

# CHALLENGING THE CULTURE OF SILENCE

## Building Alliances To End Reproductive Tract Infections

The International Women's Health Coalition (IWHC) formulated the concept of "reproductive tract infections" (RTIs) in 1987 to draw attention to a serious, neglected aspect of women's sexual and reproductive health, and to stimulate development of the necessary health services and technologies, information dissemination and wider program efforts.

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## PREFACE

The International Women's Health Coalition (IWHC) formulated the concept of "reproductive tract infections" (RTIs) in 1987 to draw attention to a serious, neglected aspect of women's sexual and reproductive health, and to stimulate development of the necessary health services and technologies, information dissemination and wider program efforts. On the request and with the involvement of colleagues in many countries, IWHC has sponsored research projects and experimental clinical services to assess how to

integrate RTI control into ongoing programs. We have commissioned and produced papers and a book on RTIs to publicize their prevalence, to document their costs and consequences, and to stimulate action.

In Bellagio, Italy, in 1991, the Rockefeller Foundation and IWHC co-sponsored a meeting of scientists, donors, and women's health advocates to review the relevance of RTIs to international health goals, including family, planning, child survival, maternal health, the prevention and control of sexually transmitted diseases and human immunodeficiency virus; and to identify specific actions to reduce girls' and women's vulnerability to RTIs. The report of the meeting and a volume containing the papers presented provide a policy assessment of information on the prevalence of RTIs, as well as detailed recommendations of participants in the Bellagio meeting.

Bellagio participants recognized that women's experiences with RTIs, their relationships with their sexual partners, the knowledge and attitudes of service providers, and other behavioral dimensions of RTIs need to be studied in greater depth. They asked IWHC to convene a meeting of women from Southern countries to explore these concerns. This is the report of that meeting, co-sponsored by IWHC and the Women and Development Unit (WAND) of the University of the West Indies.

Since its inception in 1978, WAND has pursued a vision of a more holistic, equitable, and humane global order. WAND has identified women's health promoting "wellness for women" -as a unifying motif in its work, which aims at the empowerment of women through improved access to information, sharing information and skills among women, community development, and building leadership and solidarity among women across the Caribbean region. Although WAND works primarily with Caribbean women, it has long collaborated in building alliances with women in other countries of the South, as well as with Northern women. WAND is the secretariat for Development Alternatives with Women for a New Era (DAWN), a network of Third World women. DAWN analyzes critical development issues, including reproductive health and rights, from the perspectives of poor women.

In March 1992, in Barbados, IWHC and WAND brought together forty-four women from twenty countries, primarily in Asia, Africa, Latin America, and the Caribbean, to discuss the topic "Reproductive Tract Infections among Women in the Third World: Ending the Culture of Silence." Participants included prominent women leaders, activists, health professionals, journalists, and social scientists. All the participants had worked with women from a variety of backgrounds and shared a commitment to women's

health. Some participants knew little or nothing about RTIs, though most had had at least one themselves participants learned for the first time about the wide variations from nation to nation and within countries in women's condition and in their vulnerability to RTIs. Few participants had previously had opportunities to share their experiences with RTIs in depth with other women from different countries, and many had never before been part of a women's movement.

The Barbados meeting produced detailed recommendations for national and international work on sexuality and gender relationships, and for public health and education initiatives. Participants issued an international call to action to build new alliances among women, and between men and women of all ages to generate new "sexual contracts." The purpose is to foster caring, respectful, and responsible sexual relationships, and to promote equity between women and men in the public sphere. All the participants and many of their institutions committed themselves to this vision, and to intensive efforts to prevent and control RTIs. Together, we call on donors, national governments, and international agencies to support these efforts.

Joan Dunlop  
President, IWHC

Peggy Antrobus  
Tutor-Coordinator, WAND

*When women ask for reasons for their STDs, even professionals keep silent. Gender and sexuality must be the starting points for our work to break the silence. - Maria Margarita Diaz, Brazil*

*We can't disconnect RTIs from questions of power. And you can't disconnect power from gender. - Andaiye, Barbados*

## **INTRODUCTION**

Reproductive tract infections (RTIs) include iatrogenic infections (those that result from inadequate medical procedures), endogenous infections (those

caused by overgrowth of organisms normally present in the reproductive tract), and sexually transmitted diseases (STDs) These infections cause suffering for both women and men around the world, but their consequences are far more devastating and widespread among women than among men.

- RTIs kill unknown thousands of women each year through their association with cervical cancer, the most common and preventable cancer among women in Southern countries. In addition, an estimated 500,000 women die annually from unsafe deliveries and septic abortions; many of these deaths involve infection due to poor medical practice or lack of access to services.
- RTIs are the most common preventable cause of involuntary infertility in women, and of potentially fatal tubal pregnancy. They also cause miscarriage and infections in newborns.
- RTIs in women can cause emotional distress, pain, and marital discord. The economic costs to society include the loss of women's productivity and the expense of treating the severest consequences of RTIs, such as pelvic inflammatory disease (PID).
- Some STDs increase the likelihood of transmission of human immunodeficiency virus (HIV), the virus that causes AIDS, especially from men to women The HIV epidemic cannot be controlled unless STDs are controlled.

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To the extent that RTIs have been recognized as a public health issue, they have been approached as diseases to be mapped by epidemiologists, prevented through public education campaigns, and cured by health professionals. Yet these conventional approaches are not working: RTIs are rampant in many countries, and their prevalence probably is increasing.

Participants in "Reproductive Tract Infections among Women in the Third World: Ending the Culture of Silence" (the 1992 Barbados conference) focused on the woman, rather than on the disease. They raised a number of questions from this perspective. For example:

- In what ways are women vulnerable to RTIs, and how do they experience their infections, personally and culturally?
- How can women protect their sexual and reproductive health in the private context of power imbalances with their male partners, and in the public context of stigma, inadequate information, discrimination, and weak, inaccessible services?
- What do women's health advocates suggest can be done locally, nationally, and globally to end the culture of silence about RTIs?

**Power imbalances have a major impact on women's vulnerability to RTIs, their ability to protect themselves, and the perception and management of such infections in private and public.**

To answer these questions, participants assessed the interactions between public policies and private behaviors in three interrelated dimensions:

- overarching political and economic conditions;
- underlying sociocultural conditions; and
- intimate relations between women and men.

