CHAPTER II: What are the links between Poverty, Gender and Sexual and Reproductive Health?

Sexual and reproductive health is a holistic concept that encompasses a collection of diseases as well as healthy physiological functioning. Social factors, such as gender relations, sexual identities and social inequalities, play a primary role in determining an individual's ability to achieve good sexual and reproductive health. Gender-based violence is also recognized as a determinant of poor outcomes with respect to other reproductive health indicators, such as maternal mortality and RTIs.

Poverty and gender inequality exercise considerable influence and constitute important determinants of men's and women's sexual and productive health at all ages. They also shape the access of men and women to appropriate reproductive health care. - at is, poor people are less likely than those who are better-off to purchase or access promotive, preventive or curative reproductive health services. The cumulative adverse effects of living in poverty and experiencing unequal gender relations are reflected in inequalities in the burden of poor sexual and reproductive health and differences in how men and women experience sexual and reproductive health.

In the following sections, the relationship between poverty and sexual and reproductive health is considered, followed by a discussion of the influence of gender inequality on the sexual and reproductive health of men and women. In each case, the effects of poverty and gender inequality on the reproductive health of adolescents and older people are highlighted.

The influence of poverty on reproductive health

Poverty is a determinant of sexual and reproductive health Household income Household income is a powerful determinant of sexual and reproductive health outcomes both between and within countries. Women residing in poor households are more likely to experience early childbearing, short birth spacing and high parity births.90 As much as 70% of the variance in infant mortality witnessed across and within countries can be attributed to differences in income.91 Within countries, low household income is also associated with malnutrition and low educational attainment, factors that also increase the risk of adverse sexual and reproductive health outcomes. Evidence shows that women residing in poor households are more likely than those from better

Box 2: Defining poverty

In this module, poverty is defined to encompass not only low income but also other forms of deprivation, including limited economic opportunities; diminished education and health outcomes; reduced access to services, resources and skills; and voicelessness and powerlessness to influence decisions that affect one's life.[92] This definition of poverty moves beyond the narrow association of poverty with low income and consumption, which tends to inadequately capture the experience of poverty in the Region. For example, among communities in the Pacific, poverty, as measured by income or consumption, may be deemed to be low or nonexistent. However, households in the Pacific may be vulnerable to natural disasters; located in isolated or remote places; lack economic choices or opportunities to earn income; have limited access to education, health and financial services; and suffer from social exclusion.[93]

Poverty often overlaps with and reinforces other types of social exclusion that are based on age, ethnicity, geographical location and gender. Because of this, communities, households, and even members within the same household tend to have different experiences of poverty. The poverty experienced in rural communities often differs from that of urban poor communities, such as slum dwellers. Women within poor households tend to be particularly disadvantaged, as women lag behind men in almost every social and economic indicator of well-being.

Sources: Lightfoot and Ryan 2001; Lampietti and Stalker 2000.

Figure 7: Proportion of women aged 15–49 years who know at least one way to avoid sexual transmission of HIV/AIDS, by income quintile, in Cambodia (2000), the Philippines (2003) and Viet Nam (2002)

Source: Gwatkin *et al.* 2007a, 2007b and 2007c.

off households to experience early child bearing, short birth spacing and high parity births. Adult nutrition and health-seeking have also been found to improve with income level.

A clear correlation between household income and the likelihood of HIV infection has been observed in a number of countries. Analysis of data from Cambodia and Vietnam found that household income was associated with reduced risk factors for HIV, such as increased awareness about modern contraceptives and about the benefits of using condoms. A study carried out in Thailand found that people from the poorest households were the most likely to be infected with HIV.96 Similarly, in Cambodia, the Philippines and Vietnam, women's awareness of HIV prevention appears to improve as household income rises (Figure 7).

Across countries in the Region, household incomes tend to be lower in rural areas than in urban areas. As a result, rural residence may be considered as a dimension of poverty or social exclusion. In the Lao People's Democratic Republic, knowledge of contraceptives was found to be higher among urban youth aged 15 to 24 years than youth in rural areas (79% vs. 45%). Similarly, youth in urban areas were more likely than their rural counterparts (69% vs. 40%) to have heard of STIs.

Restricted economic opportunities

Poverty may increase the likelihood of women and men engaging in income-generating activities that can be harmful to their sexual and reproductive health. Although women enter sex work for a variety of reasons, female sex workers often come from households that are poor or otherwise deprived. For example, a study carried out in Siem Reap, Cambodia found that 51.4% of female sex workers had never attended school. Similarly, transgendered individuals who face social marginalization and extreme exclusion from the labour market may be left with few options other than sex work to survive. Sex workers who live in poverty are vulnerable to inadequate working conditions that can increase the risk of physical and reproductive health problems, unwanted and complicated pregnancies, STIs and a range of other negative health outcomes.

In many parts of the world, men and women leave their homes to find work. Migration might occur from rural to urban areas within a country (internal), or to destinations outside the country of origin (external). Studies from countries across the Region show that the risk of poor reproductive health is often greater for mobile populations than for non-mobile populations. Most notably, migrant populations are more vulnerable to HIV infection than the general population in many countries. This vulnerability is attributed, in part, to the absence of family and social norms and to constrained access to reproductive health services. Work-related migration can create an imbalance in the ratio of men and women in sending or receiving areas. In some cases, these disproportions can lead to the sharing of sex partners. For example, a study in Sichuan province, China reported that migrant workers constituted the majority of male clients of female sex workers. On average, migrant workers were found to have bought sex 11 times during the previous six months and the majority (64%) had not used a condom the last time they paid for sex.

Limited access to education

Worldwide, a larger share of men (80%) than women (64%) is literate. While boys and girls in more developed countries are both enrolled in primary and secondary school, women in less developed countries complete fewer years of education than men and are more likely to be illiterate. Table 4 presents the literacy rates for men and women in selected countries in the Region.

Although the literacy rates of women are generally lower than men, evidence shows that women who can read and write are better equipped to protect their health and their family's health. Girls who have at least seven years of schooling are less likely than those with little or no education to become pregnant during adolescence and are more likely to postpone marriage. In Mongolia, a higher pregnancy rate was observed among girls with only primary schooling compared to those who had completed grade 10. In the Lao People's Democratic Republic, youth aged 15–24 years with some education were nearly three times as knowledgeable as those with no education (60% vs. 21%) about contraceptive methods. Similarly, as many as 52% of youth with some education and only 21% of those with no education had heard of STIs. In the Philippines, youth who were attending school knew more about reproductive health than out-of-school youth. Moreover, Filipino youth with lower education reported a higher incidence of sex work than those with higher levels of education. Studies report that poor, uneducated men and women have higher rates of STI including HIV. Similarly, a study conducted in Long An, Vietnam in 2002 revealed a lower prevalence of HIV among injecting drug users with high school or undergraduate education.

Educating women is a long-term strategy for advancing their reproductive health. Educated women generally have a better understanding of health care practices and nutrition. Women with higher levels of education are more likely than those with lower education to seek care during pregnancy and childbirth, to pay attention to nutrition and to increase spacing between births.

Table 4: Adult literacy rates for selected countries in the Region, 2000–2004*

Country	Adult literacy rate (%)	
	Male	Female
Cambodia	85	64
China	95	87
Fiji	94	91
Lao People's Democratic Republic	77	61
Malaysia	92	85
Mongolia	98	98
Papua New Guinea	63	51
Philippines	93	93
Singapore	97	89
Tonga	99	99
Viet Nam	94	87

*Data refer to the most recent year available during the period indicated in column heading

Source: United Nations Children's Fund 2006.

Data collected in Peninsular Malaysia from 1950 to 1998 revealed that educational attainment positively influenced a woman's decision to obtain prenatal care and to deliver in a clinic or hospital. Research from the past 20 years shows that educated women tend to have smaller and healthier families. In contrast, women with no schooling have about twice as many children as do women with 10 or more years of education. For all of these reasons, educated women are less likely than uneducated women to die in childbirth. Indeed, the World Bank estimates that, for every 1000 women, an extra year of education could prevent two maternal deaths.

Undernutrition

Hunger and undernutrition are closely associated with poverty. Undernutrition includes proteinenergy undernutrition and deficiencies in micronutrients such as iron, vitamin A, iodine and zinc. In Cambodia, the rate of undernutrition (BMI <18.5 kg/m2) was found to be higher among women from the poorest income quintile (24%) than among women from the richest (17%) in 2000. Women in rural areas of Mongolia were found to be more likely than their urban counterparts to give birth to underweight children because of relatively difficult living and working conditions.

Evidence on nutritional inequalities between men and women, and boys and girls, tends to come from countries in South Asia. Nevertheless, a few studies have investigated possible gender-based inequalities in nutrition between men and women, and boys and girls, in the Western Pacific Region. One study in the Philippines reported differences between the diet of boys and girls, i.e. boys had a higher intake of protein-rich foods than girls, who were given more vegetables. A second study from the Philippines found that the intrahousehold allocation of calories favoured boys over girls.

