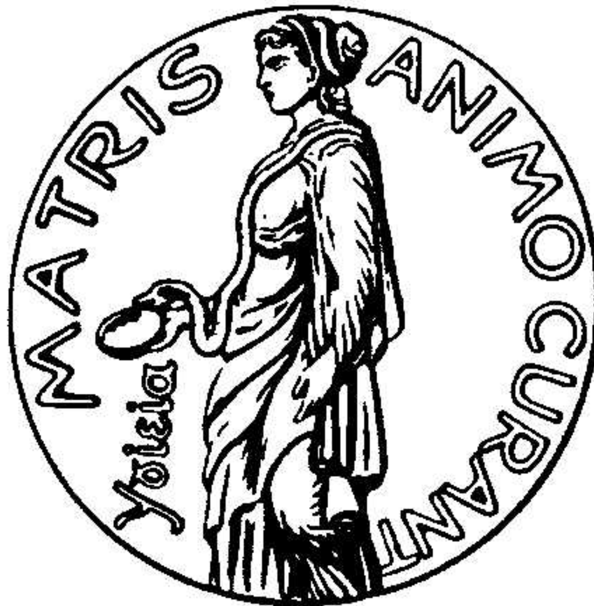
TRAINING MANUAL
FOR GENDER MAINSTREAMING
IN HEALTH



MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION

2002

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PREFACE

The Medical Women's International Association (MWIA) is an international non-governmental organization (NGO). Women physicians in more than seventy countries make up the membership. The association was founded in 1919. Embodied in its mission is the objective to raise the health status of the communities in which the members work, especially the health of women and children in those communities.

MWIA held a conference at the Rockefeller Study and Conference Center in Bellagio, Italy, under the Center's International Conference Program. The conference took place in December, 2001. Gathered together were the executive of MWIA along with gender experts from around the world.

The objective of the conference was to develop a ***Training Manual on Gender Mainstreaming in Health.*** As the word "gender mainstreaming" is foreign to the ears of physicians, the manual would be better called a ***Training Manual to Incorporate a Gender Perspective in Health and Health Care.*** These two terms will be used interchangeably in this manual.

The Fourth World Conference on Women in Beijing in 1995 produced the Beijing Platform for Action, in which there was a commitment to mainstream a gender perspective into all United Nations activities, and particularly to develop gender sensitive initiatives for women's health.

Since 1995, there has been a shift from talking about Women In Development (WID) to Gender and Development (GAD). The gender approach recognizes three things. The first is that women and men are different and need to be valued despite their differences. The second is that society values what is male over what is female and if economic and social advancements are to be made, both women and men must work together toward this goal of gender equality. The third is that gender is not just your biological sex, but rather the role society gives you by virtue of being female or male. It was this inherent power relationship between women and men that failed to improve women's position in society in the Women In Development (WID) strategies.

When using the Gender and Development Approach (GAD) in health, it has been well documented that incorporating a gender perspective into health care delivery and policy development improves the health of both women and men. Health is a basic human right.

Despite much excellent work since the Beijing Platform for Action in 1995, most physicians in clinical practice do not understand the concept of gender mainstreaming and its importance in positively influencing the health of both women and men. Women and men continue to suffer and die of readily preventable causes because of this lack of awareness. Gender differences play a very significant role in the differential in the burden of disease between men and women. As women physicians who see this human

tragedy in our day-to-day work, we feel a compelling sense of duty and responsibility to address gendered aspects of health.

Gender mainstreaming addresses gender relations and is not merely an euphemism for "women's issues" as men can also be disadvantaged by their gender roles. It leads to improvement in the fundamental principles of society to make men and women equal. Rather than excluding biology, it adds the social and cultural factors that affect power relations between men and women, which either promote or impede health.

MWIA's ***Training Manual to Incorporate a Gender Perspective in Health and Health Care,*** is directed towards educating physicians. It uses cases to make the information understandable and relevant to physicians. The immediate result of the manual will be the influence on clinical practice and on physician input into policy development. However, knowing that the sphere of influence of physicians is wide, once physicians understand the concept and are given the tools to mainstream gender, there will be a trickle down effect to those with whom they work and influence.

Our attitudes influence the way we treat each other and communicate with one another. Once we are aware of gender issues, as physicians we can re-examine our attitudes and develop skills and knowledge to make sure gender equity and equality are achieved in health and health care. As a result of this understanding, we shall be better physicians.

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Course Objectives

After completing this workshop, participants should be able to answer the following questions:

1. How does gender affect health and health care?

2. How do gender stereotypes influence our recognition and management of women's health issues?

3. Has education and research given us enough knowledge about women's health issues and the differences between caring for men and women with regards to prevention, pathogenesis, diagnosis, treatment and prognosis?

4. Are we clear about how policy decisions influence health and health care?

5. Are we able to disseminate the information on gender mainstreaming in health to our peers, our community and our policy makers?

6. Are we knowledgeable about how to implement the concepts of gender mainstreaming in health?

INTEGRATING A GENDER PERSPECTIVE INTO HEALTH AND HEALTH CARE:

AN OVERVIEW OF GENDER MAINSTREAMING

A) Understanding Gender

In order to be able to incorporate a gender perspective into health and health-care, it is critical to understand the meaning of gender, to be able to define it and to distinguish between gender, sex and sexuality.

Gender can be seen as the full range of personality traits, attitudes, feelings, values, behaviours and activities that society ascribes to the two sexes on a differential basis. It is a social construct, which varies from society to society and over time.

Sex is a biological description, which is determined by biology. However, even sex may not be wholly dichotomous as is made evident by inter-sexed individuals.

Sexuality refers to the capacity for sexual feelings and their expression – again this capacity is not necessarily dichotomous between men and women. (eg. Heterosexuality, homosexuality and bisexuality.)

In many medical articles, as well as in the lay press, the terms sex and gender are often confused and used interchangeably. Some people use the word gender when they really mean sex, but feel it is inappropriate to use that word. This can be very confusing.

Differences between women and men need to be understood to result from the complex interaction between biology (eg. genetics, hormones, physiology) and cultures
(eg. religion, hierarchical relationships, historical and geographic location and social roles).

A fuller understanding of gender includes recognition of gender as a social construct, as a system of social stratification and an institution that structures every aspect of our lives because of is embeddedness in the family, the workplace, the health care system and the state as well as in sexuality, language, and culture. It is a primary way of signifying relationships of power.[1] Each culture is deeply invested in its construction of gender roles and those who benefit from the existing system may strongly resist efforts to change, or even describe it.

Gender has many components both as a social institution and as an individual perception. From a social perspective gender is seen in terms of social status, distribution of labour, kinship, (family rights and responsibilities) sexual scripts, personalities (how one is supposed to feel and behave) social control, ideology and imagery. An individual's

gender is constructed by the sex category to which the infant is assigned, gender identity, marital and procreative status, sexual orientation, personality (internalized patterns of behaviour etc) and gender beliefs systems.

Sex and Gender are interactive. While sex and its associated biological functions are programmed genetically, gender roles and power relations vary across cultures and through time, and thus are amenable to change.

Gender roles are the particular economic, social roles and responsibilities considered appropriate for women and men in a given society. Gender roles and characteristics do not exist in isolation, but are defined in relation to one another and through the relationship between women and men, girls and boys. (3)

Gender equality is the absence of discrimination on the basis of a person's sex in authority, opportunities, allocation of resources or benefits, access to services. It is therefore, the equal valuing by society of both the similarities and differences between men and women, and the varying roles that they play.

Gender equity is the process of being fair to women and men. To ensure fairness, measures must often be available to compensate for historical and social disadvantages that prevent women and men from otherwise operating on a "level playing field**." Equity leads to equality. Gender equity** also means that health needs, which are specific to each gender, receive appropriate resources (eg. reproductive health needs) and also special needs relating to women's greater vulnerability to gender-based violence.

Gender awareness is the understanding that there are socially determined differences between men and women based on learned behaviour, which affect ability to access and control resources.

Gender sensitivity is the ability to perceive existing gender differences, issues and equalities, and incorporate these into strategies and actions.

Gender blindness is the failure to recognize that gender is an essential determinant of social outcomes, including health. It therefore impacts assessment and management of health problems.

Gender analysis identifies, analyzes and informs action. It addresses:

1) inequalities that arise from the
    a) different roles of men and women
    b) the unequal power relations between them
    c) other contextual factors: ethnicity, sexual orientation, employment citizenship, etc. and
2) the consequences of these inequalities on their lives, their health and well-being.

The way power is distributed in most societies means that women have less access to and control over resources to protect their health, are less likely to be involved in decision-making and are more likely to be responsible for caring for the health of family members and others.

Gender analysis in health highlights:

1) How inequalities disadvantage women's health
2) The constraints women face to improve their health
3) Ways to address and overcome these constraints
4) Health risks and problems men face as a result of the social construction of masculinity
5) Other contextual factors that impact health problems in men and women.

Gender biases in the health system

The health system, like society at large, tends to typecast women and men based on long-standing traditional roles and attitudes. This has affected women, both as users of health care and as caregivers, in the following ways:

1) narrowness of focus, concentrating on reproductive health
2) ignoring or circumventing women, an exclusion that translates into
    a) reduced access to resources
    b) under-representation in, or absence from, governance, research and education materials
3) treating women the same way as men, when it is inappropriate to do so, or
4) treating women differently when it is not appropriate. [4]

It has affected men by:

1) ignoring the effects of the social meaning of masculinity on men's health
2) avoiding research and practice in men's emotional health

<u>**Gender Equality in Health**</u>

Gender equality impacts the following areas of health care provision.

1) <u>**The State of Health:**</u>

    The elimination of unnecessary, unjust, and avoidable differences between men and women, and their potential for enjoying good health, and in their likelihood of becoming ill, disabled, or dying from preventable causes.

2) **Access to the Utilization of Health Services:**

That men and women receive care in accordance with their needs.

3) **The Financing of Care:**

That women are not obliged to contribute more than men by reason of the biology of reproduction and their greater longevity or that they are not disadvantage in obtaining health care by virtue of their generally lower economic status.

4) **Participation in the Development of Health Care:**

That health care activities, whether remunerated or free, be recognized, facilitated and appropriately valued, and
That women and men share in decision-making on an equal footing in the micro and macro spheres of the health care system.

Gender Planning is a process of applying the results of gender analysis to bridge the gaps/inequalities identified between women and men, through the planning process at various levels including departmental/divisional plans, sector plans and national development plans. Gender planning includes taking appropriate action to bring marginalized groups to an equal standing with others.

Incorporating a Gender Perspective in Health (Gender Mainstreaming) means applying all these concepts to health and health care so that women and men receive care in accordance with their needs.

Because gender is a relational term (defining relationship between men and women) the term must include both women and men.

Concepts of gender, gender roles and gender socialization may differ in different societies and may change over time. However, despite these differences, women as a group have less power than men in the areas of government and policy formulation, financial institutions, religion and the military in all societies.

B) Why is the concept of gender important to MWIA?

A growing literature addresses the articulation of gender roles and ideology with health status, the organization of health care, and health policies. It is thus necessary to bring a gender perspective to all fields of health related practice.

The United Nations and World Health Organization's approach has evolved from a focus on **Women in Development (WID)** to the concept of **Gender and Development (GAD).** [29]

In doing so, they recognize:

1) The important contributions that both women and men can make to development.
2) That women and men are different and require special attention to their different needs and to the various ways in which these could be met.
3) That resultant gender sensitive policies and programs will make a difference to both women and men, not only as recipients of health care but also as providers of health services.
4) That it changes the focus from women as the problem to a focus on the relationship between men and women and the way in which society devalues women's work and constrains their access to resources, as a result of the power differential between men and women which exists in virtually every society.

Dr. Gro Harlem Bruntland, Director of the World Health Association, has stated on many occasions that there is no country which treats its women the same as its men.

As an organization with a major commitment to health for all, the MWIA has made a decision to focus on the topic of "gender and health."

C) Determinants of Health

In addressing this topic, another critical concept to discuss is that of the determinants of health.

A major development in our understanding of both men's and women's health has been the recognition that health status is influenced, not only by biology or indeed by health care itself, but to a much larger extent by what have been termed the broader determinants of health.

These determinants include income and social status, social support networks, education, employment/working conditions, social environments, physical environments, housing, personal health practices and coping skills, healthy child development, biology and genetic endowment, access to health services, gender, culture/ethnicity, and immigration/refugee status.

Powerlessness, i.e. a lack of control over one's destiny, has also been identified as a risk factor for disease, chronic stress and higher morbidity and mortality.[5] A number of publications have drawn attention to the importance of these determinants.

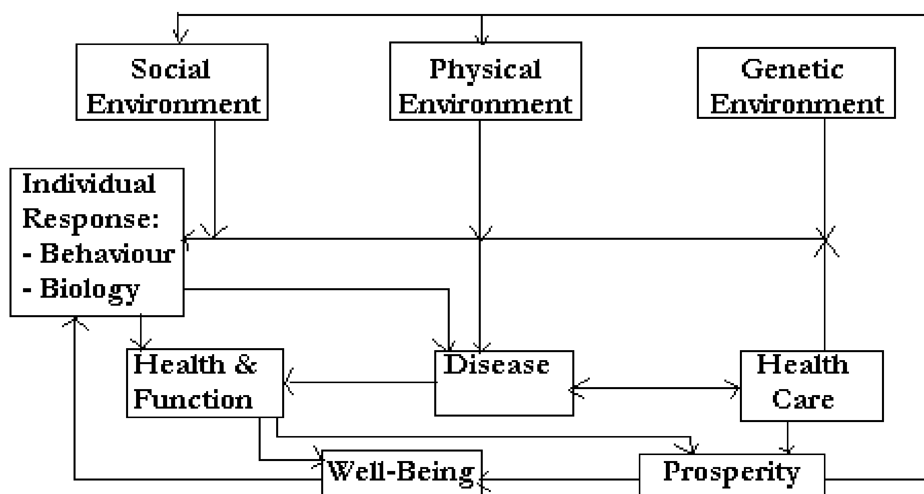
The Commonwealth Secretariat report [6] states that:
(i) women's health is directly affected by a range of sociocultural, physical and psychological factors.
(ii) women have gender roles and responsibilities which directly affect their level of access to and control of resources necessary to protect their health. These resources are external (economic, political, information/education, a safe environment free of violence, and time) as well as internal (self esteem, initiative).
(iii) women are diverse in their age, class, race or ethnicity, religion, functional capacity, sexual orientation and social circumstances.
These factors may lead to inequities, which adversely affect their health.

The Ottawa Charter for Health Promotion [7] identified the fundamental conditions and resources for health as peace, shelter, education, food, income, a stable eco system, sustainable resources, social justice and equity. As well, the publication "Population Health Promotion"[8] draws attention to the multiple determinants of health including: income and social status, social support networks, education, employment and working conditions, physical environment, biology and genetic endowment, personal health practices and coping skills and healthy child development. The document goes on to point out that to improve the health of the population, action must be taken on the full range of health determinants.

The National forum on Health (Canada) [9] in its final report, focused on the importance of addressing health from the broad perspective of the non-medical determinants of health. The Forum believed that the social and economic determinants of health merited particular attention and one of its goals was to raise awareness of the far-reaching implications to health of social and economic factors.

In the book "Why are some People Healthy and Others not," [10] Renaud states that the ways in which society regulates employment and economic cycles, provides education, assists its members in times of economic or other difficulties, sets up strategies to counteract poverty, crime and drug abuse and stimulates economic and social growth have just as much, if not more, impact on health than the quantity and quality of resources being invested in the detection and care of illness. He goes on to state that some of the best-kept secrets of longevity and good health are to be found in one's social, economic and cultural circumstances. Another way of understanding the concept of determinants of health is to discuss the model illustrated in the following diagram.

DETERMINANTS OF HEALTH MODEL



Source: Evans RG, Stoddart GL. "Producing health, consuming health care," Social Science and Medicine, 31:12:1347-1363, 1990.

While much of this attention to the determinants of health appears to be recent, it is worth noting that as far back as the 1840's Virchow stated that the biologic model of disease was not a sufficient explanation of why some people got sick and died and while others did not. He suggested that health like illness was socially produced and that to understand health and illness one must understand the social conditions in which health and illness are created, identified, defined and continued. [11]

While many of the determinants of health are the same for both men and women, as Kaufert [12] states, because of the interaction of these determinants of health with gender in a world in which access to political and economic resources and thus the allocation of power is usually gender-based and in favour of men, the experiences of health and illness may be very different for men and women. As the Gender and Health curriculum states

“The different ways in which men and women experience the world and the impact they have on each other are fundamental to health and health care (p iii)[13]

Throughout the world, women suffer a greater burden of ill health than men and are further disadvantaged by inequality of access to health care. The report of the Beijing Conference also stated, that “a major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups.” “Women’s health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate medical services to women. (Beijing)”[14] As well, gender bias in research has had an impact on our knowledge base about women’s health and illness.

While trying to remedy the manifest inequalities that currently disadvantage women, it is also important to identify the ways in which gender stereotyping may damage men. Where societies expect men to be the “breadwinner” for example, some men will feel obliged to work extremely long hours with resulting damage to their physical and mental health. Similarly, the social expectation of what it means to be a “real” man may make it difficult for men who are ill to admit weakness. Men are expected to fight in wars and to undertake dangerous work such as mining, fire fighting and fishing. Societies train boys from early childhood not to admit fear and not to identify what they are feeling in order to prepare them for these roles. This can lead to health-damaging behaviours such as adolescent risk-taking, inability to communicate about feelings, and delays in seeking care for injury and illness.

It is important to recognize the impact on the determinants of health not only of gender, but also of class, ethnicity, immigration, aboriginal status, ability/disability, and sexual orientation. Any understanding of the determinants of health must include the “diversity factor” that considers these issues in an overall analysis of health and health care.

While gender interacts with the determinants of health impacting on both sexes, at the same time and because generally women continue to have poorer health than men, it is essential that the meaning of women’s health is clearly understood and is not just defined in terms of reproductive function.

D) Definitions of Health and Why Women's Health?

According to the World Health Organization, the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, economic or social conditions.

In 1998, the World Health Organization defined health as "the dynamic state of complete physical, mental, spiritual, and social well-being and not merely the absence of disease or infirmity."

The Alma Ata Conference articulated the goal of "health for all by the Year 2000." As was stated at the Beijing Conference in 1995, "the enjoyment of this right is vital to women's life and well-being and their ability to participate in all areas of public and private life. However, health and well-being elude the majority of women." [12]

The emphasis on women's health in looking at gender is not meant to minimize the impact of gender on men's health, but to correct historical imbalances based on the fact that until the present men have been considered the norm in education, research and health services.

