scheme, and suggest that it is a literal account of the scientific truth, but they neglect to point out how, at each step, scientists have woven into the fabric their own deeply social understandings of what it means to be male or female. Let me illustrate this for several of the branches in the road. Why is it that usually XX babies grow up to be female while XYs become male? Geneticists say that it is because of a specific Y chromosome gene, often abbreviated SDY (for "Sex-Determining Gene" on the Y). Biologists also refer to the SDY as the Master Sex-Determining Gene and say that in its *presence* a male is formed. Females, on the other hand, are said to be the default sex. In the *absence* of the master gene, they just naturally happen. The story of the SDY begins an account of maleness that continues throughout development. A male embryo must activate this master gene and seize its developmental pathway from the underlying female ground plan.

When the SDY gene starts working, it turns the indifferent gonad into a functional testis. One of the first things the testis does is to induce hormone synthesis. It is these molecules that take control of subsequent developmental steps. The first hormone to hit the decks (MIS, or Mullerian Inhibiting Substance) suppresses the development of the internal female organs, which lie in wait ready to unveil their feminine presence. The next, fetal testosterone, manfully pushes other embryonic primordia to develop both the internal and external trappings of physical masculinity. Again, medical texts offer the presence/absence hypothesis. Maleness requires the presence of special hormones; in their absence, femaleness just happens.[3]

Up to this point, two themes emerge. First, masculinity is an active presence that forces itself onto a feminine foundation. Money sometimes calls this "The Adam Principle—adding something to make a male." Second, the male is in constant danger. At any point male development can be derailed; a failure to activate SDY, and the gonad becomes an ovary; a failure to make MIS,

and the fetus can end up with fallopian tubes and a uterus superimposed on an otherwise male body; a failure to make fetal testosterone, and, despite the presence of a testis, the embryo develops the external trappings of a baby girl. One fascinating contradiction in the scientific literature illustrates my point. Most texts write that femaleness results from the absence of male hormones, yet at the same time scientists worry about how male fetuses protect themselves from being femininized by the sea of maternal (female) hormones in which they grow.[4] This fear suggests, of course, that female hormones play an active role, after all; but most scientists do not pick up on that bit of logic. Instead, they hunt for special proteins the male embryo makes in order to protect itself from maternally induced feminization. (It seems that mother is to blame even before birth.)

Consider now the birth of a boy-child. He is perfect: Y chromosomes, testes descended into their sweet little scrotal sacs, a beautifully formed penis. He is perfect—except that the penis is very tiny. What happens next? Some medical texts refer to a situation such a this as a social emergency, others see it as a surgical one. The parents want to tell everyone about the birth of their baby boy; the physicians fear he cannot continue developing along the road to masculinity. They decide that creating a female is best. Females are imperfect by nature, and if this child cannot be a perfect or near-perfect male, then being an imperfect female is the best choice. What do the criteria physicians use to make such choices tell us about the construction of masculinity?

Medical managers use the following rule of thumb:

> Genetic females should always be raised as females, preserving reproductive potential, regardless of how severely the patients are virilized. In the genetic male, however, the gender of assignment is based on the infant's anatomy, predominantly the size of the phallus.[5]

Only a few reports on penile size at birth exist in the scientific literature, and it seems that birth size in and of itself is not a particularly good indicator of size and function at puberty. The average phallus at birth measures 3.5 cm (1 to 1.5 inches) long. A baby boy born with a penis measuring only 0.9 inches raises some eyebrows, but medical practitioners do not permit one born with a penis less than 0.6 inches long to remain as a male.[6] Despite the fact that the intact organ promises to provide orgasmic pleasure to the future adult, it is surgically removed (along with the testes) and replaced by a much smaller clitoris which may or may not retain orgasmic function. When surgeons turn "Sammy" into "Samantha," they also build her a vagina. Her primary sexual activity is to be the recipient of a penis during heterosexual intercourse. As one surgeon recently commented, "It's easier to poke a hole than build a pole."

All this surgical activity goes on to ensure a congruous and certain sex of assignment and sex of rearing. During childhood, the medical literature insists, boys must have a phallus large enough to permit them to pee standing up, thus allowing them to "feel normal" when they play in little boys' peeing contests. In adulthood, the penis must become large enough for vaginal penetration during sexual intercourse. By and large, physicians use the standard of reproductive potential for making females and phallus sizes for making males, although Suzanne J. Kessler reports one case of a physician choosing to reassign as male a potentially reproductive genetic female infant rather than remove a well-formed penis.[7]

At birth, then, masculinity becomes a social phenomenon. For proper masculine socialization to occur, the little boy must have a sufficiently large penis. There must be no doubt in the boy's mind, in the minds of his parents and other adult relatives, or in the minds of his male peers about the legitimacy of his male identification. In childhood, all that is required is that he be able to pee in a standing position. In adulthood, he must engage in vaginal heterosexual intercourse. The discourse of sexual pleasure, even for males, is totally absent from this medical literature. In fact, male infants who receive extensive penile surgery often end up with badly scarred and thus physically insensitive members. While no surgeon finds this outcome desirable, in assigning sex to

an intersexual infant, sexual pleasure clearly takes a backseat to ensuring heterosexual conventions. Penetration in the absence of pleasure takes precedence over pleasure in the absence of penetration.

In the world of John Money and other managers of intersexuality, men are made, not born. Proper socialization becomes more important than genetics. Hence, Money and his followers have a simple solution to accidents as terrible as penile amputation following infant circumcision: raise the boy as a girl. If both the parents and the child remain confident of his newfound female identity, all will be well. But what counts as good mental health for boys and girls? Here, Money and his coworkers focus primarily on female development, which becomes the mirror from which we can reflect the truth about males. Money has published extensively on XX infants born with masculinized genitalia. Usually such children are raised as girls, receiving surgery and hormonal treatments to feminize their genitalia and to ensure feminine puberty. He notes that frequently such children have a harder time than usual achieving clarity about their femininity. Some signs of trouble are these: in the toddler years, engaging in rough-and-tumble play, and hitting more than other little girls do; in the adolescent years, thinking more about having a career and fantasizing less about marriage than other little girls do; and, as an adolescent and young adult, having lesbian relationships.

The homologue to these developmental variations can be found in Richard Green's description of the "Sissy Boy Syndrome." Green studied little boys who developed "feminine" interests—playing with dolls, wanting to dress in girls' clothing, not engaging in rough-and-tumble play. These boys, he argued, are at high risk for becoming homosexuals. Money's and Green's ideas work together to present a picture of normality. And, surprise, surprise, there is no room in the scheme for a normal homosexual. Money makes a remarkable claim. Genetics and even hormones count less in making a man or a woman than does socialization. In sustaining that claim, his strongest evidence, his trump card, is that the child born a male but raised a female becomes a heterosexual female. In their accounts of the power of socialization, Money and his coworkers defined heterosexual in terms of the sex of rearing. Thus, a child raised as a female (even if biologically male) who prefers male lovers is psychologically heterosexual, although genetically she is not.

Again, we can parse out the construction of masculinity. To begin with, normally developing little boys must be active and willing to push one another around; maleness and aggression go together. Eventually, little boys become socialized into appropriate adult behavior, which includes heterosexual fantasy and activity. Adolescent boys do not dream of marriage, but of careers and a professional future. A healthy adolescent girl, in contrast, must fantasize about falling in love, marrying, and raising children. Only a masculinized girl dreams of a professional future. Of course, we know already that for men the true mark of heterosexuality involves vaginal penetration with the penis. Other activities, even if they are with a woman, do not really count.

This might be the end of the story, except for one thing. Accounts of normal development drawn from the study of intersexuals contain internal inconsistencies. How *does* Money explain the higher percentage than normal of lesbianism, or the more frequent aggressive behavior among masculinized children raised as girls? One could imagine elaborating on the socialization theme: parents aware of the uncertain sex of their children subconsciously socialize them in some intermediary fashion. Shockingly for a psychologist, however, Money denies the possibility of subconsciously driven behavior. Instead, he and the many others who interpret the development of intersexual children resort to hormonal explanations. If an XX girl, born with a penis, surgically "corrected" shortly after birth, and raised as a girl, subsequently becomes a lesbian, Money and others do not look to faulty socialization. Instead, they explain this failure to become heterosexual by appealing to hormones present in the fetal environment. Excess fetal testosterone caused the masculinization of the genitalia; similarly, fetal testosterone must have altered the developing brain, readying it to view females as appropriate sexual objects. Here, then, we have the last bit of

the picture painted by biologists. By implication, normal males become sexually attracted to females because testosterone affects their brain during embryonic development. Socialization reinforces this inclination.

Biologists, then, write texts about human development. These documents, which take the form of research papers, textbooks, review articles, and popular books, grow from interpretations of scientific data. Often written in neutral, abstract language, the texts have the ring of authority. Because they represent scientific findings, one might imagine that they contain no preconceptions, no culturally instigated belief systems. But this turns out not to be the case. Although based in evidence, scientific writing can be seen as a particular kind of cultural interpretation—the enculturated scientist interprets nature. In the process, he or she also uses that interpretation to reinforce old or build new sets of social beliefs. Thus, scientific work contributes to the construction of masculinity, and masculine constructs are among the building blocks for particular kinds of scientific knowledge. One of the jobs of the science critic is to illuminate this interaction. Once this is done, it becomes possible to discuss change.

Notes

1. In the 1950s Dr. John Money argued that gender was merely a matter of body image and upbringing. One of his most dramatic cases, offered over and over again in defense of his viewpoints, was a pair of twin boys. One suffered a circumcision accident at the age of eight months and lost his penis. Money decided to raise this child as a girl, advised that "she" be castrated, given reconstructive genital surgery, and at puberty be given female hormones. Money claimed that this child easily assumed a female identity and grew into a woman who accepted her gender identity. Recently, however, Dr. Milton Diamond and Keith Sigmundson *(Archives of Pediatric and Adolescent Medicine*, March 1997) found and interviewed Money's patient, now in his thirties. In fact he never accepted his female identity, and as a teenager demanded to learn his whole medical history and decided to continue life as a male, even though he did not have a functional penis. This case report made the front pages of the *New York Times* and a debate now rages about how to interpret this new information.
2. For a popular account of this picture, see John Money and Patricia Tucker, *Sexual Signatures: On Being a Man or a Woman* (Boston: Little, Brown, 175).
3. The data do not actually match the presence/absence model, but this does not seem to bother most people. For a discussion of this point, see Anne Fausto-Sterling, "Life in the XY Corral," *Women's Studies International Forum* 12 (1989): 319–31; Anne Fausto-Sterling, "Society Writes Biology/Biology Constructs Gender," *Daedalus* 116 (1987): 61–76; and Anne Fausto-Sterling, *Myths of Gender: Biological Theories about Women and Men* (New York: Basic Books, 1992).
4. I use the phrase "male hormone" and "female hormone" as shorthand. There are, in fact, no such categories. Males and females have the same hormones, albeit in different quantities and sometimes with different tissue distributions.
5. Patricia Donahoe, David M. Powell, and Mary M. Lee, "Clinical Management of Intersex Abnormalities," *Current Problems in Surgery* 8 (1991): 527.
6. Robert H. Danish, Peter A. Lee, Thomas Mazur, James A. Amrhein, and Claude J. Migeon, "Micropenis II: Hypogonadotropic Hypogonadism," *Johns Hopkins Medical Journal* 146 (1980): 177–84.
7. Suzanne J. Kessler, "The Medical Construction of Gender: Case Management of Intersexed Infants," *Signs* 16 (1990).

6. Roots of Women's Resistance

> The other dimensions of thought which have gone into the Indian family structure . . . have brought out more clearly than perhaps in any culture that women have relevance even when under-privileged; are strong, not weak; and that they continue to be the acknowledged repository of unknown, unseen yet tangible elements of human power.
> Tara Ali Baig, *India's Woman Power*[1]

The specific interests which distinguish the Indian women's movement from those of the Western countries arise from India's distinct cultural traditions and social structure. Having established that the influence of British colonialism was not unambiguously progressive in terms of women's liberation, it is nevertheless tempting to think that women's resistance to male domination in India was initiated by the British women who started the women's organisations and helped to define their aims. But just as the impact of colonial domination on women was complex and contradictory, so too the influence of the British women's movement was not a simple importation of the Western organisation, but represented a single intervention within the totality of Indian history. Women's resistance to oppression in India neither began nor ended with the British women's intervention, but had its roots in the Indian social structure and cultural heritage.

This heritage both preceded and followed on from the British women's initiatives, which meant that the two movements had very different starting points and developed in distinctive directions. The common strand was that in both countries the institutions of male supremacy supported male privilege, but the forms of male supremacy were different in each case, with different implications for the formation of gender relations and the development of women's resistance. The specific form of male supremacy in India affected men's views and treatment of women, as well as how women saw themselves and constructed their demands.

We have made the comparison between India and the West, not to examine the historical roots of Western women's subordination,[2] but to draw attention to the distinct character of the movement for women's liberation in India, so that we can understand the women who are the subject of this study, and so that today's women's movements in the West might learn from and be inspired by the history and heritage of women in India.

Liddle, J. and Joshi, R. (1986). ***Daughters of Independence: Gender, Caste and Class in India***. (Chapters 6-10), pp. 49-83.

In Part II we will examine the roots of women's inequality and of their resistance in India, by looking at what we see as the major influences on the formation of gender relations, that is, the development of the patriarchal form of family organisation, the formation of the caste hierarchy, and the impact of foreign domination. We will argue that:

One, the patriarchal form of family organisation and its associated ideology did not emerge as a universally accepted or natural way of living, but was the scene of a struggle, in which the patriarchal form gained dominance without a final victory. This struggle reveals the historical roots of women's resistance to male domination, and provides the basis for a distinct view of women as strong and powerful;
Two, the subordination of women was crucial to the development of caste hierarchy, the women being subject to increasing constraints the higher the caste in the hierarchy. Caste, too, was the subject of struggle, and the anti-caste movements were always associated with the removal of constraints on women. The upper castes maintained their supremacy by incorporating some of the opposing cultural traditions into their own, while increasing the social distinction between themselves and the lower castes. These efforts illuminate the historical connection between women's subordination and social hierarchy, and provide the basis for strong physical controls over powerful women in a patriarchal society;
Three, the impact of foreign domination on the formation of the social classes had a contradictory effect on the position of women in the middle class. The class structure appeared to build on the existing gender divisions within the caste system, reinforcing women's subordination though changing its form. But it also allowed a small number of women from the urban, educated middle class to survive independently of the patriarchal caste system in the higher levels of waged work.

As a result of these influences, we suggest that women's desire for emancipation in India did not stem primarily from the initiative of the British women who started the movement, but from the way this intervention combined with Indian women's unique cultural heritage which provides a tradition of women as strong and powerful beings, and with their position in the social structure which offered them the possibility of an independent existence.

7. Patriarchy and the Matriarchal Heritage

> The Brahmins would have liked to annihilate the Shakti [female power principle] cults altogether and replace the female with the male as the dominant and superior principle. The roots of these cults . . . are so powerful that they have persisted even to this day . . . We need to . . . understand Shakti . . . as an energy within ourselves which generates the power to act.
> Chandralekha, *The Book Review*[3]

Women in India have a unique cultural heritage. It is not always easy, however, to trace its history, since the best preserved stories are normally those of the groups who achieved dominance. India's earliest written history is recorded in the Vedas, the religious books written by the priestly groups of the Aryan-speaking race, known as the brahmins. It was the males of these groups who eventually achieved social and religious supremacy, although not without opposition.

If we only look at the dominant groups' history, we see only one side of the story. To find the other stories we have to look at alternative sources such as later written history, oral history, archaeological evidence, and surviving religious practices and social organisation. This is particularly necessary in the case of women's history, since most written history is recorded by men and represents predominantly male concerns. Piecing the picture together from other sources indicates that male supremacy was not a natural or an inevitable development in the history of gender relations, but was the result of a struggle between the female power principle and the idea of the male as the dominant source of power.

What is distinctive about this heritage compared with that of women in the West is that although the male principle attained supremacy in both areas of the world, in India the idea of women as powerful was accommodated into the patriarchal culture and retained its visibility. It also remained strong amongst certain sections of the population who opposed the patriarchal ideas of the brahmins. The visibility of women's power was maintained in Muslim cultures too, as indicated by Fatima Mernissi[4] and Azizah Al-Hibri.[5] We want to examine the struggle over the male and female principles by identifying two areas where it can be seen to have taken place. One of these is in the different forms of family structure, the other is in the different forms of religious culture.

We use the term patriarchy to refer to the particular system of family organisation which includes patrilineal inheritance, the sons and daughters-in-law staying in the father's house, and the authority of the father over the women and the younger men, supported by a cultural tradition which emphasises the supremacy of the male power principle.[6] We do not use it to refer to male dominance, since we wish to distinguish betwen patriarchy as a specific family system, and male dominance as a general system of sexual hierarchy.

The definition of matriarchy is as much in dispute as is the definition of patriarchy.[7] When we refer to the matriarchal heritage, we do not mean the obverse of patriarchy, that is, a system of family organisation where mothers have authority over men and the younger women. There is no evidence for a matriarchy having existed anywhere in the world, in the sense of women's rule over men being embodied in the family or social structure.[8] What we do mean by the matriarchal heritage is a history of struggle where the idea of female power was constantly reasserted through the religion and where family forms giving women greater freedom existed despite the opposition of the dominant patriarchal groups. The evidence for the struggle is found in the conflicts and accommodations between different modes of religious thought, and between the matrilineal and patrilineal family systems.

Matrilineal Family Organisation

The matrilineal systems of descent, although by no means constituting a matriarchy, did provide the basis for a greater degree of freedom for women compared with the patrilineal system. This freedom differed in its form and extent in different matrilineal communities; we have already seen one example amongst the Nayars of Kerala.[9] The important factor is that matrilineal groups depend on retaining a similar degree of control over both male and female members, whereas control over women is much more severe than control over men in patrilineal descent.[10] Kerala today has the highest female literacy rate,[11] the highest ratio of females to males,[12] and the second highest age of marriage for women in India.[13] These indices of women's relatively better position in the state of Kerala are normally attributed to the continued existence of the matrilineal family and the associated cultural worth attached to women.[14]

When the Aryans migrated to India around 1500 B.C., they brought with them the patrilineal form of family organisation, where the line of descent is from father to son, and the women leave their father's house on marriage to live with the husband and father-in-law. The Aryans are believed to have destroyed the superior civilisation which they encountered in the Indus Valley, in the north-west of the subcontinent, and gradually to have established dominance over the Dravidians who were the indigenous inhabitants of the main peninsula.[15]

Many historians believe that the Aryans encountered matrilineal family organisation amongst the indigenous people.[16] This they deduce from communities in outlying areas of India where matriliny has persisted. In the South of the country, Kerala and Tamil Nadu certainly seem to have been

matrilineal.[17] We have already discussed the Nayars of Malabar, whose matriliny survived to British times, but similar family forms continued amongst almost all the communities in this region of Kerala, assisted no doubt by the isolation created by the sea to the West and the mountains to the East.[18] The hills and forests of Travancore and Cochin and other parts of South India have a number of tribes, of which many are matrilineal, some are patrilineal and others use both systems, passing half the property to the sons and half to the sister's sons.[19]

In the Himalayas, the Khasis to the north and the Garos to the east are both matrilineal.[20] and there are matrilineal traces in the Brahui who live in Baluchistan in the west of the subcontinent.[21] The brahmin scriptures refer to the Arattas in the Punjab, whose heirs are their sisters' children, not their own, and to a matrilineal system in Mahishmati in central India, where women could choose a plurality of husbands.[22] This was, of course, anathema to the brahmins, where only men could have several spouses at once.

The struggle between the two family systems can best be seen in the division of castes into two factions, the Right Hand and the Left Hand. Hutton concludes that the division reflects the two descent systems, since the division occurs throughout Dravidian South India except for Malabar, where the patrilineal system barely penetrated. He suggests that the division signifies the refusal of some matrilineal groups to accept the new patrilineal system:

> The inference that the factions of the Right and Left Hand arose as a result of the introduction of the [patrilineal] principle, which some castes were unwilling to accept, is inescapable. The fact that the women of one or two castes belong to one faction while the men belong to another does nothing to weaken this inference, since there is nothing more likely than that the women of a caste might be opposed to it while the men were wishful to adopt it.[23]

Hutton's 'inescapable' inference illustrates not only the struggle between the two family forms, but also the political divisions and the conflict of interest between men and women associated with the two systems of descent. The struggle in the structure of the family is paralleled by the struggle in the religious culture between the male and the female deities as the dominant power principle.

Matriarchal Religious Tradition

Many countries, including India, have matriarchal myths. Several writers have warned that the myths, on examination, may confirm male superiority rather than provide a history of female power, since they tell of how the women were vanquished because they ruled irresponsibly.[24] Consequently, it is important to distinguish myth from reality,[25] and to make clear the level at which myths are significant. Although the myths read like a story, they are not to be taken as a history of what happened, but as a conceptual framework within which people viewed the world. The religious myths and beliefs represent a cultural

history, embodying a struggle over ideas, meanings and interpretations. The persistence of the female power principle symbolises the continued visibility of the power of women as part of the cultural heritage.

Before the arrival of the Aryans, the population of India is believed to have consisted of agricultural communities who lived according to the seasons. God was female, representing life in the form of the Earth Mother.[26] The religion of the Indus Valley was based on fertility, and the people worshipped the mother goddess together with other fertility symbols, all of which are found in Hinduism today.[27] Terracotta figurines of the mother goddess, like those excavated at Mohenjo-Daro in the Indus Valley, were also found at Buxar in Bihar, which suggests the extension of the Indus Valley culture, with its goddess religion, into the Ganges valley in the North-east.[28] Kali the destructive goddess was also known in the Indus Valley, and the Shakti cult (female power) may be traced back to this time.[29] There may also be an early form of the god Shiva.[30] Kali and Shiva are pre-Aryan deities which became more important than Indra, the major god of the early Aryan scriptures,[31] indicating that the cultural struggle for supremacy was by no means always resolved in favour of the immigrants.

Apart from numerous goddesses, a snake cult associated with the mother goddess is found in many regions of the South, and in the Himalayas to the North. Devi, the goddess in the hills, is explicitly known as Devi Mata, the mother goddess.[32] Devi is important in local ceremonies all over India, but she is also involved in the national Hindu festivals of Holi and Dasserah.[33] The Holi spring festival is associated with fertility rites and sexuality, and some of its features are thought to go back to a prehistoric 'matriarchal' stage.[34] At a local level, one study showed that half of the 90 deities worshipped in the village belonged to the 'non-brahmin tradition', and most of these were mother goddesses.[35] The 'brahmin tradition' consists of the specialist scriptures written by the brahmins and requiring a guru for interpretation,[36] although the rigid division of the religion into two parts is not really tenable, since both 'traditions' are a result of conflicts and compromises between the orthodox brahmins and the common people.

Nevertheless, significant differences occur in the 'brahmin' and the 'non-brahmin' traditions, which symbolise the opposition between the male and female principles. The concept of marriage, involving male control of female sexuality, is important for understanding how the mother goddess was incorporated into the patriarchal brahmin religion.[37] In the villages, the old matriarchal religion was brahminised by providing orthodox male deities as husbands for the mother goddesses. In Madura, the goddess is married every year to the god, but the goddess is still recognised by the people as the real deity, not the brahmin god.[38] In Bengal, the scriptures report that Adya, the mother of the gods, was married to Shiva.[39] Durga, also known as Parvati, was married to Shiva and Lakshmi was married to Vishnu.[40] Krishna married several thousand mother goddesses, and one in particular at an annual ceremony, indicating that prior to Krishna, the human representative of the goddess's consort was sacrificed every year.[41]

The features of the goddess in the 'non-brahmin' religion symbolise popular resistance to the control of women's power in the 'brahmin' religious tradition. An excellent illustration of this is found in a study of goddess worship in the region of Chattisgarh by Lawrence Babb.[42] He shows that in the 'brahminical' version, the goddess has a dual, changing nature. As Kali, she is a malevolent destroyer, the manifestation of a terrible sinister force, black anger, implacable and bloodthirsty. The story of Kali — India's matriarchal myth — is that she was created to save the gods from their more powerful enemies, but having done so, she continued on a rampage of uncontrollable killing, which could only be stopped by her husband Shiva lying down in front of her. In her malevolent aspect she receives blood sacrifice. As Lakshmi she is benevolent, bestower of wealth, progeny and happiness, and passively devoted to her husband. In this aspect she never receives blood sacrifice. The goddess is Lakshmi when she is under the control of the male god. In this aspect she is seen standing meekly beside her husband Vishnu. When she is in her terrible aspect, she stands alone, and if Shiva is there he is not her husband but her servant, also in terrible form but subordinate to the goddess. As Susan Wadley suggests, it is marriage and the dominance of the male that transforms the goddess's dangerous power into benevolence.[43]

Significantly, in the 'brahminical' form, the goddess has both aspects, but is more commonly subordinate. In the 'non-brahminical' form, however, the goddess is never represented as married, and is always dominant. In this form, the local goddess is known by many different names, one of which is Shitala, the smallpox goddess. A case of smallpox is treated as possession by the goddess, and certain things are likely to enrage her, particularly the sight of a pregnant woman, who must never approach the patient, and a married couple, who may only approach the patient singly. Remembering that the 'non-brahminical' religion belongs to the people, requires no specialists and is passed on and contributed to by the people themselves, it appears that Shitala's hatred of marriage and pregnancy symbolises the local people's rejection of the patriarchal brahmin attempts to control women's sexuality. The religious myths of the brahmins may tell the story of women's destructive power and how it was constrained by men through control of the women's sexuality, but the religion of the common people tells the story of women's continuing power and their resistance to male control.

Women's Heritage

The worship of the mother goddess does not constitute a matriarchy, but it does constitute a matriarchal *culture*, in the sense that it preserves the value of women as life-givers and sources of activating energy, and it represents the acknowledgement of women's power by women and men in the culture. Nor does the matrilineal family constitute a matriarchy: there is no guarantee that women will be as free as men in such societies, but the evidence from Kerala suggests that matrilineal organisation has had beneficial effects on women's current position compared with women in patrilineal communities.

Both of these aspects form part of the heritage of women in India. From this heritage arises a view of women as powerful and strong. Women in India have managed to maintain the visibility of their power, despite its incorporation into the patriarchal culture, and unlike in the West, the concept of women's power is built into the common cultural assumptions. Consequently, the dominant image of woman is different in India from that of the West, and has different implications for women's liberation in India.

The implications for women are that they see themselves as powerful and strong, an image upon which they can act. The heritage also demonstrates that the roots of women's struggle and resistance go back a very long way, and provide the Indian women's movement with a history of its own, in which the intervention of the British feminists represented only one strand amongst many. The heritage informs both the desire for emancipation amongst women, and the nature of their demands.

The heritage has implications for men too, in terms of how they see women, and the systems they devise for controlling women. In male-dominated societies, women's power must be contained: there are different methods of doing this. Western women are defined as weak and in need of protection. In India, amongst both Hindu and Muslim cultures, women are seen by men as dangerously powerful. Men have to constrain women since women are incapable of controlling themselves; not because they are too weak to do so, but because their power is too great. Such a view legitimates a system of strong physical controls to restrain women's power, which makes no sense within the Western concept of women as the weaker sex. The male-dominated cultures of both India and the West control women's power but in different ways, depending on the specific historical development of gender relations in the two regions. In the following chapter, we discuss the nature of the controls over women in India in the context of the historical development of the caste system.

8. Women and Caste

> The most radical of the nineteenth century reformers had seen the subjugation of women as an instrument for perpetuating brahminical domination in society.
> Vina Mazumdar, *Symbols of Power*[44]

The connection between gender and caste has been recognised for some time, and it is this we want to explore. The women's question in the 19th and 20th Centuries revolved around issues such as sati, child marriage, purdah, divorce and widow remarriage. It is significant that these issues concerned the control of women's sexuality, and that most of them affected only the two highest castes. We will argue that control over women's sexuality was essential to the development of the patriarchal caste hierarchy, both for the maintenance of the caste and for the legitimation and control of inheritance, and we will show how the constraints on women developed historically with the formation of the caste system.

In relating gender to social hierarchy, we are suggesting that women's subordination needs to be understood not in terms of their powerful sexuality alone, but also in terms of the material and ideological dangers that it posed for the caste structure. Our argument is that the development of the gender division, based on the control of female sexuality, was integral to the formation of the social structure, based on the control of economic resources, revealing the crucial link between women's sexuality and the economic position of the community.

If women are viewed as 'too powerful', it is relevant to ask what exactly was their power going to destroy? Was the threat a purely abstract notion, or was there something concrete and material that their power endangered? The key to this question lies in the system of caste. There are two systems for understanding caste: 'varna', the national system, and 'jati', the local system. We will concentrate on the national system, since although it is too crude to clarify the detailed operation of caste at local level, it does have sufficient generality to be useful for discussing caste nationally.[45]

Features of the Caste System

Caste divides the population into four major groups: the brahmin (priestly caste) at the top, followed by the kshatriya (warrior caste), then the vaishya (commoners, usually known as trading and artisan castes), and at the bottom the sudra (agricultural labourers) some of whom are beyond the pale of caste and are known as untouchables. The sudra is not allowed to take the caste initiation ceremony, at which male members of the other three castes receive the sacred thread and are 'reborn' into the caste (and therefore known as 'twice-born' castes). Within the four major groups there are thousands of sub-castes, which vary regionally.

Caste is both a structural system and a cultural one. The structure consists of a hierarchy of in-marrying groups, organised into hereditary occupations.[46] 'In-marrying' means that they will in general not marry outside their own caste or sub-caste. There are exceptions, notably of women marrying 'up' to men of a higher caste. The hereditary division of labour is also not rigid: a person from a weaving caste does not have to be a weaver, but a weaver could not be a brahmin priest, nor is a brahmin agricultural labourer likely.

The cultural system comprises belief in karma (that the circumstances of birth depend on previous actions), commitment to caste occupation and lifestyle, belief in the hereditary transmission of psychological traits associated with occupation, tolerance of distinct lifestyles for other castes, and belief in a hierarchy of values along a scale of purity and pollution.[47] In the scale of purity and pollution, brahmins are generally, but not always, the purest and sudras the most polluted. Brahmins are not 'naturally' pure; they can become polluted and in extreme cases lose caste, if they behave in impure ways or fail to perform important rituals. This ritual purity is in the nature of a religious status, but it usually coincides with economic wealth and social esteem.[48] Three of the major signs of purity are vegetarianism, teetotalism and tight constraints on women,[49] indicating that a significant degree of ritual purity comes through domestic activities.

The caste system has survived for 2,000 years, though not without modification.[50] As we shall see, the caste system was subject to many challenges over the years both to the position of the dominant castes and to the structure itself, but although the challengers established oppositional movements and changes in relative ranks, they did not succeed in eradicating the hierarchy as a whole. The system's resistance to revolt is thought to lie traditionally in the unity of manufacture and agriculture. The craft workers in the village manufactured all the tools needed by the peasants in exchange for a share in the peasants' produce, so that the community was entirely self-sufficient, but the individual never became independent of the community.[51] The cultural autonomy of the system meant that the upper castes never tried to impose their strict rules of conduct on the lower castes; in fact they forbade the lower castes from following the upper caste lifestyle, and used the differences to distinguish the lower orders from themselves.[52] This cultural autonomy was important because it enabled alternative cultures to flourish, including, as we

saw earlier, a distinctive matriarchal culture in the face of a predominantly patriarchal structure.

The Impact of Caste on Women

Increased control over women is one of the factors that a caste must observe along with vegetarianism and teetotalism before it can claim to be ritually pure. Specifically, this control involves two major aspects. One is women's disinheritance from immovable property in the form of land, and their exclusion from the productive economy, involving removal from public life to the domestic sphere of the home in the form of seclusion or purdah. The second is the far greater control exercised by men over women's sexuality, through arranged marriage, child marriage, the prohibition of divorce, and strict monogamy for women, leading to sati and a ban on widow remarriage, including infant or child widows. These strictures were enforced most severely by the higher castes, particularly the brahmins, but some of the lower castes also adopted them. A lower caste that had improved its economic position could attempt to move up the hierarchy over a number of generations, but economic power alone was not sufficient. The caste had also to adopt the cultural attributes of ritual purity, which meant constraining women's freedom.[53] This pattern of social mobility accompanied by increased control over women is not restricted to Hindus. Amongst Muslims, the Ashrafs are the former ruling groups, whilst the non-Ashrafs are the lower-caste converts from Hinduism. The control over Ashraf women is severe, and similar controls are imposed by non-Ashraf men when they improve their economic position.[54]

We want to show that the increased constraints on women are an essential part of a rise in caste hierarchy, by looking at the ideological and material basis for it. Several writers on caste have observed the relationship, but being normally more concerned with caste than with the position of women, they have failed to note the significance of the relationship for an analysis of women's subordination. For example, Hutton states:

> There are also drawbacks to the caste system in India which arise not so much because of the nature of the system as *incidentally* to its development. One of these is the hardship entailed to generations of women in all those castes that aim at raising their position in the social scale. Any caste or sub-caste that wishes to rise . . . finds it *essential* to conform to . . . the marriage of girls before they reach the age of puberty, and [to] the forbidding their remarriage even if widowed in infancy.[55]

The two words 'incidental' and 'essential' reveal a remarkable inconsistency in this passage. Hutton suggests that the hardship to women entailed in raising the caste's position is nothing to do with the nature of the system. And yet he is forced to admit that the hardship is essential to higher status. How can it be 'essential', and at the same time not 'in the nature' of the caste hierarchy? What

Hutton glosses over is the essential gender division which allows the men to benefit from higher caste status at the expense of the women, for the hardship is not experienced by all the members of the caste. The women alone are subject to it, whilst the men gain privileges both in relation to the men of the lower castes and the women of their own caste.

Amongst writers who have noted the relationship between caste and gender division is Srinivas, but he treats it descriptively rather than analytically. Whilst documenting the increasing constraints imposed on women as castes attempt to raise their position, he discusses it only as an index of 'Sanskritization', a term describing cultural social mobility. For instance:

> the institutions of the 'low' castes are more liberal in the spheres of marriage and sex than those of the Brahmins. Post-puberty marriages do occur among them, widows do not have to shave their heads, and divorce and widow marriage are both permitted and practised . . . But as a caste rises in the hierarchy and its ways become more sanskritized, it adopts the sex and marriage code of the Brahmins. Sanskritization results in harshness towards women.[56]

Srinivas does not use this relationship to reach an understanding of women's subordination, nor does he provide any analytical framework which could help to explain why caste and gender might be related in this way. It appears in his accounts to be a cultural accident.

More significantly, Nur Yalman has drawn attention to the essential nature of the relationship between gender and caste, although his discussion is specifically concerned with rituals to ensure women's purity rather than the actual constraints which limit their freedom. He links the sexual purity of women with the purity of the caste, suggesting that female sexuality presents a threat because of the danger of her introducing impure or low caste blood into the lineage.

> It is through women (and not men) that the 'purity' of the caste-community is ensured and preserved . . . [The] danger of low quality blood entering their caste . . . only exists with women. The male seed they receive should be the best available . . . The 'dangers' here are . . . the low-caste men.[57]

But his analysis does not help us to understand (nor was it his intention) why some women's lives were so much more restricted than others, regardless of the religious rituals around their sexuality, for amongst the matrilineal Nayars the rituals were purely symbolic,[58] limiting their sexuality relatively little in practice.

Veena Das takes Yalman's analysis a stage further, adding to the notion of purity the question of access:

> Women were literally seen as points of entrance, as 'gateways' to the caste system. If men of ritually low status were to get sexual access to women of higher status, then not only the purity of the women but that of the entire group would be endangered. Since the main threat to the purity of the group came from female sexuality, it becomes vital to guard it.[59]

Her suggestion is that women are so strenuously guarded by the higher castes

because sexual contact with lower caste men would not only pollute the purity of the caste, but also allow the lower castes access to it, undermining its social exclusiveness as well as its biological purity. This is important, but we need to go further, to see whether this cultural explanation has any material basis. The notion of the gateways to the higher castes being guarded against the dangers posed by female sexuality is much the same as the idea we encountered earlier about women's sexual power being potentially destructive to men. We need to know what it is that could be destroyed by lower-caste access if female sexuality were insufficiently guarded. We want to look at this by tracing the impact of the early patriarchal immigrants, as expressed in brahmin writings, on the existing culture of the common people, as depicted in Chapter 7, and examining how this process of struggle and accommodation affected women.

The Aryan Impact on Women

Our knowledge of this period comes from the Vedas, the Aryan religious books which constitute the earliest written history of the region. They were written mostly by brahmin males, so it is not clear how far their ideal view of women was actually practised, and there are contradictions even within the theory. Nevertheless, this was regarded by some of the 19th Century reformers and the revivalists of the 20th Century women's movement as the 'Golden Age', to which they looked back with nostalgia as a time of liberality for women. Yet compared with the value accorded to women in the matriarchal culture, it was far from ideal.

The Aryans held a radically different view of women from that prevailing within the indigenous culture. They brought with them a pantheon of predominantly male gods, the patriarchal joint family, and a three-class social structure, divided into kshatriyas (warriors and aristocracy), brahmins (priests) and vaishyas (commoners).[60] At first there was no caste consciousness, no hereditary occupations and no rules about marriage within the class. The development of this form of social organisation into a caste structure was a slow process which only began when the Aryans, having established dominance over the native population around 1500 B.C., began to class the indigenous people and those of mixed descent as outsiders, relegating them to a fourth category of sudras (servants) and excluding them from the Vedic religion.[61]

At this time the king was the supreme political force and the kshatriyas held the highest rank, but the brahmins began to stake their claim as the primary caste by claiming that only they could bestow divinity on the king. Slowly the brahmins established an alliance with the kings to maintain the position of both groups at the top of the hierarchy. Caste became hereditary, rules of in-marriage were established, and it became impossible for individuals to rise in the hierarchy except as members of entire sub-castes. These new strictures were laid down by the brahmin law-givers, and although they were portrayed as rigid rules, there was in fact a great deal of flexibility within the system.[62]

Within the patriarchal joint family, women were considered as part of the males' property in the same way as a field belonged to the men of the family. The analogy of the field and the seed was used to describe the right of the men to the use of women and to the women's issue.[63] Only sons inherited immovable property, the daughters taking with them a dowry in the form of goods to their marital family. These economic facts of patrilineal inheritance ensured that sons were valued and daughters were not, amongst propertied families in particular. Women could not sacrifice to the gods, because their presence was considered polluting, so a man had to have male children to perform the sacrifices which would allow his soul to rest after death.[64] However, women in propertied families had access to learning and could become scholars, poets and teachers. Women in commercial circles took an active part in business transactions, and in the lower strata they worked in agriculture, military manufacturing, weaving, dyeing, embroidery and basket-making, amongst other occupations.[65] Women also took part in the administration of the country, for the marriage hymn expresses the hope that the bride will be able to speak with composure and success in the democratic assemblies until her old age.[66]

Marriage was not compulsory for women, and young men and women could mix together socially.[67] Later, when caste rules on marriage became more important for the higher castes, the woman could choose her husband from a group of suitable men.[68] Widows could remarry and monogamy seems to have been the norm, but polygyny and polyandry were not unknown.[69] However, women were also classed with dwarfs, humpbacks, lean, lame and blind men, idiots and eunuchs, as unfit to attend the king's court.[70] That women's position was better than in later periods was true, but compared with the value given to women by the matriarchal culture, it represented a sharp decline, from woman as life-giver and equal sharer in property and produce, to woman as impure and herself the property of men.

Challenge and Response

Caste supremacy, however, with its emphasis on a social elite and the superiority of the male, did not go unchallenged either by women or the lower castes. The resistance arose at various times over the centuries, usually corresponding with some change in the economic order. The Muslim invasions later posed a further challenge to the caste hierarchy from outside the society. The high-caste response was to tighten up on caste divisions by distinguishing themselves more clearly from other castes, and to compromise by incorporating some aspects of the opponents' culture into their own.

The first major change occurred around the last few centuries B.C., when trade with other countries began to expand, currency was introduced, and large urban centres developed. The expansion in trade opened up opportunities to all the castes, and some members of the lower castes were able to raise their economic position. A large number of atheistical sects developed at this time, including Buddhism and Jainism, which appealed to the lower-caste members

of this rising class, and Ghurye has suggested that the two religions represented the assertion of kshatriya superiority over the religious authority of the brahmins.[71] For vaishyas, whose economic position did not now accord with their religious position, and for sudras, whose ritual status did not permit them caste initiation or religious knowledge, the new atheistic religions represented a humanitarian, anti-caste, anti-brahmin protest. Another radical difference was that women were allowed to join, to participate in learning and devotions, and to become nuns.[72]

The response of the brahmins to kshatriya supremacy, to vaishya and sudra protest, and to the atheistic challenge to the Vedic religion, was to defend their position by tightening up the rules on social relationships. This affected both women and the lower castes. The relationships between the four castes and their legitimate social activities were rigidly defined and strict controls over the lives of women were laid down. The brahmins at this time began to emphasise their superiority over every other group in society.[73]

The increasingly strict sex and caste orthodoxy for brahmins was imparted through the new law books known as the Smritis. These advocated for the first time a strict monogamy for women, reflected in brahmin opposition to polyandry and widow remarriage. They also advocated marriage before puberty for girls, and backed it up with the social sanction that a brahmin man who married a girl over 10 years old would be treated as the husband of a sudra woman, and not allowed to eat with other brahmins.[74] Significantly, these strictures were not adopted by the kshatriyas, the lower castes or the matrilineal groups.[75] At this time too, brahmin men increased the exclusiveness of education, by limiting it mainly to themselves. Kshatriya and vaishya men were allowed only restricted access, and sudras and women virtually none.[76] Women were no longer allowed to attend the democratic assemblies, and high-caste women were withdrawn from their previous occupations in education and the arts.[77]

The new orthodoxy finds many expressions in the Smritis. Although from the earliest Aryan times a woman's purpose had been defined only as producing sons for her husband, the Smritis introduced an additional element of total dependence, as in the famous statement from the Code of Manu: 'A woman should never be independent. Her father has authority over her in childhood, her husband in youth, and her son in old age.'[78] The reason for this was her evil nature: 'Manu (the creator) allotted to women a love of bed, seat and ornament, impure desires, wrath, dishonesty, malice and bad conduct.'[79] More specifically: 'Women remain chaste only as long as they are not in a deserted place and do not get the chance to be acquainted with any man. That is why it is necessary that respectable women should always be guarded by friends.'[80] And: 'Women, even when they are of good family, beautiful and married, do not hesitate to transgress morals . . . At the first opportunity they leave wealthy and good-looking husbands to share an adulterous bed with other men.'[81]

When caste distinction became more pronounced, women's unbridled lust for men had to be firmly controlled. According to Manu, a man could only achieve merit by protecting the purity of his wife and, through her, of his sons.[82]

Since she could not be expected to control herself, he had to do it for her. The importance of sexual control over women to the maintenance of caste distinction can be seen in the low status classifications given to the children of various mixed caste unions, of which the Chandala was the lowest, born of a sudra man and a brahmin woman.[83]

The brahminical ideal of the pativrata woman (husband worshipper) was emphasised at this time: a brahmin woman's first duty was to worship her husband as god, no matter how cruel, unfaithful or immoral he might be. The most famous example of the ideal is Sita of the Ramayana Epic, who is abducted by a demon king but, even though she has resisted seduction, has to prove her innocence through ordeal by fire after her rescue and subsequent rejection by her husband Rama. In the Mahabharata Epic, Gandhari blindfolded herself for life when she discovered at her wedding that her husband was blind.[84]

The next major decline in women's position came in the 'classical age' around 500 A.D. The word 'classical' in fact refers to the prosperity of upper-caste men in the Northern regions only. Amongst the upper castes, *women's* position deteriorated during this period. Child marriage was compulsory and widows were regarded as contemptible, and forbidden to remarry. The earliest evidence of widow-burning was in 510 A.D., and was demanded more and more by upper-caste men, especially kshatriyas, during the next few centuries. It was claimed that the act brought the woman the highest religious merit, hence the meaning of the word sati, 'a virtuous woman'. The only way a high-caste woman could be sure of avoiding such a fate was by becoming a Buddhist nun, a theatrical entertainer or a prostitute.[85]

The decline in women's position was directly connected with the brahmins finally establishing economic and social supremacy in Northern society,[86] for it was in this period that they consolidated their land holdings. The brahmins eventually won the contest for primacy over the kshatriyas and vaishyas of the mercantile communities by becoming landowners, thus providing the material basis for their caste supremacy and their power over women. The maintenance of land and other property within the joint family was the material basis of the patriarchal family structure and the in-marrying nature of the caste system, which was regulated by the religious laws.[87] The family structure was patrilineal, property passing down the male line, and patrilocal, the sons staying with the father. The daughters went to live with the husband's family on marriage. The property laws forbade the daughters from inheriting immovable property, since such property would have passed to their husbands' family at marriage. Instead, women were given a portion of movable property to take with them, known as dowry.

The transmission of property to the daughters through dowry had important implications for women, as is suggested by Jack Goody[88] more generally, and Prabhati Mukherjee more specifically in relation to India.[89] It meant that within the patriarchal family, significant portions of the property were removed from the patrilineal line of inheritance, and distributed to the daughters' marital families. This provided a substantial material reason for anxiety over the birth

of daughters. And if the daughters were allowed to marry freely, the accumulated property could not be retained within the group, but could soon be redistributed amongst families without property. To retain differentials in economic position required daughters to marry as closely as possible within the group, and this entailed both strict general rules of in-marriage for the upper castes, and control over the particular man that the woman married. The consequence was tight constraints on female sexuality and on any movements or activities which might interfere with such constraints. The more property a woman had, the more important it was to control her sexuality, since the distribution of her property coincided with her sexual attachment. So the rule of in-marriage and the control of female sexuality not only maintained the purity of caste, but also ensured that the property remained within the caste.

That women were regarded as men's property amongst the upper castes, and that control over women was important for the retention of property is suggested by the numerous references in the religious texts at this time to women and property together. For instance, it was said that 'A virtuous man never interferes with the wives or properties of others, the source of all trouble.'[90] The institutions of private property and the patriarchal family were regarded as the main reason for the origin of state authority: 'In a kingless state, private property cannot be retained and a wife is not under control.'[91]

In this time too, women and sudras were regarded as equally contemptible. The Code of Manu distinguished between the twice-born castes on the one hand, and women and sudras on the other.[92] Women and sudras were regarded as life-long slaves from birth to death, with slavery inborn in them;[93] the same value was attached to the life of a woman and a sudra, for anyone who killed an artisan, a mechanic, a sudra or a woman had to perform two penances and give 11 bulls to atone for it.[94]

Here we can see two links between gender and caste. Women's position deteriorated with the economic supremacy of the caste. And this deterioration had a material basis in the maintenance of property within the caste.

The next major challenge to brahmin supremacy came with the Muslim invasions, of which the most significant were the arrival of the Arabs and the Turks in the 11th and 12th Centuries, and the Mughals in the 16th Century. The Muslims did not destroy the caste structure, but used it to establish an administrative system designed to collect revenue and maintain law and order.[95] The invasions led to another tightening up by the brahmins on women's position. Around 1000 A.D. the rule of no remarriage for widows amongst the top castes was extended even to child widows, of whom there were large numbers because of the low age of marriage.[96] The incidence of sati increased, particularly amongst the warring regions of the North, the women often being forced onto the pyre by their husband's relatives and sometimes by their own sons.[97] And the seclusion of women, purdah, became more common amongst the higher castes.[98] Baig suggests that conquest made the people defensive, inducing particularly the upper castes to retreat into more rigid orthodoxy and providing a solid reason for protecting women from the foreign invader.[99]

The coming of the Mughals in the 16th Century consolidated Islamic power in India. They established an empire which lasted until the arrival of the Europeans in the 18th Century. During this time women's lowly position amongst the upper castes of both Muslim and Hindu communities was reinforced. Purdah, child marriage, widow discrimination and the pativrata (husband worshipping) ideal were the norm amongst high-caste Hindu women, and were regarded as symbols of prestige. Purdah in particular spread under Mughal rule, especially in areas where Muslim-Hindu conflict was strongest, based on the fear of abduction and rape from the opposing side.[100]

Muslim women, however, had a better legal status than Hindu women, even though their rights often did not work to their advantage. For example, Muslim women were allowed to study the religious books, divorce and remarriage were possible (although divorce was at the discretion of the husband) and they had rights of inheritance. Polygyny was allowed in both religions, but Islam restricted the number of wives to four, whereas Hindu law specified no limits.[101] Clearly these could be considered improvements only within a patriarchal context, but the original egalitarianism of Islam did bring a small measure of protection to Muslim women. For example, the Sharia defines suicide as illegal, and becoming sati comprised suicide, but even though the matter was discussed, no restraint on its practice by Hindus was attempted.[102] The Islamic law against suicide did, however, prevent sati being adopted by Muslims.

Resistance and Integration

So far we have looked only at the way the upper castes tightened the caste and gender divisions in response to challenges to their supremacy from below and outside. But the upper castes also responded to the challenge by loosening some of the cultural divisions and accepting certain 'non-brahmin' traditions into the orthodox religion, including aspects of the matriarchal culture. This was not as contradictory as it appears, because the notion of woman as powerful was incorporated to legitimise strong controls. The particular constraints imposed on upper-caste women had rarely applied to women of the lower castes, although they experienced their own hardships. But lower-caste women were not secluded, since their labour was needed in the fields for survival. There was no sati and widows could remarry. Many lower-caste communities allowed divorce, and polygyny, though permitted, could not be practised by those who could not afford to support a large family.[103] Amongst these communities, women's involvement in wider areas than those specified by the brahmins was a fact of life, and the demand for women's inclusion in religious and social activities became a feature of all the socio-religious reform movements in India.[104]

At the same time as brahminism was tightening its hold on its own women and the lower castes, two new movements began which embodied matriarchal and populist resistance to patriarchal brahmin elitism. One was a resurgence of mother goddess cults and fertility worship, of which the most famous was Tantra

in the 5th Century A.D. and which had its centre in the non-Aryan regions of the North-east. Tantra was open to all castes and to women. It was explicitly against both the orthodox ritual of the Hindu religion and the patriarchal caste structure of the brahmins. It worshipped the mother goddess, since life was created in the womb, and had its roots in the pre-Aryan culture. The cult influenced Buddhism to form a new school, adding female saviours, Taras, to the existing male ones. The worship of Taras still exists in Nepal and Tibet. And it influenced Hinduism, which developed the Shakti cult, representing the female power principle. Shakti believes that the female is the source of all energy and action, and only she can activate the male god.[105] Shakti is the active, practical, violent goddess, compared with the passive, contemplative, non-violent god.[106] The cults also influenced artistic expression in the form of erotic poetry, such as the story of Krishna and Radha,[107] and in the form of erotic temple sculpture such as that found at Khajuraho.[108]

The other movement was the Bhakti cult in the 6th and 7th Centuries A.D., which was strongest in the non-Aryan South, but later spread all over India. Bhakti means devotion, and was based on the belief that a direct personal relationship with god was possible, without the mediation of a brahmin expert or the performance of esoteric ritual.[109] This cult too opened religion to ordinary people, and was anti-caste and anti-establishment, representing a resistance to brahmin culture with its emphasis on caste and gender superiority. Their saints and followers included women and men, and were predominantly of the lower castes.[110] But significantly their number included women from the higher castes, particularly widows, otherwise condemned to a life of penance.[111]

So despite brahmin supremacy, the matriarchal and populist cultures continued to make their opposition felt. They found a common interest in their exclusion from the brahmin religion and the ownership of land and in the restrictions on their activities, which formed the basis for an alliance of women and the lower castes against patriarchal caste elitism. Here we can see another link between gender and caste, for the partnership against caste supremacy and male dominance was to be repeated many times over the centuries.

We have already seen that the brahmin religion, under the pressure of economic change and the threat of opposition movements, maintained supremacy by becoming more orthodox, tightening the divisions between castes and increasing the sexual controls over women of their own caste. But they also adopted a more liberal approach to other cultural groups and incorporated their different interests into the brahmin religion. They became at the same time more orthodox themselves and more tolerant of others. This was possible for two reasons. First, the high degree of integration between the religious ideology and the rural economy prevented the revolts from destroying the economic basis of the caste system in the villages.[112] And second, the tradition of cultural autonomy not only allowed other cultures to flourish, but also enabled the brahmins to use the cultural differences to accentuate caste divisions.

The brahmin priests made two important concessions. They conceded that women and the lower castes could have a direct relationship with god based on personal devotion, without the intervention of a priest, even though women,

vaishyas and sudras were still classed together as lower forms of life. This can be seen in the Bhagavad-Gita:

> For whosoever makes me his haven,
> Base-born though he may be,
> Yes, women too, and artisans, even serfs,
> Theirs it is to tread the highest Way.[113]

In making this concession the brahmins maintained control by modifying some of the popular secular writings to give them religious authority, propounding the doctrines of karma (that the circumstances of birth were determined by previous actions) and dharma (the sacred law which regulated the morality of the actions). And second, they dropped some of their own gods, incorporating the matriarchal fertility cults into the worship of Shiva and providing 'brahminical' husbands for the 'non-brahminical' mother goddesses.[114] Since the mother goddess could not be suppressed, she was finally incorporated into brahmin ritual,[115] but this integration could not occur without contradiction. It is intriguing to consider the brahmin priests, holding Manu's opinion of women, yet allowing the introduction of matriarchal goddesses into the pantheon. The mother goddess was associated with magic, sexual orgies and blood sacrifice, representing the miracle of birth, the creation of life through sexuality, and menstruation as a symbol of fertility. To the brahmin, childbirth, sexuality and menstruation were all sources of pollution, yet this polluting matriarchal culture was absorbed into the pure patriarchal religious ritual in the form of mother worship.[116] The success of such an integration was a tribute both to the persistence of the matriarchal culture and to the adaptability of the brahmin patriarchy.

Having acknowledged women's power, the contradiction was resolved culturally, as we have seen, by defining it as dangerous unless controlled by men. But the underlying material basis of this ideological resolution, as we have also seen, was the preservation of wealth within the caste, for which purpose the women had to be sexually controlled by men.

We can now answer the question of what precisely women's power endangered. Lakshmi is benevolent because her controlled sexuality bestows legitimate heirs for the maintenance of caste wealth and retains family property within the caste. Kali is malevolent because her uncontrolled passion is liable to introduce impure blood into the caste and to dissipate caste wealth, making a mockery of patrilineal inheritance and the accumulation of property, and thereby destroying the caste system itself. Unconstrained, mortal women are as much to be feared as potential destroyers and robbers of the patriarchal heritage — cultural and material — as are members of the lower orders. As the scriptures say:

> Women constantly suck the blood of men like leeches . . . That very woman whom man considers his beloved robs him of his manhood through sexual indulgence, and of his mind, his wealth and all his possessions. Hence is there any greater robber than woman?[117]

The ideas about women's ritual impurity which arose, along with the physical constraints on their activities, stressed that women's menstrual, reproductive and sexual functions made them inherently impure. These ideas justified her low ritual status within the caste and her inability to control her own sexuality in the interests of the caste. Her sexual insatiability was at the root of all problems, and the lower castes' failure to control their women's sexuality was partly what made them impure. This idea reinforced the caste divisions, for if the lower castes behaved like the brahmins, the distinctions would dissolve. So the gender division reinforced the caste division, and the gender ideology legitimated not only the structure of patriarchy but also the organisation of caste.

9. The New Middle Class

> The attempt on the part of some women to cast off their shy temperament and adopt certain useful professions like nursing, teaching and other public services, ushered in an era of socio-economic freedom for the womenfolk . . . The changing pattern of socio-economic life ultimately led to a remarkable awakening in women in general.
> Pratima Asthana, *Women's Movement in India*[117]

Caste is defined primarily by social honour, attained through personal lifestyle, in which the domestic arena is crucial. The ownership of property is usually a precondition for social honour, in that a certain economic minimum is needed to maintain the lifestyle.[118] For example, the caste has to be able to afford to maintain the women if they are withdrawn from labouring in the fields. Social mobility in the caste structure is closed for individuals both in principle and practice, but in practice whole communities can change in rank over a long period of time.[119]

Class, however, is defined primarily by the ownership of property (land under feudalism, capital under capitalism), although social honour is usually associated with property ownership. Class within a capitalist structure is defined by the wage relation, that is, whether a person earns wages or pays them, for which the occupational arena is crucial. Social mobility in the class structure is open to individuals in principle but limited in practice.[120]

Traditionally, social, economic and political power largely coincided in the caste structure, but the development of the class system introduced certain changes. The formation of social classes in India was largely the effect of the new capitalist economic structure, resulting from the British conquest and the integration of India into the British and world economy.[121] The British entered India at a time when the power of the state was weakened because of the decline of the Mughal empire. Some Indian merchants had accumulated capital from trade and begun to invest it in urban industrial enterprises, but the strength of the caste system in the villages made it difficult for the merchants to develop into a social class which could successfully challenge the power of the state, as had happened in England.[122]

The British stepped into the vacuum, and took over the administrative system designed by the Mughals for the control of the population and the collection of revenue. They destroyed Indian industry and undermined the rising merchant class. They commercialised Indian agriculture so that it produced less food for immediate consumption and more raw materials for British industry. And they changed the nature of property from collective to individual ownership.[123]

As we saw in Part I, the changes forced large numbers of people back to the land which was unable to support them. Many of the peasants found themselves in debt because the British had also changed the tax into a rent so that the size of the payment no longer varied with the harvest, but was a fixed sum which increased periodically. But the methods of agriculture did not improve since production was still precapitalist and without the benefit of machinery, so the peasants had to pay more and more rent on the basis of the same amount of production. This development created a class of money-lenders from amongst the zamindars (landlords) and the better-off peasants. The change in land ownership meant that the zamindars were able to turn the peasants off the land for non-payment of rent, creating a class of landless labourers.[124] In England the landless labourers provided the wage labour for the new urban-based capitalist industries, but in India the British inhibition of indigenous capitalism created a large surplus of pauperised 'free' labour. This was the origin of India's chronic poverty, which persists and increases to this day.

Creation of the Middle Class

The middle class arose from the British need for English-educated Indians to administer the country under British superiors. The British set up education in India for this purpose, and explicitly encouraged the men of the upper castes to avail themselves of the new opportunities. The British created the new middle class out of the existing public officials from the Mughal times, out of the money-lenders, and out of the literary class of educated brahmins.[125] The literary groups were almost exclusively brahmins, the money-lenders were predominantly brahmins and kshatriyas, and the industrialists were mainly vaishyas, since they were traders by caste occupation, although some also came from sudra, kshatriya and brahmin castes.

As a result the people who took over the adminstration of the state under the British came predominantly from those groups who had been powerful in the rural areas. The administration also needed lawyers, teachers and accountants, and soon these groups wanted their own professional services such as doctors. So the middle class in India came to consist primarily of the educated professional groups, with the merchants and the industrialists in the minority.[126] The position of the professionals in the class structure is ambiguous because, although they are wage-earners not employers, the discrepancy between their income and that of the manual labourers is sufficient to place them economically and socially closer to the larger-scale employers. The professional groups therefore constitute part of the middle class, and in India their position is particularly important since they outnumber the industrialist groups.[127]

The discontent that resulted in the formation of the Indian National Congress

by the middle class (which led but did not initiate the mass movement against British imperialism)[128] grew from the discrepancy between the supply of and demand for government jobs, and from the barriers to further progress placed by the British on the professionals and the industrialists. More people had acquired an English education than the British needed, and the pressure on agriculture and the obstruction of industry left this newly-educated middle class with few opportunities apart from the British administrative posts, over which there was increasing competition, and increasing dissatisfaction for those who were unsuccessful. Public servants could not rise to the top because the British held all the senior posts, professionals who had arisen around the administration were similarly blocked at the top levels,[129] and industrialists were inhibited in their accumulation of capital by British domination of the market and control over private investment and public finance.[130]

It was the new middle class who rose to power and took over the political and administrative machinery of the state after Independence. The circumstances of its development meant that although there was some breakdown of the caste structure, the new power elite still consisted of the higher castes.[131] A sample survey conducted in one of the states 20 years after Independence found that the professions were still dominated by the upper castes. Amongst Hindus in the Indian Administrative Service, 65 per cent were brahmins, 30 per cent were kshatriyas, and 4 per cent were vaishyas. There were no sudras.[132] There is evidence from Jamshedpur that caste is no barrier to factory employment,[133] but this is qualified by evidence from five factories in Poona which showed that although sudras are not excluded, they are given low-level jobs whilst brahmins are given high-level ones.[134] These findings on the relationship between caste and class in industrial and professional occupations suggest that the capitalist class structure is building upon the existing divisions in society, and is breaking them down to only a limited extent.

The Impact on Women

The rise of the middle class had a contradictory effect on the position of women. Similar strictures on women's activities to those prevailing amongst the rural upper castes are also imposed on women of the urban middle class, and similar discrepancies between the strictures imposed on upper- and lower-caste women in the villages seem to occur between middle- and working-class women in the towns. For example, Kamla Bhasin argues that in the middle class: 'There has been some improvement because of various social and economic factors, but even today the majority of women live in perpetual subservience, self-denial and self-sacrifice.'[135]

In the city of Chandigarh, despite the fact that the number of women taking outside employment increases towards the top of the occupational and educational hierarchy, the vast majority of educated middle-class women are still confined to domestic activities. By far the largest proportion of employed women occurs in the lowest occupational class.[136] Studies such as these suggest

that the class structure, rather than destroying the gender divisons within the caste system, may be building upon them, whilst changing their form.

The other effect was that new economic opportunities became available for some women of the middle class. The British had not allowed women to enter the new administrative occupations, but women did begin to move into other professions serving the Indian community, especially in medicine and teaching. This happened partly in response to demands for education and health care amongst female relatives of middle-class men, and partly because the maintenance of sex segregation and female seclusion demanded that these services be provided by other women.[137] Independence widened opportunities for middle-class women still further, especially in government service and public sector industry, thanks to the constitutional guarantee against discrimination in employment and offices, and expanded opportunities in the existing women's areas of education and health. So the rise of the middle class, combined with the continued segregation of the sexes, provided opportunities for women from the more liberal families of the class to enter professional occupations.

The result was that women from the middle class began to see new possibilities for change in women's position, since some of them now had access to an independent source of income and could survive outside the patriarchal caste structure. This posed problems for the traditional organisation of society, for women who were economically independent could less easily be controlled. Because of their crucial position in the organisation and maintenance of the social hierarchy, women had the potential to undermine the entire social structure. It was no accident that the women's organisations developed out of the middle class, nor was it surprising that the changes they demanded met with resistance, since many of the demands fundamentally challenged the organisation of the social hierarchy, particularly those concerning personal law.

We can now see that the resistance of women in India did not arise primarily from the liberalising influence of British imperialism (since the effect of imperialism was contradictory), nor from the direct influence of the British women's movement (although that was one intervention amongst many), but from the powerful influence of the women's own cultural heritage, and from their particular position in the social class structure which provided economic opportunities and potential independence from the existing relations of gender and social hierarchy.

10. The Problems Remain, So Does the Struggle

> Do we really believe that when all the movements subsided, all the feminists who were involved with them vanished? . . . Maybe the difficulty lies with our definition of what constitutes participation . . . The example of India raises a lot of questions about . . . our categories and definitions.
> Elizabeth Sarah, *Towards a Reassessment of Feminist History*[138]

At Independence in 1947 the women's movement succeeded in bringing women's legal position to a level in advance of many of the rich countries of the West.[139] The Constitution conferred equal rights and status on all citizens, forbidding any discrimination on grounds of caste, creed, religion or sex. The state was required to secure to all citizens — men and women — equality, the right to education and to adequate means of livelihood.[140] Women acquired full political rights including the right to vote, to contest elections and to enter the administrative services.[141] Labour legislation to protect the interests of women workers was included in the Factories Act, the Plantation Labour Act and the Mines Act, passed between 1948 and 1952, which regulate working conditions where 50 or more women are employed, providing for equal pay for equal work, maternity benefits, creches and nursing time, and specifying a maximum load and maximum hours for women. It is illegal to employ women on night work and on underground and dangerous operations, to restrict the recruitment of women, and to terminate employment on the grounds of pregnancy.[142] Under the Hindu Code, many of the disabilities suffered by Hindu women were removed by the five Acts on personal law. Monogamy was established as a rule for both men and women, divorce became permissible under certain conditions, the minimum age of marriage was fixed at 18 for women and 21 for men, and women were given the right to inherit and adopt.[143] Later laws included the Prohibition of Dowry, the Suppression of Immoral Traffic,[144] and a liberal abortion law providing social reasons as grounds for abortion.[145]

Sushila Mehta describes these laws as 'paper tigers'. They are enforced neither by the machinery of the state nor by women themselves, and equality remains a distant dream for most women even after 30 years of Independence.[146] For example, in spite of the law on equal pay, women in lower paid jobs generally receive between 10 per cent and 60 per cent of men's wages, depending on the industry.[147] The protective legislation has been used to restrict

recruitment, which is itself illegal. For example, the National Commission on Labour concluded that the ban on night work, underground and dangerous operations had adversely affected women's employment.[148] Employers often pay women daily wages in order to avoid insurance benefits, and may restrict the number of women workers to below 50, to avoid the obligation to provide equal pay, maternity leave or a creche.[149] Dowry, far from being eradicated, has grown to greater proportions — a doctor can now demand 3 lakh rupees or £20,000 in dowry — and dowry deaths have replaced sati as the married woman's fear in the urban middle class.[150]

The contradiction for women today is that despite the liberality of the laws, the inequalities remain. The implementation of the laws to secure equality continues to be hindered by patriarchal family structures and by barriers of caste and class. The position is made worse by the West's continued drain on the Indian economy, which is now preventing all but the most economically privileged middle-class women from earning an independent living.[151] Mehta draws attention to these persistent problems when she suggests that although male-dominated society has paid lip service to the new laws, most men have not accepted their practical implications. The laws also require honest implementation by the male-dominated administrative machinery. And a majority of women are both illiterate and poor, unaware of their legal rights, and without the resources to fight for them through the courts.[152]

What makes male supremacy particularly resistant to legislative change is the fact that women's subordination remains embodied in the personal relations of the patriarchal family, and patriarchal relations are part and parcel of the social structure. The former makes legal changes difficult to enforce, the latter means that many of the laws which are not directed at changing the social structure itself are attacking the symptoms rather than the causes of women's inequality.

The Movement Disappears, the Ideas Remain

The struggle for women's equality goes on. In 1977, when we did our study, the women's movement had no clear organisational focus such as the Independence movement had provided. But there were women whose ideas had their history in that movement. The women who speak in the following pages are from that privileged group of the educated middle class who work in professional occupations. They are from two of the traditional professions for women, education and medicine, and from two of the more recent areas, government service and public and private sector industry. They have similar social origins to the activists in the earlier women's movement, and they are the bearers and beneficiaries of the movement's heritage. Our study came just before the rise of the 'second wave' movement in Delhi, and 30 years after the demise of the 'first wave'. Throughout that time women had retained both the ideas of the movement and its struggles on an individual or collective basis.