Discussions centered on sexuality (the sexual relationships between individual women and men) and gender roles (the social relationships between women and men at all levels of public and private life). Although participants came from diverse backgrounds, they identified many common patterns of sexuality and gender across societies - in particular, pervasive imbalances of power between women and men. Power imbalances have a major impact on women's vulnerability to RTIs, their ability to protect themselves, and the perception and management of such infections in private and public.

Participants analyzed the global political and economic forces that affect the provision of information and services, assessed the sociocultural conditions that establish the terms of both intimate sexual encounters and public relationships, described a new vision of sexual and gender relations, and made practical recommendations.

The participants' call to action urges donors, international agencies, national governments, and health professionals to re-allocate resources to invest in improved services, technologies, and public education. Participants recognized that creating new alliances of women within and beyond the South, between women's health advocates and social institutions, between adults and young people, and between women and men is essential to preventing RTIs and to achieving more caring, responsible, and respectful sexual and gender relationships.

## **A CALL TO ACTION FOR NEW ALLIANCES BETWEEN WOMEN AND MEN TO END REPRODUCTIVE TRACT INFECTIONS**

Reproductive tract infections (RTIs) pose grave threats to women's lives throughout the world. RTIs include sexually transmitted diseases (STDs); infections related to procedures such as unsafe deliveries and abortion or IUD insertion; and infections due to over growth of organisms normally found in the genital tract. Men also experience RTIs particularly STDs but the prevalence and the consequences for women are much more severe.

Worldwide, there are well over 250 million new cases of STDs every year,

which have devastating health and social consequences. Nonetheless, women and men generally are not aware that they are vulnerable to RTIs, and policy-makers do not understand the substantial costs of failing to prevent RTIs:

- Some STDs increase HIV transmission, and therefore the HIV epidemic cannot be controlled without controlling STDs.
- RTIs are the most common preventable cause of involuntary infertility and potentially fatal tubal pregnancy; they also cause fetal loss and infections of newborns.
- RTIs lead to severe emotional distress, pain, and marital discord; their consequences carry enormous economic costs, because they reduce women's productivity in both the household and the workplace, and because treatment of consequences such as pelvic inflammatory disease and septic abortion is very expensive.
- A sexually transmitted virus kills hundreds of thousands of women each year through cervical cancer, the most common cancer among women in Southern countries. An additional 500,000 women die annually as a result of unsafe deliveries and septic abortions; many of these deaths involve infection due to poor medical practice or lack of access to services.

Severe imbalances in the relations between women and men, in all spheres of public and private life, are established early in life. These make it impossible for most girls and women to protect themselves against RTIs in sexual relations and in health services. For example, men generally determine when and under what conditions sex takes place. They frequently do not take responsibility to protect their partners against infection, and they may or may not respect the wishes of the woman. The only protective technology currently widely available is the male condom, and many women are unable to persuade men to use it. The culture of silence surrounding

sexuality further prohibits women from seeking health care, emotional support, and information for their sexual health.

The need to address RTIs is more urgent than ever. The present global political and economic context, however, fosters the spread of RTIs and is hostile to actions needed to prevent and control them. Northern governments, multilateral institutions, and Southern governments have shifted away from human development, and toward economic growth and privatization. Such policies are destroying or making basic health services and other essential resources (such as water and education) inaccessible to poor people. Compensatory programs, such as "social well-being programs," in no way offset this destruction of basic services. Furthermore, national governments, for ideological or political reasons, also institute or maintain harmful policies, such as restrictions on contraception or safe abortion.

Such international and national contradictions undermine a comprehensive approach to women's health that is responsive to the needs of women as they perceive them, and that enables women to take control of their sexual health and reproductive rights.

To break the culture of silence surrounding sexuality and RTIs, actions are required in both the public and the private spheres. To remove the burdens RTIs place on women, health systems, and national budgets, we call on governments, international donors, and health professionals to:

- Re-establish basic human needs as the objective of development policies.
  
- Integrate services for the prevention and control of RTIs into ongoing health programs, especially family planning, maternal and child health, and primary health programs, to reach both symptomatic and asymptomatic women and to optimize the cost-effectiveness of programs.
  
- Provide safe abortion services.

- Invest in improving the quality of reproductive health services and education, and in training all health providers about RTIs.
- Develop and make universally available simple, inexpensive, rapid diagnostic tests for STDs, particularly for women who do not have symptoms.
- Develop safe and effective vaginal microbicides that protect women against STDs, including HIV, and that women can use without the cooperation of their partners.
- Mobilize all public education channels so that young people, women, and men have access to information about sexuality and about the causes, dangers, prevention, and cure of RTIs.
- Substantially increase support for women's organizations to enable them to inform and support girls and women, to demonstrate effective approaches to prevention and control of RTIs, and to participate in policy-making.

The struggle to prevent and control RTIs must be inclusive. We must pay special attention to the needs and involvement of young people.

We call on men to collaborate with us to develop more caring, respectful, responsible sexual relationships and to redress the imbalances in gender power relations in all aspects of public life.

## **ECONOMIC AND POLITICAL CONDITIONS AFFECTING THE PREVENTION AND CONTROL OF**

## REPRODUCTIVE TRACT INFECTIONS

From an economic perspective, you need to see the full scope of women's lives. ..and health is a pivotal issue. - Peggy Antrobus, Barbados

Health cannot stand by itself; it has to be hacked up by other programs. - Dr. Sadia Chowdhury, Bangladesh

The woman most vulnerable [to RTIs] is the one with only one wrapper [dress] and one pot. - Dr. Adepeju Olukoya, Nigeria

The underlying factor is economic power. Women are driven to become commercial sex workers. No one thinks it is "nice." - Dr. Debrework Zewdie, Ethiopia

**RTIs can be understood -- and solutions sought -- only in the larger context of economic, political, social, and cultural institutions that define relationships between women and men, determine the information that they receive, and shape the quality and quantity of health services. The global political and economic context appears increasingly hostile to actions needed to prevent and control RTIs. Conference participants emphasized two aspects of the global context: economic and social development policies, and the resurgence of conservatism.**

## ECONOMIC AND SOCIAL DEVELOPMENT STRATEGIES

Since the 1980s, a variety of international and domestic economic policies has substantially exacerbated differences between rich and poor countries, and between rich and poor people within most countries. Shifts in foreign-assistance strategies by Northern governments and multilateral institutions away from human development and toward economic growth have severely undercut basic social-sector services and resources. Structural adjustment policies have resulted in cuts in social services, fees for public services, or privatization of services, in addition to the removal of subsidies of basic items such as food, medicines, municipal water, and transport. Massive foreign debts have restricted the efforts of many Southern governments to move away from dependence on the North, and have impeded their provision of adequate services to their populations. Furthermore, many

national governments give priority to the military and economic sectors at the expense of the social sector.