Undernutrition adversely affects the health of a woman during pregnancy and childbirth, as well as the child. These adverse effects can also be transmitted to the next generation. Children of under- or malnourished mothers often suffer malnutrition in utero, leading to low birth weight (LBW). Furthermore, an underweight girl will grow into a stunted woman, who is more likely to have LBW babies. As discussed above, LBW babies face a higher risk of disease and a greater probability of dying in the neonatal period or in infancy than their healthier counterparts.

Poverty-related inequalities in access to reproductive health care

Preventive and curative health care have been shown to effectively improve the well-being of poor households. This positive association applies to sexual and reproductive health as well. For example, inequalities between developed and developing countries in the likelihood of a woman dying in childbirth are at least partly explained by the higher coverage of good quality maternal health services in developed countries. Maternal mortality from obstructed labour rarely occurs in developed countries because of the widespread availability of services providing low-cost interventions to prevent and treat postpartum haemorrhage, infection and hypertensive disorders. In addition, preliminary estimates suggest that as many as 71% of maternal deaths could be averted in developing countries by improving the coverage of key maternal interventions: essential obstetric care, access to safe abortion, active rather than

expectant management in third stage of labour, and use of magnesium sulphate and other anticonvulsants for women with pre-eclampsia. Similarly, increasing the coverage of existing evidence-based interventions for neonatal survival could reduce neonatal deaths by an estimated 35%–55%.

Poor individuals and households who urgently need sexual and reproductive health services often have insufficient access to appropriate preventive and curative care. While the coverage of maternal health care in developing countries has risen over the last decade, an estimated 33% of women still receive no care during pregnancy. An estimated 60% of women deliver outside a health facility, and 40% of deliveries are not attended by a trained health staff.

In countries in the Region with the highest risk of maternal death, the coverage of appropriate maternal health services may be even lower. Analysis of data from Cambodia and the Lao People's Democratic Republic suggests that as many as 90% of deliveries occur at home without a skilled birth attendant. Roughly 58% of women in Papua New Guinea attended antenatal clinics during pregnancy. In the Philippines, 70% of women have the recommended four antenatal check-ups. The continued unmet need for family planning in many countries in the Region points to the incomplete coverage of family planning programmes. Unmet need for family planning among women who are married or in union was estimated to range from 40.0% in the Lao People's Democratic Republic to 18.8% in the Philippines in 2005.129 - e unmet need for contraceptives correlates strongly with household income in developing countries.130 Estimates suggest that unmet need in the poorest fifth of the population in Asia and Latin America might be twice as high as that of the wealthiest fifth.131 A similar trend is observed among countries in the Region (Table 5).

While these data illustrate the general incomplete coverage of many reproductive health services in the Region, they say little about the distribution of these services within countries

Table 5: Total fertility rates (actual and wanted) by income quintile in the Philippines, 2003

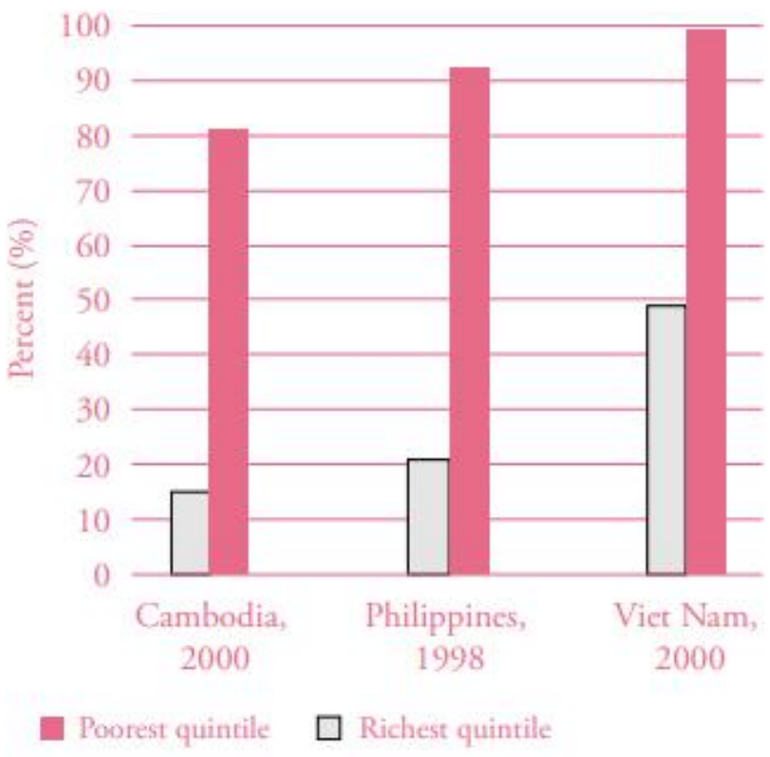
Wealth index quintile	Wanted	Actual
Lowest	3.8	5.9
Second	3.1	4.6
Middle	2.6	3.5
Fourth	2.2	2.8
Highest	1.7	2.0
Total	**2.5**	**3.5**

Source: National Demographic Health Survey 2003. In: Health Action Information Network 2005.

and between communities. Further analysis of data from more than 50 developing countries reveals that reproductive health services tend to disproportionately benefit better-off communities within countries, even though poor individuals and households are more vulnerable than the non-poor to reproductive ill-health.

Among women in the poorest income quintile, for example, births are five times less likely to be attended by trained health personnel than births to women from the highest income quintile. The proportion of women from households in the poorest income quintile in the Philippines and Vietnam who received at least one antenatal care consultation with an adequately trained person was 71.5% and 78.5%, respectively, in comparison with over 97% of women from households in the richest income quintile in both countries. The inequalities in deliveries attended by trained personnel are even starker: only 21.2% of births to women from the poorest income quintile in the Philippines were assisted by a doctor, nurse or trained midwife, while over 91.0% of women from the richest income quintile received such assistance. Figure 8 compares the proportion of deliveries assisted by a trained health worker for women in the poorest and richest income quintiles

Figure 8: Percentage of women receiving delivery assistance from a doctor, nurse or midwife in Cambodia, the Philippines and Viet Nam



Source: Gwatkin. 2000. In: Carr 2004.

in Cambodia, the Philippines and Vietnam. Over 90% of women from the poorest quintile in the Philippines gave birth at home, while a mere 20% of those from the richest quintile chose home births. Women from households in the richest quintile in Vietnam are more than 150% more likely than women from the poorest quintile to have deliveries in health facilities.

Barriers to access to services

Access to reproductive health services can be constrained by geographical, economic, knowledge- and awareness-related, or sociocultural barriers. This section describes the barriers that delay or prevent poor men and women from accessing appropriate services. It then discusses inequalities in the quality of reproductive health services received by the poor—the quality of care is often worse in health facilities serving poor communities.

Geographical barriers

The availability of appropriate reproductive health services can depend on the allocation of financial resources for health. In developing countries, the poorest 20% of the population typically receives less than 20% of the benefits from public health spending (Table 6).135 Government resources for health often disproportionately benefit wealthier households and communities; public resources tend to be allocated to hospital-based curative services in urban areas, leaving primary health services and other health initiatives targeting poor communities or households under-funded.

This skewed distribution of health resources tends to disadvantage poor populations and often

Table 6: Share of public health spending received by households in the poorest and richest income quintiles

Country	Poorest quintile	Richest quintile
Malaysia, 1989	29%	11%
Viet Nam, 1992	12%	29%

Source: Hsiao and Liu. In: Evans *et al.* 2001.

results in substandard health services in the areas were they live. In Vanuatu, for example, almost 75% of the health budget in 1996 was allocated to urban rather than rural services. As a result, only 20% of the population benefited from public spending on health services. In Cambodia, 13% of government staff are located in rural areas, where 85% of the Cambodian population lives. In Mongolia, the geographical distribution of health staff may be partly why people from rural households visit health facilities only half as often as those from urban households. In 2002, the ratio of physicians to population ranged from 1:206 in Ulaanbaatar to 1:794 in Zavhan. Similarly, health staff in the Philippines are largely concentrated in urban areas.

Inequalities in the distribution of health resources are also evidenced by the distances that some people must travel to access health services. For example, the proportion of households with access to primary health services in the Lao People's Democratic Republic ranges from 82% in the southern parts of the country to 67% in the northern areas. In the Northern Region, 13% of households live more than eight hours away from a hospital, which is more than twice the distance for those living in the other two regions. Remote islands in the Pacific, such as Torba and Tafea in Vanuatu, can suffer particular transportation constraints. Travel time to the nearest aid post (nursing station clinic) in Papua New Guinea ranges from 67 minutes in Papua/ South Coast to 28 minutes in the New Guinea Islands. The incomplete coverage of services in

rural, remote and marginalized areas can delay a poor household's access to health services and increase the overall costs of seeking health care.