Some writers have begun to question the assumption that when a movement is no longer active, the ideas on which it was built fall into disuse, and the people who acted collectively disappear.[153] In India the ideas of sexual equality and the challenge to male domination which were raised by the women's movement continued to inspire women activists. For example, Renuka Ray of the All India Women's Conference and Romola Sinha, both in their seventies, are still at work organising women into consumer action groups, and providing refuge for battered wives, prostitutes, women refugees and runaways.[154] Nor did the ideas evaporate as the women actively involved in the movement grew older, for they passed on their inspiration to the next generation. Reeta Rao, one of the women we talked to, was 19 at Independence. Her orthodox father had kept her at home, but she took comfort and inspiration from her aunt:

> My mother's elder sister was a great influence. I thought of her as my real mother . . . She stood by me through all my problems. My aunt had studied in purdah, married out of caste, worked with Gandhi, gone to jail, lived in an ashram. I wanted education desperately. My aunt had fought to learn herself. I took on my aunt's values, I knew I had to have education.

Promilla Khanna was only three in 1947, but the experience of Independence and Partition (when India and Pakistan were separated) changed her parents' lives, and their outlook. This they passed on to their children by bringing them up to continue the struggle against sexual inequality.

> My mother and father believed in equality but the social institutions gave pre-eminence to male children. My parents were trying to bring us up equally and I resented unequal treatment. I was always taught to question the social institutions, and I always rebelled against male-dominated institutions.

A significant number of women who spoke to us in 1977 expressed, without prompting, ideas which derived directly from the women's movement.[155] These women were evenly divided across age groups, and included women from all four areas of work (education, medicine, government service and industry). They were no more dormant or passive in recognising male domination and fighting for their rights in 1977, than they were in 1947. They know they are not treated as individual people but as sexual stereotypes. They experience their subordination at work and in the home. They are angry about it, and this anger is expressed in different ways. But none of these women accepts the inequality, and many of them are determined to change it.

In Part III we will examine how the gender division relates to the divisions of social hierarchy in terms of caste and class, by focusing on the change that occurs when women struggle to emerge from domestic seclusion to professional employment. In looking at the change, we will analyse the social processes by which the women's personal experiences can be seen to be not purely individual, but crucially related to the social structure.

160

Notes

1. Tara Ali Baig (1976) *India's Woman Power*. New Delhi: S. Chand, p.xiv.
2. See for example Merlin Stone (1976) *The Paradise Papers*. London: Virago.
3. Manjulika Dubey (1983), 'Interview with Chandralekha', *The Book Review* VII, 6, May-June, p.272. Chandralekha is a woman activitist, Bharata Natyam dancer, graphic artist and writer, who works in villages teaching low-cost communication and media techniques.
4. Fatima Mernissi (1975) *Beyond the Veil*. New York: Wiley.
5. Azizah Al-Hibri (1981) 'Capitalism is an Advanced Stage of Patriarchy: but Marxism is not Feminism', in Lydia Sargent (ed), *Women and Revolution: the Unhappy Marriage of Marxism and Feminism*. London: Pluto.
6. The definition of patriarchy is problematic. See Veronica Beechey (1979) 'On Patriarchy', *Feminist Review*, 3.
7. See Michelle Zimbalist Rosaldo and Louise Lamphere (1974) *Woman, Culture and Society*. Stanford, Calif.: Stanford University Press, Introduction.
8. Paula Webster (1975) 'Matriarchy: A Vision of Power', in Rayna Reiter (ed), *Towards an Anthropology of Women*. London: Monthly Review Press. We use 'matriarchal' as a cultural concept, and confine its use to an adjective describing a culture rather than a noun implying a structure.
9. See Part I, Chapter 3.
10. David Schneider (1962) 'The Distinctive Features of Matrilineal Descent Groups', in D. Schneider and K. Gough (eds), *Matrilineal Kinship*. Berkeley: University of California Press, pp.5-6.
11. Female literacy is 54.3 per cent in Kerala compared with 18.7 per cent in the whole of India. Tamil Nadu is the next highest state with female literacy of 26.9 per cent. Source: Ashish Bose (1975) 'A Demographic Profile of Indian Women', in Devaki Jain (ed), *Indian Women*. New Delhi: Government of India, p.163.
12. The sex ratio in Kerala is 1,016 females per 1,000 males, compared with 930 females per 1,000 males in all India. In all other states and union territories except Dadra and Nagar Haveli, males outnumber females, although females normally outnumber males in other countries. Source: Department of Social Welfare (1978) *Women in India: a Statistical Profile*. New Delhi: Government of India, p.6. For a discussion of the implications of the declining sex ratio, see: Kumudini Dandekar (1975) 'Why has the Proportion of Women in India's Population been Declining?', *Economic and Political Weekly* 18 Oct, pp.1663-7, and Asok Mitra (1979) *Implications of Declining Sex Ratio in India's Population*. Indian Council for Social Sciences Research: Programme of Women's Studies I. For sex ratio in selected countries, see Bose, 'Demographic Profile', p.145.
13. Mean age at marriage of women in Kerala is 20.88 years, compared with 17.23 in all India. Source: Department of Social Welfare, *Women in India*, p.59.
14. Department of Social Welfare (1974) *Towards Equality. Report of the Committee on the Status of Women in India*. New Delhi: Government of India, pp.54-6.
15. Stanley Wolpert (1977) *A New History of India*. New York: Oxford University Press, pp.14, 24, 27.
16. For example ibid., p.77, and Romila Thapar (1966) *A History of India*, vol.1. Harmondsworth: Penguin, p.103.

17. Wolpert, *New History of India*, p.77.
18. Kathleen Gough (1962) 'Nayar'; 'Tiyyar'; 'Mapilla', in Schneider and Gough, *Matrilineal Kinship*, chs.6-9. For ecology of Kerala, see pp.299-302.
19. J.H. Hutton (1963) *Caste in India*. Bombay: Oxford University Press, p.9.
20. Ibid., p.29.
21. Ibid., p.151.
22. Ibid., p.154.
23. Ibid., p.167.
24. Joan Bamberger (1974) 'The Myth of Matriarchy: Why Men Rule in Primitive Society', in Rosaldo and Lamphere, *Woman, Culture and Society*. Mandy Merck (1978), 'The City's Achievements: the Patriotic Amazonomachy and Ancient Athens', in Susan Lipshitz (ed), *Tearing the Veil*. London: Routledge & Kegan Paul.
25. Margaret Stacey and Marion Price (1980), 'Women and Power', *Feminist Review* 5, pp.35-6.
26. Baig, *India's Woman Power*, pp.4-5.
27. Thapar, *History of India*, p.43.
28. Hutton, *Caste in India*, p.152.
29. B.G. Gokhale (1959) *Ancient India*. Bombay: Asia Publishing House, p.18.
30. Ibid., p.18 and Hutton, *Caste in India*, p.224.
31. Ibid., p.225.
32. Ibid., p.152.
33. Maria Mies (1980) *Indian Women and Patriarchy*. New Delhi: Concept, p.40.
34. D.D. Kosambi (1965) *The Culture and Civilization of Ancient India in Historical Outline*. London: Routledge & Kegan Paul, p.47. Kosambi uses the word 'matriarchal' without indicating whether he means a structural or a cultural concept.
35. McKim Marriott (1955) 'Little Communities in an Indigenous Civilization', in McKim Marriott 'Village India: Studies in the Little Community', *The American Anthropologist* 57, pp.171-2. Quoted in Mies, *Indian Women and Patriarchy*, p.40. The 'Little Community' is equivalent to the 'non-brahmin tradition'.
36. Mies, *Indian Women and Patriarchy*, pp.39-41.
37. Lawrence Babb (1970) 'Marriage and Malevolence: the Uses of Sexual Opposition in a Hindu Pantheon', *Ethnology* IX, pp.137-49.
38. Hutton, *Caste in India*, pp.153-4.
39. B.K. Sarkar (1917) *Folk Element in Hindu Culture*, quoted in Hutton, ibid., p.154.
40. Kosambi, *Culture and Civilization*, p.170.
41. Ibid., p.116.
42. Babb, 'Marriage and Malevolence'.
43. Susan Wadley (1977) 'Women and the Hindu Tradition', in Doranne Jacobson and Susan Wadley, *Women in India: Two Perspectives*. New Delhi: Manohar.
44. Vina Mazumdar (1979) (ed) *Symbols of Power*. New Delhi: Allied Publishers, p.xvii.
45. See M.N. Srinivas (1962) *Caste in Modern India*. London: Asia Publishing House, ch.3.

46. Surajit Sinha (1967) 'Caste in India', in Anthony de Reuck and Julie Knight (eds), *Caste and Race*. London: Ciba Foundation, p.94.
47. Ibid., p.95.
48. Ibid., p.97.
49. Srinivas, *Caste in Modern India*, ch.2.
50. Thapar, *History of India*, p.48. See also Max Weber (1958) *The Religion of India*. New York: The Free Press.
51. Anupam Sen (1982) *The State, Industrialization and Class Formations in India*. London: Routledge & Kegan Paul, p.18.
52. N.K. Bose (1951) 'Caste in India', *Man in India* 31, pp.107-23. Quoted in Sinha, 'Caste in India', pp.96-7.
53. M.N. Srinivas (1977) 'The Changing Position of Indian Women', *Man* 12, pp.221-38.
54. Zarina Bhatty (1976) 'Status of Muslim Women and Social Change', in B.R. Nanda (ed), *Indian Women from Purdah to Modernity*. New Delhi: Vikas, p.110.
55. Hutton, *Caste in India*, p.129. Emphasis added.
56. Srinivas, *Caste in Modern India*, p.46.
57. Nur Yalman (1968) 'On the Purity of Women in the Castes of Ceylon and Malabar', *Journal of the Royal Anthropological Institute* 93, 1, pp.43-4.
58. Ibid., pp.45-6.
59. Veena Das (1976) 'Indian Women: Work, Power and Status', in B.R. Nanda, *Indian Women*, p.135.
60. Wolpert, *New History of India*, pp.26, 32.
61. Thapar, *History of India*, pp.37-8.
62. Ibid., pp.38-40, 54.
63. Mies, *Indian Women*, pp.55-7.
64. Wolpert, *New History of India*, p.28.
65. A.S. Altekar (1962) *The Position of Women in Hindu Civilization*. Delhi: Motilal Banarsidas, pp.179-81. Padmini Sengupta (1960) *Women Workers of India*. Bombay: Asia Publishing House, pp.1-4.
66. Rigveda X, 85, 86. Quoted in Altekar, *Position of Women*, p.190.
67. G.G. Mirchandani (1970) 'Status of Women in India', *India Today*. Delhi: United News of India Research Bureau, p.249.
68. Romila Thapar (1963) 'The History of Female Emancipation in Southern Asia', in Barbara Ward (ed), *Women in the New Asia*. Paris: UNESCO, p.476.
69. Mies, *Indian Women*, pp.47-8.
70. Mahabharata (Shanti Parva). Quoted in Ashok Rudra (1975) 'Cultural and Religious Influences', in Jain, *Indian Women*, p.43.
71. G.S. Ghurye (1932) *Caste and Race in India*. London: Routledge & Kegan Paul, p.69.
72. Thapar, *History of India*, pp.64-9.
73. Ibid., pp.109, 121-4.
74. Mies, *Indian Women*, pp.47-51.
75. Altekar, *Position of Women*, p.58.
76. Thapar, *History of India*, p.123.
77. Maitrayaniya Samhita IV, 7, 4. Quoted in Altekar, *Position of Women*, p.190.
78. Manusmriti, Dharmashastra IX, 3.

79. Ibid. V, 147.
80. Arundhati, Diva Purana. Quoted in Rudra, 'Cultural and Religious Influences', p.47.
81. Mahabbarata, Anusasana Parva. Quoted in ibid., p.47.
82. Manusmriti, Dharmashastra IX, 14.
83. Ibid., III, 13.
84. Mies, *Indian Women*, p.45.
85. Thapar, *History of India*, pp.136, 151-2.
86. Ibid., p.166.
87. Thapar, 'History of Female Emancipation', pp.252, 476-7.
88. Jack Goody (1976) *Production and Reproduction*. Cambridge: Cambridge University Press.
89. Prabhati Mukherjee (1978) *Hindu Women: Normative Models*. New Delhi: Orient Longman.
90. Krsnajanma Kanda 35, 77-86. Quoted in Ram Sharan Sharma (1966) *Light on Early Indian Society and Economy*. Bombay: Manaktalas p.24.
91. Ayodhya Kanda 67, 11. Quoted in ibid., pp.23 and 27-8.
92. Manu V, 139. Quoted in ibid., p.30.
93. Ibid., p.33.
94. Parasara VI, 16. Quoted in ibid., p.29.
95. Sen, *State, Industrialization and Class Formations*, p.132.
96. Mies, *Indian Women*, p.48.
97. Thapar, *History of India*, p.247.
98. Mies, *Indian Women*, p.60.
99. Baig, *India's Woman Power*, pp.12, 258.
100. Mies, *Indian Women*, pp.51-2, 65-8.
101. Thapar, 'History of Female Emancipation', p.478.
102. Thapar, *History of India*, p.292.
103. Mies, *Indian Women*, pp.65-8.
104. Thapar, *History of India*, p.67.
105. Ibid., pp.160, 261.
106. Mies, *Indian Women*, pp.40-1.
107. Nigel Frith (1975) *The Legend of Krishna*. London: Abacus.
108. Thapar, *History of India*, pp.258-61.
109. Ibid., pp.133-4.
110. Ibid., pp.184-8.
111. Department of Social Welfare, *Towards Equality*, p.43.
112. Sen, *State, Industrialization and Class Formations*, p.18.
113. Bhagavad-Gita IX, 32. In R.C. Zaehner (1966) *Hindu Scriptures*. London: J.M. Dent, p.289.
114. Thapar, *History of India*, pp.131-4.
115. Ibid., p.161.
116. Mies, *Indian Women*, pp.46-7.
117. Devi Bhagavat. Quoted in Rudra, 'Cultural and Religious Influences', p.47.
117. Pratima Asthana (1974) *Women's Movement in India*. Delhi: Vikas, pp.57-8.
118. André Beteille (1971) *Caste, Class and Power*. Berkeley: University of California Press, Ch.VI.
119. See Chapter 8.

120. Beteille, *Caste, Class and Power*, Ch.VI.
121. A.R. Desai (1959) *The Social Background of Indian Nationalism*. Bombay: Popular Book Depot.
122. Sen, *State, Industrialization and Class Formations*, pp.37-45.
123. Ibid., pp. 132, 48, 53, 64.
124. Ibid., pp.65-9.
125. Ibid., pp.80-6.
126. B.B. Misra (1961) *The Indian Middle Classes*. London: Oxford University Press, pp.307, 12-13.
127. Ibid., p.12.
128. Bipan Chandra (1974) 'The Indian Capitalist Class and British Imperialism', in R.S. Sharma (ed), *Indian Society: Historical Probings*. New Delhi: People's Publishing House, pp.390-1.
129. Jawaharlal Nehru (1939) *Glimpses of World History*. London: Lindsay Drummond, pp.434-9.
130. Chandra, 'Indian Capitalist Class', pp.394-7.
131. Misra, *Indian Middle Classes*, p.307.
132. Richard Taub (1969) *Bureaucrats under Stress*. Berkeley: University of California Press, pp.63-5.
133. M.D. Morris (1960) 'The Labour Market in India', in W.E. Moore and A.S. Feldman (eds), *Labour Commitment and Social Change in Developing Areas*. New York: SSRC, pp.173-200. Quoted in Sinha 'Caste in India', pp.102-3.
134. R.D. Lambert (1963) *Workers, Factories and Social Change in India*. Princeton: Princeton University Press, pp.34-6. Quoted in M.N. Srinivas (1966) *Social Change in Modern India*. Berkeley: University of California Press, p.174.
135. Kamla Bhasin (1972) 'The Predicament of Middle Class Indian Women — an Inside View', in Kamla Bhasin (ed), *The Position of Women in India*. Srinigar: Arvind Deshpande, p.40.
136. Victor S. D'Souza (1980) 'Family Status and Female Work Participation', in Alfred de Souza (ed), *Women in Contemporary India and South Asia*. New Delhi: Manohar, p.129.
137. Pratima Asthana, *Women's Movement in India*, p.23. See also E.C. Gedge and M. Choksi (eds), (1929) *Women in Modern India*. Bombay: D.B. Taraporewala, Ch.3, 4.
138. Elizabeth Sarah (1982) 'Towards a Reassessment of Feminist History', *Women's Studies International Forum* 5, 6, pp.520-1.
139. See comparisons, notes 140-3, and 145 below.
140. Sushila Mehta (1982) *Revolution and the Status of Women in India*. New Delhi: Metropolitan, p.104. In the USA, the most 'advanced' capitalist country of the world, the Equal Rights Amendment, adding a guarantee of sexual equality to the Constitution, failed to reach the statute book during the 1980s because the required number of states did not ratify it.
141. Ibid., p.104. Women in Switzerland, one of the richest countries of Europe, did not receive the vote until the 1970s. In at least one canton, women still do not have the vote on canton affairs.
142. The Factories Act was passed in 1948, the Plantation Labour Act in 1951, and the Mines Act in 1952. See Kamala Mankekar (1975) *Women in India*. New Delhi: Central Institute of Research and Training in Public Cooperation, p.19.

The Equal Pay Act and the Sex Discrimination Act came into force in Britain in 1975. There is no legal provision for creches or nursing time.

143. Five Acts were passed between 1954 and 1956:

1. Special Marriage Act (1954) provided for civil marriage for all Indians and divorce by mutual consent. Minimum age of marriage, 21 for men, 18 for women. If married under this Act a Hindu man would be automatically regarded as independent of the joint family, and inheritance would be governed by the Indian Succession Act.
2. Hindu Marriage Act (1955) stipulates monogamy and provides for divorce and inter-caste marriage.
3. Hindu Succession Act (1955) provides equal shares of property for widow, daughter, mother and son, in the case of non-testamentary death. Women have absolute right of ownership and disposal over property with the condition that male successors have a presumptive right to acquire any property of which the female successors wish to dispose.
4. Hindu Minority and Guardianship Act (1956) gives custody of a child under 3 years of age to the mother, and the natural guardian thereafter is first the father and second the mother.
5. Hindu Adoptions and Maintenance Act (1956) provides for the adoption of daughters, and allows women to adopt children as well as men. See Jana Matson Everett (1981) *Women and Social Change in India*. New Delhi: Heritage, pp.187-8, and Sushila Mehta, *Revolution*, Ch.7.

Eire does not allow divorce even today.

144. Suppression of Prostitution and Immoral Traffic Act 1958, Prohibition of Dowry Act 1961. See Sushila Mehta, *Revolution*, pp.115, 121.

145. Department of Social Welfare, *Towards Equality*, pp.327-9. In Spain abortion is not legal under any circumstances.

146. Mehta, *Revolution*, pp.125-6.

147. Mankekar, *Women in India*, pp.30, 31.

148. Rama Joshi (1978) 'The Status of Female Labour and the Law', *Bulletin of Comparative Labour Relations* 9, pp.225-6.

149. Mankekar, *Women in India*, p.34.

150. Mehta, *Revolution*, pp.207-8, 243-4. Most issues of Manushi carry reports of dowry deaths. See Note 3, Ch.1.

151. For a discussion of the Indian economy in 1977 in the context of world capitalism, see Andre Gunder Frank (1977) 'Emergence of Permanent Emergency in India', *Economic and Political Weekly* XII, 11, March 12. Recognition of the West's role in pauperising the Third World is expressed (more ambiguously than by Frank) by Willy Brandt (1980) *North-South: a Programme for Survival. The Report of the Independent Commission on International Development Issues*. London: Pan. 'A long and assiduous learning process was necessary until it was generally accepted that higher wages for workers increased purchasing power sufficiently to move the economy as a whole. Industrialized countries now need to be interested in the expansion of markets in the developing world.' Ibid., pp.20-1. The analogy means that if the Third World is made so poor that it cannot buy Western capitalism's goods, then the West would also suffer through the collapse of its markets. So the poverty of the Third World is seen to threaten the very structure of Western capitalism's political, industrial and financial institutions. Ibid., p.239.

152. Mehta, *Revolution*, pp.125-6.

153. Elizabeth Sarah, 'Towards a Reassessment', p.520. Dale Spender

(1983) *There's Always Been a Woman's Movement this Century*. London: Routledge & Kegan Paul.

154. Geraldine Forbes (1982) 'Caged Tigers: "First Wave" Feminists in India', *Women's Studies International Forum* 5, 6, p.535.

155. 20 out of the 120 women explicitly identified themselves as feminists, without being asked.

Reeves, H. and Baden, S. (2000, February). ***Gender and Development: Concepts and Definitions***. BRIDGE (development – gender), Report No 55. Brighton, UK: Institute of Development Studies, pp. 1-37.

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Report No 55

Gender and Development: Concepts and Definitions

Prepared for the Department for International Development (DFID) for its gender mainstreaming intranet resource

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Contents

1. Introduction

Selected concepts central to Gender and Development thinking are explained here. These are intended to help you explore some of the key ideas and issues in Gender and Development and their implications for policy and practice. The succinct explanations here are neither comprehensive nor definitive. Readers are advised to consult the recommended readings for more detailed discussions.

2. Quick Definitions

Culture	The distinctive patterns of ideas, beliefs, and norms which characterise the way of life and relations of a society or group within a society
Gender Analysis	The systematic gathering and examination of information on gender differences and social relations in order to identify, understand and redress inequities based on gender
Gender Discrimination	The systematic, unfavourable treatment of individuals on the basis of their gender, which denies them rights, opportunities or resources
Gender Division of Labour	The socially determined ideas and practices which define what roles and activities are deemed appropriate for women and men
Gender Equality and Equity	Gender equality denotes women having the same opportunities in life as men, including the ability to participate in the public sphere Gender equity denotes the equivalence in life outcomes for women and men, recognising their different needs and interests, and requiring a redistribution of power and resources
Gender Mainstreaming	An organisational strategy to bring a gender perspective to all aspects of an institution's policy and activities, through building gender capacity and accountability
Gender Needs	Shared and prioritised needs identified by women that arise from their common experiences as a gender
Gender Planning	The technical and political processes and procedures necessary to implement gender-sensitive policy
Gender Relations	Hierarchical relations of power between women and men that tend to disadvantage women
Gender Training	A facilitated process of developing awareness and capacity on gender issues, to bring about personal or organisational change for gender equality
Gender Violence	Any act or threat by men or male-dominated institutions, that inflicts physical, sexual, or psychological harm on a woman or girl because of their gender

Intra-household Resource Distribution	The dynamics of how different resources that are generated within or which come into the household, are accessed and controlled by its members
National Machineries for Women	Agencies with a mandate for the advancement of women established within and by governments for integrating gender concerns in development policy and planning
Patriarchy	Systemic societal structures that institutionalise male physical, social and economic power over women
Sex and Gender	Sex refers to the biological characteristics that categorise someone as either female or male; whereas gender refers to the socially determined ideas and practices of what it is to be female or male
Social Justice	Fairness and equity as a right for all in the outcomes of development, through processes of social transformation
WID/GAD	The WID (or Women in Development) approach calls for greater attention to women in development policy and practice, and emphasises the need to integrate them into the development process In contrast, the GAD (or Gender and Development) approach focuses on the socially constructed basis of differences between men and women and emphasises the need to challenge existing gender roles and relations
Women's Empowerment	A 'bottom-up' process of transforming gender power relations, through individuals or groups developing awareness of women's subordination and building their capacity to challenge it
Women's Human Rights	The recognition that women's rights are human rights and that women experience injustices solely because of their gender

3. Detailed Explanations and Further Reading

CULTURE

The distinctive patterns of ideas, beliefs, and norms which characterise the way of life and relations of a society or group within a society

Culturally determined gender ideologies define rights and responsibilities and what is 'appropriate' behaviour for women and men. They also influence access to and control over resources, and participation in decision-making. These gender ideologies often reinforce male power and the idea of women's inferiority. Culture is sometimes interpreted narrowly as 'custom' or 'tradition', and assumed to be natural and unchangeable. Despite these assumptions, culture is fluid and enduring.

"We talk about poverty across societies, and no-one raises any problems. We talk about gender subordination across societies, and people cry cultural imperialism!"
(White, 1993:9)

Dominant cultures reinforce the position of those with economic, political and social power, and therefore tend to reinforce male power. Globalisation also has implications for the diffusion of culture, particularly of western culture.

The defence of 'culture' and 'tradition' is often used by men to justify practices that constrain women's life chances and outcomes. Interventions to challenge power imbalances proposed by local women's organisations or NGOs are often denied legitimacy, or where an international agency is involved, denounced as 'western' interference or 'cultural imperialism'. Many within the international development community also remain resistant to goals of gender equity because they perceive these as interfering with the most intimate domain in society. Some women have themselves defended ideas of 'culture' and 'tradition' in order to hold on to what little power they have, or as a form of resistance. For example, before the revolution in Iran, women took up the veil to show resistance to the processes of westernisation that the country was experiencing.

Nevertheless, there are real issues of concern for local women's groups when externally initiated interventions are tainted by colonial attitudes. In the past, women were often seen as 'victims' that needed protection. Male colonisers, however well intentioned, perpetuated this paternalistic idea to justify their colonial domination. More recently, certain western feminists have also colluded in this notion, giving overwhelming priority to such issues as veiling, arranged marriages, and female genital mutilation, at the expense of other perhaps more immediate concerns. Southern feminists challenge this idea of women as 'victims'. They want to set their own agendas - which may imply redistributive action or tackling poverty - and gain support for these from western feminists.

See also: FAQ 'What right have we to interfere in other people's cultures?'

Further reading

Development Assistance Committee (DAC), 1998, 'Gender, Equality and Culture', in DAC Source Book on Concepts and Approaches linked to Gender Equality, OECD, Paris

Mohanty, C. (1991) 'Under Western Eyes. Feminist Scholarship and Colonial Discourse' in Mohanty, C., Russo, A. and L. Torres (eds.), 1991, Third World Women and the Politics of Feminism, Bloomington, Indiana University Press

Moore, H. 1994, A Passion for Difference, Cambridge, Polity

Oxfam, 1995, 'Women and Culture,' Gender and Development, Oxfam Journal, Vol.3, No.1, February, Oxfam, Oxford

Nussbaum, M., and Glover, J., 1995, Women, Culture and Development: A Study of Human Capabilities, Clarendon Press, Oxford

GENDER ANALYSIS

'Gender analysis, once confined to the margins of development theory, has over the last ten years penetrated both the thinking and the operations of international development institutions' (Miller and Razavi, 1998: 4)

The systematic gathering and examination of information on gender differences and social relations in order to identify, understand and redress inequities based on gender. Gender analysis is a valuable descriptive and diagnostic tool for development planners and crucial to gender mainstreaming efforts. The methodology and components of gender analysis are shaped by how gender issues are understood in the institution concerned. There are a number of different approaches to gender analysis, including the Gender Roles or Harvard framework, and Social Relations Analysis.

The Gender Roles framework focuses on describing women's and men's roles and their relative access to and control over resources. The analysis aims to anticipate the impacts of projects on both productive and reproductive roles. It takes the household, rather than the breadth of institutions, as the unit of analysis and tends to assume that women are a homogeneous category.

In contrast, the Social Relations approach seeks to expose the gendered power relations that perpetuate inequities. This analysis moves beyond the household to include the community, market, and state institutions and so involves collecting data at all these levels. It uncovers differences between women, divided by other aspects of social differentiation such as class, race and ethnicity. The aim is to understand the dynamics of gender relations in different institutional contexts and thereby to identify women's bargaining position and formulate strategies to improve this. It has proved challenging to adopt this approach in operational work.

Other gender analysis frameworks include: the Moser/DPU Framework; the Longwe Method/Women's Empowerment Framework; and Levy's Web of Institutionalisation.

Recently, tools have also been developed to apply gender analysis to the analysis of markets, of macro-economic and sectoral policies, and of public expenditure and budgets.

See also: Gender training, Gender planning, WID/GAD

Further reading

Elson, D., 1997, 'Integrating gender issues into public expenditure: six tools', mimeo, GENECON Unit, Graduate School of Sciences, University of Manchester

Elson, D., and Evers, B., 1998, 'Sector programme support: A Gender Aware Analysis', mimeo, GENECON, Manchester University

Miller, C., and Razavi, S., 1998, 'Gender analysis: alternative paradigms', Gender in Development Monograph Series, No.6, UNDP, New York

Overholt, C., Cloud, K., Anderson, M., and Austin, J., 1991, 'Gender Analysis Framework' in Overholt *et al*, 1991, Gender Analysis in Development Planning: A Case Book, Kumarian Press, Connecticut

GENDER DISCRIMINATION

The systematic, unfavourable treatment of individuals on the basis of their gender, which denies them rights, opportunities or resources

"Not all women are poor, and not all poor people are women, but all women suffer from discrimination"
(Kabeer, 1996:20)

Across the world, women are treated unequally and less value is placed on their lives because of their gender. Women's differential access to power and control of resources is central to this discrimination in all institutional spheres, i.e. the household, community, market, and state.

Within the household, women and girls can face discrimination in the sharing out of household resources including food, sometimes leading to higher malnutrition and mortality indicators for women. *(See Intra-household Resource Distribution)*. At its most extreme, gender discrimination can lead to son preference, expressed in sex selective abortion or female feticide. In the labour market, unequal pay, occupational exclusion or segregation into low skill and low paid work limit women's earnings in comparison to those of men of similar education levels. Women's lack of representation and voice in decision making bodies in the community and the state perpetuates discrimination, in terms of access to public services, such as schooling and health care, or discriminatory laws.

Gender discrimination:

- *women work 67% of the world's working hours*
- *2 out of 3 of the world's illiterate people are women*
- *women's earnings range from 50-85% of men's earnings*
- *globally women make up just over 10% of representatives in national government*

(adapted from Oxfam, 1995:181, and 'Facts and Figures' section)

The law is assumed to be gender-neutral when in fact it may perpetuate gender discrimination, being a product of a culture with oppressive gender ideologies. Even where constitutional or national legal provisions uphold gender equality principles, religious or other customary laws that privilege men may take precedence in practice. However, the law, when reformed with women's input, can be a potent tool for challenging discrimination, if combined with other strategies, including capacity-building to overcome barriers to claiming rights.

The Convention on the Elimination of all forms of Discrimination against Women (CEDAW) in 1979 brought into international focus the rights of women as human rights, including the right to be free from discrimination. Women activists regard this convention as a key tool to support their struggle against discrimination in all spheres, pushing governments towards attaining these internationally recognised minimum standards.

See also:
Women's human rights,
Social justice,
Intra-household resource allocation

Further reading

Birdsall, N., and Sabot, R., (eds.), 1991, Unfair Advantage: Labour Market Discrimination in Developing Countries, IBRD/World Bank, Washington

Seager, J., 1997, The State of Women in the World Atlas: Women's status around the Globe: Work, Health, Education and Personal Freedom, Penguin, London

GENDER DIVISION OF LABOUR

The socially determined ideas and practices which define what roles and activities are deemed appropriate for women and men

Whilst the gender division of labour tends to be seen as natural and immutable, in fact, these ideas and practices are socially constructed. This results in context-specific patterns of who does what by gender and how this is valued. Gender divisions of labour are not necessarily rigidly defined in terms of men's and women's roles, as is sometimes assumed. They are characterised by co-operation in joint activities, as well as by separation. Often, the accepted norm regarding gender divisions varies from the actual practice.

'Women's labour is not infinitely elastic. It cannot stretch to cover all the deficiencies left by reduced public expenditure. It cannot absorb all the shocks of adjustment.'
(Elson, 1995:15)

However, roles typically designated as female are almost invariably less valued than those designated as male. Women are generally expected to fulfil the reproductive role of bearing and raising children, caring for other family members, and household management tasks, as well as home based production. Men tend to be more associated with productive roles, particularly paid work, and market production. In the labour market, although women's overall participation rates are rising, they tend to be confined to a relatively narrow range of occupations or concentrated in lower grades than men, usually earning less.

Historically, women's productive roles have been ignored or under-valued, particularly in the informal sector and subsistence agriculture. This has led to misconceived development projects; for example the services of extension agents and agricultural inputs being targeted at men. Because women's labour is undervalued, it is often assumed by mainstream development policies to be infinitely elastic. For example, policy makers expect that women can take on roles previously fulfilled by public services, such as care for the sick and elderly, when cutbacks are made.

The formal documentation and recognition of women's roles and the related time burden is crucial for gender-sensitive development interventions. Recently, international organisations have begun to measure all forms of economic activity by gender. International definitions of economic activity have also been broadened to include subsistence farming, food processing and homeworking 'in anticipation of profit'. Time budget surveys are also being implemented in some places to measure women's input into reproductive work.

See also:
Gender needs,
Gender analysis,
Women's empowerment

Gender and development policies and programmes can challenge and change women's socially prescribed roles, in pursuit of gender equity. For example, women have been successfully trained and employed as water technicians or builders in communities where these were jobs previously a male

domain. However, programmes aiming to increase women's participation in spheres beyond the household must ensure that they are properly remunerated. They should also be accompanied by consideration of how men, or public provision, can reduce women's responsibilities in the home.

Further reading

Adepoju, A., and Oppong, C., (eds.), 1994, Gender, work & population in Sub-Saharan Africa, ILO, James Currey, London

Anker, R., 1997, Gender and Jobs: Sex Segregation of Occupations in the World, ILO, Geneva

Beneria, L, 1992, 'Accounting for women's work: progress of two decades,' World Development, Vol.20, No.11

Boserup, E., 1970, Women's Role in Economic Development, Gower, Aldershot

Stichter, S. and J. Parpart, (eds.), 1990, Women, Employment and the Family in the International Division of Labour, Basingstoke; Macmillan

GENDER EQUALITY & EQUITY

The term 'gender equity' is often used interchangeably with 'gender equality'. Here, a distinction is drawn between these two concepts, reflecting divergent understandings of gender differences and of the appropriate strategies to address these. Gender equality denotes women having the same opportunities in life as men, including the ability to participate in the public sphere

This expresses a liberal feminist idea that removing discrimination in opportunities for women allows them to achieve equal status to men. In effect, progress in women's status is measured against a male norm. Equal opportunities policies and legislation tackle the problem through measures to increase women's participation in public life. For example, in Chile, the National Service for Women (SERNAM) developed an Equal Opportunities Plan for Chilean Women 1994-1999. This focused on equitable participation in education, the labour market, health services, and politics. Judicial reform is another key tool in the fight for equality, but lack of implementation and enforcement might limit its impact.

However, this focus on what is sometimes called formal equality, does not necessarily demand or ensure equality of outcomes. It assumes that once the barriers to participation are removed, there is a level playing field. It also does not recognise that women's reality and experience may be different from men's.

Gender equity denotes the equivalence in life outcomes for women and men, recognising their different needs and interests, and requiring a redistribution of power and resources.

The goal of gender equity, sometimes called substantive equality, moves beyond equality of opportunity by requiring transformative change. It recognises that women and men have different needs, preferences, and interests and that equality of outcomes may necessitate different treatment of men and women.

An equity approach implies that all development policies and interventions need to be scrutinised for their impact on gender relations. It necessitates a rethinking of policies and programmes to take account of men's and women's different realities and interests. So, for example, it implies rethinking existing legislation on employment, as well as development programmes, to take account of women's reproductive work and their concentration in unprotected, casual work in informal and home based enterprises.

See also: WID/GAD, Gender analysis, Gender relations

It is worth examining the content of policies, not just the language, before deciding whether an equity or an equality approach is being followed. Gender equity goals are seen as being more political than gender equality goals, and are hence are generally less accepted in mainstream development agencies.

Further Reading

Development Assistance Committee (DAC), 1998, 'Evolution of the Thinking and Approaches on Equality Issues' in DAC, 1998, DAC Sourcebook on Concepts and Approaches linked to Gender

GENDER MAINSTREAMING

An organisational strategy to bring a gender perspective to all aspects of an institution's policy and activities, through building gender capacity and accountability

The 1970s strategies of integrating women into development by establishing separate women's units or programmes within state and development institutions had made slow progress by the mid-1980s. *(See National Machineries for Women).* In light of this, the need was identified for broader institutional change if pervasive male advantage was to be challenged. Adding women- specific activities at the margin was no longer seen as sufficient. Most major development organisations and many governments have now embraced 'gender mainstreaming' as a strategy for moving towards gender equality.

Beijing Platform for Action: *'...governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes' (cited in DAC, 1998:28)*

With a mainstreaming strategy, gender concerns are seen as important to all aspects of development; for all sectors and areas of activity, and a fundamental part of the planning process. Responsibility for the implementation of gender policy is diffused across the organisational structure, rather than concentrated in a small central unit.

Such a process of mainstreaming has been seen to take one of two forms. The agenda-setting approach to mainstreaming seeks to transform the development agenda itself whilst prioritising gender concerns. The more politically acceptable integrationist approach brings women's and gender concerns into all of the existing policies and programmes, focusing on adapting institutional procedures to achieve this. In both cases, political as well as technical skills are essential to a mainstreaming strategy.

See also: National Machineries for Women, Gender planning

Any approach to mainstreaming requires sufficient resources, as well as high-level commitment and authority. A combined strategy can be particularly powerful. This involves the synergy of a catalytic central gender unit with a cross-sectoral policy oversight and monitoring role, combined with a web of gender specialists across the institution. The building of alliances both within the institution and with outside constituencies, such as women's organisations, is crucial for success. Mainstreaming tools include gender training, introducing incentive structures which reward efforts on gender, and the development of gender-specific operational tools such as checklists and guidelines.

Further reading

BRIDGE, 1997, 'Institutionalising gender', Development and gender in brief, Issue 6, BRIDGE, IDS, Brighton

DFID (Social Development Division), 1998, 'Putting gender mainsteaming into practice', mimeo, paper presented to the DFID Management Board, 8 May

Goetz, A., (ed), 1997, Getting Institutions Right for Women in Development, Zed Books, London

Moser, C., Tornqvist, A., and van Bronkhorst, B., 1998, Mainstreaming Gender and Development in the World Bank: Progress and Recommendations, The International Bank for Reconstruction and Development/The World Bank, Washington, D.C.

Razavi, S., and Miller, C., 1995, 'Gender mainstreaming: a study of efforts by the UNDP, the World Bank and the ILO to institutionalize gender issues', Occasional Papers, No.4, UNRISD, Geneva

Schalkwyk, J., Thomas, H., and Woroniuk, B., 1996, Mainstreaming: a Strategy for Achieving Equality between Women and Men', SIDA, Stockholm

GENDER NEEDS

Shared and prioritised needs identified by women that arise from their common experiences as a gender

Certain women's interests, of a political or practical nature, related to their experience as a gendered person. Such prioritised concerns have been translated into the concept of gender needs (Moser, 1989). This identifies the way in which women's gender interests, defined by women themselves, can be satisfied in the planning process. Although needs and interests are conceptually different (Molyneux, 1998), in practice, they are closely related in the planning process. Needs, as well as interests, result from a political process of contestation and interpretation and thus should not be externally defined or seen as fixed.

Practical Gender Needs (PGNs) according to Moser (1989) are the immediate needs identified by women to assist their survival in their socially accepted roles, within existing power structures. Policies to meet PGNs tend to focus on ensuring that women and their families have adequate living conditions, such as health care and food provision, access to safe water and sanitation, but also seek to ensure access to income-earning opportunities. PGNs do not directly challenge gender inequalities, even though these needs may be a direct result of women's subordinate position in society.

See also:
Gender analysis
Gender planning
Women's empowerment

Strategic gender needs (SGNs), are those needs identified by women that require strategies for challenging male dominance and privilege. These needs may relate to inequalities in the gender division of labour, in ownership and control of resources, in participation in decision-making, or to experiences of domestic and other sexual violence. These needs are often seen as feminist in nature as they seek to change women's status and position in society in relation to men. As such, they are more likely to be resisted than PGNs.

In reality, it is difficult to distinguish so clearly between strategic and practical needs. Any policy or programme may meet both sets of needs. Through collective organising around practical gender needs, women may achieve more strategic and transformatory goals. This politicisation of practical gender needs is a favoured entry point for NGOs and women's organisations.

However, women may not always recognise or prioritise their strategic gender needs, particularly if it could threaten their immediate practical needs. At any time, gender interests may not be prioritised over women's other interests which cut across these, such as those of class and race, so assumptions cannot be made of women's solidarity.

Further reading

Molyneux, M., 1985, 'Mobilisation without emancipation? Women's interests, the state and revolution in Nicaragua', Feminist Studies, Vol.11, No.2

Molyneux, M., 1998, 'Analysing women's movements', in Jackson, C., and Pearson, R., 1998, Feminist Visions of Development: Gender Analysis and Policy, Routledge, London

Moser, C,. 1989, ' Gender planning in the third world: meeting practical and strategic needs', World Development, Vol.17, No.11, pp1799-1825

GENDER PLANNING

The technical and political processes and procedures necessary to implement gender-sensitive policy and practice

The purpose of gender planning is to ensure gender-sensitive policy outcomes through a systematic and inclusive process. If gender policy has transformatory goals, then gender planning as a process will necessarily be a political one, involving consultation with and participation of different stakeholders.

'Project planning and implementation from a gender-based perspective can have only one ultimate goal...contribute to changing the balance of the sexual division of power and resources so as to make it more equitable'
(Macdonald, 1994:45)

There is a variety of gender planning frameworks based on differing approaches to gender analysis, each with its own planning principles and tools. For example, Caroline Moser (1993) developed a gender planning framework consisting of gender planning tools, gender planning procedures, and the components of gender planning practice. The gender planning tools include gender roles identification, gender needs assessment, and the collection of disaggregated data at the household level. The gender planning procedures involve the diagnosis of the gender problem, formulation of gender objectives, procedures for monitoring and evaluation, gender-based consultation and participation, and identification of an entry strategy. The final aspect, practice, identifies the need to institutionalise gender planning, and to operationalise this through recognised procedures. Building capacity amongst planners is necessary to ensure policy is transformed into practice with the minimum of dilution.

The social relations approach differs in its focus on power in gender relations (See *Gender Analysis*). This approach uses an institutional framework for the analysis of gender inequalities as a tool for gender-aware planning. It recognises that the means through which needs are met is as important as the planned ends of any intervention. The planning process is conceived as participatory and constituted by an analysis and evaluation of causes, effects, means and ends. A seven-point 'Gender audit for development interventions' supports this framework. (Kabeer and Subrahmanian, 1996).

Whilst gender transformatory policies are increasingly being generated, concerns are focusing on the 'misbehaviour' of such policies, i.e. a tendency to slip in implementation from transformatory objectives to outcomes that fail to challenge existing gender relations. It has been recognised that GAD approaches are constrained by resistance and subversion, from within both implementing organisations and targeted communities. Gender planning needs therefore to be part of an on-going process of gender mainstreaming, backed up by sufficient resources, commitment and authority. Gender planning procedures need to involve the participation of stakeholders and clear lines of accountability.

See also:
Gender mainstreaming,
Gender training,
Gender analysis,
WID/GAD

At the project level, a variety of planning tools are used to operationalise gender policy, including general and sector-specific checklists and guidelines. Logical Framework Analysis is an

example of a planning tool which, if used in a gender-sensitive manner, can help to ensure accountability, participation of various stakeholders, and that relevant monitoring and evaluation procedures are implemented.

Further reading

Kabeer, N., and Subrahmanian, R., 1996, 'Insititutions, relations and outcomes: framework and tools for gender-aware planning', IDS Discussion Paper, No.357, IDS, Brighton

Macdonald, M., (ed.), 1994, Gender Planning in Development Agencies: Meeting the Challenge, Oxfam, Oxford

Moser, C., 1993, Gender Planning and Development: Theory, Practice and Training, Routledge, London

GENDER RELATIONS

Hierarchical relations of power between women and men that tend to disadvantage women

These gender hierarchies are often accepted as 'natural' but are socially determined relations, culturally based, and are subject to change over time. They can be seen in a range of gendered practices, such as the division of labour and resources, and gendered ideologies, such as ideas of acceptable behaviour for women and men.

'If gender is about relations between men and women, then the male side of the eqution must also be figured in. If women's gender identities are to be changed, then men's must change also.' (White in Macdonald, 1993:20)

Analyses which focus on gender relations differ in emphasis from those which take 'gender roles' as a starting point. They give more prominence to the connectedness of men's and women's lives, and to the imbalances of power embedded in male-female relations. They also emphasise the interaction of gender relations with other hierarchical social relations such as class, caste, ethnicity and race. But whether gender relations act to alleviate, or to exacerbate other social inequalities, depends on the context.

Gender relations constitute and are constituted by a range of institutions, such as the family, legal systems or the market. They are a resource which is drawn on daily to reinforce or redefine the rules, norms and practices which govern social institutions. Since historically women have been excluded from many institutional spheres, or their participation circumscribed, they often have less bargaining power to affect change who institutions operate.

So, for example, where they are perceived to transgress their accepted roles, women can be physically or sexually abused by male partners with relative impunity. In many cultures, beatings or rape in marriage are considered acceptable in the existing legal framework. Even where, following lobbying of women's groups, rape or violence within marriage is outlawed, women may be reluctant to seek redress because the male dominated judicial system is unsympathetic, or because they fear ostracism. Where women retaliate, they become criminalised themselves. However, change is possible: in a few recent cases, following sustained campaigns, women have been acquitted of 'crimes' against violent partners and new laws have been passed to respond to such attenuating circumstances.

See also: Gender equity, Gender analysis, Sex and gender, WID/GAD

Hierarchical gender relations constrain development efforts. For example, rigidities in the gender division of labour limit the effective mobilisation of women's labour to support export production. Poverty reduction efforts are hampered where men use their authority to usurp control over resources targeted at women. Development strategies need to be informed by an analysis of gender relations and to support women's own attempts to change the rules and practices which reinforce these gender hierarchies.

Further reading

Pearson, R., Whitehead, A., and Young, K., 1984, 'Introduction: the continuing subordination of women in the development process,' in Young, K., Wolkovitz, C., and McCullagh, R., 1984, Of Marriage and the Market, Routledge and Kegan Paul, London

Razavi, S., and Miller, C., 1995, 'From WID to GAD: Conceptual Shifts in the Women and Development Discourse', Occasional Paper, UNRISD, Geneva

Pearson, R., and C., Jackson, 1998, 'Introduction: interrogating development. Feminism, gender and policy', in Jackson, C., and Pearson, R., (eds.), 1998, Feminist Visions of Development: Gender Analysis and Policy, Routledge, London

GENDER TRAINING

A facilitated process of developing awareness and capacity on gender issues to bring about personal or organisational change for gender equality

Gender training is one of a range of institutional strategies used to integrate gender into the work of development co-operation agencies. Its objectives can include raising general awareness of the relevance of gender to an organisation's work and skills transfer in gender analysis, gender-aware planning, programme design and implementation. Gender training typically involves: group discussion and reflection on gender roles and relations; case studies of the impact of development policies and programmes on gender relations; as well as role plays and simulation games which highlight gender dynamics.

'Gender training...is a tool, a strategy, a space for reflection, a site of debate and possibly for struggle. Training is a transformative process' (Macdonald, 1994:31)

The trainer's, as well as the organisation's, approach to gender and development influence the training approach, and hence the framework used (*See Gender Analysis*). These vary in the degree to which they see the need for personal attitudinal and behavioural change, or focus primarily on changing organisational procedures and practices. Personal transformation tends to be a training objective for Southern NGOs/women's organisations rather than development co-operation agencies. and the 'further reading' below.

See also:
Gender analysis,
Gender mainstreaming,
Gender planning

As awareness grows within an organisation, so the emphasis of gender training shifts to more tailored courses to meet specific needs and demands, and to more skills-based training. Gender training was initially mainly focused at the project level, but more recently emphasis has shifted to sectoral and macro-economic policy-making.

Attention has recently focused on the need to evaluate the impact of gender training. Experience suggests that training is most effective when it is part of a broader strategy of organisational change.

Further reading

Kabeer, N., 1994, 'Triple Roles, Gender Roles, Social Relations: The political subtext of gender training frameworks', in Reversed Realities: Gender Hierarchies in Development Thought, Verso, London

Miller, C., and Razavi, S., 1998 'Gender analysis: alternative paradigms' Gender in Development monograph Series No.6, UNDP, New York

Moser, C., 1993, 'Training strategies for gender planning: from sensitising to skills and techniques', in Moser, C., 1993, Gender Planning and Development: Theory, Practice and Training, Routledge, London

Royal Tropical Institute (KIT), 1998, Gender Training: The Source Book, KIT Press/Oxfam Publishing, Oxford

Wach, H., and Reeves, H., 1999, 'Southern gender training materials: an overview and resource guide', BRIDGE Report, Institute of Development Studies, Brighton

Williams, S., with Seed, J., and Mwan, A., 1994, The Oxfam Gender Training Manual, Oxfam, Oxford

GENDER VIOLENCE

Any act or threat by men or male-dominated institutions, that inflicts physical, sexual, or psychological harm on a woman or girl because of their gender

Gender violence occurs in both the 'public' and 'private' spheres. It happens in virtually all societies, across all social classes, with women particularly at risk from men they know. Official figures are scarce, and under reporting is rife, especially when the violence involves another family member. Violence against women, and particularly systematic rape, has frequently been used as a weapon of war against particular ethnic groups or entire populations.

"Women should wear purdah [head-to-toe covering] to ensure that innocent men ... are not unconsciously forced into becoming rapists' Parliamentarian of the ruling Barisan National in Malaysia (cited in Heise et al 1994:iii)

There is, however, no single definition of gender violence accepted internationally and there is much debate over the breadth of inclusion. Commonly, the acts or threats of such included in the definition are rape, sexual harassment, wife-battering, sexual abuse of girls, dowry-related violence, and non-spousal violence within the home. Other definitions extend to marital rape, acts such as female genital mutilation, female infanticide, and sex-selective abortion. In addition, certain definitions include 'sexual exploitation' such as enforced prostitution, trafficking of women and girls, and pornography.

Percentage of women surveyed reporting physical assaults by intimate partner:
Japan:59%
Zambia: 40%
Colombia: 20%
Tanzania: 60%
(UN, 1995:160)

It is now recognised in international law that violence against women is a human rights issue with major health and economic implications. The rape of women in wartime has been recognised and explicitly prohibited since 1949 in article 47 of the Fourth Geneva Convention Relative to the Treatment of Civilian Persons in Times of War. The United Nations (UN) recently appointed a Special Rapporteur on violence against women. However, legislation alone is insufficient to address this problem.

The prevention and elimination of violence against women is hampered by pervasive attitudes that devalue women's lives and by institutional resistance, including from the judicial system and the police, to recognising the extent of the problem. There is hostility to interfering with 'private' domestic disputes. Even where countries have issued appropriate legislation, its implementation and enforcement may well be weak. Additional support activities are required. Legislative reform, training of the police and lawyers, provision of shelters, and the building of capacity for women to combat violence and pursue their rights, are all necessary.

See also:
Gender discrimination,
Social justice,
Women's human rights

Development policy must understand both the obstacles gender violence places in the way of effective development, and the debilitating impact it has on women's lives. Policy concerns should not only focus on programmes specifically targeted at violence against women, but on violence as an aspect of other programmes, such as microenterprise schemes. Development interventions themselves could make women more vulnerable to violence if men feel threatened by attempts to enhance women's status.

Further reading

The British Council, 1999, 'Violence against Women: A briefing document on international issues and responses', The British Council, London

Bunch, C., and Carrillo, R., Gender Violence: A Development and Human Rights Issue, Center for Women's Global Leadership

Davies, M., (ed), 1994, Women and Violence: Realities and Responses Worldwide, Zed Books, London

Heise, L., with Pitanguy, J., and Germain, A., 1994, 'Violence Against Women: The hidden health burden,' World Bank Discussion Paper, No.255, International Bank for Reconstruction and Development, The World Bank, Washington D.C.

Oxfam, 1998, 'Violence against women', Gender and Development Journal, Volume 6, no.3, November, Oxfam, Oxford

INTRA-HOUSEHOLD RESOURCE DISTRIBUTION

The dynamics of how different resources that are generated within, or which come into the household are controlled and accessed by its different members

Gender analysis has revealed some evidence of bias against female members of households in the allocation of resources such as income, food, nutrition, health care and education. These patterns are not universal, however, and are also mediated by other factors such as age, and birth order. For example, there is little evidence of nutritional bias against girl children in Sub-Saharan Africa, whereas in South Asia this pattern has been widely noted. It has also been shown that resources controlled by women, for example in female-headed households, are distributed differently to resources controlled by men. There is some evidence that women spend a higher percentage of their generally smaller incomes on family consumption and children's welfare.

'The consensus appears to be shifting to the view that intrahousehold relations are indeed characterised by power' (Kabeer, 1998:103)

Conventional macro-economics treats the activities performed within the household as non-economic and hence irrelevant. Conventional micro-economists typically sees the household as a consumption unit and treat it as a 'black-box', assuming gender-neutrality. It was the New Household Economics (pioneered by Gary Becker in the 1960s) that challenged the conventional microeconomic approach and highlighted the importance of production within the household. In this model, all resources are pooled and distributed in an altruistic manner by a benevolent male household head to maximise the welfare of household members. However, gender analysts, particularly feminist anthropologists and economists, have demonstrated that this characterisation of the household is naïve and ignores gender power imbalances and conflict within the household.

Feminist models highlighted the fact that resources are not always pooled and stressed the role of bargaining processes within the household in determining access to resources. Gender relations within the household are then seen as characterised by both conflict and co-operation, whereby women tend to have less bargaining power in the struggle over household resources (for example, Sen). The division of labour and dynamics within the household are seen also to influence opportunities and outcomes for women outside the home, in employment for example. Certain theorists suggest that women's bargaining position within the household is enhanced when they work outside the home. Other mechanisms for enhancing women's bargaining power in the home include strengthened property rights, and membership of collective organisations.

See also:
Gender relations,
Gender discrimination,
Women's human rights

The household has often been used as the basic unit of analysis in, for example, poverty measures. But because of inequalities in intrahousehold distribution, household income-based measures of poverty do not correlate neatly with gender-differentiated assessments of well-being. Consequently, poverty reduction strategies that target male household heads, erroneously assume

that benefits will 'trickle-down' to the rest of the household. Where women are targeted with income-generating opportunities, it cannot either be assumed that women will retain control of those resources they bring into the household. This suggests the need for improved data collection and analysis procedures that collect more data at individual level, incorporate consideration of intrahousehold dynamics and recognise the heterogeneity of household arrangements.

Further reading

Bruce, J., 1989, 'Homes Divided', World Development, Vol.17, No.7, pp979-991, Pergamon Press

Evans, A., 1991, 'Gender issues in rural household economics', IDS Bulletin, Vol.22, No.1, Institute of Development Studies, Brighton

Kabeer, N., 1998, 'Jumping to conclusions: struggles over meaning and method in the study of household economics', in Jackson, C., and Pearson, R, 1998, Feminist Visions of Development: Gender Analysis and Policy, Routledge, London

Sen, A., 1990, 'Gender and co-operative conflicts' in Tinker, I., (ed.), 1990, Persistent Inequalities, Oxford University Press, New York

Haddad, L., and Hoddonott, J., 1997, Intrahousehold Resource Allocation in Developing Countries: Models, Methods and Policy, International Food Policy Research Institute, John Hopkins University Press, London

NATIONAL MACHINERIES FOR WOMEN

Agencies with a mandate for the advancement of women established within and by governments for integrating gender concerns in development policy and planning

National Machineries for Women (NMWs) - whether offices, desks, or ministries – were central to the integration strategies of the 1970s (*see WID/GAD*). They expanded in numbers in the 1980s and 1990s, now being a feature of most governments. NMWs have made many positive achievements, most importantly legitmising the place of gender issues in development planning (Goetz, 1998).

'Linking NGOs and women's organisations with policy-makers in government is a key role for NMWs in the context of mainstreaming' (Oxaal, 1997:2)

However, NMWs have often proven weak, under-resourced, vulnerable to changing political fortunes, and often ghettoised within social and welfare departments. The fact that many national machineries were established during periods of fiscal restraint and government restructuring has made claims on resources difficult to advance.

Some lessons have been learned. National machineries set up during democratic transitions (e.g. Philippines, Chile, South Africa, Uganda) have been more influential and effective, at least in part because of a political commitment to greater social equality and justice. Positive experiences also highlight the importance of broad and open processes of consultation, for example in the development of national gender policies.

NMWs have therefore had varying degrees of success, and face many challenges in their ability to fulfil a catalytic role and build capacity in other ministries as well as their own. There are many constraints remaining on their effectiveness. These include: lack of strong and clear mandates; underfunding and overreliance on donor funding; lack of qualified and technically skilled staff; bureaucratic resistance; inappropriate location; lack of political autonomy; and often lack of political support from national political leadership.

The 1990s have seen a shift towards new strategies for NMWs of institutionalising or 'mainstreaming' gender through advocacy and policy oversight work across all sectors, ministries and departments. Strategies include: lobbying for gender in national development plans; setting up of focal points in other ministries; gender training at all levels; guidelines and checklists to assist planning and evaluation; and building strategic alliances with NGOs and other women's organisations.

See also:
Gender mainstreaming, Gender planning

Further reading

Byrne, B., and Koch-Laier, J., with Baden, S., and Marcus, R., 1996, 'National machineries for women in development: experiences, lessons and strategies for institutionalising gender in development policy and planning', BRIDGE Report, No.36, Institute of Development Studies, Brighton

Development Assistance Committee (DAC), 1998, 'National Machinery for Women's Affairs' in DAC Source Book on Concepts and Approaches Linked to Gender Equality, OECD, Paris

Goetz, AM., 1998, 'Mainstreaming gender equity to national development planning', in Miller, C., and Razavi, S., (eds.), 1998, Missionaries and Mandarins, IT Publications, London

Oxaal, Z., 1997, 'Bringing gender out of the ghetto: national machineries for women', Development and Gender In Brief, Issue 5, Institute of Development, Brighton

Rowan-Campbell, D., 1995, 'National Machineries for women: a balancing act', in Heyzer, N., A Commitment to the World's Women: Perspectives on Development for Beijing and Beyond, UNIFEM, New York

PATRIARCHY

Systemic societal structures that institutionalise male physical, social and economic power over women.

Some feminists use the concept of patriarchy to explain the systematic subordination of women by both overarching and localised structures. These structures work to the benefit of men by constraining women's life choices and chances.

'In attacking both patriarchy and capitalism we will have to find ways to change both society-wide institutions and our most deeply ingrained habits. It will be a long, hard struggle' (Hartmann 1976:169)

There are many differing interpretations of patriarchy. However, the roots of patriarchy are often located in women's reproductive role and sexual violence, interwoven with processes of capitalist exploitation. The main 'sites' of patriarchal oppression have been identified as housework, paid work, the state, culture, sexuality, and violence. Behaviours that discriminate against women because of their gender are seen as patriarchal 'practices'; for example occupational segregation, exclusion, and unequal pay.

The concept of patriarchy has been drawn into gender and development theorising; in order to challenge not only unequal gender relations but also unequal capitalist relations, sometimes seen as underpinning patriarchy (Mies, 1986; DAWN, 1995). Feminists who explain gender inequality in terms of patriarchy often reject male-biased societal structures and practices and propose greater female autonomy or even separatism as a strategy. In some views, women are seen as having room for manoeuvre within a constraining patriarchal system by negotiating a 'patriarchal bargain' with men. This entails a trade-off between women's autonomy, and men's responsibility for their wives and children.

An overarching theory of male power may help to conceptualise the extent of gender inequality but fails to deal with its complexity. It tends to assume that gender oppression is uniform across time and space. More recent thinking has therefore rejected such a universal concept, identifying the need for detailed historical and cultural analysis to understand gender-based oppression. Neither are women a homogeneous group constrained in identical ways. Gender inequalities are crosscut by other social inequalities such as class, caste, ethnicity and race, which could be prioritised over gender concerns in certain contexts. A rigid and universal concept of patriarchy denies women space for resistance and strategies for change. A more nuanced analysis is needed that takes into account difference and complexity, and the agency of women.

See also:
WID/GAD,
Gender discrimination,
Gender violence,
Culture

Further reading

Development Alternatives with Women for a New Era (DAWN), 1995, 'Rethinking social development: DAWN's vision (Development Alternatives with Women for a New Era)', World Development,ol.23, No.11, pp2001-04

Kandiyoti, D., 1998, 'Gender, power and contestation: rethinking bargaining with patriarchy', in Jackson, C., and Pearson, R., (eds.), 1998, Feminist Visions of Development: Gender Analysis and Policy, Routledge, London.

Mies, M., 1986, Patriarchy and Accumulation on a World Scale: Women in the International Division of Labour, Zed Books, London

Walby, S., 1990, Theorizing Patriarchy, Blackwell, Oxford.

SEX & GENDER

'Sex' refers to the biological characteristics that categorise someone as either female or male; whereas 'gender' refers to the socially determined ideas and practices of what it is to be female or male

Whilst often used interchangeably, 'sex' and 'gender' are in fact distinct terms.

'Sex': a person's sex is biologically determined as female or male according to certain identifiable physical features which are fixed. Women's marginalisation has often been seen as 'natural' and a fact of their biology. However these biological differences cannot explain why women have less access to power and lower status than men. To understand and challenge the cultural value placed on someone's biological sex, and unequal power hierarchies, we need the relational concept of 'gender'.

See also:
Gender analysis,
Gender relations,
WID/GAD

'Gender': how a person's biology is culturally valued and interpreted into locally accepted ideas of what it is to be a woman or man. 'Gender' and the hierarchical power relations between women and men based on this are socially constructed, and not derived directly from biology. Gender identities and associated expectations of roles and responsibilities are therefore changeable between and within cultures. Gendered power relations permeate social institutions so that gender is never absent.

The value of the distinction between the terms 'sex' and 'gender' has been challenged more recently as 'sex' has also been seen to be socially constructed (Baden and Goetz, 1998).

Use of the term gender, rather than sex, signals an awareness of the cultural and geographic specificity of gender identities, roles and relations. It also recognises gender inequality as the outcome of social processes, which can be challenged, rather than as a biological given. For this reason, its use can generate considerable opposition, particularly from conservative religious and cultural groups but also in mainstream development institutions.

Further reading

Baden. S., and Goetz, A., 1998, 'Who needs [sex] when you can have [gender]: Conflicting discourses on Gender at Beijing', in Jackson, C., and Pearson, R., (eds.) 1998, Feminist Visions of Development: Gender Analysis and Policy, Routledge, London

Østergaard, L., 1992, 'Gender', in Østergaard, L., (ed),1992, Gender and Development: A Practical Guide, Routledge, London

White, S., 1993, 'Gender and development: a review of key issues', mimeo, paper for JFS Workshop, Edinburgh, July 5-7

SOCIAL JUSTICE

Fairness and equity as a right for *all* in the outcomes of development, through processes of social transformation

The idea of 'social justice' as the outcome of struggles against social inequalities implies change towards a more 'fair' society. This requires strategies to redress past injustices, violation of rights or persistent economic and social inequalities. Social movements such as the women's, worker's, and human rights movements, have fought against perceived social injustices from a variety of entry points. Such movements have also challenged the ideologies and prejudices that legitimate social inequalities, in order to mobilise people for change.

There are varying conceptions of 'justice'. Common to them all is a formal idea of justice - the idea that inequalities of distribution must be justified by an impartial and rational assessment of 'relevant' differences between the people involved. One key theory of justice, based on Rawls' ideas, translates this into the idea of 'justice as fairness' with its equity overtones and need for redistributive strategies. Other thinking, derived from welfare economics, focuses on more 'efficiency' ideas of maximising overall utility or welfare, such that no-one can be made better off without someone else being worse off. In development thinking a 'capability' perspective of justice is common, based on the work of Amartya Sen, i.e. the idea that people should have the capabilities to survive and function and the freedom to pursue well-being. This requires both aggregative and redistributive considerations.

Mainstream poverty debates have tended to focus on meeting the basic needs of poor people and maximising their opportunities, rather than seeing poverty as an issue of social inequality or injustice. More radical perspectives, often adopted by NGOs, do see poverty as an issue of injustice and focus on organising and building capacity for the assertion of rights by the marginalised. The idea of poverty as an issue of rights is growing in influence in the development discourse, however, as for example in the DFID White Paper.

Strategies towards social justice have often overlooked the specific gender injustice or discrimination, as well as wider social injustices, faced by women. The women's movement has been working to ensure that efforts to address injustice, through human rights measures, or economic and social policies, are informed by an understanding of gender inequalities.

See also:
Gender discrimination,
Women's human rights

Further reading

Facio, A., 1995, 'From basic needs to basic rights', Gender and Development, Vol.3, No.2, Oxfam, Oxford

Harcourt, W., 1997, 'The search for social justice', development, Vol.40, pp5-11, The Society for International Development, SAGE Publications, London

Gasper, D., 1997, 'The capabilities approach to well-being, justice and human development', Journal of International Development, Vol.9, No.2

Sen, A., 'Gender inequality and theories of justice', in Nussbaum, M., and Glover, J., 1995, Women, Culture and Development: A Study of Human Capabilities, Ciarendon Press, Oxford

Sen, G., 1997, 'Globalization, justice and equity: a gender perspective', Development, Vol.40, No.2, pp21-26, The Society for International Development, SAGE Publications, London

'96

WID/GAD

The WID (or Women in Development) approach calls for greater attention to women in development policy and practice, and emphasises the need to integrate them into the development process

The WID perspective evolved in the early 1970s from a 'liberal' feminist framework and was particularly influential in North America. It was a reaction to women being seen as passive beneficiaries of development. It marked an important corrective, highlighting the fact that women need to be integrated into development processes as active agents if efficient and effective development is to be achieved. Women's significant productive contribution was made visible, although their reproductive role was downplayed. Women's subordination was seen in terms of their exclusion from the market sphere, and limited access to and control over resources. Programmes informed by a WID approach addressed women's practical needs by, for example, creating employment and income-generating opportunities, improving access to credit and to education. Women's 'problem' was therefore diagnosed as insufficient participation in a benign development process, through an oversight on behalf of policy-makers.

'Gender relations do not operate in a social vacuum but are products of the ways in which institutions are organized and reconstituted' (Kabeer, 1996:17)

In contrast, the GAD (or Gender and Development) approach to development policy and practice focuses on the socially constructed basis of differences between men and women and emphasises the need to challenge existing gender roles and relations

GAD emerged from a frustration with the lack of progress of WID policy, in changing women's lives and in influencing the broader development agenda. GAD challenged the WID focus on women in isolation, seeing women's 'real' problem as the imbalance of power between women and men. There are different interpretations of GAD, some of which focus primarily on the gender division of labour and gender roles focus on gender as a relation of power embedded in institutions (see *Gender Analysis*). GAD approaches generally aim to meet both women's practical gender needs and more strategic gender needs (see *Gender Needs*), by challenging existing divisions of labour or power relations (see *Gender Division of Labour; Gender Relations*).

See also: Gender analysis, Gender planning, Sex and gender

Although WID and GAD perspectives are theoretically distinct, in practice it is less clear, with a programme possibly involving elements of both. Whilst many development agencies are now committed to a gender approach, in practice, the primary institutional perspective remains as WID and associated 'anti-poverty' and 'efficiency' policies. There is often a slippage between GAD policy rhetoric and a WID reality where 'gender' is mistakenly interpreted as 'women'.