**The global political and economic context appears increasingly hostile to actions needed to prevent and control RTIs.**

These and other policies are undermining basic health infrastructures and related services. Quantitative and qualitative deterioration in health services is obvious in most countries, including poverty-stricken areas of the United States. Declines in service quality, especially when services are already inadequate, inevitably increase iatrogenic infections. Budget cuts restrict or eliminate curative RTI services; they also curtail preventive efforts. In addition, international and national economic policies and market forces have deepened and broadened poverty in most countries. As poverty deepens, more and more girls and women are forced to sell their bodies as a means of survival or, in some countries, as a "subsidy" to pay school fees. Gender-based violence tends also to increase with poverty, bringing concomitant risks of STDs, unwanted pregnancy, and all their consequences.

The experience of the 'nineties will be even harsher. . .[as] former North-South relationships are being overtaken by North-North protectionist priorities.... A better scenario [would be] a much improved understanding of the doctrine of interdependence --between North and South, social and productive sectors, men and women -- [based on] the independence of and participating parties and on mutual respect. - Billie Miller, Barbados

## **THE RESURGENCE OF CONSERVATISM**

Economic retrenchment has been accompanied in many parts of the world by a resurgence of conservative ideologies regarding women, their sexuality, and their rights. The sources are many and varied, including religious fundamentalism, ethnic nationalism, and social conservatism in reaction to what some see as excessive sexual and personal freedom. Some groups that hold conservative values about sexuality and gender roles have become political movements in national and international arenas. They seek to restrict the social roles of girls and women, to perpetuate their subordination, and to control their sexuality in ways that, paradoxically, make girls and women even more vulnerable to unwanted sex and to RTIs.

**Conservatism, along with stringent economic conditions, blocks sex education programs,**

**contraceptive information and services for young people, and even female education and employment. These conditions also prevent the adoption of a comprehensive approach to girls' and women's health that is genuinely responsive to their needs, that would enable them to manage their own health effectively, and that would ensure their ability to exercise their basic rights.**

## **SOCIOCULTURAL FACTORS AFFECTING SEXUALITY AND GENDER ROLES**

Imbalances in power and resources between the North and the South, as well as political conservatism, have parallels in national circumstances and in the imbalances of power between men and women in virtually every society. Conference participants recognized that social norms and values, beliefs, and institutions transmit powerful -- although often confusing and contradictory - - messages about gender and sexuality. Through the process of socialization within the family and beyond it, individuals absorb these messages and learn what is acceptable behavior for females and males. Beliefs that subordinate women in sexual relationships and produce a culture of silence regarding sexuality and RTIs prevent women from protecting themselves or from seeking treatment. Moreover, these same values generally foster discrimination against girls and women in access to education, employment, and political power.

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Because women are often excluded from decision-making in the public sphere, priorities, policies, and programs are identified through a lens of gender inequality and patriarchy. Male politicians and bureaucrats rarely give priority to women's needs as women define them. "Who interprets everything? It is the men, and they see what is advantageous to themselves" (Dr. Hind Khattab, Egypt). "Women always put children and men first on their agendas" (Dr. Adepeju Olukoya, Nigeria).

## **SOCIAL MESSAGES AND CONTRADICTIONS**

Inequality is rooted in societal norms and values that:

- define certain personal traits as "masculine" or "feminine";
- circumscribe gender roles and determine the balance of power between women and men;
- determine the meanings of sexuality to the community and the individual; and
- control sexual behavior.

Participants recognized diversity within and between countries in family structures, marriage patterns, and other institutions that enforce gender roles and norms of sexual behavior. Nonetheless, many similarities also exist. For example, in many societies, though not all, women are still considered the property of men -- of fathers, husbands, brothers. In India and northern Nigeria, for example, near-universal early marriage is intended to ensure the "purity" of this "property." Paradoxically, such child marriages, which are usually to older, sexually experienced men, put girls and young women at greatly increased risk of STDs and of problem pregnancies. In most societies, where unmarried girls and married women are supposed to be, respectively, chaste and strictly monogamous, they are nonetheless at risk of being infected by men, who are allowed, even encouraged, to have multiple sexual partners. At the same time, these women are widely denied necessary information and services. "I am most worried about girls and housewives. At least [now that there are some special projects,] prostitutes know how to protect themselves" (Dr. Debrework Zewdie, Ethiopia).

Participants described important variations in social behaviors allowed for women (e.g., in Guyana, women of African heritage have freedom of movement, while those of Indian heritage do not); in approved sexual behaviors (e.g., in some societies, women must demonstrate their fertility

before marriage); in the meanings of sexuality in social and personal life (e.g., some societies recognize women's right to experience sexual pleasure, while others require them not to demand or express pleasure); and in the prevalence and types of RTIs.

Religious iconography and texts almost always include messages about sexuality that differ from those implied in "social texts" such as the law or the mass media and, indeed, from the way that people typically live their lives. Such contradictions often include a mother-whore dichotomy. In the Philippines, it is not uncommon to see "a religious icon next to a poster of a nearly nude woman" (Alexandrina Marcelo, Philippines). In Chile, despite religious proscriptions, women use contraception, and despite the church and the law, they resort to abortion. "The people don't care for the church" (Dr. Paulina Troncoso, Chile); "the leaders don't care for the people" (Amparo Claro, Chile). "While ancient Indian texts celebrate and enshrine female fecundity, popular proverbs and practices identify female sexuality as potentially dangerous" (Radhika Ramasubban, India). Most societies frown on prostitution and may even outlaw it, but as long as men pay and women have no other, comparable source of income, prostitution flourishes. Extramarital sex for women is also almost universally condemned. But there are contradictions. In Cameroun, for example, if a couple has not been able to conceive, a husband may encourage his wife to have sex with another man and get pregnant so that he can claim the baby as his. "In Cameroun, the man is always fertile" (Dr. Rosa Befidi-Mengue, Cameroun).