The understanding of women's health has evolved significantly over the past half century and especially in the past decade. Earlier teachings about women' health in the Western tradition were based on the assumption that woman was dominated by her sexual functions and the physiology and pathology of her reproductive system provided the key to understanding her physical, mental and moral peculiarities. Because of her role in reproduction, woman was regarded as a special case – a deviation from the norm presented by the male. In the late 19th century, woman was considered to be disease or disorder and women's biological functions were seen as the source of a host of psychological disorders, from strange mood or feelings to hysteria and insanity. Indeed, at that time, it was stated that "any disease occurring in a woman will almost certainly involve some modification in the work of her sexual system. On the other hand, the ordinary or disturbed work of her sexual system will influence the course of any disease which may assail her, however independent this disease may be seen." [15]

Well into the 20th century, the area of women's health retained its traditional focus on reproductive issues and women's health continued to be defined primarily in terms of childbearing, menstruation and menopause – all of these, whether normal physiologic processes or pathological conditions, deemed to require medical attention. More recently, and in particular, in the past two decades, we have seen a major shift in our vision and understanding of women's health.

In 1985 a US Public Health Service Task Force defined women's health issues broadly as "diseases or conditions that are unique to, more prevalent or more serious in women, have distinct causes, manifest themselves differently in women or have different outcomes or interventions." [16] However, such a definition tended to focus more on disease than on health.

Currently, women's health is perceived as a continuum that extends throughout the life cycle and which is critically and intimately related to the conditions under which women live. Women's health is seen to depend upon complex interactions between individual biology, health behaviour and the historical, economic and socio-political context of women's lives. As a result of this evolution of our understanding of women's health, the Ontario Women's Health Interschool Curriculum committee (WHISCC) drawing heavily on the work done by the Women's Health Office at McMaster University, Hamilton, Ontario, developed the following definition of women's health.

"Women's health involves women's emotional, social, cultural, spiritual and physical well being and is determined by the social, political and economic context of women's lives as well as by biology.

This broad definition recognizes the validity of women's life experiences of health. Every woman should be provided with the opportunity to achieve, sustain and maintain health as defined by that woman herself to her full potential." [15] This definition also provided the framework for the discussions and recommendations on women and health by the Canadian Delegation at the 4th World Conference on Women (The Beijing Conference) held in September of 1995. [14]

A similar understanding of women's health was published by the Commonwealth Secretariat [6], in which the scope of women's health was defined as follows:

1) Women's health concerns extend over the life cycle and are not limited to reproductive problems,
2) Women's health problems include but are limited to conditions, diseases or disorders which are specific to women, occur more commonly in women, or have differing risk factors or course in women than in men and
3) Health must be considered in broad terms and both positively as well as negatively. Dimensions of health include the physical, mental, social and spiritual.

There are a number of areas where gender produces inequalities in relation to health and where policy intervention is required.

Women are often disadvantaged in access to health care and this may be related to:
1) Lower status/social value in the household
2) Cultural factors such as lack of a female health provider
3) Being excluded from decision making on health actions and expenditure
4) Lower literacy rates and reduced access to information
5) The high opportunity costs of women's labour time for instance, facilities may be distant and waiting times a deterrent for women having to manage other household responsibilities.

To fully understand the concept of health, we must recognize that health-related practice consists of five functions:

1) Health promotion
2) Disease prevention
3) Disease treatment
4) Rehabilitation
5) Support and Palliation

According to the Swedish International Development Agency, women are visible in the health sector both as givers and receivers of health care, but they are absent from the decision-making levels. They have been targeted most in their role as bearers and carers of children. [18]

Implicit in this understanding of women's health is the critical importance of recognizing that women do not constitute a homogeneous group and that women's diversity with respect to race/ethnicity, age, ability/disability, socio-economic class, education and sexual orientation must be taken into account whenever questions with respect to women's health are addressed.

E) Interaction of Gender and Health

Gender is more than a determinant of health that stands alone, but rather cross-cuts all other determinants, namely income and social status, employment, education, social environment, physical environment, healthy child development, personal health practices and coping skills, health services, social support networks, biology and genetic endowment, and culture.

The gender factor permeates all aspects of health and health care. The following are some examples of the interaction of gender and health.

1. **Poverty**

In the report, "The Health of Women: A Global Perspective"[16] it has been stated that "two out of three women around the world presently suffer from the most debilitating disease known to humanity. The disease is poverty. In all societies including our own, women lag behind men on virtually every indicator of social and economic status and they constitute a larger proportion of the poor. Gender bias and the differential allocation of resources generally begins at birth for overall poverty and cultural beliefs about women's worth conspire to deprive females from receiving the very resources they need to be productive members of society.
Poverty is frequently associated with many of those factors identified in health promotion programs as contributing to poor health. The UCLA Centre for Health Policy Research [20] reported that women with low incomes and those with a high school education or less are more likely to smoke, that overweight problems are more prevalent in low income women, that the proportion of women who engage in exercise increased as income and educational levels rise and that screening rates for cervical and breast cancer are lower among those who are poor.

2. **Violence**

In its publication "Women's Health: Across Age and Frontier" [21] the World Health Organization stresses that the prevalence of violence against women world-wide, with its horrifying impact on health and indeed the lives of women, can only be understood and dealt with if one understands society itself, the socialization of men and women and the power differential between men and women. Violence is pervasive and not restricted to any one class or culture. The Beijing Conference Report stated that "sexual and gender based violence, including physical and psychological abuse, trafficking in women and girls, and other forms of abuse and sexual exploitation place girls and women at high risk of physical and mental trauma, disease and unwanted pregnancy."

3. Sexually transmitted diseases

While initially HIV/AIDS was seen as a disease primarily affecting gay males, we have come to realize that this is a disease, which threatens all men, women and children. The United Nations sees HIV/AIDS as a major priority.

With respect to dealing with HIV/AIDS infection in women, the same report emphasizes that we must address the fact that prevention and supportive care will be most effective if we recognize that no individual behaviour can be changed and maintained without an environment that can sustain and promote those actions. Yet women very often lack the power to be able to negotiate safer sex practices in their sexual relationships or to access care when they themselves become ill. Indeed, a recent United Nations document stresses that the low cultural and socio-economic status of women is facilitating and speeding up the heterosexual spread of AIDS in the world today and that merely looking at Women and AIDS from a health perspective is not enough. A gender analysis of socio-economic and cultural causes and effects of the epidemic is necessary to achieve a more comprehensive picture of the magnitude of the problem and the ideas on how to combat the epidemic effectively.[22] Integrating a gender perspective into HIV/AIDS work requires ongoing awareness and efforts. [23]

4. Mental health

The WHO report directs attention to the fact that psychiatric and psychological theories and methods have been based on male perceptions and that many of the existing ideas on women and mental health are therefore misleading. New approaches to mental health are now being developed based on social realities, which incorporate women's experience and voices. The relationship between mental illness and the experience of physical and sexual violence requires further exploration. [24] Mental disorders related to marginalization, powerlessness and poverty along with overwork and stress and the growing incidence of domestic violence as well as substance abuse, are among other health issues of growing concern to women. [14] In "Health Canada's Women's Health Strategy" it is noted that one of the greatest differences between women and men is their respective profile of mental health disorders. There are gender-based differences inn the way in which women and men experience and cope with stress and life events and how they signal their distress. [4]

5. Substance abuse

With respect to alcohol and drug abuse, women's use of alcohol and drugs is significantly related to the violence in their lives. Compared to women who have not been abused, women sexually abused as children, battered or sexually assaulted are far more likely to use drugs to sleep and to relieve anxiety. In 1991, a Canadian report highlighted the link between domestic violence against girls and women and alcohol and other drug use.[25] This strongly suggests that any approach to the management of alcohol and drug abuse in women, which does not recognize the

pervasive influence of violence against women in the pathogenesis of their substance abuse, will likely be doomed to failure.

6. Nutrition

Another area, which illustrates the relationship between gender and health, is that of nutrition. The consequences of nutritional problems in women can be life long. Gender discrimination plays an important role in putting many of the world's girls and women at high risk due to grossly inadequate nutrition, where preference for sons often leads to imbalance in distribution of resources (and food) when these are limited. [19]

At the same time, there is increasing recognition of the importance of nutritional problems in women in more affluent societies where eating disorders are closely linked with societally imposed unrealistic expectations with respect to the desirability of extreme slimness.

7. Health care delivery

Gender bias has also been identified in the area of health care delivery itself. As an example, a report of the Council on Ethical and Judicial Affairs of the American Medical Association [26] highlighted the fact that although women receive more health care services overall, studies have documented gender disparities in treatment in a number of areas including kidney transplantation, cardiac catheterization and in the diagnosis of lung cancer, with women having less access than men to major diagnostic and therapeutic interventions with respect to these diseases. The AMA Report raises questions as to whether there may be non-biological or non-clinical factors which affect clinical decision making and it presents the possibility of gender bias in this process. The document goes on to state that while gender bias may not necessarily manifest itself as overt discrimination, social attitudes including stereotypes, prejudices and other evaluations based on gender roles my play themselves out in a variety of subtle ways. [26]

Canadian Health Minister, Alan Rock, in releasing the document "Women's Health Strategy" stated that "Gender Bias has affected women not only as users of the health care system but also as paid and unpaid health care providers." [4]

8. Reproductive Health

Reproductive health is the number one women's health issue in the developing world with the appalling rates of morbidity and mortality due, in part to lack of access to proper care, untrained attendants, lack of contraception options and illegal, unsafe abortion. Many of these issues are the direct result of gender bias.

Approximately 500,000 women die each year from reproductive causes. High morbidity and mortality from pregnancy is not a function of biology, but of government policy, as it relates to availability of health care resources, transportation difficulties and lack of training of health personnel. As well, lack of access to safe abortion is a major cause of maternal morbidity and mortality.

These examples of the impact of gender role socialization and gender bias on women's health make it clear that education and counselling or health promotion programs and health service delivery systems which disregard gender will be seriously flawed and run the risk of being seen as irrelevant to the needs of those very women targeted by these programs.

It is important to note, as stated previously, that the interaction of gender and health is relevant for both men and women.

For instance, in considering poverty, we know that both men and women who are poor have poorer health, poorer health care and die younger than those who are more affluent.

Aboriginal, ethnic and immigration status are often accompanied by poverty. Of course this is a critical issue in both developed and developing nations. Think of the street kids in many countries who turn to prostitution to support themselves. And in the developing world the only way that many women can escape the grinding poverty that they and their families find themselves in is through prostitution (and this also raises the issue of HIV/AIDS). We also know that girls are being lured to developed countries with promises of a new life and then forced into sexual slavery to repay the criminals who smuggled them in.

Similarly for men, the need to be a breadwinner in countries where there is no work in their own communities, may force them to go to larger communities for long periods of time and because of their sexual needs and their socialization about what is 'real' sex, they may turn to prostitutes and expose themselves to HIV/AIDS.

As mentioned earlier, male social roles and cultural expectations may lead to denial of illness—a culturally approved behaviour for many men. Similarly, the negative effects of chronic illness labelling for men may lead to a delay in seeking needed care and benefiting from it. Male sexuality in terms of expected behaviour and in response to dysfunction is also related to gender role socialization.

Male risk-taking, particularly in adolescents and young adults, (eg. automobile accidents and diving accidents) has a very serious impact on health, often leading to severe disability or death. This behaviour often occurs in response to societal expectations of male bravado.

Finally, gender can be seen to affect health in the following ways because of differences in:

1. health needs
2. access to health care
3. decision making roles
4. inadequate use of the services due to culturally inappropriate care
5. age—elderly women outnumber elderly men and many of these women are seriously disadvantaged because of poverty, chronic illness and loss of caregivers.

F) RESEARCH

To develop an effective approach to health and health care of both women and men, it is essential to establish a scientific base, which informs, supports and validates our approach to education, health and health care. However, over the years, the scientific community has been subjected to very strong criticism from a number of sectors because of what has been seen as gender bias in health sciences research with respect to a focus on women's health.

This bias has been seen to affect the ideas accepted for research, the questions addressed, the methodology used and the interpretation of the findings, thus ultimately influencing the care that patients receive. This lack of appropriate and adequate research on women is, therefore, not only discriminatory but may be dangerous.

Problems for research are:

1) Hypotheses are not formulated on gender
2) Some diseases, which affect both sexes, are defined as male diseases, eg. Heart disease
3) Research on conditions specific to females receives low priority, funding and prestige
4) Research paradigms do not include different ways in which women know the world
5) Suggestions of fruitful questions for research based on the personal experience of women have been ignored [27]

Problems in research reports have been identified as androcentricity, over-generalization, gender insensitivity and double standards [28]

Examples of gender bias are:

1) Exclusion of women from clinical trials while applying the results of the trials to women as patients: eg.
    a) Doctors Aspirin Study
    b) MrFitStudy
2) Failure to focus on topics which women identify as high priority
    a) occupational health, including in the home
    b) hormone replacement therapy
    c) contraceptive research that ignores men
    d) breast cancer, particularly etiology
    e) AIDS in women
    f) Violence against women
3) Continued focus on biological determinants of disease
4) Lack of adequate data base
5) Lack of recognition of women's diversity

The presence of gender bias in research should not be a surprise to us, for it has been stated that "researchers first and foremost are social beings influenced and shaped by their social and historical context." It should not be surprising, therefore, that the research process is vulnerable at every stage to sexist biases." [29]
"Furthermore, a lack of awareness of the issues and factors involved is primarily responsible for sexist biases in research," and often results in false images of the world of women…such a viewpoint also distorts one's understanding of men." [30]

Concerns re methodology include:

1) Quantitative vs. qualitative research and also a failure to capture women's full experiences
2) The need to involve women in all phases of the research, including formulating the questions being asked.

When funded to do so, women may conduct research, not only on different topics from men, but in a different manner, analyze results differently, and communicate the results of their findings differently, all of which may allow for novel and important areas to develop.

There is a need to increase recruitment, retention and re-entry of women in basic and clinical research careers.

Institutional barriers to recruitment and retention of women researchers are:

1) Tenure and promotion policies
2) Sexual harassment
3) Gender bias
4) Lack of accommodation to the demands of family life
5) Lack of funding for many topics of interest to women researchers

Recommendations from the 4th world conference on women in Beijing in 1995 [14] were:

1) Train researchers to provide quality women's health data
2) Promote gender sensitive women's health research
3) Increase number of women leaders in health services professions
4) Increase financial and other support
5) Broad based research on women's health problems
6) Promote research on health system
7) Study effect of gender-based inequality
8) Monitor genetic research
9) Disseminate information

Challenges in women's health research are:

1) Defining a research agenda which is gender-sensitive and inclusive
2) Conducting interdisciplinary and collaborative research involving both qualitative and quantitative methods
3) Conducting research with meaningful input and participation at every stage of the research process by women in the community at large should they wish to be involved
4) Promoting women researchers
5) Developing means of efficiently and effectively transforming the results of research into health policy. [31]

Gender sensitive research programs should:

1) Coordinate, enhance and strengthen research effort and capacity
2) Address broad range of women's health priorities
3) Address broad range of research questions
4) Be multidisciplinary, including biological, social and community health sciences
5) Be multisectoral
6) Promote diversity
7) Involve consumers and patients at all stages of research
8) Range of methodologies

G) Empowerment

If we are to succeed in incorporating a gender perspective into health care, health promotion and health policies, we must empower communities to understand the importance of such a priority, and to ensure their involvement in advocating for the changes they see will improve their health and help reach the goals they see as necessary. There are a variety of activities which can be undertaken to achieve this and these will differ from community to community. But overall we must learn to listen to what the community says and believes and what it considers to be its health priorities, for communities can and should be active participants in shaping their own lives.

Women can be empowered through better access to education, information, resources, land, income, and credit. Empowerment also comes from allowing women to meet in groups and organize, allowing them to draw strength from numbers and to derive practical solutions from each other.

A crucial aspect of equality is the empowerment of women to influence what is valuable and to share decision-making about societal priorities and development directions. [18]

Similarly, young boys and men must take responsibility for sexual functions, family planning and family responsibilities. They must be able to examine the damaging effects of notions of masculinity and male power. They must be part of the solution in the worldwide epidemic of domestic violence. They must help contain the HIV epidemic by stopping the gender inequality, which prevents women from protecting themselves, due to the power differential between women and men.

H) Influencing Policies and Programs

There is a need not only to empower communities to address their problems but a critical need to influence the social, religious and legislative leaders to begin to address issues of gender and its interaction with the determinants of health.

We must challenge these individuals to ensure that the results of policies and legislation are anticipated and that these results are as equitable as possible for all women and all men.

The ultimate goal is gender equality. This means that women and men have equal conditions for realizing their full human rights and potential to contribute to national, political, economic, social and cultural development and to benefit from the results. Health of course is an important part of this definition.

To achieve this goal gender-based analysis must be an integral part of the development of policies, programs and legislation. Gender based analysis is a process that assesses the differential impact of proposed and/or existing policies, programs and legislation on women and men. It makes it possible for policy to be undertaken with an appreciation of gender differences, of the nature of the relationship between men and women and of their different social realities, life expectations, and economic circumstances. It is a tool for understanding social processes and for responding with informed and equitable options. It compares how and why women are affected by policy issues and therefore is essential in making decisions affecting health. The gender-based analysis framework should be overlaid with a diversity analysis that considers factors such as race, ethnicity, level of ability and sexual orientation. [3]

Key Considerations of Gender Based Analysis

As you develop and analyze policy, the following questions are among the gender-related considerations that should be kept in mind. [32]

1. **Identifying the issue**
   In what ways are both women's and men's experiences reflected in the way issues are identified? How is diversity taken into account?

2. **Defining desired/anticipated outcomes**
   What does the government want to achieve with this policy and how does this objective fit into its stated commitments to social and economic equality? Who will be affected? How will the effects of the policy be different for women and men, girls and boys?

3. Gathering information
What types of gender-specific data are available? Are gender-specific data available regarding other designated equity groups (including Aboriginal peoples, persons with disabilities and members of visible minority groups)?
How is the input of women's organizations and other equality seeking groups being pursued?

4. Conducting Research
How will the research you consult or conduct address the differential experiences of gender and diversity?
If you are conducting primary research, how are gender considerations incorporated in research design and methodology?

5. Developing and Analyzing Options
How will each option disadvantage some, or provide advantage for others? Does each option have differential effects on women's or men's social and/or economic situation?
How will innovative solutions be developed to address the gender/diversity issues you have identified?
What are the solutions that affected groups have suggested?

6. Making Recommendations
In what ways is gender equality a significant element in weighting and recommending options?
How can the policy be implemented in an equitable manner?

7. Communicating the Policy
How will communications strategies ensure that information is accessible to both women and men and take into account the communications needs of diverse communities?
Has gender-aware language been used?

8. Evaluating the Analysis
How will gender equality concerns be incorporated into the evaluation criteria? How can this be demonstrated? What indicators will you use to measure the effects of the policy on women and men?

The challenges for policy-making are to pose the questions and develop a process that encourages solutions in support of equality for all women and all men in Canada.

With respect to health, policies must be developed to address gaps in the health system. These gaps include access gaps, organizational gaps, quality gaps, payment gaps, knowledge gaps, and health disparities between different segments of society. All of these policies must then be analyzed so that there is no gender bias in any of them.