Further reading

Kabeer, N., and Subrahmanian, R., 1996, 'Institutions, relations and outcomes: framework and tools for gender-aware planning', IDS Discussion Paper, No.357, Institute of Development Studies, Brighton

Miller, C., and Razavi, S., 1995, 'From WID to GAD: conceptual shifts in the Women and Development discourse', Occasional Paper, UNRISD, Geneva

Moser, C., 1993, Gender Planning and Development: Theory, Practice and Training, Routledge, London

Young, K., 1993, 'Framework for analysis', in Young, K., 1993, Planning and Development with Women, Macmillan Press, London

WOMEN'S EMPOWERMENT

A 'bottom-up' process of transforming gender power relations, through individuals or groups developing awareness of women's subordination and building their capacity to challenge it. The term 'empowerment' is now widely used in development agency policy and programme documents, in general, but also specifically in relation to women. However, the concept is highly political, and its meaning contested. Thus, there are dangers in the uncritical overuse of the term in agency rhetoric, particularly where it becomes associated with specific activities, or used in simplistic ways.

Beijing Declaration:
'Women's empowerment and their full participation on the basis of equality in all sphere of society, including participation in the decision-making process and access to power, are fundamental for the achievement of equality, development and peace (paragraph 13).'
(cited in DAC, 1998: 10)

Central to the concept of women's empowerment is an understanding of power itself. Women's empowerment does not imply women taking over control previously held by men, but rather the need to transform the nature of power relations. Power may be understood as 'power within,' or self confidence, 'power with', or the capacity to organise with others towards a common purpose, and the 'power to' effect change and take decisions, rather than 'power over' others.

Empowerment is sometimes described as being about the ability to make choices, but it must also involve being able to shape what choices are on offer. What is seen as empowering in one context may not be in another.

Empowerment is essentially a bottom-up process rather than something that can be formulated as a top-down strategy. This means that development agencies cannot claim to 'empower women', nor can empowerment be defined in terms of specific activities or end results. This is because it involves a process whereby women, individually and collectively, freely analyse, develop and voice their needs and interests, without them being pre-defined, or imposed from above. Planners working towards an empowerment approach must therefore develop ways of enabling women themselves to critically assess their own situation and shape a transformation in society. The ultimate goal of women's empowerment is for women themselves to be the active agents of change in transforming gender relations.

See also:
Gender analysis,
Gender needs,
Gender training,
WID/GAD

Whilst empowerment cannot be 'done to' women, appropriate external support can be important to foster and support the process of empowerment. A facilitative rather than directive role is needed, such as funding women's organisations that work locally to address the causes of gender subordination and promoting dialogue between such organisations and those in positions of power.

See also: FAQ
'How can we measure empowerment?'

Recently, interest has grown among development professionals in approaches to measuring women's empowerment, particularly in relation to microcredit programmes. A number of 'indicators of empowerment' have been developed in different contexts. Again, caution must be exercised in assuming that empowerment can be externally defined and objectively assessed, or that such indicators can be easily transferred.

Further reading

Development Assistance Committee (DAC), 1998, 'Empowerment' in DAC Source Book on Concepts and Approaches Linked to Gender Equality, OECD, Paris

Rowlands, J., 1996, 'Empowerment examined', in Anderson, M., (ed), Development and Social Diversity, Oxfam, Oxford

Oxaal, Z., 1997, Gender and empowerment: definitions, approaches and implications for policy', BRIDGE Report, No. 40, Institute of Development Studies, Brighton

Johnson, H., 1992, 'Women's empowerment and public action: experiences from Latin America' in Wuyts, M., Mackintosh, M., and Hewitt, T., (eds.), 1992, Open University Press, Milton Keynes

Wieringa, S., 1994, 'Women's interests and empowerment: gender planning reconsidered', Development and Change, Vol.25, No.4

200

Further reading

Brems, E., 1997, 'Enemies or allies? Feminism and cultural relativism as dissident voices in human rights discourses', Human Rights Quarterly, Vol.19 pp136-164

International Women's Tribune Centre (IWTC), 1998, Rights of Women: A Guide to the Most Important United Nations Treaties on Women's Human Rights, International Women's Tribune Centre, New York

Oxaal, Z., and Baden, S., 1996, 'Human Rights and poverty: a gender analysis' BRIDGE Report, IDS, Brighton

20L

WOMEN'S HUMAN RIGHTS

The recognition that women's rights are human rights and that women experience injustices solely because of their gender. The UN Universal Declaration of Human Rights (1948) laid out the idea of the universality of rights, but failed to take into account women's needs and interests as women. Its focus was on formal political and civil rights, hence conceiving rights to be relevant to the 'public' rather than the 'private' sphere. As such, violations of women's bodily integrity, which occurred in the private sphere were not part of the human rights discourse.

Percentage of countries that have ratified the Women's Convention (CEDAW) worldwide:

- *60 percent without reservations*
- *29 percent with reservations*
- *11 percent not ratified*

(IWTC, 1998:126)

The Convention on the Elimination of all forms of Discrimination against Women (CEDAW) established in 1979 marked an important step towards explicit prohibition of discrimination against women. During preparations for the World Conference on Human Rights in Vienna (1993), women's groups mobilised around the slogan of "Women's rights are human rights!" which signifies the indivisibility of women's rights from universal human rights. Participants in the UN Beijing Women's Conference (1995) continued with this call, attempting to broaden the conception of rights to include social, economic, and cultural rights, as well as reproductive and sexual rights put on the agenda at the 1994 Cairo population conference.

'Despite these meticulously worded international treaties, discrimination against women persists on every level in every corner of the world'
(IWTC, 1998:20)

Gender-based violence has been a high profile issue in advocacy efforts on women's human rights. Groups have campaigned for the recognition as human rights of, for example, the right of women to freedom from rape, from sexual assault as refugees and displaced women, from abuse in custody, and particularly domestic violence. The 1993 Vienna Conference on Human Rights was a watershed as it marked the first international recognition of violence against women as a human rights violation. There is now a UN Special Rapporteur on Violence Against Women with the specific remit to gather facts and report to the UN.

See also:
Culture,
Gender discrimination,
Gender violence,
Social justice,

See also: FAQ
'As gender is a human rights issue, isn't legislation the answer?' and
'What right have we to interfere with other people's cultures?'

Whilst there has been progress in the recognition of women's human rights in international human rights instruments this has not been matched by progress in the implementation and enforcement of these rights by state bodies. Many countries have failed to ratify CEDAW, and some that have ratified it have failed to uphold it. Even when international and national laws recognise women's human rights, they may be undermined by patriarchal customary laws or social practices. Furthermore, human rights advocates, including those promoting women's rights, face challenges from those who regard human rights discourse as a western, imperialist imposition on other cultures.

Mobilisation of women to claim their rights is essential in order to press for reforms, and for the implementation and enforcement of human rights and national legal instruments. This requires strategies of capacity-building in terms of literacy, legal knowledge, and political participation. Gender-awareness training for the judiciary and the police, in addition to strengthening women's participation in these fields, is also crucial.

needs, it cannot meet strategic gender needs since it does not alleviate women's burden of domestic labour and child care. In addition, in many large cities the fear of male harassment prevents low-income women from using public transport, particularly late at night. Where women-only transportation is introduced, this meets the more strategic gender need of countering male violence.

In rural communities the timing of meetings can radically affect women's attendance, and consequently their capacity to gain access to important information relevant to them in both their productive and reproductive roles. Complaints by rural extension workers that women fail to attend their meetings are widespread. In a project in Botswana, for instance, meetings were held in the morning in order to ensure that male farmers, gathering in their productive and community politics role, were sober and attentive.[9] However, this timing automatically excluded women who were busy at this point of the day with essential reproductive responsibilities. Since information about family planning as well as credit schemes was intended primarily for women, rural extension workers were obliged to reschedule the meeting to an hour later in the day when women had 'free' time.

The examples cited above show the limitations of individual sectoral interventions for low-income women. Because of the necessity to balance their triple role, women require integrative strategies which cut across sectoral lines. They also reveal that the majority of planning interventions intended for women meet practical gender needs, and do not seek to change existing divisions of labour. Therefore they are not 'feminist' in content. In reality, practical gender needs remain the only specific policy target for most of those concerned with planning for women. Nevertheless, examples such as these do show that practical gender needs can be met once planners differentiate target groups not only on the basis of income, now commonly accepted, but also on the basis of gender.

The way the state has changed its policy towards women in developing countries, and the extent to which shifts in policy have occurred during the past thirty years, can best be understood through the examination of different policy approaches to women.

4 Third World policy approaches to women in development

Moser, C. O. N. (1993). ***Gender Planning and Development. Theory, Practice and Training.*** Chapter 4 Third World Policy Approaches to Women in Development. London: Routledge, pp. 54-79.

Throughout the Third World, particularly in the past fifteen years, there has been a proliferation of policies, programmes and projects designed to assist low-income women. Until recently, however, there has been little systematic classification or categorization of these various policy initiatives, other than the informative work of Buvinic (1983, 1986). This concern for low-income women's needs has coincided historically with a recognition of their important role in development. Since the 1950s many different interventions have been formulated. These reflect changes in macro-level economic and social policy approaches to Third World development, as well as in state policy towards women. Thus the shift in policy approaches towards women, from 'welfare', to 'equity' to 'anti-poverty', as categorized by Buvinic (1983), to two other approaches which I categorize as 'efficiency' and 'empowerment' has mirrored general trends in Third World development policies, from modernization policies of accelerated growth, through basic needs strategies associated with redistribution, to the more recent compensatory measures associated with structural adjustment policies.

Wide-scale confusion still exists concerning both the definition and use of different policy approaches. Many institutions at both national government and international agency level are unclear about their policy approach to women. Often the ubiquitous, so-called 'women in development' approach has mystified rather than clarified conceptual categories. This has served to legitimize a range of approaches to women, which incorporate different underlying assumptions in relation to their practical and strategic gender needs. It is precisely because of confusions such as these that it is important to develop simple, but sufficiently rigorous, tools to enable policy-makers and planners to understand with greater clarity the implications of their interventions in terms of both their potential and limitations in assisting Third World women.

To identify the extent to which policy interventions have been appropriate to the gender needs of women, it is necessary to examine their underlying

Table 4.1 Different policy approaches to Third World women

Isssues	*Welfare*	*Equity*
Origins	Earliest approach: – residual model of social welfare under colonial administration – modernization/ accelerated growth economic development model	Original WID approach: – failure of modernization development policy – influence of Boserup and First World Feminists on Percy Amendment of UN Decade for Women
Period most popular	1950–70; but still widely used	1975–85: attempts to adopt it during the Women's Decade
Purpose	To bring women into development as better mothers: this is seen as their most important role in development	To gain equity for women in the development process: women seen as active participants in development
Needs of women met and roles recognized	To meet PGN in reproductive role, relating particularly to food aid, malnutrition and family planning	To meet SGN in terms of triple role – directly through state top-down intervention, giving political and economic autonomy by reducing inequality with men
Comment	Women seen as passive beneficiaries of development with focus on their reproductive role; non-challenging, therefore widely popular especially with government and traditional NGOs	In identifying subordinate position of women in terms of relationship to men, challenging, criticized as Western feminism, considered threatening and not popular with government

PGN = Practical gender need
SGN = Strategic gender need

Tabel 4.1 (Continued)

Anti-poverty	*Efficiency*	*Empowerment*
Second WID approach: – toned down equity because of criticism – linked to redistribution with growth and basic needs	Third and now predominant WID approach: – deterioration in the world economy – policies of economic stabilization and adjustment rely on women's economic contribution to development	Most recent approach: – arose out of failure of equity approach – Third World women's feminist writing and grassroots organization
1970s onward: still limited popularity	Post-1980s: now most popular approach	1975 onward: accelerated during 1980s, still limited popularity
To ensure poor women increase their productivity: women's poverty seen as a problem of underdevelopment, not of subordination	To ensure development is more efficient and more effective: women's economic participation seen as associated with equity	To empower women through greater self-reliance: women's subordination seen not only as problem of men but also of colonial and neo-colonial oppression
To meet PGN in productive role, to earn an income, particularly in small-scale income-generating projects	To meet PGN in context of declining social services by relying on all three roles of women and elasticity of women's time	To reach SGN in terms of triple role – indirectly through bottom-up mobilization around PGN as a means to confront oppression
Poor women isolated as separate category with tendency only to recognize productive role; reluctance of government to give limited aid to women means popularity still at small-scale NGO level	Women seen entirely in terms of delivery capacity and ability to extend working day; most popular approach both with governments and multilateral agencies	Potentially challenging with emphasis on Third World and women's self-reliance; largely unsupported by governments and agencies; avoidance of Western feminism criticism means slow, significant growth of under-financed voluntary organizations

rationale from a gender planning perspective. In this chapter different policy approaches to women in development are examined in terms of roles recognized, practical or strategic gender needs met, and the extent to which participatory planning procedures are included. (Such analysis, summarized in Table 4.1, provides the basis for the development of further principles of gender planning.)

While the policy interventions are described chronologically, from welfare through to empowerment it is recognized that the linear process that this implies is an over-simplification of reality. In practice, many of the policies have appeared more or less simultaneously. Implementing agencies have not necessarily followed any ordered logic in changing their approach, most frequently jumping from welfare to efficiency without consideration of other approaches. Similarly, different policies have particular appeal to different types of institutions. Policy-makers often favour combined policy approaches in order simultaneously to meet the needs of different constituencies. Finally, shifts in policy approach often occur not only during the formulation stage, but also during the implementation process (Buvinic 1986). Given these caveats, the following policy types described should be viewed as 'ideal types'. The purpose here is to measure how far different policies meet practical or strategic needs (see Table 4.1).

THE WELFARE APPROACH

Introduced in the 1950s and 1960s, welfare is the earliest policy approach concerned with women in developing countries. Its purpose is to bring women into development as better mothers. Women are seen as passive beneficiaries of development. The reproductive role of women is recognized and policy seeks to meet practical gender needs through that role by top-down handouts of food aid, measures against malnutrition and family planning. It is non-challenging and therefore still widely popular.

The welfare approach is the oldest and still the most popular social development policy for the Third World in general, and for women in particular. It can be identified as pre-WID. Its underlying rationale towards women reflects its origins, which are linked to the residual model of social welfare, first introduced by colonial authorities in many Third World countries prior to independence. Their concern with law and order and the maintenance of stable conditions for trade and agricultural and mineral expansion meant that social welfare was a low priority. Echoing the nineteenth-century European Poor Laws with their inherent belief that social needs should be satisfied through individual effort in the market place, administrations dealt largely with crime, delinquency, prostitution and other forms of 'deviant' behaviour.

Voluntary charity organizations in turn carried a large share of the burden of social welfare (Hardiman and Midgley 1982). Because of welfare policy's compatibility with the prevailing development paradigms of modernization, it was continued by many post-independence governments (MacPherson and Midgley 1987). On the basis that 'social welfare institutions should come into play only when the normal structure of supply, the family and the market, break down' (Wilensky and Lebeaux 1965: 138), the ministries of social welfare, created for the implementation of such residual measures for 'vulnerable' groups, were invariably weak and under-financed.

In fact it was First World welfare programmes, widely initiated in Europe after the end of World War II, specifically targeted at 'vulnerable groups', which were among the first to identify women as the main beneficiaries. As Buvinic (1986) has noted, these were the emergency relief programmes accompanying the economic assistance measures intended to ensure reconstruction. Relief aid was provided directly to low-income women, who, in their gendered roles as wives and mothers, were seen as those primarily concerned with their family's welfare. This relief distribution was undertaken by international private relief agencies, and relied on the unpaid work of middle-class women volunteers for effective and cheap implementation.

The creation of two parallel approaches to development assistance – on the one hand, financial aid for economic growth; on the other hand, relief aid for socially deprived groups – was then replicated in development policy towards Third World countries. This strategy had critical implications for Third World women. It meant that international economic aid prioritized government support for capital-intensive, industrial and agricultural production in the formal sector, for the acceleration of growth focused on increasing the productive capacity of the male labour force. Welfare provision for the family was targeted at women, who, along with the disabled and the sick, were identified as 'vulnerable' groups, and remained the responsibility of the marginalized ministries of social welfare.

In most countries these ministries and the profession of social planning, frequently seen as their mandate, were from the outset dominated by women, particularly at the lower levels. Consequently, welfare policy was, and still is, frequently identified as 'women's work', serving to reinforce social planning as soft-edged, and of lesser importance than the hard-edged areas of economic and physical planning. Further assistance was then also provided by NGOs, such as the mother's clubs created in many Third World countries, and, to a lesser extent, by bilateral aid agencies with specific mandates for women and children, such as the United Nations Children's Fund (UNICEF).

The welfare approach is based on three assumptions. First, that women are passive recipients of development, rather than participants in the development process. Secondly, that motherhood is the most important role

for women in society. Thirdly, that child-rearing is the most effective role for women in all aspects of economic development. While this approach sees itself as 'family-centred' in orientation, it focuses on women entirely in terms of their reproductive role, it assumes men's role to be productive, and it identifies the mother–child dyad as the unit of concern. The main method of implementation is through 'top-down' handouts of free goods and services, and therefore it does not include women or gender-aware local organizations in participatory planning processes. When training is included it is for those skills deemed appropriate for 'non-working' housewives and mothers. In their mothering roles low-income women have been the primary targets for improving family welfare, particularly of children, through an increasing diversity of programmes, reflecting a broadening of the mandate of welfare over the past three decades.

With its origins in relief work, the first and still the most important, concern of welfare programmes is family physical survival, through the direct provision of food aid. Generally this is provided in the short term after such natural disasters as earthquakes or famines. However, food aid has increasingly become a longer-term need for refugees seeking protection. Although the majority of refugees in camps are women, left as heads of households to care and often provide for the children and elderly, they usually do not have refugee status in their own right but only as wives within the family (Bonnerjea 1985). Projects implemented by the United Nations High Commission for Refugees (UNHCR) and NGOs most often focus on these women in their reproductive role, with special attention given to those pregnant or lactating. These are identified as a 'vulnerable' group in the same category as the elderly, orphans and the handicapped (Weeda 1987).[1]

In the extensive international effort to combat Third World malnutrition, another emphasis of welfare programmes is nutritional education. This targets children under five years, as well as pregnant and nursing mothers. Since the 1960s, Mother–Child Health Programmes (MCH) have distributed, cooked or rationed food along with giving nutrition education at feeding centres and health clinics. In linking together additional food for children and nutrition education for mothers, MCH focuses on the mother–child dyad, and the reproductive role of women, on the assumption that extra provisions will make them better mothers. Although by the early 1980s considerable criticism had been expressed about the use of food aid to guarantee nutritional improvement of children, the focus on women in their role as mothers was not seen as problematic.[2]

Most recently, especially since the 1970s, welfare policy towards women has been extended to include population control through family planning programmes. Thus development agencies responding to the world's population 'problem' identified women, in their reproductive role, as primarily responsible for limiting the size of families. Early programmes assumed that poverty could be reduced by simply limiting fertility, to be achieved through the widespread dissemination of contraceptive knowledge and technology to women. Only the obvious failure of this approach led population planners to realize that variables relating to women's status, such as education and labour-force participation, could affect fertility differentials and consequently needed to be taken into consideration. By 1984 the World Bank's World Development Report, for instance, identified reducing infant and child mortality, educating parents (especially women) and raising rural incomes, women's employment and legal and social status, as key incentives to fertility decline (World Bank 1984). However, recognition of the links between women's autonomy over their own lives and fertility control is not widespread and women continue to be treated in an instrumental manner in population programmes. The lack of satisfactory birth-control methods, and the introduction of more invasive techniques (such as IUDs and hormonal implants) is making birth control even more 'women-centred'. As DAWN (1985) has argued, this lets men off the hook in terms of their responsibility for birth control, while increasingly placing the burden on women. Their ambivalence towards contraceptive technology will only be removed when the technology is better adapted to the social and health environments in which they are used.

Although welfare programmes for women have widened their scope considerably over the past decades, the underlying assumption is still that motherhood is the most important role for women in Third World development. This means that their major concern has been with meeting practical gender needs relating to women's reproductive role. Intrinsically, welfare programmes identify 'women' rather than lack of resources, as the problem, and place the solution to family welfare in their hands, without questioning their 'natural' role. Although the top-down handout nature of so many welfare programmes tends to create dependency rather than assisting women to become more independent, they remain popular precisely because they are politically safe, not questioning or changing the traditionally accepted role of women within the gender division of labour. Such assumptions tend to result in the exclusion of women from development programmes operated by the mainstream development agencies which provide a significant proportion of development funds (Germaine 1977). The fact that the welfare approach is not concerned to meet such strategic gender needs as the right for women to have control over their own reproduction was highlighted by a Third World women's group when they wrote:

> Women know that childbearing is a social not a purely personal phenomenon: nor do we deny that world population trends are likely to exert

> considerable pressure on resources and institutions by the end of the century. But our bodies have become a pawn in the struggles among states, religions, male heads of households, and private corporations. Programmes that do not take the interests of women into account are unlikely to succeed.
>
> (DAWN 1985: 42)

Although by the 1970s dissatisfaction with the welfare approach was widespread, criticism differed as to its limitations. This depended on which of the three constituencies it came from; first, in the United States, a group of mainly female professionals and researchers who were concerned with the increasing evidence that Third World development projects were negatively affecting women; second, development economists and planners who were concerned with the failure of modernization theory in the Third World; and third, the United Nations (UN), that combined both of these concerns. The voicing of these concerns led to the United Nations 1975 International Women's Year Conference. This formally 'put women on the agenda' and provided legitimacy for the proliferation of a wide diversity of Third World women's organizations, in turn leading to the UN designating 1976–85 as the Women's Decade.

During this decade the critique of the welfare approach resulted in the development of a number of alternative approaches to women: namely, equity, anti-poverty, efficiency and empowerment. The fact that these approaches share many common origins, were formulated during the same decade and are not entirely mutually exclusive, means that there has been a tendency not only to confuse them, but indeed to categorize them together as the 'women in development' (WID) approach. With hindsight, it is clear that there are significant differences between these approaches which it is important to clarify.

The lack of definition of WID has been widespread in the proliferating number of national-level WID ministries and bureaux, which implement a large number of policies under the umbrella of the WID approach (Gordan 1984). This has also been the case with bilateral and multilateral donors.[3]

THE EQUITY APPROACH

Equity is the original 'WID' approach, introduced within the 1976–85 UN Women's Decade. Its purpose is to gain equity for women in the development process. Women are seen as active participants in development. It recognizes women's triple role and seeks to meet strategic gender needs through direct state intervention, giving political and economic autonomy to women, and reducing inequality with men. It challenges women's subordinate position,

has been criticized as Western feminism, is considered threatening and is unpopular with governments.

By the 1970s studies showed that although women were often the predominant contributors to the basic productivity of their communities, particularly in agriculture, their economic contribution was referred to neither in national statistics nor in the planning and implementation of development projects (Boserup 1970). At the same time new modernization projects, with innovative agricultural methods and sophisticated technologies, were negatively affecting women. These were displacing them from their traditional productive functions, and diminishing the income, status and power they had in traditional relations. Findings indicated that neo-colonialism, as much as colonialism, was contributing to the decline in women's status in developing countries.

Tinker, in her documentation of development projects that had widened the gap between men and women, argued that development planners were 'unable to deal with the fact that women must perform two roles in society whereas men perform only one' (1976: 22). She attributed the adverse impact of development on women to three types of planning error: first, errors of omission or failure to acknowledge and utilize women's productive role; second, errors that reinforced values which restrict women to the household engaged in childbearing and childrearing activities; and third, errors of inappropriate application of Western values regarding women's work (1976). On the basis of evidence such as this, the WID group in the United States challenged the prevailing assumption that modernization was equated with increasing gender equality, asserting that capitalist development models imposed on much of the Third World had exacerbated inequalities between men and women. Recognition of the damaging effects of ignoring women in USAID projects during the First Development Decade (1960–70) made the WID group work to influence USAID policy. Lobbying of Congressional hearings resulted in the 1973 Percy Amendment to the US Foreign Assistance Act, which mandated that US assistance help 'move women into their national economies' in order to improve women's status and assist the development process (Tinker 1982; Maguire 1984).

The original WID approach was in fact the equity approach.[4] This approach recognizes that women are active participants in the development process, who through both their productive and reproductive roles provide a critical, if often unacknowledged, contribution to economic growth. The approach starts with the basic assumption that economic strategies have frequently had a negative impact on women. It acknowledges that they must be 'brought into' the development process through access to employment and the market place. It therefore accepts women's practical gender need to

earn a livelihood. However, the equity approach is also concerned with fundamental issues of equality which transcend the development field. As Buvinic (1986) has described, its primary concern is with inequality between men and women, in both public and private spheres of life and across socio-economic groups. It identifies the origins of women's subordination not only in the context of the family, but also in relations between men and women in the market place. Hence it places considerable emphasis on economic independence as synonymous with equity.

In focusing particularly on reducing inequality between men and women in the gender division of labour, the equity approach meets an important strategic gender need. Equity programmes are identified as uniting notions of development and equality. The underlying logic is that women have lost ground to men in the development process. Therefore, in a process of redistribution, men have to share in a manner which entails women from all socio-economic classes gaining and men from all socio-economic classes losing (or gaining less), through positive discrimination policies if necessary. The rational consequence of this is seen to be greater equality with an accompanying increase in economic growth (Buvinic 1983). Although the approach emphasized 'top-down' legislative and other measures as the means to ensure equity, gendered consultative and participatory planning procedures were implicitly assumed. This was particularly the case since the introduction of the equity approach itself had been the consequence of the bottom-up confrontation of existing procedures by feminist women's organizations.

In fact, the theme selection for the 1975 International Women's Year (IWY) Conference showed that the equity approach, despite its identification as 'developmental', in many respects was more concerned to reflect First World feminist preoccupations with equality. Third World delegations, while acknowledging women's problems, identified development as their main concern, maintaining that this would increase women's status. Second World delegates were more concerned with peace, claiming that the capitalist system and its associated militarism was responsible for women's problems – hence the theme of Equality, Development and Peace (Stephenson 1982).

The World Plan of Action for the Implementation of the Objectives of the IWY firmly reflected the equity approach. It called for equality between men and women, required that women should be given their fair share of the benefits of development, and recognized the need for changes in the traditional role of men as well as women (UN 1976a). The Plan set the agenda for future action for the Women's Decade, with the common goal of integrating women into the development process. In reality, the interpretation of the agenda varied. This was reflected in the language used, which ranged from the definitely expressed aim to 'integrate', 'increase', 'improve' or 'upgrade'

women's participation in development to the more tentatively worded desire to 'help create a more favorable climate for improving women's options in development' (World Bank 1980: 14).

Despite such rhetoric, equity programmes encountered problems from the outset. Methodologically, the lack of a single unified indicator of social status or progress of women and of baseline information about women's economic, social and political status meant that there were no standards against which 'success' could be measured (USAID 1978). Politically, the majority of development agencies were hostile to equity programmes precisely because of their intention to meet not only practical gender needs but also strategic gender needs, whose very success depended on an implicit redistribution of power. As Buvinic has commented:

> Productivity programmes for women usually require some restructuring of the cultural fabric of society, and development agencies do not like to tamper with unknown and unfamiliar social variables. As a rule of thumb they tend to believe in upholding social traditions and thus are reluctant to implement these programmes.
>
> (1983: 26)

From the perspective of the aid agency, equity programmes necessitated unacceptable interference with the country's traditions. At the same time recognition of equity as a policy principle did not guarantee its implementation in practice. In Europe the Organization for Economic Cooperation and Development Assistance Committee's (OECD/DAC) Guiding Principles to Aid Agencies for Supporting the Role of Women in Development identified 'integration' as critical for a policy on WID issues. However, in a review of European Development Assistance, Andersen and Baud (1987) argued that although policy statements of most donor countries were in general accord with the idea of equality, nevertheless at the level of policy, integration had been mainly interpreted to mean an increasing number of women in existing policies and programmes. Thus, they concluded that 'implicit in such an approach was the idea that current development models were in principle favourable to women, and that they therefore did not need to take account of women's vision or priorities' (1987: 22).

Despite their endorsement of the Plan of Action, similar antipathy was felt by many Third World governments, legitimized by their belief in the irrelevance of Western-exported feminism to Third World women. In fact, one of the outcomes of the 1975 Conference was the labelling of feminism as ethnocentric and divisive to WID. Many Third World activists felt that to take 'feminism to a woman who has no water, no food and no home is to talk nonsense' (Bunch 1980: 27), and labelled Third World socialists and feminists as bourgeois imperialist sympathizers. At the same time the fact that there

was only one reference to women in the various documents of the 1970 UN New International Economic Order Conference revealed that the importance of women was still identified in terms of their biological role by those formulating policies for the Third World.

In a climate of widespread antagonism to many of its underlying principles from development agencies and Third World governments alike, the equity approach has been effectively dropped by the majority of implementing agencies. However, its official endorsement in 1975 ensured that it continues to provide an important framework for those working within government to improve the status of women through official legislation, on issues such as those described in Chapter 3. Tinker and Jaquette (1987), in reviewing the 1976–85 Women's Decade conference documents, noted that the goal of legal equality of women had been accepted as a minimum basis of consensus from which to begin the discussion of more controversial issues. This included the rights of divorce, of custody of children, property, credit, voting and other citizen rights.

Significant though the ratification of such legislation is, it is necessary to recognize that it meets potential strategic gender needs, rather than actual needs. As illustrated in Chapter 3, property rights, arranged marriages, dowry and child custody rights provide much cited examples of the highly sensitive strategic gender needs which are often still curtailed by custom, even when amended by law. Even the incorporation of practical gender needs into the mainstream of development plans does not guarantee their implementation in practice. Mazumdar (1979) noted that the incorporation of women's concerns into the framework of India's Sixth Year Plan indicated India's constitutional commitment to equality of opportunity. Such constitutional inclusions, however, in no way ensured practical changes. In her opinion these are largely a function of the strength of the political power base of organized women's groups. Ultimately, the equity approach has been constructed to meet strategic gender needs through top-down legislative measures. The bottom-up mobilization of women into political pressure groups to ensure that policy becomes action is the mandate of the empowerment approach, developed by Third World women, and described later.

THE ANTI-POVERTY APPROACH

Anti-Poverty is the second WID approach, the 'toned down' version of equity, introduced from the 1970s onwards. Its purpose is to ensure that poor women increase their productivity. Women's poverty is seen as the problem of underdevelopment, not of subordination. It recognizes the productive role of women, and seeks to meet practical gender needs to earn an income, particularly through small-scale income-generating projects. It is most popular with NGOs.

The anti-poverty approach to women can be identified as the second WID approach, in which economic inequality between women and men is linked not to subordination but to poverty. The emphasis thus shifts from reducing inequality between men and women, to reducing income inequality. Women's issues are separated from equity issues and linked instead to the particular concern for the majority of Third World women, as the 'poorest of the poor'. Buvinic (1983) has argued that this is a toned-down version of the equity approach, arising out of the reluctance of development agencies to interfere with the manner in which relations between men and women are constructed in a given society. However, this shift also coincided with the end of the unsuccessful First Development Decade, and the formulation of alternative models of Third World economic and social development.

By the early 1970s it was widely recognized that modernization theory, with its accelerated growth strategies based on maximizing GNP, had failed, either to redistribute income or to solve the problems of Third World poverty and unemployment. Contrary to predictions about the positive welfare effects of rapid economic growth, financial benefits had not 'trickled down' to the poor. An early initiative was the International Labour Organization's (ILO) World Employment Programme in which employment became a major policy objective in its own right. The 'working poor' were identified as the target group requiring particular attention, and the informal sector with its assumed autonomous capacity to generate employment was seen as the solution (Moser 1978, 1984). In 1972 the World Bank officially shifted from a preoccupation with economic growth to a broader concern with the eradication of absolute poverty and the promotion of 'redistribution with growth'. Integral to this was the 'basic needs strategy', with its primary purpose to meet 'basic needs' such as food, clothing, shelter and fuel, as well as social needs such as education, human rights and 'participation' in social life through employment and political involvement (Ghai 1978; Streeton *et al.* 1981). Low-income women were identified as one particular 'target group' to be assisted in escaping absolute deprivation: first, because the failure of 'trickle-down' was partially attributed to the fact that women had been ignored in previous development plans; and secondly, because of the traditional importance of women in meeting many of the basic needs of the family (Buvinic 1982).

The anti-poverty policy approach to women focuses mainly on their productive role, on the basis that poverty alleviation and the promotion of balanced economic growth requires the increased productivity of women in low-income households. Underlying this approach is the assumption that the

origins of women's poverty and inequali y with men are attributable to their lack of access to private ownership o land and capital, and to sexual discrimination in the labour market. Co isequently, it aims to increase the employment and income-generating opti ons of low-income women through better access to productive resources. The preoccupation of basic needs strategies with population control also resulted in increasing recognition that education and employment programmes could simultaneously increase women's economic contribution and reduce fertility.[5]

One of the principal criticisms of employment programmes for women is that since they have the potential to modify the gender division of labour within the household, they may also imply changes in the balance of power between men and women within the family. In anti-poverty programmes this redistribution of power is said to be reduced, because the focus is specifically on low-income women, and because of the tendency to encourage projects in sex-specific occupations in which women are concentrated, or to target only women who head households. The fear, however, that programmes for low-income women may reduce the already insufficient amount of aid allocated to low-income groups in general means that Third World governments have remained reluctant to allocate resources from national budgets to women. Frequently, the preference is to allocate resources at the family or household level, despite the fact that they generally remain in the hands of the male head of household.

While income-generating projects for low-income women have proliferated since the 1970s, they have tended to remain small in scale, to be developed by NGOs (most frequently all-women in composition), and to be assisted by grants, rather than loans, from international and bilateral agencies. Most frequently they aim to increase productivity in activities traditionally undertaken by women, rather than to introduce women to new areas of work, with a preference for supporting rural-based production projects as opposed to those in the service and distribution sectors, which are far more widespread in the urban areas of many developing countries.[6]

Considerable variation has been experienced in the capacity of such projects to assist low-income women to generate income. Buvinic (1986) has highlighted the problems experienced by anti-poverty projects in the implementation process, due to the preference to shift towards welfare-orientated projects. However, such projects also experience considerable constraints in the formulation stage. In theory, 'basic needs' assumed a participatory approach, yet in practice anti-poverty projects for women rarely included participatory planning procedures; mechanisms to ensure that women and gender-aware organizations be included remained undeveloped. In the design of projects, fundamental conditions to ensure viability are often ignored, including access to easily available raw materials, guaranteed markets and small-scale production capacity (Schmitz 1979; Moser 1984). Despite widespread recognition of the limitations of the informal sector to generate employment and growth in an independent or evolutionary manner, income-generating projects for women continue to be designed as though small-scale enterprises have the capacity for autonomous growth (Schmitz 1982; Moser 1984).

In addition, the particular constraints that women experience in their gendered roles are also frequently ignored. These may include problems of perception in separating reproductive from productive work, as well as those associated with 'balancing' productive work alongside domestic and child-care responsibilities. In many contexts there are cultural constraints that restrict women's ability to move freely outside the domestic arena and therefore to compete equally with men running similar enterprises (Moser 1981). Where men control household financial resources, women are unable to save unless special safe facilities are provided (Sebsted 1982). Equally, where women cannot obtain equal access to credit, such as through lack of collateral, they are often unable to expand their enterprises unless non-traditional forms of credit are available to them (Bruce 1980; IWTC 1985). Finally, the tendency to distinguish between micro-enterprise projects for men, and income-generating projects for women, is indicative of the prevailing attitude, even among many NGOs, that women's productive work is of less importance than men's, and is undertaken as a secondary earner or 'for pocket money'.

Anti-poverty income-generating projects may provide employment for women, and thereby meet practical gender needs, by augmenting their income, but unless employment leads to greater autonomy it does not meet strategic gender needs. This is the essential difference between the equity and anti-poverty approaches. In addition, the predominant focus on the productive role of women in the anti-poverty approach means that their reproductive role is often ignored. Income-generating projects which assume that women have 'free time' often only succeed by extending their working day and increasing their triple burden. Unless an income-generating project also alleviates the burden of women's domestic labour and child care – for instance, through the provision of adequate socialized child caring – it may fail even to meet practical gender need to earn an income.

THE EFFICIENCY APPROACH

Efficiency is the third, and now predominant WID approach, particularly since the 1980s debt crisis. Its purpose is to ensure that development is more efficient and effective through women's economic contribution. Women's participation is equated with equity for women. It seeks to meet practical

gender needs while relying on all of women's three roles and an elastic concept of women's time. Women are seen primarily in terms of their capacity to compensate for declining social services by extending their working day. It is very popular as an approach.

Although the shift from equity to anti-poverty has been well documented, the identification of WID as efficiency has passed almost unnoticed. Yet, I would argue the efficiency approach is now the predominant approach for those working within a WID framework – indeed, for many it may always have been. In it the emphasis has shifted away from women and towards development, on the assumption that increased economic participation for Third World women is automatically linked with increased equity. This has allowed organizations such as USAID, the World Bank and OECD to propose that an increase in women's economic participation in development links efficiency and equity together. Amongst others, Maguire (1984) has argued that the shift from equity to efficiency reflected a specific economic recognition of the fact that 50 percent of the human resources available for development were being wasted or under-utilized. Although the so-called development industry realized that women were essential to the success of the total development effort, it did not necessarily follow that development improved conditions for women.[7] The assumption that economic participation increases women's status and is associated with equity has been widely criticized. Problems such as lack of education and under-productive technologies have also been identified as the predominant constraints affecting women's participation.

The shift towards efficiency coincided with a marked deterioration in the world economy, occurring from the mid-1970s onwards, particularly in Latin America and Africa, where the problems of recession were compounded by falling export prices, protectionism and the mounting burden of debt. To alleviate the situation, economic stabilization and adjustment policies designed by the International Monetary Fund (IMF) and the World Bank have been implemented by an increasing number of national governments. These policies, through both demand management and supply expansion, lead to the reallocation of resources to enable the restoration of a balance of payments equilibrium, an increase in exports and a rejuvenation in growth rates.

With increased efficiency and productivity as two of the main objectives of Structural Adjustment Policies (SAPs), it is no coincidence that efficiency is the policy approach towards women which is currently gaining popularity amongst international aid agencies and national governments alike. Again top-down in approach, without gendered participatory planning procedures, in reality SAPs often simply mean a shifting of costs from the paid to the unpaid economy, particularly through the use of women's unpaid time. While

the emphasis is on women's increased economic participation, this has implications for women not only as reproducers, but also increasingly as community managers. In the housing sector, for instance, one such example is provided by 'site and service' and upgrading projects with self-help components which now regularly include women in the implementation phase. This is a consequence of the need for greater efficiency: not only are women as mothers more reliable than men in repaying building loans, but also as workers they are equally capable of self-building alongside men, while as community managers they have shown far greater commitment than men in ensuring that services are maintained (Fernando 1987; Nimpuno-Parente 1987).

Disinvestments in human resources, made in the name of greater efficiency in IMF and World Bank 'conditionality' policies, have resulted in declines in income levels, severe cuts in government social expenditure programmes, particularly health and education, and reductions in food subsidies. These cuts in many of the practical gender needs of women are seen to be cushioned by the elasticity of women's labour in increasing self-production of food, and changes in purchasing habits and consumption patterns. In fact, underlying many SAPs, as Elson has identified, are three 'kinds of male bias' (Elson 1991: 6; Moser 1992a). The first male bias, as described above, focuses on the unpaid domestic work necessary for reproducing and maintaining human resources. It concerns the extent to which SAPs implicitly assume that processes carried out by women in such unpaid activities as caring for children, gathering fuel, processing food, preparing meals and nursing the sick will continue regardless of the way in which resources are reallocated. For SAPs define economies only in terms of marketed goods and services and subsistence cash production and exclude women's reproductive work. This raises the question as to how far SAPs are only successful at the cost of longer and harder working days for women, who are forced to increase their labour both within the market and the household. Preoccupation has been expressed regarding the extent to which women's labour is infinitely elastic, or whether a breaking point may be reached when their capacity to reproduce and maintain human resources may collapse (Jolly 1987).

Moreover, the issue not only concerns the elasticity of time, but also the balancing of time. Evidence from a longitudinal study of a low-income community in Guayaquil, Ecuador, showed that the real problem was not the length of time women worked, but the way, under conditions of recession and adjustment, they were forced to change the balance of their time between activities undertaken in each of their triple roles. Over the past decade these low-income women have always worked between twelve and eighteen hours per day, depending on such factors as the composition of the household, the

time of year and their skills. Therefore, the hours worked have not changed fundamentally. What has changed is the time allocated to different activities. The need to gain access to resources has forced women to allocate increasing time to productive and community managing activities, at the expense of reproductive activities, which in many cases have become a secondary priority delegated wherever possible to daughters or other female household members. The fact that paid work and unpaid work are competing for women's time has important impacts on children, on women themselves and on the disintegration of the household (Moser 1992a).

The problem of balancing time is also of importance in relation to a second 'male bias' in SAPs. This involves ignoring barriers to labour re-allocation in policies designed to switch from non-tradables to tradables, by offering incentives to encourage labour-intensive manufacturing, and, particularly in sub-Saharan Africa, crops for export. In the urban sector, gender barriers to the re-allocation of labour have often meant greater unemployment for men displaced from non-tradables, while for any women drawn into export-orientated manufacturing, they have meant extra work, as factory employment is added to the unpaid domestic work which unemployed men remain reluctant to undertake. In rural areas the introduction of export-orientated crops has often meant increased agricultural work for women with less time for the production of subsistence family crops, resulting in both increased intra-household conflict and in worrying consequences for children's nutrition levels (Evans and Young 1988; Feldman 1989) (see Chapter 2, section beginning on page 18).

The third 'male bias' concerns the household as the social institution which is the source of the supply of labour. This concerns the assumption of an equal intra-household distribution of resources, which in turn means that changes in resource allocations in income, food prices and public expenditure, accompanying stabilization and SAPs, affect all members of the household in the same way (Elson 1991). Here policy assumes that the household has a 'joint utility' or 'unified family welfare' function with a concern to maximize the welfare of all its members, even if it assumes the altruism of benevolent dictatorship. Consequently, planners have treated it as 'an individual with a single set of objectives' (Evans 1989; Elson 1992) (see also Chapter 2, section beginning on page 18).

Until recently, structural adjustment has been seen purely as an economic issue, and evaluated in economic terms (Jolly 1987). Although documentation regarding its social costs is still unsystematic, it does reveal a serious deterioration in living conditions of low-income populations resulting from a decline in income levels. A gender-differentiated impact on intra-household resource distribution, with particularly detrimental effects on the lives of children and women, is also apparent (Cornia *et al.* 1987, 1988; Afshar and Dennis 1992). Within the household a decline in consumption often affects women more than men. The introduction of charges for education and health care can reduce access more severely for girls than for boys. The capacity of the household to shoulder the burden of adjustment can have detrimental effects in terms of human relationships, expressed in increased domestic violence, mental health disorders and increasing numbers of women-headed households resulting from the breakdown in nuclear family structures (UNICEF n.d.).

UNICEF's widely publicized plea to devise adjustment policies 'with a human face' now challenges the efficiency basis of IMF and World Bank policy. It argues that women's concerns, both in the household and in the workplace, need consciously to be made part of the formulation of adjustment policies. This in turn will require the direct involvement of women in both the definition of development and the adjustments in its management (Jolly 1987). On paper, UNICEF's current recommendations to assist low-income women would appear highly laudable. Yet optimism that an international agency has the capacity to effect policy measures designed to increase the independence of women must be treated with caution.

This point can be illustrated through the appraisal of some of the recent compensatory policies endorsed by UNICEF. These are designed to protect basic health and nutrition of the low-income population during adjustment, before growth resumption enables them to meet their basic needs independently. In a number of nutrition interventions, such as targeted food subsidies and direct feeding for the most vulnerable, it is assumed that women in their community managing role will take responsibility for the efficient delivery of such services. For example, in Lima, Peru, the Vaso de Leche (Glass of Milk) direct feeding programme, which provides a free glass of milk to young children in the low-income areas of the city, is managed by women in their unpaid time. Similarly, the much-acclaimed communal kitchen organizations which receive targeted food subsidies depend on the organizational and cooking ability of women to ensure that the cooked food reaches families in the community (Sara-Lafosse 1984). While both programmes are aimed at improving the nutritional status of the population, especially the low-income groups, this is achieved through reliance on women's unpaid time (Cornia *et al.* 1988).

These examples illustrate the fact that the efficiency approach relies heavily on the elasticity of women's labour in both their reproductive and community managing roles. It only meets practical gender needs at the cost of longer working hours and increased unpaid work. In most cases this approach fails to reach any strategic gender needs. Because of the reductions in resource allocations, it also results in a serious reduction in the practical gender needs met.

THE EMPOWERMENT APPROACH

Empowerment is the most recent approach, articulated by Third World women. Its purpose is to empower women through greater self-reliance. Women's subordination is seen not only as the problem of men but also of colonial and neo-colonial oppression. It recognizes women's triple role, and seeks to meet strategic gender needs indirectly through bottom-up mobilization around practical gender needs. It is potentially challenging, although it avoids the criticism of being Western-inspired feminism. It is unpopular except with Third World women's NGOs and their supporters.

The fifth policy approach to women is that of empowerment. It is still neither widely recognized as an 'approach' nor documented as such, although its origins are by no means recent. Superficially it may appear synonymous with the equity approach, with references often made to a combined equity/empowerment approach. In many respects empowerment developed out of dissatisfaction with the original WID as equity approach, because of its perceived co-option into the anti-poverty and efficiency approaches. However, the empowerment approach differs from the equity approach. This relates not only in its origins, but also in the causes, dynamics and structures of women's oppression which it identifies, and in terms of the strategies it proposes to change the position of Third World women.

The origins of the empowerment approach are derived less from the research of First World women, and more from the emergent feminist writings and grassroots organizational experience of Third World women; it accedes that feminism is not simply a recent Western urban middle-class import. As Jayawardena (1986) has written, the women's movement was not imposed on women by the United Nations or Western feminists, but has an independent history. The empowerment approach acknowledges inequalities between men and women, and the origins of women's subordination in the family. But it also emphasizes the fact that women experience oppression differently according to their race, class, colonial history and current position in the international economic order. It therefore maintains that women have to challenge oppressive structures and situations simultaneously at different levels.

The empowerment approach questions some of the fundamental assumptions concerning the interrelationship between power and development that underlie previous approaches. It acknowledges the importance for women to increase their power. However, it seeks to identify power less in terms of domination over others (with its implicit assumption that a gain for women implies a loss for men), and more in terms of the capacity of women to increase their own self-reliance and internal strength. This is identified as the

right to determine choices in life and to influence the direction of change, through the ability to gain control over crucial material and non-material resources. It places far less emphasis than the equity approach on increasing women's 'status' relative to men. It thus seeks to empower women through the redistribution of power within, as well as between, societies. It also questions two underlying assumptions in the equity approach: first, that development necessarily helps all men; and secondly, that women want to be 'integrated' into the mainstream of Western designed development, in which they have no choice in defining the kind of society they want (UNAPCWD 1979).

The best-known articulation of the empowerment approach has been made by the Development Alternatives with Women for a New Era (DAWN). This is a loose formation of individual women and women's groups set up prior to the 1985 World Conference of Women in Nairobi.[8] Their purpose has been not only to analyze the conditions of the world's women, but also to formulate a vision of an alternative future society, which they identify as follows:

> We want a world where inequality based on class, gender and race is absent from every country and from the relationships among countries. We want a world where basic needs become basic rights and where poverty and all forms of violence are eliminated. Each person will have the opportunity to develop her or his full potential and creativity, and women's values of nurturance and solidarity will characterize human relationships. In such a world women's reproductive role will be redefined: childcare will be shared by men, women and society as a whole ... only by sharpening the links between equality, development and peace, can we show that the 'basic rights' of the poor and the transformations of the institutions that subordinate women are inextricably linked. They can be achieved together through the self-empowerment of women.
>
> (1985: 73–5)[9]

Using time as a basic parameter for change, DAWN distinguishes between long-term and short-term strategies. Long-term strategies are needed to break down the structures of inequality between genders, classes and nations. Fundamental requisites for this process include national liberation from colonial and neo-colonial domination, shifts from export-led strategies in agriculture and greater control over the activities of multinationals. Short-term strategies are identified as necessary to provide ways of responding to current crises. Measures to assist women include food production through the promotion of a diversified agricultural base, as well as in formal and informal sector employment.

Although short-term strategies correspond to practical gender needs,

long-term strategies contain a far wider agenda than do strategic gender needs, with national liberation identified as a fundamental requisite for addressing them. DAWN in their description of this approach, however, do not identify the means to ensure that once national liberation has been achieved, women's liberation will follow. As discussed in Chapter 3, recent liberation and socialist struggles in countries such as Cuba, Nicaragua and Zimbabwe have shown this not necessarily to have been the case (Murray 1979a, 1979b; Molyneux 1981, 1985b). One of the reasons why the categorization of practical and strategic gender needs does not consider time as a determinant of change lies in the implicit, underlying assumptions that short-term change leads to long-term transformation. In the same way it cannot be assumed that meeting practical strategic gender needs will automatically result in the satisfaction of strategic gender needs.

The new era envisaged by DAWN also requires the transformation of the structures of subordination that have been so inimical to women. Changes in law, civil codes, systems of property rights, control over women's bodies, labour codes and the social and legal institutions that underwrite male control and privilege are essential if women are to attain justice in society. These strategic gender needs are similar to those identified by the equity approach. It is in the means of achieving such needs that the empowerment approach differs most fundamentally from previous approaches. Recognition of the limitations of top-down government legislation actually, rather than potentially, to meet strategic gender needs has led adherents of the empowerment approach to acknowledge that their strategies will not be implemented without the sustained and systematic efforts of women's organizations and like-minded groups. Hence it explicitly includes gendered consultative and participatory planning procedures. Important entry points for leverage identified by such organizations are therefore not only legal changes but also political mobilization, consciousness raising and popular education. All of these are mechanisms to ensure that women and gender-aware organizations are included in the planning process.

In its emphasis on women's organizations, the empowerment approach might appear similar to the welfare approach, which also stressed the importance of women's organizations. This has led some policy-makers to conflate the two approaches. However, the welfare approach recognizes only the reproductive role of women and utilizes women's organizations as a top-down means of delivering services. In contrast, the empowerment approach recognizes the triple role of women and seeks through bottom-up women's organizations to raise women's consciousness to challenge their subordination. In fact, Third World women's organizations form a continuum. This ranges from direct political action, through exchanging research and information, to the traditional service-orientated organizations with their class

biases and limited scope for participatory action. While acknowledging the valuable function of different types of organizations, the empowerment approach seeks to assist the more traditional organizations to move towards a greater awareness of feminist issues. Thus Sen (1990) acknowledges that the perceptions of the individual interests of women tend to be merged with the notion of family well-being. The 'political agency' of women may be sharpened by their greater involvement with the outside world.

Another important distinction between the empowerment and equity approaches is the manner in which the former seeks to reach strategic gender needs indirectly through practical gender needs. The very limited success of the equity approach to confront directly the nature of women's subordination through legislative changes has led the empowerment approach to avoid direct confrontation. It utilizes practical gender needs as the basis on which to build a secure support base, and a means through which strategic needs may be reached. The following examples of Third World women's organizations are much quoted 'classics' of their kind, which have provided important examples for other groups of the ways in which practical gender needs can be utilized as a means of reaching strategic gender needs.

In the Philippines, GABRIELA (an alliance of local and national women's organizations) ran a project which combined women's traditional task of sewing tapestry with a non-traditional activity, the discussion of women's legal rights and the constitution. A nation-wide educational 'tapestry-making drive' enabled the discussion of rights in communities, factories and schools, with the end product a 'Tapestry of Women's Rights' seen to be a liberating instrument (Gomez 1986).

A feminist group in Bombay, India, the 'Forum against Oppression of Women' first started campaigning in 1979 on such issues as rape and bride-burning. However, with 55 percent of the low-income population living in squatter settlements, the Forum soon realized that housing was a much greater priority for local women, and, consequently, soon shifted its focus to this issue. In a context where women by tradition had no access to housing in their own right, homelessness, through breakdown of marriage or domestic violence, was an acute problem, and the provision of women's hostels a critical practical gender need. Moreover, mobilization around homelessness also raised consciousness of the patriarchal bias in inheritance legislation as well as in the interpretation of housing rights. In seeking to broaden the problem from a 'women's concern' and to raise men's awareness, the Forum has become part of a nation-wide alliance of NGOs, lobbying national government for a National Housing Charter. Through this alliance the Forum has ensured that women's strategic gender needs relating to housing rights have been placed on the mainstream political agenda, and have not remained simply the concern of women.

Conflicts often occur when empowered women's organizations succeed in challenging their subordination. One widely cited example is the Self-Employed Women's Organization (SEWA) started in Ahmedabad, India, in 1972 by a group of self-employed women labourers. It initially struggled for higher wages and for the defence of members against police harassment and exploitation by middlemen. At first, with the assistance of the male-dominated Textile Labour Association (TLA), SEWA established a bank, as well as providing support for low-income women such as skill training programmes, social security systems, production and marketing co-operatives (Sebsted 1982). It has been said that the TLA expelled SEWA from its organization, not only because the TLA leaders felt increasingly threatened by the women's advance towards self-independence, but also because their methods of struggle, in opposition to TLA policy of compromise and collaboration, provided a dangerous model for male workers (Karl 1983). SEWA has survived considerable setbacks in its development largely due to its widespread membership support. The fact that it has developed into a movement has made it increasingly difficult to eliminate. In addition, at various times the grant support SEWA has received from international agencies has assisted in giving the organization a level of independence within the local political context.

As highlighted by DAWN, 'empowering ourselves through organization' has been a slow global process, accelerating during and since the Women's Decade. A diverse range of women's organizations, movements, networks and alliances have developed. These cover a multitude of issues and purposes. Common interests range from disarmament at the international level to mobilization around specific laws and codes at the national level. All share a similar commitment to empower women, and a concern to reject rigid bureaucratic structures in favour of non-hierarchical open structures, although they are not necessarily the most efficient organizational form. Experience to date has shown that the most effective organizations have been those that started around concrete practical gender needs relating to health, employment and basic service provision, but which have been able to utilize concerns such as these as a means to reach specific strategic gender needs. In Chapter 9 this issue is further examined with the categorization of the range of women's organizations.

The potentially challenging nature of the empowerment approach has meant that it remains largely unsupported either by national governments or bilateral aid agencies. Despite the widespread growth of Third World groups and organizations, whose approach to women is essentially one of empowerment, they remain under-funded, reliant on the use of voluntary and unpaid women's time, and dependent on the resources of those few international

NGOs and First World governments prepared to support this approach to women and development.[10]

It is clear that the 'room for manoeuvre' still remains limited, with welfare, and more recently efficiency, the predominant policy approaches endorsed by most governments and international agencies. With increasing political and ideological control in many contexts, severe difficulties continue to be encountered in shifting policy towards the anti-poverty, equity or empowerment approach. However, there are also individuals and groups involved in changing policy approaches; government and aid agency personnel who argue that a 'gendered' efficiency approach can also be the means, with a hidden agenda, to empower women; the proliferating number of under-financed, small-scale Third World women's organizations in which women are increasingly struggling not only to meet practical gender needs but also to raise consciousness to struggle for strategic gender needs.

Part One of this book has provided the conceptual rationale for gender planning. This is based on the identification of the triple role of women, the fundamental analytical distinction between practical and strategic gender needs, and the identification of five different policy approaches to WID, which differ in terms of roles recognized and gender needs met. In Chapter 5, the methodological tools deriving from these principles are further elaborated in a description of gender planning. This is a new planning tradition, which in incorporating gender into planning, challenges current planning stereotypes.

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9

The Meaning of Women's Empowerment: New Concepts from Action[1]

Srilatha Batliwala

Since the mid-1980s, the term *empowerment* has become popular in the field of development, especially in reference to women. In grassroots programs and policy debates alike, *empowerment* has virtually replaced terms such as *welfare*, *upliftment*, *community participation*, and *poverty alleviation* to describe the goal of development and intervention. In spite of the prevalence of the term, however, many people are confused as to what the empowerment of women implies in social, economic, and political terms. How empowerment strategies differ from or relate to such earlier strategies as integrated rural development, women's development, community participation, conscientization, and awareness building is even less clear.

Nonetheless, many large-scale programs are being launched with the explicit objective of "empowering" the poor and "empowering" women. Empowerment is held to be a panacea for social ills: high population growth rates, environmental degradation, and the low status of women, among others.[2]

The attention given here to women's empowerment is based on the premise that it is an enabling condition for reproductive rights (Correa and Petchesky, this volume). This chapter attempts an operational definition of women's empowerment, and delineates the components and stages of empowerment strategies, on the basis of insights gained through a study of grassroots programs in South Asia. Undoubtedly, the nature and priorities of the women's empowerment process in South Asian countries are shaped by the historical, political, social, and economic conditions specific to that region. Still, there are sufficient commonalities with other regions — such as an extended period of colonial rule; highly stratified, male-dominated social structures; widespread poverty and vulnerable economies; and fairly rigid gender- and class-based divisions of labor — to render the definition and analytic framework for empowerment presented in this essay more widely relevant.

The Concept of Empowerment

The concept of women's empowerment appears to be the outcome of several important critiques and debates generated by the women's movement throughout the world, and particularly by Third World feminists. Its source can be traced to the interaction between feminism and

ıe concept of "popular education" developed in ıtin America in the 1970s (Walters 1991). The ›tter had its roots in Freire's theory of "con-cientization," which totally ignored gender, but ..as also influenced by Gramscian thought, which ressed the need for participatory mechanisms in ıstitutions and society in order to create a more quitable and nonexploitative system (Forgacs 1988; Freire 1973).

Gender subordination and the social con-ruction of gender were a priori in feminist nalysis and popular education. Feminist popular ducators therefore evolved their own distinct approach, pushing beyond merely building aware-ıess and toward organizing the poor to struggle ctively for change. They defined their goals in ıe following terms:

> ...To unambiguously take the standpoint of women; [and]...demonstrate to women and men how gender is constructed socially,...and...can be changed...[to show] through the lived experience of the participants, how women and men are gendered through class, race, religion, culture, etc.;...to investigate collectively... how class, [caste], race and gender intersect...in order to deepen collective understanding about these relationships...
>
> ...To build collective and alternative visions for gender relations...and...deepen collective analysis of the context and the position of women...locally, nationally, regionally and globally,...To develop analytical tools...to evaluate the effects of certain development strategies for the promotion of women's strategic interests... [and develop strategies] to bring about change in their personal and organizational lives...
>
> ...To help women develop the skills to assert themselves...and to challenge oppressive behavior...to build a network of women and men nationally, [and internationally]...[and] to help build democratic community and worker organizations and a strong civil society which can pressurize for change (Walters 1991).

Meanwhile, in the 1980s feminist critiques emerged of those development strategies and grassroots interventions that had failed to make significant progress toward improving the status of women. They attributed the failure mainly to the use of welfare, poverty alleviation, and managerial approaches, for example, that did not address the underlying structural factors that perpetuate the oppression and exploitation of poor women (Moser 1989). These approaches had made no distinction between the "condition" and the "position" of women (Young 1988). Young defined *condition* as the material state in which poor women live — low wages, poor nutrition, and lack of access to health care, education, and training. *Position* is the social and economic status of women as compared with that of men. Young argues that focusing on improving the daily conditions of women's existence curtailed women's awareness of, and readiness to act against, the less visible but powerful underlying structures of subordination and inequality.

Molyneux (1985) made a similar distinction between women's "practical" and "strategic" interests. While women's practical needs — food, health, water, fuel, child care, education, improved technology, and so forth — must be met, they cannot be an end in themselves. Organizing and mobilizing women to fulfill their long-term strategic interests is essential. This requires

> ...analysis of women's subordination and...the formulation of an alternative, more satisfactory set of arrangements to those which exist...such as the abolition of the sexual division of labor, the alleviation of the burden of domestic labor and child care, the removal of institutionalized forms of discrimination, the establishment of political equality, freedom of choice over childbearing and...measures against male violence and control over women (Molyneux 1985).

It is from these roots that the notion of empowerment grew, and it came to be most clearly articulated in 1985 by DAWN[3] as the "empowerment approach" (Sen and Grown 1985). Empowerment, in this view, required transformation of structures of subordination through radical changes in law, property rights, and other institutions that reinforce and perpetuate male domination.

By the beginning of the 1990s, women's empowerment had come to replace most earlier terms in development jargon. Unfortunately, as it has become a buzzword, the sharpness of the perspective that gave rise to it has been diluted. Consequently, its implications for macro- and micro-level strategies need clarification. The key question is: How do different approaches to women's "condition," or practical needs, affect the possibility or nature of changes in women's "position," or strategic interests?

This question is most pertinent to the whole issue of women's reproductive rights. Many of the existing approaches to contraception and women's reproductive health, for example, focus entirely on improved technologies and delivery systems for birth control, safe delivery, prenatal and postnatal care, and termination of fertility. But none of these addresses the more fundamental questions of discrimination against girls and women in access to food and health care; male dominance in sexual relations; women's lack of control over their sexuality; the gender division of labor that renders women little more than beasts of burden in many cultures; or the denial by many societies of women's right to determine the number of children they want. These issues are all linked to women's "position," and are not necessarily affected by reduced birthrates or improvements in women's physical health. This is one of the dichotomies that an empowerment process must seek to address.

What is Empowerment?

The most conspicuous feature of the term *empowerment* is that it contains the word *power*, which, to sidestep philosophical debate, may be broadly defined as control over material assets, intellectual resources, and ideology. The material assets over which control can be exercised may be physical, human, or financial, such as land, water, forests, people's bodies and labor, money, and access to money. Intellectual resources include knowledge, information, and ideas. Control over ideology signifies the ability to generate, propagate, sustain, and institutionalize specific sets of beliefs, values, attitudes, and behavior — virtually determining how people perceive and function within given socioeconomic and political environments.[4]

Power thus accrues to those who control or are able to influence the distribution of material resources, knowledge, and the ideology that governs social relations in both public and private life. The extent of power held by particular individuals or groups corresponds to the number of kinds of resources they can control, and the extent to which they can shape prevailing ideologies, whether social, religious, or political. This control, in turn, confers the power of decisionmaking.

In South Asia, women in general, and poor women in particular, are relatively powerless, with little or no control over resources and little decisionmaking power. Often, even the limited resources at their disposal — such as a little land, a nearby forest, and their own bodies, labor, and skills — are not within their control, and the decisions made by others affect their lives every day.

This does not mean that women are, or have always been, totally powerless; for centuries they have tried to exercise their power within the family (Nelson 1974; Stacey and Price 1981). They also have taken control of the resources to which society has allowed them access, and even *seized* control of resources when they could — the Chipko movement in northern India and the Green Belt movement in Kenya, for example (Misra 1978; Rodda 1991). They have always attempted, from their traditional position as workers, mothers, and wives, not only to influence their immediate environment, but also to expand their space. However, the prevailing patriarchal ideology, which promotes the values of submis-

ion, sacrifice, obedience, and silent suffering, often undermines even these attempts by women to assert themselves or demand some share of resources (Hawkesworth 1990; Schuler and Kadirgamar-Rajasingham 1992).

The process of challenging existing power relations, and of gaining greater control over the sources of power, may be termed *empowerment*. This broad definition is refined by feminist scholars and activists within the context of their own regions. For instance:

> The term empowerment refers to a range of activities from individual self-assertion to collective resistance, protest and mobilization that challenge basic power relations. For individuals and groups where class, caste, ethnicity and gender determine their access to resources and power, their empowerment begins when they not only recognize the systemic forces that oppress them, but act to change existing power relationships. Empowerment, therefore, is a process aimed at changing the nature and direction of systemic forces which marginalize women and other disadvantaged sections in a given context (Sharma 1991–1992).

Empowerment is thus both a process and the result of that process. Empowerment is manifested as a redistribution of power, whether between nations, classes, castes, races, genders, or individuals. The goals of women's empowerment are to challenge patriarchal ideology (male domination and women's subordination); to transform the structures and institutions that reinforce and perpetuate gender discrimination and social inequality (the family, caste, class, religion, educational processes and institutions, the media, health practices and systems, laws and civil codes, political processes, development models, and government institutions); and to enable poor women to gain access to, and control of, both material and informational resources. The process of empowerment must thus address all relevant structures and sources of power:

> Since the causes of women's inferior status and unequal gender relations are deeply rooted in history, religion, culture, in the psychology of the self, in laws and legal systems, and in political institutions and social attitudes, if the status and material conditions of women's lives is to change at all, the solutions must penetrate just as deeply (Schuler and Kadirgamar-Rajasingham 1992).

Theories that identify any one system or structure as the source of power — for instance, the assertion that economic structures are the basis of powerlessness and inequality — imply that improvement in one dimension would result in a redistribution of power. However, activists working in situations where women are economically strong know that equal status does not necessarily result. If anything, ample evidence exists that strengthening women's economic status, though positive in many ways, does not always reduce their other burdens or eradicate other forms of oppression; in fact, it has often led to intensifying pressures (Brydon and Chant 1989; Gupte and Borkar 1987; Sen and Grown 1985). Similarly, it is evident that improvements in physical status and access to basic resources, like water, fuel, fodder, health care, and education, do not automatically lead to fundamental changes in women's position. If that were so, middle-class women, with higher education, well-paid jobs, and adequate nourishment and health care, would not continue to be victims of wife beating or bride burning.

There is widespread confusion and some degree of anxiety about whether women's empowerment leads to the disempowerment of men. It is obvious that poor men are almost as powerless as poor women in terms of access to and control over resources. This is exactly why most poor men tend to support women's empowerment processes that enable women to bring much-needed resources into their families and communities, or that challenge power structures that have oppressed and exploited the poor of both genders.

existing social order is *unjust* and *unnatural*. They seek to change other women's consciousness: altering their self-image and their beliefs about their rights and capabilities; creating awareness of how gender discrimination, like other socioeconomic and political factors, is one of the forces acting on them; challenging the sense of inferiority that has been imprinted on them since birth; and recognizing the true value of their labor and contributions to the family, society, and economy. Women must be convinced of their innate right to equality, dignity, and justice.

The external agents of change necessary for empowerment may take many forms. The anti-arrack[5] agitation of 1992–1993 in Nellore District of Andhra Pradesh State in southern India, for instance, in which thousands of women participated, was triggered by a lesson in an adult literacy primer depicting the plight of a landless woman whose husband drank away his meager wages at the local liquor shop. The agitation has created a major political and economic crisis for the state government, which earns huge revenues through licensing of liquor outlets and excise duties on liquor (see Box 1; also, Anveshi 1993; Joseph 1993).

A key role of the external activist lies in giving women access to a new body of ideas and information that not only changes their consciousness and self-image, but also encourages action. This means a dynamic educational process. Historically, the poor in much of South Asia, and especially poor women, were beyond the pale of formal education, and so developed learning systems of their own. Valuable oral and practical traditions evolved to transfer empirical knowledge and livelihood skills from generation to generation: about agriculture, plant and animal life, forest lore, weaving, dying, building craft, fishing, handicrafts, folk medicine, and a myriad of other subjects. This body of traditional knowledge and skills was, however, developed within specific ideological and social frameworks. Such knowledge and practices are often suffused with taboos, superstitions, and biases against women. For example, menstruating women are prohibited from touching books, and women and men of certain castes are forbidden to touch religious books.