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## **SOCIALIZATION INTO THE CULTURE OF SILENCE**

A woman describes a headache [or weakness] to her doctor, somehow hoping he will ask questions that will allow her to talk about [discharge or other symptoms of infection]. - Dr. Rani Bang, India

Definitions of gender roles, male and female sexuality, power relationships, and the meanings of RTIs are transmitted, maintained, and reproduced by

the family and by society. Women themselves -- as mothers, aunts, or mothers-in-law -- are often the key agents of socialization into inequitable gender roles and sexual relationships, enforcing patriarchal norms and perpetuating a remorseless cycle of gender inequality.

Intimate, personal encounters mirror the public imbalance between male and female decision makers. Subordination of women in sexual relations jeopardizes women's self-esteem and hampers their ability to protect themselves from unwanted or unsafe sex, from poor medical practice, and from endogenous infection. Such social values have resulted in a nearly unbreakable culture of silence about sexual matters, in double standards for male and female sexuality, in misinformation, and in a lack of health information services. Females and males of all ages end up ignorant, confused, anxious, or uncertain about sexuality, and at increased risk of infection.

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The falsehood that women are the source of infection is enshrined in the many languages that call STDs "the woman's disease" or "'female problems." Generally the opposite is true: women are biologically at higher risk of acquiring most STDs in a single sexual encounter with an infected partner than men are. For social as well as biological reasons, women are at much higher risk than men of acquiring iatrogenic and endogenous infections of the reproductive tract.

For both sexes, the risk of infection is increased by the numbers of partners and certain types of sexual behavior of each partner, but male sexual behavior is especially critical as a determinant of female risk. For men, having multiple sexual partners, and sometimes even genital discharge, is a sign of sexual prowess or manhood. Males generally are sexually initiated at an earlier age (often with prostitutes) and have more partners than females. For women, multiple partners are frowned on, and discharges or other evidence of infection are shameful and humiliating. An infected woman may be vulnerable to physical abuse, abandonment, or worse. "Woe betide a woman if a man knows she has anything wrong with her genitals" (Dr. Adepeju Olukoya, Nigeria).

Most women cannot talk to their partners about RTIs -- "A woman cannot admit she has a health problem; men don't like disabled women" (Dr. Hind

Khatab, Egypt) -- nor can they discuss other aspects of sex, especially their partners' behavior. They cannot talk to health professionals because of their own inhibitions, or because health professionals do not have the time, interest, or knowledge of RTIs. Also, many believe that symptoms of infection -- pain and discharge -- are simply a "woman's lot" in life, not something for which she should seek health care. It is thus not surprising that few women are able or willing to attend clinics for the treatment of STDs.

We [health care providers] have to change. RTIs are more common than we think, for all women, not just commercial sex workers. Most clients that we see are not sex workers. Veronica Baez-Pollier, Chile

Participants described other beliefs and practices that increase women's risk of infection. In Cameroun, for example, as in some other countries, women "clean" the inside of their vaginas frequently to remove even normal discharge. This practice increases the risk of infection, makes the vaginal wall dry, and thus makes intercourse painful for women. Similarly, women use traditional remedies or appeal to local healers for help, not realizing that many remedies are toxic and that certain interventions make matters worse.

## PERCEPTIONS OF SEXUALITY

Although participants talked mostly of heterosexual relationships, they recognized that other forms of sexual expression, including homosexuality, bisexuality, and celibacy, are important, and that individuals and their partners may engage in more than one type of sexuality. Sexuality can be a positive experience of mutual love and enjoyment, physical pleasure, emotional support, and wanted pregnancy. It can be a source of self-confidence and esteem for women as well as for men. Too often, however, sexual relations are not positive experiences for women.

**The social meanings attached to sexuality and gender, to masculinity and femininity, directly affect a person's experience of sexuality.**

The social meanings attached to sexuality and gender, to masculinity and femininity, directly affect a person's experience of sexuality. This in turn can fundamentally affect the individual's identity, sense of self-worth, and ability to act on her own behalf, or even in her own defense. In sexual relationships with women, men use and reinforce the power socially vested in them: "Sex

has been used as an instrument of domination by men in a way that [exceeds the power of] even bullets" (Madhu Kishwar, India).

**As one father who had sexually abused his five-year-old daughter replied when confronted, "If I plant the mango seed, I have the right to the fruit."**

In the context of silence and misinformation about RTIs, young people in many societies are pressured by their peers, the media, and other sources to experience sex early. Parents and religious institutions often refuse to provide facts about sexuality, insisting that young people "just say no." Boys may encourage each other to have heterosexual experiences early and press girls to accommodate them. "Of the 30 to 40 percent of sexually active teens in Mexico City, most had sex with other youngsters, not prostitutes" (Gabriela Rodriguez, Mexico). Girls and women frequently confront a profoundly painful dilemma. They are under pressure to have sex, but, unlike their male partners, they are likely to face severe social, physical, and personal consequences if they do. In many areas, girls and young women are also increasingly subjected to advances from older men who -- promising presents or financial support -- seek virgins in order to avoid HIV infection or to "cure" their own STDs.

Sex is generally a private act, recognized as such by the state. Thus, the stronger partner, usually the man, can, with impunity, subject the weaker partner to abuse. Public demonstrations of male power take the form of sexual harassment of girls and women, or rape. For the most part, states either do not intervene or they side with the abuser; thus, many cases of incest or child abuse and of marital and acquaintance rape go unpunished. Victims are often too intimidated to take action, and the perpetrator may see nothing wrong in his behavior. As one father who had sexually abused his five-year-old daughter replied when confronted, "If I plant the mango seed, I have the right to the fruit" (as recalled by Dr. Rani Bang, India).

Participants pointed out that the double standard of sexual behavior perpetuates and justifies the demand for commercial sex. "To be a good woman [and wife] is to tolerate the husband's sexual behavior" (Dr. Kritaya Archanavikul, Thailand), even if it includes extramarital relations or visits to prostitutes. The commercialization of women's sexuality and the sex act, reflected in international and national commercial sex industries, pornography, advertising, and the media, projects women as sexual objects all men are entitled to. These images affect women's views of themselves, as well as men's expectations. Although in most countries it is widely accepted

for men to patronize commercial sex workers, the prostitute is treated as an outcast, as are the unwed pregnant teenager and the married woman who has an affair. A man's encounters with commercial sex workers or other female or male partners increases the risk of STDs for himself and all his partners. Nevertheless, it is prostitutes who are most frequently blamed for the spread of STDs, including AIDS. "Commercial sex workers are not [the only] transmitters, and should not be made to feel that burden. Scientifically, we do not know that prostitutes are [the major] transmitters of STDs or HIV" (Dr. Debrework Zewdie, Ethiopia).