I) Forming Strategic Alliances

Forming strategic alliances in general requires identification of like-minded organizations and people who are influential in a variety of ways in various structures within society and also being able to be articulate and be credible in putting forward your perspective to enlist the support of members of the community. This is a topic where we might learn from the successes and failures of the participants in gender training workshops, community activities and policy-making.

LIST OF POTENTIAL STRATEGIC ALLIANCES

MEDICAL

- -MWIA member countries and individuals
- -Local, regional & national medical associations
- -Medical licensing bodies
- -University medical school curricula
- -Continuing Medical Education
- -College of Family Physicians
- -Council of Specialists

LIKE-MINDED ORGANIZATIONS

- -UN (including ECOSOC)
- -WHO
- -UNAIDS
- -UNFPA
- -UNIFEM
- -UNICEF
- -WONCA and National Equivalents
- -FIGO and National Equivalents
- -Planned Parenthood
- -Commonwealth Secretariat
- -Various NGO’s

POLITICAL CONNECTIONS

- -MD/Politician Networks
- -Women’s Health Networks/Machineries

Our attitudes influence the way we communicate with one another. Once we are aware of gender issues, as physicians we can re-examine our attitudes and develop skills and knowledge to make sure gender equity and equality are achieved in health and health care.

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SEX/GENDER QUIZ

Do the following describe sex, gender, both or neither:

1. Emphasis on biological differences between males and females
2. Factors that explain well-being and illness
3. The basis for social inequalities that can change exposure to risk factors that endanger health
4. Closely related to inequality
5. Recognizes that the peer relations between men and women may either protect or impede health

TRUE OR FALSE

1. The social construction of female roles may disadvantage women and create risk factors that endanger health.
2. The social construction of male roles may disadvantage men and create risk factors that endanger health.

TRUE OR FALSE

1. **Maleness and femaleness are entirely determined by differences in reproductive systems and hormonal variations.**

2. **Because they have the capacity for motherhood, women are more caring than men and therefore more fit for certain kinds of jobs than men.**

3. **Women undergoing heart surgery are more likely to die than men.**

4. **Despite their diversity, all societies are divided along what can be called the "fault line of gender."**

5. **In all societies, women and men are defined as different types of beings, each with their own opportunities, roles and responsibilities.**

6. **In most societies, the category of "female" has less access than those in the category "male" to a wide variety of both economic and social resources.**

7. **Worldwide, wealth and poverty are nearly equally divided between males and females.**

8. **Although women do suffer material discrimination, women enjoy equal social status with men in most societies in the world.**

9. **Leaders in the movement to develop gender analysis are almost equally inclusive of men and women.**

10. **The "feminization" of poverty," although it exists in less developed countries, has been largely eliminated in developed countries.**

CASE PRESENTATIONS

The Executive of the Medical Women's International Association met at the Rockefeller Study and Conference Center in Bellagio, Italy, to develop this *Training Manual for Gender Mainstreaming in Health.*

The following cases were developed by participants at the Bellagio Conference.

These cases are specific examples to illustrate how a gender awareness or lack thereof affects health and health care. There is no intention to generalize to the population at large from these specific examples.

The intention of case presentations is to present information on gender mainstreaming in a format easily understood by physicians, as the initial intention of this manual is to train physicians.

It is anticipated that during the workshops that other cases will come forward from participants' experiences that may be incorporated into this Training Manual.

For all cases, consider different approaches to the cases, and what community action or policy development might alter the situation.

The ideas contained in this manual are those of the Medical Women's International Association and do not necessarily represent the official policy of the funding agencies.

Cases

1. Ice-breaker Case of the Mysterious Surgeon
2. Case of Disease Diagnosis
3. Case of Undervalued Women's Work
4. Case of Unplanned Pregnancy and Secondary Infertility
5. Case of Delivering Away from Your Own Community
6. Case of Women Physicians
7. Case of Obstetric Malpractice and Psychiatric Sequelae
8. Case of A Young Female with Multiple Scars on Forearm
9. Case of Schistosomiasis
10. Case of Uterine Fibroid Embolization
11. Case of Pregnant Female Medical Resident
12. Cases of Domestic Violence
13. Case of Sexual Concern
14. Case of Pediatric Surgery
15. Case of a 37 year old Female with Small Breasts
16. Cases of HIV/AIDS
17. Case of Primary Infertility due to the Male Factor
18. Case of Female Genital Mutilation (Cutting)
19. Case of Domestic Violence in India
20. Case of Sex Selection
21. Case of Widowed Woman
22. Case of Early Marriage
23. Case of an Iranian immigrant with Nausea and Vomiting of Pregnancy
24. Case of a Somali Refugee with Fetal Distress in Labour
25. Case of Male Erectile Difficulty

FACILITATOR'S GUIDE TO CASES

1. Ice-breaker Case of the Mysterious Surgeon

This case study is useful as an "ice-breaker" in helping people who think they are gender sensitive in really assessing themselves. Most people will deny their biases at the beginning of the sessions.

The case of the mysterious surgeon

A father and his son were travelling from the capital city to a city 100 kilometres away. The newly purchased imported car burst a tire, somersaulted and crashed into the railings at the side of the road. The father died on the spot and his son was rushed to the nearest hospital in a critical condition, obviously requiring surgery to save his life. The surgeon on duty, who was a very prominent person in the country, was called to come and attend to the boy. On arriving on the ward to examine the boy, a loud gasp was heard from the surgeon who said: "I can't operate on this boy, he is my son!"
Can you explain this? Write down as many explanations as you can within 2 minutes.

Tutor's Notes

There is no doubt about the identity of the father but most people will think in a stereotypic fashion and presume that the surgeon is a man.
You can discuss stereotypes and socialization.
Issues of gender equity and equality can also be introduced here.

The surgeon is actually also the boy's mother, which is why she exclaims about her inability to operate on the lad. In appropriate groups you can also discuss role models and limitations if any with both sexes.
Most people get the answer wrong and this provides a good opportunity to illustrate how easily one can become gender blind, even the well educated.

Reference

Adapted from D. Gorkin's unpublished paper, State University New York at Stony Brook

2. Case of Disease Diagnosis

Objectives

1. Symptoms may be interpreted differently depending on whether it is a man or woman presenting.
2. Women may have symptoms of angina that do not mimic those of men and this can mean the condition remains undiagnosed or under-treated.
3. Doctors will practice more effective medicine if they are trained in gender awareness, to help them understand the difference between men and women in risk factors, presentation, diagnosis, treatment and outcome of disease.

Narrative Case:

Mrs. Smith was a 68-year-old Caucasian woman who presented to her family doctor with increasing indigestion. This indigestion had become worse since the death of her husband last year. Not only had she lost her husband, but he had also been her best friend, and had always made all decisions for the household. Mrs. Smith had never learned to drive, had never done the banking, and even the grocery shopping was done by both, with Mr. Smith paying the bill. [1] As she was now only cooking for one, she would often fry her foods, as it was quicker and easier than making a big meal. [2]

After her husband's death, the family helped Mrs. Smith sell her large house at the other side of the city and moved her into a lovely apartment that was part of a large shopping mall and only two blocks from the Seniors' Centre. The grown children lived close by and often stopped by for a few minutes for a cup of tea, but Mrs. Smith spent most of her time alone. [3]

When her doctor asked about her indigestion, Mrs. Smith said that it bothered her most when she was walking over to the Seniors' Centre. She would be fine when she started out, but after a block and a half along the slightly inclined street, she would get this terrible pressure in her chest, a burning acidy feeling in her throat, a bit of nausea and achy arms. After she stopped and rested for a minute or two, and took some antacid, it would disappear and she was fine for the remaining half block. She quite enjoyed the game of cards at the Centre. She found that the walk home downhill did not bother her so much.

Realizing that she had significant life changes, her doctor asked if she was feeling depressed. Mrs. Smith agreed that she was depressed, so she suggested that Mrs. Smith try a small dose of antidepressant, while waiting for her abdominal ultrasound and Barium meal examinations. [4]

Two days later, the doctor received a call from the hospital emergency, telling them that Mrs. Smith had been admitted with an acute myocardial infarction. [5]

Tutor's Notes/ Learning Points

[1] Society has its ideas of appropriate male and female roles. A generation or two ago, it was quite accepted that the man would be the breadwinner, look after the finances and make the daily decisions. The wife was to be the queen of the house, looking after the cooking, cleaning and the children. Many older women, who live longer than their husbands, find themselves widowed and unable to manage the external day-to-day activities. Conversely, widowers often find they have no home-making skills and do not know how to cook, shop, clean and look after themselves. In European and North American societies these strict role definitions are now breaking down, although the women are changing faster than the men.

[2] The nutrition of seniors is often very poor, as they find it difficult to make a balanced meal when only cooking for one person. Men are especially vulnerable as older men may not have any experience of food preparation.

[3] Social isolation is often a reality of older age. This woman has been moved from the area where she lived all her adult life and where she was familiar with the neighbourhood, the shopping and had made all her social contacts to a new area of the city. Maintaining friendship and social support networks is a major contributor to women's health, at all ages. Making new friendships is harder to do for older people, so particular care should be taken not to fracture existing social networks.

[4] Mrs. Smith was depressed and had poor eating habits. Despite the fact that Mrs. Smith's symptoms were characteristic for heart disease, the doctor did not even consider this diagnosis, as heart disease is often thought to be a disease of men.

[5] A reduced index of suspicion about heart disease in women among doctors sometimes results in a delay in diagnosis for women with heart disease. Women may also present with symptoms that are different from the symptoms doctors have been taught to recognize, since until recently coronary artery disease was seen as a male disease.

Doctors have been taught about the male experience of heart disease, and respond to this promptly and with skill. However, until recently, the research and training has not included good evidence about the way women experience heart disease, and they often are diagnosed much later in the course of disease, and under-treated as a result.

Community Strategies:

[1] Funding could be provided for seniors' centres to have some basic training courses and help for widowed women, who are not familiar with finances. They could also provide skills training for men who need to learn how to cook and clean and shop, and help women and men adapt to shopping and cooking for themselves alone.

[2] Public health officials could make seniors aware of the food options such as Meals on Wheels, and other healthy food options could be made available at a nominal cost.

[3] Efforts could be made to involve people in the activities that are available. Although she lives close to the Senior Centre, it would not do her much good if she never participated in events. The family must realize that just plunking mother down next to the grocery store and the Seniors' Centre may not meet her social and emotional needs.

[4] The new antidepressants are often helpful and it was good of the doctor to recognize the depressive element to her story. However, the medical profession must be aware that when symptoms sound like they would be heart disease in men they are probably heart disease in women as well. However, women often present with non-textbook symptoms because the textbooks have been written on the basis of research done on men. As well, physicians are more likely to attribute physical symptoms as depression in women than in men.

[5] Doctors will make better clinical decisions when they are trained to incorporate a gender perspective into their patient care.

3. Case of Undervalued Women's Work

Objectives

1. To understand the gendered nature of the allocation of unpaid work.
2. To develop insight into some health consequences of the gendered nature of responsibility for unpaid work.

Narrative case:

Elizabeth was a 54-year woman who had a good job at the bank. She had recently been promoted, and the new job required a great deal of travelling. She felt this was a good opportunity, as her only child, a son of 21 was off at university and she was on her own, having divorced ten years ago. Six months into the new job, she presented to her family doctor, asking for time off work, as she could not cope.

As the details evolved, she was the only one of three children who was not perceived to have family responsibilities by her siblings, and thus they expected her to be responsible for her mother's care. Her sister had young children who were involved in many extracurricular activities and had to be driven to and fro. She also had a full-time job and a husband who expected the house to be cleaned and the meals to be on the table when he returned home from work. Her brother was a doctor, who was never at home, and his wife spent all her spare time with her own family. [1]

Elizabeth's 83-year-old mother had always been independent. However, in the last year, she sustained a fractured hip and was in hospital for four months. She was also diagnosed with Alzheimer's disease while in hospital. During her hospital stay, her husband had a massive stroke and died. Mother was now in a nursing home, but called Elizabeth at work ten times a day to ask her to come over and help her. [2]

Elizabeth had always been a bit anxious and had been on antidepressants on and off for the last six years. However, she had never felt like she did now, so hopeless, frustrated and unable to make any decisions. This new job was requiring lots of time outside of work to update her skills, but no matter how often she read the material, she could not comprehend it. The travelling, which initially looked so glamorous, was exhausting her. [3]

Elizabeth finally collapsed in a pool of tears when talking to her siblings. On the advice of her doctor, she told the siblings that she could no longer deal all by herself with Mother, but needed them to help with the nursing home visits as well. She attended a seminar for caregivers and was amazed that she was not alone in dealing with an aging parent who was no longer the capable mother she once was. She spoke to the nursing supervisor at the nursing home who was unaware that Elizabeth's mother had been calling her endlessly to do jobs that the care aids were quite willing to do for her, and she saw that this problem was rectified.

With these changes in place, Elizabeth was able to return to her previous job. Mother was settled in the nursing home and no longer called several times a day. Each of the siblings took their turn visiting mother and attending to her emotional needs. All three siblings attended a workshop on living with Alzheimer's and had a much better understanding of mother. [4]

Tutor's Notes/ Learning Points:

[1] Society sees the woman as the caregiver and particularly the woman who does not have children and a husband who need her attention. The division of labour is usually unequal.

[2] Although families feel that the nursing home will provide for the needs of their loved ones, the care is often in the area of activities of daily living, and time must be scheduled for the family to attend to their emotional needs. The nursing home probably has no idea that mother is calling ten times a day, asking for things to be done, that should be handled by the care aides. The reason mother ended up in a nursing home was two-fold: she developed a hip fracture due to osteoporosis, knowing that one-fifth to one-tenth of women who have a hip fracture die within a year and one-quarter must move permanently to a nursing home, and she had Alzheimer's disease, which often goes unrecognized until a crisis situation arises. Only half of people who break a hip return to independent care. Women tend to fracture ten years earlier than men.

Women experience more disability and use of health services than men, although men die younger than women.

[3] An anxious or depressive premorbid personality may evolve into full-blown depression with the onset of several stressors. Mental illness such as depression is not strictly biological but rather a result of the interaction between biology and psychosocial factors.

[4] Attention needs to be paid to proper medication and counselling to bring the symptoms under control and to formulate a proper plan of action. Acknowledging the situation as real is important. With proper treatment and recognition of the problems, Elizabeth was back functioning both at work and in her personal life. Gender related issues are often not recognized by physicians and they rely on the use of medication only to treat depression.

Community action:

[1] Women are expected to provide care to family members at the expense of their own careers and mental and physical well-being. This caregiver role is placed on the unpaid back of women, where it goes unrecognized, under compensated and devalued.

[2] There is opportunity for better education on prevention of osteoporosis, as well as how families can deal with Alzheimer's, as well as expectations of a nursing home.

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4. Case of Unplanned Pregnancy and Secondary Infertility

Objectives

1. To consider the health risks that can arise from deliberately withheld information.
2. To discuss the ethical responsibility of physicians and to consider that lack of ethical responsibility can lead to abuse of patients.
3. To focus on an aspect of women's health, namely choice over reproductive function.
4. To show how the determinants of health, namely education, religion, social environment, health services, employment, income and social support networks interact with health care delivery.

Narrative case:

Sandra is a 29 year old woman, married for the last three years, who presents to her family doctor in Vancouver, Canada, with the complaint of being unable to become pregnant, despite using no contraception for the last 2 years and having frequent sexual intercourse.

As the history unfolded, she stated that she became pregnant at the age of 15, at the time of her first intercourse. She had gone to a private school, where sex education was not allowed on the curriculum, as it was felt to be unnecessary for unmarried girls.[1]

On her own, she went to see her family doctor to ask for an abortion. The family doctor told her that he did not believe in abortion and sent her home. [2] As time went by, her mother commented that she noticed Sandra was gaining weight. Sandra broke down and told her mother about her unwanted pregnancy, which was now at 15 weeks gestation. Sandra's mother, although very upset, was understanding and took the situation in hand and took her to Planned Parenthood, where her concerns and hopes were fully explored. After full counselling, she continued to request an abortion and was referred to a reputable gynaecologist in town, who would perform the abortion.

Sandra had to attend the office twice before the operation, each time to have the insertion of a laminaria tent. Although expensive, it was explained that this was necessary to help dilate the cervix and make the termination less damaging to her cervix. [3]

The day of the surgery arrived and Sandra was relieved that everyone at the clinic was so kind to her. She had been very nervous upon arriving at the clinic, as there were protesters across the street waving placards, condemning abortion. [4]

Although awake, the local anesthetic used by the doctor helped ease the pain, but did not take it away completely. She remembers how scared she was. [5]

A few days after the surgery, Sandra felt so sick with fever and chills and her menstrual flow was smelly. The doctor gave her antibiotics, but it took her a long time for the pain in her abdomen to disappear. [6]

When she was 19, Sandra had unprotected sex. [7] She went to the drugstore the next morning and asked for the morning after pill, which she had heard was now available over the counter without a doctor's prescription, at the cheap cost of $5. How disappointed she was when she got to the drugstore to find that there was a $25 counselling fee added to the cost of the morning after pill. [8] She was unable to afford the $30, so went home and crossed her fingers until her next period, which fortunately came on time.

Sandra met Jim, her husband at age 25 and they have been married for the last 3 years. As previously mentioned, they have been trying to conceive for the last 2 years. Investigations were carried out and Sandra was found to have blockage of both fallopian tubes, most likely related to the infection she had after her abortion.

Fortunately, Sandra and Jim both made good money, and were able to afford the in vitro fertilization. [9] Even more fortunately, this resulted in a viable pregnancy and they are now the proud parents of an eight-pound baby girl.

Tutor's Notes/Learning Points

[1] Sex education is still a very controversial topic in Canadian schools. It is taught in varying degrees, depending on the school district. Some schools are owned and run by religious sects, which believe that sex is only permissible within a marriage, that young people should not be sexually active, and that sex education increases sexual activity among adolescents. This philosophy may not be restricted to religious schools. Research from The Netherlands demonstrates that providing young people with the knowledge they need to negotiate their transition to sexual activity reduces the risks of sexual intercourse and sexually transmitted disease, and also provides young people with the skills to resist pressure to become sexually active until they are ready. This is an example of how health policy and gender intermix to place certain groups of people, in this instance adolescent girls, at particular risk. Some parents find it difficult to speak to their children about sex.

[2] Sandra's family doctor behaved unethically. He did not help her to explore her options. He took advantage of his power in relation to her and put her well-being at risk through abuse of that power. This is more likely to occur to women than men. He also allowed his personal beliefs to intrude into his clinical management. He was the only medical contact that she had known all her life. When she turned to him in time of great need, he let his moral beliefs interfere in what was, by the law of the land, legally available to Sandra, and intrude in his clinical management.