Through empowerment, women gain access to new worlds of knowledge and can begin to make new, informed choices in both their personal and their public lives. However, such radical changes are not sustainable if limited to a few individual women, because traditional power structures will seek to isolate and ostracize them. Society is forced to change only when large numbers of women are mobilized to press for change. The empowerment process must organize women into collectives, breaking out from individual isolation and creating a united forum through which women can challenge their subordination. With the support of the collective and the activist agent, women can re-examine their lives critically, recognize the structures and sources of power and subordination, discover their strengths, and initiate action.

The process of empowerment is thus a spiral, changing consciousness, identifying areas to target for change, planning strategies, acting for change, and analyzing action and outcomes, which leads in turn to higher levels of consciousness and more finely honed and better executed strategies. The empowerment spiral affects everyone involved: the individual, the activist agent, the collective, and the community. Thus, empowerment cannot be a top-down or one-way process.

Armed with a new consciousness and growing collective strength, women begin to assert their right to control resources (including their own bodies) and to participate equally in decisions within the family, community, and village. Their priorities may often be surprising, even baffling, to the outsider. In the aftermath of the 1991 Bangladesh cyclone, one of the first demands made by women in a badly affected area was the rebuilding of the schoolhouse and the providing of schoolbooks to their children; this was in stark contrast to the demands of the local men, who talked only about houses, seeds, poultry, and loans (Akhtar 1992). In another project in southern India, one of the first issues taken up by the

Resistance, however, occurs when women compete with men for power in the public sphere, or when they question the power, rights, and privileges of men within the family — in other words, when women challenge patriarchal family relations (Batliwala 1994). This is, in fact, a test of how far the empowerment process has reached into women's lives; as one activist put it, "the family is the last frontier of change in gender relations ... You know [empowerment] has occurred when it crosses the threshold of the home" (Kannabiran 1993).

The process of women's empowerment must challenge patriarchal relations, and thus inevitably leads to changes in men's traditional control over women, particularly over the women of their households. Men in communities where such changes have already occurred no longer have control over women's bodies, sexuality, or mobility; they cannot abdicate responsibility for housework and child care, nor physically abuse or violate women with impunity; they cannot (as is the case in South Asia at present) abandon or divorce their wives without providing maintenance, or commit bigamy or polygamy, or make unilateral decisions that affect the whole family. Clearly, then, women's empowerment does mean the loss of the privileged position that patriarchy allotted to men.

A point often missed, however, is that women's empowerment also liberates and empowers men, both in material and in psychological terms. First, women greatly strengthen the impact of political movements dominated by men — not just by their numbers, but by providing new energy, insights, leadership, and strategies. Second, as we saw earlier, the struggles of women's groups for access to material resources and knowledge directly benefit the men and children of their families and their communities, by opening the door to new ideas and a better quality of life. But most important are the psychological gains for men when women become equal partners. Men are freed from the roles of oppressor and exploiter, and from gender stereotyping, which limits the potential for self-expression and personal development in men as much as in women. Furthermore, experiences worldwide show that men discover an emotional satisfaction in sharing responsibility and decisionmaking; they find that they have lost not merely traditional privileges, but also traditional burdens. As one South Asian NGO spokeswoman expressed it:

> Women's empowerment should lead to the liberation of men from false value systems and ideologies of oppression. It should lead to a situation where each one can become a whole being, regardless of gender, and use their fullest potential to construct a more humane society for all (Akhtar 1992).

The Process of Empowerment

In order to challenge their subordination, *women must first recognize the ideology that legitimizes male domination and understand how it perpetuates their oppression.* This recognition requires reversal of the values and attitudes, indeed the entire worldview, that most women have internalized since earliest childhood. Women have been led to participate in their own oppression through a complex web of religious sanctions, social and cultural taboos and superstitions, hierarchies among women in the family (see Adams and Castle in this volume), behavioral training, seclusion, veiling, curtailment of physical mobility, discrimination in food and other family resources, and control of their sexuality (including concepts like the "good" and "bad" woman). Most poor women have never been allowed to think for themselves or to make their own choices except in unusual circumstances, when a male decision maker has been absent or has abdicated his role. Because questioning is not allowed, the majority of women grow up believing that this is the just and "natural" order.

Hence, the demand for change does not usually begin spontaneously from the condition of subjugation. Rather, empowerment must be externally induced, by forces working with an altered consciousness and an awareness that the

Women's Mobilizing: Anti-Liquor Agitation by Indian Women

"Even a cow must be fed if you want milk. Otherwise it will kick you. We have kicked! We will do anything to stop saara [country liquor] sales here" (Villager, Totla Cheruvupalli, Andhra Pradesh).

The anti-liquor movement that began in the southern Indian state of Andhra Pradesh in 1992 is unusual among popular uprisings. Initiated and led entirely by poor rural women in a few villages of one district (Nellore), the movement spread rapidly throughout the state. It has no centralized leadership or base in any political party, but is led entirely by groups of women in each village. It has no unified strategy; rather, women use whatever tactics they find most appropriate. The movement has been enormously successful, even overcoming the state government's interest in revenues from taxes on arrack (a crude liquor).

The movement was triggered by the Akshara Deepam (Light of Literacy) campaign, launched by the government and several volunteer organizations in Nellore District. The campaign not only brought women literacy programs, but also raised their consciousness about their status and potential to act. One of the chapters in the literacy primer described the plight of a poor woman whose husband drank away his wages at the local liquor shop. Ignited by this story, which mirrored their own reality all too well, the women readers asked: How is it that liquor supplies arrive in a village at least twice a day, but there are always shortages of food in the government-controlled ration shops, kerosene for lighting, drinking water, medicines at the health center, learning materials for schoolchildren, and myriad other basic essentials?

A decade earlier, the party in power in the state launched the Varuna Vahini (Liquor Flood) policy, through which the state's liquor excise revenues increased from 1.5 billion rupees in 1981–82 to 6.4 billion rupees in 1991–1992. The state government's development outlay for 1991–1992 was 17 billion rupees. Many local employers and landlords pay part of men's wages in coupons that can be used at the local liquor shop, further boosting liquor sales — and ensuring that in most poor households, men's earnings fatten the liquor lobby and state government, while their families struggle for daily food and survival. Regular harassment and physical abuse by drunken men drives some women to suicide.

The anti-liquor movement began with a few women picketing liquor shops and forcing their closure. News spread through the village grapevine and the media, and soon the whole of Nellore District, then the entire state of Andhra Pradesh, was taken up in the cause. Women used a wide variety of tactics with substantial symbolic import: In one village, for example, the women cooked the daily meal, took it wrapped in leaves to the liquor shop, and demanded that the owner eat all their offerings. "You have been taking the food from our bellies all these years, so here, eat! Eat until it kills you, the way you have been killing us!" The terrified proprietor closed shop and ran, and has not reopened since.

With less arrack being consumed, there is more money for food and other essentials, less physical and emotional abuse of women, and far less violence in general. For the most part, men have reacted surprisingly passively to the whole movement, perhaps because women directed their outrage and attacks at the liquor suppliers, rather than at their men.

The greatest victory of the movement is that no politician or party has been able to derail it, nor has the state government been able to suppress it. It cannot, after all, be characterized as antigovernment or seditious, since it is upholding one of the directive principles of the Indian constitution. However, the state is trying to repress the movement in more devious ways. Officials have floated a rumor that if liquor sales are not resumed, the price of rice will be increased. Attempts are also afoot to sabotage the literacy program that gave rise to the movement. Further, since legal sales have been effectively stopped, liquor contractors and local officials are promoting underground sales by smuggling liquor into villages in milk cans and vegetable baskets.

Though women in the anti-liquor movement have not directly challenged the state, they have managed to weaken it by attacking the nexus between the state and the liquor lobby. Poor women have mobilized and struck a blow for themselves and their families.

Source: Joseph 1993.

emerging Mahila Sangha (women's collective) of one village was the demand for a separate *smashana* (cremation ground); being scheduled castes, they said, they were not allowed to use the upper-caste area. In both cases, external activists were surprised by the women's priorities, which were quite different from those issues the activists considered most pressing.

Traditionally, women have made choices — if, indeed, they can be called choices — only within tight social constraints. For example, a woman can pay a dowry and marry off her daughter, or run the risk that the daughter will remain unmarried and be a burden to the family; a woman can bear many children, especially sons, to prove her fertility, or face rejection by her husband and in-laws. Because of the acute poverty and overwhelming work burden of poor women, most activists face a recurring dilemma: Should they respond to women's immediate problems by setting up services that will meet their practical needs and alleviate their condition? Or should they take the longer route of raising consciousness about the underlying structural factors that cause the problems, and organize women to demand resources and services from the state? Or should they enable women to organize and manage their own services with resources from the state and themselves?

A New Understanding of Power

Empowerment should also generate new notions of power. Present-day notions of power have evolved in hierarchical, male-dominated societies and are based on divisive, destructive, and oppressive values. The point is not for women to take power and use it in the same exploitative and corrupt way. Rather, women's empowerment processes must evolve a new understanding of power, and experiment with ways of democratizing and sharing power — building new mechanisms for collective responsibility, decisionmaking, and accountability.

Similarly, once women have gained control over resources, they should not use them in the same shortsighted and ecologically destructive manner as male-dominated capitalist societies. Women's empowerment will have to lead women — and the "new men" — to address global concerns and issues, including the environment; war, violence, and militarism; ethnic, linguistic, religious, or racial fanaticism; and population.

Such radical transformations in society obviously cannot be achieved through the struggles of village or neighborhood women's collectives. Just as individual challenges can be easily crushed, so can the struggles of small, local collectives of women be negated by far more powerful and entrenched socioeconomic and political forces. In the final analysis, to transform society, women's empowerment must become a political force, that is, an organized mass movement that challenges and transforms existing power structures. Empowerment should ultimately lead to the formation of mass organizations of poor women, at the regional, national, and international levels. Only then can the poor women of the world hope to bring about the fulfillment of their practical and strategic needs, and change both the "condition" and the "position" of women. They can form strategic alliances with other organizations of the poor — such as trade unions, and farmers and tenant farmers groups — and thus involve men in the change process as well. Most important, these federations must remain wholly autonomous and maintain a suprapolitical stance to prevent the cooptation and dilution of the empowerment process by pervasive patriarchal forces. This does not mean that women leaders who emerge through grassroots empowerment cannot participate in political processes like elections; on the contrary, they can, and have done so. However, they should run as candidates of existing parties, not as representatives of autonomous women's federations. This way, the latter can play a vigilant role and call to account its own members if they betray women's aspirations and needs in their performance of other roles.[6]

In a study of selected South Asian NGOs (nongovernmental organizations) engaged in women's empowerment, I was able to gather and review project reports and other published and

unpublished material, discuss the empowerment question with project leaders and field workers, and visit with field organizers. Three major approaches to women's empowerment were identifiable: integrated development programs, economic development, and consciousness-raising and organizing among women. These are not mutually exclusive categories, but they help to distinguish among the differing interpretations of the causes of women's powerlessness and, hence, among the different interventions thought to lead to empowerment.

The integrated development approach ascribes women's powerlessness to their greater poverty and lower access to health care, education, and survival resources. Strategies are focused on providing services and enhancing economic status; some NGOs also emphasize awareness building. This approach improves women's condition mainly by helping them meet their survival and livelihood needs.

The economic development approach places women's economic vulnerability at the center of their powerlessness, and posits that economic empowerment has a positive impact on other aspects of women's existence. Its strategies are built around strengthening women's position as workers and income earners by mobilizing, organizing or unionizing, and providing access to support services. Though this approach undoubtedly improves women's economic position *and* condition, it is not clear that this change necessarily empowers them in other dimensions of their lives.

The consciousness-raising and organizing approach is based on a more complex understanding of gender relations and women's status. This method ascribes powerlessness to the ideology and practice of patriarchy and socioeconomic inequality in *all* the systems and structures of society. Strategies focus more on organizing women to recognize and challenge both gender- and class-based discrimination in all aspects of their lives, in both the public and the private spheres. Women are mobilized to struggle for greater access to resources, rather than passively provided with schemes and services. This approach is successful in enabling women to address their position and strategic needs, but may not be as effective in meeting immediate needs. A more detailed analysis of the goals, strategies, and dilemmas of each of these approaches is contained in Box 2 (on next page).

Lessons for a Women's Empowerment Strategy

No one magic formula or fail-safe design exists for empowerment. Nonetheless, experience clearly shows that empowerment strategies must intervene at the level of women's "condition" while also transforming their "position," thus simultaneously addressing both practical and strategic needs. Within the conceptual framework developed in the first part of this chapter, several elements appear essential. They are designed to challenge patriarchal ideology, and to enable poor women to gain greater access to and control over both material and informational resources. Although these elements are set out below in a particular sequence, they may be reversed or interchanged, or several may be undertaken concurrently, depending on the context.

An organization concerned with bringing about women's empowerment must begin by locating the geopolitical region (urban or rural) in which it wants to work, and identifying the poorest and most oppressed women in that area. Activists then have to be selected and trained. Intensive preparatory training is critical; it must impart to activists an awareness of the structures and sources of power, especially gender, and it must equip them with skills needed to mobilize, while learning from, the women whose consciousness they plan to raise. In general, female activists are preferable, since they are in a better position to initiate the empowerment process with other women, notwithstanding differences in class, caste, or educational background.

In the field, the activists encourage women to set aside a separate time and space for themselves —as disempowered women rather than as passive recipients of welfare or beneficiaries of programs

Box 2

Empowerment: Three Approaches

Three experimental approaches to empowering women have been undertaken in South Asia: integrated development, economic empowerment, and consciousness-raising. While these approaches differ from each other in concept, most organizations working on the ground take a mix of approaches. Common to all three is the importance placed on group formation to build solidarity among women.

The *integrated development* approach views women's development as key to the advancement of family and community. It therefore provides a package of interventions to alleviate poverty, meet basic survival needs, reduce gender discrimination, and help women gain self-esteem. This approach proceeds either by forming women's collectives that engage in development activities and tackle social problems such as dowry, child marriage, and male alcoholism (Proshika in Bangladesh; RDRS in Rajasthan, India), or by employing an "entry point" strategy, using a specific activity, such as a literacy class or health program, to mobilize women into groups (Gonoshastya Kendra in Bangladesh, United Mission to Nepal, Redd Barna in Nepal).

The *economic empowerment* approach attributes women's subordination to lack of economic power. It focuses on improving women's control over material resources and strengthening women's economic security. Groups are formed using two methods: organizing women around savings and credit, income generation, or skill training activities (Grameen Bank in Bangladesh, Program of Credit for Rural Women in Nepal); or by occupation or location (SEWA in India, Proshika). These groups may work in a range of areas, including savings and credit, training and skills development, new technologies or marketing, as well as provide such ancillary supports as child care, health services, literacy programs, and legal education and aid.

The *consciousness raising* approach asserts that women's empowerment requires awareness of the complex factors causing women's subordination. This approach organizes women into collectives that tackle the sources of subordination (ASTHA, Deccan Development Society, Mahila Samakhya, WOPin India; Nijera Kori in Bangladesh). Education is central and is defined as a process of learning that leads to a new consciousness, self-worth, societal and gender analysis, and access to skills and information. In this approach, the groups themselves determine their priorities. Women's knowledge of their own bodies and ability to control reproduction are also considered vital. The long-term goal is for the women's groups to be independent of the initiating NGO. This approach uses no particular service "entry point" and attempts to be open-ended and non-directive. It gives considerable emphasis to fielding "change agents," who are trained to catalyze women's thinking without determining the directions in which a particular group may go.

— collectively to question their situation and develop critical thinking. These forums should enable women to evolve from an aggregate of individuals into a cohesive collective, wherein they can look at themselves and their environment in new ways, develop a positive self-image, recognize their strengths, and explode sexist misconceptions. The activists also help women collectively to claim access to new information and knowledge, and to begin to develop a critical understanding of the ideology of gender, the systems and institutions through which it is perpetuated and reinforced, and the structures of power governing their lives. This is the process

that expands women's awareness beyond their "condition" to their "position."

With a growing consciousness and collective strength, women's groups prioritize the problems they would like to tackle. They begin to confront oppressive practices and situations both inside and outside the home, and gradually to alter their own attitudes and behavior; this often includes changing their treatment of their girl children and asserting their reproductive and sexual rights. In the course of both individual and collective struggles for change, women also build their skills of collective decisionmaking, action, and accountability and they may forge new strategies and methods, such as forming alliances with other groups of exploited and oppressed people, or involving sympathetic men of their own communities. With the help of training and counsel provided by the NGO or activists working with them, they also acquire real skills — vocational and managerial know-how, literacy and arithmetic competence, basic data collection techniques for conducting their own surveys — that enhance their autonomy and power.

These women's collectives then begin to seek access to resources and public services independently, demanding accountability from service providers, lobbying for changes in laws and programs that are inaccessible or inappropriate, and negotiating with public institutions such as banks and government departments. Collectively they may also set up and manage alternative services and programs, such as their own child care centers, savings banks, or schools. Finally, village- or neighborhood-level women's collectives may form associations at the local, regional, national, and global levels, through which poor women can more effectively challenge higher-level power structures and further empower themselves for the well-being of society as a whole.

Conclusion

Grassroots experiments in empowerment have made considerable headway since the mid-1980s, but it is clear — at least in South Asia — that they have a long way to go. One obvious reason is the absence of a democratic environment. An empowerment process of the kind outlined here is impossible without democratic space for dissent, struggle, and change. Theocratic, military, or other kinds of authoritarian states, based on ideologies of dominance and gender subordination, simply will not allow radical women's empowerment movements to survive. Perhaps for this reason, many approaches to empowerment in South Asia tend to avoid overtly political activities; activists provide women with opportunities and services, and encourage a certain level of awareness, but avoid more serious challenges to the dominant ideology or power structures.

A second, more pervasive, obstacle is a fragmented understanding of the concept and process of empowerment itself, with an accompanying lack of clarity about the nature of power, patriarchy, and gender. Male domination and gender discrimination tend to be oversimplified, equated with conspicuously oppressive practices like child marriage, dowry demands, wife beating, bigamy and polygamy, and denial of women's rights to equal food, employment, education, or physical mobility. The resultant approach focuses on women's practical rather than strategic needs. The organizing and consciousness-raising approach has come somewhat closer to a holistic strategy of empowerment, but still needs to solve many methodological problems before the complexities of the social construction of gender — and the ways in which family, class, caste, religion, and other factors perpetuating women's subordination — can be changed.

Notes

1 This chapter is based on the author's study of empowerment programs in three South Asian countries, entitled "Women's Empowerment in South Asia: Concepts and Practices" (forthcoming), sponsored by the Freedom from Hunger Campaign and Asia South Pacific Bureau of Adult Education).

2 This has come through clearly in my interactions in South Asia with nongovernmental organizations (NGOs), international aid agency representatives, academics, women's activists, government bureaucrats, and others.

Development Alternatives with Women for a New Era, a South-driven network of feminist scholars and women's groups, formed in 1984 in Bangalore, India.

4 The promotion of religious obscurantism in India, with its accompanying redefinition of Hinduism, is a case in point. We in the subcontinent are experiencing the revival and spread of a whole ideology, which culminated in the destruction of the Babri Mosque on December 6, 1992.

5 Arrack is a form of country liquor.

6 In India, members of a peasant and landless women's federation in southern Maharashtra, and of an urban slum women's federation (with chapters in 10 major cities) have successfully contested and won elections to municipal and local government bodies with different party platforms. The federations thereafter exercised the right to monitor their performance vis-à-vis the agenda for women's advancement, thus continually pressuring the concerned political parties to take up such issues.

References

Akhtar, F. (UBINIG, an NGO engaged in empowerment of rural women, Dhaka). 1992. Personal communication.

Anveshi. 1993. *Reworking gender relations, redefining politics: Nellore village women against arrack*. Hyderabad.

Batliwala, S. 1994 (forthcoming). *Women's empowerment in South Asia: Concepts and practices*. New Delhi: Food and Agricultural Organization/Asia South Pacific Bureau of Adult Education (FAO/ASPBAE).

Brydon, L., and S. Chant. 1989. *Women in the Third World: Gender issues in rural and urban areas*. New Brunswick, N.J.: Rutgers University Press.

Forgacs, D. (ed.). 1988. *An Antonio Gramsci reader: Selected writings, 1916–1935*. New York: Schocken Books.

Freire, P. 1973. *Pedagogy of the oppressed*. New York: Seabury Press.

Gupte, M., and A. Borkar, 1987. *Women's work, maternity and access to health care: Socioeconomic study of villages in Pune District*. Bombay: Foundation for Research in Community Health.

Hawkesworth, M. E. 1990. *Beyond oppression: Feminist theory and political strategy*. New York: Continuum.

Joseph, A. 1993. Brewing trouble. *The Hindu*, March 7.

Kannabiran, K. (a feminist activist of ASMITA, a women's resource center in Hyderabad, India). 1993. Personal communication.

Misra, A. 1978. *Chipko movement: Uttarakhand women's bid to save forest wealth*. New Delhi: People's Action.

Molyneux, M. 1985. Mobilization without emancipation? Women's interests, the state, and revolution in Nicaragua. *Feminist Studies* 11:2.

Moser, C. 1989. Gender planning in the Third World: Meeting practical and strategic needs. *World Development* 17:1799-1825.

Nelson, C. 1974. Public and private and politics: Women in the Middle Eastern world. *American Ethnologist* 1(3):551-563.

Rodda, A. 1991. *Women and the environment*. London: Zed Books.

Schuler, M., and S. Kadirgamar-Rajasingham. 1992. *Legal literacy: A tool for women's empowerment*. New York: UNIFEM.

Sen, G., and C. Grown. 1985. *Development alternatives with women for a new era: Development crises and alternative visions*. London: Earthscan.

Sharma, K. 1991–1992. Grassroots organizations and women's empowerment: Some issues in the contemporary debate. *Samya Shakti* 6:28–43.

Stacey, M., and M. Price. 1981. *Women, power, and politics*. London and New York: Tavistock Publications.

Walters, S. 1991. Her words on his lips: Gender and popular education in South Africa. *ASPBAE Courier* 52:17.

Young, K. 1988. *Gender and development: A relational approach*. Oxford: Oxford University Press.

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Maternal Deaths in an Indian Hospital: A Decade of (No) Change?

Vinaya Pendse

This paper examines changes in the profile of women dying in childbirth in Zanana Hospital, a specialist hospital in Udaipur, Rajasthan, India, based on information about 100 consecutive maternal deaths in the hospital during 1983-85 and 1994-96. In the interim, there were significant improvements in the management of obstetric emergencies in the hospital and rapid improvements in Rajasthan's infrastructural facilities. The women who died in childbirth in the hospital in 1994-96 were poorer and in poorer health compared to women who died in childbirth in the hospital during 1983-85, and more of them belonged to socially disadvantaged groups. Almost the same proportion of women in both groups had received inadequate antenatal care. Similarly, the same proportion had been attended by a trained midwife during the initial stages of delivery. Many more had travelled longer distances and spent more money getting to the hospital in 1994-96 than in the previous decade, and more had arrived at the hospital in a moribund condition who could not be saved. Lastly, more of them succumbed to clearly preventable causes of death than in the previous decade – complications resulting from illegal abortions, severe anaemia and malaria. Most of the women who died in hospital in 1994-96 would have died at home in the earlier decade, and their deaths would never have been recorded. To that extent, the changes over the decade may be viewed as positive. However, poverty, gender and social inequalities and lack of access to care and treatment at a point when their lives could have been saved are still bringing as many women to die in our hospital as ten years ago. Until these problems are addressed, women will continue to die needlessly in childbirth within and outside hospitals.

AFTER more than three decades of work as a specialist in obstetrics and gynaecology in Rajasthan, India, I retired in 1998. During my post-graduate training between 1965 and 1968 and in my early years as a teacher in medical colleges (1969-1980), I witnessed a large number of maternal deaths. The number seemed to be unchanging year after year. I was often gripped by a sense of helplessness.

Rajasthan is one of the poorest states of India, both economically and in terms of health status. The per capita income is much lower than the average for India, and the infant mortality rate is the fourth highest in the country.[1,2] During 1992-93, antenatal coverage in Rajasthan, i.e. at least one contact with a trained nurse-midwife attached to a government primary health centre, was only 23 per cent, the lowest in the country, compared to the national average of 49 per cent.[3] The state also had the lowest proportion of deliveries in a health facility (11.6 per cent) during the same year. More than 40 per cent of births were attended at home by traditional birth attendants (TBAs), and 37 per cent by other untrained persons.[4] The maternal mortality ratio for Rajasthan, estimated to be 938 per 100,000 live births during the period 1982-86, was the second highest in India, almost double the estimated national average of 555 per 100,000 live births.[5]

In 1980, I was appointed as Professor and Head of the Department of Obstetrics and Gynaecology at the RNT Medical College and the Zanana Hospital attached to it, a position I held for the next 17 years. At the time I assumed this position, the emergency maternity care available in the hospital was inadequate. The hospital had been set up in 1959 to accommodate 2,000 deliveries annually. However, the number of deliveries being conducted had crossed 4,000 by

1980, and was continuing to rise rapidly with no concomitant increase in manpower, beds or space. Indeed, the bed capacity was only 150 beds, with 20 beds exclusively earmarked for women having tubal ligation. As a result, there were no beds available for nearly 40 per cent of the women coming in to give birth, who had to lie on mats on the floor. Further, there was no septic ward, and women with sepsis and others were all accommodated in the same ward, with a high risk of cross-infection.

There was also a perpetual shortage of essential drugs and equipment. The labour room had no proper laboratory, store or preparation room attached to it. There was one common operating theatre for obstetric cases, gynaecological cases and sterilisations. The increase in the number of delivery cases, and tremendous increase in the inflow of women with serious obstetric complications from rural areas, contributed to the deterioration of the hospital's obstetric emergency services, resulting in the high rates of maternal mortality observed in the hospital.

It was during 1983-85 that I decided to document the maternal deaths which were happening in the hospital, with a view to drawing public attention to this serious issue. I prepared a report in 1985 on 100 women who had died in Zanana Hospital, which I mailed to government ministers, administrators at the federal and state government levels, the World Health Organization and leaders of local non-governmental organisations. The report did succeed in drawing attention to the problem, and was further helped in 1987 by the launch of the Safe Motherhood Initiative internationally. Eventually, in 1990-91, I received help in the form of government funds to improve the hospital's facilities for dealing with obstetric emergencies. A new operating theatre was constructed, a septic maternity complex was set up and additional staff were employed.

In 1985, I instituted medical audit of all cases of maternal death in the Zanana Hospital, with a view to evaluating care and treatment and bringing about improvements in the hospital's emergency obstetric services. Meetings were held monthly, and all maternal deaths in the previous month were analysed and discussed, and classified as 'avoidable' or 'unavoidable'. The resident post-graduate student who was on duty at the time of any maternal death was responsible for collecting additional details about the woman who died from her relatives, to present at the meeting. Teaching staff as well as non-teaching staff and all post-graduate students would attend the meetings and participate in the discussions.

The analysis and professional interaction in these meetings have led to considerably better management of serious obstetric emergencies and some necessary improvements in services. The setting up of additional facilities has also helped. Even so, several bottlenecks and constraints have remained: power failures, generator failures, ambulance break-downs and strike in the factory which supplies oxygen are a few examples.

Further, although there have been rapid socio-economic changes in the state of Rajasthan and improvements in the state's infrastructural facilities, these have not been matched by improvements in access to primary health care; in the decade 1985 to 1995, there was only a small increase in the proportion of villages with a health centre – from 14.5 per cent to 20.5 per cent.[6]

In 1994-96, I collected information on a further 100 women who died from maternal causes in Zanana Hospital. I found that despite improvements inside and outside the hospital, the number of maternal deaths seen in the hospital had not declined in the decade 1985 to 1995. At the same time, however, the profile of women who were dying did appear to have changed. The present paper is an attempt to analyse the nature of these changes and the possible underlying factors. It seeks to understand whether or not there has been progress in the prevention of maternal deaths in Rajasthan, or even in the districts served by Zanana Hospital.

The study and its limitations

The first study was based on 100 consecutive cases of maternal deaths at Zanana Hospital, Udaipur, Rajasthan, between 1 January 1983 and 31 July 1985. The follow-up study in the same setting, carried out between 1 March 1994 and 30 June 1996, similarly included 100 maternal deaths.

In both instances, in addition to medical

history, information on each patient's socio-economic status and place of residence, the nature of any care received prior to hospital admission was recorded, the distance covered to reach the hospital, and the nature of and expenditure on getting to the hospital. Cases in which any of these details could not be obtained were excluded from the analysis.

Neither data set has information on the population from which the women who died came. In the absence of this information, it is not possible to make observations regarding changes in the maternal mortality rate or in the relative risk of maternal death based on characteristics of the women. The analysis is only indicative, but it throws up some interesting hypotheses regarding the factors underlying the changes in the profile of maternal deaths in the hospital during the decade concerned.

A context of poverty and gender discrimination

A major factor underlying many avoidable maternal deaths is the combination of gender discrimination and poverty, which begin to have an effect from birth for girls. Higher female infant mortality (92 per 1000) than male (88 per 1000) in Rajasthan (1992), a differential which continues through the adult years, is a clear indicator of this. Rajasathan also has the highest gap within India between female and male mortality rates in the 20-24 age group, with female mortality 1.7 times greater than male mortality.[2] Furthermore, there is also evidence to suggest that gender discrimination, rather than diminishing over time, may in fact be increasing. Thus, the ratio of female to male child mortality rates increased from 1.11 in 1982-84 to 1.16 in 1994.

Education of girls is rare, despite the increase in the number of villages which have a primary school. Rajasthan has the lowest female literacy rate in the country, 21 per cent, while the male literacy rate is 55 per cent.[7] The gender gap in educational status is likely to continue for many more decades, given that the primary school enrolment rate for girls in 1991 was only 50.1 per cent as compared to 106.7 for boys.[8]

Even today, mass child marriage ceremonies arranged by parents, where hundreds of boys and girls wed each other, are very common. The mean age at marriage for women (16.1 yrs) is among the lowest in the country.[7] Once a girl goes to her marital home, it is her duty to beget a child as soon as she can. Her sex life therefore starts immediately or soon after menarche, and in some cases, even earlier.

Forcing early pregnancies and motherhood on teenage girls under the banner of social custom and family is tragic. Not much has changed in Rajasthan in the past decade with respect to frequent childbearing and grand multiparity. Fertility rates remain high, with a total fertility rate in 1991 of 4.7 as compared to 3.9 for the country as a whole. Coming to the hospital in an obstetric emergency will not help prevent the deaths of women who are in a vulnerable state of health to begin with. Maternal mortality is thus, in addition to a health services and poverty issue, also a gender issue.

Yet another factor is the nature of 'development' that has taken place in the state of Rajasthan and the rest of the country over the last decade. Few jobs and income earning avenues appear to be percolating down to the rural areas, but prices of essential commodities and especially food have increased several fold. It would appear that economic inequality has increased, with the lion's share of benefits of technological and economic development cornered by the urban middle and upper classes.

Findings

Demographic characteristics and socio-economic status

There were more maternal deaths (12 per cent) in women aged 18 or less in 1994-96 than in 1983-85 (7 per cent). In both series, nearly one fourth of the deaths were in women over 30 years of age, a trend similar to other Indian states. Twenty-one per cent of deaths in 1983-85 and 24 per cent in 1994-96 occurred in women of gravidity five and above.

A greater proportion of maternal deaths in 1994-96 (68 per cent) occurred in women of the 'very poor' or 'poor' groups, as compared to ten years earlier (55 per cent).[9] Further, a slightly higher proportion of women who died in 1994-96 (88 per cent) were illiterate as compared to those who died a decade earlier (82 per cent), and fewer (4 per cent) had more than five years of schooling than those who died a decade earlier (9 per cent).

There was a statistically significant increase in 1994-96 as compared to 1983-85 in the percentage of those belonging to the 'Scheduled' castes and 'Scheduled' tribes – among the most economically and socially marginalised groups in India (74 per cent vs. 45 per cent). The proportion of maternal deaths among those belonging to higher castes declined to less than half of what it had been in the earlier series.

Interestingly, the decline in the number of maternal deaths was not uniform across the various 'higher' caste groups. The number of maternal deaths among the 'Rajput' caste women remained almost unchanged, from 18 in the 1983-85 study to 14 in the 1994-96 study, while deaths among other 'higher' castes declined from 35 to only 8.

Anaemia

Overall, the haemoglobin levels of women who died in 1994-96 were much worse than those observed in women who died a decade before. Every one of the women (100 per cent) who died from maternal causes in 1994-96 suffered from anaemia (Hb < 10.1 gm %) , while the proportion was 83 per cent in the earlier series. In particular, the proportion in the 1994-96 series with very severe anaemia (Hb < 4 gm%) was three times greater, from 11 to 34 per cent.

When the haemoglobin level is less than 4 gm%, the risk of sudden heart failure is very high (up to 40 per cent of all cases).[10] Available blood was preventing some of these deaths in 1983-85. However, administrative and managerial problems related to blood transfusion in acutely anaemic patients have multiplied since 1992, with the advent of newer risks of bloodborne infection – HIV, hepatitis B, syphilis and malarial parasites, and screening for these infections has become mandatory since then. This has frequently resulted in the hospital being unable to provide blood for transfusion because the equipment or supplies to carry out the mandatory tests were not available. Blood donation by relatives continues to be rare. All these factors have contributed to maternal deaths related to anaemia in the 1994-96 series.

Antenatal and delivery care

The proportion of women who had received any primary-level antenatal care had increased statistically significantly during the decade, from 28 per cent to 50 per cent. However, on further exploring the nature of the care received by the two groups of women, we found that the only major change observable was that more women had received tetanus toxoid injections during pregnancy in 1994-96 than in 1983-85 (52 as compared to 32). There was only a very marginal increase (10 per cent vs. 6 per cent) in the proportion who had received adequate antenatal care (comprising four contacts with a health worker, immunisation against tetanus and anaemia prophylaxis). Eighteen per cent had

Table 1. Changes in the profile of women dying in childbirth at the Zanana Hospital, Udaipur, Rajasthan, India, 1983-85 and 1994-96

Characteristics of the women	No. of cases	
	1983-85 (n=100)	1994-96 (n=100)
Age 18 years and below	7	12
Age 31-40 years	21	22
Gravidity 5 +	21	22
Illiterate	82	88
Belonging to higher castes	53	22 *
Belonging to Scheduled castes/ Scheduled tribes	45	75 *
Poor and very poor	52	68
Moderate to severe anaemia (Hb < 8 gm%)	49	78 *
TBA the main person responsible for antenatal & intra-natal care	68	60
Tetanus toxoid immunisation	32	52
Booked cases	10	5
No primary care	72	50 **
Women from the city	15	7
Women who travelled 100 km to reach hospital	11	20
Transported by jeep	27	62
Transport expenditure Rs. 201- 500	26	38
Transport expenditure Rs. 501 >	3	12
Mortality within 4 hrs of hospital admission	25	34
Eclampsia cause of death	28	13
Haemorrhage cause of death	23	31
Severe anaemia cause of death	4	24
Ruptured uterus cause of death	4	7
Septic induced abortion cause of death	4	15 #

* *p < .01, highly significant*

** *p < .05, significant*

\# *11 cases of sepsis and 4 cases of haemorrhage*

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Causes of death

Some changes in the pattern of direct causes of death over the period from 1983 to 1996 can be observed. Some of these are positive. For example, although the number of women admitted with pregnancy-induced hypertension remained more or less the same, the proportion of deaths due to eclampsia dropped from 28 per cent in 1983-85 to 13 per cent in 1994-96. This is directly due to hospital policy since 1990 of timely administration of magnesium sulphate to all women with suspected cases of eclampsia except those who had received other drugs prior to admission.

On the other hand, it was disturbing to find that malaria was probably responsible for the deaths of 17 women in the 1994-96 series, of whom 9 women had a confirmed diagnosis of malaria. In contrast, there were no deaths related to malaria in the 1983-85 series. Further, there was a six-fold increase in the number of deaths due to severe anaemia (Hb < 6 gm%), probably all related to malaria. Deaths due to ruptured uterus were also slightly higher (7 per cent as compared to 4 per cent), but this was not statistically significant.

An equally disturbing finding was a significant increase in the proportion of deaths from complications of induced abortion. There were 15 maternal deaths related to induced abortion during 1994-96, as compared to only 4 during 1983-85. Of these, cases of septic abortion were three times higher in 1994-96 than in 1983-85 (11 vs. 4), and four women died from haemorrhage following induced abortion in 1994-96 as compared to none in 1983-85. All the abortion deaths in both series resulted from abortions carried out by unregistered and unskilled practitioners, sought because of the absence of proper abortion services, even at district referral hospitals.

A decade of (no) progress?

Since it opened in 1959, Zanana Hospital in Udaipur has remained the only tertiary care hospital in southern Rajasthan to render proper, specialist emergency obstetric services to the women not only of Udaipur city, but also Udaipur district, adjacent districts and the adjoining state of Madhya Pradesh. Although there are two other government health centres in

received erratic antenatal care (one or two contacts with a health worker when the latter chooses to make a domiciliary visit) or inadequate antenatal care (falling short of one or more components), while 50 per cent had received no antenatal care at all in the 1994-96 series, as compared to 4 per cent and 72 per cent respectively in the 1983-85 series.

Traditional birth attendants still remained the main people responsible for delivery care for 60 per cent of the women in 1994-96, as compared to 68 per cent in 1983-85.

Distance and mode of transport to the hospital

With the improvement in roads and transport facilities which took place in the years between the two studies, an increased number of women who died in the hospital had travelled from distant places and had arrived at the hospital with the hope of surviving. The proportion of women who had travelled more than 100 km almost doubled, from 11 per cent during 1983-85 to 20 per cent during 1994-96. At the same time, the proportion of maternal deaths from among women from Udaipur city had been halved, from 15 per cent during 1983-85 to 7 per cent in 1994-96.

Because of the hilly terrain and poor (even if improved) roads for the long distances, delays in bringing women to the hospital, leading to deterioration in the woman's condition, were always a strong possibility in the majority of the cases.

As regards means of transport, the most noticeable change was that many more women who died in the 1994-96 group (62 per cent) had travelled in by jeep as compared to those in the past (37 per cent). This vehicle, suitable for rough and bumpy roads, has gained popularity as a mode of private transport because it is far less expensive than a private taxi, and faster than other traditional modes of transport available at the village level. There was not much change in the other modes of transport used, which included buses, trucks and the age old bullock-cart. Three-wheeler taxis (auto-rickshaws) were available for transport in Udaipur city.

Eight women in the 1994-96 group were carried manually on a cot or on someone's back. More than one third of the women had used more than one mode of transport to reach the hospital. Often, a woman would be carried on a cot or on someone's back from her village to the nearest motorable road. From there a passing private bus, minibus or truck would be flagged down and asked to transport her to some part of Udaipur city, and then a three-wheeler would be hired to reach the hospital. Distance and lack of transport together may have contributed to far more maternal deaths in the community than among women who reached the hospital.

Only 8 percent of the women in the 1994-96 study and 6 per cent in the 1983-85 study were transported by hospital ambulance. Despite the passage of ten years and repeated requests and reminders from us at Zanana Hospital, there has as yet been no policy directive from the Health Department regarding the transport of emergency maternity cases from rural areas to hospital. Transport is not provided by the government, even for serious cases referred from primary health centres in the district.

Expenditure on transport

All but those who used hospital ambulances had to hire private transport and pay for it. The exorbitant amounts they had to pay are of great concern, given that the majority of them were extremely poor.

The average expenditure on transporting the dying woman in each case had doubled in the period between the two studies, from Rs. 150 to Rs. 300. This may partly be due to the increased cost of fuel and the longer distances travelled. However, more families in 1994-96 had ventured to come to the hospital from longer distances, in the hope of saving the woman's life. We gathered that many of the families had to borrow from a local moneylender or pawn some of their belongings before undertaking the journey. The whole experience left them poorer both materially and emotionally, especially when, despite their desperate efforts, the woman's life could not be saved.

Interval between hospital admission and death

Twenty-one per cent of the women in 1994-96, as compared to 13 per cent in 1983-85, died within two hours of admission, which indicates that their condition was so bad that nothing could be done for them in the way of hospital emergency care. While this was also true in the past, the number of women arriving in a moribund condition was much higher in the 1994-96 series.

the city, these only provide outpatient services and have not been upgraded to offer emergency obstetric care.

What have we at the Zanana Hospital learned from this comparison of the profile of women dying from complications of pregnancy, birth and induced abortion during the mid-1990s with those who died in the mid-1980s? A larger proportion suffered from infections and were severely anaemic than their counterparts in the mid-1980s. Nearly half of them did not receive any antenatal care, and the care received by most of the rest was erratic and inadequate. Many more had travelled longer distances and their families had spent more money getting them to the hospital. Many more arrived in a condition where nothing could be done to save them. Finally, more of them lost their lives from clearly preventable causes than the women who died in the decade before them, i.e. complications resulting from illegal abortions, and severe anaemia and malaria.

As regards socio-economic status, the women who died in 1994-96 were less educated and poorer, and more of them belonged to socially disadvantaged groups compared to those who had died in 1983-85, with one exception. There was a continuing high representation of Rajput women among maternal deaths both during 1983-85 (18 per cent) and 1994-96 (14 per cent), while that among other caste groups declined dramatically (from 35 per cent to 8 per cent).[11] Rajputs are a comparatively affluent and politically powerful caste group, but the women are subject to more restrictions than in other higher caste groups. This includes norms of *purdah*, segregation of women at social gatherings, *sati* (self-immolation at the death of the husband), female infanticide and non-acceptance of widows remarrying, which are still very commonly practised among them. The relationship between these manifestations of a high level of gender discrimination and the continuing high proportion of maternal deaths among Rajput women, warrants further scrutiny.

As regards causes of death, the increase in anaemia is directly related to an increase in the frequency of malaria caused by *Plasmodium falciparum*, which is more often fatal than other kinds of malaria, and is becoming increasingly resistant to chloroquine.[12]

It is not possible to determine from the data whether more women were having induced abortions than in the past, or whether more women who developed complications were able to reach the hospital or were being brought in for treatment in 1994-96 than in the past. Although there is little hard data, access to induced abortions from trained providers is mainly available only in large public and private hospitals in India, which means that poor, rural women have little or no easy access and continue to rely on unskilled providers and dangerous methods.[13] In any case, the proportion of deaths due to illegal abortions in recent years is unacceptable in a country where abortion has been legal since 1972.

These problems must be added to the fact that the health services at primary and referral level have not been improved sufficiently to safeguard women's lives until they can reach our hospital in cases of emergencies. Hence, although our efforts within the hospital to improve emergency obstetric care have made a difference in terms of saving some women's lives, we are able to succeed only up to a point.

These observations, based on experience, are mostly corroborated by data available for the state of Rajasthan, and suggest the following. The health status of the population has not improved in crucial aspects, including maternal mortality. The resurgence of malaria has taken a heavy toll of lives during the present decade and is especially dangerous in pregnancy. Further, since 1993-94, the state has also witnessed a resurgence of viral hepatitis which has also been associated with maternal deaths in recent years, although precise figures for these are not available.

Health service infrastructure has improved only marginally. Access to antenatal care has improved mainly with respect to immunisation against tetanus. The overall quality of antenatal care remains poor or is inaccessible. Worse still, abortion services as well as emergency obstetric services remain almost unavailable to the vast majority of rural women. Women who want to space pregnancies do so at great risk to their lives. This also points to the failure of the family planning programme to meet women's need for birth spacing methods.

The only positive change brought about by 'development' has been improvements in the network of roads and access to public transport.

In addition, there has been a general improvement in the level of awareness of the people, probably because of seasonal migration to urban areas in search of work, as more of them seem to know about the emergency obstetric services available at our hospital.

The consequence is what is reported here: many of the women who would have died at home in the past, and whose deaths would never have been counted, are now arriving at our hospital. However, because the problems of transport, money and distance remain so large for them, we are unable to prevent their deaths. Hence, the number of maternal deaths taking place in the hospital remains unabated after a decade.

To the extent that more women are now coming to the hospital from farther away and from poorer and lower caste groups, the changes in the profile of women dying over the past decade may be viewed as positive. However, unless and until all the factors contributing to the continuing high numbers of maternal deaths are put right, starting from the social and economic inequalities which place women at a disadvantage even before they become pregnant, women will continue to die needlessly in childbirth, both within and outside hospitals.

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References and Notes

1. The per capita income for Rajasthan was Rs. 3983 in 1990-91 (current prices), as compared to Rs. 4325 for India as a whole. Department of Family Welfare, 1992. *Family Welfare Programme in India – Year Book 1991-92.* New Delhi, . Ministry of Health and Family Welfare, Government of India.
2. The infant mortality rate for the state was 90 per 1000 live births in 1992, the fourth highest in the country. Office of the Registrar General, Vital Statistics Division, (various years). *Sample Registration System: Fertility and Mortality Indicators.* New Delhi, Ministry of Home Affairs, Government of India.
3. International Institute for Population Sciences. 1995. *National Family Health Survey: India, 1992-93. Introductory Report.* Bombay.
4. International Institute for Population Sciences. 1994. *National Family Health Survey: India, 1992-93.* Bombay.
5. Mari Bhat PN, K Navaneetham, S Irudaya Rajan. 1992. *Maternal Mortality in India: Estimates from an Econometric Model.* Dharwad, Population Research Centre, Working Paper 24 (January).
6. During 1981-1991, there were several major improvements in the state's infrastructure and in that of Udaipur district. The proportion of villages in the district connected by public transport increased from 21 per cent to 37 per cent. Villages with a primary school increased from 46 per cent of all villages to 73 per cent. Office of the Registrar General, India. 1993. *Census of India, 1991.* District Census Abstract, Udaipur district. New Delhi, Ministry of Home Affairs, Government of India.
7. Office of the Registrar General, India. 1991. Provisional Population Totals, *Census of India, 1991.* Paper 1 of 1991, Series 1. New Delhi, Ministry of Home Affairs, Government of India.
8. Department of Education, 1993. Selected Educational Statistics: 1990-91. New Delhi, Ministry of Human Resources Development, Government of India.
9. The definitions of 'poor' and 'very poor' are as follows: Those who are very poor are those with no regular employment or source of income and no assets. The 'poor' are defined as those whose household income is less than Rs. 1600/- per month (US$ 40) in 1994-96, which is below the 'poverty line' income specified by the Planning Commission of India as Rs. 2600/- per capita per month (US $65). For 1983-85, the poor were defined as those with a household income of less than Rs. 500 per month at current prices.
10. World Health Organization, 1992. *The Prevalence of Nutritional Anaemia in Women: A Tabulation of Available Information.* Geneva. WHO/MCH/MSM/92.3.
11. Rajputs are a warrior caste who rank immediately below the Brahmins in the caste hierarchy and form the top rung of the economic and political hierarchy.
12. World Health Organization-South East Asia Regional Office, 1999. *Health situation in the South East Asia Region 1994-1997.*
13. See for example Gupte M, Bandewar S, Pisal H, 1997. Abortion needs of women in India: a case study of rural Maharashtra. *Reproductive Health Matters.* No. 9(May):77-86.

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TUTORIAL

Genders, sexes, and health: what are the connections—and why does it matter?

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Open up any biomedical or public health journal prior to the 1970s, and one term will be glaringly absent: *gender*. Open up any recent biomedical or public health journal, and two terms will be used either: (1) interchangeably, or (2) as distinct constructs: *gender* and *sex*. Why the change? Why the confusion?—and why does it matter? After briefly reviewing conceptual debates leading to distinctions between 'sex' and 'gender' as biological and social constructs, respectively, the paper draws on ecosocial theory to present 12 case examples in which gender relations and sex-linked biology are singly, neither, or both relevant as independent or synergistic determinants of the selected outcomes. Spanning from birth defects to mortality, these outcomes include: chromosomal disorders, infectious and non-infectious disease, occupational and environmental disease, trauma, pregnancy, menopause, and access to health services. As these examples highlight, not only can gender relations influence expression—and interpretation—of biological traits, but also sex-linked biological characteristics can, in some cases, contribute to or amplify gender differentials in health. Because our science will only be as clear and error-free as our thinking, greater precision about whether and when gender relations, sex-linked biology, both, or neither matter for health is warranted.

Keywords Epidemiological methods, epidemiological theory, gender, men's health, sex, women's health

Open up any biomedical or public health journal prior to the 1970s, and one term will be glaringly absent: *gender*. Open up any recent biomedical or public health journal, and two terms will be used either: (1) interchangeably, or (2) as distinct constructs: *gender* and *sex*. Why the change? Why the confusion?—and why does it matter?

As elegantly argued by Raymond Williams, vocabulary involves not only 'the available and developing meaning of known words' but also 'particular formations of meaning—ways not only of discussing but at another level seeing many of our central experiences' (ref. 1, p. 15). Language in this sense embodies 'important social and historical processes', in which new terms are introduced or old terms take on new meanings, and often 'earlier and later senses coexist, or become actual alternatives in which problems of contemporary belief and affiliation are contested' (ref. 1, p. 22).

So it is with 'gender' and 'sex'.[2,3] The introduction of 'gender' in English in the 1970s as an alternative to 'sex' was expressly to counter an implicit and often explicit biological determinism pervading scientific and lay language.[2–8] The new term was deployed to aid clarity of thought, in a period when academics and activists alike, as part of and in response to that era's resurgent women's movement, engaged in debates over whether observed differences in social roles, performance, and non-reproductive health status of women and men—and girls and boys—was due to allegedly innate biological differences ('sex') or to culture-bound conventions about norms for—and relationships between—women, men, girls, and boys ('gender') (Table 1). For language to express the ideas and issues at stake, one all-encompassing term—'sex'—would no longer suffice. Thus, the meaning of 'gender' (derived from the Latin term 'generare', to beget) expanded from being a technical grammatical term (referring to whether nouns in Latin and related languages were 'masculine' or 'feminine') to a term of social analysis (ref. 1, p. 285; ref. 4, p. 2; ref. 5, pp. 136–37). By contrast, the meaning of 'sex' (derived from the Latin term *secus* or *sexus*, referring to 'the male or female *section* of humanity' [ref. 1, p. 283]) contracted. Specifically, it went from a term describing distinctions between, and the relative status of, women and men (e.g. Simone DeBeauvoir's *The Second Sex*[9]) to a biological

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Table 1 Definitions of 'sex' and 'gender'. From *A Glossary for Social Epidemiology*[2]

Term	Definition
Gender, sexism, & sex	Gender refers to a social construct regarding culture-bound conventions, roles, and behaviors for, as well as relations between and among, women and men and boys and girls. Gender roles vary across a continuum and both gender relations and **biologic expressions of gender** vary within and across societies, typically in relation to social divisions premised on power and authority (e.g., class, race/ethnicity, nationality, religion). **Sexism**, in turn, involves inequitable gender relations and refers to institutional and interpersonal practices whereby members of dominant gender groups (typically men) accrue privileges by subordinating other gender groups (typically women) and justify these practices via ideologies of innate superiority, difference, or deviance. Lastly, **sex** is a biological construct premised upon biological characteristics enabling sexual reproduction. Among people, biological sex is variously assigned in relation to secondary sex-characteristics, gonads, or sex chromosomes; sexual categories include: male, female, intersexual (persons born with both male and female sexual characteristics), and transsexual (persons who undergo surgical and/or hormonal interventions to reassign their sex). Sex-linked biological characteristics (e.g., presence or absence of ovaries, testes, vagina, penis; various hormone levels; pregnancy, etc.) can, in some cases, contribute to gender differentials in health but can also be construed as **gendered expressions of biology** and erroneously invoked to explain **biologic expressions of gender**. For example, associations between parity and incidence of melanoma among women are typically attributed to pregnancy-related hormonal changes; new research indicating comparable associations between parity and incidence of melanoma among men, however, suggests that social conditions linked to parity, and not necessarily—or solely—the biology of pregnancy, may be aetiologically relevant.
Sexualities & heterosexism	**Sexuality** refers to culture-bound conventions, roles, and behaviors involving expressions of sexual desire, power, and diverse emotions, mediated by gender and other aspects of social position (e.g., class, race/ethnicity, etc.). Distinct components of sexuality include: sexual identity, sexual behavior, and sexual desire. Contemporary 'Western' categories by which people self-identify or can be labeled include: heterosexual, homosexual, lesbian, gay, bisexual, 'queer', transgendered, transsexual, and asexual. **Heterosexism**, the type of discrimination related to sexuality, constitutes one form of abrogation of sexual rights and refers to institutional and interpersonal practices whereby heterosexuals accrue privileges (e.g., legal right to marry and to have sexual partners of the 'other' sex) and discriminate against people who have or desire same-sex sexual partners, and justify these practices via ideologies of innate superiority, difference, or deviance. Lived experiences of sexuality accordingly can affect health by pathways involving not only sexual contact (e.g., spread of sexually-transmitted disease) but also discrimination and material conditions of family and household life.

term, referring to groups defined by the biology of sexual reproduction (or in the meaning of 'having sex', to interactions involving sexual biology) (ref. 1, p. 285; ref. 4, p. 2; ref. 5, pp. 136–37).

As the term 'gender' began to percolate into everyday use, however, it also began to enter the scientific literature,[3–8,10] sometimes with its newly intended meaning, other times as a seemingly trendy substitute for 'sex'—with some articles[11] even including both terms, interchangeably, within their titles! Other studies, by contrast, have adhered to a strict gender/sex division, typically investigating the influence of only one or the other on particular health outcomes.[3–8,10] A new strand of health research, in turn, is expanding these terms from singular to plural by beginning to grapple with new constructs of genders and sexes now entering the scientific domain, e.g., 'transgender', 'transsexual', 'intersexual', which blur boundaries not only between but also within the gender/sex dichotomy (Table 1).[8] The net result is that although lucid analyses have been written on why it is important to distinguish between 'gender' and 'sex',[4–8] epidemiological and other health research has been hampered by a lack of clear conceptual models for considering both, simultaneously, to determine their relevance—or not—to the outcome(s) being researched.

Yet, we do not live as a 'gendered' person one day and a 'sexed' organism the next; we are both, simultaneously, and for any given health outcome, it is an empirical question, not a philosophical principle, as to whether diverse permutations of gender and sex matter—or are irrelevant. Illustrating the importance of asking this question, conceptually and analytically, Table 1 employs an ecosocial epidemiological perspective[2,12] to delineate 12 examples,[13–24] across a range of exposure–outcome associations, in which gender relations and sex-linked biology are singly, neither, or both relevant as independent or synergistic determinants.[25] These examples were chosen for two reasons. First, underscoring the salience of considering these permutations for any and all outcomes, the examples range from birth defects to mortality, and include: chromosomal disorders, infectious and non-infectious disease, occupational and environmental disease, trauma, pregnancy, menopause, and access to health services. Second, they systematically present diverse scenarios across possible combinations of gender relations and sex-linked biology, as singly or jointly pertinent or irrelevant. In these examples, expressions of gender relations include: gender segregation of the workforce and gender discrimination in wages, gender norms about hygiene, gender expectations about sexual conduct and pregnancy, gendered presentation of and responses to symptoms of illness, and gender-based violence. Examples of sex-linked biology include: chromosomal sex, menstruation, genital secretions, secondary sex characteristics, sex-steroid-sensitive physiology of non-reproductive tissues, pregnancy, and menopause.

As examination of the 12 case examples makes clear, not only can gender relations influence expression—and interpretation—of biological traits, but also sex-linked biological characteristics can, in some cases, contribute to or amplify gender differentials in health. For example, as shown by case No. 9, not recognizing that parity is a social as well as biological phenomenon, with meaning for men as well as women, means important clues about why parity might be associated with a given outcome might be missed. Similarly, as shown by case No. 11, recognition of social inequalities among women (including as related to gender disparities between women and men) can enhance understanding of expressions of sex-linked biology.

Table 2 Selected examples of differential roles of gender relations and sex-linked biology on health outcomes: only gender, only sex-linked biology, neither, and both

Case	Diagrammed illustration	Exposure—outcome association	Relevance of: Gender relations	Relevance of: Sex-linked biology	Explication
1	gender relations; sex-linked biology; exposure → health outcome	Greater prevalence of HIV/AIDS due to needle-stick injury among female compared with male health care workers providing patient care[13]	Yes: for exposure	No	• Gender relations: determinant of risk of exposure (needle stick injury), via gender segregation of the workforce (e.g. greater likelihood of women being nurses) • Sex-linked biology: not a determinant of risk of exposure • Risk of outcome, given exposure: risk of seroconversion same among women and men
2	gender relations; sex-linked biology; exposure → health outcome	Greater prevalence of contact lens microbial keratitis among male compared with female contact lens wearers[14]	Yes	No	• Gender relations: determinant—among those wearing contact lenses—of risk of exposure to improperly cleaned contact lenses (men less likely to properly clean them than women) • Sex-linked biology: not a determinant of exposure • Risk of outcome, given exposure: risk of contact lens microbial keratitis same among women and men, once exposed to improperly cleaned contact lenses
3	gender relations; sex-linked biology; exposure → health outcome	Greater prevalence of short stature and gonadal dysgenesis among women with Turner's syndrome compared with unaffected women[15]	No	Yes: for exposure	• Gender relations: not a determinant of exposure (X-monosomy, total or mosaic, or non-functional X chromosome) • Sex-linked biology: determinant of exposure • Risk of outcome, given exposure: not influenced by gender relations
4	gender relations; sex-linked biology; exposure → health outcome	Both similar and different adverse health outcomes among women and men due to ubiquitous exposure to cooking oil contaminated by polychlorinated biphenyls (PCB) ('Yusho' disease)[16]	No	Yes: once exposed	• Gender relations: not a determinant of risk of exposure (ubiquitous exposure to the contaminated cooking oil, in staple foods) • Sex-linked biology: not a determinant of risk of exposure • Risk of outcome, given exposure: partly influenced by sex-linked biology, in that although both women and men experienced chloracne and other dermal and ocular lesions, only women experienced menstrual irregularities
5	gender relations; sex-linked biology; exposure → health outcome	Higher risk of stroke among both women and men in the US 'stroke belt' in several Southern states, compared with women and men in other regions of the US (as distinct from differences in risk for women and men within a given region)[17]	No	No	• Gender relations: not a determinant of risk of exposure (living in the US 'stroke belt') • Sex-linked biology: not a determinant of risk of exposure • Risk of outcome, given exposure: neither gender relations nor sex-linked biology determine regional variation in stroke rates among men and among women (even as both may contribute to within-region higher risks among men compared with women)
6	gender relations; sex-linked biology; exposure → health outcome	Higher risk of hypospadias among male infants born to women exposed to potential endocrine-disrupting agents at work[18]	Yes: for exposure	Yes: once exposed	• Gender relations: a determinant of risk of exposure, via gender segregation of the workforce (e.g. high level of phthalate exposure among [illegible] mainly women) • Sex-linked biology: not a determinant of risk of exposure • Risk of outcome, given exposure: different for women and men, and for female and male fetus, as only women can be pregnant, and adverse exposure can lead to hypospadias only among fetuses with a penis

238

Table 2 continued

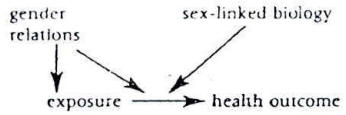
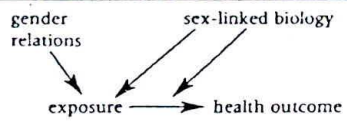
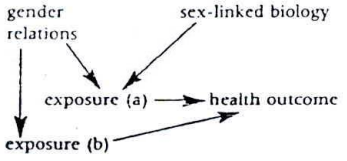
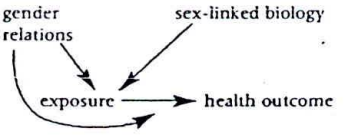
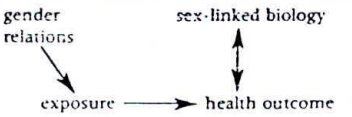
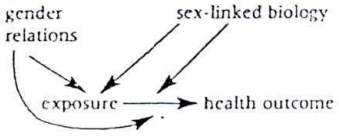
Case	Diagrammed illustration	Exposure—outcome association	Relevance of: Gender relations	Relevance of: Sex-linked biology	Explication
7		Geographical variation in women's rates of unintended pregnancy as linked to variation in state policies re family planning[19]	Yes: for exposure and once exposed	Yes: once exposed	• Gender relations: a determinant, at societal level, of risk of exposure, i.e. state policies and spending for family planning • Sex-linked biology: not a determinant, at individual level of the girl or woman at risk of pregnancy, of state policies and spending for family planning • Risk of outcome, given exposure: gender relations, at the individual level, influence women's access to—and ability to act on information obtained from—family planning programs, and sex-linked biology is a determinant of who can get pregnant
8		Earlier age of human immunodeficiency virus infection among women compared with heterosexual men (in the US)[20]	Yes: for exposure	Yes: for exposure and once exposed	• Gender relations: a determinant of age of sexual partner and risk of unprotected sex (e.g. gender power imbalance resulting in sex between older men and younger women, the latter having a lesser ability to negotiate condom use) • Sex-linked biology: a determinant of exposure, via genital secretions • Risk of outcome, given exposure: sex-linked biology a determinant of greater biological efficiency of male-to-female, compared with female-to-male, transmission
9		Parity among both women and men associated with increased risk of melanoma[21]	Yes: for exposures	Yes: for exposure	• Gender relations: a determinant of parity (via expectations of who has children, at what age) • Sex-linked biology: a determinant of who can become pregnant and pregnancy-linked hormonal levels • Risk of outcome, given exposure: decreased risk of melanoma among nulliparous women and men indicates that non-reproductive factors linked to parity may affect risk among both women and men, even as pregnancy-related hormonal factors may also affect women's risk
10		Greater referral of men compared with women for interventions for acute coronary syndromes[22]	Yes: for exposure and once exposed	Yes: for exposure	• Gender relations: a determinant of how people present and physicians interpret symptoms of acute coronary syndromes • Sex-linked biology a determinant of age at presentation (men are more likely to have acute infarction at younger ages) and possibly type of symptoms • Risk of outcome, given exposure: gender relations are a determinant of physician likelihood of referral for diagnostic and therapeutic interventions (women less likely to be referred, especially at younger ages)
11		Earlier age at onset of perimenopause among women experiencing greater cumulative economic deprivation over the life course[23]	Yes: for exposure	Yes: as outcome	• Gender relations: a determinant of poverty, across the life course, among women (via the gender gap in earnings and wealth) • Sex-linked b[illegible] determinant of who can experience perimenopause • Risk of outcome, given exposure: risk of earlier age at perimenopause among women subjected to greater economic deprivation across the life course, including non-smokers, may reflect impact of poverty on oocyte depletion

Table 2 continued

Case	Diagrammed illustration	Exposure—outcome association	Relevance of: Gender relations	Relevance of: Sex-linked biology	Explication
12		Greater rate of mortality among women compared with men due to intimate partner violence[24]	Yes: for exposure	Yes: for exposure and once exposed	• Gender relations: a determinant of likelihood of men versus women using physical violence against intimate partners, plus being encouraged to and having access to resources to increase physical strength • Sex-linked biology: a determinant of muscle strength and stamina, at a given level of training and exertion, and also body size • Risk of outcome, given exposure: risk of lethal assault related to on-average greater physical strength and size of men, and gender-related skills and training in inflicting and warding off physical attack

KEY MESSAGES

- Gender, a social construct, and sex, a biological construct, are distinct, not interchangeable, terms; the two nevertheless are often confused and used interchangeably in contemporary scientific literature.
- The relevance of gender relations and sex-linked biology to a given health outcome is an empirical question, not a philosophical principle; depending on the health outcome under study, both, neither, one, or the other may be relevant—as sole, independent, or synergistic determinants.
- Clarity of concepts, and attention to both gender relations and sex-linked biology, is critical for valid scientific research on population health.

e.g. age at perimenopause. Because our science will only be as clear and error-free as our thinking, greater precision about whether gender relations, sex-linked biology, both, or neither matter for health is warranted.

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References

[1] Williams R. *Keywords: A Vocabulary of Culture and Society. Revised Edn.* NY: Oxford University Press, 1983.

[2] Krieger N. A glossary for social epidemiology. *J Epidemiol Community Health* 2001;55:693–700.

[3] Krieger N, Fee E. Man-made medicine and women's health: the biopolitics of sex/gender and race/ethnicity. *Int J Health Serv* 1994;24:265–83.

[4] Oudshoorn N. *Beyond the Natural Body: An Archeology of Sex Hormones.* London: Routledge, 1994.

[5] Hubbard R. Constructing sex differences. In: Hubbard R. *The Politics of Women's Biology.* New Brunswick, NJ: Rutgers University Press, 1990. pp. 136–40.

[6] Schiebinger L. *Nature's Body: Gender in the Making of Modern Science.* Boston: Beacon Press, 1993.

[7] Doyal L. Sex, gender, and health: the need for a new approach. *BMJ* 2001;323:1061–63.

[8] Fausto-Sterling A. *Sexing the Body: Gender Politics and the Construction of Sexuality.* New York, NY: Basic Books, 2000.

[9] DeBeauvoir S. *The Second Sex.* NY: Vintage Books, 1974 (1952).

[10] Institute of Medicine, Committee on Understanding the Biology of Sex and Gender Differences. Wizemann TM, Pardue M-L (eds). *Exploring the Biological Contributions to Human Health: Does Sex Matter?* Washington, DC: National Academy Press, 2001.

[11] Boling EP. Gender and osteoporosis: similarities and sex-specific differences. *J Gend Specif Med* 2001;4:36–43.

[12] Krieger N. Theories for social epidemiology in the 21st century: an ecosocial perspective. *Int J Epidemiol* 2001;30:668–77.

[13] Ippolito G, Puro V, Heptonstall J, Jagger J, De Carli G, Petrosillo N. Occupational human immunodeficiency virus infection in health care workers: worldwide cases through September 1997. *Clin Infect Dis* 1999;28:365–83.

[14] Liesegang TJ. Contact lens-related microbial keratitis: Part I: Epidemiology. *Cornea* 1997;16:125–31.

[15] Ranke MG, Saenger P. Turner's syndrome. *Lancet* 2001;358:309–14.

[16] Aoki Y. Polychlorinated biphenyls, polychlorinated dibenzo-p-dioxins, and polychlorinated dibenzofurans as endocrine disrupters—what we have learned from Yusho disease. *Environ Res* 2001;86:2–11.

[17] Pickle LW, Gillum RF. Geographic variation in cardiovascular disease mortality in US blacks and whites. *J Natl Med Assoc* 1999;91:545–56.

[18] Van Tongeren M, Nieuwenhuijsen MJ, Gardiner K *et al.* A job-exposure matrix for potential endocrine-disrupting chemicals developed for a study into the association between maternal occupational exposure and hypospadias. *Ann Occup Hyg* 2002;46:465–77.

[19] Melvin CL, Rogers M, Gilbert BC *et al.* Pregnancy intention: how PRAMS data can inform programs and policy. *Matern Child Health J* 2000;4:197–201.

