ANNEX 7. HANDOUT – SELECTED ISSUES IN CONDUCTING GENDER ANALYSIS OF MATERNAL HEALTH

Risk factors and vulnerability

- **Women’s anatomy and physiology** may contribute to poor pregnancy outcomes.* Examples include the following:
  - Women have greater risk than men of contracting HIV infection and sexually transmitted infections (STI) from unprotected heterosexual intercourse, and
  - Women have higher risk of iron-deficiency anaemia than men.¹
- **Immunosuppression during pregnancy** leads to a high risk of malaria or severe malaria infection, especially if the woman is pregnant for the first time.² Malaria in pregnancy can lead to maternal death, low birth weight or neonatal death.³
  - Childbirth may occur in an area with poor hygiene and/or with unskilled birth attendants. Unhygienic substances such as cow dung may be used for umbilical cord care.⁴,⁵ Mortality decreases when a skilled attendant is present at childbirth,⁴ and proper hygiene in cord care can reduce neonatal infection.
- **Infants’ underdeveloped immune systems** make them vulnerable to exposure to environmental hazards such as unsafe drinking-water and infectious disease. Children and infants are particularly susceptible to the harmful effects of ultraviolet radiation.⁶,⁷ Male infants have a higher risk of mortality than female infants.⁸
- **Lack of women’s decision-making power** can negatively affect maternal health.
  - Women’s lower social status in several settings contributes to limited power to negotiate with sexual partners about condom use, age and time of marriage, timing and spacing of pregnancies. Unwanted, early pregnancies or STI may result. Unwanted pregnancy has been linked with low birth weight and preterm birth.⁹,¹⁰ Early pregnancy increases the risk of maternal mortality and obstetric fistula. Child marriage can put girls at risk of intimate partner violence, social isolation and lower education levels.⁴,¹¹,¹²
  - Transactional or “survival” sex may decrease the negotiation power of low-income girls for the use of contraception or condoms, which could lead to unintended pregnancy, HIV infection or other STI. Transactional sex with older men is a common practice among adolescent girls in several contexts. Receiving gifts or money in exchange for sex is much more common among girls than boys.¹¹,¹³,¹⁴
  - Unequal household decision-making power may restrict women’s autonomy in reproductive health matters. This could lead to high fertility rates, unwanted pregnancy, forced termination of pregnancy, lack of prompt health care seeking or inadequate birth spacing.¹²
  - Sex-selective abortions take place due to a strong preference for sons in some contexts. Abortion-related complications may lead to disability or death, especially if the abortion is conducted under unsafe conditions.
- **Gender norms, roles and relations that assign greater value and power to men increase women’s risk of gender-based violence, which can contribute to poor maternal health,⁸,¹⁵**
  - Sexual violence is related to increased risk for poor pregnancy outcomes, STI and chronic pelvic pain. It is also associated with decreased use of antenatal care and cervical screening.¹²
  - Forced sexual initiation of girls is a problem in many settings and can lead to early pregnancy (which can result in poor pregnancy outcomes), poor mental health, HIV infection and STI.¹²
  - Women’s experience of intimate partner violence may increase or even begin in pregnancy. Violence can lead to poor health outcomes for the woman, fetus, child or even to homicide of pregnant women.¹²
  - Suicide in pregnancy is associated with adolescents and may be related to unwanted pregnancy in settings in which access to contraception or abortion is limited or unavailable. In some settings, pregnant women may commit suicide to preserve family honour. Suicide in pregnancy has also been linked with poverty and abuse.¹²

* Poor pregnancy outcomes refers to conditions such as maternal death, postpartum haemorrhage, eclampsia, sepsis, obstructed labour, miscarriage, infant mortality, neonatal infection, low birth weight, mother-to-child transmission of HIV or sexually transmitted infections, obstetric fistula, infertility, uterine prolapse and perineal or lower abdominal pain.
Other gender norms, roles and relations can also affect maternal health.

- In many settings, men are given a greater share of household food because of their higher status, leading to poor nutrition among women. This results in increased pregnancy complications.

- Women have a higher risk than men of developing eating disorders in several contexts. This may be because women face social pressure to maintain more stringent standards of physical beauty (including body shape) than men. Perceived pressure from the mass media to maintain idealized standards of shape, beauty and attractiveness has been linked with the incidence of eating disorders among women. Anorexia and bulimia can lead to miscarriage and retard intrauterine growth.

- In settings with high fertility rates, women’s multiple pregnancies over the life course place them at repeated risk of maternal morbidity and mortality.

- In some settings, girls’ sexual debut tends to be several years earlier than that of boys. This can lead to early pregnancy, which increases the risk of obstetric fistula or maternal mortality.

- Gender norms stipulating that girls should remain modest, chaste or innocent about sexual matters may limit adolescent girls’ access to information on sexuality, contraception, pregnancy and related services.