The distribution of reproductive health services correspondingly reflects the low and incomplete coverage of health services in many poor and marginalized areas of the Region. In Mongolia, reproductive health information, education and communication (IEC) materials and infrastructure are concentrated in Ulaanbaatar. A study in Cambodia found that HIV/AIDS prevention efforts were largely focused on urban populations, thereby missing the 85% of the population living in rural areas. Research carried out in the Lao People's Democratic Republic in 1999 found that contraceptives were not reaching rural communities. Indeed, transportation was cited as a key challenge in obtaining contraceptives. Maternal deaths from infection, hypertension and uterine rupture are rarely reported in urban areas of Vietnam. In contrast, these are the most common causes of maternal death in rural areas.

Urban–rural inequalities in the coverage of antenatal care and skilled attendance at delivery appear to be prevalent in countries in the Region. A survey carried out in 2000 in Cambodia found that only 33.8% of rural women with a recent birth had one or more antenatal care (ANC) visits to medically trained personnel as compared with 62.3% of urban women. The proportion of urban births assisted by a trained health worker was almost double (57.2%) that in rural areas (28.0%). Similarly, in 2003, women in urban areas of the Philippines were more likely than those in rural areas (91.2% vs. 83.9%) to have had at least one ANC visit to a trained health worker. The discrepancy in births assisted by a trained health worker were even more striking, however, ranging from 79.0% among urban women to 40.8% among rural women. In the same way, many women in rural parts of China have been found to deliver at home with no skilled health worker in attendance. Antenatal care coverage in Solomon Islands ranges from 78% in Honiara to 47% in the remote province of Rennell Bellona.

Economic barriers

The total cost of seeking care can be disaggregated into direct costs (such as fees charged for health services), indirect costs (such as the cost of transportation and food) and opportunity costs (such as time away from work). Many people in the Region, particularly those who are poor, have to pay for their own health care at the time of illness and greatest need. For example, in the Lao People's Democratic Republic, out-of-pocket payments financed more than 50% of household health care costs, which consisted mainly of drugs.

Yet the costs of seeking health care are often more than poor households can bear. In Tianjian, China, for example, 64.8% of women and 55.6% of men reported that financial difficulties prevented them from accessing hospital services when referred by a doctor. A case study in three poor rural counties in China found that financial difficulties prevented 41% of sick peasants from seeking treatment. With regards to sexual and reproductive health specifically, studies from Bangladesh and India found that the cost of delivery in government facilities could be two to eight times the monthly income of the poorest 25% of the population. In Rajasthan, India, treatment for one RTI episode in a government health centre costs more than the average monthly household income, while the cost of an abortion is two to three times the monthly income. In one rural area of China, the cost of health care deterred 74% of women with complications related to pregnancy or delivery from seeking care in 1994-1995.

Payments for health care services, such as user fees, have been found to adversely affect the ability of poor men and women to access services, including those for reproductive health. A study in Kenya observed that the introduction of user fees, which were equivalent to half a day's income for poor individuals, resulted in fewer men and women seeking care for STIs, and the reduction in access was significantly greater for women than men. A study in Nigeria showed that government attempts to improve health services by charging user fees led to a precipitate decline in the uptake of maternity services, accompanied by increasing numbers of deaths. In a study in the rural areas of Yunnan province in China, local women were unwilling to pay the 15 yuan charged by village birth attendants for home delivery and medication in 1999. At the time of the study, the cost of a normal delivery at a hospital was 200 yuan. In 2002, the cost of a normal delivery had increased to 30 yuan at village level, 250 yuan at township level and 600-800 yuan at county level institutions.

Even when services are provided free of charge, the indirect costs of transportation, drugs, and food and lodging for accompanying family members can increase the financial burden of seeking reproductive health care. A number of studies have observed that, when admitted to a health facility for delivery, women must purchase bleach to sterilize materials, bed sheets, gauze, gloves, sanitary pads and other supplies. A case study in a northern district of Vietnam reported that the cost of transportation alone was equivalent to one third of monthly expenditure in the locality. A 1999 study from the Lao People's Democratic Republic estimated the cost of transportation in case of emergencies to be 2000–3000 kip for less than 8 km and 60 000 for a trip longer than 70 km in 1999. The high cost of transportation for long trips can limit the access of men and women living in rural areas to adequate health services, depriving them of basic care. It can also stop women from seeking emergency obstetric care, which tends to be more available in district or provincial health facilities located in larger communities.

In addition, the economic costs associated with seeking health care can be amplified for women who typically have lower access to and control over household and community resources, including means of transportation. In such cases, many women must rely on their husbands, other family members or community leaders to decide whether or not their health emergency warrants the use of household or community resources.

In some countries, reproductive health services are included in benefit packages under health insurance schemes. However, vulnerable groups who need these services the most are often unable to participate in such schemes. For example, all Mongolian children under the age of 16 or up to the age of 18 while in school are covered by the health insurance scheme. The notable exception is street children and young migrants, who might not have the documentation required to access services. In the Philippines and Vietnam, as in other countries, the poor are underrepresented in insurance schemes because few are employed in the formal sector. They are also less likely to have sufficient income to pay the fees associated with membership.

Lack of knowledge and awareness

Access to reliable information can enable women and men to recognize the signs and symptoms of reproductive health problems, such as STIs. On the other hand, limited health-related information and awareness have been found to reduce demand for preventive and curative health services. A study conducted in the Lao People's Democratic Republic found a generally low understanding of danger signs during pregnancy, particularly among ethnic minorities. In addition, limited understanding of the risk of malaria for pregnant women

resulted in few pregnant women being given anti-malarial medications. Knowledge of sexual and reproductive health was found to be low among female sex workers in Cambodia regardless of their age. A study carried out in 2002 in an urban slum in New Delhi reported that only 12.5% of respondents knew that a Pap test could diagnose cervical cancer. Further analysis showed that education was significantly and positively associated with correct knowledge and health-seeking.

Health information may not reach poor and marginalized households and communities for a variety of reasons. Most simply, IEC materials may not be available in health facilities serving poor communities. A study in Vietnam reported that abortion clinics did not have patient-friendly materials to help women to make an informed choice about the method used. A similar lack of IEC materials for patients was observed among health clinics in the Lao People's Democratic Republic. In particular, no IEC materials were available in ethnic minority languages.

Poor men and women, who may have little education, are less likely to be able to read printed information materials and labels on drug packaging. Marginalized populations, such as ethnic minorities, may not be able to benefit from IEC materials and outreach activities if they do not speak the main language in the area.

Other forms of media may be similarly inaccessible to individuals residing in poor households that may not have radios or televisions. For example, a study in Indonesia observed that poor women were less likely than their better-off counterparts to be exposed to family planning messages through broadcast media. Among the poorest women, 20% recalled having seen or heard a family planning message in the previous six months, as compared to 56% of the wealthiest. Fewer radios and televisions among the poor households partially explained the disparity.

Communities in remote or rural areas may not benefit from outreach activities. In contrast to the generally high level of awareness about contraceptives in the Lao People's Democratic Republic, for example, one study fund that rural and remote communities not reached by the national programme knew little about contraceptives.

Sociocultural barriers

Access to health services can be a particular problem for women and men from indigenous or ethnic minority groups. Throughout the world, health care for ethnic minorities has proved to be challenging. Reasons for this challenge include:

- poverty and isolation of many ethnic minority populations
- differences between the dominant and ethnic minority populations with respect to:
    - cultural norms and values that differ from the dominant culture
    - health care practices that differ from the dominant culture
    - health-seeking behaviours
    - beliefs and values about life, death and destiny
    - religious beliefs and practices

Quality of care

Many health facilities that serve poor communities are poorly resourced and thus tend to lack adequate medicines, equipment and supplies. These same communities often suffer from substandard infrastructure such as roads, transportation, electricity, water, sanitation, communication and links with other levels of care. In Solomon Islands, for example, roughly 70% of the population lives within one-hour walking distance of a health facility. However, a study found that many of these facilities lacked staff and essential drugs and equipment. A review of health facilities in the Lao People's Democratic Republic in 1999 reported that few had the supplies and equipment needed to provide adequate pregnancyrelated care. In many facilities, privacy for patients was questionable and referral systems were generally inadequate: many health facilities lacked telephones or transmitters to contact district or provincial hospitals in the case of emergency. In other cases, preventive efforts to reduce the risk factors for reproductive health problems have not been integrated into general health care services. For example, preventive efforts for cervical cancer appear to be lacking and effective methods of screening and treating cervical cancer have not yet become routinely available in primary health care.