[20] Hader SL, Smith DK, Moore JS, Holmberg SD. HIV infection in women in the United States: status at the Millennium. *JAMA* 2001;285:1186–92.

[21] Kravdal O. Is the relationship between childbearing and cancer incidence due to biology or lifestyle? Examples of the importance of using data on men. *Int J Epidemiol* 1995;4:477–84.

[22] Feldman T, Silver K. Gender differences and the outcome of interventions for acute coronary syndromes. *Cardiol Rev* 2000;8:240–47.

[23] Wise LA, Krieger N, Zierler S, Harlow BL. Lifetime socioeconomic position in relation to onset of perimenopause: a prospective cohort study. *J Epidemiol Community Health* 2002;56:851–60.

[24] Watts C, Zimmerman C. Violence against women: global scope and magnitude. *Lancet* 2002;359:1232–37.

[25] Darroch J. Biological synergism and parallelism. *Am J Epidemiol* 1997;145:661–68.

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LESLEY DOYAL

1

In Sickness and in Health

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Introduction

There is a widespread belief that doctors are the 'real' experts on women's health and that biomedicine holds the key to improving it. This book demonstrates the limitations of such an approach. Instead of exploring the interior of female bodies, it steps outside to investigate the ways in which women's lives can make them sick. Through examining economic, social and cultural influences on their well-being it identifies the major obstacles that prevent women from optimising their health.

There are obvious differences between male and female patterns of sickness and health. Not surprisingly, these stem in part from biological differences between the sexes. But as we shall see, the situation is more complex than might at first appear. All societies continue to be divided along the 'fault line' of gender and this too has a profound effect on the well-being of both men and women (Moore, 1988; Papanek, 1990).

Gender differences are especially significant for women, since they usually mean inequality and discrimination. Though female subordination can take many forms it is an extremely pervasive phenomenon, demonstrating 'both endless variety and monotonous similarity' (Rubin, 1975). This does not, of course, mean that all women are worse off in every way than all men. But it remains true that in most societies the male is valued more highly than the female. Men are usually dominant in the allocation of scarce resources and this structured inequality has a major impact on women's health.

Material discrimination against women has been extensively documented. Worldwide, they do more work than men, yet their labour is seen to be of less value. Typically they receive about 30-40 per cent less pay than men if employed and no pay at all for most domestic work. They hold only 10–20 per cent of managerial and administrative jobs and are very poorly represented in the ranks of power, policy and decision making (United Nations, 1991, p. 6). As a result, many face

major challenges in acquiring the material resources needed for a healthy life.

Cultural devaluation is also important, though more difficult to map. All social groups operate through a variety of discourses that naturalise gender differences and inequalities. Women have to create their identity – their sense of themselves – within the framework of these culturally constructed and sometimes conflicting definitions of womanhood (Martin, 1987; Ussher, 1989). They may be revered as mothers for instance, or as the guardians of morality, while also being regarded as 'sickly', neurotic, polluted or just fundamentally less valuable than men. The dominant message is that women are not just different, but physically, psychologically and socially inferior. In a world defined by and for men, women are 'the other' (de Beauvoir, 1972). Under these circumstances it is hardly surprising that many find it difficult to develop the feelings of competence and self-worth associated with positive mental health.

However these similarities do not mean that women constitute a unified and homogeneous group. Though they share a gender identity and a common biology, women are differentiated by factors such as age, sexual preference, race, class and, very importantly, geopolitical status – the wealth or poverty of the country in which they live.

> no-one 'becomes' a woman (in Simone de Beauvoir's sense) purely because she is female. Ideologies of womanhood have as much to do with race and class as they have to do with sex . . . it is the intersections of the various systemic networks of class, race, (hetero)sexuality and nation . . . that position us as women (Mohanty, 1991, pp. 12–13).

These differences between women are clearly signalled in both national and international health statistics (Momsen and Townsend, 1987; Seager and Olson, 1986; United Nations, 1991).

This book will describe variations in patterns of health and illness between women and men, as well as identifying the inequalities in health status and access to medical care that separate groups of women from each other. It will then explore the complex processes shaping these biological and social realities. If they are to be effective, strategies for improving women's health must be based on a clear understanding of how these differences are created and sustained. The remainder of this chapter provides a preliminary framework for developing such an analysis.

What This Book Is and Is Not About

This is not a book about the health of both sexes. It is quite unapologetically a book about women. Though men are present, they appear mainly as actors in women's lives rather than as subjects of the analysis itself. However this should not be taken to imply that men's health is unimportant or that it cannot be subjected to the same methods of analysis. Indeed it would be one measure of the book's success if the framework presented here were adapted for a similar study of the influence of gender divisions on male health problems.

Neither is this a book about women and medicine. A comprehensive treatment of this important topic would require a very different approach with extensive coverage of issues that have hardly been addressed here (Lupton, 1994; Martin, 1987). In particular it would include a more detailed analysis of how doctors and other health workers 'treat' women in the context of individual medical encounters (Miles, 1991, Ch. 6; Roberts, 1985; Fisher, 1986).

Instead the analysis will focus on two specific aspects of modern medicine. First, knowledge generated within a biomedical framework will be combined with that from other disciplines to develop a more holistic understanding of women's health and illness. Second, the impact of medical practices on women's health will be critically reviewed and compared with that of other factors influencing their wellbeing – for good or ill. Though doctors sometimes play an important role in their lives, we will see that modern medicine is rarely the major determinant of women's health status.

This analysis will not produce a detached and objective account of women's health problems – if such a thing were even possible. Instead it will be explicitly feminist in the broadest sense. This claim to feminism does not derive from the use of specific methods of data collection or particular styles of argument (Harding, 1986; Harding, 1987; Maynard and Purvis, 1994). Indeed the evidence marshalled throughout is eclectic, both in its disciplinary orientation and in the manner of its collection and presentation. It includes both quantitative and qualitative data, some of which have been produced by people who would not define themselves as in any sense feminist. However, the analysis itself is shaped by a fundamental concern to identify – and change – those aspects of women's lives that cause them serious harm.

Physical and mental health are basic human needs yet they remain unmet for millions of women. As we shall see, the reasons for this are rarely 'natural' in the sense that they are unavoidable; too often they

are, quite literally, 'man-made', requiring feminist imagination(s) for their understanding and ultimately their transformation. But to declare one's feminism in the 1990s requires further elaboration. In particular it necessitates a clear statement on the thorny question of 'difference', which has been at the heart of recent feminist debates.

In this analysis of women's health we will reject both crude universalism and crude difference theories. Instead we will attempt to identify the commonalities in women's situations while at the same time remaining sensitive to the complex social, economic and cultural variety of their lives. In other words, we will focus on their 'common difference' (Joseph and Lewis, 1981). Only in this way can we construct a theory that makes both moral and political sense.

Rejecting Crude Universalism

During the last decade, women from many different constituencies working-class women, lesbians, black women, women with disabilities and women from third world countries have challenged the white, western, middle-class domination of feminist theory and practice (Humm, 1992, Ch. 5; Lovell, 1990; Segal, 1987; McDowell and Pringle, 1992). In particular they have been critical of those feminists who prioritise gender over other social divisions, representing all women as members of the same oppressed group, unified by their experience of male domination and their uniquely female emotionality. This political critique has been reinforced by a shift towards post-modernism in much feminist thinking. Women working in this tradition have emphasised the dangers of inaccurate and inappropriate generalisations, stressing instead, the importance of 'hearing many voices' (Barrett and Phillips, 1992; Braidotti *et al.*, 1994; Mohanty *et al.*, 1991; Nicholson, 1991).

In response to these arguments, many feminist writers are now placing much greater emphasis on the differences between women. Rejecting the ideas of 'universal sisterhood' that characterised much feminist thinking in the 1980s, they have begun to develop a more sophisticated understanding of the relationships between race, class and gender. The analysis contained in this book should be seen as a contribution to that process, with the social construction of health and sickness offering important examples of how such links are forged in concrete historical circumstances.

As we shall see, there are very marked inequalities in the health status of women from different classes and racial backgrounds and these will be explored in detail as the book progresses. However the greatest disparities are those that divide the majority of women in the developed countries from the majority of those living in what is often called the 'third world'. Though the diversity of social forms in 'third world' countries is immense, they are similar enough to generate comparable patterns of disease and death for the mass of their female populations. It is important therefore that we specify these common features, as well as defining the term 'third world' more precisely.

About two thirds of the world's women live in countries where per capita income is low and life expectancy relatively short, where the fertility rate continues to be high and a comparatively small percentage of the paid labour force is female, where class and gender inequalities in income and wealth continue to be very great and the state provides few health and welfare services. Though they are both culturally and materially heterogeneous most of these countries do share common experiences of colonialism and imperialism, which have resulted in varying degrees of subordination within the world economic system. Geographically they are located in the southern part of the globe in the Latin American, Caribbean, African, Asian and Pacific regions.

All the terms currently used to summarise the complex reality of these economic and social divisions are problematic. They tend inevitably towards over simplification – there are huge differences for instance, between the newly industrialising nations of Asia and Latin America and the majority of African countries. Such terms also have the potential to reinforce economic, cultural and ideological hierarchies (Mohanty, 1991). Yet it is difficult to avoid their use altogether. 'Third world' is probably the most frequently used and widely understood of currently available options (Mohanty, 1991, p. 75, note 1; Sen and Grown, 1988, p. 9, note 3). It also continues to be employed as an affirmative identification by many political activists around the world, and will therefore be used here (with care) to locate women's lives within a broader geopolitical context.

However we need to acknowledge that this categorisation of global reality into first and third worlds excludes those countries that used to be called 'second world' but are now 'post-communist' or 'desocialising'. A number of recent texts have made the lives of women in Central and Eastern Europe much more visible outside their own countries (Buckley, 1989; Corrin, 1992; Funk and Mueller, 1993). Though health has not been their major focus, most of these accounts imply that the

rapid social changes now taking place in this part of the world have been detrimental to women's well-being.

Both the political realities of the recent past and the economic and social pressures of the present have contributed to a situation where the life expectancy of women in the countries of Central and Eastern Europe is five years less, and that of women in the Newly Independent States (the former Soviet Union) six years less, than that of women in the European Union (WHO, 1994, p. 4). In some of these countries life expectancy has declined further since 1991, and female deaths from cardiovascular disease are a particular cause for concern (ibid, p. 6). Attempts to make sense of these differences and to explore more qualitative aspects of women's health are now beginning, but detailed evidence remains sparse. Hence women in the second world are seriously underrepresented both in this text and in most other discussions of women's health.

Rejecting Crude Difference Theories

It is clear that women's lives vary enormously and recognition of this reality must remain at the heart of any analysis of their health and welfare. However this rejection of crude universalism does not mean that we should embrace crude difference instead - that we should deny any possibility of women having beliefs, values or interests in common.

A number of strands in contemporary women's studies contain within them the implication of radical difference, the belief that we cannot make meaningful judgements about the relative situations of women in different cultures. For some, this relativism reflects a political commitment to the acceptance of all 'other' cultural beliefs and practices. To do otherwise is said to denigrate those who live their lives in accordance with values that are different from our own. In the context of women's health, this can mean a refusal to engage with the hazards of procedures such as genital mutilation because they are defined as 'traditional' practices. It has also led in some instances to a reluctance to condemn male violence in cultures where it is widely condoned.

Similar tendencies are evident in the work of some post-modernist writers (Maynard and Purvis, 1994; Nicholson, 1991). Their rejection of any universal criteria for determing what is right or wrong, good or bad, real or unreal, implies that the situations of women in different cultures cannot be compared in any meaningful way. Thus even 'worse' or 'better' health cannot be measured, except perhaps by the crudest measure of all - survival. According to some writers even the category 'woman' is itself so culturally variable - so discourse - specific - that it is not a useful category for social analysis. Thus the very project of feminism is called into question as women are seen to have radically different interests.

This has led in some parts of the world to a political paralysis that is becoming increasingly intolerable (Maynard and Purvis, 1994; Ramazanoglou, 1993). Despite their undoubted heterogeneity, women do have important things in common. All share broadly similar bodily experiences, even though the meanings they attach to them may vary dramatically (Martin, 1987). Their bodies are not merely social constructs as some post-modernist writers seem to imply (Haraway, 1991). Nor are they infinitely malleable. Bodies do impose very real (though varying) constraints on women's lives as well as offering enormous potential, and this is evidenced by the fact that the fight for bodily self-determination has been a central feature of feminist politics across very different cultures (Jacobus *et al.*, 1990; Lupton, 1994, Ch. 2; Morgan and Scott, 1993; Pringle, 1992).

Women also share the reality of occupying (more or less) subordinate positions in most social and cultural contexts. Though this subordination is linked in complex ways with divisions of race, class and nationality, women do have common experiences as the objects of sexist practices. Some of these are psychological, as women struggle to construct their sense of themselves in the face of cultural messages about their intrinsic 'otherness' and inferiority. However they also have a material dimension as women deal with the consequences of poverty and economic inequality between the sexes. Again, women in very different cultures have identified similar processes of gender discrimination as powerful obstacles to their achievement of both mental and physical well-being.

As we shall see, it is a common recognition both of their need for control over their own bodies, and of the social origins of many of their health problems, that has led many women into political action. Physical and mental health are universal and basic human needs and all women have an equal right to their satisfaction.

Why Is Health Important?

At first sight the answer to this question might seem obvious. Even minor illness can be temporarily distressing, while serious illness can

have a devastating impact on how individuals feel about themselves, others and the world. Indeed it may eventually kill them. For someone to be 'happy' and to be seriously ill is usually a contradiction in terms. Illness is feared not just for its physical consequences but also because of the distress – the pain, fear, anxiety and depression – it can engender. It is not surprising, therefore, that health is generally regarded as a 'good thing' – a state of being that everyone would wish to achieve and maintain. However the benefits conferred go beyond immediate feelings of subjective well-being.

In order for women or men to flourish they must interact with others. It is only through social participation that people learn what they are capable of and how these capabilities may best be used (Sen, 1985). Personal identity is forged through family relationships, friendships, waged work and a variety of other communal activities (Braybrooke, 1987). Any artificial and sustained constraint on an individual's ability to relate to people in these and other areas of social life will constitute serious and objective harm. This harm derives not just from any subjective feelings of pain and unhappiness they might have about their situation, but also from the fact that arbitrary limits have been placed on the realisation of their capabilities - on their potential as human beings.

Health and Human Needs

Whatever their culture, individuals have at least two basic needs that must be met if they are to minimise such harm (Doyal and Gough, 1991). Their first and most immediate need is to survive and be physically healthy. Death is clearly the ultimate harm, while physical disease may seriously impair both their ability to interact with others and their capacity to benefit from it. But physical health is not enough. Both men and women will also be prevented from realising their potential when their need for mental health is unsatisfied. This will occur when their ability to make informed choices and to act upon them is limited over sustained periods of time by their cognitive and or emotional incapacity to negotiate physical and social realities.

Thus inequalities in health between social groups are not simply inequalities in desired states of subjective well-being. They also represent objective inequalities in the capacity of individuals to play an active part in social and community life – to realise their own potential and help others to do the same. For those who wish to improve the situation of women, physical and mental health are therefore strategic issues. They are important goals to be sought in their own right, but they also provide the key to women's effective participation in attempts to create a fairer and healthier society.

Comparing Health Across Cultures

Cultural variations in concepts of sickness and health are now well documented and their significance will be obvious in future chapters (Baer, 1987; Kleinman, 1988; Lock and Gordon, 1988; Lupton, 1994; Whelehan, 1988; Wright and Treacher, 1982). However they do not mean that we cannot compare the health status of women in different societies. This can still be achieved if we distinguish as clearly as possible between the objective manifestations of 'disease' and the subjective experience of 'illness' (Eisenberg, 1977). These two elements will certainly be inextricably intertwined in the minds and bodies of particular individuals. Yet we can still measure the social distribution of disease and death while also understanding and respecting the cultural relativity of illness.

Women in different cultures who contract tuberculosis or pelvic infection for instance may well experience these diseases in very different ways. However they will also have a great deal in common. Some will die, most will 'feel ill' (in some sense or other), all will show similar physiological signs (albeit in varying degrees) and all will respond in broadly similar ways to scientifically tested treatments such as antibiotics. It is these commonalities that we can measure, and use to compare the health status of different social groups (Doyal and Gough, 1991, pp. 56–9).

What western medicine defines as mental illness poses more difficult problems of interpretation and measurement since usually there are no objective 'signs' independent of the subjective symptoms. But again, similarities in its effects can be identified across cultures. Whatever the form of their distress, or the words and concepts used to describe it, women with poor mental health will all experience a significant reduction in their capacity for successful participation in their culture. Though each will have their own contribution to make, all will be disabled to a greater or lesser extent in the exercise of their cognitive and emotional capabilities. It is this disability that can be compared between societies (Doyal and Gough, 1991, pp. 62–3).

A Picture of Health?

All women whose physical or mental health is damaged will therefore be harmed in broadly similar ways, and morbidity and mortality rates can give us a preliminary indication of the global distribution of this harm. Of course such statistics can provide only a partial picture since they are not measuring the subjective or experiential aspects of illness. Moreover they offer a negative view of sickness and death rather than a positive picture of well-being. However they do represent important points of reference between societies and social groups as well as offering clues to structural factors underlying any perceived inequalities.

Inequalities in Mortality

In most of the developed countries women can now expect to survive for about 75 years (United Nations, 1991, p. 55). However this average conceals significant variations in life expectancy between women in different social groups. In Britain women married to men in semi-skilled or unskilled jobs are about 70 per cent more likely to die prematurely than those whose husbands are professionals (OPCS, 1986). Similar social divisions are apparent in the United States, where black women now have a life expectancy of 73.5 years compared with 79.2 for white women while their risk of dying in pregnancy or childbirth is three and a half times greater (US National Institutes of Health, 1992, pp. 8, 13). In most underdeveloped countries the social inequalities in health are even more dramatic.

There are also major differences in mortality rates between rich and poor nations. In Latin America and the Caribbean average life expectancy is lower than in developed countries but still relatively high at around 70. In Asia and the Pacific it is 64 and in Africa as low as 54 (UN, 1991, p. 55). The lowest rates recorded for individual countries are in Afghanistan, East Timor, Ethiopia and Sierra Leone, where women can expect to live for only about 43 years (ibid.) These inequalities are at their most extreme in deaths related to childbearing. In developed countries mortality of this kind is rare, with less than five deaths for every 100 000 live births. In South Asian countries, on the other hand, the rate is more than 650 deaths per 100 000 with the African average a close second at around 600 deaths (UN, 1991, p. 56).

Though these figures are extremely dramatic they do not show the true extent of the inequalities in reproductive hazards facing women in

different parts of the world. The maternal mortality rate reflects the risk a woman runs in each pregnancy. However we also need to examine fertility rates to assess the lifetime risk to an individual woman of dying of pregnancy-related causes. Recent estimates suggest that for a woman in Africa this risk is 1 in 23 compared with only 1 in 10 000 in developed countries (Rooney, 1992). Pregnancy causes almost no deaths among women of reproductive age in developed countries but between a quarter and a third of deaths elsewhere (Fortney *et al.*, 1986). Reproductive deaths are therefore an important indicator both of the different health hazards facing men and women and also of the heterogeneity of women's own experiences.

Turning from mortality to morbidity statistics – from death to disease – we are immediately faced with what appears to be a paradox. Around the world, women usually live longer than men in the same socio-economic circumstances. In most of the developed countries the gap between male and female life expectancy is about 6.5 years (UN, 1991, p. 55). In Latin America and the Caribbean it is 50 years, in Africa 3.5 years and in Asia and the Pacific, 30 years (ibid.) Only in a few countries in Asia do women have a lower life expectancy than men. Yet despite their generally greater longevity, women in most communities report more illness and distress. This pattern of excess female morbidity is reasonably well documented in the developed countries and we examine that evidence first. The more limited information on women in third world countries will be considered later.

Sickness and Affluence

A number of studies in the United Kingdom have found that women's own assessment of their health is consistently worse than that of men (Blaxter, 1990; Whitehead, 1988). Similar findings have emerged from studies in the United States (Rodin and Ickovics, 1990; Verbrugge, 1986). US women are 25 per cent more likely than men to report that their activities are restricted by health problems and they are bedridden for 35 per cent more days than men because of acute conditions (US National Institutes of Health, 1992, p. 9). In community surveys throughout the developed world, women report about twice as much anxiety and depression as men (Paykel, 1991; Weissman and Klerman, 1977).

Women also use most medical services more often. This fact cannot be taken as a straightforward indicator of the relative well-being of the two sexes since admitting illness may well be more acceptable for

women than for men. However it does highlight certain important features of women's health status. The most immediate reason for their greater use of medical care is longevity. Deteriorating health and increasing disability are a frequent, though not inevitable accompaniment of the ageing process and women make up a large proportion of the elderly in the population – especially the 'old old' (Doty, 1987). In the United States 72 per cent of those over 85 are female (US National Institutes of Health, 1992, p. 8). Older women appear to receive less assistance from relatives and friends than older men of the same age, despite the fact that they suffer higher rates of certain disabling diseases, including arthritis, Alzheimer's Disease, osteoporosis and diabetes (Heikkinen *et al.*, 1983; Verbrugge, 1985).

Because of the incorporation of birth control and birthing itself into the orbit of doctors, younger women too make more use of medical services. This is not usually associated with organic pathology but reflects the growing role of medicine in the management of the 'normal' process of pregnancy and childbirth (or its prevention). Women also appear to experience more problems with their reproductive systems than men, and again this is likely to bring them into more frequent contact with the formal health care system.

Finally, evidence from across the developed world suggests that more women than men consult doctors about psychological and emotional distress. In the United Kingdom, female consultation rates with general practitioners for depression and anxiety are three times and nearly two and a half times, respectively, those of males (Office of Health Economics, 1987; UK Royal College of Practitioners, 1986). Over the course of a year one British woman in every twenty aged between 25 and 74 seeks help for emotional problems from her GP, compared with one in fifty men. There is also evidence from a range of countries that women are at least twice as likely as men to be prescribed mild tranquillisers (Ashton, 1991; Balter *et al.*, 1984).

Broadly speaking then, the picture in the developed countries is one where women live longer than men but appear 'sicker' and suffer more disability. They are ill more often than men and use more medical services. Men do not suffer such frequent illness though their health problems are more often life-threatening. But sex and gender are not the only factors influencing women's health status, as we can see if we look again at the differences between women themselves.

Even within developed countries there are major variations in the health of women in different social groups. In the United States, strokes occur twice as often in black women as in white women, and

they have the highest incidence of gonorrhoea and syphilis (US National Institutes of Health, 1992, p. 13). Though black women have a lower incidence of breast cancer than white women it is significant that they are more likely to die from it (ibid.) In the United Kingdom women in the lowest social class are much more likely to experience chronic illness than their more affluent counterparts. In a national survey 46 per cent of unskilled and semi-skilled women aged between 45 and 64 reported a long-standing illness compared with 34 per cent of professional and managerial women (Bridgewood and Savage, 1993). Women in the lowest social groups were also more likely than those in the professional and managerial groups to report that illness limited their daily activities (30 per cent in comparison with 20 per cent) (ibid.)

Sickness and Poverty

However it is in the poorest countries that the state of women's health is at its worst. Though some affluent women are as healthy as those in the developed countries, it is clear that millions of others live in a state of chronic debility, afflicted by the diseases of poverty and the hazards of childbearing (Jacobson, 1992; Smyke, 1991). Estimates suggest that for every one of the half million women who die of pregnancy-related causes each year, at least 16 suffer long-term damage to their health – an annual total of about eight million (Royston and Armstrong, 1989, p. 187). Reproductive tract infections are also extremely common (International Women's Health Coalition, 1991). In some African countries gonorrhoea is estimated to affect as many as 40 per cent of women (WHO, 1992). These diseases are not just distressing and disabling in themselves, but often result in chronic infection with serious effects on women's overall well-being.

Millions of women in third world countries also have to cope with the broader health consequences of poverty – communicable diseases and undernutrition. While they risk contracting the same endemic diseases as men, both biological and social factors may increase their exposure or worsen the effects. Malaria, hepatitis and leprosy, for instance, can be especially dangerous during pregnancy, while women's responsibility for domestic tasks increases their chance of contracting water-borne diseases.

The extent of undernutrition in girls and women is dramatically documented in the incidence of anaemia. Estimates suggest that at least 44 per cent of all women in third world countries are anaemic compared

with about 12 per cent in developed countries (WHO, 1992, p. 62). In India the figure is as high as 88 per cent (World Bank, 1993, p. 75). This is an important indicator of general health status, suggesting that many women are chronically debilitated, never reaching the levels of good health that most women in the first world take for granted.

In these conditions of poverty, deprivation and disruption, mental distress is clearly a major risk. Though there is little statistical evidence of its prevalence, most community surveys show a pattern similar to that of developed countries, with more women than men reporting feelings of anxiety and depression. However the pattern of treatment is very different, with many more men than women receiving psychiatric help (Paltiel, 1987). Indeed evidence from many third world countries suggests that women receive less medical treatment of all kinds than men, despite their greater need. Rural women in particular are often unable to gain access to modern services, even for obstetric care. Around 75 per cent of all births in South Asia and 62 per cent in Africa still take place without a trained health worker, compared with about 1 per cent in the developed countries (UN, 1991, p. 58). While this reflects very low levels of health spending overall, it also suggests a particular reluctance to invest in the health of women and girls.

Though female life expectancy continues to rise in most third world countries, the 'harsh decade' of the 1980s and the economic rigours of structural adjustment policies have meant deteriorating health for many women (Smyke, 1991; Vickers, 1991). The number of those who are malnourished has risen, resulting in an increased incidence of high-risk pregnancies and low birth-weight babies. Diseases of poverty such as tuberculosis are re-emerging while the so-called 'diseases of affluence' are beginning to proliferate, with cancer already one of the leading causes of death for women between the ages of 25 and 35. Environmental degradation has made many women's lives harder and millions are without access to clean water or sanitation. Yet fewer resources are available to care for them. In recent years a real decline in per capita health spending has been documented in three quarters of the nations in Africa and Latin America and women appear to have been the major losers (UNICEF, 1990).

Does Medicine Have the Answer to Women's Health Problems?

This brief sketch has generated a wide range of questions about women's health. Why do women in most countries have a longer life expectancy than men? Why do women in some countries live nearly twice as long as those in others? Why do rates of morbidity and mortality vary between social classes and ethnic groups? Why do so many women still die in childbirth? Why do women report more sickness than men? How does their race or their culture affect women's experiences of health and health care? As we shall see, medical science can offer only limited resources either for answering these questions or for changing the reality that they represent.

The 'Biomedical Model'

Western medicine offers a powerful framework for describing and classifying much of the sickness afflicting individuals. Using this 'biomedical model' doctors have developed the means to prevent or cure many diseases and to alleviate the symptoms of others. However many other health problems have remained resistant to their ministrations. This has drawn increasing attention to the limitations of the conceptual schema employed by doctors and other health care providers to understand complex human phenomena. Two aspects of medical practice have come under particular scrutiny: its narrowly biological orientation and its separation of individuals from their wider social environment (Busfield, 1986, p. 28).

It is no longer appropriate (if it ever was) to categorise western medicine as a monolithic unified institution devoted only to hard science and high technology. Recent years have been marked by a revival of interest in public health and a 'humanisation' of some areas of research and clinical practice. Yet the natural sciences continue to be seen as the only 'real' basis of medicine, with attention focused predominantly on the internal workings of the human body.

Health and disease are still explained primarily through an engineering metaphor in which the body is seen as a series of separate but interdependent systems (Doyal and Doyal, 1984). Ill health is treated as the mechanical failure of some part of one or more of these systems and the medical task is to repair the damage. Within this model, the complex relationship between mind and body is rarely explored and individuals are separated from both the social and cultural contexts of their lives:

> The notion of disease itself refers to a process that unfolds and develops within the individual and what occurs within the individual and what the individual does is the prime subject of medical interest

and endeavour, rather than the individual's relationship to others or to the environment or vice versa (Busfield, 1986, p. 25).

This biological and individualistic orientation of modern medicine has led to enormous successes in our understanding of different types of disease and their treatment. Indeed it was precisely the concentration of effort made possible by this explanatory model that led to major achievements such as anaesthesia, antisepsis, antibiotics, analgesia and a wide range of other therapies that most people in developed countries now take for granted. The 'magic bullet' that works is a powerful weapon indeed. However its obvious success has led to a neglect of prevention and an over-reliance on this curative model, both in explaining the causes of disease and in exploring the different ways in which illness is experienced.

Perils of Reductionism

Attempts to explain the causes of disease primarily by reference to specific biological hazards are too limited. They rarely examine the social and economic aspects of the environments within which such pathogens flourish. Hence they can offer little help in understanding why some individuals or groups are more likely to become sick than others. We have also seen that there is more to poor health than disease. The subjective experience of illness is the product of complex processes involving the interaction between the whole person and their social and cultural environments. Because the biomedical model focuses almost exclusively on the material rather than the mental dimension of the 'patient', it can offer little help in clarifying and explaining such experiences. In particular it is often of little use in understanding psychological distress and disability.

This tendency of modern medicine to reduce the complexity of sickness and health to matters of specific biological causation has limited its potential either to understand or to ameliorate the ills of both sexes. But the interests of women have been especially damaged by the narrowness of this approach (Birke, 1986). Their higher rates of depression for instance have often been blamed on hormonal disturbance, leading not only to inappropriate treatment but also to a mistaken naturalisation of gender divisions that are essentially social in origin. Too often women's problems have been blamed on their reproductive systems when it is the social relations of both production and reproduction that need further examination.

Gendered Research

However it is not just its narrowly biological orientation that limits the capacity of medicine to deal with women's health problems. Even within its own terms there is growing evidence that both the priorities and the techniques of biomedical research reflect the white male domination of the profession (Kirchstein, 1991). Bias has been identified in the choice and the definition of problems to be studied, the methods employed to carry out the research, and the interpretation and application of results (Cotton, 1990; Rosser, 1992, pp. 129–30). While women are in the majority as health care providers, they continue to be in the minority as practising doctors (Doyal, 1994a; Lorber, 1984). They hold few positions of power and therefore have little influence on how funds are allocated or research carried out (Rosser, 1992; US National Institutes of Health, 1992; Witz, 1992).

There has been relatively little basic research into non-reproductive conditions that mainly affect women – incontinence and osteoporosis for instance. In the United States, Congressional Hearings in 1990 showed that only 13 per cent of government research funds were spent on health issues specific to women (US National Institutes of Health, 1992). Even the menstrual cycle itself has not been extensively researched. Hence we have little detailed knowledge about an extremely important aspect of women's bodily functioning that generates a large amount of distress and many medical consultations (Koblinsky *et al.*, 1993). Where health problems affect both men and women, few studies have explored possible differences between the sexes in their development, symptoms and treatment (American Medical Association, 1991).

Researchers working on coronary heart disease, for example, have continued to act as though it were only a 'male' problem, despite the fact that it is the single most important cause of death in post-menopausal women, killing half a million a year in the United States. The Physician Health Study, which demonstrated the effectiveness of daily aspirin consumption in preventing cardiovascular disease, had a sample of 20 000 men but no women, while the sample in the 'Mr. Fit' study of the relationship between heart disease, cholesterol and lifestyle consisted of 15 000 men (Freedman and Maine, 1993, p. 165). AIDS, too, has been treated for research purposes as a predominantly male disease. Though it is now growing faster among women than among men, we still know very little about the differential effects it may have on them (Bell, 1992; Denenberg, 1990b; Kurth, 1993).

As long as most biomedical research continues to be based on male samples there will be significant gaps in our knowledge about women. Even more importantly, treatments tested only on men will continue to be given to women, when they may not be appropriate to their needs (Hamilton, 1985). There have recently been indications, for example, that anti-depressant drugs can have very different effects on men and women and may affect women differently during the various phases of the menstrual cycle. However preliminary testing excluded women, despite the fact that they are the major users of the drugs (ibid.)

It is clear that biomedicine has generated valuable knowledge that has been used to improve the health of individual women. But as we have seen, this understanding is often partial and sometimes erroneous. This is because research has selectively ignored many of the biological differences between the sexes while paying little or no attention to the particularity of women's psychological and social circumstances. Hence it can offer little help in answering the questions posed at the beginning of this section.

In order to remedy these deficiencies we need to move beyond the boundaries of biology. No single discipline will provide an adequate conceptual framework for understanding the complex relationship between women's health and the quality of their daily lives. Instead methods and insights from a variety of disciplines, including history, sociology, psychology, economics, anthropology and cultural studies need to be combined with more traditional biomedical and epidemiological approaches to create an interdisciplinary and interactive framework of analysis (Lupton, 1994, Ch. 1; Turner, 1992:, Ch. 4). The value of bringing the work of natural and social scientists together in this way can be illustrated by a brief history of differences in male and female life expectancy.

Are Women Really the Weaker Sex?

Women have not always been longer lived than men. Indeed what little evidence we have from the pre-industrial period suggests that in most places they had a shorter life expectancy (Shorter, 1984). In Europe and the United States the female advantage over men first became apparent in the latter part of the nineteenth century as the life expectancy of both sexes increased. This gap between the sexes has continued to widen ever since (Hart, 1988, p. 117). In most countries women now experience greater longevity than men, with the size of their advantage being

proportional to the life expectancy of the population as a whole. Only in a few countries do men continue to live longer than women. As we shall see, these major historical changes in life expectancy cannot be explained by reference to either biological or social factors alone.

Biological and Social Advantages of Females

Far from being the 'weaker sex', women do seem to begin life with a biological advantage over men (Waldron, 1986a). Around the world, significantly more male than female foetuses are actually conceived but they are more likely to be spontaneously aborted or to be stillborn (Hassold *et al.*, 1983). By the time of birth the ratio is down to about 105 males to every 100 females and in most societies the excess of male mortality continues to be especially marked during the first six months of life (Kynch, 1985; Waldron, 1986a, p. 66).

The reasons for this inherently greater 'robustness' of girl babies are not entirely clear but they seem to include sex differences in chromosomal structures and possibly a slower maturing of boys' lungs due to the effects of testosterone (Waldron, 1986a, p. 66). In adult life too, women may have a biological advantage - at least until menopause - as endogenous hormones protect them from ischaemic heart disease. Thus biological factors do confer an initial advantage on females. However social factors also make a major impact on their longevity. In some societies these factors enhance inherent biological advantage but in others they reduce it or even cancel it out.

European experience suggests that the gap between male and female life expectancy grew as economic development and social change removed two major risks to women's health. As food became more widely available, most women were assured of adequate diets. This improved nutrition contributed in particular to a reduction in female mortality from infectious diseases such as tuberculosis (Hart, 1988). At the same time reduced fertility and safer childbirth combined to lower the maternal mortality rate.

Even before these female hazards began to decline, changes in the sexual division of labour meant that men were taking on new risks. The reasons for this are complex, but two factors are especially significant. The emergence of the male 'breadwinner' in industrial economies led to more men than women taking on potentially life-threatening jobs. At the same time their increased command over resources and their greater freedom contributed to men's more frequent pursuit of dangerous pastimes, including the use of hazardous substances (ibid.)

Young men now run a much greater risk than young women of dying from accidents (especially in motor vehicles) and violence. In the United States in particular, gunshot wounds are now a major cause of male deaths, especially among African Americans. In the United Kingdom, accidents and violence cause 70 per cent of deaths of men under the age of 35, compared with only 35 per cent of female deaths. Later in life men die more often of coronary heart disease and lung cancer. Both of these are influenced by occupational factors but are mainly due to smoking, which has traditionally been heavier among men than among women. According to one estimate, 50 per cent of the entire sex differential in life expectancy in the United States and Sweden can be attributed to (past) gender differences in smoking (Waldron, 1986b). Men's higher rates of alcohol consumption also contribute to their higher mortality rates at all ages.

It would appear therefore, that as many societies have industrialised, a variety of social and cultural factors have combined to allow women's inherent biological advantage to emerge. The hazards of infectious diseases and the dangers of childbearing have been reduced, and certain male risks have increased, giving women longer – though not necessarily healthier – lives. However there are important exceptions to this pattern, showing how biological and social factors may interact in very different ways.

The Impact of Discrimination on Life Expectancy

In certain countries in South Asia, including Bangladesh, men outlive women, while in India and Pakistan the two sexes have almost equal life expectancy (UN, 1991, p. 69). In these societies there is an excess of female deaths both in childhood and in the childbearing years, which most researchers have attributed to material and cultural discrimination against girls and women. In the most extreme cases this sexism leads to female infanticide either during pregnancy or after birth. However it more commonly involves chronic neglect. In childhood, girls may receive less care than boys in a variety of different ways (Sundari Ravindran, 1986; UNICEF, 1990; WHO, 1992, pp. 17–26). They tend to be breastfed less often than boys and for shorter periods, and throughout their childhood receive less food and medical care (Koenig and d'Souza, 1986; Kynch and Sen, 1983; Sen, 1988). In some populations this lifelong discrimination has reached the point where the ratio between men and women has become unbalanced.

In India, for instance, the sex ratio fell from 972 women per thousand men in 1901 to 935 per thousand in 1981, while the ratio of women to men was increasing in most other parts of the world (Kynch and Sen, 1983, p. 377; Sen, 1990b). In these 'classic patriarchies' the biological advantage of most women is therefore cancelled out by their social disadvantage (Kabeer, 1991). This offers a sharp reminder that there is no reason to assume that economic development will necessarily allow women more opportunity to flourish. While discrimination continues, their life chances will be diminished in comparison with those of men:

> Women are biologically stronger, live longer than men and naturally outnumber them. Where they do not it is only because of the effects of war, or if they have been forced to migrate in search of work or because they have suffered severe and systematic discrimination (Seager and Olson, 1986, p. 12).

Redefining Women's Health

If the biological finality of death can only be explained in a wider social context then the complex realities of women's sickness and health must be explored in similar ways. In order to do this, traditional epidemiological methods have to be turned on their head. Instead of identifying diseases and then searching for a cause, we need to begin by identifying the major areas of activity that constitute women's lives. We can then go on to analyse the impact of these activities on their health and well-being.

Any attempt to separate the various parts of women's lives in this way is, of course, fraught with difficulty. The balance of these activities varies both within and between different societies as well as changing over the lifetime of individual women. Moreover, in many social contexts it is precisely the inseparability and co-mingling of their various tasks that tends to differentiate women's lives from those of men:

> Working in production and reproduction are increasingly simultaneous superimposed occupations for women held in an uneasy tension, misleadingly called the 'double day' because there is never any neat division where one job ends and the other begins (Petchesky, 1979).

It is the cumulative effects of these various labours that are the major determinants of women's states of health. This is true even in old age, when many of these activities will themselves have ceased but their impact on well-being becomes increasingly evident. However, we need to begin by examining each aspect of women's lives separately. This will enable us to identify some important similarities between women, but it will also highlight some of the major differences.

An analysis of this kind offers the opportunity to explore the complex interactions between social, psychological and biological dimensions of health. At the macro-level we can describe the material context within which women's health is formed. We can also identify the cultural constraints within which they can make choices affecting their own well-being. However we need to relate these broader issues to the physical and psychological state of individual women – to their lived experience of health and illness.

At present the conceptual tools for such an analysis remain significantly underdeveloped and continue to be the subject of debate (DiGiacomo, 1992; Scheper-Hughes and Lock, 1987). How, for instance, do we make sense of the complex relationship between the social construction of motherhood in different societies and individual women's experiences of postnatal depression? How do we develop a model of the links between different modes of economic organisation and the 'mindful bodies' of women trying to make ends meet? (Scheper-Hughes and Lock, 1987). The following analysis cannot provide all the answers but it can frame some of the questions more clearly, provide relevant empirical data and indicate important areas for future investigation.

We begin in Chapter 2 with an exploration of women's domestic work. Around the world the most fundamental feature of women's lives is their responsibility for home, family and household labour. Caring for and caring about others is a central feature of these activities wherever in the world they are carried out. However the content of the work itself will vary significantly between rich and poor countries, rural and urban areas and industrialised and non-industrialised modes of production.

In developed countries women are primarily responsible for what is traditionally referred to as 'housework', using a variety of purchased goods to cook, clean and wash for their immediate family group. In other parts of the world they may have to produce the food themselves, as well as acquiring fuel, water and other physical necessities. Home may also be the workplace in which women carry out a variety of economic activities to help their families survive (Young, 1993, Ch. 6). A major theme of our discussion will be the health implications of these cross-cultural similarities and differences in the nature of domestic labour.

Despite its variety of forms in different societies, the household also remains the basic unit within which most women's labour is rewarded – both materially and emotionally (ibid. Ch. 7). Yet there is substantial evidence to show that despite the 'caring' image of the family, resources may not be distributed according to need (Bruce and Dwyer, 1988; Folbre, 1988; Kabeer, 1991). If there are men in the household they usually acquire the greater share of income and wealth as well as emotional support, status and decision-making power. Very importantly they usually monopolise physical power too, putting many women at serious risk of violence. We will therefore examine both the physical and the psychological consequences of the unequal distribution of resources within families. The analysis will place particular emphasis on mental health, since for many women the nature of their labour combined with their limited access to household resources constitute a potential threat to their emotional well-being.

Having opened the door to domestic life, subsequent chapters will look in more detail at the different aspects of sexuality and reproduction that are usually (but not always) contained within the household. Chapter 3 explores the relationship between sex and health. As well as being a significant source of pleasure, sexual activity can also contribute to emotional well-being. However it is increasingly evident that sex with men can sometimes pose a serious threat to women's health. This applies not just to rape and sexual abuse but also to consensual sex. As the AIDS epidemic has spread it has highlighted the continuing constraints both on women's capacity to determine their own sexuality and sexual practices, and on their ability to protect themselves from sexually transmitted diseases. These issues are discussed in more detail in an analysis of the health hazards of heterosex.

For many women the conceiving of a child is a desired outcome of heterosexual intercourse. However others will wish to separate sex and reproduction entirely during their fertile years. They will seek either to prevent conception or, if necessary, to interrupt an established pregnancy, and it is these strategies for birth control that we examine in Chapter 4. An inability to determine her own pattern of procreation will severely limit a woman's capacity to control the rest of her life. Yet as we shall see, many are still constrained in their ability to make

informed choices by material, social, cultural and religious pressures. If women do seek medical help in controlling their fertility, doctors may be reluctant to acknowledge their right to choose and the techniques offered may themselves be hazardous to health.

Whatever their circumstances, the vast majority of the world's women do embark, at some point in their lives, on the road to motherhood. In Chapter 5 we discuss the ways in which the social context of this childbearing can have a major impact on their health. Indeed it may determine whether they live or die since for overworked and undernourished women, motherhood can be fatal. It is, of course, this potential for biological reproduction that separates women's health needs most clearly from those of men. But as we have seen, it also separates women most markedly from each other, with the risk of death or disability varying dramatically between rich and poor countries.

Women's relationship with organised medicine is one of the key factors influencing their experiences of pregnancy and childbirth. If a pregnancy goes wrong, lack of access to obstetric care can be fatal and in many third world countries this is the situation many millions of women face each year. In developed countries, on the other hand, doctors are often accused of dominating childbirth to the detriment of mothers and babies. This paradox will be explored as we place contemporary childbearing in its broader social and economic context.

Many millions of women combine motherhood and their domestic responsibilities with economic activities both inside and outside the home. Officially 40 per cent of women around the world are now in the labour force, though this is clearly an underestimate since many are unrecorded, especially in the informal sector or in casualised work (Rowbotham and Mitter, 1994; UN, 1991; Young, 1993). As Chapter 6 will demonstrate, many employed women improve their general well-being through greater access to the basic necessities for physical health, through enhanced social status and through their involvement in wider support networks.

However the circumstances of some women's employment will limit the potential health benefits of waged work. Because they usually retain responsibility for domestic labour, many women workers become physically and emotionally exhausted. This is especially true of those with the least material and social support. The nature of the work itself can also be hazardous. Employment has brought many women into contact with the same hazards that men have faced for generations. Meanwhile there is growing evidence that what is regarded as 'women's work' may involve risks of its own. The impact of women's economic activity on their health therefore needs very careful assessment.

An examination of these different dimensions of women's lives offers a framework for understanding the social context of their health and illness. When these various activities are put alongside each other, it becomes clear that for many women the pressures of demanding work under conditions of inequality and discrimination may lead to considerable distress. During the childbearing years they may have very little time for rest or renewal, always feeling themselves to be carrying a significant burden of responsibility. Later in life, poverty, isolation and poor health may make relative longevity a dubious benefit. In Chapter 7 we explore some of the means by which women have sought to alleviate the negative feelings associated with these experiences.

Psychoactive substances of one kind or another are available in most societies and men have usually been the major users. However the last two decades have seen a marked rise in substance use and misuse by women, often with negative effects on their health. There is evidence of a huge increase in women's consumption of cigarettes and their abuse of alcohol is now becoming visible. In developed countries there has also been an epidemic of tranquilliser use, as some doctors have colluded with women in the creation of a dependency that can have both physical and psychological consequences. This provides us with a further opportunity to assess women's complex relationship with organised medicine and the contradictory effects it may have on their health.

Much of this book will be concerned with women's troubles – with the ways in which their attempts to realise their own potential and that of others can be damaging to their well-being. However its major purpose is to contribute to the process of making their lives healthier. The final chapter will therefore highlight the many strategies adopted by women around the world to promote their own health and that of their families. This will include a discussion of campaigns for reforming medical care. However it will also cover much broader issues, including the fight for reproductive rights and occupational health and safety, the struggle against violence against women, and the role of women in broader environmental and development politics. It will explore the potential contribution of both (reformed) biomedicine and wider social change in promoting women's health.

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EXPLAINING URBAN–RURAL VARIATIONS IN HEALTH: A REVIEW OF INTERACTIONS BETWEEN INDIVIDUAL AND ENVIRONMENT

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Abstract—In order to gain insight into the relation between health and people's environment, literature published between 1985 and 1994 was gathered from several international databases. An introduction into existing theory regarding geographic disparities is presented: geographical drift and breeder hypotheses are discussed. This is followed by a critical review focusing on interaction effects of urbanicity and individual characteristics on health. This leads to two major conclusions. First, emphasis in past research has been primarily on urban constraints rather than opportunities. Positive aspects of urban living are often insufficiently appreciated. Second, positive and negative environmental aspects have an effect on health that is often dependent on individual characteristics. The extent to which the environment exerts influence on a person's health is dependent on that person's individual characteristics. These conclusions are relevant only for further developing the breeder hypothesis, however. Large scale individual based longitudinal data should be studied in order to gain more insight into the relative importance of the geographical drift hypothesis.

Key words—urbanization, mental health, well-being, perceived health

INTRODUCTION

Health is believed to be influenced by both ecological (aggregate) as well as individual characteristics, yet much large scale sociological and geographic research focuses on either the individual or his environment. Until recently the division between these two levels was unsurmountable because of methodological statistical problems. With the increasing use of multilevel modelling techniques into health research, however, it has become possible to do justice to this basic understanding. Individual and environmental determinants of health can be studied simultaneously [1]. Multilevel modelling is a relatively new technique that provides some new possibilities for exploration of human–environment relations. The theoretical bases for multilevel modelling are still being formulated. We begin by critically reviewing recent research in a quest for answers to the question: *What is the role of the environment in explaining the health of individuals?*

The environmental characteristic that is central in this paper is urbanicity, which is meant to indicate the extent to which a place is urban or rural. It should not be confused with urbanization which refers to the process of a place becoming urban. While urbanization is still a major concern in developing countries, in the Western world urbanicity is more important. For example, the weighted average annual growth rate of urban population in OECD countries between 1980 and 1991 was 0.8%, while the comparable figure for 'low and middle income economies' was 6.3%. On the other hand, the 1991 weighted average urban population was 77% in OECD countries and 46% in low and middle income countries. In this paper we will concentrate on urbanicity in OECD countries [2].

There are two interconnected reasons for focusing on urbanicity: the popularity of the subject, combined with the lack of understanding of its impact on health. First, urbanicity constitutes indeed one of the most often employed environmental features in health research. In many cases it is in fact the only ecological variable that is taken into account and usually is the only ecological variable that does have, at least to some extent, a universal meaning (contrary to, for instance, the variable 'region'). Furthermore, popularity of the concept of urbanicity can be illustrated by the fact that the World Health Organization (WHO) has been developing a Healthy Cities Project that aims at improving the health of urban residents. A large number of European cities are today participating in this project. Within this project a socio-ecological model of health is fundamental [3, 4]. As yet, however, insight into the mechanisms behind this ecological approach is lacking and, moreover, it is unclear if urban residents are indeed less healthy than others.

This leads us to the second reason for focusing on urbanicity: the vagueness of the concept. As Hoggart [5] writes: "I do not mean (. .) that there are no differences between (most) rural and urban places, but rather that in the main these are generated by the uneven presence of some known causal factor '*X*', as

opposed to either rurality or urbanity. The obvious follow-up point is that for theory to progress we should focus on '*X*'" (p. 251). A similar point is made by Webb [6]: "as far as the differential prevalence of mental disorder is concerned, the rural–urban variable has little utility", and "Rather the area being studied must be defined in terms of more relevant criteria, especially the detailed composition of the population". In other words, we should concentrate on the content of the concept of urbanicity. Later on it will be shown that this is more than just the composition of the population. In order to gain more insight into the content of urbanicity we will emphasize the relation between individual and environment.

We begin with a short description of the methodology, followed by an introduction to the existing theory of spatial variations in health. In the latter, the relevance of interaction effects is also explained. We then examine the literature on mental health, well-being, and physical health, followed by a discussion of the more important findings and their implications for the present research.

METHODS

For our purposes, a distinction is made between three aspects of health: mental health, physical health, and 'well-being'. A discussion of whether health is the absence of illness, or something else, is beyond the scope of this article. Well-being is regarded as a combination of the absence of physical as well as mental problems. Literature published after 1985 was gathered from various international data bases, such as Medline, PsychLit, Sociofile, Econlit, SCI and GSI, using the keywords morbidity and epidemiology together with the keywords urban and rural. We also searched the catalogue of the Netherlands Institute of Primary Health Care (NIVEL). This search produced a large number of studies in which comparisons are made between urban and rural health. In the interest of space limitations, literature dealing with either urban or rural health was not included, even though a comparison of these studies are in themselves interesting. We limited our review to papers that deal with explicit studies of interaction effects. We also excluded studies on mortality and research from other than OECD countries. The reason for limiting our search to these nations is that there is at least *some* common agreement among them of what constitutes an urban or rural area. Even though cities like Amsterdam and New York are different in many respects, they share a high level of economic development (which is one of the principal determinants of health). For recent reviews of the relationship between urbanization and health in developing countries, the reader is referred to Marsella [7] and Harpham [8].

THEORETICAL FRAMEWORK

Before presenting a review of the literature on the relation between urbanicity and health, a brief introduction is made to possible mechanisms behind spatial variations in health: the breeder and drift hypotheses (Table 1).

Behind the drift hypothesis (see for example Lewis *et al.* [9]) there is a notion of selection processes that result in a higher concentration of either ill people (direct selection) or in a spatial concentration of more susceptible persons (indirect selection). Direct selection may take place because healthy people stay and ill people move, or the other way around. Indirect selection takes place if people with certain health related characteristics move to or from specific places. An empirical confirmation of the drift hypothesis would be that urban/rural differences would not persist when accurate measures of past and present illness, together with past and present other individual determinants of health are included in analytic models.

It is not surprising that very little is known about the importance of direct and indirect selection. In order to investigate direct selection effects longitudinal data are needed about large numbers of individuals, including mobility and (past) illness behaviour. Only seldom (if ever) are these demands met. Pre-1985 literature, such as reviewed in Jones and Moon [10, Chap. 5], often has the additional problem of being based on aggregate data. Although more often based on individual data, recent studies still have a cross-sectional design, and no study contains detailed variables on spatial mobility or on past illness, making it virtually impossible to detect selection effects if they are present.

Two studies were found in which an attempt was made to control for selection effects (within a cross-sectional design). Both of these tend to reject the drift hypothesis. In Blazer *et al.* [9], evidence is found against the drift hypothesis, as far as depressive symptomatology is concerned. They tried to get a

Table 1. Four mechanisms to account for geographical variations in health

Breeder hypothesis: spacial concentration of ill-	Drift hypothesis:

grip on migration by asking respondents whether they had moved in the last 5 years. "When moving within the last five years is controlled (. .), the urban/rural effect remains" (p. 655). Another attempt is provided by Lewis *et al.* [11], who employed a model including cannabis use, parental divorce, and family history of psychiatric disorder, and concluded that being raised in a city increased the odds of becoming a schizophrenic by 57%, thereby giving support to the breeder hypothesis.

However, the study by Blazer *et al.* [9] provides only circumstantial evidence against (in)direct selection, because no information is included concerning the respondent's personal and illness characteristics before migrating. Furthermore, they do not take account of the fact that a relatively large part of all migration takes place within cities. The study by Lewis suffers from the fact that no comparison is made between the influence of place of upbringing and place of residence (which is probably the same in many cases). Large scale longitudinal studies are necessary to test the drift hypothesis but have yet to take place.

Behind the breeder hypothesis again two mechanisms may be at work. First, there may be certain environmental factors to which people are directly exposed. Obvious examples of the physical environment are the negative externalities of nuclear plants, high traffic densities, high levels of noise and pollution. Also, the social environment may be important: exposure to activities of other persons that are specific to certain environments. For example, high levels of social support are often thought to be a particular aspect of rural areas. Exposure to stress is another important example of the breeder hypothesis. The stress-hypothesis [7] that is frequently used to explain urban–rural differences in mental health and well-being can be regarded as another example of exposure. According to this hypothesis urban residents are more frequently and more severely confronted with stressors than rural residents, resulting in higher levels of psychiatric morbidity.

The second mechanism is associated with certain types of illness-related behaviour. Smoking, drinking and substance abuse are examples of health behaviour that is (somewhat) more common in urban residents [12]. The distinction between exposure and behaviour is somewhat artificial since one part of the population may be exposed to the behaviour of another part (e.g. passive smoking, unsafe driving, crowded housing). A combination of both mechanisms is evident in the stress-hypothesis: stress can be attributed to one's own behaviour, but also to exposure to the behaviour of others.

According to Marsella [7], studying urban–rural differences alone does not materially advance our knowledge and future research should focus on specific sub-populations. To appreciate this, one only has to realize that most environments have positive and negative qualities but that these qualities are not experienced equally by all residents. For some categories of people the positive sides may prevail, while for others the negative sides are more important. Some environments may, for instance, be characterized as 'tolerant', but this is only beneficial to those who deviate from what is normal. Good air quality may serve as another example. It was observed by Jones *et al.* [13] that the lung capacity of non-smokers was negatively related to the urbanicity of residence, while such negative relationship was absent in smokers. While showing the importance of looking at sub-populations, these examples also demonstrate that the importance of sub-populations will only appear by contrasting such populations. Sub-populations should be compared with other sub-populations. Therefore, the remainder of this paper will be primarily concerned with interaction effects found in the literature.

MENTAL HEALTH

There is an abundance of literature on the relationship between mental health and urbanicity. The literature discussed here is not a complete review, but it provides insight into the current understanding of urban–rural variations in mental health. For this review we attempted to find all post-1985 literature that involved screening instruments like GHQ and CES-D, and the more symptom-oriented approach of DSM-III and PSE.

Very little attention will be paid to the incidence of specific diagnoses. The reason for this is that most of these studies deal with so-called 'revealed incidence', inevitably mixing utilization and health. Especially milder forms of psychiatric morbidity will often remain undetected, and because of geographical differences in provision of health care, this omission will not be equally distributed over space.

Though some attention will be paid to studies that deal with aggregate data, the larger part of the literature discussed below builds on individual data. First, the main determinants of mental illness used in empirical studies will be discussed. Second, the emphasis will be on interaction effects between these determinants and urbanicity. Table 2 gives an overview of findings from studies in which significant interaction effects were found. This table shows the most important individual determinants of mental illness. It has long been recognized that mental illness is to some extent associated with demographic variables like age and gender, as well as socio-economic variables. It is not surprising to find that such variables are most commonly taken into account. Differences exist concerning the inclusion of race, health behaviour, social support variables and mobility measures. Race is included only in studies in which there is a substantial amount of variation in race, which is usually not the case in European studies. Among measures of health behaviour drinking seems to matter [14]. Social support variables

Table 2. Urbanicity and mental health: main effects and interactions with urbanicity found in empirical research after 1985

Source	Country	Health measure	Model main effects	Interaction urbanicity with	Mechanism behind interaction effect
[17]	US	depression (CES-D)	age, gender, race, income, education, marital status, length of residence	race	fewer opportunities in rural areas and in black people → learned helplessness, especially in rural black people → depression
[50]	US	depression (CES-D)	age, gender, race, unemployment, family status, education, income, urbanicity	race, gender, family status, race/gender, gender/family status	ghettos relatively unhealthy
[22]	GB	psychiatric caseness (GHQ)	gender, unemployment, urbanicity	unemployment	more social support and informal employment in rural
[23]	NL	depressive symptoms (self reported)	demographic-, financial-, network variables, type of worries, aspects of unemployment	duration of unemployment, type of financial worries	more stigmatization in rural
[14]	US	depression (CES-D)	gender, age, race, income, education, marital status, religious commitment, drinking behaviour	life changes/drinking behaviour	not given
[15]	NZ	psychiatric caseness (PSE/GHQ)	age, gender, SES, unemployment, social networks, past sexual abuse	age, marital satus, unemployment	social buffering in rural, tolerance in urban
[16]	US	major depression (DIS/DSM-III)	age, gender, race, SES, family status, social network variables, mover, urbanicity	age	social change more negative effects in young people in urban areas
[25]	US	somatization (DIS)	age, gender, race, education, marital status, health care utilization, urbanicity	gender, education	more role conflicts in urban females
[27]	US	existence of mental health problems	gender, age, stressful life events, urbanicity	type of stressful life events	not given

may concern the "availability and adequacy of social integration and attachment" [15], but also more simple measures like the availability of a confidant [16]. Mobility is usually measured by asking whether or not one has recently moved (see, for example [9, 17]).

It is often found that urban residents are in worse mental shape. There are many exceptions, however. A Finnish study by Joukamaa *et al.* [18] found no effect of urbanicity on mental health. Reitzes *et al.* [19] found no direct effect or urbanicity on mental health in an elderly population, controlling for personal and social characteristics, network and activity variables (interaction effects found by these authors will be discussed below). Also, among children in Sweden no urbanicity-effect was found regarding depressive symptoms [20]. Another study involving New Zealand women failed to show any urban/rural differences in mental health [15]. The oft-cited conclusion drawn by Dohrenwend and Dohrenwend [21] that the level of mental problems is on the whole higher in urban areas can not be maintained on the basis of recent literature.

—besides these main effects, interaction effects were observed between urbanicity and race, gender, education, unemployment, marital status, physical health, occurrence of stressful life events, and drinking behaviour. These will be discussed below.

Neff and Husaini [17] found an urbanicity–race interaction effect on depression (CES-D). Black respondents had higher levels of depressive symptoms overall and less positive affect than white participants, though only in the rural sample, while race differences in positive affect were absent in the urban sample. "Race differences were largely specific to the rural sample, and urban–rural differences were largely specific to black participants" [17], (p. 531). Neff and Husaini challenged the stress-hypothesis and state that besides more stress and disorganisation, the city also provides more freedom and other opportunities. They suggest a 'learned helplessness' hypothesis that states that the rural lack of opportunities and lacka of freedom stimulates helplessness and thereby depression. A similar causation is followed to account for race differences. Black persons experience fewer opportunities than white persons, so that negative stimuli are concentrated in black urban persons, explaining the relatively high depression scores of black rural residents. Although Neff and Husaini offer the valuable insight that urban stress may be counterbalanced by urban opportunities, the

question of which of these prevails in which cases remains to be answered.

The relationships described above were only found for depressions, not for general well-being and physiological symptoms. Assuming that both depression and low well-being are caused by stress, the authors make a distinction between acute and chronic stressors. Depressive symptoms are in their view caused by chronic stressors (such as caused by living in a ghetto) and general well-being is mostly influenced by acute stressors (transient life events), which are more evenly distributed among urbanicity/race categories. Although not specifically linked to one type of disorder, this distinction is also made by Harpham [8]. On the basis of such suggestions it is clear that future research into urban–rural variations should benefit from the inclusion of explicit stress measures and that a distinction between chronic and acute stressors might be useful. One of these stressors is unemployment.

Also, the relation between unemployment and the incidence of depression has been found to vary according to urbanicity [22]. Contrary to what might have been expected, Harding and Sewel [22] found that unemployment among urban men has a more negative effect on mental health than among rural men. Two possible explanations are offered. First, there may be a higher level of social support in the rural area that counteracts the negative effects of unemployment. Second, the distinction between employment and unemployment may be sharper in urban areas than in rural areas. In the particular research-setting, rural areas, may have more opportunities for informal employment, which may dampen the effects of formal unemployment.

It was hypothesized by Leeflang *et al.* [23] that the influence of unemployment on general health would differ from urban to rural areas. This, generally speaking, appeared not to be the case in their study: "interaction effects were found in none of the demographic variables, so we can assume that existing differences between employed and unemployed are the same in the rural and in the urban area" (p. 345). However, the power of certain variables in explaining depressive symptoms did differ from urban to rural areas. In rural areas these symptoms were to a higher extent dependent on not being able to provide for dwelling costs and to a lesser extent on the duration of the unemployment.

Besides demographic and socio-economic characteristics the effect of certain types of health behaviour may vary between urban and rural areas. Neff and Husaini [14] concentrated on the urban–rural differences in the effects of alcohol consumption on depressions. The buffering effect of alcohol consumption on the relationship between depression and life events appeared only to be significant in rural areas. Translating this into a causal relationship would mean that drinking helps against depressions, but only in the countryside. An explanation for this is not offered by Neff and Husaini. However, Tousignant and Kovess [24] in their study among urban and rural alcoholics found that borderline personality traits were found only among the urban samples, which led them to conclude that alcoholism is better tolerated in rural areas and, therefore, drinkers are not pushed into deviant behaviour. A possible side effect may be that the presumed depression-buffering effect of alcoholism is more prevalent in rural communities.

Romans-Clarkson *et al.* [15] also find interesting interactions: age and unmarried were found to be associated with psychiatric problems in urban but not in rural women. Urban elderly women and rural divorced and separated women were more likely to exhibit psychiatric disorders than other women. According to the authors, elderly women find it easier to cope with travails in a rural environment. An urban environment tends to be more tolerant of a variety of behaviours.

Crowell *et al.* [1.] found an association between urbanicity and age. Younger residents in urban areas appeared to be at greater risk for major depression, while in rural areas it was the older residents who were at greater risk, controlling for the other independent variables. Apparently the depression buffering quality of rural areas and the depression enhancing quality of urban areas is something that mostly affects younger people. This may be related to the possibility that social change in general is experienced first and most rapidly in urban areas, particularly by young adults. If the rural-buffer hypothesis is correct, their rural counterparts would be less prone to depression.

Research by Swartz *et al.* [25] indicates that the effects of urban residence on somatization differs by gender and education. They measured somatization with the Diagnostic Interview Schedule, which indicates the extent to which people tend to translate psychiatric problems into somatic problems. In rural areas, somatization decreases with education. In urban areas this relationship is almost absent. According to the authors education was less effective in reducing somatization in urban areas. Apparently there are environmental pressures on more highly educated urban respondents that counteract the effect of education [25] (p. 51). Urban women exhibit more somatization symptoms than rural women. As the authors interpret this it may be due to the possibility that urban women experience more role conflicts. Why these mechanisms would trigger more somatization (instead of direct psychiatric complaints) remains unclear.

Yet another urbanicity–education interaction was found by Carpiniello *et al.* [26]. Less educated elderly women living in urban areas were especially more often depressed than their rural counterparts. The authors see this result as confirming the urban stress hypothesis. Even with respect to the impact of stressful life events it seems to make a difference whether women live in an urban or a rural community [27].

In a rural sample of women the total number of stressful events was an indicator of mental health problems, while in the urban sample this was replaced by the number of negative stressful life events. An explanation for this intriguing result is not offered.

Well-being

It is of course hard, if not impossible, to give an objective definition of well-being. We use the term here only as a means to group and discuss jointly those studies that have some health measure that is self assessed and does not directly refer to either mental or physical health. Such health measures may be referred to as happiness, life satisfaction, or well-being. Again we will first pay some attention to the main determinants before turning to interaction effects with urbanicity.

It is not surprising to also find evidence of effects of demographic and socio-economic variables. Considering our definition of well being it is also not surprising to find that health statis plays an important explanatory role. Social network variables are also sometimes included [19, 28]. Health behaviour variables, such as drinking, smoking, etc., are usually not considered to relate to well being. Some puzzling interaction effects and the possible mechanisms behind them will be discussed below.

Palisi *et al.* [29] report on health–urbanicity relations involving race. They find a consistent negative relation between urbanicity and happiness among white people, but no significant relation among black people (though this may also be due to smaller numbers). They come up with a relative deprivation hypothesis according to which people tend to judge their happiness by comparing it with others in their vicinity (and of their own colour). Though black people in urban areas usually live in unhealthy ghetto-like neighbourhoods, they will not regard themselves very unhappy, because their neighbours and friends live in the same circumstances. The reverse would then be true for urban white persons, who live more dispersed. A study conducted among poor Americans, however, reports that poor black Americans are happier in rural areas, while poor white Americans are happier in urban areas [30].

In yet another study urbanicity–race interaction effects on well-being were absent. Neff and Husaini [17] did not find any urbanicity–race interaction with happiness, but they did find such an interaction with depression. They explain this by suggesting that depression is mostly related to chronic stressors, while well-being is more related to acute stressors. These acute stressors (transient life events) are more evenly distributed among urbanicity–race categories.

Amato and Zuo [30] report that it feels worse to be poor in a rural than an urban area. In addition, an urbanicity–race interaction effect on happiness was found. Poor African Americans seem to be happier (and less depressed!) in rural areas, while poor white Americans seem to be happier in urban areas. The authors explanation of this is that harsh inner-city living conditions are more important to poor blacks. They note that it is not surprising that poor African Americans experience a particularly low level of psychological well-being in urban areas. This population is concentrated in inner-city neighbourhoods characterized by substandard housing, inferior schools, high crime rates, poor services, and inadequate transportation. For the more dispersed poor white population, the rural environment has a detrimental influence on happiness because of stigmatization. However, this argument runs counter to Palisi's relative deprivation hypothesis, which maintains that urban blacks would be relatively happier than urban whites. Perhaps the reason for this contradiction is that Amato and Zuo's study concentrates on poor people and Palisi's does not.

Amato and Zuo's study shows that the relationships of urban–rural poverty also differ by family status and gender. Poor urban married women without children show high levels of well-being (and low depression scores) compared to their rural counterparts. The authors explain this quite tautologically by stating that poor urban women are better off with a husband, without the responsibility for children. On the other hand poor rural single men show relatively

Table 3. Urbanicity and well-being: main effects and interactions with urbanicity found in the literature

Source	Country	Health measure	Model main effects	Interaction urbanicity with	Mechanism behind interaction effect
[28]	GB	life satisfaction scale	health status, social activities, social network variables	physical health status	fewer open spaces, multistorey buildings in urban
[19]	US	well-being (Affect Balance Scale)	physical health, wealth, education, marital status, social network variables, social activities	physical health	public transport absent in suburban
[30]	US	happiness (one item scale)	gender, race, employment status, family status, age, education, family income, urbanicity	race	ghettos relatively unhealthy
[29]	US	happiness	age, gender, race, education, unemployment, urbanicity	race	relative deprivation

low scores on well-being. Rural family orientation may have something to do with this phenomenon, leaving rural single men relatively isolated.