The sanctity of the privacy of the sexual act, the dominant role and prerogatives allowed to men, and the devaluation of female sexual expression and mutually enjoyable sexuality all serve the interests of individual men and of social institutions in maintaining power asymmetry. Women collude in this pattern of domination for reasons that are not always clear, but that seem to relate to their need for love, security, and the protection of children. "We're paying with our lives our emotions, our bodies. How much more do we have to pay?" (Elaine Hewitt, Barbados).

**Participants concluded that interventions that are often suggested to control RTIs -- for example providing women with income information health education and services -- will be effective only if the imbalances in gender power relations are directly addressed.**

- Providing women with economic resources will not solve the RTI problem if women are still expected to be "available" for sex; have partners who refuse to use condoms; are subjected to violence; or are denied contraceptives, safe abortion, and medical care.
- Education will not be effective unless factual information is accompanied by messages regarding socialization sexuality; and gender power relations that encourage equity, caring, and respect in male-female relationships.
- Even if messages are improved they can be effective only if they are backed up by efforts to require men to act more responsibly and by

health services designed to meet girls' and women's multiple needs and accommodate their constraints.

- Services can be effective only if women have the means and power to use them.

Acknowledging and confronting the deep-seated power imbalances that women face globally nationally and personally are great challenges. Strong alliances need to be built to undertake these difficult tasks.

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## **THE CONTRADICTIONS OF WOMEN'S SUBORDINATION**

- Women's biological role as mothers should be a source of their power; instead, it is used to justify their subordination.
- Women's capacity to give sexual pleasure is used by men, but also despised or feared, while women's right to experience sexual pleasure is often denied or sharply restricted.
- Women are everywhere valued as mothers, yet economic conditions often force them into multiple, conflicting roles they may be criticized for.

- Women are revered in most religious traditions, yet they are subjected to many forms of abuse.
- A woman cannot be a chaste, modest wife and also meet a husband's demand for the sort of sex that commercial sex workers provide.
- If a woman asks her partner about symptoms of RTIs (hers or his), or if she denies her partner sex until he is cured of infection or willing to use a condom regularly, she may be accused of being unfaithful, and risks violence or desertion.
- A woman may want prenatal and delivery care, or a safe abortion, but her government may refuse to provide it, or her partner may not pay for it, or she may be denied the opportunity to earn the necessary money herself.
- A woman may realize that she and other women are receiving inadequate medical care, but have no personal, social, or political power to bring about changes in the health system.

## **BOYS AND SEX**

*One day my ten-year-old son came home from school crying. When I asked him why he was crying, he said his classmates at school had been teasing him because he hadn't had sex yet! Can you imagine? Ten years old! -Dr. Rosa Befidi-Mengue, Cameroun*

Adolescent boys often feel strong social pressures from their peers or even from their fathers to have sex in order to prove they are not "sissies," not gay; that they are "real men." For boys as well as girls, these first sexual encounters can be stressful and dehumanizing. They can also set in motion a chain of sexual encounters in which girls are treated as sexual objects with no feelings or rights. Instead, girls' bodies become "proving grounds" for masculine identities. The following sentiments were expressed by boys in Brazil:

When I was fourteen, people used to say, "You have to do it, you have to lose your virginity. . .it'll be good for you. You'll feel like a man." -Mairio

So you put it into your head: "I've got to do it. If everyone else does it, why don't I, right? What's wrong with me?" -Ski

Your first time comes, and you can't tell anyone, "Wow, that was my first time". . . 'cause you've already said you've done it. I mean... lies just keep growing. -Mauri

A time comes when that mask becomes your own face and you don't know who you are anymore. -Gugu

My first time, it was beautiful but very brutal. It's true, it was very brutal. -Mario

My first time, I couldn't do it because I was really afraid.... I cried. -Fernando

**Programs are clearly needed to reach adolescent boys directly with different images of what it means to be "male" -- that is, caring, informed, and responsible.**

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Boy's quotes excerpted with permission, from the video "Meninos: A Primeira Vez" ("Boys: The First Time"), produced by ECOS (Estudos Comunicaca em Sexualidade e Reproducao Humana), 1990, Sao Paulo, Brazil

The whispering about "female problems" must stop. -Billie Miller, Barbados

We need to deconstruct masculinity. It is always linked to violence, control, and dominance....it is the next generation that counts. -Lori Heise, United States

We cannot begin to backpedal because men say they are threatened or they are hurting. We have been hurting for a while. We need to find new ways to communicate [with] and involve men. -Billie Miller Barbados

## **PUBLIC INFORMATION AND EDUCATION**

Public education is a vehicle for disseminating information, building skills, communicating across social boundaries, and reconstructing social attitudes. Information alone typically does not change behavior. Education however can provide the skills to implement behavioral change if it is based on an understanding of the cultural characteristics of the community.

Women have been victimized by men's ignorance and irresponsibility and by their own ignorance of the existence and consequences of RTIs. At the same time key actors in the health field typically have little understanding of RTIs and their impact on women's lives. Health and education professionals and service providers are not trained to address RTIs or sexuality. The messages they disseminate are often ineffective inappropriate or inaccurate. As a result women and men who suffer from RTIs often have no medical information or are misinformed. Information that is culturally appropriate, medically correct, and supportive of mutual understanding and respect could greatly enhance relationships between women and men.

Participants identified the goals of public education on RTIs as preventing and controlling the spread of infections and transforming social relationships that put women at special risk because of their partners behavior. The prime objectives of a public education program should be:

- to correct misinformation about RTIs by providing all necessary facts;
- 
- to empower women to become informed consumers of reproductive

health (and other social) services; and

- to change norms and media images about gender roles in ways that promote more equitable relationships.