[3] Although abortion care is covered by the medical plan in Canada, there are often additional costs beyond the procedure itself, such as transportation as abortion services

are not available in many regions. Abortion is not covered when the service is obtained out of province, in contrast to other medically necessary services. This is often a real deterrent to those people without financial means, particularly adolescents.

[4] There is a strong anti-abortion element in the population. Individuals regularly picket the abortion clinics and threaten staff, doctors and patients. Vancouver, British Columbia, Canada, was one of the first places where a gynaecologist was shot for performing abortions.

[5] The psychological aspect associated with abortion is often ignored in the busy routine of the clinic. There may be a lack of personnel with the time to counsel the patient. Despite some anxiety and occasional complications, 80% of the women having therapeutic abortions were relieved afterwards. (Reference 1)
Fear and pain increase the overall trauma of the situation and therefore increase the risk of depression and/or PTSD like phenomena.

There is a need for special clinics, where staff is trained in the psychosocial aspects, as well as the medical, and can offer appropriate counselling and follow up. Prior to abortion, the patient should be counselled regarding her various options, but also supported emotionally and made aware of various supportive organizations. Follow-up counselling is important to support the patient through the psychological and physical aspects of their decision.

Family doctors may have their own prejudices, which make it difficult for them to send their patient for an abortion. However, ethically, they must make the patient aware that such help can be obtained elsewhere. The family doctor may be placed in the middle of complex family dynamics, knowing both the parents and the child. Clinics should be free and easily accessible.

[6] Even in countries where abortion is legal, the procedure is not without complications, especially when performed in the second trimester. The sequelae are most often depression but post-traumatic stress disorder can occur if the circumstances of the procedure are particularly traumatic, such as in the second trimester, with a younger patient, without a supportive family or partner. There may be a sense of either guilt or grief, increased as the length of time the patient is pregnant and she can either feel movement or sees the aborted fetus. There are many countries around the world that do not allow legal abortion.

[7] The female often bears the consequences of premarital sex, with the male partner rarely mentioned when an unplanned pregnancy occurs. Doctors must beware of blaming women and making them feel solely responsible.

[8] The World Health Organization recommends that to decrease unplanned pregnancies the morning after pill (MAP) be made available without a prescription. The Federation of Medical Women of Canada and the Society of Obstetricians and Gynaecologists of Canada championed this idea. The MAP was made available without a prescription in

the province of British Columbia. The pharmaceutical company that made the pre-packaged MAP decreased their cost to an affordable $5. Despite the known safety of the product, at the pharmacy level, a $25 consultation fee has been added to the cost of the MAP. This additional charge may act a deterrent for some women. It is often the female who has to pay for the morning after pill, but females are more likely to be poorer than males due to the differential in average pay. There has been some debate about this approach among physicians.

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[9] The cost of the new reproductive health technologies is not fully covered by health insurance, as these technologies are not felt to be an essential health service.

<u>Controversial thoughts for the facilitator to bring out in discussion</u>

[1] Adolescent sexuality needs to be discussed more freely, both in the school curricula and at home with families. Pretending that adolescents are not going to engage in sex does not equate with reality. It has been shown that sex education does not increase the level of adolescent sexuality. Rather than sex education alone, the most important correlate with pregnancy is the general level of education of females. Good sex education does not mean that teen girls will practise safe sex. Teenage girls may still get pregnant even with good sex education because they usually do not go out intending to have intercourse. It happens without planning and without adequate prophylaxis. (Reference 2) It is difficult for young women to negotiate safe sex practices due to socio-cultural norms that foster female sexual passivity and innocence. If the young woman is empowered to seek sexual pleasure and sexual safety on her own terms, she is labelled with a poor sexual reputation as being "easy" and is socially and sexually deviant. Similarly if a young man uses a condom, he is labelled as un-masculine. It is socially accepted and expected that men control the sexual decision-making and condom use.

[2] It must be reinforced to doctors, who do not personally believe in abortion, that ethically they must inform the patient where they can seek the advice of another practitioner who will counsel her as to her options for the pregnancy, including legal abortion.

[3] It is often those who can least afford services that require them. There must be means for financial support for medically necessary adjunctive procedures, such as provision of abortion and the MAP.

[4] It is a woman's right to have control over her reproductive functions. Abortion is one choice that must be available. To ensure that there are doctors who will perform abortions, providers must feel safe and be protected from those who intend to do them harm because of the service they provide. The Beijing Declaration defines reproductive health and includes the woman's right to choice over her reproductive function.

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[5] Timely access to abortion is not always available. In this case, it was delayed because of medical practitioner bias, but often can be delayed because it is not available in the community where the woman lives. The fear of harm to the abortion provider has made the availability of abortion much more difficult.

[6] Although the morning after pill has become available without a prescription in some areas, there remain barriers to access..

Reference

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2. The Surgeon-General's Call to Action to Promote Sexual Health and Responsible Sexual Behaviour 2001. Office of the Surgeon-General, Rockville, MD. USA

5. Case of Delivering Away from Your Own Community

Objectives

1. To show the interaction of various determinants of health with gender.
2. To show valuing of one sex over the other.
3. To show how personal health practices and availability of social networks influence health and health care.
4. To show the lack of availability of health care to many communities both in developed and developing countries.

Narrative case:

A 30 year old Inuit woman from Cape Dorset in the Canadian north is pregnant for the fourth time. Her first three pregnancies were delivered in her home village at the Northwest Territories Health Station, without complication.

This pregnancy is different. She is now 35 weeks gestation, with a known fraternal twin pregnancy, with one male and one female fetus. She was found to be gestational diabetic at her 28-week glucose tolerance test, and she has been able to keep her sugars under control with diet and exercise.

She is transferred 500 miles to your care in Winnipeg, Manitoba, where there are facilities to care for her high-risk pregnancy. [1] She is alone and her English is very limited, but she can make the staff understand that she wants to smoke. [2] She knows no one in Winnipeg and is very lonely and homesick. She thinks constantly of her children back home who are being looked after by her extended family.[3]

She goes into labour at 36 weeks gestation. She has a very quick two-hour labour and delivers both babies by the cephalic presentation. She has a brisk postpartum hemorrhage, requiring a blood transfusion. (The doctor back in Cape Dorset is very thankful that he transferred her before she went into labour.) [4]

After another two weeks in Winnipeg, she goes home with the babies. She only has enough breast milk for the boy [5], so feeds the girl powdered commercial formula, that she mixes with melted snow from the barrel outside the door. [6]

After a week at home, the girl develops gastroenteritis and is flown out to the Toronto Sick Children's Hospital, 3000 miles away, where she dies.

Learning points:

[1] She is transferred away from all that is familiar to a strange city with people of a different culture, who speak a different language. Isolation of many of Canada's native peoples in the north gives them only the most basic of health care delivery close to home.

This adversely affects their experience of health care, particularly for women who have to obtain their pregnancy care in larger centres. For many indigenous people, being born in your own area is the essential basis for good spiritual and physical health in the future.

[2] The cigarette smoking is an example of the interaction of personal health practices with health. There has been so much education about the dangers of smoking during pregnancy in Canada that it has become socially unacceptable. This is less true in the isolated populations. Smoking is known to alleviate depression and elevate mood and is thus a form of self-medication for dispossessed or alienated people. The relationship between smoking and small for dates babies is well known, yet more women are smoking than men, especially women in poor communities. Aboriginal women report the highest rates of smoking in Canada, double the rate of other women in Canada. "The industry artfully exploits the contradictory elements of women's smoking by offering freedom and escape alongside control, while nicotine addiction is the ultimate controlling element". Lorraine Greaves, *Filtered Policy, Women and Tobacco in Canada*, BC Centre of Excellence in Women's Health, 2000:28

[3] Knowing no one and missing her children is making her depressed. There is no provision for counselling, as language is also a barrier. A health system that does not take into account spiritual and cultural as well as gender issues struggles to deliver appropriate care to non-mainstream women.

[4] The stress for health care providers in remote areas is tremendous. They are often required to provide services beyond the knowledge and training of their urban colleagues. Many are trained for this, but they depend on effective referral to regional centres for more complex management.. This leads to early burnout of professionals.

[5] Although she has twins, she is giving the best milk to the boy, which may be an indication of more value being ascribed to males in her society. It is also possible that her culture does not value twins. Many nomadic cultures allow one twin to die as the mother cannot care for them both. This is a gender distinction issue characteristic of almost all cultures.

[6] Mixing the formula with snow without boiling the water shows the interaction of lack of education about introduced health practices (formula feeding) plus personal health practices and culture with health. Education of women has been shown to have a very positive effect on infant mortality. Isolated communities have limited access to doctors who may also have an important role to play in this education.

Tutor's Notes re Community Issues

[1] With health care reform the buzz word of today, there is a tendency to concentrate health care delivery in bigger centres. This means that any condition with even a remote chance of complication cannot be handled near home. This causes great social dilemma

with separation of families, lack of support networks in a strange place, psychological stress for the patient and family, as well as increased expense for both patient and government who pays for health care. The motto of obtaining health care "closer to home" is being replaced with "farther from home." There is a significant negative impact on the well-being of the woman who is separated from her family. In their reproductive years, women are more often hospitalized than men.

[2] Canada's native populations do not enjoy the level of good health of the rest of Canada's population. They have been marginalized and have not benefited from many of the preventative medicine campaigns. Smoking, drinking, unemployment and lack of educational opportunities are but a few of the areas that need to be addressed.

[3] It would be helpful in the referral centres to make sure there is a list of people who can speak different languages to aid in communication. Knowing the customs of the various cultures may help in making a patient feel more at home in a strange environment. Having affordable arrangements for accompanying persons would decrease the social isolation and lessen the depression.

[4] Increased support for health care providers in isolated areas is necessary. With the improvements in telemedicine, expert help is easier. Providing periodic time away from the workplace and providing appropriate skills training would be helpful.

[5] Although not as blatant in Canada as in some other countries, there is still an unspoken valuing of boys over girls. The increasing status of women is still only superficial, and preventative education at the grade school level and up needs to increase.

[6] Lack of basic knowledge that would allow this mother to mix the formula with contaminated water shows the interaction of education, culture, physical environment and personal health practices with health. Public health needs to work on education strategies, using educators from within the culture.

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6. Case of Women Physicians

Objectives

1. To illustrate how women are excluded from contributing to the development of policy in medicine.
2. To explore how women can be co-opted to the process of marginalizing women by their need for male approval.
3. To demonstrate that when women are included in policy development the outcome is more useful and of a higher standard.

Narrative Case

There is a meeting of male and female medical doctors in progress. They have come together to discuss further training and political aspects arising from their work. Among other things the future of the medical profession, the best possible networking, the financial situation and the acceptance of male and female doctors in health care politics is to be discussed.

The panel consists of five highly qualified male doctors, one expert female doctor and an experienced female journalist, acting as moderator. She introduces each of the male doctors individually to the audience, using their titles. She introduces the female doctor and uses instead her first name, [1] and begins the discussion. [2]

The discussion grows heated, the moderator calms each of them, smiles, is charming and clever, and gives each male participant the feeling of being important. Invariably, the male doctors begin their contributions with a remark about the charm, the good looks, the smile, etc. of the moderator. The female doctor is virtually ignored. [3]

There are many requests to speak, among others a woman has been trying for some time to have her turn. The moderator, however, has ignored this woman and only asked men to participate in the discussion. [4]

After a somewhat lengthy discussion, one of the participants points out that this female doctor has been trying to speak for some time and has been ignored so far. The moderator says that she has actually intended to bring this debate to an end and adds, "I think it is nice that a woman wants to participate. Why don't we listen to her too." [5]

This female participant turns out to be the chair of all the doctors in this district, knows the subject matter better than anyone else in the room and delivers such an excellent and factual statement that she receives the most applause of the evening.

Everyone agrees that no better closing words could have been spoken, and the meeting is brought to an end.
Afterwards the moderator goes over to meet her and says somewhat amazed “You have done an excellent job”. [6]

The female doctor points out the moderator’s “sexist behaviour” in a warm and friendly manner and illustrates this by her sentence ”I think it is nice that a woman wants to participate. Why don’t we listen to her too.”

The moderator is embarrassed and remarks that she has not seen the gender aspect at all and that until today she has not realized that she has been treating women differently from men. She adds that without this evidence she would not have believed it and that she is very grateful to have been told. She admits with astonishment that there is an urgent need for clarification for both men AND women in order to ensure that a gender perspective is incorporated into everyday life.

Tutor’s Notes/Learning Points

[1] This is a common and unconscious process of investing the men with legitimacy and the women with familiarity. In introductions and in written material, if one person has a title, then all should. If one person is called by their first name, then all should be called by their first name.

[2] As usual, men are seen to be the experts who give their opinions, the only woman is more or less used as a token to show that at least one woman is included in the panel, even though women physicians ar equally involved in medical training and the problems facing the profession.

[3] The actual discussion takes place among the men, the woman moderator is ornamental, and appreciated and ensnared because of her sexual attraction. She actively colludes with this by inflating the men and ignoring the woman physician, although she will not be aware she is doing this. She has been trained to do so.

[4] Owing to socialization, many a woman is in the habit of primarily allowing men to take the floor and having a tendency to neglect or underestimate their own sex.

[5] The moderator acts in the same patronising way in which men treat women: condescendingly, sympathetically, graciously, why shouldn’t a woman have the right to speak up.

[6] That sentence is meant to be nice but shows, however, that some women still find it amazing when other women are good at what they do.

7. Case of Obstetric Malpractice and Psychiatric Sequelae

Objectives

1. To explore the expectations of female patients when they select female doctors.
2. To show how physical complaints in women are interpreted as having an emotion or psychological basis.
3. To show how postpartum depression can arise from both the patient's and society's expectations of new mothers.
4. to explore the gender differences of malpractice suits between female and male physicians.

Narrative case

Brigitte is referred to a forensic psychiatrist for a psychiatric examination as part of a medico-legal case against her female gynecologist, Dr. Ahlgren. She accuses Dr. Ahlgren of ruining her life, due to her urinary and fecal incontinence related to a rectovaginal fistula, resulting from a missed fourth degree tear during delivery of her daughter. Dr. Ahlgren's legal counsel argues that Brigitte is exaggerating the seriousness of her problem, as a consequence of a severe postpartum depression, for which she was hospitalized in a psychiatric ward for two weeks postpartum.

Prior to her delivery, Brigitte was a 32-year-old financial consultant in Brussels, married but with no children. She had always insisted on attending a female gynecologist and while attending Dr. Ahlgren for her Pap smears, discussed her plans for pregnancy. When she became pregnant, Brigitte was disappointed in Dr. Ahlgren for not warning her that she did not accept patients for primary care obstetrics. However, Brigitte was happy to find that Dr. Genest, her female partner, would gladly accept her. After all, Dr. Ahlgren would not work with a partner she would not recommend.

The antenatal visits are uneventful and Brigitte develops a good rapport with Dr. Genest.

When Brigitte arrives in labour at the hospital, she is surprised to find that it is not Dr. Genest who will be delivering her, but rather the doctor on duty, Dr. Ahlgren, assisted by a midwife.

Labour progresses well and Brigitte is very pleased that she has not required any analgesic, as her birthing plan stated that she wanted to do things naturally. At the time of crowning, Dr. Ahlgren announces that an episiotomy is necessary. After the delivery is complete, Dr. Ahlgren congratulates Brigitte on a model birth.

During her stay in hospital, Brigitte is surprised how much her stitches and her hemorrhoids are bothering her and requires frequent analgesia. The nursing staff and

doctors check her stitches and hemorrhoids externally and provide topical and oral analgesia.

Brigitte is discharged home with advice re contraception and a reminded to make her appointment with Dr. Genest for 6 weeks hence.

Brigitte does not cope with this crying child. She is overtired, her nipples are cracked and sore, and she feels like such a failure having to supplement with formula. She cries a lot. She develops such a postpartum depression that she is admitted to a psychiatric hospital, under the care of Dr. Charboneau, a male psychiatrist. She tends to be a loner, with her excuse being urinary and fecal incontinence. Her physical discomfort is downplayed by the doctor and nursing staff and she is accused of being non-compliant with treatment.

The hospital notes by the psychiatrist describe Brigitte as a perfectionist, who cannot adapt to the versatile demands of a baby. She desires to be in total control over her baby and her needs, but is incapable of exerting this control, resulting in exhaustion and depression. Dr. Charboneau feels that she has been shaken by the loss of control over her personal time schedule as a result of the baby's demands. Her feels that her bonding with the baby is incomplete and inadequate. He fails to make mention of her urinary and fecal incontinence, despite nursing notes to this effect. He goes on to say that he has concerns for the baby's safety, and that Brigitte should allow her mother-in-law to take care of the baby in the weeks following discharge.

While at the home of her mother-in-law, Brigitte has an unexpected loss of stool that leaves her standing in a pool of feces. Her mother-in-law calls Dr. Genest, who tells her to come right over to the office. Examination by Dr. Genest detects the recto-vaginal fistula, secondary to the fourth degree tear. Brigitte cannot understand how her perfect delivery could have resulted in this problem and becomes quite teary. Brigitte states that she is afraid she is going to lose her husband. Dr. Genest tells her to get a grip on herself and not to give in to self-pity.

Dr. Genest consults with Dr. Ahlgren and they send Brigitte off to see the general surgeon, who recommends a temporary colostomy. Brigitte feels that all the doctors are conspiring against her and blaming her for her own incontinence.

During the litigation, the report from the general surgeon confirms the recto-vaginal fistula and disrupted anal sphincter. However, Dr. Genest's lawyers maintain that all the "fuss" is merely part of a psychiatric problem, namely postpartum depression as a result of Brigitte's perfectionism and overblown expectations of motherhood.

<u>Tutor's Notes/Learning Points</u>

1. A woman often chooses a female gynecologist, thinking that a woman will be more empathetic than a male physician. Patients are often disappointed and surprised when this is not always so. They are even more surprised to find that

even in empathetic physicians, this does not break down the doctor-patient relationship into a more personal woman-to-woman relationship.

2. In a professionally successful woman, doctors tend to attribute somatic complaints to insufficient “femininity,” eg. Breastfeeding difficulties to insufficient mothering capacities.

3. In women, somatic problems are often too readily interpreted as based on emotional or psychological grounds.

4. A woman often feels vulnerable and incompetent after giving birth. She may have difficulty breastfeeding or coping with the demands of a small baby. A lack of support in her environment may discourage her and impair her self-esteem, which many lead to serious depression.

5. Being over-tired and having huge responsibility for mothering with no prior training, postpartum women may convert their somatic symptoms into self-accusatory psychological positions, contributing to postpartum depression.

6. A young mother’s family, as well as her doctor, tend to focus on the psychological situation, thus misinterpreting and/or ignoring actual medical problems.

7. Why do some women only want female doctors? Has there been a bad experience with male doctors or do they expect a different doctor-patient relationship than they would achieve with a male doctor? Are they of a fundamentalist religion that does not allow men to examine them? Have they been sexually abused in the past?