Also, the relation between health status and well-being seems to vary according to urbanicity. One study, carried out by Bowling *et al.* [28], reports that health status is a better predictor of life satisfaction in urban than in rural areas. Apparently, physical impairment has more serious consequences in urban than in rural areas. The authors suggest that poor health is a greater handicap for elderly people living in densely populated areas with many stairs to climb, higher traffic densities and fewer possibilities for relaxation in open spaces. On the other hand, retired suburban men with poor health in the U.S. have lower well-being than their urban and rural counterparts [19]. The authors suspect that the loss of physical mobility associated with poor health makes the use of automobiles more difficult and bridging distances more problematic. Differences between the U.S. and England in the availability of public transportation may account for these differing results. In the study by Bowling, a well developed semi-rural area with relatively good public transport was compared with a very densely populated area in London. The study by Reitzes concerned a national U.S. sample in which central city, suburban and non-metropolitan areas were compared. Indeed public transport in general is not as readily available in the U.S. as a whole and especially not in suburban areas.

Physical health

Compared to the measures of well-being and mental health discussed above, it is much more difficult to conduct large scale population surveys on distinct physical health problems. The incidence or prevalence figures are often simply too low to allow this. Therefore, in this area of research, aggregate studies are more common and it does not make sense to limit ourselves to population based surveys. The exception is perhaps the area of self-assessed general physical health. This health measure will be discussed first, followed by five broad categories of disorders: cancer, respiratory diseases, musculo-skeletal disorders, sexually transmitted diseases and cardiovascular diseases.

General physical health. General physical health is usually measured in terms of 'self assessed health' or 'functional ability'. Multivariate individual-based studies have found varying results. In some studies, taking into account confounding variables, higher urban morbidity is reported, and in other studies higher rural morbidity is found. For example, a Finnish study by Vuorinen *et al.* [31] reports a smaller number of restricted activity days in children on the periphery compared to children in the core area (but no difference in chronic diseases). In a Dutch study [32] urbanicity was regarded as an unimportant but not negligible factor compared to gender, marital status, and level of education. A British study based on the National Household Survey [33] revealed unexplained urban–rural variation in perceived health in a controlled study. On the other hand, Krout [34], adjusting for age, gender, race, living arrangement, marital status and several SES measures, did not find significant residential differences in health despondency and self-assessed health in elderly people. Also, in a sample of elderly in Finland no significant differences were found, controlling for gender [35]. In Northern England, the relationship between urbanicity and health at the ward level weakens when wealth is controlled for [36].

In conclusion, there seems to be a tendency towards better perceived health in rural areas, but this tendency disappears in many studies when controlling for demographic variables such as gender and age and enabling variables like socioeconomic status. We will enlarge upon these results below, paying additional attention to interaction effects.

Using a rather unusual combined urbanicity measure that includes population characteristics as well as characteristics of the physical environ-

Table 4. Urbanicity and physical health: main effects and interactions with urbanicity found in the literature

Source	Country	Health measure	Model main effects	Interaction urbanicity with	Mechanism behind interaction effect
[33]	UK	self reported morbidity	age, gender, SES, car availability, region, socioeconomic ward classification	gender*	not given
[29]	US	self reported health	age, gender, race, education, unemployment, neighbourhood fear, urbanicity	socio-economic status	relative deprivation
[37]	NL	perceived health	age, gender, social contacts, social participation, marital status, SES, medical consumption, urbanicity	gender	not given
[23]	NL	somatic symptoms (self reported)	demographic-, financial-, network variables, type of worries, aspects of unemployment	not having partner, duration of unemployment, type of financial problems	lower tolerance in rural

*For acute sickness only.

ment, Haynes [33] reports lower age and gender standardized acute and chronic morbidity figures in high status wards (which are non-urban). An interaction effect was found where women in inner city areas are often confronted with acute sickness. The weakness of social supportive networks in inner city areas with transient populations is one example of a possible, previously ignored link with the perception of illness [33] (p. 366). Why this link would be particularly important to women remains unclear.

Also Perenboom *et al.* [37] found significant urban/rural differences in perceived health, especially for elderly women (as opposed to elderly men). Rural elderly rated their health better than urban elderly, rural elderly also have fewer problems with ADL, and there are no apparent explanations for differences between rural and urban elderly in income, social contacts, social participation, or availability of community care or medical consumption. This finding refutes the suggestion made by Haynes [33] that urban–rural differences may be explained away by taking account of social networks.

Another Dutch study, by Leeflang *et al.* [23] reports that the importance of variables in explaining somatic symptoms in unemployed people varies between rural and urban areas. Long duration of unemployment and financial problems are more detrimental to one's health in the urban area, while rural unemployed men suffer more from not having a partner. According to the authors, rural people are less tolerant of deviant behaviour.

An interaction effect between urbanicity and education was found by Palisi *et al.* [29] who found that lower educated people have slightly better health when they reside in an urban area. For higher educated people this rural–urban difference was absent. They found a similar interaction when looking at happiness and suggest a similar 'relative deprivation' hypothesis.

Cancer. Concerning urban–rural differences in the risk of cancer the literature is quite unequivocal. For most types of cancer higher incidence rates were found in urban areas. The models that are used to explain variations in cancer incidence usually include only age, gender, and place of residence. Interaction effects were seldom investigated, and one might well ask: would the results differ if other variables were included in the analysis?

Greenberg *et al.* [38] found higher incidence rates in urban black people in Georgia, adjusting for age and gender. Hoe *et al.* [39], using a four group categorization of urbanicity based on population density, found higher incidence rates of various types of cancer in urban counties, controlling for age, gender and race composition of these counties. This is consistent with Doll [40] who compared incidence rates of several types of cancer in several countries and found higher incidence rates in urban areas.

Interaction-effects were found between urbanicity and gender by Doll [40]. Urban excesses in the prevalence of cancer are more often observed in men than in women, and in men the urban–rural difference is larger, with almost no exception. This may be due to differences in the (etiology of) the type of illness under study or the confounding factor of gender-related health habits like drinking and smoking.

There are other examples of gender/urbanicity interactions. Schouten *et al.* [41], controlling for age composition, found higher urban incidence rates for cancer in all sites in men but only cancers of the respiratory tract in women. A French study [42] on liver cancer found higher incidence rates in urban areas in men but no differences in women. Colorectal cancer in men also shows higher incidence rates in men in urban areas, while there is no such difference in women. An American study by Masca *et al.* [43] showed a higher urban excess in cancer incidence figures in males than in females. Similar results were found in Denmark [44].

There are some exceptions to the excess in urban cancer incidence generally found. Higher age-adjusted *rural* incidence rates were found for cancer of the oesophagus in men in France [44]. This was partly explained by regional differences in agricultural employment, level of education, and housing quality. This conclusion is, however, challenged by Doll [40] who found an excess incidence of cancer of the oesophagus among urban men.

Leukemia and Hodgkin's disease also seem to be exceptions to the rule of higher cancer incidence in urban areas. Alexander *et al.* [45, 46] found the highest incidence rates for both diseases among children in wards that were farthest away from urban centers with high socio-economic status. According to the authors urban–rural status functions as an inadequate proxy for isolation. Lifestyle in isolated communities is conducive to an unusual exposure to some specific infectious agent or to general infections, and this exposure in turn increases the risk of childhood leukaemia. Other exceptions are, according to Doll [40], cancers of the lip and eye, which are more common in rural areas. Confounding factors are, according to Doll, more pipe smoking and exposure to UV-light in rural areas.

Respiratory problems. Concerning respiratory problems the picture is again diffuse. In some studies a better health status was found in urban areas and in other studies in rural areas. The analytical models usually include age, gender, and—less often—smoking habits.

A Swedish study and two studies in the U.S. come to the conclusion that asthma and chronic bronchitis are more prevalent in urban areas [47–50]. The same applies to allergic rhinitis in the U.S. [51] and COPD in Greece [52]. Higher levels of pollution are often thought to account for this difference. The possibility that the differences are due to migration is usually regarded as only marginal [50, 53].

On the other hand, no urban–rural differences were observed in non-allergic nasal complaints in Sweden [54], in respiratory allergies in Austria [55], in COPD in the Netherlands [56], nor in the U.S. for age and smoking adjusted figures on chronic rhinitis, asthma, chronic bronchitis and chronic cough [51]. The only study in which interaction effects were explicitly investigated was by Spinaci *et al.* [57] but an effect of gender/geographic area on children's lung function was not found.

Musculoskeletal disorders. Literature on urban–rural differences in musculoskeletal disorders concentrates almost exclusively on hip fractures. Among the broad category of musculoskeletal disorders, hip fractures are the most popular when urban–rural comparisons are concerned. With some exceptions the studies were carried out in Scandinavian countries [58–63]. All studies showed significantly more hip fractures in urban areas. This difference is usually attributed to lower bone mineral content in urban areas and a higher tendency to fall [61]. Causes of hip fractures in urban areas more often concern traffic accidents [63], a finding that is consistent with Thouez *et al.* [64], who found higher urban incidence from non-severe car accidents.

Interaction-effects were found between urbanicity and gender, especially in elderly persons. Urban excess morbidity appeared most strongly in (elderly) women [63, 65] as compared to elderly men.

Sexually transmitted diseases. Most sexually transmitted diseases are regarded as typically urban problems. In the case of AIDS and HIV infection, the major associations are substance abuse, prostitution, and prevalence of homosexuality. The literature also describes other modes of transmission [66]. Diffusion may be partly due to urban emigration of HIV-infected persons. Other sexually transmitted diseases that are linked to urbanicity include chlamydia infections [67], gonococcal infections [68], hepatitis B [69], cervical condylomas [70], and syphilis [70]. In all cases higher incidence rates were found in urban areas, but interaction effects were not explicitly investigated.

Circulatory system/cardiovascular diseases. Hypertension in young adults was investigated by Thomas and Groer [71]. High systolic blood pressure is associated with age, gender, body mass and urban residence. Urban residence was the strongest predictor of female systolic pressure. Hypertension in elderly people was studied by Weiler and Lubben [72]. They also found higher hypertension prevalence in urban areas. Finally, in a Swedish study among bus drivers, myocardial infarction was more common in urban areas. Interaction-effects were not explicitly investigated.

SUMMARY AND CONCLUSIONS

The central issue in this paper is the relation between individual and ecological variables in explaining health. Analyzing these relations has become more viable with the introduction of multilevel modelling techniques. The central question in this paper was: *What is the role of the environment in explaining the health of individuals?* The focus was on urbanicity as it is one of the most commonly used ecological variables in empirical research, while at the same time the mechanisms behind its impact are not well understood.

To explore the possible answers to this question a short introduction was given on possible reasons behind geographical disparities in health. The breeder hypothesis points to exposure and behaviour, while the drift hypothesis refers to movements of specific categories of people. It was subsequently concluded that it does not pay to focus on the drift hypothesis because studies in which the drift hypothesis could be investigated are very rare. Longitudinal data are needed but not available. It was decided that—in order to address our question by means of a review—it was best to focus on the breeder hypothesis, controlling as much as possible for the compositional differences resulting from indirect selection effects. It was argued that interactions between aggregate and individual level deserve special attention. Living in a particular type of area (rural or urban) seems to be related to other demographic variables as they affect health. The impact of the environment may vary from person to person, or the impact of individual variables may vary from place to place. It will therefore only be possible to tease out the relevant health related aspects of urbanicity by investigating interaction effects. A summary of interaction effects that were found in the literature is given in Table 5. Caution should be used with interpreting the signs. They indicate only the *relative* position of urban vs rural residents in the same demographic or behavioural category.

Beginning with physical health, the most convincing interaction is between urbanicity and gender. Urban–rural health differences seem to be particularly prevalent in women. One author contended that this may be due to the presumed weakness of supportive networks in cities. This would imply, however, that social networks are more important for women's health than for men's health. This could not be corroborated with other literature. An alternative explanation for this is perhaps found in an article by Gabe and Williams [73]: if there are health differences that can be attributed to environmental differences, these health differences should be observable particularly in those groups that are most tied to the house and immediate neighbourhood: women.

Regarding stress-related variables such as unemployment, financial problems and low education (which stands for low SES) it must again be concluded that they are not only associated with urbanicity but that their influence also differs according to urbanicity of residence.

Regarding cancer we may conclude that most types are more common in urban areas, with the exception

Table 5. Interaction effects found in the literature and their explanations

Health problem	Interaction urbanicity with	Specification	Explanation
Mental health	race [17]	+ black urban + − black rural −	learned helplessness
	unemployment [22]	− urban men − + rural men +	informal employment possibilities in rural areas, social support
	alcohol consumption [14]	− urban drinkers − + rural drinkers +	not given
	age [16]	+ elderly urban + − young urban − − elderly rural − + young rural +	social change
	marital status [15]	+ urban divorced + − rural divorced −	stigmatization/tolerance
Well-being	physical health status [28]	− bad ph. health urb. − + bad ph. health rur. +	constraints in physical environment
	family status [30]	+ married no children urban + − married with children urban −	street violence, traffic
	race [30]	− poor black urb. − + poor white urban + + poor black rur. + − poor white rural −	ghettos relatively unhealthy
Physical health	gender [33, 37]	− female urban − + female rural +	women higher exposure to unhealthy citylife
	not having a partner [23]	+ single urban + − single rural −	stigmatization/tolerance
	low education [29]	+ low education urban + − low education rural −	relative deprivation

Signs indicate the relative position of urban versus rural residents in the same (demographic or behavioural) category. + indicates better health status, − indicates worse health status.

of leukemia, Hodgkin's disease and possibly cancer of the oesophagus. Furthermore, for most types of cancer urban excess is typical of men. This is probably due to gender-differences in lifestyle. Much can be improved regarding the models that are used. A first step in the right direction is including more individual-based data. Including lifestyle characteristics is another step, though this is easier said than done: the time lag between, for instance, smoking and cancer is unknown. With regard to musculoskeletal disorders, urban morbidity is higher than rural morbidity as far as women are concerned. No explanation for this finding was offered. Concerning the circular system again urban excess morbidity was found, but interaction effects were nowhere explicitly investigated. The most important conclusion regarding the broad categories of physical disorders considered here must be that very little attention is paid to interaction effects and that especially in this field much remains to be done.

Regarding the relation between mental health and urbanicity the stress-hypothesis is most popular, contending that the urban environment is more stressful, leading to higher levels of mental disorder. Evidence is found by several authors in the fact that there is a direct effect of stress-indicating variables that are indeed associated with city life.

However, the frequent occurrence of interaction effects shows that this is too simple an explanation. Indeed we have seen that the impact of stress variables themselves varies according to urbanicity. In Table 5 there are two urban conditions that may prove to be important: stigmatization/tolerance and learned helplessness. Divorce can, for instance be regarded as a stressor that is strongly associated with city life. At the same time, however, it is city life that offers better opportunities to cope with divorce via a higher tolerance and less stigmatization towards the unusual, as well as offering more opportunities to meet new partners, thereby limiting the negative health consequences of divorce. Another example of urban–rural differences in possibilities for coping with individual trouble is learned helplessness which is suggested to prevail among black rural residents and not in black urban residents and which counterbalances the fact that urban blacks tend to live in relatively unhealthy environments. Negative aspects of city life may be present in the stress resulting from social change and limited informal employment possibilities. The first would then explain a higher prevalence of mental problems in young city residents as compared to older city residents.

Similar conclusions may be drawn from looking at well-being: here too urbanicity moderates the relation between stressors and health. The evidence is rather convincing regarding physical health as a stressor. Physical health problems clearly constitute a meaning for well-being that differs from city to countryside. Factors that make living with a physical handicap more problematic, like stairclimbing or crossing busy roads, occur much more frequently in urban areas. Regarding race there is less agreement among authors. Race–urbanicity interactions are found but not consistently so. The distinction between chronic and acute stressors is important to remember, the hypothesis being that well-being is largely affected by acute stressors, while mental disorders are more associated with chronic stressors.

Regarding the three aspects of health two important conclusions can be drawn. First, based on the fact that very often bivariate analyses have shown an urban disadvantage regarding health, the

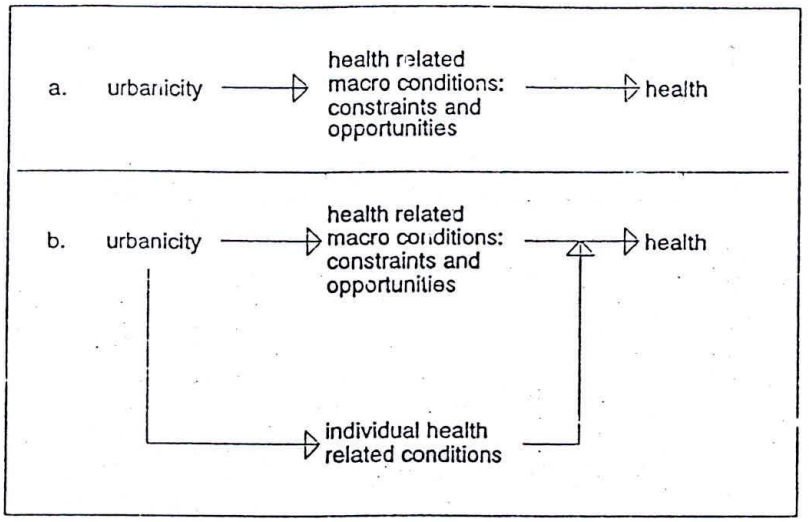

Fig. 1. Two simple explanatory models.

emphasis has been primarily on urban constraints instead of opportunities. Possibly combined with the 18th century pastoral romanticist ideology regarding the purity and salutary qualities of rural societies the result has been an insufficient appreciation of the positive aspects of urban living. Second, it is important to note that these environmental constraints and opportunities have an effect on health that is in many cases dependent on the person who is living in that environment.

The extent to which the environment exerts its influence on a person's health is dependent on that person's individual characteristics. Much previous work on urban–rural differences has conceptualized this relation as depicted in Fig. 1(a). The current review, however, suggests to replace this by Fig. 1(b), in which interactions between the individual level and environment are more fully appreciated.

However, these conclusions are important only for further investigating the breeder hypothesis. In order to gain more insight into the drift hypothesis much more work remains to be done. A start can be made with gathering population based longitudinal data in which breeder and drift hypotheses can be examined together.

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REFERENCES

1. Jones K. *Everywhere is Nowhere: Multilevel Perspectives on the Importance of Place.* University of Portsmouth, Portsmouth, 1993.
2. World Bank. *World Development Report 1993. Investing in Health.* Oxford University Press, Oxford, 1993.
3. Tsouros A. D. (ed.) WHO healthy cities project: a project becomes a movement. *Review of Progress 1987 to 1990.* FADL publishers, Copenhagen, 1991.
4. Hancock T. The healthy city from concept to application. In *Healthy Cities. Research and Practice* (Edited by Davies J. K. and Kelly M.), p. 14–24. Routledge, London, 1993.
5. Hoggart K. Let's do away with rural. *J. Rural Stud.* 6, 245, 1990.
6. Webb L. Rural–urban differences in mental disorder. In *Mental Health and the Environment* (Edited by Freeman H.). Livingstone-Churchill, London, 1984.
7. Marsella A. J. Urbanization and mental disorders: an overview of theory and research and recommendations for interventions and research. WHO, Geneva, 1990 (unpub).
8. Harpham T. Urbanization and mental health in developing countries: a research role for social scientists, public health professionals and social psychiatrists. *Soc. Sci. Med.* 39, 233, 1994.
9. Blazer D., George L. K., Landerman R. *et al.* Psychiatric disorders. A rural/urban comparison. *Arch Gen. Psychiat.* 42, 1142, 1985.
10. Jones K. and Moon G. *Health, Disease and Society: An Introduction to Medical Geography.* Routledge & Kegan Paul, London, 1987.
11. Lewis G., David A., Andreasson S. and Allebeck P. Schizophrenia and city life. *Lancet* 340, 137, 1992.
12. Garretsen H. F. L. and Raat H. Urban health in the Netherlands: health situation, health care facilities an public health policy. *Hlth Policy* 18, 159, 1991.
13. Jones K., Duncan C. and Moon G. Individuals and their ecologies: analysing the geography of chronic illness within a multilevel modelling framework. Paper presented at the *6th International Medical Geography Symposium*, 1994.
14. Neff J. A. and Husaini B. A. Stress-Buffer Properties of Alcohol Consumption: The Role of Urbanicity and Religious Identification. *J. Hlth Soc. Behav.* 26, 207, 1985.
15. Romans-Clarkson S. E., Walton V. A., Herbison G. P. and Mullen P. E. Psychiatric morbidity among women in urban and rural New Zealand: psycho-social correlates. *Br. J. Psychiat.* 156, 1990.

16. Crowell B. A., George L. K., Blazer D. and Landerman R. Psychosocial risk factors and urban/rural differences in the prevalence of major depression. *Br. J. Psychiat.* 149, 307, 1986.
17. Neff J. A. and Husaini B. A. Urbanicity, race, and psychological distress. *J. Commun. Psychol.* 15, 520, 1987.
18. Joukamaa M, Saarijärvi S. and Salokangas R. K. The TURVA project: retirement and adaptation in old age. *Zeit. Geront.* 26, 170, 1993.
19. Reitzes D. C., Mutran E. and Pope H. Location and well-being among retired men. *J. Geront. Soc. Sci.* 46, S195, 1991.
20. Larsson B. and Melin L. Prevalence and short-term stability of depressive symptoms in schoolchildren. *Acta Psychiat. Scand.* 85, 17, 1992.
21. Dohrenwend B. P. and Dohrenwend B. S. Psychiatric disorders in urban settings. In *American Handbook Psychiatry, 2nd Edition, Vol. 2* (Edited by Arieti S. and Caplan S.). Basic Books, New York, 1974.
22. Harding L. and Sewel J. Psychological health and employment status in an island community. *J. Occ. Organ. Psychol.* 65, 269, 1992.
23. Leefiang R. L. I., Klein-Hesselink D. J. and Spruit I. Health effects of unemployment—I. Long-term unemployed men in a rural and an urban setting. *Soc. Sci. Med.* 34, 341, 1992.
24. Tousignant M. and Kovess V. Borderline traits among community alcoholics and problem-drinkers: rural urban differences. *Can. J. Psychiat.* 34, 796, 1989.
25. Swartz M., Landerman R., Blazer D. and George L. Somatization symptoms in the community: A rural/urban comparison. *Psychosomatics* 30, 44, 1989.
26. Carpiniello B., Carta M. G. and Rudas N. Depression among elderly people: a psychosocial study of urban and rural populations. *Acta Psychiat. Scand.* 80, 445, 1989.
27. Bigbee J. L. Stressful life events and illness occurrence in rural versus urban women. *J. Commun. Hlth Nurs.* 7, 105, 1990.
28. Bowling A., Farquhar M. and Browne P. Life satisfaction and associations with social network and support variables in three samples of elderly people. *Int. J. Geriatric Psychiat.* 6, 549, 1991.
29. Palisi B. J., Ransford H. E. and Pampalon R. Effects of urbanism, race, and class on happiness and physical health. *Soc. Spectrum* 7, 253, 1986.
30. Amato P. R. and Zuo J. Rural poverty, urban poverty, and psychological well-being. *Sociol. Q.* 33, 229, 1992.
31. Vuorinen H. S., Mäkelä M., Tuomikoski H. and Floman P. Core-periphery differences in children's health and use of general practitioner services in Finland from 1964 to 1987. *Soc. Sci. Med.* 33, 1023, 1991.
32. Mackenbach J. P. Inequalities in health in The Netherlands according to age, gender, marital status, level of education, degree of urbanization, and region. *Eur. J. Publ. Hlth* 3, 112, 1993.
33. Haynes R. Inequalities in health and health service use: evidence from the General Household Survey. *Soc. Sci. Med.* 33, 361, 1991.
34. Krout J. A. Rural versus urban differences in health dependence among the elderly population. *International J. Aging Hum. Dev.* 28, 141, 1989.
35. Matilla V., Joukamaa M. and Salokangas R. K. Mental health in the population approaching retirement age in relation to physical health, functional ability and creativity: Findings of the TURVA project. *Acta Psychiat. Scand.* 77, 42, 1988.
36. Phillimore P. and Reading R. A rural advantage? Urban-rural health differences in Northern England. *J. Publ. Hlth Med.* 14, 290, 1992.
37. Perenboom R. J., Lako C. J. and Schouten E. G. Health status and medical consumption of rural and urban elderly. *Comp. Geront. Section B, Behav. Soc. Appl. Sci.* 2, 124, 1988.
38. Greenberg R. S., Stevens J. A. and Whitaker J. Cancer incidence rates among blacks in urban and rural Georgia, 1978–82. *Am. J. Publ. Hlth* 75, 683, 1985.
39. Howe H. L., Keller J. E. and Lehnherr M. Relation between population density and cancer incidence, Illinois, 1986–90. *Am. J. Epidemiol.* 138, Monotonic, 1993.
40. Doll Sir R. Urban and rural factors in the aetiology of cancer. *Int. J. Cancer* 47, 803, 1991.
41. Schouten L. J., Kiemeney L. A. L. M., Verbeek A. L. M. and Brandt P. A. vd. Stad-platteland verschillen in kankerincidentie in Midden- en Zuid-Limburg. *Tijdschrift Soc. Gezondheidszorg* 69, 345, 1991.
42. Boutron M. C., Faivre J., Milan C., Bedenne L., Hillon P. and Klepping C. Primary liver cancer in Côte d'Or (France). *Int. J. Epidemiol.* 17, Cirrhosis, 1988.
43. Bremond A., Mamelle N., Laumon B. and Aknin D. Dépistage des condylomes plans du col utérin dans le département du Rhône. *Rev. d'Epidémiol. Santé Publique* 36, 209, 1988.
44. Frisch M., Melbye M. and Møller H. Trends in incidence of anal cancer in Denmark. *Br. Med. J.* 306, 419, 1993.
45. Alexander F. E., Ricketts T. J., Mckinney P. A. and Cartwright R. A. Community lifestyle characteristics and incidence of Hodgkin's disease in young people. *Int. J. Cancer* 48, 10, 1991.
46. Alexander F. E., Ricketts T. J., Mckinney P. A. and Cartwright R. A. Community lifestyle characteristics and risk of acute lymphoblastic leukaemia in children. *Lancet* 336, 1461, 1990.
47. Lundbäck B., Nyström L., Rosenhall L. and Stjernberg N. Obstructive lung disease in northern Sweden: respiratory symptoms assessed in a postal survey. *Eur. Resp. J.* 4, 257, 1991.
48. Gergen P. J., Mullally D. I. and Evans R. National survey of prevalence of asthma among children in the United States, 1976 to 1980. *Pediatrics* 81, 1, 1988.
49. Gerstman B. B., Bosco L. A., Tomita D. K., Gross T. P. and Shaw M. M. Prevalence and treatment of asthma in the Michigan Medicaid patient population younger than 45 years, 1980–1986. *J. Allergy Clin. Immunol.* 83, 1032, 1989.
50. Heinonen O. P., Horsmanheimo M., Vohlonen I. and Terho E. O. Prevalence of allergic symptoms in rural and urban populations. *Eur. J. Resp. Dis.* (Suppl.) 152, 64, 1987.
51. Turkeltaub P. C. and Gergen P. J. Prevalence of upper and lower respiratory conditions in the US population by social and environmental factors: data from the second National Health and Nutrition Examination Survey, 1976 to 1980 (NHANES II). *Ann. Allergy* 67, 147, 1991.
52. Tzonou A., Maragoudakis G., Trichopoulos D *et al.* Urban living, tobacco smoking, and chronic obstructive pulmonary disease: a study in Athens. *Epidemiology* 3, 57, 1992.
53. Viegi G., Paoletti P., Carrozzi L *et al.* Prevalence rates of respiratory symptoms in Italian general population samples exposed to different levels of air pollution. *Environ. Hlth Perspect.* 94, 95, 1991.
54. Jessen M. and Janzon L. Prevalence of non-allergic nasal complaints in an urban and a rural population in Sweden. *Allergy* 44, 582, 1989.
55. Popp W., Swick H., Steyrer K, Rauscher H. and Wanke T. Sensitization to aeroallergens depends on environmental factors. *Allergy* 44, 572, 1989.
56. Rijcken B., Schouten J. P., Weiss S. T., Speizer F. E. and Lende R. van der. The relationship of nonspecific

FUNDAMENTAL RIGHTS (From Part III of THE CONSTITUTION OF INDIA)

Right to Equality

ARTICLE

14. **Equality before law.**

15. **Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth.**

16. **Equality of opportunity in matters of public employment.**

17. **Abolition of Untouchability**

18. **Abolition of titles.**

Right to Freedom

ARTICLE

19. **Protection of certain rights regarding freedom of speech, etc.**

20. **Protection in respect of conviction for offences.**

21. **Protection of life and personal liberty.**

22. **Protection against arrest and detention in certain cases.**

Right against Exploitation

ARTICLE

23. **Prohibition of traffic in human beings and forced labour.**

24. **Prohibition of employment of children in factories, etc.**

Right to Freedom of Religion

ARTICLE

25. **Freedom of conscience and free profession, practice and propagation of religion.**

Cultural and Educational Rights

Saving of Certain Laws

Right to Constitutional Remedies

PART III

FUNDAMENTAL RIGHTS

General

ARTICLE

Right to Equality

ARTICLE

Right to Freedom

ARTICLE

Right against Exploitation

ARTICLE

Right to Freedom of Religion

ARTICLE

Cultural and Educational Rights

ARTICLE

Saving of Certain Laws

ARTICLE

Right to Constitutional Remedies

ARTICLE

Universal Declaration of Human Rights

Adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948

On December 10, 1948 the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights the full text of which appears in the following pages. Following this historic act the Assembly called upon all Member countries to publicize the text of the Declaration and "to cause it to be disseminated, displayed, read and expounded principally in schools and other educational institutions, without distinction based on the political status of countries or territories."

PREAMBLE

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law,

Whereas it is essential to promote the development of friendly relations between nations,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in co-operation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge,

Now, Therefore **THE GENERAL ASSEMBLY** proclaims **THIS UNIVERSAL DECLARATION OF HUMAN RIGHTS** as a common standard of achievement for all peoples and all nations, to the end that every individual and every

organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article 1.

All human beings are born free and equal in dignity and rights.They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2.

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty.

Article 3.

Everyone has the right to life, liberty and security of person.

Article 4.

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5.

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6.

Everyone has the right to recognition everywhere as a person before the law.

Article 7.

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8.

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9.

No one shall be subjected to arbitrary arrest, detention or exile.

Article 10.

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11.

(1) Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.

(2) No one shall be held guilty of any penal offence on account of any act or omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12.

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13.

(1) Everyone has the right to freedom of movement and residence within the borders of each state.

(2) Everyone has the right to leave any country, including his own, and to return to his country.

Article 14.

(1) Everyone has the right to seek and to enjoy in other countries asylum from persecution.

(2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15.

(1) Everyone has the right to a nationality.

(2) No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16.

(1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

(2) Marriage shall be entered into only with the free and full consent of the intending spouses.

(3) The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17.

(1) Everyone has the right to own property alone as well as in association with others.

(2) No one shall be arbitrarily deprived of his property.

Article 18.

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19.

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20.

(1) Everyone has the right to freedom of peaceful assembly and association.

(2) No one may be compelled to belong to an association.

Article 21.

(1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.

(2) Everyone has the right of equal access to public service in his country.

(3) The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22.

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with

the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23.

(1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.

(2) Everyone, without any discrimination, has the right to equal pay for equal work.

(3) Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

(4) Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24.

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25.

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26.

(1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

(2) Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.

(3) Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27.

(1) Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

(2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28.

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29.

(1) Everyone has duties to the community in which alone the free and full development of his personality is possible.

(2) In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

(3) These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30.

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

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AND CULTURAL RIGHTS
Twenty-second session
Geneva, 25 April-12 May 2000
Agenda item 3

SUBSTANTIVE ISSUES ARISING IN THE IMPLEMENTATION OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

General Comment No. 14 (2000)

The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)

1. Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments. Moreover, the right to health includes certain components which are legally enforceable. (1)

2. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize "the

DRAFT STAG REPORT 2001

8.1 Women's perspectives and gender issues

Training initiative in gender and reproductive health

This training initiative, which is a collaborative effort between WHO, the Women's Health Project at the University of the Witwatersrand (South Africa) and the François Xavier Bagnoud Centre for Health and Human Rights (Harvard School of Public Health, USA), is moving into its final phase during this Biennium. (Please refer to the Annual Technical Report 1999 for a full description ~~of the aims~~ of the initiative.)

During 1999 four regional institutions ran a regionally adapted version of the course. These institutions are: Centre for African Family Studies (CAFS), Nairobi, Kenya (October); Centre for the Study of State and Society (CEDES), Buenos Aires, Argentina (August); Key Centre for Women's Health in Society, University of Melbourne, Australia (July); and Yunnan Reproductive Health Research Association (YRHRA), Kunming Medical College, Kunming, China (September). In March 2000, representatives from these training institutions attended a workshop together with the international coordinating committee to evaluate the experience and to select case studies and approaches that had been successful in the regional courses, for inclusion in the final curriculum. As a result of the evaluation, extensive revisions were proposed to the curriculum, particularly in the level of detail given and in the content and approach of some sessions.

Between March and August these revisions were incorporated by an editor, Dr Sundari Ravindran, who is a member of the coordinating committee. The revised curriculum was then tested at the South African course on Gender and Reproductive Heath in September, by trainers who had not previously taught the course. Key sessions of the course were also presented to the staff of ~~the~~ RHR for comment and input. As a result of these field tests, some revisions were again made to the curriculum which, at the time of

writing, is under review by all the collaborating institutions and three outside reviewers. The training manual, entitled *Transforming health systems: gender and rights in reproductive health*, will be published in 2001.

The centres in Australia, and Kenya ran the course for the second time in 2000, and in China, YRHRA ran the course twice – once in February and once in September (?). All of the courses run in 2000 met with positive response. In South Africa, for instance, many of the those attending the course were responsible for ensuring that gender issues are addressed in their institutions. They were therefore urgently seeking tools to help them do this, and found the course timely and relevant.

All four centres expect to run the course in 2001, and the South African course will be run for the fifth time. CEDES and YRHRA, will translate the revised curriculum into Spanish and Mandarin respectively, with support from WHO and (in the case of China) the Ford Foundation.

The Course is a major contribution to making the concepts and practice of gender equality and reproductive rights accessible to health programme managers. Considerable interest in the course has been generated over the four years of its development and testing. In the coming year and over the next Biennium, the Department plans to give technical support to five additional regional centres to run the training course. In order to facilitate this, it will support a high-level "training of trainers" team composed of members from the five regional institutions collaborating with the initiative, to provide training to these new centres. The curriculum will also be made available in electronic form, and further translations supported if there is a demand.

right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties ... to achieve the full realization of this right". Additionally, the right to health is recognized, *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed by the Commission on Human Rights, (2) as well as in the Vienna Declaration and Programme of Action of 1993 and other international instruments. (3)

3. The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

4. In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". However, the reference in article 12.1 of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

5. The Committee is aware that, for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.

6. With a view to assisting States parties' implementation of the Covenant and the fulfilment of their reporting obligations, this General Comment focuses on the normative content of article 12 (Part I), States parties' obligations (Part II), violations (Part III) and implementation at the national level (Part IV), while the obligations of actors other than States parties are addressed in Part V. The General Comment is based on the Committee's experience in examining States parties' reports over many years.

I. NORMATIVE CONTENT OF ARTICLE 12

7. Article 12.1 provides a definition of the right to health, while article 12.2 enumerates illustrative, non-exhaustive examples of States parties' obligations.

8. The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body,

including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

9. The notion of "the highest attainable standard of health" in article 12.1 takes into account both the individual's biological and socio-economic preconditions and a State's available resources. There are a number of aspects which cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus, genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

10. Since the adoption of the two International Covenants in 1966 the world health situation has changed dramatically and the notion of health has undergone substantial changes and has also widened in scope. More determinants of health are being taken into consideration, such as resource distribution and gender differences. A wider definition of health also takes into account such socially-related concerns as violence and armed conflict. (4) Moreover, formerly unknown diseases, such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and others that have become more widespread, such as cancer, as well as the rapid growth of the world population, have created new obstacles for the realization of the right to health which need to be taken into account when interpreting article 12.

11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels.

12. The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs. (5)

(b) *Accessibility.* Health facilities, goods and services (6) have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. (7)

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas (8) concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) *Acceptability.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) *Quality.* As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

13. The non-exhaustive catalogue of examples in article 12.2 provides guidance in defining the action to be taken by States. It gives specific generic examples of measures arising from the broad definition of the right to health contained in article 12.1, thereby illustrating the content of that right, as exemplified in the following paragraphs. (9)

Article 12.2 (a). The right to maternal, child and reproductive health

14. "The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child" (art. 12.2 (a)) (10) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, (11) emergency obstetric services and access to information, as well as to resources necessary to act on that information. (12)

Article 12.2 (b). The right to healthy natural and workplace environments

15. "The improvement of all aspects of environmental and industrial hygiene" (art. 12.2 (b)) comprises, *inter alia*, preventive measures in respect of occupational accidents and diseases; the requirement to ensure an adequate supply of safe and potable water and basic sanitation; the prevention and reduction of the population's exposure to harmful substances such as radiation and harmful chemicals or other detrimental environmental conditions that directly or indirectly impact upon human health. (13) Furthermore, industrial hygiene refers to the minimization, so far as is reasonably practicable, of the causes of health hazards inherent in the working environment. (14) Article 12.2 (b) also embraces adequate housing and safe and hygienic working conditions, an

adequate supply of food and proper nutrition, and discourages the abuse of alcohol, and the use of tobacco, drugs and other harmful substances.

Article 12.2 (c). The right to prevention, treatment and control of diseases

16. "The prevention, treatment and control of epidemic, endemic, occupational and other diseases" (art. 12.2 (c)) requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The control of diseases refers to States' individual and joint efforts to, *inter alia*, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies of infectious disease control.

Article 12.2 (d). The right to health facilities, goods and services (15)

17. "The creation of conditions which would assure to all medical service and medical attention in the event of sickness" (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.

Article 12. Special topics of broad application

Non-discrimination and equal treatment

18. By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls General Comment No. 3, paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes.

19. With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any

discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health. (16) Inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

Gender perspective

20. The Committee recommends that States integrate a gender perspective in their health-related policies, planning, programmes and research in order to promote better health for both women and men. A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. The disaggregation of health and socio-economic data according to sex is essential for identifying and remedying inequalities in health.

Women and the right to health

21. To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

Children and adolescents

22. Article 12.2 (a) outlines the need to take measures to reduce infant mortality and promote the healthy development of infants and children. Subsequent international human rights instruments recognize that children and adolescents have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness. (17)

The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children. (18) Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

23. States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of

youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

24. In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.

Older persons

25. With regard to the realization of the right to health of older persons, the Committee, in accordance with paragraphs 34 and 35 of General Comment No. 6 (1995), reaffirms the importance of an integrated approach, combining elements of preventive, curative and rehabilitative health treatment. Such measures should be based on periodical check-ups for both sexes; physical as well as psychological rehabilitative measures aimed at maintaining the functionality and autonomy of older persons; and attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.

Persons with disabilities

26. The Committee reaffirms paragraph 34 of its General Comment No. 5, which addresses the issue of persons with disabilities in the context of the right to physical and mental health. Moreover, the Committee stresses the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities.

Indigenous peoples

27. In the light of emerging international law and practice and the recent measures taken by States in relation to indigenous peoples, (19) the Committee deems it useful to identify elements that would help to define indigenous peoples' right to health in order better to enable States with indigenous peoples to implement the provisions contained in article 12 of the Covenant. The Committee considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension. In this respect, the Committee considers that development-related activities that lead to the displacement of indigenous peoples against their will from their traditional territories and environment, denying them their sources of nutrition and breaking their symbiotic relationship with their lands, has a deleterious effect on their health.

Limitations

28. Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States. Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to allow doctors to treat persons believed to be opposed to a government, or fails to provide immunization against the community's major infectious diseases, on grounds such as national security or the preservation of public order, has the burden of justifying such serious measures in

relation to each of the elements identified in article 4. Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.

29. In line with article 5.1, such limitations must be proportional, i.e. the least restrictive alternative must be adopted where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, they should be of limited duration and subject to review.

II. STATES PARTIES' OBLIGATIONS

General legal obligations

30. While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on States parties various obligations which are of immediate effect. States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) towards the full realization of article 12. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health. (20)

31. The progressive realization of the right to health over a period of time should not be interpreted as depriving States parties' obligations of all meaningful content. Rather, progressive realization means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of article 12. (21)

32. As with all other rights in the Covenant, there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible. If any deliberately retrogressive measures are taken, the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources. (22)

33. The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect*, *protect* and *fulfil*. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. (23) The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

Specific legal obligations

34. In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs. Furthermore, obligations to respect include a State's obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and

from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. (24)

In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters. States should also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.

35. Obligations to *protect* include, *inter alia*, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence. States should also ensure that third parties do not limit people's access to health-related information and services.

36. The obligation to *fulfil* requires States parties, *inter alia*, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health. States must ensure provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions. Public health infrastructures should provide for sexual and reproductive health services, including safe motherhood, particularly in rural areas. States have to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns, in particular with respect to HIV/AIDS, sexual and reproductive health, traditional practices, domestic violence, the abuse of alcohol and the use of cigarettes, drugs and other harmful substances. States are also required to adopt measures against environmental and occupational health hazards and against any other threat as demonstrated by epidemiological data. For this purpose they should formulate and implement national policies aimed at reducing and eliminating pollution of air, water and soil, including pollution by heavy metals such as lead from gasoline. Furthermore, States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services. (25)

37. The obligation to *fulfil (facilitate)* requires States *inter alia* to take positive measures that

enable and assist individuals and communities to enjoy the right to health. States parties are also obliged to *fulfil (provide)* a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to *fulfil (promote)* the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favouring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health.

International obligations

38. In its General Comment No. 3, the Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. In the spirit of article 56 of the Charter of the United Nations, the specific provisions of the Covenant (articles 12, 2.1, 22 and 23) and the Alma-Ata Declaration on primary health care, States parties should recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health. In this regard, States parties are referred to the Alma-Ata Declaration which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. (26)

39. To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required. (27) States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health. Similarly, States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions.

40. States parties have a joint and individual responsibility, in accordance with the Charter of the United Nations and relevant resolutions of the United Nations General Assembly and of the World Health Assembly, to cooperate in providing disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons. Each State should contribute to this task to the maximum of its capacities. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population. Moreover, given that some diseases are easily transmissible beyond the frontiers of a State, the international community has a collective responsibility to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard.

41. States parties should refrain at all times from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as an instrument of political and economic pressure. In this regard, the Committee recalls its position, stated in General Comment No. 8, on the relationship between economic sanctions and respect for economic, social and cultural rights.

42. While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realization of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities.

Core obligations

43. In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, (28) the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

44. The Committee also confirms that the following are obligations of comparable priority:

(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(b) To provide immunization against the major infectious diseases occurring in the community;

(c) To take measures to prevent, treat and control epidemic and endemic diseases;

(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) To provide appropriate training for health personnel, including education on health and human rights.

45. For the avoidance of any doubt, the Committee wishes to emphasize that it is particularly incumbent on States parties and other actors in a position to assist, to provide "international assistance and cooperation, especially economic and technical" (29) which enable developing countries to fulfil their core and other obligations indicated in paragraphs 43 and 44 above.

III. VIOLATIONS

46. When the normative content of article 12 (Part I) is applied to the obligations of States parties (Part II), a dynamic process is set in motion which facilitates identification of violations of the right to health. The following paragraphs provide illustrations of violations of article 12.

47. In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under article 12. This follows from article 12.1, which speaks of the highest attainable standard of health, as well as from article 2.1 of the Covenant, which obliges each State party to take the necessary steps to the maximum of its available resources. A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.

48. Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. The adoption of any retrogressive measures incompatible with the core obligations under the right to health, outlined in paragraph 43 above, constitutes a violation of the right to health. Violations through *acts of commission* include the formal repeal or suspension of legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health.

49. Violations of the right to health can also occur through the omission or failure of States to take necessary measures arising from legal obligations. Violations through *acts of omission* include the failure to take appropriate steps towards the full realization of everyone's right to the enjoyment of the highest attainable standard of physical and mental health, the failure to have a national policy on occupational safety and health as well as occupational health services, and the failure to enforce relevant laws.

Violations of the obligation to respect

50. Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Examples include the denial of access to health

facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination; the deliberate withholding or misrepresentation of information vital to health protection or treatment; the suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health; and the failure of the State to take into account its legal obligations regarding the right to health when entering into bilateral or multilateral agreements with other States, international organizations and other entities, such as multinational corporations.

Violations of the obligation to protect

51. Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others; the failure to protect consumers and workers from practices detrimental to health, e.g. by employers and manufacturers of medicines or food; the failure to discourage production, marketing and consumption of tobacco, narcotics and other harmful substances; the failure to protect women against violence or to prosecute perpetrators; the failure to discourage the continued observance of harmful traditional medical or cultural practices; and the failure to enact or enforce laws to prevent the pollution of water, air and soil by extractive and manufacturing industries.

Violations of the obligation to fulfil

52. Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone; insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized; the failure to monitor the realization of the right to health at the national level, for example by identifying right to health indicators and benchmarks; the failure to take measures to reduce the inequitable distribution of health facilities, goods and services; the failure to adopt a gender-sensitive approach to health; and the failure to reduce infant and maternal mortality rates.

IV. IMPLEMENTATION AT THE NATIONAL LEVEL

Framework legislation

53. The most appropriate feasible measures to implement the right to health will vary significantly from one State to another. Every State has a margin of discretion in assessing which measures are most suitable to meet its specific circumstances. The Covenant, however, clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. This requires the adoption of a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks. The national health strategy should also identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources.

54. The formulation and implementation of national health strategies and plans of action should

respect, *inter alia*, the principles of non-discrimination and people's participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States.

55. The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health. In order to create a favourable climate for the realization of the right, States parties should take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.

56. States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and the time-frame for their achievement; the means by which right to health benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organizations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures. In monitoring progress towards the realization of the right to health, States parties should identify the factors and difficulties affecting implementation of their obligations.

Right to health indicators and benchmarks

57. National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party's obligations under article 12. States may obtain guidance on appropriate right to health indicators, which should address different aspects of the right to health, from the ongoing work of WHO and the United Nations Children's Fund (UNICEF) in this field. Right to health indicators require disaggregation on the prohibited grounds of discrimination.

58. Having identified appropriate right to health indicators, States parties are invited to set appropriate national benchmarks in relation to each indicator. During the periodic reporting procedure the Committee will engage in a process of scoping with the State party. Scoping involves the joint consideration by the State party and the Committee of the indicators and national benchmarks which will then provide the targets to be achieved during the next reporting period. In the following five years, the State party will use these national benchmarks to help monitor its implementation of article 12. Thereafter, in the subsequent reporting process, the State party and the Committee will consider whether or not the benchmarks have been achieved, and the reasons for any difficulties that may have been encountered.

Remedies and accountability

59. Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. (30) All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.

60. The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases. (31) Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant.

61. Judges and members of the legal profession should be encouraged by States parties to pay greater attention to violations of the right to health in the exercise of their functions.

62. States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.

V. OBLIGATIONS OF ACTORS OTHER THAN STATES PARTIES

63. The role of the United Nations agencies and programmes, and in particular the key function assigned to WHO in realizing the right to health at the international, regional and country levels, is of particular importance, as is the function of UNICEF in relation to the right to health of children. When formulating and implementing their right to health national strategies, States parties should avail themselves of technical assistance and cooperation of WHO. Further, when preparing their reports, States parties should utilize the extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks.

64. Moreover, coordinated efforts for the realization of the right to health should be maintained to enhance the interaction among all the actors concerned, including the various components of civil society. In conformity with articles 22 and 23 of the Covenant, WHO, The International Labour Organization, the United Nations Development Programme, UNICEF, the United Nations Population Fund, the World Bank, regional development banks, the International Monetary Fund, the World Trade Organization and other relevant bodies within the United Nations system, should cooperate effectively with States parties, building on their respective expertise, in relation to the implementation of the right to health at the national level, with due respect to their individual mandates. In particular, the international financial institutions, notably the World Bank and the International Monetary Fund, should pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes. When examining the reports of States parties and their ability to meet the obligations under article 12, the Committee will consider the effects of the assistance provided by all other actors. The adoption of a human rights-based approach by United Nations specialized agencies, programmes and bodies will greatly facilitate implementation of the right to health. In the course of its examination of States parties' reports, the Committee will also consider the role of health professional associations and other non-governmental organizations in relation to the States' obligations under article 12.

65. The role of WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/Red Crescent and UNICEF, as well as non governmental organizations and national medical associations, is of particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, including assistance to refugees and internally displaced persons. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population.

Adopted on 11 May 2000.

Notes

1. For example, the principle of non-discrimination in relation to health facilities, goods and services is legally enforceable in numerous national jurisdictions.

2. In its resolution 1989/11.

3. The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care adopted by the United Nations General Assembly in 1991 (resolution 46/119) and the Committee's General Comment No. 5 on persons with disabilities apply to persons with mental illness; the Programme of Action of the International Conference on Population and Development held at Cairo in 1994, as well as the Declaration and Programme for Action of the Fourth World Conference on Women held in Beijing in 1995 contain definitions of reproductive health and women's health, respectively.

4. Common article 3 of the Geneva Conventions for the protection of war victims (1949); Additional Protocol I (1977) relating to the Protection of Victims of International Armed Conflicts, art. 75 (2) (a); Additional Protocol II (1977) relating to the Protection of Victims of Non-International Armed Conflicts, art. 4 (a).

5. See WHO Model List of Essential Drugs, revised December 1999, WHO Drug Information, vol. 13, No. 4, 1999.

6. Unless expressly provided otherwise, any reference in this General Comment to health facilities, goods and services includes the underlying determinants of health outlined in paras. 11 and 12 (a) of this General Comment.

7. See paras. 18 and 19 of this General Comment.

8. See article 19.2 of the International Covenant on Civil and Political Rights. This General Comment gives particular emphasis to access to information because of the special importance of this issue in relation to health.

9. In the literature and practice concerning the right to health, three levels of health care are frequently referred to: *primary health care* typically deals with common and relatively minor illnesses and is provided by health professionals and/or generally trained doctors working within the community at relatively low cost; *secondary health care* is provided in centres, usually hospitals, and typically deals with relatively common minor or serious illnesses that cannot be managed at community level, using specialty-trained health professionals and doctors, special equipment and sometimes in-patient care at comparatively higher cost; *tertiary health care* is provided in relatively few centres, typically deals with small numbers of minor or serious illnesses requiring specialty-trained health professionals and doctors and special equipment, and is often relatively expensive. Since forms of primary, secondary and tertiary health care frequently overlap and often interact, the use of this typology does not always provide sufficient distinguishing criteria to be helpful for assessing which levels of health care States parties must provide, and is therefore of limited assistance in relation to the normative understanding of article 12.

10. According to WHO, the stillbirth rate is no longer commonly used, infant and under-five mortality rates being measured instead.

11. *Prenatal* denotes existing or occurring before birth; *perinatal* refers to the period shortly before and after birth (in medical statistics the period begins with the completion of 28 weeks of gestation and is variously defined as ending one to four weeks after birth); *neonatal*, by contrast, covers the period pertaining to the first four weeks after birth; while *post-natal* denotes occurrence after birth. In this General Comment, the more generic terms pre- and post-natal are exclusively employed.

12. Reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services that will, for example, enable women to go safely through pregnancy and childbirth.

13. The Committee takes note, in this regard, of Principle 1 of the Stockholm Declaration of 1972 which states: "Man has the fundamental right to freedom, equality and adequate conditions of life, in an environment of a quality that permits a life of dignity and well-being", as well as of recent developments in international law, including General Assembly resolution 45/94 on the need to ensure a healthy environment for the well-being of individuals; Principle 1 of the Rio Declaration; and regional human rights instruments such as article 10 of the San Salvador Protocol to the American Convention on Human Rights.

14. ILO Convention No. 155, art. 4.2.

15. See para. 12 (b) and note 8 above.

16. For the core obligations, see paras. 43 and 44 of the present General Comments.

17. Article 24.1 of the Convention on the Rights of the Child.

18. See World Health Assembly resolution WHA47.10, 1994, entitled "Maternal and child health and family planning: traditional practices harmful to the health of women and children".

19. Recent emerging international norms relevant to indigenous peoples include the ILO Convention No. 169 concerning Indigenous and Tribal Peoples in Independent Countries (1989); articles 29 (c) and (d) and 30 of the Convention on the Rights of the Child (1989); article 8 (j) of the Convention on Biological Diversity (1992), recommending that States respect, preserve and maintain knowledge, innovation and practices of indigenous communities; Agenda 21 of the United Nations Conference on Environment and Development (1992), in particular chapter 26; and Part I, paragraph 20, of the Vienna Declaration and Programme of Action (1993), stating that States should take concerted positive steps to ensure respect for all human rights of indigenous people, on the basis of non-discrimination. See also the preamble and article 3 of the United Nations Framework Convention on Climate Change (1992); and article 10 (2) (e) of the United Nations Convention to Combat Desertification in Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa (1994). During recent years an increasing number of States have changed their constitutions and introduced legislation recognizing specific rights of indigenous peoples.

20. See General Comment No. 13, para. 43.

21. See General Comment No. 3, para. 9; General Comment No. 13, para. 44.

22. See General Comment No. 3, para. 9; General Comment No. 13, para. 45.

23. According to General Comments Nos. 12 and 13, the obligation to fulfil incorporates an obligation to *facilitate* and an obligation to *provide*. In the present General Comment, the obligation to fulfil also incorporates an obligation to *promote* because of the critical importance of health promotion in the work of WHO and elsewhere.

24. General Assembly resolution 46/119 (1991).

25. Elements of such a policy are the identification, determination, authorization and control of dangerous materials, equipment, substances, agents and work processes; the provision of health information to workers and the provision, if needed, of adequate protective clothing and equipment; the enforcement of laws and regulations through adequate inspection; the requirement of notification of occupational accidents and diseases, the conduct of inquiries into serious accidents and diseases, and the production of annual statistics; the protection of workers and their representatives from disciplinary measures for actions properly taken by them in conformity with such a policy; and the provision of occupational health services with essentially preventive functions. See ILO Occupational Safety and Health Convention, 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161).

26. Article II, Alma-Ata Declaration, Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978, in: World Health Organization, "Health for All" Series, No. 1, WHO, Geneva, 1978.

27. See para. 45 of this General Comment.

28. Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex, chaps. VII and VIII.

29. Covenant, art. 2.1.

30. Regardless of whether groups as such can seek remedies as distinct holders of rights, States parties are bound by both the collective and individual dimensions of article 12. Collective rights are critical in the field of health; modern public health policy relies heavily on prevention and promotion which are approaches directed primarily to groups.

31. See General Comment No. 2, para. 9.

Right to Health in International Documents

Universal Declaration of Human Rights, Article 25

Everyone has the right to a standard of living adequate for health and wellbeing of himself and his family, including food, clothing, housing, medical care and the right to security in the event if sickness, disability.... Motherhood and childhood are entitled to special care and assistance.

International Covenant on Economic, Social and Cultural Rights, Article 7, 11 and 12

The state... recognize the right of everyone to ... just and favourable conditions of work which ensures... safe and healthy working conditions; the right to adequate standard of living; the enjoyment of the highest attainable standards of physical and mental health. The steps to be taken to achieve the full realization of this right shall include those necessary for the reduction of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, occupational and other disease; the creation of conditions which would assure to all medical services and medical attention in the event of sickness.

Convention on the Elimination of All Forms of Discrimination Against Women, Article 10, 12 and 14

State shall ensure to women access to specific educational information to help to ensure the health and wellbeing of families, including information and advice on family planning. State shall eliminate discrimination against women in health care to ensure, on a basis of equality if men and women access to health care services, including those related to family planning; ensure appropriate services in connection with pregnancy. State shall ensure that women in rural areas have access to adequate health care facilities, including information counseling and services in family planning.

Convention on the Elimination of all forms of Racial Discrimination, Article 5

States undertake to eliminate racial discrimination and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before law, the right to public health, medical care social security and social service.

Convention on the Rights of the Child, Article 24

States recognizes the right of the child the enjoyment of the highest attainable standards of health and to facilities for the treatment of illness, and rehabilitation of health.

Constitutional Provisions Relating to Health

Unfortunately, in the Constitution of India, health is not a fundamental right of the citizens. The provision of healthcare is contained in the Directive Principles and it is a duty of the State to raise the level of nutrition and the standard of living and to improve public health.

Fundamental Rights:

Article 21: No person shall be deprived of his life or personal liberty except according to procedure established by law.

Directive Principles of State Policy

Article 39: The State shall, in particular, direct its policy towards securing; that the health and strength of workers, men and women, and the tender age of children be not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength.

Article 41: The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.

Article 42: The State shall make provision for securing just and humane conditions of work and for maternity relief.

Article 47: The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption except for medical purposes of intoxicating drinks and of drugs which are injurious to health.

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

(Adopted by UN General Assembly in 1976)

"...the full and complete development of a country, the welfare of the world and the cause of peace require the maximum participation of women on equal terms with men in all fields "

CONTENTS

INTRODUCTION

On 18 December 1979, the Convention on the Elimination of All Forms of Discrimination against Women was adopted by the United Nations General Assembly. It entered into force as an international treaty on 3 September 1981 after the twentieth country had ratified it. By the tenth anniversary of the Convention in 1989, almost one hundred nations have agreed to be bound by its provisions.

The Convention was the culmination of more than thirty years of work by the United Nations Commission on the Status of Women, a body established in 1946 to monitor the situation of women and to promote women's rights. The Commission's work has been instrumental in bringing to light all the areas in which women are denied equality with men. These efforts for the advancement of women have resulted in several declarations and conventions, of which the Convention on the elimination of All Forms of Discrimination against Women is the central and most comprehensive document.

Among the international human rights treaties, the Convention takes an important place in bringing the female half of humanity into the focus of human rights concerns. The spirit of the Convention is rooted in the goals of the United Nations: to reaffirm faith in fundamental human rights, in the dignity,and worth of the human person, in the equal rights of men and women. The present document spells out the meaning of equality and how it can be achieved. In so doing, the Convention establishes not only an international bill of rights for women, but also an agenda for action by countries to guarantee the enjoyment of those rights.

In its preamble, the Convention explicitly acknowledges that "extensive discrimination against women continues to exist", and emphasizes that such discrimination "violates the principles of equality of rights and respect for human dignity". As defined in article 1, discrimination is understood as "any distinction, exclusion or restriction made o.1 the basis of sex...in the political, economic, social, cultural, civil or any other field". The Convention gives positive affirmation to the principle of equality by requiring States parties to take "all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men"(article 3).

The agenda for equality is specified in fourteen subsequent articles. In its approach, the Convention covers three dimensions of the situation of women. Civil rights and the legal status of women are dealt with in great detail. In addition, and unlike other human rights treaties, the Convention is also concerned with the dimension of human reproduction as well as with the impact of cultural factors on gender relations.

The legal status of women receives the broadest attention. Concern over the basic rights of political participation has not diminished since the adoption of the Convention on the Political Rights of Women in 1952. Its provisions, therefore, are restated in article 7 of the present document,

whereby women are guaranteed the rights to vote, to hold public office and to exercise public functions. This includes equal rights for women to represent their countries at the international level (article 8). The Convention on the Nationality of Married Women - adopted in 1957 - is integrated under article 9 providing for the statehood of women, irrespective of their marital status. The Convention, thereby, draws attention to the fact that often women's legal status has been linked to marriage, making them dependent on their husband's nationality rather than individuals in their own right. Articles 10, 11 and 13, respectively, affirm women's rights to non-discrimination in education, employment and economic and social activities. These demands are given special emphasis with regard to the situation of rural women, whose particular struggles and vital economic contributions, as noted in article 14, warrant more attention in policy planning. Article 15 asserts the full equality of women in civil and business matters, demanding that all instruments directed at restricting women's legal capacity ''shall be deemed null and void". Finally, in article 16, the Convention returns to the issue of marriage and family relations, asserting the equal rights and obligations of women and men with regard to choice of spouse, parenthood, personal rights and command over property.

Aside from civil rights issues, the Convention also devotes major attention to a most vital concern of women, namely their reproductive rights. The preamble sets the tone by stating that "the role of women in procreation should not be a basis for discrimination". The link between discrimination and women's reproductive role is a matter of recurrent concern in the Convention. For example, it advocates, in article 5, ''a proper understanding of maternity as a social function", demanding fully shared responsibility for child-rearing by both sexes. Accordingly, provisions for maternity protection and child-care are proclaimed as essential rights and are incorporated into all areas of the Convention, whether dealing with employment, family law, health core or education. Society's obligation extends to offering social services, especially child-care facilities that allow individuals to combine family responsibilities with work and participation in public life. Special measures for maternity protection are recommended and "shall not be considered discriminatory". (Article 4). "The Convention also affirms women's right to reproductive choice. Notably, it is the only human rights treaty to mention family planning. States parties are obliged to include advice on family planning in the education process (article 1 O.h) and to develop family codes that guarantee women's rights "to decide freely and responsibly on the number and spacing of their children and to hove access to the information, education and means to enable them to exercise these rights" (article 16.e).

The third general thrust of the Convention aims at enlarging our understanding of the concept of human rights, as it gives formal recognition to the influence of culture and tradition on restricting women's enjoyment of their fundamental rights. These forces take shape in stereotypes, customs and norms which give rise to the multitude of legal, political and economic constraints on the advancement of women. Noting this interrelationship, the preamble of the Convention stresses "that a change in the traditional role of men as well as the role of women in society and in the family is needed to achieve full equality of men and women". States parties are therefore obliged to work towards the modification of social and cultural patterns of individual conduct

in order to eliminate "prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women" (article 5). And Article 10.c. mandates the revision of textbooks, school programmes and teaching methods with a view to eliminating stereotyped concepts in the field of education. Finally, cultural patterns which define the public realm as a man's world and the domestic sphere as women's domain are strongly targeted in all of the Convention's provisions that affirm the equal responsibilities of both sexes in family life and their equal rights with regard to education and employment. Altogether, the Convention provides a comprehensive framework for challenging the various forces that have created and sustained discrimination based upon sex.

The implementation of the Convention is monitored by the Committee on the Elimination of Discrimination against Women (CEDAW). The Committee's mandate and the administration of the treaty are defined in the Articles 17 to 30 of the Convention. The Committee is composed of 23 experts nominated by their Governments and elected by the States parties as individuals "of high moral standing and competence in the field covered by the Convention".

At least every four years, the States parties are expected to submit a national report to the Committee, indicating the measures they have adopted to give effect to the provisions of the Convention. During its annual session, the Committee members discuss these reports with the Government representatives and explore with them areas for further action by the specific country. The Committee also makes general recommendations to the States parties on matters concerning the elimination of discrimination against women.

The full text of the Convention is set out in the pages that follow.

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CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN
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The States Parties to the present Convention,

Noting that the Charter of the United Nations reaffirms faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of man and women, Noting that the Universal Declaration of Human Rights affirms the principle of the inadmissibility of discrimination and proclaims that all human beings are born free and equal in dignity and rights and that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, including distinction based on sex, Noting that the States Parties to the International Covenants on Human Rights have the obligation to ensure the equal right of men and women to enjoy all economic, social, cultural, civil and political rights, Considering the international conventions concluded under the auspices of the United Nations and the specialized agencies promoting equality of rights of men and women, Noting also the resolutions, declarations and recommendations adopted by the United Nations and the specialized agencies promoting equality of rights of men and women, Concerned,

however, that despite these various instruments extensive discrimination against women continues to exist, Recalling that discrimination against women violates the principles of equality of rights and respect for human dignity, is an obstacle to the participation of women, on equal terms with men, in the political, social, economic and cultural life of their countries, hampers the growth of the prosperity of society and the family and makes more difficult the full development of the potentialities of women in the service of their countries and of humanity, Concerned that in situations of poverty women have the least access to food, health, education, training and opportunities for employment and other needs, Convinced that the establishment of the new international economic order based on equity and justice will contribute significantly towards the promotion of equality between men and women, Emphasizing that the eradication of apartheid, of all forms of racism, racial discrimination, colonialism, neo-colonialism, aggression, foreign occupation and domination and interference in the internal affairs of States is essential to the full enjoyment of the rights of men and women, Affirming that the strengthening of international peace and security, relaxation of international tension, mutual co-operation among all States irrespective of their social and economic systems, general and complete disarmament, and in particular nuclear disarmament under strict and effective international control, the affirmation of the principles of justice, equality and mutual benefit in relations among countries and the realization of the right of peoples under alien and colonial domination and foreign occupation to self-determination and independence, as well as respect for national sovereignty and territorial integrity, will promote social progress and development and as a consequence will contribute to the attainment of full equality between men and women, Convinced that the full and complete development of a country, the welfare of the world and the cause of peace require the maximum participation of women on equal terms with men in all fields, Bearing in mind the great contribution of women to the welfare of the family and to the development of society, so far not fully recognized, the social significance of maternity and the role of both parents in the family and in the upbringing of children, and aware that the role of women in procreation should not be a basis for discrimination but that the upbringing of children requires a sharing of responsibility between men and women and society as a whole, Aware that a change in the traditional role of men as well as the role of women in society and in the family is needed to achieve full equality between men and women, Determined to implement the principles set forth in the Declaration on the Elimination of Discrimination against Women and, for that purpose, to adopt the measures required for the elimination of such discrimination in all its forms and manifestations, Have agreed on the following:

PART I

Article 1. For the purposes of the present Convention, the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. Article 2. States

Parties condemn discrimination against women in all its forms; agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:

(a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle;

(b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;

(c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;

(d) To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;

(e) To take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise;

(f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;

(g) To repeal all national penal provisions which constitute discrimination against women.

Article 3. States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.

Article 4. 1. Adoption by States Parties of temporary special measures aimed at accelerating de facto equality between men and women shall not be considered discrimination as defined in the present Convention, but shall in no way entail as a consequence the maintenance of unequal or separate standards; these measures shall be discontinued when the objectives of equality of opportunity and treatment have been achieved.

2. Adoption by States Parties of special measures, including those measures contained in the present Convention, aimed at protecting maternity shall not be considered discriminatory.

Article 5. States Parties shall take all appropriate measures:

(a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women;

(b) To ensure that family education includes a proper understanding of maternity as a social function and the recognition of the common responsibility of men and women in the upbringing and development of their children, it being understood that the interest of the children is the primordial consideration in all cases.

Article 6. States Parties shall take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women.