It is often difficult to recruit, educate and retain health workers in rural and remote areas. As a result, reproductive health services in poor areas are often provided by partially trained or untrained birth attendants and community or family members using traditional therapies and delivery methods. These methods often put the woman and baby at considerable risk.

Health staff in rural and remote areas may also lack the skills to assess and manage complex conditions or to know when a woman's condition requires referral to a higher-level health facility. Some women in peri-urban and rural areas prefer to give birth at home for this reason, even when institutional care is available. A study in the Lao People's Democratic Republic observed that women cited low quality of care in health facilities and the absence of drugs and equipment as reasons for preferring home deliveries. A study in four poor counties in Yunnan found that 29%–55% of township-level reproductive health service providers and 71%–91% of village-level providers lacked the competencies to diagnose and treat common RTIs. Clinics providing treatment for STIs in Papua New Guinea are generally concentrated in the larger cities, such as the provincial capitals. Rural health staff were generally found to lack the training necessary to provide appropriate treatment and care for STIs, and the required drugs were not always available.

Drug sellers in the Region often provide treatment for STIs. However, the quality of their services may be uneven. For example, evidence from Vietnam suggests that drug sellers rarely dispense treatment for STIs in accordance with national guidelines or provide an adequate daily dose of drugs.

In seeking health care, the poor are interested not only in the technical competence of health staff, but also in their interpersonal skills. This may be especially the case for women. The importance of interpersonal relations between clients and health service providers is evidenced by a study from Bangladesh. The study was carried out from January 1998 to July 2000 in two urban and two rural areas of Bangladesh to assess the impact of fees for services offered by nongovernmental organizations. The study concluded that poor respondents were willing to travel farther and pay more for better quality services, where the interpersonal dimension—treating clients with respect and kindness—was a critical dimension of

Table 7: Infant mortality rates in provinces with a high concentration of ethnic minorities compared to the national average in the Lao People's Democratic Republic and Viet Nam

Country	National IMR	IMR in provinces
Lao People's Democratic Republic	100 per 1000 (1995)	132 per 1000 (Luang Prabang, 1999)
Viet Nam	36 per 1000 (1996)	52 per 1000 (Northern Highlands) 55 per 1000 (Central Highlands, 1996)

Source: Asian Development Bank 2001.

quality. Yet health staff may not receive training on interpersonal communication, as was found to be the case in the Lao People's Democratic Republic, for example. Similarly, counselling by health staff for reproductive health conditions appears to be rare in Vietnam.

Poor women are particularly unlikely to seek care from providers they view as disrespectful and insensitive to their needs. Studies from Mongolia and Vietnam report that, even though induced abortions are offered by the public health system, women, especially those who are young, prefer to seek care at private hospitals because of the confidentiality and privacy afforded. In some cases, however, private providers may have few skills and little training.

Inequalities in reproductive health outcomes

The relatively high burden of reproductive ill-health among poor individuals, combined with their generally lower access to preventive and curative reproductive health services, results in significantly worse reproductive health outcomes, including morbidity and mortality, as compared with the non-poor.

The risk of death in childhood was estimated to be 10 times higher for the poorest 20% of the global population than for the richest 20%. Within countries in the Region, infants and children from poor households and communities suffer disproportionately from disease and death. An inverse association between infant mortality and maternal education has been observed in Cambodia, the Philippines and Vietnam. In 2003, the IMR in rural areas of Papua New Guinea was 2.5 times higher than in urban areas. Rates of infant and child survival tend to be lower among marginalized communities in the Region, such as ethnic minorities (Table 7).

As noted above, data on the prevalence of STIs in the Region are scarce, particularly data on the distribution of STIs within countries. Rates of RTIs among rural women in Yunnan province, China, might be as high as 50%. Evidence suggests that genital discharge was higher among poor rather than non-poor women in the Philippines in 2003.

Inequalities in the total fertility rate within countries correlate with various indicators of social exclusion. In the Lao People's Democratic Republic, the TFR ranges from 5.4 in rural areas to 2.8 in urban areas. Similarly, the TFR has been found to be significantly higher among uneducated women as compared with those who are educated. The TFR of Mongolian women living in remote western *aimags* is 3.85, which is higher than the national average of 3.00 and significantly higher than the TFR for women living in Ulaanbaatar (2.17).

In more than 50 developing countries, the rates of undernutrition among women from the poorest income quintile are almost twice the rates among women from the richest income quintile. For example, the incidence of anaemia is 71% among women living in rural Mongolia,

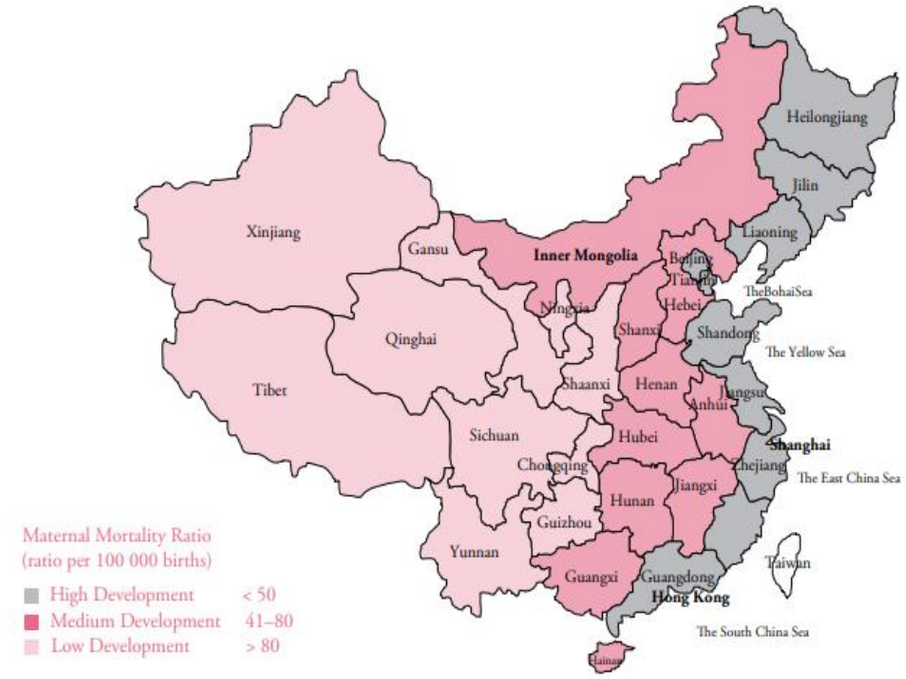
compared to 45% among women residing in urban areas. Anaemia is similarly more prevalent among rural than urban women in Cambodia (59.1% vs. 51.2%). Furthermore, women with no education in Cambodia were found to be more likely to be anaemic (62.1%) than their better-educated counterparts (57.8%). Directly or indirectly, anaemia contributes to a significant proportion of maternal deaths in the developing world. Severe anaemia can lead to cardiac failure in pregnancy and childbirth with lesser grades of severity accounting for haemorrhage, infection and decreased maternal well-being. Anaemia may also contribute to perinatal morbidity and mortality by increasing the likelihood of intrauterine growth retardation and pre-term delivery.

Across developing countries in the Region, the likelihood of a woman dying in childbirth is higher in rural than in urban communities. In Mongolia, the maternal mortality rate in rural areas is 145 per 100 000 live births as compared with 79 in urban areas. Women from herding communities appear to be particularly disadvantaged. Although these women constitute 29.0% of all pregnant women in Mongolia, they account for 49.3% of maternal deaths. The risk of maternal death in the Lao People's Democratic Republic is the highest in the Region, estimated to be 530 per 100 000 live births. Some estimates suggest that the MMR in rural areas might be as high as 900 per 100 000.

Areas and communities in the Region that are poor and marginalized appear to experience higher rates of maternal mortality than those that are better-off. For example, the MMR in western areas of China is as high as 200 per 100 000 live births, which is four times higher than the average in urban areas and twice as high as that in rural areas (Figure 9). The floating (migrant) population in China appears to be particularly vulnerable to maternal deaths.The risk of maternal death in Vietnam has been found to be 3.25 times higher for illiterate women than for literate women.

Women from ethnic minorities appear to be particularly vulnerable to death in childbirth. In Vietnam, the risk of maternal death was calculated to be 3.92 times higher for women from ethnic minorities than for Kinh women. A second calculation found that the MMR in the highland areas of Vietnam, where ethnic minorities are concentrated, was nearly 10 times that in the lowland areas. Maternal deaths occur more frequently in the Autonomous Region of Muslim Mindanao (ARRM) of the Philippines (320 per 100 000) than among the general population (96 per 100 000). Similarly, estimates from China suggest that the MMR in Tibet province (466 per 100 000 live births) is much higher than the national average (43 per 100 000).

Figure 9: Maternal deaths per 100 000 live births in China, 2003



Source: United Nations Country Team China, 2004. In: World Health Organization Regional Office for the Western Pacific 2005e.