8. There is a good literature on the practice patterns of male and female physicians. Patients perceive that they have been given more time and attention by female physicians than by male physicians, although time-wise, this many not be true. Is there something about the way female doctors listen to patients that gives them this sense of having received more time? Some women believe that because female doctors have had similar experiences they will understand them better.

9. How do female vs. male doctors react when they realize that their professional competence or reputation is under question. In North America, litigation is forever increasing. When presented with the possibility of a lawsuit, the stress for the physician is extreme.

8. Case Of A Young Female with Multiple Scars on Forearm

Objectives

1. Awareness of the health consequences of childhood abuse.
2. Awareness of the gendered nature of self mutilation.

Narrative Case

Clara is a 20 year old but still teenage-looking young woman who consults her family practitioner because of multiple scars on her left forearm. The scars are well healed, not hypertrophic transverse scars, most of them 2 cm long and 1-2 mm wide. You count at least 15. She insists on a referral for plastic surgery.

From previous visits it is known that she has been admitted several times to the psychiatric department and diagnosed as having Borderline Personality Disorder. [1] The cuts were self-inflicted by a razor-blade. [2]

As a general practitioner what should you do, when Clara asks for a referral to a plastic surgeon? [3]

Clara´s self destructive manners alerts you to check her domestic situation, and you ask her if she experienced abuse or neglect when she was growing up? She is evasive and does not want to reveal anything about her childhood years. [4] You refer her to a psychotherapist and it becomes clear that her mother was an alcoholic and that Clara was sexually abused when she was a very young girl and raped several times by a man also who dated her mother. [5]

With careful psychotherapy, Clara becomes more self-assertive and less self-destructive. There is a long way to go however before she is well functioning and is capable of maintaining a job.

Tutor's Notes/Learning Points:

[1] Borderline personality disorder is predominantly seen in females (75%).

[2] Women are more likely to self-mutilate than males who may turn their aggression outwards. 80% of females who self-mutilate have a history of childhood sexual abuse.

[3] As a general practitioner, you should not send her for plastic surgery as there is nothing the plastic surgeon can do for this patient with well healed narrow scars.

[4] With a patient like this you should always expect that she has been the victim of serious traumatic experiences and psychiatric expertise should be sought, ideally with continued contact with the same psychotherapist for as long as needed.

[5] Sexual abuse of children is common and not confined to female children but more common with female children. About 30% of women give a history of childhood sexual abuse and about 15% of men. In 90% of cases, the perpetrator is a male, and often well known to the child.

9. Case of Schistosomiasis

Objectives

1. To illustrate the interactions of education, culture, women's lack of empowerment, child labour, early marriage and childbearing with health and health care.
2. To illustrate that environmental hazards do not affect men and women equally.
3. To demonstrate the health effects of the subordinate status of women.
4. To sensitise doctors to the inter-relationship between poverty and lack of priority of health care for women within families.
5. To enhance understanding about the health effects of restricted access to health care for rural women.

Narrative Case

When Noura was 12 years old she was no longer allowed to go to school as she was needed at home to help her mother in taking care of younger siblings. She also spent part of her day in the rice field as a paid daily worker. [1]

Noura's mother noticed that Noura was smaller than other girls her age and she had little energy to play with the other girls when her day's work was done. She took her to the local health center where she was diagnosed as having urinary tract schistosomiasis and anemia .[2]

She was given oral medication for schistosomiasis as a single dose and advised to take iron for at least 2 months . Noura did not follow the treatment. She continued working in the rice field, with her feet and legs constantly wet.

Noura married at the age of 16 years, went to live with her husband's family and was pregnant within the first year of marriage. She married into a poor family who could not afford prenatal care by the midwife, as they were living far from the health centre. Her mother-in-law advised her to use the services of the local birth attendant in labour only, to save money. [3]

Because of her anemia and her physical underdevelopment, her pregnancy was difficult and ended in a complicated premature labour. She lost a lot of blood in labour under the care of the local birth attendant. She was finally taken to the health centre hospital for intervention, where she gave birth to a premature child. [4]

Lab investigation in hospital showed her hemoglobin to be 7 grams and she was found to have schistisoma eggs in her urine. [5] The hospital asked her family to buy blood for her but they refused and her husband discharged her from hospital . [6]

Tutor's Notes/Learning Points

[1] The use of child labour results in the child missing the opportunity to be educated. Without education, there is little chance of improving her lot in life. Many girls carry a heavy domestic workload even if they are allowed to go to school. Without some childhood play time, she knows nothing but the drudgery of unstimulating work and her emotional state is affected by this.

[2] Schistosomiasis is a chronic parasitic infestation affecting millions of men and women in tropical and subtropical countries . People get the infection through penetration of the skin by the parasite released during the day from infected fresh water snails. Girls and women get infected during agricultural and domestic activities, as they collect water, wash their utensils and clothes in the river and help in irrigation.

The infection results in continuous loss of blood and vague manifestations of fatigue, ill-health and anemia.

Noura's medical care was inadequate because no attention was paid to her need to be given permission to take care of herself, and no information was given that made sense to her about why she should take the medicine. She did not complete her initial treatment for the schistosomiasis and the anemia. This was compounded by the drain on her system from pregnancy, then brought to crisis level with the significant blood loss at delivery.

[3] Early marriage with inadequate contraception does not allow for full physical development before pregnancy. The woman goes to live with the husband's family, where she has no input into decision making and is isolated from the influence and mentoring of her own family. Pregnancy is seen as a normal course of events on which money should not be wasted. Lack of education results in lack of appreciation for the value of antenatal care by a trained provider.

[4] Pregnant women need to be looked after by trained birth attendants to receive adequate care. For rural women, there is the danger that such trained birth attendants are not available. There needs to be a basic skill level that can identify when a woman needs to be transferred. Often once the decision to transfer the patient is made, the logistics of transfer from remote rural areas to the health centres is difficult due to lack of infrastructure such as roads and transport vehicles. Proper care means giving the necessary care when and where it is needed and this means providing resources to rural communities and training rural people in health care.

[5] Women are much more subject to re-infection than men are. As children, both boys and girls work in the rice fields, but as they mature, women remain working in the field while the boys mature and go onto non-water based activities. Daily contact with infected water leads to re-infection very easily.

[6] Poverty influences the access to health care. In this case, Noura was allowed to continue with her anemia as the family could not afford to buy her blood. Her husband

made the decision to discharge her from hospital, even though she was ill and required transfusion. The wife is treated as the husband's property and has no say in her own welfare.

10. Case of Uterine Fibroid Embolization

Objectives

1. To consider how some cultures consider women's reproductive organs only in view of their childbearing potential.
2. To show how more conservative therapies are not considered when the reproductive organs are considered to be past their reproductive capacity.
3. To show that physicians are not always interested or aware of new technologies in patient care, when these new technologies advance an area that they feel is of little concern .

Narrative Case

Ms. Chuapetchasoporon is a 45-year-old single female, who works as a research assistant at the University of Bangkok. She has suffered from menorrhagia for the last 6 months. As her job provided her with good medical insurance, she was able to choose a gynecologist in one of the private hospitals. [1] After physical examination and ultrasound, the diagnosis of multiple uterine fibroids was made. The gynecologist recommended a total abdominal hysterectomy and bilateral salpino-oophorectomy.

She told Ms. Chuapetchasoporon that she may as well be rid of her uterus and ovaries as being a single woman, she would not need these organs for reproduction and menopause was very close. [2]

When she got home, she called her friends who told her that they had been reading about uterine fibroid embolization (UFE) in the latest edition of Chatelaine. [3] This method would not involve major surgery. Ms. Chuapetchasoporon went back to her gynecologist to ask about this treatment, but was told that it was more practical to take out the uterus and ovaries in her age group. [4]

She went for another opinion and this second female gynecologist sent her for this embolization procedure. [5] Her treatment was successful, she still has her uterus and ovaries and did not require hormone replacement therapy due to sudden surgical menopause. [6]

Tutor's Notes/Learning Points

[1] Finances often determine what medical care a patient receives. If this patient did not have a good private insurance plan, she would have been seen in the public clinic. Women often have jobs that are part-time or less well paid that those of men, with fewer employee benefits.

[2] It is a common assumption that a woman's uterus and ovaries are expendable organs when they are not to be used for reproduction any longer. Whether she had decided on embolization or surgery, there was no need to remove the ovaries, which would have caused a premature and sudden menopause.

[3] Women are empowered when they are able to talk about private matters with friends and other women, often coming away with new ideas and methods of implementing these ideas.

[4] There are a variety of possible motives as to why the surgeon still encouraged the surgical approach on Ms. Chuapetchasoporon's second visit, including higher fee from surgery, lack of knowledge of or skill in uterine fibroid embolization, or resistance to change.

[5] It is well known that women physicians and male physicians practice a different style of medicine. However, as shown in this case, women physicians do not all practice the same. This can be very confusing for women who expect the female doctor to be on their side.

[6] The discussion of menopause management is of interest, as normal physiologic events are often pathologized. There is a variety of opinion regarding benefits vs risks of hormone replacement therapy which varies from culture to culture. However with a sudden menopause, as with taking out the ovaries, flushes can be severe.

Reference

UFE is now starting to become more and more acceptable treatment especially in the USA. 10,500 cases have been reported for the whole world up to mid 2001. Very few complications have been reported (around 1-3 % and most are minor) Using local anesthesia, the radiologist inserts a catheter through the skin in the groin into the common femoral artery, exactly as in an angiogram procedure. The catheter is advanced into the uterine artery, blocking the artery with small pieces of blockage material to cut the blood supply to the fibroids, making them shrink as a result. The patient stays in the hospital for a night and leaves hospital with a tiny half centimeter wound at the groin, which does not require sutures.

www.scvir.org The web contains details about how the procedure is done, complications etc. There is also interview of some patients who already have this procedure done

11. Case of Pregnant Female Medical Resident

Objectives

To question the way the medical establishment deals with female physicians, especially residents, in their reproductive years.

Narrative Case

Pin is a 25 years old female doctor who just finished her internship and is applying for a residency spot in the radiology training program. She and her husband, who is a busy surgeon, working at another hospital, have been married for a year, and do not want to wait until Pin is finished residency to start their family. [1]

During the interview for her residency position, one of the interviewers asked about her personal life and she told him about her intention to have children. The other interviewer warned her that pregnancy during training radiology might be a problem. It would mean avoiding some radiology procedures that had a high risk of radiation exposure, that were part of the residency training program. [2]

Thinking that they had convinced Pin that she should wait to have children until after residency, the interviewers recommended her acceptance into the program. Pin was a wonderful resident and showed a natural skill for the specialty, even though this was felt to be a specialty more suitable for male physicians. [3]

At the end of the first year of residency, she became pregnant and asked the department to schedule her out of the high risk radiation areas until after her delivery. Her fellow residents, all of whom were male, were irate. Imagine a resident asking for special privileges, especially when it meant they would have to do extra work as a result! Her pregnancy was her private problem and nothing to do with them. [4]

There was so much ill feeling that Pin felt overly stressed and decided to drop out of the residency program. [5]

Tutor's Notes/Learning Points

[1] Medical marriages have their own challenges, such as whose career is going to be allowed to advance at the sacrifice of the other. When children arrive, who is going to make the bigger sacrifice in terms of working hours, responsibilities, etc.

[2] In Canada and Australia for example, questions of a personal nature are not allowed in the interview process. Is this included in the human rights legislation or constitutional protections of other countries?

[3] In medical recruitment, certain specialties are seen as being more suited for males. Most of the surgical specialties fall into this category. To succeed in these specialties, women physicians often have to be "one of the boys."

[4] Pregnancy benefits, shared residency positions and maternity leave have been issues pursued by the national women's medical associations for many years, with variable success. Provisions have to be made for pregnant residents, so that they will not be made to feel guilty for inconveniencing their fellow residents. The fellow residents who object to doing the extra work are not necessarily male, but may be females who do not plan to have children during residency training. Health and well-being of all citizens, including women who are pregnant, is a societal responsibility and concern and not a personal one.

[5] There is little in the way of support mechanisms for pregnant women physicians, particularly those who are in the minority in a specialty. Developing these supports is an informal mandate of many of the national medical women's organizations. Female radiologists and female personnel in radiology can be more aware and help empower each other. Have national organizations such as the female radiologists in the USA done anything to further this cause?

Medicine in general and residency programs in particular are organized on a male model, which disadvantages women and their health. This is particularly true with respect to pregnancy, childbearing and child care. This is an academic policy issue.

<u>Background information</u>

Most radiology departments in Thailand will not allow personnel to transfer from a high radiation exposure area to a lesser one while pregnant, due to the lack of trained personnel. There is no formal legal support to insist that women be transferred out of these high risk areas when pregnant.

In Canada, maternity leave is more commonplace, but those in insecure or unsteady job sectors (often where women work disproportionately more than men do), are not necessarily subject to the same legal protection (see generally Canadian Human Rights Commission at www.chrc.ca).

12. Cases of Domestic Violence

CASE A

Objectives

1.To consider the interaction of domestic violence with the social determinants of health.

Narrative Case

Case summary

Mary is a 28 year old woman who suffered childhood abuse and neglect and then domestic violence (DV) in her adult life. Her partner, Tom, is a 37 year old man who comes from a similar background. He has never been employed and is chronically dependent on alcohol.

To review Mary's history, Mary's mother was addicted to drugs and had a variety of men in her life, many of whom abused Mary. Being the oldest child, Mary took on the responsibility of getting her siblings fed and to school. [1]

Mary did poorly at school and by the time she was in high school was associating with a group of her peers who were also not doing well in school. She was using drugs herself. At age 14, she moved in with Tom who was 23, and showed her special attention. [2] Tom himself had been thrown out of his home at 14 by an abusive father and spent most of his teenage years in detention centres as a result of petty crimes. [3]

The relationship between Mary and Tom developed a certain pattern. They would drink for days at a time, then they would argue, this would escalate to the point of physical and verbal abuse. [4] Mary was often badly beaten by Tom and became frightened of him. He would tell her to 'get out' but the idea of being on her own frightened her even more. Tom would then apologize, they would make love and Mary would forgive him, believing that things would get better. [5]

After a number of abortions, Mary had Katy, their first child. [6] Tom was violent towards her during the pregnancy and she became more frightened and moved out to stay with her mother. [7] Mary was very depressed after the birth.[8] She felt alone and abandoned. She went back to Tom. She hoped 'that things would improve' now that they had a child, but the drinking and violence and verbal abuse continued. [9] She found herself pregnant again, soon after returning to Tom.

Mary was now so depressed that she thought about suicide. Mary was afraid to leave and was always afraid that Tom would eventually kill her or the children or himself – or all of

them. [10] She went to many doctors about her depression and was prescribed numerous antidepressants, with little help. [11] She never told anyone about the abuse to which she was subjected. [12] She felt that she deserved the beatings, as Tom had told her so often that she was worthless and nobody else would have her, that she now believed this herself. [13]

Tom had been drinking for days and there was no money in the house, Mary did not know how she was to feed the children or pay the rent. There was yet another fight and Mary tried to lock Tom out of the house but he banged on the door and woke the neighbourhood. The older child woke up crying and afraid that her father would come into the house. Katy then told her mother that Tom had sexually abused her on a number of occasions. Shocked by Katy's disclosure, Mary then made a very serious attempt to kill herself and her two children.

Mary was charged with the attempted manslaughter of her children and they were removed from her care and placed with the Tom and his mother.

Tutor's Notes/Learning Points

[1] Female children especially become 'parentified', taking on the role of 'little mother' in the household. This pattern of caring for others – no matter how dysfunctional or even abusive they are - becomes entrenched and is repeated in adult life. Generally it is reinforced by cultural prescriptions of appropriate female roles and behaviours.

[2] Adolescent girls who have been abused and neglected are easily attracted to a man who seems able to take care of them and offer protection. There was also the social imperative that she be attached to a man – in most cultures this is necessary to provide a woman with status and with 'protection'. In some cultures a woman has no social and/or economic option but to remain with her male partner.

[3] Most youngsters with this profile are running away from impoverished and/or neglectful and/or abusive families. Their time spent in detention centres further stigmatises them so that they are less able to secure employment and this often reinforces a criminal life style. Similarly, men like Tom are repeating behaviour that has been their own experience of family life. They are impulsive and aggressive – they have a fragile sense of self worth and cultural mores of masculinity may dictate that they not acknowledge this fragility but rather that they express aggressive and challenging behaviours.

[4] This is a typical pattern in DV: alcohol and/or drug abuse leads to fighting and then reconciliation. Often the man feels overcome with remorse after beating the woman and there are pleas for forgiveness, promises to reform, lovemaking and then further cycles. The perpetrator is often very loving and repentant following a violent outburst and this intensifies the partner's attachment to him. . In many cultures a woman had little option but to endure the situation since leaving the man may make her more stigmatized or vulnerable or she may have no economic support without him.

[5] Her childhood background of neglect and abuse meant that Mary was unable to develop a sufficient sense of worthiness or entitlement to be treated any better. In some cultures this is compounded by social mores, which marginalize women like Mary. Typically she remained in the relationship in spite of repeated violence, partly because her self-protective mechanisms were impaired by trauma and partly because whatever love and affection Tom provided her in between the episodes of violence simply reinforced her attachment to him and the hope that things would get better.

[6] With little sex education she was vulnerable to pregnancy and STDs. Intravenous drug use compounds the vulnerability to blood borne viruses. Her mother had no time to tell her about safe sex.

[7] DV increases during a pregnancy and is the commonest cause of injury in pregnant women. Men like Tom often feel threatened by the prospect of having a child – economically they have little to offer and emotionally it means one more person to be cared for. This intensifies the man's feelings of worthlessness and he defends against this by being more angry and violent.

[8] Mary had two children in quick succession and was severely depressed following both births. Postpartum depression is common in women in situations of abuse and/or deprivation. There was insufficient follow up in spite of the fact that she was patently at high risk.

[9] This is a typical pattern of hoping that a child will change him and not recognising that it may in fact worsen the situation. With a history of teenage pregnancy with additional history of abuse and DV, Mary needed more vigorous follow up from the clinic (eg home visits).

[10] This situation involves psychological entrapment and is sometimes referred to as a 'hostage' situation (Herman, 1991). It is common in situations of domestic violence where abused women usually feel helpless and powerless and unable to leave the situation and often they fear for their lives or for the welfare of their children if they attempt to leave. This perception is actually quite accurate – homicide statistics show that women are most likely to be killed by their partners when they attempt to leave the relationship. Walker's concept of Battered Woman Syndrome is similar – the problem of the battered woman's entrapment is described, as one of 'learned helplessness', meaning that the victim learns that to resist is pointless because it only leads to further abuse. This leads to feelings of helplessness and surrender to the power of the abuser.

These descriptions (both Walker and Herman) are psychological ones that assume a woman has a choice, socially and economically. In Mary's case this applies because she lives in a culture where she has social and economic support to leave the relationship. However, in many other cultural contexts a woman has no social or economic alternative and then psychological analyses are less important and the most compelling causes of the woman's entrapment are social and/or economic.