- FGM is considered necessary for girls in preparing for marriage in some settings. FGM can damage the vagina, trigger anaemia from continuous bleeding or lead to chronic reproductive tract infections, scarring, vaginal obstruction during childbirth, perineal and vaginal tears, which in turn may lead to postpartum haemorrhage and postpartum infection of the perineum. Performing vaginal examinations is also more difficult for women who have undergone FGM.

- Engaging men in their partners’ pregnancy can decrease infant and maternal mortality by increasing the likelihood of prompt care in the event of complications.

Access to and use of health services

- Pregnant women in rural settings required to walk long distances to access a health facility are disadvantaged by restricted physical capacity for strenuous exercise.

- Pregnant women may have more access than other women and men to HIV screening, and even antiretroviral therapy, through programmes for preventing the mother-to-child transmission of HIV.

- Government policies, based on social or religious mores, may render safe access to abortion or access to family planning illegal. Women may thus resort to unsafe procedures, which could lead to death or disability.

- Women may be unable to access available health services if services do not offer sufficient privacy and confidentiality. For example, an adolescent girl may fear that her doctor will inform her parents about her pregnancy and abortion, a woman who has had an abortion may fear that her community will discover this and stigmatize her or a private space for physical examination may not be provided.

Health-seeking behaviour

- Women may not be taken to a health centre or may not have access to household resources for health care, as family priorities may focus on household breadwinners, which are more likely to be male in many settings.

- In some settings, the idea that only weak women go to a hospital to give birth may be common. This may lead to underutilization of health services for labour and delivery.

- Young, unmarried women in some settings may be labeled promiscuous if they seek reproductive health services or counselling for family planning. This may reduce care-seeking.

- Embarrassment or modesty related to discussing sexual health problems, such as vaginal discharge or genital discomfort, may prevent or delay care-seeking, especially when female health care providers are not available.
Treatment options
- A lack of accurate health information, possibly due to low education and literacy, may lead to fears that contraception can lead to infertility. This could lead to greater reliance on traditional methods of fertility regulation, which may be less reliable in preventing pregnancy than modern contraception methods. In many low- and medium-income countries, women have higher rates of illiteracy and lower levels of education than men.11,26

Experiences in health care settings
- Women’s interaction with health care providers may be unsatisfactory for various gender-related reasons:
  - Women seeking treatment for complications of unsafe abortion may be treated rudely by health care personnel or, in countries where abortion is illegal, reported to the police.12
  - Health care personnel may stigmatize and disrespect single mothers and pregnant adolescents. Judgmental personnel may prevent adolescents from accessing contraception or sexual and reproductive information or services.
  - Pregnant adolescents may have low negotiation skills and low status due to their age, sex, and context-specific gender norms. Pressure to engage in harmful practices, such as excessive use of Caesarean section, episiotomies or forced positions for childbirth, may result.*

Health and social outcomes and consequences
- The mothers of baby girls may be “penalized” (with mental health implications) because of social and family preference for male children. In contrast, the mothers of baby boys may enjoy enhanced status and self-esteem.
- Gender roles may overburden women with household tasks; this can affect maternal health by leading to fatigue, strain or loss of time due to care-taking responsibilities.
- In some settings, infertility, which can result from inadequate sexual and reproductive health care, is more likely to lead to shame, social ostracism or divorce among women than among men.27
- Obstetric fistula, often the result of the physical stress girls face in childbirth, can lead to social ostracism, divorce and poor mental health. Women with obstetric fistula have an increased risk of suicide.12
- In some contexts, unmarried or adolescent daughters who become pregnant may be killed under the pretext of preserving family honour.
- Emotional support from fathers has been linked to greater ability among pregnant women to quit smoking, benefiting maternal and fetal health.23
- Pregnancy and postpartum rituals may enhance the emotional well-being of pregnant women. For example, the traditional Chinese practice of a woman resting at home for one month following the birth of a baby may be associated with lower incidence of postnatal depression.28,29 However, traditional pregnancy and postpartum rituals in some settings may be harmful.4
- Women with high reproductive or maternal morbidity may be unable to work. Impoverishment may result-- especially if these women are the sole breadwinners in the household.
- Pregnancy and childbearing often cut short an adolescent’s education and threaten her future economic prospects.
- Unmet need for family planning may lead to unwanted pregnancy and deepening poverty as families cope with raising children with limited financial means to care for them.

* Public health professionals participating in a gender-mainstreaming workshop conducted by WHO raised this point. This may be an area for future research.
References


27 Looking back, looking forward: a profile of sexual and reproductive health in India. New Delhi, Population Council, 2004 (http://www.searo.who.int/LinkFiles/Reproductive_Health_Profile_RHP-India.pdf, accessed 15 January 2010.)