PART II

Article 7. States Parties shall take all appropriate measures to eliminate discrimination against women in the political and public life of the country and, in particular, shall ensure to women, on equal terms with men, the right:

(a) To vote in all elections and public referenda and to be eligible for election to all publicly elected bodies;

(b) To participate in the formulation of government policy and the implementation thereof and to hold public office and perform all public functions at all levels of government;

(c) To participate in non-governmental organizations and associations concerned with the public and political life of the country.

Article 8. States Parties shall take all appropriate measures to ensure to women, on equal terms with men and without any discrimination, the opportunity to represent their Governments at the international level and to participate in the work of international organizations.

Article 9.

1. States Parties shall grant women equal rights with men to acquire, change or retain their nationality. They shall ensure in particular that neither marriage to an alien nor change of nationality by the husband during marriage shall automatically change the nationality of the wife, render her stateless or force upon her the nationality of the husband.

2. States Parties shall grant women equal rights with men with respect to the nationality of their children.

PART III

Article 10. States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women:

a) The same conditions for career and vocational guidance, for access to studies and for the achievement of diplomas in educational establishments of all categories in rural as well as in urban areas; this equality shall be ensured in preschool,

general, technical, professional and higher technical education, as well as in all types of vocational training;

b) Access to the same curricula, the same examinations, teaching staff with qualifications of the same standard and school premises and equipment of the same quality;

c) The elimination of any stereotyped concept of the roles of men and women at all levels and in all forms of education by encouraging coeducation and other types of education which will help to achieve this aim and, in particular, by the revision of textbooks and school programmes and the adaptation of teaching methods;

d) The same opportunities to benefit from scholarships and other study grants;

e) The same opportunities for access to programmes of continuing education including adult and functional literacy programmes, particularly those aimed at reducing, at the earliest possible time, any gap in education existing between men and women;

f) The reduction of female student drop-out rates and the organization of programmes for girls and women who have left school prematurely;

g) The same opportunities to participate actively in sports and physical education;

h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

Article 11. 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:

(a) The right to work as an inalienable right of all human beings;

(b) The right to the same employment opportunities, including the application of the same criteria for selection in matters of employment;

(c) The right to free choice of profession and employment, the right to promotion, job security and all benefits and conditions of service and the right to receive vocational training and retraining, including apprenticeships, advanced vocational training and recurrent training;

(d) The right to equal remuneration, including benefits, and to equal treatment in respect of work of equal value, as well as equality of treatment in the evaluation of the quality of work;

(e) The right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave;

(f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

2. In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:

(a) To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in dismissals on the basis of marital status;

(b) To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;

(c) To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities;

(d) To provide special protection to women during pregnancy in types of work proved to be harmful to them.

3. Protective legislation relating to matters covered in this article shall be reviewed periodically in the light of scientific and technological knowledge and shall be revised, repealed or extended as necessary.

Article 12. 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connexion with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 13. States Parties shall take all appropriate measures to eliminate discrimination against women in other areas of economic and social life in order to ensure, on a basis of equality of men and women, the same rights, in particular:

(a) The right to family benefits;

(b) The right to bank loans, mortgages and other forms of financial credit;

(c) The right to participate in recreational activities, sports and all aspects of cultural life.

Article 14. 1. States Parties shall take into account the particular

problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of this Convention to women in rural areas.

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

(a) To participate in the elaboration and implementation of development planning at all levels;

(b) To have access to adequate health care facilities, including information, counselling and services in family planning;

(c) To benefit directly from social security programmes;

(d) To obtain all types of training and education, formal and non-formal,including that relating to functional literacy, as well as, inter alia, the benefit of all community and extension services, in order to increase their technical proficiency;

(e) To organize self-help groups and co-operatives in order to obtain equal access to economic opportunities through employment or self-employment;

(f) To participate in all community activities;

(g) To have access to agricultural credit and loans, marketing facilities, appropriate technology and equal treatment in land and agrarian reform as well as in land resettlement schemes;

(h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.

PART IV

Article 15.

1. States Parties shall accord to women equality with men before the law.

2. States Parties shall accord to women, in civil matters, a legal capacity identical to that of men and the same opportunities to exercise that capacity. In particular, they shall give women equal rights to conclude contracts and to administer property and shall treat them equally in all stages of procedure in courts and tribunals.

3. States Parties agree that all contracts and all other private instruments of any kind with a legal effect which is directed at restricting the legal capacity of women shall be deemed null and void.

4. States Parties shall accord to men and women the same rights with regard to the law relating to the movement of persons and the freedom to choose their residence and domicile.

Article 16. 1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:

(a) The same right to enter into marriage;

(b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent;

(c) The same rights and responsibilities during marriage and at its dissolution;

(d) The same rights and responsibilities as parents, irrespective of their marital status, in matters relating to their children; in all cases the interests of the children shall be paramount;

(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;

(f) The same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation; in all cases the interests of the children shall be paramount;

(g) The same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation;

(h) The same rights for both spouses in respect of the ownership, acquisition, management, administration, enjoyment and disposition of property, whether free of charge or for a valuable consideration.

2. The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.

PART V

Article 17.

1. For the purpose of considering the progress made in the implementation of the present Convention, there shall be established a Committee on the Elimination of Discrimination against Women (hereinafter referred to as the Committee) consisting, at the time of entry into force of the Convention, of eighteen and, after ratification of or accession to the Convention by the thirty-fifth State Party, of twenty-three experts of high moral standing and competence in the field covered by the Convention. The experts shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical

distribution and to the representation of the different forms of civilization as well as the principal legal systems.

2. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals.

3. The initial election shall be held six months after the date of the entry into force of the present Convention. At least three months before the date of each election the Secretary-General of the United Nations shall address a letter to the States Parties inviting them to submit their nominations within two months. The Secretary-General shall prepare a list in alphabetical order of all persons thus nominated, indicating the States Parties which have nominated them, and shall submit it to the States Parties.

4. Elections of the members of the Committee shall be held at a meeting of States Parties convened by the Secretary-General at United Nations Headquarters. At that meeting, for which two thirds of the States Parties shall constitute a quorum, the persons elected to the Committee shall be those nominees who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

5. The members of the Committee shall be elected for a term of four years.However, the terms of nine of the members elected at the first election shall expire at the end of two years; immediately after the first election the names of these nine members shall be chosen by lot by the Chairman of the Committee.

6. The election of the five additional members of the Committee shall be held in accordance with the provisions of paragraphs 2, 3 and 4 of this article, following the thirty-fifth ratification or accession. The terms of two of the additional members elected on this occasion shall expire at the end of two years, the names of these two members having been chosen by lot by the Chairman of the Committee.

7. For the filling of casual vacancies, the State Party whose expert has ceased to function as a member of the Committee shall appoint another expert from among its nationals, subject to the approval of the Committee.

8. The members of the Committee shall, with the approval of the General Assembly, receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide, having regard to the importance of the Committee's responsibilities.

9. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention.

Article 18. 1. States Parties undertake to submit to the Secretary-General of the United Nations, for consideration by the Committee, a report on the legislative, judicial, administrative or other measures which they have adopted to give effect to he provisions of the present Convention and on the progress made in this respect:

(a) Within one year after the entry into force for the State concerned;
and

(b) Thereafter at least every four years and further whenever the Committee so requests.

2. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Convention.

Article 19. 1. The Committee shall adopt its own rules of procedure.

2. The Committee shall elect its officers for a term of two years.

Article 20. 1. The Committee shall normally meet for a period of not more than two weeks annually in order to consider the reports submitted in accordance with article 18 of the present Convention.

2. The meetings of the Committee shall normally be held at United Nations Headquarters or at any other convenient place as determined by the Committee.

Article 21. 1. The Committee shall, through the Economic and Social Council, report annually to the General Assembly of the United Nations on its activities and may make suggestions and general recommendations based on the examination of reports and information received from the States Parties. Such suggestions and general recommendations shall be included in the report of the Committee together with comments, if any, from States Parties.

2. The Secretary-General shall transmit the reports of the Committee to the Commission on the Status of Women for its information.

Article 22. The specialized agencies shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their activities. The Committee may invite the specialized agencies to submit reports on the implementation of the Convention in areas falling within the scope of their activities.

PART VI

Article 23. Nothing in this Convention shall affect any provisions that are more conducive to the achievement of equality between men and women which may be contained:

(a) In the legislation of a State Party; or

(b) In any other international convention, treaty or agreement in force for that State.

Article 24. States Parties undertake to adopt all necessary measures at the national level aimed at achieving the full realization of the rights recognized in the present Convention.

Article 25. 1. The present Convention shall be open for signature by all States.

2. The Secretary-General of the United Nations is designated as the depositary of the present Convention.

3. The present Convention is subject to ratification. Instruments of ratification shall be deposited with the Secretary-General of the United Nations.

4. The present Convention shall be open to accession by all States. Accession shall be effected by the deposit of an instrument of accession with the Secretary-General of the United Nations.

Article 26. 1. A request for the revision of the present Convention may be made at any time by any State Party by means of a notification in writing addressed to the Secretary-General of the United Nations.

2. The General Assembly of the United Nations shall decide upon the steps, if any, to be taken in respect of such a request.

Article 27. 1. The present Convention shall enter into force on the thirtieth day after the date of deposit with the Secretary-General of the United Nations of the twentieth instrument of ratification or accession.

2. For each State ratifying the present Convention or acceding to it after the deposit of the twentieth instrument of ratification or accession, the Convention shall enter into force on the thirtieth day after the date of the deposit of its own instrument of ratification or accession.

Article 28. 1. The Secretary-General of the United Nations shall receive and circulate to all States the text of reservations made by States at the time of ratification or accession.

2. A reservation incompatible with the object and purpose of the present Convention shall not be permitted.

3. Reservations may be withdrawn at any time by notification to this effect addressed to the Secretary-General of the United Nations, who shall then inform all States thereof. Such notification shall take effect on the date on which it is received.

Article 29. 1. Any dispute between two or more States Parties concerning the interpretation or application of the present Convention which is not settled by negotiation shall, at the request of one of them, be submitted to arbitration. If within six months from the date of the request for arbitration the parties are unable to agree on the organization of the arbitration, any one of those parties may refer the dispute to the International Court of Justice by request in conformity with the Statute of the Court.

2. Each State Party may at the time of signature or ratification of this Convention or accession thereto declare that it does not consider itself

bound by paragraph 1 of this article. The other States Parties shall not be bound by that paragraph with respect to any State Party which has made such a reservation.

3. Any State Party which has made a reservation in accordance with paragraph 2 of this article may at any time withdraw that reservation by notification to the Secretary-General of the United Nations.

Article 30. The present Convention, the Arabic, Chinese, English, French,Russian and Spanish texts of which are equally authentic, shall be deposited with the Secretary-General of the United Nations.

IN WITNESS WHEREOF the undersigned, duly authorized, have signed the present Convention.

TARSHI. (2001). ***Common Ground: Sexuality. Principles for Working on Sexuality.*** New Delhi: TARSHI and SIECUS, pp. 7-8.

SEXUAL RIGHTS

COMMON GROUND *Sexuality*

"Sexual rights are a fundamental element of human rights. They encompass the right to experience a pleasurable sexuality, which is essential in and of itself, and, at the same time, is a fundamental vehicle of communication and love between people. Sexual rights include the right to liberty and autonomy in the responsible exercise of sexuality."

– HERA Statement

Because sexuality is a basic part of being human, the notion of sexual rights is part of the larger body of human rights. Human rights affirm the dignity, worth, respect, equality, and autonomy of all people in all aspects of their lives. Sexual rights are necessary in order for women and men to express and enjoy their sexuality, and promote overall health through access to information, education and services regarding their sexual health.

Human rights affirm the dignity, worth, respect, equality, and autonomy of all people in all aspects of their lives. Sexual rights are necessary in order for women and men to express and enjoy their sexuality...

Therefore,

- Sexual rights are not privileges or favours, but are entitlements of all women and men.
- Sexual rights protect the individual as well as the collective.
- The concept of sexual rights, like that of human rights, provides a framework to ensure non-discrimination, and therefore cannot be used to privilege any one individual or group over another.
- Sexual rights are as valid as other rights such as the right to food, health and housing.
- Sexual rights affirm entitlements, such as the right to bodily integrity, as well as rights that protect against violations, such as the right not to be coerced into sexual activity.

- Sexual rights are based on certain ethical principles (Correa and Petchesky). These are the principles of:

- **Bodily Integrity** – the right to security in and control over one's body. This means that all women and men have a right to not only be protected from harm to the body but also to enjoy the full potential of the body.

- **Personhood** – the right to self-determination. This means that all women and men have a right to make decisions for themselves.

- **Equality** – all people are equal and should be recognized as such without discrimination based on age, caste, class, ethnicity, gender, physical ability, religious or other beliefs, sexual preference, or other such factors.

- **Diversity** – respect for difference. Diversity in terms of people's sexuality and other aspects of their lives should not be a basis for discrimination. The principle of diversity should not be misused to violate any of the previous three ethical principles.

Sexual Rights Include:

- The right to sexual pleasure without fear of infection, disease, unwanted pregnancy, or harm.
- The right to sexual expression and to make sexual decisions that are consistent with one's personal, ethical and social values.
- The right to sexual and reproductive health care, information, education, and services.
- The right to bodily integrity and the right to choose if, when, how and with whom to be sexually active and engage in sexual relations with full consent.
- The right to enter relationships, including marriage, with full and free consent and without coercion.
- The right to privacy and confidentiality in seeking sexual and reproductive health care services.
- The right to express one's sexuality without discrimination, and independent of reproduction.

Sami, L. (2001, July-October). ***A Summary of the National Population Policy and the State Population Policies of Uttar Pradesh, Madhya PRadesh, Rajasthan, Maharashtra and Andhra Pradesh***. Medico Friend Circle Bulletin, Special Issue on Population, 286-288-89, pp. 2-6.

A Summary of the National Population Policy and the State Population Policies of Uttar Pradesh, Madhya Pradesh, Rajasthan, Maharashtra, and Andhra Pradesh

Leela Sami

This paper seeks to summarize the population policies of five Indian states; namely, Uttar Pradesh, Madhya Pradesh, Rajasthan, Maharashtra and Andhra Pradesh. In the year 2000, the Government of India released the National Population Policy (NPP) document which made an explicit commitment to" voluntary and informed choice and consent of citizens while availing of Reproductive and Child Health (RCH) services and continuation of the target free approach in administering family planning services."

The NPP also acknowledges a "need to simultaneously address issues of child survival, maternal health and contraception, while increasing outreach and coverage of a comprehensive package of RCH services by government, industry and voluntary NGO sectors working in partnership."

The NPP lists its objectives in terms of three time frames: its immediate objective is to address unmet needs for contraception, healthcare infrastructure and health personnel and to provide integrated service delivery for basic reproductive and child health. The medium term objective is to bring the TFR back to replacement level by 2010, through vigorous implementation of intersectoral operational strategies. The long- term objective is to achieve a stable population by 2045,at a level consistent with the requirements of sustainable economic growth, social development and environmental protection.

In pursuance of these objectives, the NPP lists fourteen sociodemographic goals to be achieved at an all- India level by 2010. These include addressing the unmet need for basic RCH services, supplies and infrastructure, increasing access to schooling, reduction in Infant Mortality Rates (IMR) and Maternal Mortality Ratio (MMR), universalisation of immunization, delayed marriage for girls, universalising delivery by trained personnel and increasing the number of institutional deliveries, achieving a delayed average age at marriage for girls, increased access to information and counselling, universal registration of vital events, control of communicable diseases, convergence of RCH programmes and Indian Systems of Medicine and Homeopathy(ISMH), and convergence of different social sector programmes.

The NPP stresses the need for decentralised planning, the empowerment of women for population stabilisation, child health and survival, collaboration with the voluntary and NGO sector, and encouragement of research in contraceptive technology.

In order to promote the policy, it lists a number of measures. These include rewarding of Panchayats and Zilla Parishads for exemplary performance in Family Welfare and maternity benefits for mothers who give birth to their first child after the age of nineteen. Also, a family welfare-linked social insurance is to be given to couples below the Poverty Line with two or less children who undergo sterilisation. The government proposes to reward couples who marry after the legal age at marriage, register their marriage, have their first child after the age of 21 years, accept the small family norm and adopt a terminal method after the birth of their second child. It is also proposed to have a revolving fund for income generating activities by village level self help groups who provide community health care services, the establishment of crèches and child care centres in rural areas and the urban slums, a wide choice of contraceptives, facilities for safe and legal abortion, and vocational training for girls.

One of the central features of the policy is a commitment to a target- free approach and a refusal to use disincentives or coercion in order to achieve the demographic goals set by the state. The NPP also stresses the need for involvement of local bodies at the lowest level- i.e. the Panchayati Raj Institutions (PRI's)-in the achievement of the goals that make for population stabilization. It suggests the devolution not only of rights, responsibilities and powers to the PRI's but also of funds and resource generation. This latter is extremely critical in order for decision making to be truly decentralised. In doing so, the NPP extends the scope of population policy to a broader notion of democracy and welfare.

With the NPP as the background, we move on to examine the state level policies.

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1.Uttar Pradesh:

The population policy of Uttar Pradesh links the growth of population to pressure on natural resources, and declares the inability of the state and its government to improve the quality of life of the people, in the face of this pressure of population growth. It mentions the need to address issues of gender and child development in the attempt to stabilise population growth.

In terms of its specific objectives, the following are mentioned:

The need to reduce TFR from 4.3 in 1997 to 2.6 in 2011 - 2016.

Proportionate increases in use of contraceptive methods by increasing demand for the same.

Increase in average age of the mother at the birth of her first child.

Reduction in unmet need for both spacing and terminal methods.

Reduction in MMR from 707/ 1000,000 live births in 1997 to 394 in 2010 to below 250 in 2016.

Reduction in infant mortality from 85/1000 live births in 1997 to 73 in 2010 and 67 in 2016.

Reduction in incidence of sexually transmitted diseases (STI's) and reproductive tract infections (RTI's).

Increase awareness of AIDS.

The strategies to be adopted to improve RCH include raising the average age of effective marriage, introducing and focusing on adult education, empowerment of women and enhancing the involvement both of the private and voluntary/ NGO sector and the role of PRI's.

The policy lists a number of incentives and disincentives to achieve its objectives, which include some of the following:

Disqualification of persons who marry before the legal age at marriage from eligibility for government jobs.

"Performance- based " disbursement of 10 per cent of the total financial resources for PRI's. Panchayats which "perform" well in the provision of RCH services will be rewarded. While the total transfer of funds will amount to only four per cent of state revenue, the PRI's are to be entirely responsible for advocacy, identification of contraceptive needs and recording of vital events.

The performance of medical officers and health workers is to be based on their performance in the RCH programme. While ostensibly, this would mean more efficient RCH services, it would perhaps place extreme pressure on health workers to reach targets with regard to limiting of family size. Also, linking performance appraisal of individuals to performance in RCH would probably result in lopsided health services provision, leading to an overemphasis on family planning and a neglect of other aspects of primary health care such as control of communicable diseases.

The document also calls for "an active dialogue with the GOI for wider availability of injectables and other new technologies through private, commercial and government channels in the state". The state thus intends to actively push the introduction of these newer technologies.

Finally, the explicit commitment to charging user fees ostensibly to improve the quality of services will place a further burden on the poor to pay for the entire gamut of health services. The decision of the government to disallow those who marry before the legal age and who have more than two children from government service will adversely affect women who may have no say in their age at marriage. In this case, even the implementation of 33% reservation for women in elected bodies and employment will not necessarily result in greater gender equity, except in a narrow sense for some sections of women.

2. Madhya Pradesh

The population policy of Madhya Pradesh stresses the need to curb high fertility and mortality, which impinge upon the quality of life and the balance between population, resources and the environment. The policy document mentions the process of democratic decentralisation underway in the state and speaks of the need to change the thrust of family welfare from female sterilization to include raising the age at marriage for women, provision of RCH services, universalization of education and empowerment of women.

The specific objectives of the MP policy include:

Reducing total fertility rates from 4 in 1997 to 2.1 in 2011.

Increasing contraceptive usage and sterilisation services.

Increasing the age of the mother at the birth of her first child from 16 years in 1997 to 20 years in 2011.

Reduction in MMR from 498 to 220 between 1997 and 2011 through greater registration of pregnant women, increases in proportions of

institutional and trained deliveries and pregnancy testing centres.

Reduction in IMR through increases in immunization, use of Oral Rehydration Solution (ORS) therapies for diahorrea in rural areas, reduction in incidence of Acute Respiratory Infections (ARI's), coverage of pregnant women and children with Vitamin A, Iron and Folic Acid (IFA) tablets.

Increases in levels of HIV testing.

Services for infertile couples.

Universalizing access to primary education by 2005; with a goal of ensuring that 30% of girls in the age group of 14-15 years in 2005 would complete elementary education.

The strategies advocated by the policy document include the need to involve PRI's, and to empower women in the endeavour to reach population stabilisation. A number of initiatives are suggested such as

making men realize their responsibility to empower women.

strengthening local women's groups.

reducing the burden of housework and drudgery on women by providing cooking gas connections and electricity to rural households.

Reservation of 30% of government jobs for women.

However the MP policy also has a number of disincentives. These include

Debarring of persons who marry before the legal age for marriage from seeking government employment.

Persons who have more than two children will be debarred from contesting Panchayat elections.

The provision of rural development schemes in villages will depend upon the level of family planning performance by Panchayats. The flow of resources to PRI's is also to be linked to performance in RCH. While there is no specific commitment to increasing devolution and control of resources to PRI's, these institutions are to be made responsible for the implementation of the RCH programme.

Performance by Panchayats in family planning is also to be linked to the starting of income generating schemes for women and poverty alleviation programmes.

3. Rajasthan

The population policy of Rajasthan, like those of Madhya Pradesh and Uttar Pradesh, also links deceleration in the population growth rate to sustainable development. It mentions the need to reduce infant mortality, gender discrimination and undernutrition, and to increase household security.

With regard to its specific objectives, it mentions

The need to increase the median age at marriage for girls from 15 in 1993 to 19 by 2010 through education and increasing awareness.

Increase institutional deliveries from 8% in 1995 to 35% by 2016 and assistance by trained persons in child delivery from 35% in 1995 to 75% in 2010.

Educate all women in the reproductive age groups about antenatal services and on establishing linkages between female health workers, anganwadi workers and trained dais at the village level.

Improved child health is to be achieved through assuring better quality ARI care, strengthening links between ICDS and health workers, and coverage of all children for immunization and Vitamin A dosage.

With regard to operational strategies, it mentions the need to encourage men to use low-cost sterilization services, and recognizes that quality of the sterilization and spacing methods need to be improved. While the thrust of the policy is on provision of RCH services, improvement of management of service delivery systems, encouraging involvement of PRI's, NGO's the private sector,and co-operatives , and on information, education and communication (IEC).

There are, however, a number of incentives and disincentives mentioned, which include the debarring of persons with two or more children from contesting elections. It is also mentioned that "the same provisions can be considered for other elected bodies like co-operative institutions and as a service condition for state government employees." The policy also states that "the legal provisions barring people with more than two children from election to panchayats and municipal bodies is a testimony of the firm political will and commitment to population control."

The policy is cautious on the question of introducing new reproductive technologies, although the policy draft mentions that " new contraceptive methods, as and when approved by the GOI will be introduced to make new technology accessible." Finally, it mentions the need to address issues of infertility, RTI's and female literacy.

4. Maharashtra

The population policy of Maharashtra begins with a statement of the need to bring down the rate of population growth. Its specific objectives include:

Reducing TFR to 2.1 by 2004.

Reducing CBR to 18 by 2004.

Reducing IMR to 25 by 2004.

Reducing neonatal mortality to 2 by 2004.

The policy extract lists a number of measures in order to achieve these objectives. These include:

The provision of subsidies and perquisites to government employees is to be linked to acceptance of the small family norm or permanent methods of family planning by couples.

Service in government jobs is also to be dependent on the acceptance of the small family norm.

Provision of village health schemes will also be linked to the performance of panchayats in the RCH programme.

Assessment of medical officers will depend upon their level of performance in the RCH programme.

Persons having two or more children will be debarred from contesting panchayat elections.

Other schemes include cash incentives to couples undergoing sterilization after the birth of one or more daughters, training of dais, and strict enforcement of the Child Marriage Restraint Act, the ban on prenatal sex determination testing, etc. Also, women's self- help groups are to be set up at the village level.

Funding of PRI's will depend upon performance in the RCH programme.

The policy makes no provision for the representation of women in elected or other bodies. It also does not mention the devolution of resources or decision- making powers to PRI's.

5. Andhra Pradesh

The Andhra Pradesh population policy links population stabilization to improvements in standards of living and quality of life of the people. It states that "production of food may not keep pace with growing population....pressure on land and other facilities will increase further, resulting in social tension and violence... housing in both rural and urban areas will become a serious problem...there will be an increase in unemployment....there will be serious pressure on the country's natural resources causing deforestation, desertification and more natural calamities."

The demographic goals as stated in the policy include:

Reduction of natural growth rate from 1.44 in 1996 to 0.80 in 2010 and 0.70 by 2020.

Reduction in CBR from 22.7 in 1996 to 15.0 by 2010 and 13.0 by 2020.

Reduction in CDR from 8.3 in 1996 to 7.0 in 2010 and 6.0 in 2020.

Reduction in IMR from 66.0 in1996 to 30.0 in 2010 and 15.0 in 2020.

Reduction in MMR from 3.8 in 1996 to 1.2 in 2010 and 0.5 in 2020.

Reduction in TFR from 2.7 in 1996 to 1.5 in 2020

Increase in Couple Protection Rate from 48.8 % in 1996 to 70 % in 2010 and 75 % in 2020.

These objectives are to be attained by:

(a) The promotion of spacing, terminal and male contraceptive methods.

(b) Increasing the coverage of pregnant women for TT inoculation and provision of IFA tablets.

(c) Increasing the number of trained and institutional deliveries.

(d) Strengthening of referral systems and equity in accessibility of services.

(e) Eradicating polio, measles and neonatal tetanus by 1998.

(f) Reducing diahorreal deaths, deaths due to ARI's and incidence of low birth weight babies.

(g) Increasing female literacy levels, increasing the median age at marriage for girls and reduction in severe and moderate malnutrition among children.

(h) Reduction in the incidence of child labour.

The policy lists a number of operational strategies relating to promotion of terminal and spacing methods, ensuring safe deliveries as well as safe abortions, prevention and management of RTI's and STD's, increasing the average age at marriage of girls, and increasing female literacy and child survival. It also mentions a role for NGO's and the private sector in social marketing of contraceptives and delivery of health care.

The document explicitly lists a number of incentives

to be used in the achievement of its objectives. These include the following:

1) At the community level, performance in RCH and rates of couple protection will determine the construction of school buildings, public works and funding for rural development programmes.

2) Performance in RCH is also to be made the criterion for full coverage under programmes like TRYSEM, Weaker Section Housing Scheme, and Low Cost Sanitation Scheme.

3) Funding for programmes under the DWCRA and other social groups will be dependent on RCH performance.

4) At the individual level, cash prizes will be awarded to couples adopting terminal methods of family planning.

5) Allotment of surplus agricultural land, housing sites, as well as benefits under IRDP, SC Action Plan, BC Action Plan to be given in preference to acceptors of terminal methods of contraception.

6) Special health insurance schemes for acceptors of terminal methods of family planning.

7) Educational concessions, subsidies and promotions as well as government jobs to be restricted to those who accept the small family norm.

8) Cash awards on the basis of performance to service providers.

9) An award of Rs. 10,000 each to 3 couples to be selected from every district on the basis of lucky dip, from the following categories: (a) 3 couples per district with two girl children adopting permanent methods of family planning (b) 3 couples per district with one child adopting permanent methods (c)3 couples per district with two or less children adopting vasectomy.

The policy document mentions the need for involvement of people's representatives, religious leaders, professional social bodies, professionals, chambers of industry and commerce, youth, women and film actors and actresses. While it underscores the need for delegation of rights to PRI's, there are no provisions for delegation or devolution of resources to the panchayats.

To summarize, the National Population Policy lays the groundwork for a policy of population stabilization based on the premise that the provision of health, safety, security and protection of vulnerable groups is a precondition for population stability. It also affirms the need for a policy based on the ethics of informed choice and consent. In doing so, it eschews any measure that would be ethically hazardous or coercive. However, the state policies all suggest some measure of disincentives in order to achieve their targets.

(cont.d from page 14)

development processes have a direct impact on poverty and community health, giving rise to a host of unmet needs. We would, for example, posit that toilet facilities, systematic garbage remove facilities should intrinsically be part of the population policy. Because the lack of these creates the conditions for worsening health conditions.

7. Given the fact that Gujarat has had an abysmal record with regard to girl child infant mortality rates between girls and boys in the age group 0-4. Special care needs to be expended on programmes that will plug the shocking gap between the deaths of boy child and the girl child. This will include social awareness programmers as part of the population policy. It is important to realize that these social awareness programmers should aim at discussions with men as well as women.

Rao, M. (2001, July-October). ***Anti-people State Population Policies.*** Medico Friend Circle Bulletin, Special Issue on Population, 286-288-89, pp. 7-8.

Anti-People State Population Policies

Mohan Rao

In February last year, the Government of India adopted the National Population Policy 2000. *This policy is weak on many counts: population is not integrated with health, it has population stabilization rather than the health and well being of the population as a goal and so on. Yet one aspect on which the policy is to be hailed is that it resolutely affirms the "commitment of the government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services". It is thus surprising that several state governments have announced population policies, which, in very significant manners, violate the letter and the spirit of the National Population Policy. Equally distressing is that several private members bills are pending in Parliament that seek to reinforce a punitive and anti-democratic approach to issues of population.*

Before considering why these measures are anti-democratic, it might be pertinent to recall some of the measures proposed by the states. The Uttar Pradesh policy, for instance, disqualifies persons married before the legal age of marriage from government jobs, as if children are responsible for child marriages. Further, 10 per cent of financial a``ssistance to Panchayats is to be based on family planning performance. Indeed, frightfully recalling the Emergency, the assessment of the performance of medical officers and other health workers is linked to performance in the Reproductive and Child Health (RCH) programme, the new avatar of the family welfare programme. The policy also recommends User Fees for government health services when it is widely accepted that these are inaccesible to the poor. And in a daring departure from other states, the policy recommends the induction of contraceptives such as injectables and implants which are both unsafe and dangerous to the health of women.

Madhya Pradesh, besides debarring persons married before the legal age at marriage from government jobs, also forbids them from contesting Panchyat elections. As in the case of U.P., disbursement of resources to PRIs is linked to family planning performance. In a piquant twist, the provision of rural development schemes, income generating schemes for women, and indeed poverty alleviation programmes as a whole, are all linked to performance in family planning. Rajasthan, besides debarring persons with more than two children from Panchayat elections, also bars them from other elected bodies like cooperative institutions. It makes adherence to a "two-child norm" a service condition for state government employees.

In addition to many of the above, the Maharashtra government in an Order announced the two-child norm as an eligibility criterion for a range of schemes for the weaker sections, including access to the public distribution system and education in government schools. The Andhra Pradesh government's fervour is exhibited by the fact that performance in RCH and the Couple Protection Rate will determine construction of school buildings, public works, and funding for rural development. Performance in RCH is also a criterion for coverage under programmes like TRYSEM, Weaker Section Housing Scheme, Low Cost Sanitation Scheme and DWCRA. Allotment of surplus agricultural land, housing sites, benefits under IRDP, S.C. Action Plan and B.C. Action Plan are to be given in preference to acceptors of family planning. Further, educational concessions, subsidies, promotions and government jobs are to be restricted to those accepting the small family norm. In a macabre metaphor of the lottery that is the life of the poor in the country, awards of Rs.10,000/- each are to be given to three couples per district chosen by lottery. Eligible couples comprise those with two girl children with the mother sterilised, those with one girl child with the mother sterilised and couples two children or less with the father sterilised.

Newspaper reports indicate that Gujarat, that crucible of Hindutva politics, has unveiled a population policy that, besides carrying a range of disincentives, also explicitly makes a two-child norm mandatory for all communities.

These state policies are thus in complete disjunction with the National policy and indeed with commitments made by the Government of India at the International Conference on Population and Development in Cairo. Policy makers so anxious to control numbers need to be reminded that such policies are unnecessary as a significant demographic transition is underway in large parts of the country. Areas where this transition has lagged behind need assistance towards strengthening their health and anti-poverty programmes and not measures that punish the poor. As the NPP itself points out, there is a large unmet need for health and family planning services. In such a situation, without meeting this unmet need, to propose punitive measures is both irrational and absurd.

The disincentives proposed are particularly anti-poor, anti-dalit and anti-adivasis, with these weaker sections having to bear the brunt of the withdrawal of a range of subsidies and measures to mitigate poverty and deprivation. The National Family Health Survey for 1998-99 shows that the Total Fertility Rate (TFR) is 3.15 for S.Cs, 3.06 for S.Ts, 2.66 among O.B.Cs and 3.47 among illiterate women as a whole. In contrast, it is 1.99 among women educated beyond Class X. Significant sections among these already deprived populations will thus bear the brunt of these policies of disincentives. In addition to privatisation that de facto deprives S.Cs and S.T.s of jobs in the organised sector, these explicit policy measures will further curtail the meager employment opportunities available to them. Indeed this measure is pregnant with pro-natalist possibilities.

The disincentives are also anti-women since women in India seldom decide the number of children they wish to bear, when to bear them and indeed have no control over how many will survive. By debarring such women from contesting elections makes a mockery of policies to empower women. Further, they will provide an impetus to some women to resort to sex selective abortions and female feticide, worsening an already terrible sex ratio in the country.

The proposals are also anti-minorities since they ignore the fact that the somewhat higher TFR among some sections of these communities are a reflection of their poorer socio-economic situation. It need hardly be stated that just as the Hindu rate of economic growth is a chimera, so is a Muslim rate of population growth.

Finally, the proposals are deeply anti-democratic and violate several provisions of the Constitution (the right to livelihood, the right to life, the right to privacy, among others) and several International Covenants that India is signatory to, including the Rights of the Child.

The fact that structural adjustment policies have led to the collapse of a weak and underfunded public health care system, and that these same policies have also led to an increase of infant mortality rates in ten of the fifteen major states of the country, do not seem to concern our policy makers. So single-minded are they in their short-sighted policies that they do not realise the appalling fact that it is the fearsome pursuit of family planning programmes that has led to the distrust of the health system among the poor. The fact too is that it was these same people who brought down a government for the "excesses" of family planning not too long back. Is the fear of the poor so strong among our legislators and policy makers that their memories are so short?

-23

Khanna, R. (2001, July-October). ***Women's Perspective on Population Policies; Feminist Critique o Population Policies; Population Policy Statement for Gujarat.*** Medico Friend Circle Bulletin, Speci Issue on Population, 286-288-89, pp. 15-20.

Women's Perspective on Population Policies; Feminist Critique of Population Policies; Population Policy Statement for Gujarat

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Feminists believe that population policies are designed to control the bodies, the fertility and the lives of women, because it is women who bear children. Population policies have in-built racist and eugenic ideologies. These ideologies operate through the process of selection of the ones who have the right to survive while dismissing the minorities, the disabled and indigenous people. They have the goal of eliminating the poor instead of poverty. Population policies represent the interests of the privileged elite and a lifestyle of over-consumption in the countries of the North as well as the elite of the Third World.

Population policies and programmes of most countries and international agencies have been driven more by demographic goals than by quality of life goals. Population size and growth have often been blamed inappropriately as the exclusive or primary causes of problems such as global environmental degradation and poverty. Fertility control programmes have prevailed as solutions when poverty and inequity are root causes that need to be addressed. Population policies and programmes have typically targeted low-income countries and groups, often reflecting racial and class biases.

Women's fertility has been the primary object of both pro-natalist and anti-natalist population policies. Women's behaviour rather than men's has been the focus of attention. Women have been expected to carry most of the responsibility and risks of birth control, but have been largely excluded from decision-making in personal relationships as well as in public policy. Sexuality and gender-based power inequities have been largely ignored, and sometimes even strengthened, by population and family planning programmes.

Population control programmes of the 1960s and 70s, devised supposedly for 'poverty eradication' subjected women in the South to a whole range of coercive technologies and methods which have often ruined their health and their lives. By presenting population policies as an expansion of 'reproductive choice' these policies try and cloak the population control agenda in the language of the women's liberation movements. Feminists have also rejected the tendency of the media to blame "population explosion" for the economic and political crises in the Third World. These media images, feminists state, maintain the domination of the privileged elite over the marginalised and under-privileged sections of society.

The economic reforms introduced through the World Bank's and the International Monetary Fund's Structural Adjustment Programmes are reducing the health and food subsidies for the poor in the Third World. The public health and welfare infrastructure are being systematically dismantled and privatized. The reduced health delivery services are being technologized and the poor in general, and poor women in particular, are the main victims of this global policy everywhere. The globalisation of the world market economy is threatening the food security of the poor.

The growth oriented development model is leading to severe environmental degradation in most parts of the world, which is in turn undermining peoples' security and livelihoods. Feminists reject the notion that 'overpopulation' has a causal connection with environmental degradation. The North with 20 per cent of the world's people, consumes 80 per cent of the total resources. One of the key factors causing environmental destruction is the excessive use of energy in production and consumption, energy from non-sustainable resources such as petrochemical, coal and nuclear energies, extraction of which itself destroys the environment.

The growth oriented development model has increased the number of poor, environmental and political migrants and refugees. The phobia of over-population has not only distracted policies from the actual causes of migration but has further victimized the victims. It is estimated that 65 per cent migrants and 90 per cent of refugees are women and children. The northern countries in response to migration issues are making stricter laws to close their borders, while in the new free market economy, the resources and capital are flowing freely from the South to the North, dragging migrant and low-wage workers with them. Double standards are practised when it comes to the movement of the world's citizens

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between those who are welcome and can afford to move freely and those who are shunned or exploited for their labour. Goods can move without restriction whereas migration remains constrained.

Increasingly, reproductive technologies that are invented that are controlled by the providers, that is, the physicians, the drug companies and the state. Contraceptives like the diaphragm, more under the control of women, are not easily available. Provider-controlled technologies effectively undermine women's control over their lives while burdening them with full responsibility for fertility and absolving men of their responsibility.

In the North, reproductive technologies serve a pro-natalist rather than an anti-natalist goal. In Japan, Canada and elsewhere where the fertility rate has fallen, the government and media are stating that the 'population' is endangered by this fall. This campaign along with the notion that motherhood must be central to women's lives places pressure on women to have children.

Insufficient research is directed towards indigenous people's traditional family planning and health practices. These are discarded in favour of modern technology and practices.

Feminists of the South state that women's basic needs of food, education, health, work, social and political participation, a life free of violence and oppression should be addressed on their own merit. Meeting women's needs should be not be linked with fertility goals and norms. Women should have access to safe contraception, legal and safe abortion and a wide range of necessary health services of good quality.

Population Policy Statement for Gujarat

The State Health and Family Welfare Department and UNFPA jointly organised a consultative workshop for the State Population Policy Development on May 1, 2000. This state level workshop was attended by representatives from Government departments, NGOs and institutions working in the field of development. The main objective of this consultative workshop was to bring together experts from various fields to deliberate upon issues related to population and development and to suggest major points for drafting the State Population Policy. Discussion took place on five issues identified by the working group at the state level:
Reproductive and Child Health (RCH); Gender and development; Decentralisation; Public-private partnerships and inter-sectoral co-ordination and resource mobilisation, alternative financing, incentives and disincentives. A host of recommendations emerged, many of which have been included in the statement. The state-level consultation helped to widen the debate and generate creative ideas for the contents of the policy. But the absence of representatives from the departments of education and rural development at the meeting must be criticised, especially as issues of population and development require inter-sectoral approaches.

Population Policy Statement for Gujarat

Under the directive of Chief Minister of Gujarat, the state government has setup a Social Infrastructure Development Board for achieving overall development in the state. Population stabilization by 2008 is a priority of the Board. Towards this end, a population policy is under development.

Goal

In accordance with India's National Population Policy, Gujarat's population policy will also focus on improving the quality of life of the people, reducing gender discrimination, empowering women, and ensuring extension service support to achieve replacement level fertility 2.1 by 2008. Respecting the reproductive rights of men and women will be an underlying principle of Gujarat's Population Policy.

Objective

Achievement of this goal calls for 100% access to quality and affordable reproductive health services, including family planning and sexual health services, and significant reduction in infants and maternal mortality. Women's education will remain an important objective not only because it is strongly associated with lower infant mortality and lower fertility, but also for its own sake. Universal access to primary education particularly, for girls, and closing of the "gender gap" in education will receive priority. Specific measures will be undertaken to achieve gender equity and equality, and to empower women. The latter requires strong support from men, and their participation in women's empowerment. Women's health and women's education will be encouraged.

Specific Objectives

The immediate objective of the State Population Policy is to provide integrated reproductive health services,

including addressing the unmet need for contraception. The state will strengthen health care infrastructure and support systems to improve access to these services. The long term objective is to reduce the Total Fertility Rate from its current level of 3.2 to replacement level, i.e. to 2.1, by the year 2008. In achieving these objectives, an inter-sectoral approach will be adopted Specific objectives include the following

§ Increase contraceptive prevalence to 70.
§ Reduce Infant Mortality Rate to 16 per 1000 live births.
§ Reduce maternal mortality rate to 100 per 100000 live births.

To achieve these objectives in the context of sustainable economic growth, social development and environmental protection need to be pursued in strategic ways. These are discussed below.

PARADIGM SHIFT IN REPRODUCTIVE AND CHILD HEALTH SERVICES

Reproductive and Child Health (RCH) services will be strengthened to meet the needs of women, men, adolescents and children. To address the needs of a variety of clients, the range and quality of RCH services will be improved. The focus will be on delaying child bearing among newly married couples, making spacing methods available to those couples who want to space births, improving access to permanent contraception, providing services for emergency contraception, providing safe abortion services, and managing reproductive tract infections and sexually transmitted diseases. Counseling for family planning and other reproductive health services will also be provided, including to adolescents. In addition, efforts will be made to increase the participation of men in family planning, encourage responsible sexual and reproductive health behaviors among men, and promote responsible fatherhood. Looking to inter-regional variation in service utilization and other sections needing special attention.

Setting quality indicators and providing rewards for PHCs that effectively provide quality services to clients will strengthen the quality of services. Incentives will be given to health service personnel for increasing quality and availability of services. Great autonomy will be provided to health service institutions, and accountability to communities encouraged. Staff development programmes will be introduced to strengthen capacity. This will include clinical and management training. Cash incentives will no longer be provided for family planning acceptors.

Promote Gender Equality, Women's Empowerment, and Male Participation

The active participation of men is vital for safeguarding the reproductive health of women. To encourage men to share the burden of contraception, vasectomies will be repopularized, in particular non-scalpel vasectomy. Information and education campaigns will also address men, to enhance their understanding of reproductive health concerns and the need for supportive action.

Gender perspectives will be institutionalized in education and training programs, and communication, education and training materials will be screened from a gender perspective. Women and girls will be protected against violence. Laws against sex determination will be vigorously enforced. Efforts will be made to increase age at marriage for girls, and ensure compulsory registration of marriages. The government will take a proactive role in promoting gender equality, and particularly in universalizing primary education for girls.

De-Centralization; Structural Changes and Administrative Reforms along with Financial Reforms

Panchayati Raj institutions are important means of furthering decentralized planning and programme implementation. The 73rd and 74th constitutional amendments act of 1992 has made he4alth, family welfare and education a responsibility of village panchayats. Gujarat has a Panchayati Raj system in operation since 1963. In order to strengthen the potential of this system, appropriate support will be given to panchayats to carry out community need assessments, resource planning and resource mobilization.

Promote Partnership and Inter-sectoral Coordination between GO, NGOs, Corporate, Co-operatives and Private Sector

Partnerships will be promoted between government, non-governmental organizations, the corporate and private sectors, and co-operatives. Intersectoral coordination within government will also be enhanced. These efforts will promote synergy, minimize duplication, and facilitate utilization of resources.

Resources Mobilization, Alternative Financing, Insurance, Userships, Incentives and Disincentives

Further optimizing the use of resources, the operational efficiency of the system will be improved through research and development initiatives. The government will make efforts to mobilize resources from various sectors. Community cost sharing will be encouraged while safeguarding the poor.

Critique of the population policy statement

The participants at the WOHTRAC meeting came up with the following critique and recommendations:

The Government's initiative to set up a Social Infrastructure Development Board for achieving overall development in the State is laudable. Apart from population stabilization by 2008 being a priority, it would be useful to know other priorities of the Board. This would help us to analyse the total context within which Gujarat's Population Policy is being developed and to assess links for consistency in approach.

The Goal of Gujarat's Population Policy, with its focus on improving the quality of life of people, reducing gender discrimination, empowering women and respecting reproductive rights of men and women in addition to ensuring achievement of replacement level, is also noteworthy. Similarly, the objectives are impressive: 100 per cent access to quality and affordable RH Services, the emphasis on women's education not just to reduce IMR and TFR but, also for its own sake, specific measures to achieve gender equity and equality and encouraging men's participation in women's empowerment. However, just as the Policy Statement in its later sections, promotes partnerships and inter-sectoral co-ordination, reproductive and sexual health needs to be contexualised within the framework of comprehensive Primary Health Care. In practical terms, this would entail forging partnerships and co-ordination links with, for instance, communicable diseases control programmes, such as Tuberculosis and Malaria while also emphasising issues such as water supply, sanitation and nutrition, among others. Also gender perspective analysis needs to be applied to health as a whole and not only to reproductive and sexual health. The differential impact and outcome of all diseases on men and women needs be analysed and responded to accordingly. Thus, gender analysis needs to be part of the training and education curricula of all categories of health care providers and managers.

The paragraph on Specific Objectives reveals a domination of demographic objectives like Unmet Need for Contraception, reducing the Total Fertility Rate (TFR) and increasing Contraceptive Prevalence Rate (CPR). Other objectives like increasing safe Medical Termination of Pregnancies (MTPs), providing quality infertility services and so on, would better reflect the goal of improving the quality of life of the people and a shift away from the demographic orientation of all population policies.

Although the linkages between Nutrition and RCH are evident; the high prevalence of under nutrition in women and children continues to be a challenge, yet the policy gives only a cursory mention of malnutrition reduction in the context of population and quality of life improvement.

Paradigm Shift in Reproductive and Child Health: Gujarat has a rich tradition of self-help, herbal remedies, other innovations in community health through mature and experienced community health and women's organisations and peoples' organisations. This section of the Policy Statement needs to mention how the existing rich experience will be incorporated in the paradigm shift of the RCH Services. For example, can Gujarat's RCH Programme incorporate Indigenous Systems of Medicines for reproductive tract infections? Can some of the health promoting pregnancy care and post partum practices be recognised in the MCH package? Can the State adopt a formulary consisting of generic essential drugs?

The section on gender equality, women's empowerment and male participation is rather progressive. None of the other State Population Policies mention violence against women as a health issue, or the need to institutionalise gender perspectives in education and training programmes and screen educational and IEC materials from a gender perspective. The challenge will lie in the translation of these ideas into operational programmes such that the spirit and meaning of gender sensitivity is not lost.

The section on Decentralization, points out that health, family welfare and education are a responsibility of the village panchayats. The Policy Statement mentions that appropriate support will be given to panchayats to carry out community needs assessments, resource planning and resource mobilisation. It also needs to mention that special support will be given to strengthen women's roles within the panchayat system both as panchayat members and as members of the gram sabha.

Partnerships and inter-sectoral co-ordination between Government Organisations (GO), NGOs, corporate, co-operative and private sectors is the need of the hour. Partnerships should take the form of genuine and mutually respectful collaboration between all concerned. The bottom-line of such partnerships should be clear to all: social and health benefits to the largest sections of most needy sections of society with exploitation of none. Mechanisms for monitoring partnerships should be clearly spelt out right from the beginning.

The participants at the workshop concluded that the Population Policy Statement for Gujarat is

essentially a 'progressive document'. It has most of the elements that can form part of a Women's Health Policy. In a memorandum to the Government of Gujarat they urged the government to move a step forward and, instead of a Population Policy, bring out a progressive Women's Health Policy. Gujarat would perhaps be the second state in India (Andhra Pradesh announced a Women's Health Policy in 1996) to bring out such a policy, and the first state to bring out a progressive Women's Health Policy. Such a policy would be more consistent with the stated goal of improving the quality of life of people. It would move away from the continuing focus on controlling women's fertility to a focus on

- improving health services for women
- providing health information for women
- addressing sexuality and gender based power inequities that have been ignored until recently.

The process being followed by the Government of Gujarat in formulating the Population Policy, with its emphasis on a series of consultations, is also consistent with the process of formulating a Women's Health Policy. Brazil, Colombia, South Africa and Australia, countries that have brought out Women's Health Policies in the last decade, have followed highly inclusive processes. Decentralised discussions were held with a wide variety of persons, including representatives of the women's movement, health care providers, researchers and scholars, and men with relevant grassroots experience. Extensive networking and consultations ensured that grassroots' ideas were incorporated in the proposals.

In conclusion the memorandum reiterated the salient recommendations from the earlier sections. Firstly, the effort of the Gujarat Government should be not only on providing quality reproductive and sexual health services, crucial though these are, but also quality comprehensive and universal Primary Health Care services including services for nutrition and control of communicable diseases such as TB and Malaria. Secondly, the policy statement must clearly specify the parameters on which the implementation of the policy will be monitored and the processes that will be institutionalised for monitoring.

Government of Gujarat's Proposal for a 'Two-child Norm'

Contrary to the generally progressive tone of the Population Policy Statement, in June 2001, the Gujarat Government proposed the passing of a bill and enactment of a law for enforcing the 'two-child norm'. The bill would have allowed the Government to give various incentives and disincentives for the enforcement of a two-child norm. The Chief Minister stated in press reports that the recent poverty and unemployment increases in the state were a result of the population growth rate of 22.48 per cent (compared to 21.19 per cent in the preceding decade). The Health Secretary stated that the disincentives would be for entire village communities that did not agree with the two- child norm.

In a concerted advocacy campaign, WOHTRAC made representations to the Chief Minister and the Health Minister as well gave press releases on its stand on the two-child norm . The public debate among several sections of the civil society and the resultant pressure forced the Government of Gujarat to withdraw its proposal.

WOHTRAC's Perspectives on the Two Child Norm

We, at WOHTRAC strongly oppose this move of the Gujarat Government. Our reasons are as follows

(i) The decision on the number of children to have is a personal decision of the family. No government can decide how many children anyone can have. Doing so goes against the basic tenets of democracy.

(ii) Introducing incentives and disincentives for the implementation of such a law would in practice amount to coercion, which violates the basic human rights of citizens by denying them autonomous decision making. Disincentives deprive people, especially the neediest, of the minimum support that is their entitlement, support in terms of rations, health care, education, employment. Both incentives and disincentives lead to increased corruption in the system.

(iii) The two child norm would actually be discriminatory. The disincentives against population increase would be largely applicable to only those couples who already have inadequate exposure to state government facilities, schemes and aid. Those who practice the two child norm are and will be from the class of people who do not depend on state government's facilities. WOHTRAC urges the Government to remove incentive and disincentives either at the individual level or at the level of the community.

(iv) the two child norm in a society which values sons, would lead to an increase in female foeticide. The sex ratio in our state has already declined from 1000 : 936 in 1991 to 1000 : 919 in 2001 – the two child norm would push down the sex-ratio to the 800s in 2011.

(v) the State Governments' move is surprising because the Central Government in its post ICPD agenda has announced the withdrawal of coercive measures like targets for family planning. The Government of Gujarat has been a signatory to the ICPD's Plan of Action and has committed itself to upholding the principles which respect human rights of all individuals and gender equity amongst its citizens.

(vi) the Government should have a more gender sensitive and women friendly policy.

(vii) WOHTRAC endorses the Government's decision to have a wide ranging debate with representative of women's group, NGOs working with women as well as academics from University departments of Sociology, Women Studies Centres etc. who have been involved in issues related to female foeticide and other similar practices which discriminate against the female population.

(viii) we recommend training of doctors, nurses and other health personnel to provide services which are humane.

(ix) we further recommend that copies of the Medical Termination of Pregnancy (MTP) Act as well as the regulation of the Sex Determination test be prepared in simple and understandable language and are widely disseminated among women groups, PHCs and other centres where health care is provide.

The Government of India has also in the last one year intervened in certain states like Maharastra and Rajasthan to have them take back their two child norm policies. Would we want the Central Government to intervene in our State on this matter?

Can we be progressive and interpret the Vision 2020 for Human Development for our State in a spirit that upholds the dignity of its citizens?

We would also like to be included in any consultation meetings that the State has in this regard.

References:

Declaration of People's Perspectives on 'Population' Symposium; Comilla, Bangladesh; December 12-15, 1993.

Women's Declaration on Population Policies; Women's Voices '94; (In preparation for the 1994 International Conference on Population and Development)

Renu Khanna and Vaishali Zararia; Report of Meeting on Women's Perspective on the Nation Population Policy (2000) and the Population Policy Statement for Gujarat; WOHTRAC; M.S. University, Baroda, June 2000.

National Population Policy 2000; Government of India.

Population Policy Statement for Gujarat; May 11, 2000.

'Salient Features of Population Policies of India, Selected States and Sri Lanka: a comparison'. Dr. Arivind Pullikal, UNFPA, Gandhinagar (undated)

Maharashtra Population Policy Statement: Vision 2010.

State Level Consultation Workshop for Population Policy Development - Gujarat, organised by Department of Health and Family Welfare Government of Gujarat and United Nations Population Fund (UNFPA), May 1, 2000.

Women's Health Policies: Organising for Change by T K Sundari Ravindran, Reproductive Health Matters, No: 6, November 1995.

The Andhra Pradesh Women's Health Policy: A Review by M. Prakasamma. Paper presented at the 'National Consultation Towards Comprehensive Women's Health Policy and Programmes', VHAI - WAH ! - DSE, February 18-19, 1999.

329

WHO. (2001). ***Advancing Safe Motherhood Through Human Rights***. Occasional Paper 5 WHO/RHR/1.05. Geneva: WHO, 21-48.

ADVANCING SAFE MOTHERHOOD THROUGH HUMAN RIGHTS

World Health Organization

III. Human Rights Affecting Safe Motherhood

This section addresses the range of human rights, whether found in national law or in regional or international human rights conventions. These rights can be applied individually or combined with others to advance safe motherhood. In the legal application of human rights, it is important to identify those bound by the legal duty to observe human rights, such as governmental agencies, those working under the authority of government, and those carrying out governmental responsibilities. Human rights not backed by legally enforceable duties remain moral rights, and various agencies, officers and others can be made morally accountable through their moral duties to observe them.

The legal challenge is to find not only the human rights breached in unsafe motherhood, but also the rights that would contribute most effectively to future remedies. For instance, a woman may have suffered because a family member was allowed to veto or frustrate her request for necessary care. A remedy may be approached by ensuring respect for a woman's confidentiality in requesting health care, and in applying human rights to achieve women's economic and social equality in access to health care.

It is helpful to have an understanding of how courts and tribunals have applied a particular human right in the past. This understanding will provide an insight into the potential for success in invoking the right to prevent and remedy a violation causing a maternal death. Human rights have been applied in recent decades at national, regional and international levels to secure women's interests in access to contraception, voluntary sterilization, safe abortion and reproductive health information, and in women's freedom from involuntary sterilization and veto powers over their requests for care. These developments provide promise of the capacity of human rights to advance safe motherhood.[62]

A. Sources of Human Rights

Sources of human rights to advance safe motherhood are found in all national constitutions and in international and regional human rights treaties based on the Universal Declaration of Human Rights, adopted in 1948[63] (see Appendix 2). The Universal Declaration itself was not proposed as a legally enforceable instrument, but it has gained legal acceptance and legal enforceability through a series of international human rights conventions, which are also called treaties, covenants or charters. The primary modern human rights treaty concerning women's rights is

- the Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention).[64]

This Convention gives expression to the values implicit in the Universal Declaration of Human Rights, and reinforces the Universal Declaration's two initial legally-binding implementing covenants,

- the International Covenant on Civil and Political Rights (the Political Covenant),[65] and

- the International Covenant on Economic, Social and Cultural Rights (the Economic Covenant).[66]

Similarly derived from the Universal Declaration are:

- the International Convention on the Elimination of All Forms of Racial Discrimination (the Race Convention),[67] and
- the Convention on the Rights of the Child (the Children's Convention).[68]

Regional human rights conventions of legal force also draw inspiration from the Universal Declaration, and they include:

- the European Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention),[69]
- the European Social Charter - Revised (the European Charter),[70]
- the American Convention on Human Rights (the American Convention),[71]
- the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (the Protocol of San Salvador),[72]
- the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (the Convention of Belém do Pará),[73] and
- the African Charter on Human and Peoples' Rights (the African Charter).[74]

Additional documents (see Appendix 2) reflect widespread international consensus on issues of women's health and human rights, notably:

- the Cairo Programme of Action (the Cairo Programme)[75] and the Cairo Plus Five follow-up document[76] developed respectively at the 1994 UN Conference on Population and Development, held in Cairo, and its five year review; and
- the Beijing Declaration and Platform for Action (the Beijing Platform),[77] developed at the 1995 Fourth World Conference on Women, held in Beijing, and its five-year review.[78]

Throughout this discussion document, the international and regional instruments above will be referred to by the short names that follow them in brackets.

Like national constitutions that have constitutional courts to monitor compliance with constitutional provisions, the human rights treaties have monitoring bodies to monitor compliance with treaty provisions. For example, the Women's Convention established the Committee on the Elimination of Discrimination Against Women

(CEDAW), and the Committee on the Rights of the Child (CRC) was established under the Children's Convention to monitor state compliance. The Political Covenant established the Human Rights Committee (HRC) to monitor state compliance, and the Committee on Economic, Social and Cultural Rights (CESCR) was established to monitor compliance with the Economic Covenant. Unlike national courts, however, which act only on the occasions when parties bring cases before them, the treaty monitoring bodies receive reports that treaty member states must submit periodically, usually at three to five year intervals.

Countries that are members of an international human rights convention (see Appendix 3) are obligated to report on a periodic basis to the respective treaty monitoring body to provide information on their national performance.[79] For example, the reporting procedure of the CESCR requires States Parties to file an initial report within two years of the Covenant coming into force and thereafter every five years, or at any other time the Committee deems appropriate.[80] States Parties to the Children's Convention are similarly required to submit reports to the CRC two years after the Convention comes into effect for the state concerned, and every five years thereafter.[81] The Committee on the Elimination of Racial Discrimination (CERD), established under the International Convention on the Elimination of All Forms of Racial Discrimination, requires states to report within one year of their ratification and thereafter every two years and whenever the Committee so requests.[82]

Article 18 of the Women's Convention requires States Parties to submit a report within one year of the Convention going into effect for the state concerned and every four years thereafter, and explains that reports may indicate factors and difficulties affecting the degree of fulfilment of obligations. In the specific area of women's health, 166 ratifying states have committed themselves to report regularly to CEDAW on what they have done to:

> "... take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure ... access to health care services, including those related to family planning ... pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."[83]

Once a treaty monitoring committee has considered a country report and any additional information on treaty compliance, and discussed the report with the representatives of the reporting government, it issues Concluding Observations. These Concluding Observations note the achievements of the reporting state to take steps to brings its laws, policies and practices into compliance with its treaty obligations, and the concerns the committee has with lack of compliance.[84]

To assist countries to fulfil their reporting obligations, treaty-monitoring bodies have developed a series of General Recommendations or General Comments (see Appendices 4, 7-9).[85] These explain the content and meaning of duties that arise under treaty articles, and outline the kind of information that treaty bodies find useful to receive in reviewing reporting countries' compliance records. Committees have issued general guidelines for reporting and guidelines that are specific to particular articles. In 1995, for instance, HRC amended its general guidelines for

periodic reports to include, "[f]actors affecting and difficulties experienced in the implementation of the [Economic] Covenant including any factors affecting the equal enjoyment by women of that right."[86] CESCR has stressed the importance of observance of the Economic Covenant's minimum core obligations in its general guidelines for reporting.[87]

With regard to guidance on specific articles of the Women's Convention, the CEDAW General Recommendation on Women and Health requires that:

> "... in order to enable the Committee to evaluate whether *measures to eliminate discrimination against women in the field of health care are appropriate*, States Parties must report on their health legislation, plans and policies for women with reliable data disaggregated by sex on the incidence and severity of diseases and conditions hazardous to women's health and nutrition and on the availability and cost-effectiveness of preventive and curative measures."(see Appendix 4, para 90) (emphasis added)

This Recommendation stresses that:

> "... [r]eports to the Committee must demonstrate that health legislation, plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and take into account any ethnic, regional or community variations or practices based on religion, tradition or culture." (see Appendix 4, para 9)

Complaint procedures are available under some of these conventions, such as the Race Convention,[88] or under Optional Protocols to others, such as the Political Covenant[89] and the Women's Convention.[90] These procedures enable individuals or groups of individuals from ratifying countries to bring complaints to the relevant treaty body of alleged violations they have suffered, once they have exhausted available domestic remedies. The decisions of treaty bodies help to develop the content and meaning of rights. A successful complaint can have the effect of requiring governments to change or apply laws or to provide remedies that might benefit individuals as well as groups that are harmed (see Appendix 10).

B. Obligations of Government to Implement Human Rights

Under their national constitutions and regional and international human rights treaties, governments face a variety of obligations, including general obligations that can be applied to particular circumstances, core obligations, and immediate and long-term obligations. The CEDAW General Recommendation on Women and Health (see Appendix 4) and CESCR's General Comment on Health (see Appendix 7) explain that governments have three different kinds of general legal obligations to implement human rights. They are:

- the obligation to *respect* rights, which requires states to refrain from interfering with the enjoyment of rights;
- the obligation to *protect* rights, which requires states actively to prevent violations of human right by third parties; and

- the obligation to *fulfil* rights, which requires states to take appropriate governmental measures toward the full realization of rights.

These obligations are elaborated by treaty monitoring bodies in their development of General Recommendations or General Comments. For example, the CEDAW General Recommendation on Women and Health explains the obligations with respect to Article 12 of the Women's Convention in the following way:

> "The obligation to *respect rights* requires states parties to refrain from obstructing action taken by women in pursuit of their health goals. States parties should report on how public and private health care providers meet their duties to respect women's rights to have access to health care." (see Appendix 4, para 14)

This General Recommendation explains that states are obliged to change laws or policies that require women to seek the authorization of their husbands, parents or health authorities to obtain health services, because such laws or policies obstruct women's pursuit of their health goals. The Recommendation also states that the Women's Convention may be infringed by "laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures." (see Appendix 4, para 14)

The General Recommendation further observes that:

> "The obligation to *protect rights* relating to women's health requires states parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations."(see Appendix 4, para 15)

The Recommendation explains that the duty to protect rights requires the "enactment and effective enforcement of laws that prohibit ... marriage of girl children" (see Appendix 4, para 15). The duty of protection also includes responsibility to develop health care protocols and programmes of gender training for health care providers and in the provision of health services, in order to identify, address, prevent and remedy the causes of unsafe motherhood.

The General Recommendation goes on to make clear that:

> "The duty to *fulfil rights* places an obligation on States Parties to take appropriate legislative, judicial, administrative and budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care." (see Appendix 4, para 17)

The General Recommendation explains that studies that show high rates of maternal mortality and morbidity, or large numbers of couples who would like to limit their family size but lack access to contraception, provide important indications about possible breaches of duties to ensure women's access to health care.

In addition to these general obligations, CESCR has issued a General Comment which explains the minimum core obligations of Article 12 on the right to the

highest attainable standard of health (see Appendix 7). This General Comment establishes that states have core obligations to provide essential primary health care in order to satisfy the right to the highest attainable standard of health. The General Comment explains that "core obligations are not subject to resource limitations or progressive realization, instead their realization is required immediately" (see Appendix 7, para 19). The General Comment requires governments at least:

43(a) "to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalized groups;

(b) to ensure access to minimum essential food which is sufficient, nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

...

(e) to ensure equitable distribution of ail health facilities, goods and services;

(f) to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of actions is devised, as well as their content, shall give particular attention to vulnerable or marginalized groups;

...

44(a) to ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

...

(d) to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them

(e) to provide appropriate training for health personnel, including education on health and human rights...." (see Appendix 7, para 43-44)

The General Comment explains that immediate obligations with regard to the right to health include the obligation to eliminate health-related discrimination, for example in access to health care, and to take no retrogressive measures with regard to health, including withdrawal of services.

C. The Application of Human Rights to Safe Motherhood

Safe motherhood may be advanced through several specific legally established human rights. The choice of which rights to apply will depend on the immediate and underlying causes of maternal death and ill health.[91] Several human rights may be cumulatively and interactively applied to advance particular interests. The rights addressed below are not exhaustive but are indicative of rights that may be applied to promote safe motherhood. Moreover, the discussion is only suggestive of how

different rights have been or could be applied. As human rights are applied to advance safe motherhood by different countries under their respective constitutions and regional and international human rights commitments, it is hoped that additional ways of applying rights will be developed.

The discussion below will explore how specific rights, clustered around the following categories, might be applied to different factors contributing to maternal death and disability:

- rights relating to life, survival and security of the person;
- rights relating to maternity and health;
- rights to non-discrimination and due respect for difference; and
- rights relating to information and education.

The determination of which rights to apply will depend on:

- how the rights have been applied in the past by national courts, regional and international human rights tribunals (see Appendix 6);
- an assessment of how successful their application might be in the future; and
- an identification of which causes of maternal mortality and morbidity appear amenable to a human rights approach.

The success of individual and collective efforts to apply human rights to prevent and remedy maternal mortality and morbidity will vary. However, each attempt to apply human rights generates further debate and understanding that is helpful to future efforts to foster compliance with requirements for safe motherhood.

1. Rights relating to life, survival and security

Notions of health are beginning to illuminate the content and meaning of the right to life and survival, the right to liberty and security of the person and the right to be free from inhuman and degrading treatment. This development is happening at both the national level, particularly in national courts, and at the regional and international levels. While these rights have yet to be applied to secure the services to promote safe motherhood, it is perhaps timely to think about how they can be applied for this purpose.

a. The right to life and survival

> The Political Covenant, Article 6(1):
>
> "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."

The right to life is the most obvious right that could be applied to protect a woman at risk of dying in childbirth due to lack of obstetric care. Historically, this right

generally has been applied legally only to ensure that capital punishment is not imposed in an arbitrary way. However, judicial tribunals are beginning to apply the right to life to matters relating to health by addressing the positive nature of the right, and by providing a context of health and human dignity to the right to life. For example, HRC has explained that "the expression 'inherent right to life' cannot be properly understood in a restrictive manner, and the protection of this right requires that States adopt positive measures."[92] When explaining what positive measures might be adopted, HRC gave, as an example, measures necessary to reduce infant mortality and to increase life expectancy.[93] HRC has specified through its General Comment on Equality between Men and Women that States Parties are now required to provide data on "pregnancy and childbirth-related deaths of women." (see Appendix 8, para 10)

In 1991, the European Commission of Human Rights considered a complaint alleging a state's violation of the right to life of a woman who had died in childbirth.[94] The Commission held that the complaint was inadmissible on technical grounds. However, the Commission took the opportunity to emphasize that the right to life in the European Convention[95] has to be interpreted not only to require states to take steps to prevent intentional killing, but also to take measures necessary to protect life against unintentional loss. The European Commission had earlier considered a claim that a governmental vaccination programme that resulted in damage and death to babies was a violation of the right to life.[96] The Commission found that appropriate and adequate measures to protect life had been taken in this case. The Commission did explain, however, that had the state not shown that such measures had been taken, the state would have been found in breach of its duty under human rights law to safeguard life and health. This shows that states are bound to explain and justify their efforts to protect their citizens' lives and health.