[11] Prescribed medication is unlikely to help while the situation is unaltered. Women are prescribed more psychotropic medication than men – often without attention to the underlying problem – this is especially true in DV.

[12] There is a pattern of consulting doctors but not disclosing. Primary care physicians need to be alert to DV as a common precipitant of depression. It is one of the commonest reasons for apparently accidental injury in females and presentation to Emergency Rooms.

[13] Verbal abuse and attack on her self image leading, typically, to false beliefs, ie 'I am what he says I am'. For many women it may be true that no one else will have them – in many cultural groups a woman like Mary, with a child and seen as having 'deserted' her husband, will be outcast.

BACKGROUND INFORMATION ON DOMESTIC VIOLENCE
This is defined as abuse between persons in an intimate relationship, independent of gender, sexuality or marital status. The term usually excludes abuse of children and the elderly.
Prevalence:
23% of women experience DV in their relationships at some time.
45% female homicide victims are murdered by their partners.
(Australian Bureau of Statistics: Women's safety survey, 1996.)
Women presenting to ER (Australian study)
49% had experienced DV, 40% in the last 12/12.
25% had a history of childhood abuse plus adult DV (Roberts et al, 1998).
Psychiatric sequelae:
Women with acute psychiatric presentation to a community mental health service:
40% have a history of abuse, 16% experienced it in the last 6/12
24% have a history of DV, 8.6% in the last 6/12 (Tham et al 1995).

DV AND SUBSTANCE ABUSE
75% of women with D&A problems have history of sexual/physical violence.
72% have experienced assaults in their adult life, mostly from partners.
(Swift et al, 1996)
Effects of DV on children
There is a strong association between witnessing DV and severe PTSD symptoms: withdrawal, clinging, regressive behaviour, hyperactivity, aggression, difficulties in concentration (Kilpatrick et al, 1997). Child witnesses are much more likely to grow up to be either victims (females) or perpetrators (males).

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CASE B

Objectives of the Case

1. To show that domestic violence is independent of education, economic situation, social class or culture.
2. To show that emotional abuse is often a precursor to serious acts of physical abuse.

Narrative Case

Dr. Bob Smith is a general surgeon and his wife, Dr. Carol Jones, is a general practitioner, both practising in an urban setting. They have been in practice for ten years. They met in medical school and married in their first year of residency. They have two children, ages 5 and 7. [1]

Carol took three weeks off on maternity leave with each child, as her practice was still relatively new at that time and she did not feel she could take the year maternity leave that many of her friends in salaried positions could take. [2]

Things are not going well. Bob is on call every second night since the third general surgeon left for the States last year and the hospital has not been able to attract another surgeon. He is so tired that he wonders at the completion of some surgeries whether he has done his best. He is currently in the middle of a legal suit, which is taking so much of his time. He finds that if he comes home at night and drinks vodka, he feels much more relaxed and yet does not have to worry about the smell of alcohol on his breath if he should get called back. [3] He does not want to seek help in case word of his difficulties negatively influences his medical practice.

Carol is becoming increasingly stressed as well. Her office is always overbooked, as she has had to cut down to 3 days of office work, to be able to take care of the needs of the children. She still has the office overhead to contend with, but not the volume of patients to justify the costs. She is feeling more like a single parent, running the two children to lessons and sports by herself as Bob is always either at the office or the hospital.

On one particularly tiring day, Carol comes home after the children's swimming lesson to find Bob drunk and asleep on the couch. After putting the children to bed, Carol awakens Bob and confronts him with his increasing use of alcohol and withdrawal from family duties. Bob is so angry that he hits Carol and blackens her eye.

At the office the next day, Carol makes up an excuse about a household injury to explain her black eye. She realizes that Bob is a good husband and that the stress of work, the current litigation, both coupled with alcohol, brought out this atypical behaviour. [4]

After repeated episodes of physical abuse, their relationship deteriorates and Carol tells Bob that she is going to leave him and take the children. Bob pleads for Carol to go to joint counselling, as he has not been himself and really does love them all.

Carol does not have much hope for success from the counselling, but feels guilty about leaving, so she gives counselling a try. The female counsellor feels threatened dealing with two physicians. After six sessions, nothing is resolved and Carol makes plans to leave with the children. [5]

Bob finishes his court case and is found guilty of malpractice. He wonders what is the point in living—his reputation as a surgeon is tarnished, his wife and children are leaving him and he is exhausted and overworked. He goes home and drinks. When he hears Carol and the children driving into the garage, he picks up his hunting rifle, killing them and then turning it on himself. [6]

Tutor's Notes

[1] Medical marriages are often difficult. The woman often has to take second place to her husband in career choice and academic advancement.

[2] Women physicians often have an excessive sense of commitment to make their work successful, just to show that they are capable of "having it all"-career, family, husband, etc.

[3] Bob realizes that he is not coping but as a physician and leader in the community does not want to let anyone know that he needs any help. He turns to substance abuse.

[4] Despite having counselled patients against staying in a relationship where there has been physical abuse, Carol makes excuses for Bob's behaviour.

[5] Being in a position of authority when seeking personal help is not always an advantage. The male often presents a more threatening figure than the female and this may affect the performance of the caregiver and consequently the outcome.

[6] Accustomed to being in control and being an authority figure, Bob cannot cope with all these loses and having humbled himself to go to counselling and that failing, he decides that there is only one alternative. He struggles with feeling powerless in a society that tells him he should be powerful, with the seeming lack of options and with the socialization that has taught him not to seek help. All this translates into violence against his female partner.

13. Case of Sexual Concerns

Objectives of Case

1. To illustrate sexual concerns and problems as they relate to gender roles.
2. To illustrate how poor or absent sex education or repressive attitudes and values can affect future sexual satisfaction.

Narrative Case

A 48 year old man, married for 20 years, is now awaiting the completion of a divorce, following a three year separation. He is presently engaged to be married again, and asked his physician to refer him to a sex therapist.

Throughout his married life he has had poor ejaculatory control (premature ejaculation), lasting from 30 to 90 seconds following the onset of vaginal penetration. He has never offered, nor did his ex-wife ever request that he stimulate her genitals to help her achieve orgasm. She has never indicated any disappointment or frustration to him regarding their sexual relationship.

He is a university graduate, and has had a very successful career in banking and investment fields. He received no sexual education from his family or at school. As a relatively shy adolescent he never discussed sex with his peers, and had only two brief sexual relationships, with the same outcome as in his marriage. His wife came from a very religious background in which sex was never discussed at home with her or her siblings. At the time of marriage she was a virgin. By his description, she was waiting for him to teach her what she needed to know about sex, assuming that as a man he would be knowledgeable about such things. Throughout their marriage she was a passive partner, always waiting for him to initiate sexual activity.

During a few sexual encounters with his current fiancee, he again ejaculated very rapidly during intercourse. Now, however his new partner has indicated her disappointment, and suggested that he seek help. For the first time in his adult life, he is beginning to question his adequacy and knowledge as a sexual partner

At the end of his first session with the sex therapist the patient admitted that he had already learned more useful sex information than in all his previous life, and requested the name of an appropriate book to further his knowledge and understanding.

Tutor's Notes/Learning Points

[1] What are some of the inaccurate sexual beliefs (myths), that both women and men accept as a result of their socialization (gender roles with respect to sexual behaviour), that limit their sexual knowledge and practice? From childhood on, this is what many women and men learn from the media, their peers, their teachers, their religion, and sometimes from their parents.

For Men:

-That sex is primarily a "male thing"
-That men need sex more than women
-That the man knows it all, and particularly what needs to be done
-That the man must take the responsibility for his partner's needs (In this case he was totally unaware that she had any sexual needs).

For Women:
-That he will teach her all she needs to know about sex (Where was he to learn this?)
-That the woman is to be a passive partner
-That it doesn't matter if she is sexually satisfied as long as her partner is

[2] Acceptance of these beliefs by women, leads them to deny that they have the same capacity, need and right for sexual fulfillment as do their male partners. Only when she stops denying that her satisfaction is <u>not</u> a priority will she be able to:

-Learn about her sexual responses
Share her sexual needs and feelings with her partner, including disappointments and frustrations
-Not consider it "down-putting" to show or tell him how she would like him to make love to her for her maximal satisfaction
-Insist on seeking accurate sex information

Suggested Reading:

1. Cohen G, Cohen M
"The General Practitioner as an Effective Sex Counsellor"
Australian Family Physician; Vol. 18(3); 207-11; 1989

2. Cohen G, Cohen M
"Sexual Health Care in Family Medicine"
Canadian Family Physician; Vol. 31 (April); 767-71; 1985

3. Zilbergeld B
"The New Male Sexuality"
Bantam (Canada and USA); 1992/1993
Revised Paperback – July, 1999

4. Doyle, James A.

"The Male Experience"
Wm. C. Brown Publishers, DuBuque, Iowa

5. Sheila Kitzinger
   "Woman's Experience of Sex"
   -The Facts and Feelings of Female Sexuality at Every Stage of Life
   Penguin Books

14. Pediatric Surgery Case

Objectives

1. To increase awareness of the role gender plays in the timing of presentation of illness.
2. To increase awareness of the way gender issues affect diagnosis, both in the presentation of the sick person and in the doctor's reaction.
3. To increase knowledge about how to implement gender awareness in health care.

Narrative Case

Abena A. is a 2-month-old female infant who presents to the clinic with failure to thrive and a large swelling in her abdomen. She has been unwell on and off with abdominal pain and vomiting which has been occasionally bile- stained. Her parents have not been unduly concerned about her condition because her mother also vomited frequently during her pregnancy [1]. This condition in her mother however settled on its own. Moreover, her 4 year old brother Kwasi has one undescended testes and money has to be saved for his operation in a few months time [2].

Her father, Egya Kodjo, is convinced that Abena's mother, Yaa Obiniba, is just making a fuss about her daughter who after all will eventually take her wealth and health to her husband's family. [3] Any money should be saved for their son who is their future.[4] This morning, there is a large swelling in Abena' abdomen which moves from place to place. Egya Kodjo orders his wife to take Abena to the hospital [5]. He cautions her not to spend too much on the girl.

Living in the country, Yaa gets up very early to catch the first bus to the city. After two hours on the bus, they are tired when they reach the full waiting room of the outpatient clinic.

In hospital, Abena is examined by a junior doctor whose initial diagnosis is that of gastroenteritis. After checking that Yaa has enough money to pay, a blood workup is requested and done and Yaa is advised to give Abena a lot of oral rehydration salt solution (ORS).
Abena's mother does so but her condition continues to worsen as she continues to vomit.[6].
On her third daily visit to the hospital, she is examined by the resident who begins to suspect the diagnosis is wrong and requests an ultrasound to help diagnose congenital hypertrophic pyloric stenosis which is often described as a disease of male infants, often first born sons [7].
The diagnosis is confirmed and the treatment is started. Abena recovers fully and is discharged.

Tutor's Notes/Learning Points

[1]. Certain symptoms such as vomiting are considered "normal" for women. As a result, their presence may indicate significant disease but risks not being taken seriously.

[2]. The female child often receives less attention than her male sibling among lower socio-economic classes in most developing countries. The boy's complaints are considered more important and worth spending money on than the girl's complaint.

[3]. As the girl child becomes the property of her husband's family, she is believed to take wealth and property to her husband's family on marriage thus depriving her own family of these, but brings poverty, disease and misery home if not married or on divorce.

[4]. It is often true that money is more readily spent on the boy child than on the girl child, not only for health care but for many aspects of life. Boys are more highly valued than girls.

[5]. Most rural or poor women are socialised not to make independent decisions but to wait for their husbands. If she is told to go to the hospital, she will go as he will give her money also but with a caution as to the amount she can spend.

[6] The initial examination by the junior doctor is cursory as he fails to take into account the gender dimensions of vomiting in the neonatal period. He unconsciously takes the illness of a girl child less seriously than that of a boy. The diagnosis is missed!

[7]. Congenital hypertrophic pyloric stenosis is often missed in girls because it is described as occurring in first-born males. The doctor needs to constantly remind her/himself that male: female ratios of conditions are a guide only and that conditions cut across sex, although their presentation and management are likely to be affected by gender.

Community strategies

Education has to be intensified to change negative socio-culturalization about the female child. The value of the girl-child must be raised and equated to the boy child using examples of the multiple role models that each community has e.g. women lawyers, teachers, doctors, painters, mechanics, drivers etc.

15. Case Of A 37 year old Female with Small Breasts

Objectives:

1. Sensitivity to the health consequences of sex role stereotyping, particularly with respect to body image.
2. Validation that non-surgical management of issues arising from low self-esteem are appropriate and gender-sensitive

Narrative Case

Jane is a 37-year-old female who sees a plastic surgeon because she has small breasts. Jane is the newly separated mother of two school children whom she breastfed when they were babies. Her husband ran off with a younger woman. Jane who is neatly dressed works in the perfume shop in a department store. She is 168 cm tall and weighs 50 kg., thus she is underweight. Jane smokes 15 cigarettes per day. She wears an A-cup bra and her breasts are ptotic. She requests breast implants.

When you examine her breasts you find that there is actually some glandular tissue there, but due to the sagging skin the breasts look ”empty”. You realize that her breasts look much the same as many other women who have had children and who are not young anymore. She has normal but aging breasts.

You tell her this. She begins to cry. Jane tells you that she does not dare to meet a new man and have an intimate relation unless she has breast surgery. She would refuse to take off her bra. [1] You tell her that plastic surgery can offer her either mastoplexy or breast implants.

If you interview Jane further, she tells you that she was the middle sibling in a family with four children. She grew up without her parents taking very much notice of her and her two brothers and one sister were always more demanding. Her parents did not have the strength to support her psychologically, her father being away for long periods traveling. The mother was chronically depressed. [2]

Back to Jane´s problem, what should you do as a plastic surgeon? [3]

The patient proceeds with a mastopexy as she has clearly ptotic breasts. It has been explained that as breast implants run the risk of capsular contraction, making the breasts firmer. [4]

Tutor's Notes/Learning Points:

[1] To go through a separation, especially the way it happened to Jane, is a serious blow to your self esteem. With a low level of self assertiveness, you tend to magnify the little deformities you have. If you are an ambitious and critical person with strong demands on yourself, you want to have a perfect external appearance.
Body image is influenced by our socialization and the media and is especially tied into having large breasts. The fashion is for women to be thin and to exercise a lot and this often means that they lose a lot of breast tissue. With respect to body image, most girls are conscious of body size and dieting long before puberty, as young as age 5. The Barbie doll figure is one to which young girls are exposed from very early and Barbie clearly has anorexia. Note that action men dolls that are available for boys are actually big and muscular. Both girls and boys learn from a very young age that they will be judged by their appearance, but the emphasis for girls is to be slim with large breasts.

[2] There are psychological studies showing that among women who see plastic surgeons for breast augmentation there is an over-representation of women with low self esteem who grew up in insecure homes with little love and support from their families (Meyer and Ringberg 1987). Here the support of the fathers seem to be especially important. Women who have had strong supportive fathers are over-represented among those who are successful in their professional careers.

[3] The first thing is to encourage her to stop smoking and gain some weight as this also makes the breasts more full. Also check if she is actually anorectic, as the basal metabolic index score is about 17, which is close to anorexia. Women with anorexia often will not admit to it. The next thing is to encourage her to consult with a psychotherapist who is aware of gender issues. This therapist may help Jane to realize that she has more worth than just a pair of breasts that men find attractive.

[4] It may be argued that if you operate on people with objective deformities, giving them a more normal appearance, that this is usually a good help for the patient making her/him more self confident. (Is the breast size an objective deformity?) However, if this woman has anorexia, it is unlikely that anything will make her feel happy about how she looks. In that case, it may be important to consult a psychiatrist or a psychologist with special expertise in Eating Disorders.

16. Case of HIV/AIDS

CASE A

Objectives

1. To provide clear, immediate and relevant evidence of the significance of gender in the management of a life-threatening medical condition.
2. To provide a structured, resourced framework within which to teach and learn about gender and health.
3. To identify points of intersection between gender and health in the presentation of an HIV positive woman as a patient.
4. To describe the impact of the status of women on vulnerability to, progression and management of, HIV infection in a developing country.
5. To describe three key points in the interplay between culture and the experience of disease.
6. To consider the provision of gender-sensitive clinical care to a patient with HIVAIDS.
7. To consider how to develop public policy in the management of HIV that reflects the needs of women and men.
8. To consider what gender blind scientific research and clinical management would be beneficial in the provision of medical care to HIV positive patients.

Nonhlanhla is a 21 year old mother of two children aged four years and eight months and she lives just outside Mt Frere, Eastern Cape, South Africa, with her husband's mother and grandparents in a mud hut. She does not have a regular income. Her husband sends his mother R 500 ($44) a month and the grandparents each get an old age pension of R460 ($40) per month. Nonhlanhla has to ask her mother in law for money for her needs.[1] She has a Grade 4 education and has never been employed. Her mother works as a domestic in Cape Town, her father died when she was 10. Her family has a home in nearby village where 3 of her 5 siblings live, and have no employment. The family are aware that there is an illness that has resulted in an increase in people coming home sick from the urban areas. They have heard of HIV but have never understood how one gets AIDS. People think that HIV is spread with TB. Locally there is also an increase in the number of orphans in the village and some homes do not have an adult family member. It is the women in the household who care for the sick person.

Her first sexual experience was when she was 15 years old. She was taken into the fields by an uncle aged 40 and forced to have sexual intercourse with him. [2] He had recently come home from the city after being diagnosed as having AIDS and had heard that you can cure AIDS if you have sex with a virgin. He warned her that if she told the family about his actions he would say she encouraged him and she would be severely punished, and she knew this to be true. Shortly after that incident she met Sandile and since then has not had sex with any man other than him. As he paid a bride price for her, he

considers her his property and she must care for their children and be available to have sex when he wishes and be faithful to him.

As there was no work in Mt Frere (unemployment rate is 70% and the highest rate is among women), her husband, Sandile, left to find work in Cape Town. [3]

He lives in a one room shack in the Joe Slovo informal settlement in Langa (black township in Cape Town).

He does not have another regular town girl friend, as some of his friends do, but has sex with various sex workers when he feels the need. These sex workers live nearby and make a living servicing migrant labourers. They have little choice about their work as there is a high rate of unemployment amongst the women, the flexi hours of the work suits their other work of caring for their young children and the remuneration is better than that of a domestic worker, They have heard about the disease AIDS and that they must use condoms to prevent it.

They have been supplied with them by a local NGO. Men prefer sex without the condom (they say having sex with a condom is like eating candy with the paper on) and they offer to pay more for sex without a condom. The sex workers try using the female condom but the men complain that it squeaks and is too greasy. They can get away with using it only when the man was too drunk to notice. [4]

Sandile is able to go home twice a year. When at home, he has sex regularly with Nonhlanhla. He would not consider using a condom. They practice dry sex to increase his pleasure. [5] She gathers special leaves that she uses to dry her vagina. He believes that if she is wet she has been unfaithful to him. Nonhlanhla obliges as she fears mental and/or physical abuse from him if she does not please him or if he thinks she has been unfaithful. She would be chased out of the village.