**The goals [...are] preventing and controlling the spread of infections and transforming social relationships that put women at special risk.**

## **MESSAGES AND METHODS**

Public education campaigns must emphasize the prevention and treatment of RTIs. They should stem from the needs of the people they are intended to reach -- information gaps, misinformation, things that people want to know about sexuality and RTIs-and must be linked to the realities of men's and women's lives. What common practices are likely to cause infection -- unsafe abortion? genital mutilation or unsafe birthing practices? multiple sexual partnerships? specific sexual practices? How can these risk factors be addressed ?

Participants agreed that messages need to include sexuality issues along with positive and nonstereotyped portrayals of gender roles. Current public health and family planning messages, including those conveyed in AIDS campaigns, need to be evaluated for their accuracy and mode of presentation, to ensure that they do not blame victims (such as women and prostitutes) and perpetuate norms of male entitlement. Women should be portrayed as human beings with full dignity and rights, and as partners with men in all aspects of personal and public life, rather than as sexual objects or personal property.

Modes of communication should be adapted to local and national conditions. Using appropriate, commonly used local idioms and symbols is important. Communications planners should not make assumptions about the meanings of symbols, colors, or words, or use words and symbols that have in the past communicated false beliefs or negative gender roles. Messages should be short, clear, consistent, and pretested, with special consideration for the needs of nonliterate women. Scare tactics without information are not helpful.

To be most effective, messages should have the following three components: reinforcement, a multiplying effect, and sustainability. Repetition of the message is critical to reinforcing it.

**Participants agreed that messages need to include sexuality issues along with positive and nonstereo typed portrayals of gender roles.**

A variety of methods can be used to promote public education. Programs need to recognize the characteristics of different groups that need information, design appropriate messages for each group, and use all possible avenues for reaching people. These avenues include existing sexuality or family-life education programs; family-planning education and AIDS programs; mass media, including magazines, newspapers, radio and television, and commercial films; schools; community-based workers and groups; and popular national and local public personalities. Types of presentation include participatory games, drama, role-playing, folklore and songs, stories, and other traditional educational methods, as well as commercial channels of information and entertainment. Support groups and peer education and training have proved to be useful venues for giving health, sexuality, and contraceptive information in many settings. The content of RTI campaigns can be interwoven in each of these approaches.

## **RESEARCH AND TRAINING**

Baseline data on the prevalence of different types of RTIs among males and females, and follow-up data to monitor change, are essential for designing, implementing, and modifying effective information, education, and communication campaigns. Everywhere, research is needed on communities' knowledge, attitudes, and practices relating to sexuality and RTIs. Language and symbols must be interpreted before messages and strategies can be designed. Media experts, technical people familiar with RTI types and prevalence, and local and national women's groups all need to collaborate in the formulation of materials.

Participants agreed that emphasis must be given to operations research; that is, research by people directly involved in education and services; rather than to "academic" research without direct application. Appropriate message development and testing are especially crucial in countries with heterogeneous populations. Evaluation of materials and messages is also critical. RTI programs could learn what works and what does not in public

health and family planning campaigns (e.g., condom advertisements), as well as in other public information programs or advertising campaigns. Full participation of women's health activists who are not only familiar with local beliefs and practices but are also sensitive to gender role portrayals is essential, as are focus groups and other work with boys and men.

**Everywhere, research is needed on communities' knowledge, attitudes, and practices relating to sexuality and RTIs.**

For effective communication, training of educators should be multidisciplinary and include the topics of sexuality, gender relationships, and communications skills, and information on both the biomedical and the behavioral aspects of RTIs. Educators may be health and family-planning providers, schoolteachers, social workers, and other professional workers. They may be local political leaders, youths, midwives, housewives, parents, or popular local figures, men as well as women. On an informal basis, training and education can be conducted in community institutions such as churches, women's groups, sports clubs, literacy programs, and work or recreational settings.

Trainers need to be carefully selected, and they should not impose messages; rather, they should facilitate the exchange of information and draw out the implications of this knowledge and attitude base. "Men must be involved because they share the responsibility of reproductive health, and both men and women do not understand their own and each other's bodies" (Dr. Rani Bang, India). Educators need to be supervised and their training reinforced with periodic retraining and evaluation of their technical and social skills.

Conference participants emphasized that women's health advocates and representatives of other community groups must be involved in program development to ensure that educational messages and materials are specific to the needs of the community as the community defines them. Education should be decentralized, participatory, and continuously evaluated, with close contact between policy-makers and communities. A multidisciplinary approach to integrating RTI information into the curricula of all schools and other formal educational programs, training centers, literacy programs, and other informal avenues of education could be instituted through government policy. Nongovernmental organizations involved in health and education can also play an important role in educational efforts, by integrating RTI education into their activities on a national and local level, and by collaborating with government programs.

In view of the discussion of sexuality and gender reported earlier, it is clear that gender sensitivity in policy development, research, training, and program implementation is a top priority. Notions of masculinity and femininity need to be redefined, and gender images in the media scrutinized, so that political pressure can force the removal of exploitative and negative images of women. This, of course, is a broad agenda, which moves well beyond the boundaries of what is typically considered the rubric of an educational program on RTIs or STDs. Participants strongly asserted, however, that these broader issues of sex discrimination and female subordination must be confronted directly if educational campaigns are to successfully challenge behaviors and beliefs that perpetuate disease transmission.

If we don't understand the way we are discriminated against sexually , then how can we have the possibility of empowerment? We mustn't b e afraid to put these things on the table. . . .We face discrimination, and RTIs are part of that. -Amparo Claro, Chile

Sometimes the passion is our own. Advocacy is not going to work until people concerned about the issue create themselves into a constituency that can be used to make change. -Andaiye, Barbados

**Men must be involved because they share the responsibility of reproductive health, and both men and women do not understand their own and each other's bodies.**

## **CREATING RESPONSIVE SERVICES**

How can RTI services be made more available, more hospitable? Most women who need RTI diagnosis or treatment are reluctant to attend conventional STD clinics because of the stigma attached to such centers, or even to visit a doctor who knows them, preferring instead to ignore their symptoms or seek alliterative therapies. Yet primary health care centers and family planning services are in a key position to offer RTI diagnosis and treatment as a routine service. Humane and realistic services treat patients with respect, and in so doing, help remove the stigma that the community, individuals, and health providers widely attach to infection.