Given the magnitude of an estimated 1,400 maternal deaths worldwide each day, it is remarkable that so few legal proceedings have made their way into national courts to require that governments take all appropriate measures to identify the causes of maternal mortality in their respective countries, and take precautionary measures necessary to prevent further maternal deaths. This is due in part to families and communities in which women have died of pregnancy-related causes not understanding how governmental neglect of the conditions in which women bear pregnancies and give birth violates their right to life. Effective protection of the right to life requires that positive measures be taken that are necessary to ensure "access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[97]

Positive measures might include progressive steps are taken to ensure an increasing rate of births are assisted by skilled attendants, as required by the Cairo and Beijing processes.[98] Where such measures are not taken, states need to be encouraged to take steps to ensure compliance with treaty obligations to protect and promote the right to life.

Some national courts are giving an expanded meaning to the right to life that could be applied to require ministries of health to address the causes of preventable maternal deaths. For example, the Supreme Court of India decided that the right to

life contained in the Indian Constitution[99] was breached when various government hospitals denied a complainant emergency treatment for serious head injuries.[100] The Court explained that the state cannot use financial constraints to ignore its constitutional obligation to provide adequate medical services to preserve human life, and even detailed which measures the state might take to comply. While this case addressed emergency medical care to treat head injuries, the reasoning could be applied to require governments to provide emergency obstetric services where they are not sufficiently available.

The Venezuelan Supreme Court recognized the interrelationship between the rights to life[101] and to health[102] contained in the Venezuelan Constitution, when ruling in favour of a claim for HIV treatment.[103] In underscoring the positive nature of the right to life, the Court required the Ministry of Health to:

- provide the medicines prescribed by government doctors;
- cover the cost of HIV blood tests in order for patients to obtain the necessary anti-retroviral treatments and treatments for opportunistic infections;
- develop the policies and programmes necessary for affected patients' treatment and assistance; and
- make the reallocation of the budget necessary to carry out the decision of the Court.

While the successful claim was brought on behalf of 172 individuals living with HIV, the Court applied the decision to all people who are HIV positive in Venezuela.

As a result of these decisions, it is now timely to explore how a claim might be brought on behalf of women whose lives and health are at risk because of denial or neglect of life-saving obstetric care. Such a claim would certainly be feasible in Venezuela, and in light of the Supreme Court of India's judgement it might be credible in India and other countries, especially Commonwealth countries. Governmental health administrations might be wise to plan their resource allocations and programmes in anticipation of judicial sympathy with the courts in Venezuela and India, and of their need in court to explain the adequacy of their responses to the requirements of safe motherhood.

b. The right to liberty and security of the person

> The Political Covenant, Article 9(1):
>
> "Everyone has the right to liberty and security of the person ... No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law."

The right to liberty and security of the person is one of the strongest defences of individual integrity and the right of women to free choice of maternity. The right is being applied beyond its historical prohibition of arbitrary arrest or detention, to

require governments to provide health services when the lack of services jeopardises liberty and particularly health security of the person. The Inter-American Commission of Human Rights has recognized a right to the satisfaction of basic health needs as part of a right to personal security in observing that:

> "The essence of the legal obligation incurred by any government ... is to strive to attain the economic and social aspirations of its people by following an order that assigns priority to the basic needs of health, nutrition and education. The priority of the 'right to survival' and 'basic needs' is a natural consequence of the right to personal security."[104]

If governments and agencies to which they delegate responsibility to administer health services fail to provide conditions necessary for safe motherhood, they are accountable for violations of women's right to liberty and security of the person, and must take all appropriate steps to prevent and remedy the situation. Medical, social, health system and other factors that place a woman at risk of maternal mortality or morbidity deny her the right to security of her person. Health care agencies may have to take account of more than medical service remedies to address the causes of unsafe motherhood.

Unsafe abortion can be the second largest cause of maternal mortality in some countries, such as Colombia.[105] Where unsafe abortion is a major cause of maternal death, it may be possible to apply the right to liberty and security to require governments to improve services for treatment of unsafe abortion, to change restrictive laws regarding access to abortion and to ensure the provision of contraceptive and abortion services. The right to liberty and security has been applied by national constitutional courts in abortion cases to protect a woman's "freedom to decide if, when and how often" [106] to bear children. In Canada, for instance, the Supreme Court held that a restrictive criminal abortion provision violated a woman's right to security of the person.[107]

Several constitutional courts, including those of France,[108] Italy[109] and the Netherlands, [110] have found that liberal abortion laws are consistent with women's right to liberty. Even laws expressed only prohibitively usually have an implied exception that allows lawful abortion when a woman's life or enduring health is in danger. However, the punitive context of the law deters women from seeking medical treatment, and doctors from proposing it, where the public at large and medical practitioners in particular are not informed that restrictively worded laws have this exception for preservation of life and health.

Women's liberty and security require clinic policies and laws that ensure their care and confidentiality. Under the Women's Convention, CEDAW has made a General Recommendation reiterating the importance of confidentiality. The Recommendation observes that, although lack of confidentiality affects both men and women to a certain degree,

> "it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason [unreliable confidentiality], to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases

where they have suffered sexual or physical violence." (see Appendix 4, para 12(d))

Given this clear explanation of the impact of failures to respect confidentiality, health care administrators and providers can appreciate that the absence of confidentiality is a contributing factor in maternal mortality and morbidity, and a violation of a woman's right to health and wider aspects of security.

The right to liberty and security of the person can be applied to require that positive measures be taken to ensure respect in the delivery of reproductive health services to women who are at particular risk. They include women, especially adolescent girls, presenting with stigmatizing conditions, such as unmarried or extra-marital pregnancy, or incomplete abortion. Sometimes, adolescents hesitate to seek reproductive health services because they fear that their confidentiality might be breached. They fear, perhaps incorrectly, that information about their sexual behaviour, which they have to make for appropriate health care, will be disclosed to their parents, parents of their partners, teachers and others. As a result, special care and attention needs to be given to informing adolescents in the community through positive assurances that confidentiality will be protected, and to training health personnel appropriately. Clinics may have to withhold information not only of what treatment their patients have received, but also of who their patients are, although some disclosure may be required for billing purposes.

c. The right to be free from inhuman and degrading treatment

The Political Covenant, Article 7:

"No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment..."

Decisions of human rights tribunals have required states to ensure that health services are provided when their denial would constitute inhuman treatment. The European Court of Human Rights held that a governmental deportation of a person at an advanced stage of terminal AIDS to his own country, where he would have no hope of receiving appropriate care, would constitute inhuman treatment, contrary to Article 3 of the European Convention.[111] Similarly, denying a prison inmate any adequate medical treatment for his mental condition, even when he was liable to capital punishment, has been held to constitute inhuman treatment contrary to Article 7, and denial of respect for the inherent dignity of his person contrary to Article 10(1), of the Political Covenant.[112]

Accordingly, a state might be held bound to ensure provision of emergency obstetric care and treatment for maternal morbidities, because lack of such provision could constitute inhuman treatment and denial of respect for the inherent dignity of women. Care could provide for a woman's access to medically indicated treatment, which may include services to treat a high risk pregnancy, and to terminate pregnancy safely where her life or continuing health, including mental health and social well-being, are at risk.

HRC addressed the inhuman and degrading nature of maternal death from unskilled abortion in considering a report submitted by the Government of Peru under the Political Covenant. When examining what the country had done to bring its laws, policies and practices into compliance with the Covenant, the Committee addressed the human rights of women, including the rights denied them by Peru's restrictive criminal abortion law. In its Concluding Observations, the Committee expressed its concern "that abortion gives rise to a criminal penalty even if a woman is pregnant as a result of rape and that clandestine abortions are the main cause of maternal mortality."[113] The Committee found that the restrictions of the criminal law subjected women to inhuman treatment, contrary to Article 7 of the Covenant. Moreover, the Committee explained that this aspect of the criminal law was possibly incompatible with Article 3, on equal entitlement of men and women to enjoyment of the rights set forth in the Covenant. The Committee said this would include Article 6, which protects the right to life, since men could request medical care of a life endangering condition without fear that they or their care-providers would face criminal prosecution.

The Committee recommended that "necessary legal measures should be taken to ensure compliance with the obligations to respect and guarantee the rights recognized in the Covenant."[114] Moreover, the Committee explained that the "provisions of the Civil and Penal Codes [of Peru] should be revised in light of the obligations laid down in the Covenant," particularly Articles 3 and 26 requiring that countries ensure the rights of women under the Covenant.[115] The requirement that a country conform to human rights standards, if necessary by amending national law to be compatible with individuals' human rights entitlements, shows that governments can be expected to comply with the duties they have assumed to protect women's rights, including to safe motherhood.

A state is responsible, at a minimum, to require its health care providers and facilities to ensure women's reasonable access to safe abortion and related health services, as its law permits. Moreover, since the law in Peru, which strictly penalised abortion, was shown to result in inhuman treatment of women and undue maternal mortality, Peru was held obliged to consider legal reform so that its law would comply with human rights standards for women's health and dignity. A new national policy could be expressed in law that more adequately balances limitations on abortion with women's rights to safe and humane access to health services necessary to protect their lives and dignity, and their security in health.

2. Rights relating to maternity and health

a. Rights relating to maternity

Rights relating to maternity have been developed through interrelated rights requiring maternity protection in general, maternity protection during employment in particular, rights to marry and to found a family and, for instance, rights relating to free choice of maternity and to private and family life.

i. The right to maternity protection

> The Economic Covenant, Article 10(2):
>
> "Special protection should be accorded to mothers during a reasonable period before and after childbirth..."

The exact wording of Article 10(2) of the Economic Covenant, above, is found in Article 27(1) of the 1992 Constitution of Ghana. Other examples of national constitutional rights relating to family life that require the protection of motherhood include Article 10 of the 1980 Constitution of the Arab Republic of Egypt, which provides that "[t]he State shall guarantee the protection of motherhood..." Brazil's 1988 Constitution explains in Article 6 that protection of motherhood is a social right under the Constitution.

The special contribution that women make to society through maternity and motherhood is recognized in many national constitutions and human rights documents. Under Article 5(b) of the Women's Convention, States Parties agree to take all appropriate measures:

> "[t]o ensure that family education includes a proper understanding of maternity as a social function..."

The Universal Declaration of Human Rights in Article 25(2), addressing health and well-being, explains that

> "Motherhood and childhood are entitled to special care and assistance."

The American Declaration similarly recognizes that "[a]ll women, during pregnancy and the nursing period ... have the right to special protection, care and aid."[116] Through Article 15 of the Protocol on Economic, Social and Cultural Rights to the American Convention, states agree to "provide special care and assistance to mothers during a reasonable period before and after childbirth."

Under Article 24(d) of the Children's Convention, States Parties commit to ensure appropriate prenatal and postnatal care for mothers. Article 12(2) of the Women's Convention requires provision of free maternity services where necessary:

> "... States Parties shall ensure to women appropriate services in connexion with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."

Where services that are appropriate for pregnancy, confinement and the postnatal period are not provided,[117] States Parties might be encouraged to take steps to provide these services in order that they are in compliance with Article 12(2) of the Women's Convention and Article 24(2) of the Children's Convention.

Necessary though these provisions are, their focus tends to link protection of women's health to motherhood and care of infants and children, reinforcing a perception that protection of women's health is an instrumental means of serving children, rather than an inherent right for women to enjoy for themselves. Whatever the motivation is for such provisions, they do obligate states to ensure that motherhood is safe. Legal research is needed to show if and how these provisions have been or could be applied to ensure women are adequately protected during pregnancy.

ii. The right to maternity protection during employment

Article 10(2) of the Economic Covenant requires that "working mothers should be accorded paid leave or leave with adequate social security benefits" during a reasonable period before and after childbirth. The maternal health of women during employment has been an objective of the International Labour Organisation (ILO) since its establishment in 1919. The Maternity Protection Convention, No. 3 (1919)[118] was among the first instruments to be adopted. The 1919 Convention stipulates in Article 3(c) that the pregnant woman is entitled to free attendance by a doctor or qualified midwife.

In 1952, this Convention was revised[119] to take into consideration developments in national law and practice. The 1952 Convention, Convention No. 103, began to reflect the increasing participation of women in the workforce, as well as rising social expectations regarding the rights of women during their childbearing years, particularly with respect to a growing commitment to eliminate discrimination in employment. The 1952 Convention provides in Article 4(1) for the material support of mother and child through financial benefits and medical care. Article 4(3) explains that medical care includes "prenatal, confinement and postnatal care by qualified midwives or medical practitioners as well as hospitalisation care where necessary; freedom of choice of doctor and freedom of choice between a public and private hospital" where applicable. The Maternity Protection Recommendation, No. 95 (1952),[120] provides further guidance on the health protection of employed women with regard to conditions of work, such as the prohibition of work prejudicial to the health of mother and child.

Article 1 of the 1952 Convention suggests that its provisions apply to "women employed in industrial undertakings and in non-industrial and agriculture occupations, including women wage earners working at home." However, the provisions of domestic laws defining the scope of persons to whom the maternity protections apply vary widely from country to country. Even so, a survey of legislation indicates that the scope of women whose maternity protection is covered in most countries approaches or exceeds that prescribed by the Convention, and is moving toward broad coverage for all employed women.[121] Women are generally covered across the industrial and non-industrial sectors, and in both the private and public sectors.[122] However, significant gaps still exist with respect to the agricultural sector, as well as to part-time workers, homeworkers, domestic workers, and casual, contract and temporary workers.[123] While these gaps are decreasing, much remains to be done to ensure that legal protection available in principle becomes effective in practice.

The 1952 Convention was further revised by the Maternity Protection Convention (Revised), 2000.[124] In addition, the 1952 Recommendation was revised in 2000.[125] These revisions were undertaken, in part, to reflect the growing commitment to eliminate discrimination in the workforce. Through all of these conventions and their accompanying recommendations, member states are obligated to devote attention to the health aspects of maternity protection, since they state that women have the right to medical care as well as to financial benefits.

iii. The right to marry and to found a family

The Political Covenant, Article 23:

"1. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.
2. The right of men and women of marriageable age to marry and to found a family shall be recognized.
3. No marriage shall be entered into without the free and full consent of the intending spouses.
4. States Parties to the present Covenant shall take appropriate steps to ensure equality of rights and responsibilities of spouses as to marriage, during marriage and at its dissolution. In the case of dissolution, provision shall be made for the necessary protection of any children."

The obligations of states to protect the family are found in many human rights treaties (see Appendix 2). Wording similar to that of Article 23(1) of the Political Covenant is found in Article 18 of the African Charter requiring protection of the family. The exact wording of Article 23(1) is repeated in Article 17(1) of the American Convention. Article 23(2) is slightly revised in Article 17(2) of the American Convention, to read:

> "[t]he right of men and women of marriageable age to marry and to raise a family shall be recognized..."

Article 10(1) of the Economic Covenant stresses the importance of states ensuring protection and assistance for the "establishment" of the family and for "the care and education of dependent children." It reads:

> "The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses."

The Women's Convention stresses the importance of equal rights within the family. Article 16 reads:

> "(1) States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family

relations and in particular shall ensure, on a basis of equality of men and women:

(a) The same right to enter into marriage;
(b) The same right to choose a spouse and to enter into marriage only with their free and full consent;
(c) The same rights and responsibilities during marriage and at its dissolution…"

(2) The betrothal and marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory."

Laws setting a legal minimum age of marriage, if implemented, can help to ensure that young women are of sufficient age and maturity to be able voluntarily to consent to marriage, and to avoid the health risks of premature childbearing.

Evidence shows while most countries have set a legal minimum age of marriage, governments generally do not provide the resources or the leadership for their effective implementation, for instance through a requirement of marriage licensing dependent on submission of evidence of age, such as dated certificates of birth. This is the case in India where marriage registration is not legally required. In their Concluding Observations on the report of India submitted under the Political Covenant, the HRC explained that:

"[w]hile acknowledging measures taken to outlaw child marriages (Child Marriage Restraint Act) [which sets the minimum age of marriage at 18 for girls and 21 for boys], … the Committee remains gravely concerned that legislative measures are not sufficient and that measures designed to change the attitudes which allow such practices [child marriages] should be taken… The Committee therefore recommends that the Government take further measures to overcome these problems…."[126]

The Committee's concern about child marriages entered "without free and full consent of the intending spouses" is underscored by a study in Rajasthan, India which explained that:

"[e]ven today, mass child marriage ceremonies arranged by parents, where hundred of boys and girls wed each other, are very common. The mean age at marriage for women (16.1 years) is among the lowest in the country. Once the girl goes to her marital home, it is her duty to beget a child as soon as she can. … Forcing early pregnancies and motherhood on teenage girls under the banner of social custom and family is tragic."[127]

The tragedy of child marriages is not unique to Rajasthan. CEDAW expressed similar concerns in its Concluding Observations on the report of Nepal in noting that:

> "traditional customs and practices detrimental to women and girls, such as child marriage, dowry, polygamy, deuki (a tradition of dedicating girls to a god or goddess, who become "temple prostitutes", which persists, despite the prohibition of the practice by the Children's Act), badi (the ethnic practice of forcing young girls to become prostitutes) and discriminatory practices that derive from the caste system are still prevalent."[128]

"Protection by society and the State"

There is significant scope for the right to marry and to found a family to be applied to advance safe motherhood, because this right imposes positive obligations on the state to protect the right. State authorities can be liable for not providing vulnerable women and girls with effective protection against the acts of private individuals. Courts of law are, of course, public authorities, and obliged to apply and develop the law consistently with human rights treaties binding their states. As a result, where governmental or judicial branches of the state do not constrain those who arrange marriages of children under the legal age of marriage, or against the will of one of the parties to the marriage, the government would be accountable for the state's violation of Article 23(1) of the Political Covenant.

The human right to family life is seriously jeopardised by neglect of the needs of women who are at risk of maternal death or disability to receive reproductive, including maternity, care. In addition, the rights to family life of children and fathers are prejudiced due to the harmful impact of mothers' deaths on the potential of surviving infants, children and other family members to lead healthy lives. Children of women who die following childbirth are "three to ten times more likely to die within two years than those with both living parents."[129] Preservation of maternal health and prevention of maternal death are so central to the enjoyment of family life that they are part of the human rights entitlements not only of women but also of children and husbands.

"Marriageable age"

The right to marry and to found a family, available to persons of "marriageable age," may be applied to achieve the desirable result of adolescent girls marrying later, giving them more choice over the age at which they have children. The expression "marriageable age" in Article 23(2) of the Political Covenant needs to be interpreted in light of the Children's Convention. Article 1 of that Convention explains that "a child means every human being below the age of eighteen unless, under the law applicable to the child, majority is attained earlier."

National family laws have traditionally set ages at which adolescents could marry without parental consent, and even over parental objection. This age often coincided with the general age of majority (traditionally 21 but now commonly 18). A lower age was also set at which adolescents could marry provided that their parents consented, or "emancipated" them. In addition, laws often had an exception allowing an underage girl to marry if she was pregnant, in order that her child would be legitimate at birth.

An objection to parental consent laws is that they protect marriages the parents arrange. Daughters may accept the arrangements as an act of obedience to their parents rather than of emotional commitment to their husbands and to raising their own children. Accordingly, the better view may be that the reference in legal provisions to "marriageable age" not be taken to refer to the minimum age of marriage with parental consent, but to the age of marriageability without the legal requirement of emancipation by parents.

This view is reinforced by the health advantages, for both mothers and children, of marriages not being undertaken before adolescent girls have achieved sufficient physical maturity to bear pregnancy and deliver safely, and the emotional and intellectual maturity for self-care, child-care, and resort to necessary assistance. Physical maturity can be approximately related to a chronological age, but this age may not be as reliably related to emotional and intellectual maturity.

Health and social effects of child marriage

HRC and other treaty monitoring bodies could benefit significantly from the work of women's health specialists in adding content and meaning to an understanding of "marriageable age." For example, a serious health dysfunction of early marriage and childbearing is younger girls' vulnerability to suffer different forms of obstetric fistulae. A fistula is a maternal disability arising from obstructed labour that has been reported particularly in Africa and Asia.[130] It has been explained that:

> "an obstetric fistula is a hole which forms in the vaginal wall communicating into the bladder (vesico-vaginal fistula – VVF) or the rectum (recto-vaginal fistula – RVF) or both (recto-vesico-vaginal fistula RVVF), as a result of prolonged and obstructed labour...The immediate consequences of such damage are urinary incontinence, faecal incontinence if the rectum is affected, and excoriation of the vulva from the constantly leaking urine and faeces. Secondary amenorrhoea is a frequently associated problem. Women who have survived prolonged obstructed labour may also suffer from local nerve damage which results in difficulty in walking, including foot drop."[131]

The social stigma resulting from obstetric fistulae can be devastating to those who cannot obtain prompt surgical repair. It has been explained that:

> "The social consequences of these physical disabilities are severe. Most victims of obstructed labour in which the fistula subsequently occurred will also have given birth to a stillborn baby. In some areas, a high percentage of fistulae occur during the first pregnancy. Women who live in cultures where childlessness is unacceptable will therefore suffer from this fact alone. As long as they are incontinent of urine they are also likely to be abandoned by their husbands on whom they are financially dependent, and will probably be ostracised by society."[132]

Moreover, in many situations the "social isolation compounds the woman's own belief that she is a disgrace and has brought shame on her family. Women with VVF often work alone, eat alone, use their own plates and utensils to eat and are not

allowed to cook for anyone else. In some cases they must live on the streets and beg."[133]

The denial of the right to enjoy marriage and to found a family that failure to prevent and remedy this condition causes is obvious from the history of women who suffer it. States need to ensure that adolescent girls are of sufficient physical maturity for marriage and childbearing. Once adolescent girls are married, states need to ensure that they obtain the necessary health care to survive pregnancy and delivery. In the event of complications, such as obstetric fistulae, states are obliged to ensure that they quickly obtain necessary surgical treatment in order that they may found and enjoy their families.

"Free and full consent"

The burden falls on those employing state authority, whether by enacting legislation or by taking executive or judicial action, to ensure that entry into marriage relationships conforms to human rights standards concerning women's voluntary choice to marry and protection of their health and welfare.

CESCR, in its Concluding Observations on the report from Suriname, recommended that "the laws permitting persons to marry without the acknowledgement or consent of the partner be abolished..."[134] In its Concluding Observations on the report of Cameroon, CESCR also deplored "the lack of progress made by the Government in combating ... the forced early marriage of girls...."[135]

Significantly, the National Court of Justice of Papua New Guinea decided in favour of a girl who wanted to continue her education and find a job, over her family's opposition, instead of being married involuntarily.[136] In so doing, the Court declared unconstitutional the 'head pay' custom of providing young women for marriage or other employment in victims' families as part of legitimate compensation for causing accidental deaths.

The Court's judgement is consistent with CEDAW's General Recommendation on Equality in Marriage and Family Relations.[137] This Recommendation makes the following observation on Article 16(1)(a) and (b) of the Women's Convention:

> "A woman's right to choose a spouse and enter freely into marriage is central to her life and to her dignity and equality as a human being. An examination of States parties' reports discloses that there are countries which, on the basis of custom, religious beliefs or the ethnic origins of particular groups of people, permit forced marriages or remarriages. Other countries allow a woman's marriage to be arranged for payment or preferment and in others women's poverty forces them to marry foreign nationals for financial security. Subject to reasonable restrictions based for example on a woman's youth or consanguinity with her partner, a woman's right to choose when, if, and whom she will marry must be protected and enforced at law."[138]

This Recommendation has been echoed in HRC's General Comment 28 Equality of Rights between Men and Women, which explains that:

> "States are required to treat men and women equally in regard to marriage in accordance with article 23.... Men and women have the right to enter into marriage only with their free and full consent, and States have an obligation to protect the enjoyment of this right on an equal basis. Many factors may prevent women from being able to make the decision to marry freely. One factor relates to the minimum age for marriage. That age should be set by the State on the basis of equal criteria for men and women. These criteria should ensure women's capacity to make an informed and uncoerced decision. A second factor in some States may be that either by statutory or customary law a guardian, who is generally male, consents to the marriage instead of the woman herself, thereby preventing women from exercising a free choice." (see Appendix 8, para 23)

iv. The right to free choice of maternity/the right to private and family life

The Women's Convention, Article 16(1):

States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure...

> (e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

The Political Covenant, Article 17(1):

"No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence...."

The right to free choice of maternity is derived from the right to private and family life and the right to decide on the number and spacing of one's children. These rights, however formulated, are found in many national constitutions and human rights treaties. For example, the 1998 Constitution of Ecuador says that:

> "[t]he State shall guarantee the right of persons to decide on the number of children they want to conceive, adopt, maintain and educate. It is the obligation of the State to inform, educate and provide means that contribute to the exercise of this right."[139]

The implementation of such rights reduces state power to compel individuals to account to governmental officers for their reproductive choices, and to compel individuals to employ their reproductive capacities in compliance with governmental preferences. Free choice of maternity is increasingly recognized as an attribute of private and family life, in order that individuals may propose whether, when and how often to have children, without governmental control, accountability or coercion. The common approach now is that choices on reproductive practice and

health, including maternity, are private decisions between consenting partners, not governmental decisions. Accordingly, women may in principle protect their health in maternity by determining whether and when to plan pregnancy.

The issue of choice of termination of unplanned or health-endangering pregnancy remains legally contentious in many countries, although countries are progressively liberalising their laws.[140] Governmental agents such as police officers have powers of enquiry and investigation where criminal abortion is suspected that may prevail over human rights of privacy. Women are often deterred from seeking health care when they know that governmental officers could have access to their health care information. The deterrent effect on women is especially strong when others' knowledge of their pregnancy, or possible pregnancy, risks their exposure to disadvantage. They may fear, for instance, loss of personal and family reputation where pregnancy outside marriage is stigmatized, and subjection to personal violence, which in some cultures, notwithstanding prohibitive law, may go so far as to accommodate or only lightly punish a so-called "honour killing." Further, a premature end to a pregnancy of which those bound or disposed to notify police officers are aware may expose a woman, and perhaps others close to her, to investigation on suspicion of unlawfully inducing abortion.

Courts respecting women's choices on pregnancy and childbirth have relied on rights to private life to prevent potential fathers, whether married or unmarried, from forcing women to bear children against their will. The European Commission has held that a husband could not veto his wife's lawful abortion and force her to endure pregnancy against her will.[141] This decision gives priority to a wife's right of decision with respect to childbearing over a husband's right to family life in the birth of his child. Husbands' rights do not include the right even to be consulted about abortion, because wives' rights of confidentiality and privacy prevail. This reasoning supports the argument that the state has no greater interest in the birth of a child than a husband or biological father. As a result, the state should have no right to prevent women's choice about the timing of their families and their full exercise of their right to private and family life.[142]

A 1998 study of maternal mortality in Nepal indicates how the right of women to privacy is not sufficiently protected by prevailing practices regarding decisions to seek health care. The Nepalese study demonstrates that the husband is the most frequent decision-maker in whether to seek hospital maternity care,[143] and that delay in seeking care is a contributing factor to maternal deaths. The husband alone made the decision to seek care in 42.5% of all families that sought hospital care, and the husband and family of the husband together made the decision in 39.1% of the cases. In only 11.5% of cases did maternal family members make the decision. The Nepalese experience suggests that a great deal of effort is needed to educate husbands and wives and their families on the importance of seeking maternity care promptly, and the importance of respecting the woman's decision to seek care promptly when she feels in need of assistance.

b. The right to the highest attainable standard of health

The Economic Covenant, Article 12:

"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

The right to health is also protected by other regional and international human rights instruments (see Appendix 2) as well as by various national constitutions. The Constitution of the Federative Republic of Brazil is particularly clear in providing that:

> Health is the right of all and the duty of the State and shall be guaranteed by social and economic policies aimed at reducing the risk of illness and other maladies and by the universal and equal access to all activities and services for its promotion, protection and recovery.[144]

The CESCR General Comment on Health significantly develops the understanding of what is required to implement the right (see Appendix 7). The General Comment explains that

> "the right to health in all its forms and at all levels contains the following interrelated and essential features:
>
> *(a) Availability* - functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary according to numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by WHO's Action Programme on Essential Drugs.
>
> *(b) Accessibility* - health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:
>
> Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the

population, in law and fact, without discrimination on any of the prohibited grounds.

Physical accessibility: health facilities, goods and services must be within safe physical reach for all parts of the population, especially for vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities, and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitary facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, have to be based on the principle of equity ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: Accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) Acceptability - All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) Quality - As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation." (see Appendix 7, para 12)

WHO is currently working to develop indicators to determine how fully the substantive elements of the right to health services, namely their availability, accessibility, acceptability and quality, are satisfied. Laws and policies that unreasonably restrict health services according to these criteria would not comply with this right. For instance, a law or policy requiring unnecessary qualifications for health service providers will limit the availability of a service that contributes to safe motherhood. Examples of such policies are those that require excessive qualifications for health service providers to perform caesarean deliveries, and that require several specialists to determine satisfaction of criteria for lawful termination of pregnancy. Such policies may be proposed in good faith in order to ensure excellence in women's health care. However, it is poor policy, and may be a human

rights violation where health services are jeopardised, to allow the excellent to be the enemy of the good, or the good the enemy of the adequate.

Some or all of the standards proposed in the CESCR's General Comment on Health and other general recommendations, such as the CEDAW General Recommendation on Women and Health, and those arising out of the Cairo Programme and the Beijing Platform are used to determine whether states are in compliance or in violation with treaty obligations.[145] These standards are also reflected in UN agency consensus documents on the major components of a woman's right to health. For example, a report on maternal health care explains that women-friendly health services should:

(i) be available, accessible, affordable and acceptable;
(ii) respect technical standards of care by providing a continuum of services in the context of integrated and strengthened systems;
(iii) be implemented by staff motivated and backed up by supervisory, team-based training, and incentive-linked evaluation of performance; and
(iv) empower users as individuals and as a group by respecting their rights to information, choice, and participation.[146]

Much work is still required to apply the right to health care effectively so as to ensure the availability, accessibility, acceptability and quality of maternity services in particular countries. However, treaty-monitoring bodies, through their Concluding Observations on country reports, have made some significant beginnings. For example, CESCR, in its Concluding Observation on a report by Gambia, explained that:

> "[r]egarding the right to health in Article 12 of the Covenant, the Committee expresses its deep concern over the extremely high maternal mortality rate of 1,050 per 100,000 live births. UNICEF identifies the main causes to be haemorrhage and infection related to the lack of access to [appropriate services] and poor services."[147]

Important studies have been undertaken to show how tribunals have addressed the general right to health in different countries, through Concluding Observations and through complaint procedures.[148] These kinds of analyses could similarly be undertaken regarding the right of women to maternity care in general and obstetric services in particular.

i. Available resources

Under the Economic Covenant, states are required to take immediate and progressive steps to achieve specific health standards. States are judged on the extent to which they are moving toward "the realization" of the right to the highest attainable standard of health. CEDAW's General Recommendation on Women and Health provides that: "the duty to fulfil rights places an obligation on States parties to take appropriate ... budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care" (see Appendix 4, para 17).

The Constitutional Court of South Africa has addressed the issue of whether the government is required under the South African Constitution[149] to provide long term dialysis treatment for a claimant's chronic renal failure.[150] The Court found that the government is not so required, because the constitutional obligations regarding access to health care services, including reproductive health care, "are dependent upon the resources available for such purposes, and ... the corresponding rights themselves are limited by reason of the lack of resources."[151] The Court stated, however, that emergency services cannot be denied in situations where a person "suffers a sudden catastrophe which calls for immediate medical attention."[152] Thus, it would seem that under the South African Constitution, and possibly under similar provisions of other national constitutions, women seeking emergency obstetric care have a right of reasonable access to treatment.

A state's willingness in principle to give effect to women's rights to health and safe motherhood may be deterred by the fear that full implementation will have indeterminate economic consequences for the national health budget. A finding in a World Bank study, however, has "estimated that providing a standard 'package' of maternal and new-born health services would cost approximately $3 [U.S.] per person per year in a developing country; maternal health services alone could cost as little as $2 per person."[153]

The same World Bank study has also found that family planning and maternal health services are the most cost-effective governmental health interventions, in terms of death and disability prevented.[154] When a mother dies, the economy loses her productive contribution to the work force, her community loses the domestic and wider caring services of a vital member, and her death puts others around her at risk and impaired capacity to function in social, employment and other roles. Studies have shown that when their mother dies, the surviving children are three to ten times more likely to die within two years than children that live with both of their parents.[155]

The study also explains that the savings resulting from investing in maternal health and reduction of maternal morbidity are significant.[156] The population will have fewer poor women, and the work force will be healthier and therefore capable of higher productivity. Reducing maternal mortality and morbidity reduces household poverty and benefits the health system. Moreover, preventative care may save money when there are fewer sick women. Practical and economically viable solutions to the problem of maternal death and sickness include the purchase of a community ambulance where resources exist for fuel and maintenance of an ambulance, or financial help is available to a community to cover emergency transport costs.

ii. Economic access

Some policy makers advocate that users of services should pay at least partial or token fees. Their reasons include needs to raise revenues to be available for health care, but also fears that irrational use may be made of publicly funded health services. Moreover, there is a perceived need to impress upon users of health services that their use of services has economic costs. Paying from their own pockets is believed to bring home this reality to them, and to cause them to question whether

their request for services is based on a real health need, or is rather a frivolous indulgence at others' expense that they will not allow at their own. There is a market-based perception that people exercise rationality in expenditure of their own resources that they do not exercise in expenditure of others' or of public resources, and that cost-effective utilization of resources can be achieved by imposition of user fees for services.

It is uncertain and problematic what effect the imposition of user fees would have on safe motherhood among poor people in developing countries, particularly whether such fees would deter or prevent poor women's resort to necessary maternity care. A study on safe motherhood funded by the U.K. Department for International Development and WHO reported in 1999 that "[t]he paucity of relevant global, let alone local, information on cost poses a challenge to maternal health planners and managers in developing countries, for in the development of health financing schemes, programme costs are critical."[157] Evidence following removal of user fees by the post-apartheid government elected in South Africa in 1994 "suggests that gains in maternal health care ... have been relatively modest," and that more deliveries within health facilities and improvements in the quality of services are also required to reduce maternal and perinatal mortality.[158]

Contrasting evidence has come from other countries experimenting with general user fees, including Kenya. A review of safe motherhood there has observed that:

> "Cost is known to affect both uptake and delays in seeking care. The GOK [Government of Kenya] introduced cost-sharing in 1989 for specific services, but excluding promotive and preventive services, which includes antenatal care ... Evidence from other developing countries indicates a direct decline in utilization of maternity services linked with the introduction of user fees, and this will need to be monitored in Kenya. Fees appear to vary from facility to facility, but generally women are charged in proportion to the service rendered. A caesarean section for example, is more expensive than a normal delivery. This appears logical in terms of the health service inputs but may also be an important deterrent for poor women seeking care."[159]

The inability of impoverished families to pay for the full range of safe motherhood services, including antenatal, delivery and postpartum care, available only by payment, appears evident. When medical services are themselves free of charge, however, poverty may remain an obstacle to safe motherhood. It has been observed that:

> "Even when formal fees are low or non-existent, there can be other costs that deter women from seeking care. These costs may include transport, accommodation, drugs, and supplies, as well as informal or under the table fees that may be imposed by health staff. When women lack control over resources and are dependent on others to provide funds, fees of any kind can be a serious obstacle to their use of services."[160]

Proposed options to overcome economic barriers to safe motherhood services include making medical services free of charge, having means-related sliding fees, insurance schemes based on community membership or, for instance, employment

and community trust fund or loan schemes, each with advantages and disadvantages concerning coverage and effectiveness.

In responding to the problem of economic barriers to services that promote safe motherhood, and to economic conditions that aggravate unsafe motherhood, governments are accountable under the Economic Covenant for denials of the right to the highest attainable standard of health that are due to individuals' poverty. Moreover, Article 12(2) of the Women's Convention, addressing maternity services, requires States Parties to grant "free services where necessary."[161] Accordingly, governments will have to explain the extent to which, in their countries, measures of what standards of health are attainable include issues of personal poverty and of national allocation of economic and other resources.

iii. Transparency and fairness in the allocation of resources

Women whose governments have failed to address their basic obstetric needs in the allocation of health resources in a fair and transparent way may be able to ground a complaint in the right to procedural fairness in administrative decision-making. Courts are slowly applying the right to procedural fairness to require that health benefits are allocated equitably, or at least are not denied in an unfair or arbitrary way.[162] For example, the European Court of Human Rights has found that a sickness allowance should not be arbitrarily withdrawn.[163] This decision could be applied to require the restoration of health services, including maternity services, where they have been withdrawn in an unfair and arbitrary way, and governmental explanation and justification of policies that disfavour safe motherhood services against other health expenditures or budgetary allocations. Further, since in the world's prevailing global economy few if any countries exercise full fiscal sovereignty, governments may be amenable to international persuasion and inducement to invest in such services compatibly with their human rights undertakings.

c. The right to the benefits of scientific progress

> The Economic Covenant, Article 15(1)(b):
>
> "The States Parties to the present Covenant recognize the right of everyone…[t]o enjoy the benefits of scientific progress and its applications."

Scientific progress can play a vital role in the reduction of maternal mortality and morbidity rates. One of the most fundamental methods of reducing risk in pregnancy is to afford women the ability to plan the number and timing of their pregnancies; this can most easily be accomplished through the use of birth control technologies. The right to receive the benefits of scientific progress includes a woman's entitlement to receive the advantages of better and more acceptable means of fertility control, including emergency contraception and non-surgical methods of early abortion.

The right to the benefits of scientific progress can also support the claim that governments should spend public funds on research designed to benefit the reduction of maternal mortality. The modern history of ethical regulation of research involving human subjects originated in the trial of physicians who conducted

inhumane experiments on vulnerable subjects, including inmates of concentration camps, to serve military and scientific interests in the Second World War. Their trial before the International War Crimes Tribunal in Nuremberg resulted in the 1947 Nuremberg Code, which invoked concepts of human rights to prohibit non-consensual medical experimentation. The subsequent decades saw reinforcement of protections against improper medical experimentation in a series of international human rights conventions. Under this inspiration, medical research recovered its moral standing, and its benefits came to be almost universally recognized. In the 1980s it began to be perceived, however, that women were not participating equitably in these benefits.

Human rights protections had been implemented by rigorously excluding women of reproductive age from research initiatives, in order to guard against injuring unborn children. Their exclusion was also economic, since it was costly to have sufficiently large-scale studies to achieve statistically valid data on women at every stage of their menstrual cycle. The effect, however, was that women's health was not seriously studied, except regarding fertility. The health-related factors that predisposed women to maternal mortality and morbidity, other than fertility itself and its control, were under-researched.

In the 1980s it came to be realized, however, that women had been denied their collective human right to benefits of progress in medical science. Reversing the Nuremberg-influenced perception that individuals would be protected by their exclusion from medical studies, women's groups showed that women's health protection depended on scientific research, and that exclusion of research on women's health from governmental funding constituted discrimination. Women allied themselves with AIDS activists to require the conduct of medical research, to address and remedy causes of mortality and morbidity of special concern to them. They pointed to states' legal commitments, made for instance under Article 15 of the Economic Covenant, to respect their rights "to enjoy the benefits of scientific progress and its applications."

Health care providers can accordingly rely on this right to argue for funding to achieve equity in the recruitment of members of both sexes into studies, and in the topics they choose to investigate. Similarly, research agencies, health research centres and, for instance, governmental health departments should remember human rights responsibilities to pursue the goal of safe motherhood through sponsorship and support of appropriate scientific studies. These should include not only biomedical studies, but also epidemiological or public health research, health systems research and social science research that could expose and remedy social causes of unsafe motherhood.

Family Care International (FCI) and the Safe Motherhood Inter-Agency Group (IAG). (1998). ***Safe Motherhood: A Matter of Human Rights and Social Justice.*** Safe Motherhood Factsheet. New York: FC

Safe Motherhood: a Matter of Human Rights and Social Justice

Making safe motherhood a reality for all the world's women is a challenge that calls for significant changes in the way maternal health care is currently provided and in the priorities of national governments, multi-lateral and funding agencies, and non-governmental organisations (NGOs). In the wake of recent international conferences, reducing maternal mortality and providing care for pregnant women must be seen as integral to reproductive health. But changes in service delivery and accessibility are not sufficient. The goals of the Safe Motherhood Initiative will not be achieved until women are empowered and their human rights — including their rights to quality services and information during and after pregnancy and childbirth — are realised.

Empowering Women, Ensuring Choices[1]

The sluggish decline in maternal mortality and morbidity is rooted in the powerlessness of women, and women's unequal access to resources in families, society and economic markets. These factors set the stage for poor reproductive health and unsafe motherhood even before a pregnancy occurs, and make it worse once pregnancy and childbearing have begun.

Women face multiple barriers to attaining good health. These include:

- **Limited information and options:** Women's limited exposure to new ideas and information means that they are socialised to accept pain and suffering as women's "lot", and they do not perceive pregnancy as requiring any additional care. As a result, many women do not recognise danger signs during pregnancy, and do not know where or when to seek medical services.
- Unequal power relations that constrain women's decision-making ability, physical mobility and access to material resources: In some settings in developing countries, the decision to deliver at home is generally made by the husband or other family member. Many women need permission from their husbands to visit a health facility. Women's lack of economic resources constrains their ability to make independent health-related choices, and to gain access to health and other social services.
- Poor quality of interaction with health care providers: Women in many cultures are reluctant to use health services because they perceive health care providers to be rude, patronising and insensitive to the context in which they live. Interactions with providers can be threatening and humiliating, and women often feel pressured to make choices that conflict with their own health and fertility goals.

Empowering women means enabling them to overcome these barriers and to make fully informed choices, particularly in the areas affecting the most intimate aspect of their lives — their reproductive health. Empowerment is critical to securing safe motherhood because it enables women to:

a) articulate their health needs and concerns;

b) access services with confidence and without delay;

c) seek accountability from service providers and programme managers, and from governments for their policies;

d) act to reduce gender bias in families, communities and markets; and

e) participate more fully in social and economic development.

Empowering women in the area of health requires more than simply health-related interventions; it requires social, economic and cultural conditions in which freedom and responsibility are given concrete meaning. Women must have the means — both physical and psychological — to overcome the barriers to safe motherhood. Central to all empowerment is choice, and far too many women still have far too few choices.

What Can be Done[1]

In order to address the constraints on women, multiple actions will be needed in the private and public spheres to ensure women's empowerment:

- Women must have greater freedom to determine their own health and life choices within families and communities; they must have opportunities to learn about their rights and their health, to question the acceptability of unfair practices and to develop a feeling of entitlement to medical care and other services.
- Women must have access to accurate information about their reproductive health as well as to high quality, women-centred care.
- Women must have expanded access to educational and economic opportunities, and control over economic and other resources.
- Adolescents must be offered the opportunity to develop life skills, including self-esteem, so that they can act to protect their own health.
- Men must be sensitised to their role in expanding choices for women within households and communities, and in ensuring responsible sexual and family life.

- Women must be supported by policies and laws that promote and ensure safe motherhood, good quality maternal care and gender equality; correspondingly, governments must engage women in planning, implementing, monitoring and evaluating health programmes for women.
- Training of providers must stress the importance of preserving women's dignity; encouraging informed choices; recognising the realities of women's lives and providing sensitive counselling to uncover and treat the conditions that women are accustomed to endure.

Reducing inequalities in social and economic policies, and protecting and promoting women's rights, choices and autonomy, are core public activities. They are also critical to reducing maternal deaths and ill-health, achieving the goals of the Safe Motherhood Initiative, and bringing about sustainable, equitable development for all the world's women and men.

Advance Safe Motherhood Through Human Rights[2]

Preventing maternal death and illness is an issue of social justice and women's human rights. Redefining maternal mortality from a "health disadvantage" to a "social injustice" provides the legal and political basis for governments to ensure maternal health care for all women — care that will save their lives. The challenge in applying human rights to advance safe motherhood is to characterise women's multiple disempowerments — during pregnancy as well as from birth — as injustices that governments are obligated to remedy through political, health and legal systems.

The protection and promotion of the human rights of women can help ensure that all women have the right to:

- make decisions about their own health, free from coercion or violence, and based on full information; and
- have access to quality services and information before, during and after pregnancy and childbirth.

Existing national constitutions and international human rights treaties offer under-utilised opportunities to advance safe motherhood. Relevant international treaties include:

- Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention);
- International Covenant on Civil and Political Rights;
- International Covenant on Economic, Social and Cultural Rights;
- Convention on the Rights of the Child;
- European Convention on Human Rights;
- American Convention on Human Rights; and
- African Charter on Human and Peoples' Rights.

Each of these treaties has a monitoring body that develops performance standards for signatory countries, and monitors their compliance with these standards. Countries are to report regularly to the relevant monitoring bodies on what they have done to ensure the full development and advancement of the rights enshrined in the human rights treaties they have ratified. The Women's Convention, which has been ratified by more than 160 countries and is being used to advance safe motherhood, is monitored by the Committee on the Elimination of Discrimination Against Women (CEDAW).

The Challenge[2]

Efforts to advance safe motherhood through human rights must build on the existing framework of human rights recognised in most national constitutions and international human rights treaties. These rights include:

- *rights relating to life, liberty and the security of the person,* which require governments to ensure access to appropriate health care during pregnancy and childbirth (women's right to life), and to ensure women's rights to decide if, when and how often to bear children (right to liberty and security of the person);
- *rights relating to the foundation of families and of family life,* which require governments to provide access to health care and other services women need to establish families and to survive to enjoy life within the family;
- *rights relating to health care and the benefits of scientific progress,* including to health information and education, which require governments to provide reproductive and sexual health services and information for women; and
- *rights relating to equality and non-discrimination* on grounds such as s' marital status, race, age and class, whic require governments to provide access to services such as education and health care for women and girls — especially for women or girls of a particular marital status, age, minority group or socio-economic status.

What Can be Done[2]

Much has been achieved in the past ten years to develop standards of human rights that support and protect women's reproductive health needs. For example, the Programme of Action of the International Conference on Population and Development (1994) states that governments must work to reduce by h number of maternal deaths by the year 2000, and then reduce maternal deaths by another half by 2015.

Three critical actions needed now are:

- reforming laws that contribute to maternal mortality (e.g., laws that require women seeking health services to obtain the authorisation of their husbands, and laws that inhibit access to safe reproductive health services);
- implementing laws that protect women's health interests (e.g., laws that prohibit child marriages, female genital mutilation, rape and sexual abuse); and

- applying human rights in national constitutions and international conventions to advance safe motherhood (e.g., by requiring states to take effective preventive and curative measures to reduce mortality and to treat women with respect and dignity).

The ICPD Programme of Action in itself was non-binding; however, in 1995, CEDAW agreed to use the Programme of Action in developing performance standards for the Women's Convention. Therefore, signatories to the Women's Convention are obligated to uphold and advance the ICPD commitments, including the right of women and men to decide if, when and how often to reproduce, and to have access to appropriate health services that enable women to enjoy safe pregnancy and childbirth.

States have a legal obligation to account for their practices regarding human rights by reporting to human rights treaty bodies. Where states do not take all appropriate measures to bring laws, policies and practices into compliance with the human rights of women, they have been and can continue to be held accountable by constitutional courts and treaty monitoring bodies for denying women their human rights, which are necessary for their dignity and empowerment.

Sources:

1. S.J. Jejeebhoy, "Empower Women, Ensure Choices: Key to Enhancing Reproductive Health". Presentation at Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

2. R.J. Cook, "Advancing Safe Motherhood Through Human Rights". Presentation at Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

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1998

Safe Motherhood: A Matter of Human Rights and Social Justice

For a woman to die from pregnancy and childbirth is a social injustice. Such deaths are rooted in women's powerlessness and unequal access to employment, finances, education, basic health care and other resources. These factors set the stage for poor maternal health even before a pregnancy occurs, and make it worse once pregnancy and childbearing have begun.

Making motherhood safer, therefore, requires more than good quality health services. Women must be empowered, and their human rights — including their rights to good quality services and information during and after pregnancy and childbirth — must be guaranteed.

The Powerlessness of Women[1]

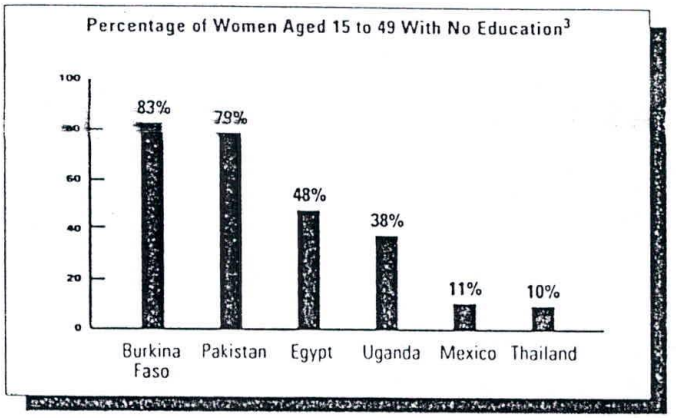
- Millions of women in the developing world do not have the social and economic support they need to seek good health and safe motherhood. Physical and psychological barriers include:

— *Limited exposure to information and new ideas:* In many communities pregnancy is not seen as requiring special care, and women do not recognise danger signs during pregnancy. Even if they are experiencing pain and suffering, they may have been taught that these conditions are inevitable, and therefore do not seek medical care.

— *Limits on decision-making:* In many developing countries, men make the decisions about whether and when their wives (or partners) will have sexual relations, use contraception or bear children. In some settings in Asia and Africa, husbands, other family members or elders in the community decide where a woman will give birth and must give permission for her to be taken to a hospital.

— *Limited access to education:* In much of Africa and Asia, 75% of women age 25 and over are illiterate.[2] When girls are denied schooling, as adults they tend to have poorer health, larger families and their children face a higher risk of death.

— *Limited resources:* Poverty, cultural traditions and national laws restrict women's access to financial resources and inheritance in the developing world. Without money, they cannot make independent choices about their health or seek necessary services.



- Health services that are insensitive to women's needs, or staffed by rude health providers, do not offer women a real choice: In many cultures, women are reluctant to use health services because they feel threatened and humiliated by health workers, or pressured to accept treatments that conflict with their own values and customs.

HOW CAN EMPOWERING WOMEN MAKE MOTHERHOOD SAFER?[1]

It enables women to:

- speak out about their health needs and concerns.
- seek services with confidence and without delay.
- demand accountability from service providers, and from governments for their policies.
- participate more fully in social and economic development.

Political Commitment to Safe Motherhood[4]

- National policy-makers can establish a legal and political basis for safe motherhood by defining maternal mortality as a "social injustice", as well as a "health disadvantage". By doing so, they will commit their governments to:

— *Identifying the powerlessness that women face* — throughout their lives as well as during pregnancy — as an injustice that countries must remedy through political, health and legal systems.

— *Ensuring that all women have the right* to make decisions about their own health, free from coercion or violence, and based on full information.

— *Guaranteeing that all women have access* to good quality care before, during and after pregnancy and childbirth.

Using International Human Rights to Advance Safe Motherhood[4]

■ **International human rights treaties can be used to advance safe motherhood (see below). These documents, as well as most national constitutions, guarantee:**

— *The right to life, liberty and the security of the person.* These rights require governments to provide access to appropriate health care, and to guarantee that citizens can choose when and how often to bear children.

— *Rights that relate to the foundation of families and of family life.* These rights require governments to provide access to health care and other services women need to establish families and enjoy life within their families.

— *The right to health services (including information and education) and the benefits of scientific progress.* These rights require governments to provide reproductive and sexual health care to women.

— *The right to equality and nondiscrimination.* These rights require governments to ensure that *all* women and girls have access to services (such as education and health care)—regardless of age, marital status, ethnicity or socio-economic status.

■ **Recent international conferences and conventions set explicit goals that support and protect women's reproductive health needs.**

— Governments participating in the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women agreed that women and men have the right to decide if, when and how often to bear children, and should have access to reproductive health services. They also pledged to cut the number of maternal deaths in half by the year 2000, and in half again by 2015. Although these commitments are non-binding, the Committee on the Elimination of Discrimination Against Women, which monitors the Women's Convention (see below), is using them as standards for the 161 countries that signed the Convention.

THE FOLLOWING INTERNATIONAL TREATIES PROVIDE FRAMEWORKS THAT CAN BE USED TO ADVANCE SAFE MOTHERHOOD:

- Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention);
- International Covenant on Civil and Political Rights;
- International Covenant on Economic, Social and Cultural Ri[illegible]ss
- Convention on the Rights of the Child;
- European Convention on Human Rights;
- American Convention on Human Rights; and
- African Charter on Human and Peoples' Rights.

Each is monitored by a group that develops performance standards for member countries and tracks compliance through periodic reports provided by each country.

What Can Be Done

■ **Governments must provide a framework for ensuring safe motherhood by:**

— *Reforming laws and policies that contribute to maternal mortality* (e.g. those that restrict women's access to reproductive health services and information) and implementing laws and policies that protect women's health (such as prohibitions against child marriage and female genital mutilation).

— *Guaranteeing all women access to good quality maternal health care and accurate information,* and involving women in planning, implementing, monitoring and evaluating health programmes.

■ **Community leaders, women's advocates, private organisations and individuals must:**

— *Allow women greater freedom* to make their own health and life choices, encourage them to question unfair practices, and give them opportunities to learn about their rights and health and to develop a feeling of entitlement to medical care and other services.

— *Help men understand their role in expanding choices for women,* and in ensuring responsible sexual and family li[illegible] (by

■ **Everyone, including women's health advocates and donors, must:**

— *Hold governments accountable for effectively protecting the human rights of their citizens* by reporting any violations to constitutional courts and international monitoring bodies.

Sources:

1: S.J. Jejeebhoy, "Empower Women, Ensure Choices: Key to Enhancing Reproductive Health". Presentation at Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

2: *The World's Women, 1970-1990, Trends and Statistics.* United Nations, New York, 1991.

3: *Women's Lives and Experiences: A Decade of Findings from the Demographic and Health Surveys Program.* Macro International, Calverton, MD, 1994.

4: R.J. Cook, "Advancing Safe Motherhood Through Human Rights". Presentation at Safe Motherhood Technical Consultation in Sri Lanka, 18-23 October 1997.

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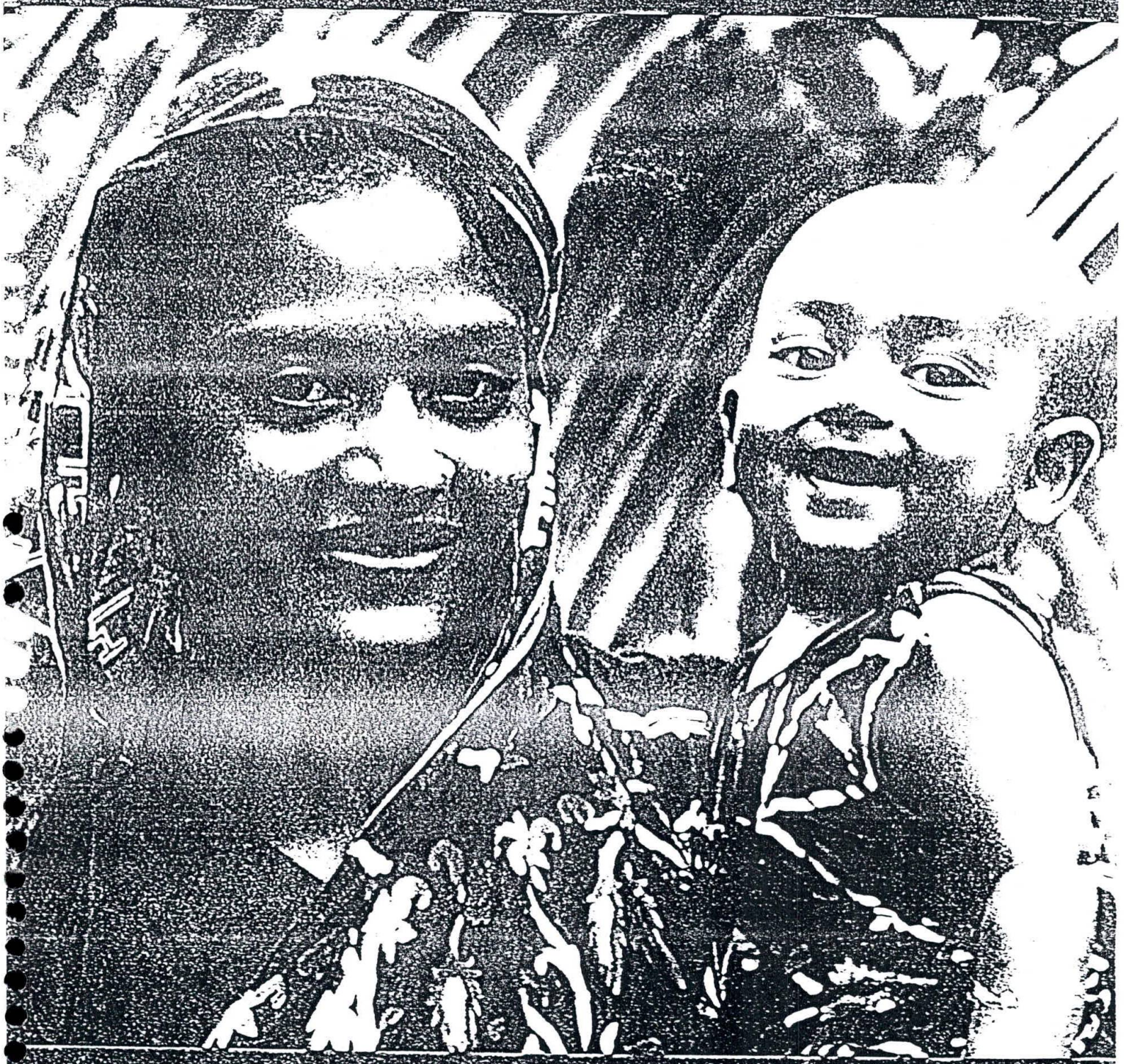
UNICEF, Regional Office for South Asia. (2003). ***A Human Rights-based Approach to Programming for Maternal Mortality Reduction in a South Asian Context. A review of Literature.*** Geneva: UNICEF, pp. 100-106.

A HUMAN RIGHTS-BASED APPROACH TO PROGRAMMING FOR MATERNAL MORTALITY REDUCTION IN A SOUTH ASIAN CONTEXT

A review of the literature



or every child
lth, Education, Equality, Protection
DVANCE HUMANITY

unicef

Appendix 1:
A Summary of Human Rights[701]

World Health Organization, *Transforming Health Systems: Gender and Rights in Reproductive Health*, http://www.who.int/reproductive-health/

Human rights necessary for survival and dignified living include:

- The rights to life and liberty
- The right to a standard of living adequate for health and well-being of the individual and his/her family
- The right to social protection in times of need
- The right to the highest attainable standard of physical and mental health
- The right to work and to just and favourable conditions of work
- The right to food and housing
- The right to privacy and family life

Human rights also cover rights and freedoms related to human dignity, creativity and intellectual and spiritual development, for example:

- The right to education and access to information
- Freedom of religion, opinion, speech and expression
- Freedom of association
- The right to participate in the political process
- The right to participate in cultural life

Human rights also include rights necessary for liberty and physical security, for example:

- Freedom from slavery and servitude
- The right to security of person (physical integrity)
- The right to be free from arbitrary arrest or imprisonment
- Freedom from torture and from cruel, inhuman or degrading treatment or punishment

Appendix 2:
Human Rights Affecting Safe Motherhood[702]

The following is a summary of the rights mentioned in Appendix 1 plus the major articles quoted.

1. Rights relating to life, survival and security

These include:

The right to life and survival: ICCPR[703] 6(1)
- Most obvious right to protect pregnant women
- Requires government to address avoidable deaths by taking positive measures
- Includes increasing the rate of births attended by skilled birth attendants

The right to liberty and security of person: ICCPR 9(1)
- Supports women's free choice of maternity
- Holds governments accountable to provide conditions for safe motherhood
- Requires clinic policies and law that ensure women's care and confidentiality
- Requires positive measures to ensure respect for women at particular risk

The right to be free from inhuman and degrading treatment: ICCPR 7
- Requires states to provide health services when their denial would constitute inhuman treatment.

2. Rights relating to maternity and health

These include:

The right to maternity protection: ICESCR 10(2), CEDAW 5(b), 12(2), UDHR 25(2) CRC 24(d)
- Obligates states parties to provide free maternity services if necessary

The right to maternity protection during employment: ICESCR 10(2), MPC 1, 4(1)(3)
- Requires paid maternity leave plus health care without discrimination

The right to marry and found a family: ICCPR 23, ICESCR 10(1), CEDAW 16
- Covers full and free consent to marriage, minimum age for marriages
- Includes right of children and husbands to family life with mother/wife

The right to free choice of maternity/the right to private and family life: CEDAW 16(1), ICCPR 17(1)
- Includes the right to decide freely and responsibly on the number and spacing of children
- Right to have access to the information, education and means to enable women to exercise these rights

The right to the highest attainable standard of health: ICESCR 12
- Includes essential features such as availability, accessibility, acceptability, and quality
- Available resources: obliges states to take appropriate budgetary, economic and other measures to the maximum extent of resources
- Economic access: requires governments to give services free if necessary
- Transparency and fairness in the allocation of resources: protects women from being arbitrarily denied resources or services

The right to the benefits of scientific progress: ICESCR 15(1)(b)
- Requires that recent advances be made available to women

- This right is used to argue for funding for appropriate research on maternal health

3. Rights relating to non-discrimination and due respect for difference

States parties obligations include: ICCPR 2(1),26

- States parties are obliged to change laws and policies which discriminate on the face (e.g. women, not men, need spousal consent for health services) and in effect (e.g. everyone must pay equally discriminates against the poor)

- Women have distinct interests in safe pregnancy and childbirth, which if not protected would constitute discrimination

Issues to be considered include:
Sex and gender
Sex and gender non-discrimination in the family: CEDAW 1
Sex and gender non-discrimination in health: CEDAW 12

- Particular mention of adolescents sexual and reproductive health education

Marital status: ICCPR 2(26)

- Requires that there is no discrimination in services offered to married and single women

Age: CRC 2, 14(2)

- Requires governments to provide reproductive health care to adolescents and to take into due account the "evolving capacities of the child"

Race and ethnicity: ICERD 1

- Requires that attention is given to the distribution of resources to districts with different racial composition

Other status

- Includes rural residence, poverty

- Different forms of discrimination often overlap.

4. Rights relating to information and education

These include:

The right to receive and to impart information: ICCPR 19

- Requires governments to provide information about how to save lives of women before, during and after delivery

The right to education: ICESCR 13

- Relates to safe motherhood as girls education is linked to decreased maternal mortality, probably due to informed choice on timing and number of pregnancies, awareness of pregnancy complications and removing misconceptions about pregnancy and childbirth

There is also recognition of the right to specific educational information to help ensure the health and well-being of families.

5. Rights relating to physical integrity

These include:

The right to be free from torture, cruel, inhuman or degrading treatment or punishment: UDHR 5, ICCPR 7,CRC 37a, CAT 12

The right to be free from medical or scientific experimentation against ones will: ICCPR 7

The right to be protected from violence against women: CEDAW General Recommendation 12, DEVAW

The right to protection in situations of armed conflict: PFA 144b, DPWCEAC 4 requires states to protect women from rape, forced prostitution, persecution, torture, degrading treatment, violence and any other form of assault and sexual slavery

The right not to be forced to return to a country where one may be in danger of torture: CAT 3

6. Rights relating to participation

These include:

The right to vote in all elections and public referenda CEDAW 7a
The right to participate in the formulation and implementation of government policy CEDAW 7b

The right to participate in development planning and implementation CEDAW 14.2.a

The right to participate in all community activities CEDAW 14.2.f

The right to participate in non-governmental organisations and associations CEDAW 7.c

The right to represent their government at the international level and to participate in the work of international organisations CEDAW 8

Appendix 3:
Ratification of Relevant Rights Documents by South Asian Countries (May 2003)

	CRC	CEDAW	ICESCR	MPC**	ICERD
Afghanistan	R	R	R	R	R
Bangladesh	R	R	R	R	R
Bhutan	R	R			R
India	R	R	R	R	R
Maldives	R	R			R
Nepal	R	R	R	R	R
Pakistan	R	R		R	R
Sri Lanka	R	R	R	R	R

R = Ratification
S = Signature
Source: http://www.unhchr.ch
** Ratifications as of May 31, 1997, Source: International Women's Tribune Center, Rights of Women, page 129
# Ratification as of December 31, 1998, Source: http://www.unesco.org

Acronyms:

CRC :	Convention on the Rights of the Child
CEDAW:	Convention on the Elimination of All Forms of Discrimination against Women
ICESCR:	International Covenant on Economic, Social and Cultural Rights
MPC:	Maternity Protection Convention (Revised)
ICERD:	International Convention on the Elimination of All Forms of Racial Discrimination

Appendix 4:
Documents Relevant to the Rights Related to Women's Health

Documents Relevant to Women's Health[704]

Universal Declaration on Human Rights
Articles 2, 3, 5, 16, 25

International Covenant on Civil and Political Rights: Articles 2, 6, 7, 9, 17, 23.

International Covenant on Economic, Social and Cultural Rights: Articles 2, 10, 12, 15

Convention on the Elimination of All Forms of Discrimination Against Women: Articles 1, 2, 3, 5, 6, 10, 11, 12, 14, 15, 16

Convention on the Rights of the Child:
Articles 6, 16, 19, 24, 34, 37

International Convention on the Elimination of All Forms of Racial Discrimination: Article 5

International Conference on Population and Development Programme of Action:
See paragraphs 7.1-7.48; 8.19-8.35; 4.1-4.23; 11.1-11.10.

UN Fourth World Conference on Women Platform for Action
See paragraphs 89-130; 259-285.

CEDAW General Recommendation No. 12 or 19 on Violence Against Women states that the Committee considers gender-based violence to be a form of gender discrimination, and therefore outlawed by CEDAW

CEDAW General Recommendation No. 14 on Female Circumcision states the Committee's view that appropriate and effective measure must be taken to eradicate female genital mutilation.

CEDAW General Recommendation No. 15 on HIV/AIDS requires states parties to include information on AIDS and its effect on women and recommends certain national-level action to address such effects.

CEDAW Recommendation No 21. on Equality in Marriage and Family Relations outlines the Committee's views on the importance of women's basic rights within the family.

CEDAW General Recommendation No. 24 on Women and Health affirms the obligation of State parties to ensure women's access to health care as a basic right.[705]

Appendix 5:
Conceptual Framework for Assessing and Analysing the Situation of Children and Women from a Rights Perspective[706]