During this time, Nonhlanhla has two children. She notices that the younger child, 8-month-old, Bongi, has frequent diarrhoea and is not gaining weight like her previous child. She is still breastfeeding and will continue, as she did for her first child, until Bongi is about 2 years old. The grandparents insist she visits an inyanga, who gives Bongi an enema. He does not improve so she decides to travel to her husband in Cape Town and seek treatment at the Langa clinic. Before she can do this, she must get permission from her father-in-law, as the patriarch in the family. [6]

Sandile is pleased to see her but is worried about the baby's health and next day on the way to work takes her to the primary care clinic (which provides a free service). Bongi is weighed and found to be below the weight for a child of his age. Nonhlanhla feels guilty and responsible for her baby's illness. She thinks she may have displeased her ancestors and that is why the baby is ill. Mothers are responsible for the health of their children and to have a fat and thriving baby means she is a success. As the mother this underweight sickly child she feels she is a failure as a woman and risks the anger of her mother-in-law. [7]

The doctor suspects that Bongi may be HIV positive and counsels Nonhlanhla, providing her with information and correcting her misinformation. With so much new information, Nonhlanhla finds it too much and quite confused but agrees to have an HIV test because it seems the doctor wants her to before she can make Bongi better.

When Nonhlanhla tells Sandile, he says that HIV is a woman's disease. Sandile is angry and abusive and accuses her of infidelity and being the cause of their child's illness and chases her away. [8]

Tutor's Notes/Learning Points

[1] Nonhlanhla is disempowered, being economically dependent on her husband and his family and is isolated from her own family. She has no authority for decision-making but must please those who have this authority.

[2] Due to lack of education, there are many myths regarding HIV, how it is spread and how it is cured.

[3] The economics of working away from home have both physical and emotional health risks. The myth that men must have sexual intercourse to satisfy their urges may lead to the acceptance of the town girlfriend or the use of sex workers.

[4] Despite the knowledge of using either male or female condoms to protect themselves from sexually transmitted infections, the sex workers are often powerless to enforce their use.

[5] The practice of dry sex and its linkage to pleasure and fidelity is another myth and due to the trauma experienced during dry sex increases the likelihood of transmitting STI's to the woman.

[6] Although Nonhlanhla wishes to take her son to see the doctor in the city, she is still disempowered to make this happen without the permission of her father-in-law, who heads the family

[7] The woman is not valued for herself but rather for her role in reproduction and childrearing. This brings up a side issue of infertility, where a woman becomes of no value if she cannot produce children.

[8] Although she has been counselled, much of the information is overwhelming. The knowledge that Nonhlanhla is HIV positive has resulted in her husband blaming her and sending her away. The public health crisis is in educating people on the transmission of HIV, how to practice safe sex either to keep themselves HIV negative or to prevent further spread if HIV positive, what their options are for pregnancy, how to care for themselves when they are HIV positive.

Background Information

Gender issues included in the case

The impact of women's poverty on vulnerability to disease and access to health care
Low educational status of women and its impact on health
Impact of lack of access to accurate health information by men and women
Health consequences of high rates of unemployment and limited job opportunities for rural men
The health impact of the subordination of women and subsequent lack of bodily integrity
The impact on the health of women of a culture of male dominance
The effect of male dominance in sexual relationships on a woman's ability to protect her health

- Condom use
- Female condom gives women control but often still rejected
- Poor support system in family
- Biological vulnerability aggravated by dry sex
- Sex traded for survival

Pregnancy and breast feeding risks
A women's illness
Health consequences of men being forced to seek work outside their home place
Involving men in the solution

HIV/AIDS

1. RISK FACTORS AND EXPOSURES

- Lifetime number of sexual partners:
  People who report more than four sexual partners in a lifetime are at greater risk than those who report less than four (Malamba, Wagner et al. 1994).
- History of genital ulcerative disease:
  Chancroid and herpes zoster, particularly herpes are very prevalent in this community (Malamba, Wagner et al. 1994). 85% of young women aged 20-25 years have had a case other sexually transmitted HSV2 which is double that of men of the same age (Wagner, Van Dyck et al. 1994).
  - Existing treatable STD's include gonorrhoea, chlamydia and syphilis that are common in this population (Whitworth 1997)
  - Almost 70% of adult women in this area have an unhealthy vaginal discharge, however only 5% realise they have a problem, many of them waiting up to six weeks before they seek treatment (Whitworth 1997).
- Uncircumcised men are at increased risk of HIV transmission (Bongaarts, Reining et al. 1989)
- Poverty is associated with increased risk of HIV:

Most likely because of economic survival strategies employed by poorer people including sex for economic assistance and support (Seidel 1993).

- Sex with older partner:

Both boys and girls report pressure from people older than them for sex. 'Sugar daddies' enticing young women with gifts and money have been widely reported. (Mati 1989)

- Regular drinkers are more likely to become HIV+ than non drinkers probably because of the environment in which alcohol is sold (MRC 1999).

2. SOCIAL AND CULTURAL RESPONSES TO THE DISEASE
   - In an area where many people are Catholics resistance to condom use as a safer sexual practice is strong (Cowell 1993).
   - In Uganda, women are expected to have only their husbands as sexual partners whereas men are expected to have affairs outside their marriages. (Mulder, Nunn et al. 1995; Kamali, Carpenter et al. 2000). This expectation places them and their families at risk. Women are ten times more likely to become HIV positive with an HIV+ male partner than men are with an HIV+ female partner. Men are twice as likely to bring HIV into a marriage than women are. Yet because of their low social status, many women are still blamed for bringing the disease into their families. Men are only recently coming to understand that their behaviour has contributed considerably to the spread of the disease.
   - Initially Ugandans were fatalistic about the possibility of dying from the disease and rationalized their risky behaviours as low risk (McGrath, Schumann et al. 1992)but since the mid 1990's when whole communities have been devastated by the disease the reality has sunk in. Experience of living with a disease for 20 years has made people very aware, and they have modified their behaviour to some extent (Mulder, Nunn et al. 1995; Kamali, Carpenter et al. 2000).

3. THE EPIDEMIC IN SOUTH AFRICA
   - Sero-prevalence rates from in South Africa (SA) from the antenatal survey, show that 25% of women tested were HIV positive
   - The HIV epidemic in SA is the fastest growing in the world.
   - Young women aged 20-30 have the highest prevalence rates
   - Mortality men and women from HIV/AIDS *(Figures to be included)*
   - Ref. The MRC Technical Report. The impact of HIV / AIDS on adult mortality in South Africa.
   - 40% of adult deaths aged 15-49 that occurred in the year 2000 were due to HIV/AIDS
   - 20% of adults in SA HIV and estimated 4.2 million persons infected with HIV
   - Ref UNAIDS. AIDS Epidemic Update December 2000, WHO Geneva, 2000

Prescribed readings:

[1] MWIA International Congress, Sydney 2001

[2] Gender, HIV and Human Rights: A Training Manual, *United Nations Development Fund for Women (2000).*

[3] UNAIDS child death and people living with HIV slides

[4] A Time for Frankness on AIDS and Africa, *Pascoal Mocumbi, Prime Minister of Mozambique, New York Times, dk*http://www.nytimes.com

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Pascoal Mocumbi, Prime Minister of Mozambique: A Time for Frankness on AIDS and Africa

APUTO, Mozambique In the special United Nations session on AIDS, there will be much discussion about international aid, about drugs and vaccines. But there is likely to be too little said about what is the primary means by which AIDS is spread in Sub -Saharan Africa: **risky heterosexual sex**.
AIDS is not like smallpox or polio. We may not be able to eliminate it simply with a one-time vaccination or course of shots for children, since new strains of HIV. are constantly evolving. **And unlike the communicable killer diseases we have encountered most often in the past, HIV is transmitted through the most intimate and private human relationships, through sexual violence and commercial sex; it proliferates because of women's poverty and inequality.**
In Mozambique, the overall rate of HIV infection among girls and young women 15 percent is twice that of boys their age, not because the girls are promiscuous, but because nearly three out of five are married by age 18, 40 percent of them to much older, sexually experienced men who may expose their wives to HIV and sexually transmitted diseases. Similar patterns are common in other nations where HIV is rapidly spreading.
Abstinence is not an option for these child brides. Those who try to negotiate condom use commonly face violence or rejection. And in heterosexual sex, girls and women are biologically more vulnerable to infection than are boys or men.
As a father, I fear for the **lives of my own children** and their teenage friends. Though they have secure families, education, and the information and support they need to avoid risky sex, too few of their peers do.
As prime minister, I am **horrified that we stand to lose most of a Generation**, maybe two. The United Nations estimates that 37 percent of the 16-year-olds in my country will die of AIDS before they are 30.

As a man, I know **men's behaviour must change**, that we must raise boys differently, to have any hope of eradicating HIV and preventing the emergence of another such scourge. In 1994, at the International Conference on Population and Development, and again in 1995, 1999 and 2000, most nations agreed that adolescents have a right to information about their sexuality. We agreed that programs should help build adolescent girls' self-confidence and boys' respect for girl's rights. We agreed to develop both adolescent-friendly health services and the education and training that will give young people hope. Today, in Africa and elsewhere, we are far from achieving these goals. Most political leaders still view adolescent sex as a politically volatile subject to be avoided. Community and religious leaders wrongly believe that sexuality education promotes promiscuity. Health providers and teachers are ill-trained about sexuality and ill at ease with it. Parents know little about sexuality, contraception or sexually transmitted diseases, and many believe that early marriage will "protect" their daughters. They may themselves condone or perpetrate sexual violence as a legitimate expression of masculinity.

For the long term, we need to develop HIV vaccines and provide treatment to everyone with HIV. We need to develop protection methods like microbicides that women can use with or without a partners knowledge or co-operation.

Above all, we must summon the courage to talk frankly and constructively about sexuality. We must recognize the pressures on our children to have sex that is neither safe nor loving. We must provide them with information, communications skills and, yes, condoms.
To change fundamentally how girls and boys learn to relate to each other and how men treat girls and women is slow, painstaking work. But surely our children's lives are worth the effort.

Pascoal Mocumbi, prime minister of Mozambique and its former minister of health, is a physician and a board member of the International Women's Health Coalition.

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CASE B

Objectives

1. To show the interaction of gender and HIV/AIDS in the developed world.

Narrative Case

Don is a 38 year old hemophilic, married with two children, ages 12 and 14, living in New York. With a great deal of restructuring having taken place in the labour force, he lost his job as a computer systems analyst with a high tech company.

Shortly after he had lost his job, his high-school buddy, Gary, noticed how much stress Don was under, so took him out for a night on the town. [1] They had way too much to drink and Don remembers Gary convincing him to try a bit of heroin to make him feel better.[2] Don woke up to find himself in a cheap hotel room with a prostitute. [3] Don kept the night's activities secret and decided that Gary was best left in his past.

Don found another job within the year and his life carried on as normal. Being athletic, he would periodically require Factor VIII for minor bleeding episodes. He was pleased that the Factor VIII for his hemophilia was now synthetic and not a blood product, as he always worried about the chance of HIV when he received factor VIII made from blood, despite the rigorous testing by the authorities.

His wife, Linda, aged 36, has been unwell for the past 6 months with one infection after another. When she told the doctor her history and her marriage to Don who had hemophilia, her doctor suggested she have an HIV test.

When Linda returned home devastated with the news that she was HIV positive, Don immediately phoned his lawyer to see what steps could be taken to sue the authorities for improper testing of the blood used to make Factor VIII. [4]

Tutor's Notes

[1] Economic decisions in recent years have resulted in the loss of income for many families. The male typically sees himself in the role of breadwinner and when unemployed, the mental stress can result in a variety of psychiatric conditions from low self-esteem to depression to suicidal ideation.

[2] In North America, drinking has become a common stress reliever, as it is socially acceptable. What has become increasingly more socially acceptable, although not legally acceptable, is the use of cocaine, heroin and crystal meth in middle class working people. Despite knowledge of HIV transmission, there is still a common practice of the sharing of needles.

[3] Despite the North American population being well-educated in the practice of safe sex, there is a complacency that with drugs available for treatment that HIV is no longer the dreaded disease it was. Although nothing could be further from the truth, sex workers and homosexuals are lax in their use of condoms.

[4] Although the family immediately blames the use of blood products, the IV drug use and the night with the prostitute are just as likely to be the source of infection. Linda is unaware of the IV heroin and the prostitute, until the lengthy investigation through the blood services confirms that Don never received any tainted blood.

17. Case of Primary Infertility With Male Factor

Objectives

1. To show that infertility is still believed to be primarily a female problem.
2. To show that medical advances do not always mean acceptance by the local authorities.

Narrative Case

Satwand is a 30 year old East Indian computer specialist married to a 32 year old East Indian engineer for the last five years. She has been referred to the infertility clinic as she has failed to become pregnant in the last two years.

Although when booking the appointment, it was made clear that both the patient and her husband must be present for the first appointment, only Satwand appeared. Soon after the history taking began, she broke into tears, stating that her husband has insinuated that she is not meeting his expectations by failing to become pregnant. The marital relations are becoming increasingly more strained. [1]

Satwand gave a history of using an IUD early in the marriage, but had it removed due to a low-grade infection. With this history, a hysterosalpingogram was performed, and her tubes were found to be patent.

Satwand booked her next appointment, at which she was to return with her basal body temperature charts and her husband.

At the next appointment, her basal body temperature charts show a good ovulatory cycle. Her husband still refused to accompany her, but did produce the semen analysis as requested. The semen analysis showed oligospermia and the doctor told Satwand that she could proceed no further without meeting with the husband.

A very hostile husband accompanies Satwand on the next visit, wanting to know how dare the doctor suggest that he is less than a man by insulting his sperm count. [2] After calming him down, the doctor manages to get a history of a very healthy man who lived in a small town near Delhi. The only time he can remember being sick was about age 16, when he had swollen glands in his neck and a terrible pain and swelling in his genitals. He remembers the female WHO visiting doctor, diagnosing him with mumps. He remembers how his mother wanted him to have the vaccine for mumps, measles and rubella that had come to the town when he was 10, but his father said he would be a stronger man if he fought disease on his own. [3] The local doctor was unhappy that the WHO doctor gathered the women and told them that it was better to immunize the children, when he had already decided that his town would not accept the vaccines. [4]

Turning to Satwand and her husband, the doctor explained that there were still ways of having Satwand conceive, such as taking a single sperm from husband and injecting it into an egg from Satwand, or using sperm from a donor. [5]

Somewhat relieved, Satwand and her husband went home, to return later with their decision.

Tutor's Notes/Learning Points

[1] Responsibility for reproductive health is still seen to be the responsibility of the female, whether it be in contraception or infertility.

[2] Finding that it is the male that is infertile can be a compromise to his self-esteem, as it is expected that he should be virile. As a result of learned gender expectations he may become angry.

[3] Gender roles dictate often that women are not in the decision-making role in the family, but must do what is decided by their husband. (Immunization is one example of medical advances that often meet with resistance. Although it is widely accepted that immunizing against a disease is preferable to suffering from that disease, people will often refuse to have a vaccine for fear it causes side effects, forgetting that the natural disease may very well kill them.)

[4] When bringing new ideas, it is beneficial to get those in a position of authority to support you, rather than oppose you. This opposition may be only because of ego and not because they disagree with what you are saying. Again, those in the position of authority do not want the women making the decisions.

[5] The doctor has the opportunity to offer options in a way that considers gender based analysis. For example, when talking of donor insemination versus the intracytoplastic sperm injection (ICSI), the first option can be presented as a method that poses fewer risks, is easier on the woman's body and is less expensive.

18.Case of Female Genital Mutilation (Cutting)

Objectives

1. To show the subjugation of women on the basis of traditional practices.
2. To show the effect of the lack of gender sensitivity in the doctor-patient relationship.
3. To show the power relationship between men and women, in the area of informed consent.

Narrative Case

Mrs. X is a refugee from Somalia, recently arrived in Vancouver. She and her husband were only married 6 months before immigrating. She is homesick for her family, as the move to Canada was the first time she had left her village.

Since they married, her husband has not been able to penetrate during sexual relations. She still recalled the day at age 12 when her mother and grandmother took her to the local circumciser [2] and the pain was unbearable as they told her she was to become a woman. After the pain of the operation settled, she found it difficult to urinate without pain and her periods always caused her such vaginal pain. [3]

Now in Canada, she found herself pregnant and the local Canadian doctor was horror-struck when he tried to examine her. She was so embarrassed that she never went to another prenatal appointment, but rather went directly to the hospital when the labour pains began. The doctor on call had never seen a perineum like that before and insisted that she deliver by Cesarean section. [4]

Her husband refused to let her have an operation, as he said that was not done in Somalia. The doctor could do nothing but watch her continue to labour. Unable to examine her, he figured she was in the second stage when she began pushing. After several hours of pushing there was a terrible scream and the baby's head emerged, soon to be followed by the rest of the female infant. The perineum was unrecognizable with tears and bleeding everywhere, necessitating taking the patient to the OR, to repair the damage. [5]

After surgery, the patient's first question to the doctor was whether he had stitched her to her previous infibulated state. [6]

Tutor's Notes/Learning Points

[1] Lack of extended family support when going to a new land is a big stress for new immigrants. Mrs. X has only known the ways of her village in Somalia. She has only been married six months, so is just getting to know her own husband.

[2] Those women of the village who perform the circumcision make their living from this job. In the process of re-education about this tradition practice in the hope of its

eradication, there needs to be thought given to providing these women with a new means of livelihood.

[3] As it is tradition, mothers and grandmothers insist on the infibulation of their daughters. In a land where their only means of survival is marriage and where marriage is only possible if they have been circumcised, the practice continues.

[4] Lack of gender and cultural perspective when dealing with patients can make them feel very threatened and insecure and they will not return unless the situation is emergent, as in labour.

[5] The husband makes the decisions, even though the potential morbidity is that of his wife. She is given no input into the decision-making process.

[6] So engrained is the tradition, that the woman knows that to please her husband, she must be re-infibulated. This has become a normal way of life as the woman has been socialized to believe this is so and therefore the woman would want to be reinfibulated for her own reasons. Care must be taken not to medicalize these practices. Canadian law has made infibulation or re-infibulation illegal. Refugee status has been given to women who will be circumcised.

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19. Case of Domestic Violence in India

Objectives

1. To show how early arranged marriage usually results in lack of education, support networks and empowerment of women.
2. To show how the family hierarchy allows the mother-in-law to have absolute control over her daughter-in-law, to the point of influencing lack of proper nutrition.
3. To show that domestic violence is accepted as normal, affecting policy, as shown by the lack of action on the part of the police and legal systems.