The influence of reproductive health on poverty

Evidence suggests that the social and developmental consequences of poor reproductive health outcomes can be far-reaching and can weaken poverty reduction efforts at the household and national level.

Household impoverishment as a result of poor reproductive health can arise from the economic costs of seeking health care, as discussed above. Reproductive health-related morbidity can lead to decreased productivity and time away from work, thereby reducing household income. The death of an income-earning adult can have severe consequences for household survival. In addition, the opportunity costs of caring for an ill household member may also impose a substantial burden for poor households. Household members (usually girls and women) may have to forgo income-generating activities or leave school to provide the necessary care. In Sri Lanka, for example, the annual lifetime earnings lost because of an AIDS death were estimated to be 11 times the annual cost of treatment. In Nepal, these costs were equivalent to more than four times the per capital annual income.The negative impact of poor reproductive health can be especially severe or prolonged if households are forced to sell productive assets, such as land or livestock.

Limited access to contraceptives can undermine a household's efforts to escape from poverty. Early pregnancy has been found to reduce women's educational attainment. A study in northeastern Brazil found that young women who continued their pregnancy were more likely to drop out of school than were those who sought an abortion. Evidence also suggests that early pregnancy can negatively affect women's economic opportunities. For example, a study in Mexico observed that early childbearing led to lower monthly earnings for mothers and lower

child nutritional status for women who were poor, but not for women who were not poor. However, the negative effects of early pregnancy on women may be transitory and can be overcome with time.

Early marriage is of great concern for the well-being of women and their children. A recent report uncovered the negative consequences of early marriage for women. - e study argued that women who married young had less education and fewer schooling opportunities, had less household and economic power than older married women, and had limited access to modern media and social networks. In addition, young married women were found to be at greater risk of gender-based violence and of poor health, including exposure to HIV and the negative health effects associated with early childbearing.

Available evidence shows that children who are unwanted at conception and birth can be disadvantaged with regards to the allocation of household resources, such as nutrition and education. For example, an analysis of data from 11 countries and one Indian state concluded that unwanted children were 10%–50% more likely to be ill than wanted children. Large families must allocate household resources among more children, which can result in fewer investments in the health and education of each child. For example, a child's school enrolment is negatively associated with the number of siblings with whom the child lives.

The death of a mother can have staggering repercussions for her surviving children. In Nepal, for example, infants of mothers who died during childbirth were six times more likely to die in the first week of life, 12 times more likely between eight and 28 days, and 52 times more likely between four and 24 weeks. A mother's death can negatively affect the health of her other children as well. A study from the Kagera region of Tanzania reported that children in households where an adult woman had died in the previous six months spent half as much time in school than did those from households with no female adult deaths. The same pattern was not observed in households where an adult male had died. Analysis of data from Indonesia shows that the loss of a mother decreases the likelihood of school

Box 3: Economic growth, poverty reduction and reproductive health

Arguments for investing in family planning and reproductive health have historically concentrated on the relationship between population dynamics (population growth, the age structure, and rural–urban migration) and economic growth. While these theories remain controversial, attention is increasingly being devoted to elucidate the mechanisms through which reproductive health can spur economic growth and poverty reduction.

Recent analysis suggests that demographic changes contribute an estimated 25%–40% to macroeconomic growth, which is roughly split between decreased mortality and decreased fertility. Decreased mortality is associated with improved productivity while lower fertility leads to improved investments in human capital (health and education).

More nuanced arguments show that, as fertility declines, a window of opportunity opens when youth dependency in a society declines before the dependency associated with ageing increases. Research has shown that, when combined with good economic policies, the resulting swell in the working age population can create a 'demographic bonus' or 'dividend' that leads to economic growth. The most solid evidence for this theory comes from East Asia, where the demographic bonus is estimated to have contributed up to one-third of economic growth between 1965 and 1990. Further analysis suggests that this bonus could reduce poverty in developing countries by about 14% between 2000 and 2015.

Conversely, societies with a high dependency ratio need to devote a greater proportion of output to consumption than investments in education, nutrition or health. Such lower rates of investment can undermine the potential for economic growth and poverty reduction.

Sources: Birdsall 2001. In: United Nations Millennium Project 2006; Bloom and Canning 2004. In: United Nations Population Fund 2005; Mason and Lee 2004. In: United Nations Population Fund 2005.

enrolment, and increases the probably of child death and undernutrition.

Aggregating these costs to the national level, the negative effect of poor reproductive health on economic growth and development may be substantial. For example, ill-health among women has been estimated to reduce the productivity of the female labour force by as much as 20% Moreover, healthier and better-educated women have smaller families, invest more in each child's health and education and enjoy greater earning opportunities than women who are less educated. This suggests that improved reproductive health has strong intergenerational effects.

The influence of gender on reproductive health

Analysis reveals that men and women's experience of sexual and reproductive health tends to differ. These differences are now understood to arise not only from biological characteristics (male and female sex), but also from the socially constructed category of gender.

Biological differences in sexual and reproductive health

Biological differences between men and women include anatomical and physiological differences and variations in genetic susceptibilities and immune systems. Women experience reproductive health issues related to pregnancy, childbearing and menopause. The biological characteristics of young women, namely immature reproductive and immune systems and incomplete body growth, contribute to an increased risk of negative outcomes from pregnancy and delivery. While women must deal with health issues such as RTIs and cervical and breast cancer, men must contend with cancer of the prostate and haemophilia, for example.

During the neonatal period, newborn girls have a biological survival advantage over newborn boys. Evidence also shows, however, that older women are more vulnerable than men to anaemia, osteoporosis and STIs, among other health issues, due to physiological factors. The transmission of HIV from men to women appears to be 24 times more efficient than transmission from women to men. Women have a larger surface area of mucosa exposed to their partner's sexual secretions during intercourse. Semen also contains a higher concentration of HIV than vaginal secretions. Moreover, semen can stay in the vagina for hours after intercourse. In addition, STIs are more frequently asymptomatic in women than in men.

Pregnancy also influences the biological vulnerability of women to poor sexual and reproductive health outcomes. Pregnant women tend to be more vulnerable than non-pregnant women or men to malarial infection, in areas of stable and unstable malaria transmission. In Papua New Guinea, for example, the prevalence and incidence of malaria are highest in young children and pregnant women. A study from Uganda observed that the risk of infection with

Box 4: Defining gender

Gender refers to the differences and inequalities in the situations and needs of men and women that are based on societal understanding of being male or female, not on biological differences. Gender dynamics are understood as the different roles, expectations, identities, needs, opportunities and obstacles that society assigns to women and men based on sex. While sex is biologically determined, gender is socially ascribed. Girls and boys, women and men, may have the same rights, potential and capacities, but discrimination against girls and women based on sociocultural norms often relegates them to lower status and value. This bias often places them at a considerable disadvantage in terms of access to resources and goods, decision-making power, choices and opportunities across all spheres of life. It determines how individuals and societies perceive what it means to be male or female and influences how roles, attitudes, behaviours and relationships are enacted.

HIV was much higher for pregnant and lactating women than for non-pregnant or non-lactating women. The incidence of HIV was reported to have increased from 1.1 per 100 person years to 2.3 in pregnant women. The study concluded that biological changes in pregnant and lactating women accounted for a large proportion of this increased risk.

Gender-based differences in sexual and reproductive health

Gender inequality within societies can influence the sexual and reproductive health of men and women, starting with the differential exposure of men and women to various determinants of sexual and reproductive health, and continuing on to differences in health-seeking and utilization of good quality health services. The discussion that follows analyses how gender inequality influences the sexual and reproductive health of men and women.

Gender is a determinant of sexual and reproductive health

Gender norms

Social norms give primacy to heterosexual relationships, which are primarily defined in terms of male dominance and desire. These gender norms and others often translate into different ideas about appropriate behaviour for men and women with regards to sexuality and reproduction. According to dominant gender norms in many societies, men are expected to be macho, while women are to be sexually passive. In the Philippines, as in many countries in the Region, there is greater tolerance, and even expectation, of premarital sex for men, while women are expected to remain virgins until marriage. Moreover, while men are encouraged to engage in sexual activity and to have multiple partners, women are expected to control and put limits on male sexual behaviour. Societal norms in Cambodia dictate that women should be shy, submissive and unassertive. In contrast, men are understood to have irrepressible sexual needs and, therefore, are accepted to have multiple partners or to visit sex workers.

In many settings, women have no legal or customary right to refuse sex with their husbands. In Cambodia, for example, a study documented the widely held belief that husbands have a right to the bodies of their wives. In other countries, the laws regarding marriage and divorce have different implications for men and women. For example, Philippine law defines extramarital affairs differently for men than for women. Under such circumstances, women find it difficult to assert their preference for safer sex, for their partner's fidelity or for no sex at all. Double standards on sexuality deny women the ability to refuse sex or negotiate condom use and at the same time encourage men to have multiple sex partners, thereby putting both at increased risk of STIs. Such sexual norms and practices put men and women at great risk for infection and poor reproductive health outcomes.