## HOSPITABLE ENVIRONMENTS

**Special programs for young people need to address their needs for information and services and to build toward the profound changes that are required.**

Involving health and family planning clients and women's groups in decisions about planning, managing, and evaluating RTI, health, and family planning services will ensure that programs are sensitive to gender issues, build confidence, and treat clients with privacy and dignity. RTI services, along with contraception and safe abortion, need a strong dose of humanity. We need to avoid the conveyor-belt approach and avoid over-medicalizing services at the expense of the individual human being and her particular strengths and vulnerabilities. "The inner person is a neglected person, and needs to feel powerful. To feel powerful inside, the woman must hear an echo on the outside" (Nalini Singh, India). Having service personnel spend more time with each client in open, two-way communication must be part of program policy.

Services need to be sensitive to the special needs of all women—not only sexually active women and mothers, but also prepubertal girls; adolescents; menopausal women; and women who are unmarried, celibate, or childless. Special programs for young people need to be developed to address their needs for information and services and to build toward the profound changes that are required. Viewing service provision through a "women's lens" suggests a self-help approach -- empowerment through self-awareness -- that includes teaching women how to distinguish between normal vaginal discharge and abnormal discharge, discomfort, or pain. Women need to know that pain and discomfort during intercourse or at other times are not a woman's lot in life, but conditions that can be corrected.

Ideally, RTI services would be readily available and integrated with existing family planning and maternal and child health (MCH) facilities. Counseling is a key factor, as is follow-up care to ensure that women clients and their partners receive full treatment and know how to prevent further infection. Quality medical care is also essential to prevent iatrogenic infection and ensure accurate diagnosis and treatment of STDs. Where possible all clinic services should be provided in one place so that clients' needs are considered holistically rather than separated by function or "body part." RTI diagnosis and treatment are natural components of other reproductive health services, such as contraceptive counseling, safe and early termination of unwanted pregnancies, prenatal care and safe delivery of wanted pregnancies, infertility diagnosis and treatment, and infant and child health care.

Available services need to be advertised: warning messages that do not state clearly where people can go for information and services are insufficient. Participants pointed out that the gender and age segregation of many existing services must be modified if all people are to be adequately served. In particular, they noted that boys and men have rarely been considered "clients" of family planning programs. Little is accomplished by treating women's infections if their partners' infections remain untreated and their sexual behavior unchanged. How, and where, can adolescent boys and men best receive sexual and reproductive health care? In many cases, it may be feasible to offer combined services; in others, separate hours or separate facilities may be needed. Conventional STD clinics are probably not enough. Although conference participants focused primarily on women's needs, they recognized that the failure to address men's needs results in cycles of misinformation, inadequate treatment, and repeated infection.

"Structural adjustment" programs and other economic forces resulting in cutbacks in the funding of social services, including health services, have wreaked havoc with community health and family planning programs in many countries. Such cuts have also encouraged territoriality among agencies and had a chilling effect on adding new programs. It is clear that outside donors and private organizations, as well as national governments, will need to reassess priorities. Participants urged that donors broaden their mission to encompass a wider range of reproductive health elements, not just "family planning" as conventionally defined. Such an approach serves people best and is also likely to be more efficient. Donors will also need to pay particular attention to population subgroups who cannot pay for services or for whom previous services are no longer available or accessible.

**Little is accomplished by treating women's infections if their partners' infections remain untreated and their sexual behavior unchanged.**

## **TECHNOLOGY AND TRAINING NEEDS**

Community health and family planning programs have been reluctant to take on the diagnosis and treatment of RTIs, in part because of the perceived expense and technical expertise required, and in part, perhaps, because of the stigmatized nature of most RTIs. There is an urgent need for cheaper, simpler, and more accessible diagnostic technologies. There is a need for research on alternative or traditional therapies for RTIs, including single-

dose antibiotics. And there is a need for further work on woman-controlled barrier methods that can be used without the cooperation or knowledge of their partners to protect against STDs and HIV infection (with and without protection against pregnancy). Vaginal microbicides need to be developed that, ideally, would permit a woman to get pregnant if she wishes (in other words, that do not act as spermicides) while protecting her from sexually transmitted viral and bacterial infections. Most important, providers need to be motivated and enabled to offer services instead of just closing their eyes to what they see; for example, commenting on the frequency of observed discharges in family planning clients without offering routine diagnosis and treatment.

In this connection, participatory research into how particular contraceptive methods may prevent, inhibit, or facilitate the spread of STDs needs higher priority, with the full collaboration of clients women's health activists to ensure that ethical standards are maintained. Links between research and service urgently need to be strengthened. Counseling clients on the connections between RTIs and contraceptive use (as well as sexual behavior) should be a routine component of family planning service provision. Each individual needs to weigh the likely contraceptive effectiveness of barrier methods against their effectiveness in inhibiting disease transmission, for example, and clients need to understand that hormonal or surgical contraceptive methods do not offer protection against infection. To protect themselves against STDs, women who use means of protection other than condoms need to be counseled and supported to require their partners to use condoms; need to give higher priority to condom provision than they have in the past. Men who have had a vasectomy and who have multiple partners need to be encouraged to use condoms.

As is the case for RTI educators, health-care providers at all levels should be trained to see RTIs in the context of gender power, sexuality, and violence. Medical and health training should emphasize the social, cultural, and economic contexts of health and sexual behavior, and should address gender bias in textbooks and other educational materials. The curricula of pre-service and in-service training of family planning workers, community health workers, and medical students should include materials on RTIs. Health and family planning education needs to emphasize the human qualities of mutual caring and respect, not simply the scientific and medical aspects of service delivery.

**There is an urgent need for cheaper, simpler, and more accessible diagnostic technologies and for research on alternative or traditional therapies for RTIs.**

Providers at all levels need to be trained to respect women's perceptions of their own problems, to appreciate women's knowledge, and to understand the socioeconomic context of women's lives. Provider training should include sessions that would expose and challenge personal biases and internalized prejudices toward sexual issues; gender relations; and particular subpopulations that may be marginalized or stigmatized, such as sexually active teenagers, welfare mothers, illiterate clients, racial or ethnic minorities, or other individuals or groups that providers may think of as "unworthy." Too little is known of the effect of providers' attitudes on quality of care, especially in the personally sensitive realms of sexuality, contraception, and STDs.

## **NEGOTIATING CONDOM USE**

Most campaigns for the control of STDs and HIV stress the use of male condoms as a primary method of disease protection. But without fundamental changes in the balance of power between women and men "condom use" is often difficult for women. "Women do not use condoms; they have to negotiate their use" (Lori Heise, United States).