Narrative Case

Davinder is a young girl of age 20 who has been married for two years and has a nine-month-old child. [1] She belongs to the working class and is responsible for the housework for nine members of her husband's family, who all go out of the home to work. [2]

She is becoming increasingly fatigued due to her anemia. [3] Despite requesting permission from her mother-in-law to eat her evening meal before the other family members, for doing so, she was badly bruised and injured by her husband and other family members, including her mother-in-law. [4]

Davinder manages to inform her parents. Her brother arrives the next day to act as her advocate, but is told to mind his own business. [5]. He went to the police station to complain about the assault on his sister, but the police said it was not in their jurisdiction. [6]

Her brother then took Davinder to the doctor, who treated her wounds and advised her to go to a social organization and to seek legal help. [7]

The organization advised the girl not to return to the marital home. They requested that the husband come and meet with them. The husband would not come to the meeting, but instead, he sent a legal notice to the girl, claiming conjugal rights and asking her to come immediately back and never to go to her parental home. [8] (the conjugal right is now not a legal provision). The organization advised the girl not to go and helped her file a case in the family court. After many calls by the court, the husband did come with his whole family. He abused the girl and her family and was most rude to the counsellor. [8]

When this failed he was served with a charge of assault and was told that if he did not meet with the organization, that the assault charge would go for prosecution. This finally got his attention and he gave assurance that neither he nor his family members would abuse or assault the wife and would permit her to visit her parental home.

This was made into a contractual memorandum of understanding signed by all. Both were asked to report to the court for failure of performance and visit the counsellor at least for a few months.

A month later, the counsellor heard from the husband's family that the wife had been burned while cooking. In hospital, she told the nurse that here clothes had been set on fire by her husband. She survived for a few days, but expired to infectious complications. [9]

Tutor's Notes/Learning Points

[1] Girls in India are subjected to early arranged marriage with early childbearing and no chance for education.

[2] She has no training or opportunity to work outside the home or to have any empowerment as to what she wants to do. She has lost the support network of her own family, as she is now living with her husband's family and is dependent on them for her survival.

[3] She is always the last to eat and gets the leftovers, that are nutritionally inadequate, resulting in anemia.

[4] Her mother-in-law has power over her every action. She is helpless to defend herself against violence, either verbal or physical.

[5] Davinder is now the property of her husband's family and they want no outside interference. There is a power issue between the two families.

[6] It is difficult to know to whom to turn, when those in authority ignore your pleas for help. Wife beating is seen as a domestic matter, to be decided within the home.

[8] The husband's family is very supportive of his cause, and comes enmasse to the counsellor.

[9] The law is that any woman dying within 2 years of marriage under suspicious circumstances is to be considered a dowry death and action taken by way of police complaint to enable them to investigate and prosecute. Women still have to bring wealth to the husband's family upon marriage. Women may be killed for this wealth.

20. Case of Sex Selection

Objectives

1. To show that the woman risks being treated as merely a vehicle for reproduction.
2. To show that the values ascribed to sex and gender roles dictate that she must keep reproducing until she has a son, if she is going to have any position in society.
3. To discuss the ethics of using in vitro fertilization to ensure a male fetus.

Narrative Case

Mrs. Jain is a 40-year-old woman from Mumbai who is pregnant for the 19th time. She has 14 living female children and had 4 spontaneous abortions. She has been married since she was 15 years old and repeatedly conceived soon after delivery. She cannot remember when she last had a menstrual period. [1]

The doctor is forcing her to have a tubal ligation after this delivery, as she tells Mrs. Jain that it is unhealthy and dangerous to be pregnant so many times. [2] She had been offered in vitro fertilization with this pregnancy, to ensure a male fetus, but refused, wanting to have a male child by natural means. [3] Mrs. Jain phones to say that she is changing doctors, as she does not want to be forced to stop having children or to undergo IVF.

Tutor's Notes/Learning Points

[1] Family planning is generally accepted as being part of the culture of the western world, but is not necessarily the case in other parts of the world.

[2] The family and societal pressures made Mrs. Jain feel like she would have no position in society if she did not have a male child. The issue of the doctor dictating appropriate steps for her to take, rather than offering choices and discussing options, allowing her the decision, reflects a lack of respect for her as either a patient or a woman. Her desire to change doctors indicates the inappropriateness of his approach, which can place limits on women's access to equitable health care.

[3] Sex selection is controversial, with the ethical dilemma of the male child being preferred to the female.

21. Case of Widowed Woman

Objectives

1. To show women's lack of empowerment as a result of lack of education and poverty.
2. To show lack of attention to health due to financial reasons.
3. To show how government policy affects health and health care delivery.
4. To show that society does not value women's unpaid work.

Narrative case

Ana María is a 65-year-old woman from Guadalajara. She has always worked at home, looking after her husband and children. She had always struggled as her husband made a meagre living working for the Department of Highways. Her children have moved away and her husband recently died at work when he was hit at the side of the road by a speeding car at the age of 50. He left her destitute. She never had the opportunity to learn to read or write and finds that she cannot get a job. [1]

Her daughter, Marife, asks her mother to come and live with her. Her husband left her last month for another woman and she has two young children to raise. Before marrying, she worked as a secretary, but cannot afford to go to work if she has to pay for childcare. [2]

Ana María lives with her daughter and does the housework and looks after the grandchildren. She is poorly nourished. She has diabetes and high blood pressure, and during the last six months has had vaginal bleeding. She has no access to medical attention, as she has no government medical insurance and has no money. The government only provides insurance to those who have a paying job, as there is a tax from the wage for medical insurance. [3]

Marife comes home from work one day to find the children playing in the yard unattended. When she goes inside, she finds Ana Maria collapsed in a pool of blood on the kitchen floor. Marife calls the ambulance to take her mother to hospital. She dies two hours later. The autopsy revealed that she had advanced cervical cancer, which had eroded a blood vessel, resulting in massive hemorrhage. [4]

Tutor's Notes/Learning Points

[1] This woman has been totally dependent on her husband, who has died unexpectedly, and left her without an income. She has no education and because of previous gender role socialization, she is ill-equipped to help herself.

[2] Her daughter is somewhat better off as she has skills to get a job, but no funds to pay for childcare. The government has not developed any subsidized childcare programs.

Husband has left with no recourse to obtaining child support from him.
[3] Dependent care is mainly done by women and is largely unpaid. As there is no salary, there is no tax paid toward medical benefits. Despite being in poor health, Ana Maria cannot afford to go to the doctor or to buy any prescribed medications.

[4] Lack of timely medical care due to financial or other access reasons results in patients becoming sicker and either requiring more care or dying while waiting for care.

22. Case of Early Marriage

Objectives

1. To show that girls can be disempowered, being owned by the family and given away as presents.
2. To show how early marriage and partuition along with traditional practices can result in serious health consequences.

Narrative Case

Selia was given out as a present at the age of 12 years to her father's friend. [1] She was his fourth wife. She became pregnant within a year. Whenever she cried and said she wanted to go back to her parents, she was beaten and placed under strict surveillance. One day she did escape, but her parents told her she could not stay, as it would be a disgrace for the family.

She was returned to her husband, and as punishment, she was not allowed to leave her room, even to attend prenatal care. One night she went into labour. She was scared as she did not know what was happening. By morning, she could bear it no longer and her screams woke everyone up. The "traditional birth attendant"[2] was called, but she was still not delivered by evening. The birth attendant finally made a "Gishri" cut into her birth canal. The pain of that cut reminded her of the time she was held down and circumcised as was the custom of her people before young girls left for their husbands' homes. [3] Following the Gishri cut, she collapsed and bled profusely.

Shortly thereafter, her husband came back from his visit to the capital. He gave permission for her to be taken to the Health Centre 10 km away in the morning. It would cost money to hire the donkey to take her there. At the health Centre, the midwife declared the baby dead on delivery. Selia was exhausted, tired and lonely. She cried, because she would still have to go back to her husband. [4]

The worst was not yet over. She noticed a few days later that her wrapper became wet wherever she sat. Before she woke up in the morning the mat was wet. It smelled of urine. It smelt very badly. As soon as her husband got to know about her problem, she was driven out. She was a failure. She could not go back home. She lived rough for the next 6 months, begging along the roadside. One day, she met the midwife in the market place where she helped to carry purchases for a small price. She recognised her immediately and told her how she had started to leak urine a few days after delivery. Her husband found out and sent her away! The midwife felt sorry for her, but there was nothing that she could do. If Selia could find the money to take her to the state capital, she might be able to get help from the government hospital. She barely ate 2 meals a day. She could never have that kind of money.

She decided to go back to her parents. They were relieved to see that she was alive, but did not have the money for her treatment at the state capital. Two of her brothers who were attending school cost the family great expense already.[5] She was allowed to stay in the back where she would not be an embarrassment to the family. For the next 15 years she lived in isolation, misery and shame.

One day, one of her brothers came home with the news that women leaking urine can be cured, free of charge! He wanted his sister to be cured. He worked hard and saved enough money to take his sister to the state capital for help. It was a miracle. She had the operation done and it was successful, but she did not want to go back to her village. She chose to help with menial jobs around the hospital as a way of saying thank you for her cure. [6]

Tutor's Notes/Learning Points

[1] Girls have no say over their future, but are commodities owned by the family. It is felt that early marriage will prevent girls from becoming prostitutes.

[2] In many parts of the world, pregnant women are not attended by trained personnel. Despite the Safe Motherhood Initiative, there has been little if any improvement in maternal morbidity and mortality as emphasis was put on improving the skills of these traditional birth attendants. It is now realized that this emphasis has been wrong and that emphasis must be put on attendance by trained midwives or doctors.

[3] Traditional practices such as female genital mutilation disempower women. The practice is so engrained in the culture, that mothers and grandmothers insist that their girls undergo this procedure.

[4] She had to wait for her husband to give permission and money to get her to medical help.

[5] Education of the male is given preference to education of the female. It is felt pointless to educate the girl who will just go to the husband's family anyway.

[6] The Fistula Hospital in Addis Ababa in Ethiopia was one of the first hospitals to offer this complicated fistula repair to these social outcasts. Despite continence being achieved post-op, it was found to be quite common for the women to wish to stay at the hospital as workers rather than wishing to return to their villages.

Reference:

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23. Case of Nausea and Vomiting of Pregnancy

Objectives

1. To show that health care priorities as identified by physicians do not match other priorities as identified by patients.
2. To show the lack of support mechanisms for immigrant families.

Narrative Case

The patient in question is a 29-year-old teacher from Iran with a 32 year old engineer husband with 2 daughters, ages four and two. She is currently 10 weeks pregnant, losing weight due to severe nausea and vomiting of pregnancy. Due to electrolyte disturbance, the plan is to admit her to hospital, but she refuses. She feels unable to leave home, as who would take care of her children and who would help her husband on their farm?

Tutor's Notes/Learning Points

[1] The doctor has decided from a medical point of view that the patient needs to be admitted to hospital for the treatment of nausea and vomiting of pregnancy, but has not considered the social responsibilities that this woman must fulfill, namely childcare and agricultural work.

[2] The woman is not aware of any social supports that would allow her to go to hospital, yet cover her other responsibilities.

[3] After asking the group to discuss how to deal with this situation, ask what might be the situation 3 to 4 years later? How would this happen?

24. Case of a Somali Refugee with Fetal Distress in Labour

Objectives

1. To show that the woman is often not the decision-maker in her own health care.
2. To show that the authority of the female doctor is questioned by the husband.
3. To show the difficulty in communication when the patient does not understand the language of the new country.
4. To show how it is often the man who has a working knowledge of the new language from being out in the workforce, while the wife remains at home without the opportunity to acquire the new language.
5. To show that the woman is viewed in terms of her reproductive capacity.

Narrative Case

The patient in question is a 25-year-old female with a 2 year old son. She is from Somalia and speaks some English, but her husband is translating. She is currently 37 weeks pregnant, reporting that the pregnancy has been normal. She is in town in Ontario, visiting some friends, but lives in Vancouver.

She goes into labour and arrives at the local hospital 5 centimetres dilated, bleeding and with a fetal bradycardia. You tell her through her husband that to save the baby's life, you need to do a Caesarean.

Her husband says, no way, as they plan to have many, many children and he does not want to limit her reproductive capacity with a surgery now. Besides that, who would look after their 2 year old if she had to stay in hospital an extra couple of days?

You ask her to sign the consent for surgery. She looks at her husband and her husband says, "Wait and see what happens."

Tutor's Notes/Learning Points

1. Although the female doctor is concerned about the safety of the child due to the fetal distress, she cannot communicate this urgency to the couple in a manner that they understand. This is partly due to language but partly due to the lack of authority of the female doctor and the husband's bigger concern about future reproductive capability if surgery occurs now.
2. Although the life of every child is considered valuable, the husband seems willing to sacrifice this one child for the long term reproductive capability of his wife.
3. The woman looks to her husband for his approval when signing the consent form. As the husband does not give his approval, the consent is not signed. The woman is not empowered to look after her own health and that of her child.

25.Case of Male Erectile Difficulty

Objective

1. To understand how gender socialization as it pertains to sexuality, may lead to erroneous beliefs (myths) in both women and men, with development of subsequent marital and sexual dysfunction.

Narrative Case—Part A

A 60-year old man, happily married for 30 years, feels that he and his wife have enjoyed a very satisfying sexual relationship. However, during the past year he has become aware that his erections have not been as rigid as in the past, that on occasion he has lost his erection prior to or very shortly after starting intercourse, and that a few times he has been unable to get any erection, even after extended love making.

He has become very anxious about this, but neither he nor his wife have engaged in any discussion about this. He gradually began to withdraw from any form of physical intimacy, stopped initiating any love making, made excuses for not responding to his wife's advances, and gradually became more despondent and depressed.

Ultimately, he moved out of the bedroom, using as an excuse that he felt his snoring was disrupting his wife's sleep.

He later learned that his wife was very concerned and hurt by his behaviour, since she believed that he no longer loved her or found her sexually attractive. In fact, she seriously worried that he might be having a sexual affair with another woman.

Tutor's Notes/Learning Points

1) A number of physiological changes occur in middle-aged and elderly men that can affect their sexual function. These may include a longer time to get an erection, less rigidity than earlier in life, and an increasing need for direct stimulation of the penis. In some men, illnesses (eg. diabetes), or prescribed medication (eg. Beta-blockers), may also inhibit erections. A lack of awareness of these changes can be devastating to both the male and female partners.

2) Many men (and many women) believe that a man's virility and therefore his ego is tied in with his ability to achieve an adequate erection, and to engage in intercourse whenever the opportunity is present.

3) He believes that if he cannot get an adequate erection to engage in intercourse, there is no point in continuing to be physically intimate with his partner. This leads to his belief that if he cannot make love the way he did earlier in life, his wife, too, will no longer be able to fulfill her sexual needs and desires. He is not

willing to consider alternative ways to satisfy her needs in the absence of his erection, since that is not the way a "real man does it". There is such shame for him if he cannot have a strong erection, that he cannot even share this with his wife, but instead seeks excuses to cover up his discomfort.

4) For his wife to ask him to stimulate her using his hand or mouth, instead of his erect penis, would make him feel even more helpless as a man (in the literal sense of the term "impotent").

5) As a result of <u>her</u> socialization she has believed that a woman should not tell a man what to do in the sexual area.

6) For her, the lack of knowledge about changes in sexual function that occur in aging men, or her belief that any discussion about his problem might cause further loss of self-esteem for him, leads her to place the "blame" on herself, by devaluing her attractiveness as a sexual woman and the quality of his love for her.

<u>Part B</u>

His wife finally convinced him to see his doctor, who arranged a consultation with a sex therapist. After one visit attended by both, they learned that:
- He was not alone; his problem was shared by many men of his age;
- It was not her fault; she was then able to become very supportive to him, and he was able to reaffirm his love for her;
- He returned to their "marital" bed, and as suggested by the therapist, became physically intimate again. They were able to reset their goals to include mutual pleasuring without worrying whether erection or intercourse occurred, in the short term at least. With his focus off erection his frantic anxiety diminished.
- He agreed to return to his physician to explore any possible medical conditions that might be contributing to his sexual problem (eg diabetes).
- A follow-up visit was arranged with the sex therapist to discuss other possible strategies (eg sildenafil), if needed, once this couple felt that their relationship had been restored and both agreed that they would like to resume intercourse if at all possible.

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QUIZ ANSWERS

Page 49 **Sex/Gender Quiz**

Do the following describe sex, gender, both or neither:

1. Emphasis on Biological differences between Males and Females — Sex
2. Factors that Explain Well-Being and Illness — Both
3. The Basis for Social Inequalities that Can Create Exposure to Risk Factors that Endanger Health — Both
4. Closely related to Inequality — Both
5. Recognizes that the Peer Relations between Men and Women May Protect or Impede Health — Gender

Page 49 **True or False**

1. The Social construction of Female Roles May Disadvantage Women and Create Risk Factors that Endanger Health — True
2. The Social Construction of Male Roles May Disadvantage Men and Create Risk Factors that Endanger Health — True

Pages 50 **True or False**

1. Maleness and femaleness are entirely determined by differences in reproductive systems and hormonal variations. — False
2. Because they have the capacity for motherhood, women are more caring than men and therefore more fit for certain kinds of jobs than men. — False
3. Women undergoing heart surgery are more likely to die than men. — True
4. Despite their diversity, all societies are divided along what can be called the 'fault line of gender.' — True
5. In all societies, women and men are defined as different types of beings, each with their own opportunities, roles, and responsibilities. — True
6. In most societies, the category of 'female' has less access than those in the category 'male' to a wide variety of both economic and social resources. — True
7. Worldwide, wealth and poverty are nearly equally divided between males and females. — False
8. Although women do suffer material discrimination, women enjoy equal social status with men in most societies in the world. — False
9. Leaders in the movement to develop gender analysis are almost equally inclusive of men and women. — False
10. The "feminization" of poverty, although it exists in less developed countries, has largely been eliminated in developed countries. — False

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EVALUATION FORM FOR PARTICIPANTS

Your area of medical practice	________________________________
Date and location of workshop	Taken off webpage_________________
Facilitator	Self____________________________
Overall evaluation of the workshop	Poor Fair Good Very Good Excellent
Pre-distributed material	Poor Fair Good Very Good Excellent
Workshop content	Poor Fair Good Very Good Excellent
Interactive nature of workshop	Poor Fair Good Very Good Excellent
Evaluation of the facilitator	Poor Fair Good Very Good Excellent

Evaluation of cases (please comment on two cases)

1) Relevant to your work

Case 1	No	Somewhat	Yes
Case 2	No	Somewhat	Yes

2) Need for gender perspective clearly illustrated in the case

Case 1	No	Somewhat	Yes
Case 2	No	Somewhat	Yes

3) Additional comments ____

List any changes you might consider making in your practice of medicine as a result of this manual on gender mainstreaming in health.

____

List one or more topics you would like to see developed into a case presentation

____

General comments on the manual ____

____