Gender norms spill over into other aspects of women's lives. In the Lao People's Democratic Republic, for example, pregnancy is not expected to interfere with a woman's workload and women must often resume work shortly after delivery. Many women feel pressured to have many, closely spaced children to fulfil their reproductive roles in society.

Gender norms also tend to marginalize transgendered individuals and people whose sexual identities do not conform to social ideals. In many societies, heterosexuality is considered the norm and gender roles demand that individuals only express desire for the opposite sex. In many areas, individuals who are lesbian, gay, bisexual and transgendered face discriminatory attitudes and, at times, violence. For example, a study from Cambodia found that

transgendered individuals experience discrimination and abuse. In India, established communities of transgendered people, known as Hijras, are often stigmatized and harassed. In some areas, discrimination is rooted in the law, while in others, progressive laws protecting against discrimination on the basis of sexual orientation may not be implemented. For example, although Fiji was one of the first countries to enshrine protection against discrimination on the basis of sexual orientation in its 1997 Constitution, implementation of this law has been weak in practice.

Social movements for LGBT rights from around the world are increasingly drawing attention to gender and sexual orientation as an important source of bias and discrimination. These movements challenge common understandings of gender to move beyond the male/female dichotomy and to explore the possibility of "gender plurality."

Masculinity and male dominance

Gender norms in many societies prescribe male dominant behaviour, with the expectation that men be risk-takers and the initiators of sex. For example, wearing a condom can be considered "unmanly", so men may be unwilling to do so as well as being ill-informed about the health risks of such actions. Admitting to gaps in their knowledge can also be difficult, due to social expectations that men "know everything".

In many countries in the Region, men are more likely than women to have several sexual partners. In other cases, some men find it difficult to conform to the male stereotype of masculinity and may feel compromised by their inability to match up to expectations. For example, homosexual men may be the subject of harassment, discrimination or physical abuse because their sexual orientation differs from the norm. In addition, men may have sex with men without recognizing the need to practice safe sex.

Gender stereotypes can also lead men to take up certain occupations or behaviours that affect their health. For example, men often hold jobs that require seasonal migration or frequent travel, removing them from their home environment. Such circumstances result in the increased likelihood of causal sex with multiple partners, including with commercial sex workers. Importantly, men's behaviour and attitudes not only affect their own health but also the health of their partners.

Women's lack of power and autonomy

The low status of women relative to that of men in many societies limits their ability to control their own lives, including their fertility and access to health services. In many communities, gender roles assign men primary authority over sexual and reproductive health decisions. Thus, women may lack the ability to make independent decisions about using contraceptives or seeking reproductive health services. For example, a study from the Lao People's Democratic Republic found that when couples use contraceptives, men often make the decision regarding the method to be used. Similarly, husbands and other family members, particularly in-laws, appear to make decisions concerning whether or not a woman can seek health care. A study in Indonesia found that one in seven women surveyed did not use contraceptives because their husband did not approve. Similarly, a study from Diandong county in rural China found that 45%–55% of women respondents required their husbands' permission to go to the market, clinic or natal village.

Gendered communication patterns

In many instances, communication between partners is limited. It is often taboo for couples to discuss issues related to sexual and reproductive health. Also, many men have erroneous information about sexual and reproductive health because their sources of information are generally their peers, who may be as uninformed as they are. However, men often share many of the same concerns as women about family planning, childbirth, child spacing and number of children, whether contraception is safe, and how to select and use an effective contraceptive. In addition, gender role expectations may also make men feel constrained in expressing their feelings and intimate experiences associated with sexuality. Cultural norms also often make it difficult for men to express devotion to their partners or to participate in child raising or household management, lest they risk ridicule from friends and neighbours.

Such gendered communication patterns can particularly affect young men and women's access to information on sexual and reproductive health. Often, parents, teachers and health service providers are unwilling or embarrassed to discuss such issues with young people. For example, a recent study from Mongolia reported parents and the health system devote little attention to the reproductive health of young people. Consequently, only 25% of adolescents had basic knowledge of reproductive health and 50% had some knowledge of STIs. According to a 2002 study, most sexually active Filipino youth were not aware of safe sex practices.

Adult discomfort with young people's sexuality is common and often rooted in notions of appropriate behaviour for young men and women. Some adults mistakenly believe that providing young people with information on sexual and reproductive health will lead to promiscuity. In addition, many traditional families believe that a young girl should enter marriage innocent about issues related to reproductive and sexual health. As a result, young people in countries in the Region, particularly women, may be unable to access accurate information on sexual and reproductive health. As young people tend to be denied explicit information about sexuality and reproduction, they are often ill prepared for sexual relations or unable to protect themselves from unintended pregnancy and STIs.

Son preference

In some communities, the higher social value ascribed to men has resulted in practices that prefer sons over daughters. As noted earlier, evidence suggests that the distribution of food among children within households might benefit male children at the expense of female children in some places in the Region. In some cases, the birth of girls may not be registered or girls may not be counted in censuses. In other cases, sex-selective abortions may be performed. In more extreme forms, practices that prefer sons over daughters can result in the death of daughters over time, resulting in a skewed sex ratio or a disproportionate share of men within populations. In countries where sons are favoured over daughters, the natural ratio of 105 boys born to every 100 girls tends to be exceeded. Son preference is evident in China, the Republic of Korea and Vietnam, where the sex ratios at birth in 2005 were 112:100, 108:100 and 108:100, respectively.

Early marriage, sexual activity and childbearing

Worldwide, most men and women become sexually active in their late teen years, although there is substantial variation between regions. For most women, sexual activity has been

closely associated with marriage. Early marriage can lead to childbearing before physical development is complete and to frequent pregnancies thereafter. As discussed above, adolescent pregnancies can be particularly damaging to women's health. The association between marriage and first sexual intercourse among men is more variable.

The practice of women marrying and bearing children at a young age is slowly changing in the Region with economic development and rural– urban migration. Variations within countries, however, are increasingly noticeable. For example, rural women in the Philippines marry at a younger age than do those from urban areas. In Vietnam, adolescent marriage and childbearing are generally more common among rural and ethnic minority communities than among urban communities. A 2002 review in Mongolia found that 11.5% of adolescents in provincial centres gave birth as compared with 4.4% in Ulaanbaatar. The highest rate of adolescent births was found in rural areas of the south (26.3%). Adolescents in rural areas of the Lao People's Democratic Republic were found to be twice as likely as their urban counterparts (21% vs. 9%) to have started childbearing.

Education is generally inversely associated with the initiation of childbearing, as was found to be the case among Laotian adolescents, for example. In Cambodia, women with high school education or higher marry a year later than their less educated counterparts on average. Adolescent births were also found to be more common among women with low educational attainment in the Philippines. Among women with low educational outcomes, 40% had given birth before the age of 20 as compared with 20% among women who were better educated.

As young people in the Region are waiting longer to marry and have children, they are becoming increasingly sexually active outside of marriage. that is, the average time between the first sexual encounter and marriage is widening for both men and women. For example, dating has become common among young people in urban areas of Malaysia. Premarital sex was found to be more common among women in urban than in rural areas of the Philippines (23.1% vs. 10.7%). A study in the Lao People's Democratic Republic found that early sexual activity was more common among women who were less educated, less literate, and from the northern region or rural areas. Whatever their reasons, such changing sexual norms—and the increasing delay between sexual initiation and marriage—can have important implications for the sexual and reproductive health of young people in the Region.

Gender-based violence

Gender-based violence encompasses physical, sexual and psychological violence.258 Although both men and women experience violence, women

Table 8: Locus and manifestations of gender-based violence

Locus and agent		
Family	**Community**	**State**
Physical aggression • murder (dowry or other) • battery • genital mutilation • foeticide • deprivation of food • deprivation of medical care • reproductive coercion and/or control	**Social reference group** • violence directed towards women within or outside the group (e.g. cultural, religious)	**Political violence** (policies, laws, etc.) • illegitimate detention • forced sterilization • tolerating gender violence by non-state agents
Sexual abuse • rape • incest	**Physical abuse** • battery • physical chastisement • reproductive coercion and/or control • witch burning • *sati* (widow burning)	**Custodial violence** (military, police, etc.) • rape • torture
Emotional abuse • confinement • forced marriage • threats of reprisal	**Sexual assault** • rape	
	Workplace sexual aggression • harassment • intimidation	
	Commercialized violence • trafficking • forced prostitution	
	Media • pornography • commercialization of women's bodies	

Source: Schuler 1992.

constitute a higher share of victims of gender-based violence throughout the lifespan, from pre-birth to old age. Acts of violence against women (and girls) are manifestations of the power dynamics in the family, society and state, which seek to control women and ensure their subjugation to patriarchy. Table 8 provides an overview of the power dynamics of family, society and state that underpin gender-based violence.