- Women are often powerless to negotiate condom use with their partners facing threats of abuse or accusations of infidelity if they insist.
- 
- A man may use a condom with a commercial sex worker in order to protect his health but will not use a condom with his wife or primary partner to protect her health even if he has had unprotected sex with someone else.

- When a woman asks a husband or partner to use a condom, he may feel she mistrusts him, or has been unfaithful.
- Most women find it difficult to obtain condoms, which are often not distributed in family planning clinics and may be inaccessible or too expensive commercially.
- A woman who keeps condoms for her partner's use is likely to be thought "unfeminine" or even promiscuous, while a man may consider it "unmasculine" to use a condom which he interprets as denying his full sexuality.

The promotion of condom use exposes fundamental contradictions in sexual relationships, STD prevention messages, technology and services. The development of a female condom represents a partial solution, but the device is expensive, clumsy, and largely unavailable, and still requires men's cooperation.

What is needed are new technologies such as vaginal microbicides that can prevent disease transmission without preventing wanted pregnancies and that a woman herself can use without her partners knowledge or consent.

## **BUILDING ALLIANCES TO PROMOTE A NEW VISION OF REPRODUCTIVE HEALTH**

*[It is important] to involve all women in this work. [We need to] establish links with women in the health sector who are not usually identified as "feminist" or "activist." - Maria Margarita Diaz, Brazil*

*We must bring men into the movement as allies. - Dr. Debrework Zewdie, Ethiopia*

Preventing and treating RTIs, whether they are sexually transmitted or result from poor medical care or harmful practices, requires simultaneous work on the most intimate of personal relationships and the most public of health infrastructures. Prevention and control of RTIs demands analysis, investment, and change at every level --

- from personal interactions to public policy;
- 
- in cultural, economic, social, and political life; and
  
- at the household, community, state, national, and international levels.

## **PERSONAL AND ORGANIZATIONAL PARTNERSHIPS**

Alliances of different groups will be essential to address power imbalances that block the development of comprehensive programs of RTI prevention. Indeed, the strength of such alliances was a characteristic of the meeting itself, as participants from countries throughout the world discovered similarities and diversities within the group, shared information and ideas, and decided on global priorities. Alliances among women are key mobilizing tools to challenge existing power structures and identify alternatives and priorities.

Participants agreed that women should work together within and between Southern countries and between the South and the North to gain support for changing their own sexual relationships, utilizing and transforming health

services, and influencing policy. Cooperative action will increase women's understanding of themselves and of each other -- on a personal as well as on a political level -- as people working for change in a variety of ways and settings. "[We need to] understand the differences [between us] so we can use them best to come together" (Dr. Judith Wasserheit, United States).

Men are key players in women's personal and public lives -- whether nurturing or exploiting, cooperating or obstructing, concerned or indifferent. Participants agreed strongly that building a successful movement for the prevention and control of RTIs requires solidarity and alliances with men at all levels to change male behavior. Strong efforts are needed to reach men as well as women in education and treatment. Programs that serve women should better understand women's personal relationships -- most frequently as sexual partners with men -- in order to build women's confidence to negotiate their sexual relationships and protection from unwanted sex, unwanted pregnancies, and STDs.

We need to forge alliances with adolescents to develop appropriate and effective programs. Their reproductive and sexual health is too often defined in terms of teenage pregnancy and AIDS. We should be looking to young people -- to the next generation -- for solutions to sexual and health dilemmas, rather than simply defining adolescents as being "at risk." Young people can challenge unequal power relationships early in their development and should be encouraged to create new definitions of male-female interactions based on more egalitarian and mutually supportive norms. Program managers should solicit their opinions in the design and management of RTI programs for them. Alliances between student groups or out-of-school teenagers and adults concerned with RTIs would recognize Common problems as well as differences.

In addition, women's health advocates need to create linkages with political leaders, churches, associations of doctors and nurses or midwives, schools, social workers, community activists, and family planning organizations, among others, to mobilize support for a new vision of gender relations that incorporates the sexual and reproductive health and rights of people. In particular, activists, policy makers, and service providers need networks to bring them together, and a forum for exchanging view points and planning strategies.

In particular, activists, policy makers, and service providers need networks to bring them together, and a forum for exchanging view points and planning strategies.

## FUNDING PRIORITIES AND NORTH SOUTH COOPERATION

Where is the collaboration? Where is the North-South dialogue? Where is the money? People are suffering! - Dr. Lilian Wambua, Cameroun

Participants made a number of recommendations about the contributions that funding agencies can make. For example:

- Funding agencies interested in health care and family planning should redefine their mission to include issues such as sexuality and RTIs; broaden their measures of program development; and include groups currently excluded, such as the young and the unmarried.
- 
- Family planning policies should be based on a sexual and reproductive health and rights approach, not on population control.
- The realities of gender and power relations, RTIs, sexuality, and violence should become an explicit part of the policy dialogue.
- Donor agencies need to listen closely to what feminists and women's health advocates have to say in each country, rather than making assumptions about what women need.
- Donors should funnel money to nongovernment organizations and

community groups so that they can design their own programs and simultaneously work toward influencing government policies and programs.

- A sustained commitment to change, including long term financial support, is essential.
  
- Donors should provide timely access to information on the availability of funds and the procedures for obtaining them.
  
- Donors should allow considerable flexibility in the use of their funds so that recipient organizations can define their own priorities and experiment more freely with innovations in program design, implementation, and evaluation.
  
- Funding is needed for educational efforts, for training of trainers and providers, and for the development and improvement of simple RTI diagnostic technologies and barrier methods of protection, as well as for program design, services, and evaluation.
  
- Donors should support intracountry and international meetings to promote the collaboration of women's health activists, research scientists, and service providers.
  
-

Information on research findings, on international policies, and on emerging donor priorities must be quickly disseminated to interested organizations.

In working toward a vision of a more egalitarian world based on mutual respect and recognition of commonalities and diversities, participants urged that health, including sexual and reproductive health, be perceived and treated as a basic human right. This recognition is central to the prevention and control of RTIs.

Our advocacy [as women] must include [our] self-interest. - Madhu Kishwar, India

[We need to] think realistically, but we need to think big. - Dr. Judith Wasserheit, United States

**Participants urged that health, including sexual and reproductive health, be perceived and treated as a basic human right.**