The roots of gender-based violence are complex and multiple, ranging from culture to patriarchal systems. Just as victims of gender-based violence are usually women, the perpetrators of such violence tend to be men. Male violence stems from the patriarchal model of masculinity that enables and justifies such behaviour. Men who tend to be violent believe that violence, like sexuality, is a biological and uncontrollable "instinct", and thus an integral part of their masculinity. These men, who are often raised in a violent atmosphere, tend to learn how to be violent from their fathers.

Women who experience violence or the threat of violence are often unable to meet their reproductive health needs.260 Coerced sex can lead to unwanted pregnancies, STIs (including HIV/ AIDS) and gynaecological problems. In addition, physical abuse during pregnancy is associated with miscarriage, stillbirth and low birth weight babies. Abuse at an early age is also associated with risky behaviours later in life, including substance abuse, sexual risk-taking and smoking. Violence can also lead to mental health problems, such as depression, anxiety, post-traumatic stress disorder and suicide.

Gender-based inequalities in access to health services

A number of studies from the Region have observed that access to services may not be equitably distributed between men and women or boys and girls. For example, a study from 2000 in Cambodia found that an estimated 36.1% of boys suffering from fever were seen by a health service provider, while only 32.0% of girls were seen. Evidence from the Philippines shows that in 2002 girls were slightly more likely than boys to be taken to a health service provider when they were sick with fever, while boys were more likely than girls to receive medical attention when suffering from acute respiratory tract infection (ARI). In 2002, the proportion of Vietnamese children with ARI seen by a health service provider was 76.0% among boys and 64.8% among girls. A study from Papua New Guinea found that mothers took their sons to health centres more often and travelled further with them than with their daughters.

A study from three rural counties in Yunnan province, China in 1994–1996 found that most women suffering from RTIs did not seek health care. A second study from Yunnan province

Box 5: Female genital mutilation

Female genital mutilation (FGM) refers to the removal of part or all of the genitalia. FGM is prevalent in Africa, in some parts of the Middle East and Asia, and also among immigrant populations in many other parts of the world.

Many parents view FGM as an essential rite for their daughters to find a husband. Some in-laws insist on FGM for their sons' spouses as a sign of chastity and purity. In many cases, older family members, such as grandmothers and mothers-in-law, and circumcision providers, influence the decision to have a girl mutilated.

Type I FGM involves the removal of the clitoral hood, with or without the rest of the clitoris. Type II involves the removal of the clitoris and part or all of the labia minora. Type III is also called infibulation, where part or all of the external genitalia is removed and the vaginal opening stitched together until only a small opening is left.

While Type III is the most serious, all forms of FGM can lead to internal bleeding, painful sexual intercourse, urinary tract infections, blocked menses and difficult deliveries that can end in the death of the mother and child and depression.

Source: World Health Organization 2007.

reported that while as many as 71.7% of women surveyed suffered from RTI symptoms, as few as 25.38% had sought care. Similarly, unmarried women in the Lao People's Democratic

Republic appear not to seek care for RTIs. Among the men and women in the Lao People's Democratic Republic who did seek care for STIs, men tended to visit drug sellers, while women sought care at a later stage of infection and therefore suffered more serious complications. In India, a study found that only 8% of rural women had ever sought care for gynaecological illnesses, although 92% had one or more reproductive health problems, including some relatively serious conditions such as reproductive tract infections, pelvic inflammatory disease, genital prolapse and urinary tract infections.

Barriers to access to services

Such differences in the access of men and women to sexual and reproductive health services may arise for a number of reasons. Some of the barriers to access that were discussed above—geographical, economic and sociocultural—often constrain women from seeking health care to an even greater extent than men.

Geographical barriers

In some areas, women may enjoy less mobility than men. Women may have difficulty accessing transportation either because they do not have their own source of transportation or because their generally lower access to and control over household resources or cash income prevents them from using public transportation. These constraints can be further reinforced through normative expectations that women remain in the private sphere or near the household or village while men move freely over long distances in public space. In some areas, women must obtain permission from their husbands or fathers to seek health care, while in others they must be accompanied, often by a male family member, when travelling beyond their community. This increases the cost of seeking care, both in terms of lost household labour and transportation costs.

A study of demand for prenatal care among pregnant women in Cebu, Philippines observed that women living in rural areas faced significantly longer travel times to facilities than did those living in urban areas. Travel costs in rural areas were reported to be almost double those in urban areas.269 When faced with such constrained mobility, women may seek diagnosis and treatment from nearby but less qualified providers, traditional healers or village pharmacies, or may self-medicate rather than travelling farther to access better quality primary health care.

Economic barriers

Compared to men, women's generally lower access to and control over economic resources, including income, productive assets and health insurance, might constrain their access to preventive and curative health services. A case study in Tianjian, China found that women were less likely than men (41.9% vs. 46.3%) to be covered by the Government Insurance Scheme or the Labour Insurance Scheme in 1998. Additional estimates suggest that up to 70% of women in China are not covered by any health insurance. In the case of sexual and reproductive health, stereotypical notions about men and women's roles might restrict men's financial access to services. For example, in Mongolia, reproductive health services are covered by health insurance only for women.

The association between household income and health has been found to be further influenced by the degree to which women can influence how their household income is spent. Studies suggest that use of health care services, as measured by antenatal visits, is less common among

women who have relatively lower control over household resources.274 A study in the Philippines observed that as the value of women's time (as measured by an estimated wage rate) increases, so does the intrahousehold allocation of calories to women and children, resulting in improved nutritional status for women and their children.

Many women work in the informal sector or at home during their reproductive years. Because of inequalities in income and wealth in earlier life, older women are more likely to have fewer material resources, and are less likely than men to receive assistance from their relatives and friends during their old age.276 In general, women outlive men. However, widow's pensions, old age security payments and medical insurance coverage are often meagre or non-existent for older women. In addition, in circumstances where older women have the benefit of a husband's pension, this may be severely reduced or discontinued upon the death of the husband.

Sociocultural barriers

The lower priority typically given to women's health in households and communities, relative to that of men, can delay health care seeking by women and girls. In some areas, women continue to rely on traditional birthing practices. This is partly due to prevailing norms and values within society and partly due to women's low status in the family.

In many parts of the developing world, access to appropriate perinatal care is limited. Women often prefer traditional birth attendants to hospital care, since they may feel isolated and alienated from their cultural norms and values in hospital settings. For example, in the Lao People's Democratic Republic, women from the Lao Theung community (an ethnic minority group) normally deliver alone in a forest or field behind her house because the blood of childbirth is understood to be "dirty". More recently, women have begun to give birth in small huts or underneath the house. In some areas of the Lao People's Democratic Republic, intrauterine devices are not a popular form of contraceptive because of traditional notions of the uterus as a moving organ. In rural areas of Yunnan province, China, RTIs among women are seen to be normal and therefore are not considered to require medical attention.

The social norms of communities may influence people's decisions on their health. Low condom use in Malaysia and the Lao People's Democratic Republic, for example, has been ascribed to the commonly held belief that condoms are used during extramarital affairs and with sex workers and not in the context of marriage. In many communities in the Region, adults deny the possibility of young people, particularly young women, engaging in sexual relations. As a result, young people may be discouraged from discussing or asking questions about sexual matters. Stigma can also deter men and women from being tested for HIV and other STIs. Evidence suggests that stigma and discrimination restrict the access of men who have sex with men to information and health services.

Gender bias in health service provision

Health systems and services also suffer from gender bias. For example, health service providers may demonstrate disrespectful or dismissive attitudes towards women patients, as compared to men. In addition, some physicians may view women's bodies and their reproductive processes as potential medical problems. This medicalization of normal reproductive health and childbirth has been noted as a problem in many industrialized countries with a loss of control by

women over decisions concerning their bodies, health and reproduction, as well as lack of psychosocial support for women.

In many of the parts of the world, women prefer to seek care for reproductive health issues from women health care professionals. Where women health workers are not available, treatment by a man may be deemed to dishonour a woman and her family, deterring women from seeking care. Evidence from China demonstrates the importance of having women staff available for reproductive health services. One study in rural Yunnan province found that male rural doctors appeared to be reluctant to provide care for women's reproductive health. In turn, rural women were embarrassed to seek care for RTIs from male doctors. A second study observed that women in China were unwilling to speak with male health service providers about physical and contraceptive problems and that follow-up by male providers after women's sterilization was rare because of the perceived impropriety of a man visiting another man's wife.

For sexually active young people, particularly unmarried women, obtaining reproductive health services is even more difficult than gaining accurate, culturally relevant and age-specific information. Few clinics are designed, prepared or even willing to provide services to young people. Many young people are left with an unmet need for contraception and other reproductive health services. For example, many health service providers in the Lao People's Democratic Republic and Viet Nam disapprove of premarital sex and, therefore, may provide poorer quality services to young men and women. A study of formal and informal health service providers in Vientiane in 2000-2001 found that 18% of providers surveyed would inform parents if their unmarried children sought reproductive health services. A second study in the Lao People's Democratic Republic reported that youth aged 15 to 24 years prefer to seek treatment for STIs at pharmacies because of the perceived greater confidentiality and greater ease of obtaining the required drugs. A study in Vietnam found that health providers are not adequately trained to counsel young people on sexual and reproductive health issues. Similarly, a recent survey in Cambodia found that female sex workers—many of whom were between the ages of 16 and 26 years—preferred to seek care from private health providers. They described public facilities as lacking in confidentiality, privacy and anonymity. In addition to providing more privacy, the staff at private facilities were perceived to treat them with more dignity and respect.

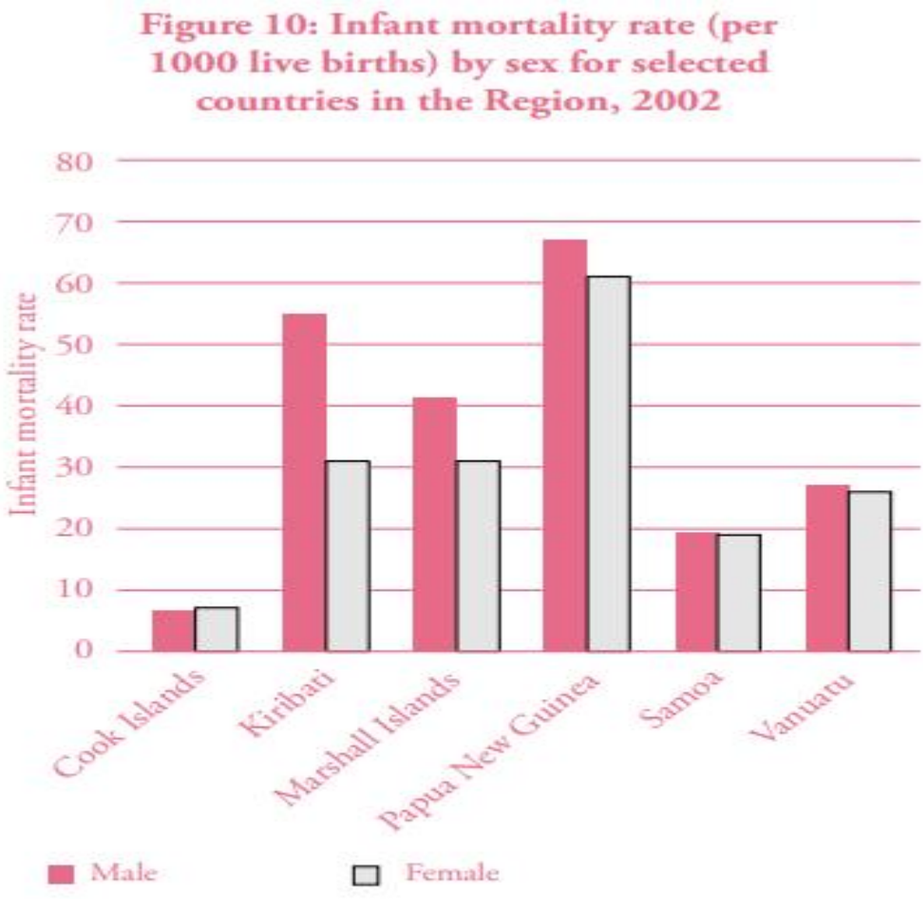
In many countries, the reproductive health needs of men have been neglected. Historically, most family planning and reproductive health programmes have focused exclusively on (married) women. For example, a study found that family planning programmes in Solomon Islands targeted only women.289 Male gender stereotypes may also discourage men from accessing health care services. Barriers to men's inclusion in reproductive health services include:

- lack of information about men's perspectives that could be used to help design appropriate programmes;
- men's discomfort at reproductive health clinics (many feel out of place or unwelcome because they have been excluded from services for so long);
- men's hesitation in seeking medical care; t limited availability of contraceptive methods for men;

- negative attitudes of policy-makers and service providers towards men (e.g. men can be viewed as irresponsible, not interested in playing a positive role or not appropriate clientele for reproductive health services);
- unfavourable policies, such as prohibitions on condom advertising; and
- logistical constraints such as lack of trained male staff, male-friendly clinics, convenient hours, or separate waiting and service areas for men.

Access to termination of pregnancy

Roughly 61% of the world's population reside in countries where induced abortion is permitted for



Source: World Health Organization Regional Office for the Western Pacific 2005a.

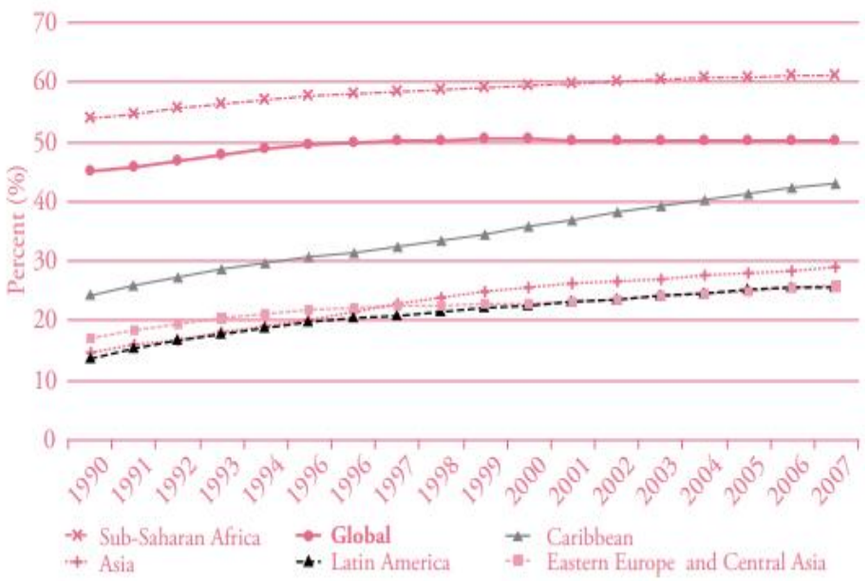
a range of reasons, while 26% live in countries where abortion is prohibited or allowed only to save a woman's life. In countries in the Region where abortion is legal, evidence suggests that some clinics provide poor quality services, with very little pre- and post-abortion counselling. The lack of privacy in public facilities can lead women, particularly those who are young, to seek care from private providers. In areas where government regulation of the private sector remains weak, the skills of private providers and standards of care do not necessary comply with mandated guidelines and protocols. As a result, women seeking care in private facilities may suffer abortion-related complications, including long-term disability and death. To be accessible, abortion services need to be affordable, respectful and offered in the communities where women live.

Gender-based differentials in sexual and reproductive health outcomes

While sex-disaggregated data on health outcomes in countries in the Region are limited, there is some evidence of how sex and gender interact to produce differential sexual and reproductive health outcomes among men and women and boys and girls. For example, data collected in 2002 suggest that infant mortality is higher among boys than girls in the Region (see Figure 10). In contrast, the risk of dying is estimated to be 33% higher among girls than boys in China.

Women's biological characteristics, combined with gender inequality, increase their vulnerability to infection with STIs. Globally, the burden of STIs among women is five times higher than among men. Globally, 15.4 million women were living with HIV/AIDS in 2007. The prevalence of HIV in men and women differs across countries in the Region. This is because the nature of the HIV epidemic, as well as gender norms, varies across countries. According to projections, the number of newly infected men and women in Cambodia was more or less equal in 2007. Thereafter, it is projected to be higher in the male population. In the Philippines, where the status of HIV was previously described as "low and slow", but where local experts now consider the possibility of a "hidden and growing" trend in HIV, almost twice as many men as women were reported to be living with HIV by the end of 2007. Similarly, in Vietnam men accounted for 85.2% of total reported HIV cases, as of 2007. Since its early days, the HIV epidemic in Malaysia has been predominantly male, with intravenous drug use as the main mode of transmission. However, by 2006, women and girls comprised almost 20% of newly-infected persons, compared to only

Figure 11: Percentage of adults (15+) living with HIV who are women, 1990–2007



about five percent 10 years ago, with heterosexual intercourse being the main mode of transmission for women. In Papua New Guinea, where the epidemic is now generalized, of the total number of people diagnosed with HIV by the end of 2006, 46% were men and 48% women (six percent of infections occurred among those whose sex was not reported). Besides, the number of infected young women is rising the fastest. Worldwide, women constitute an increasing proportion of adults (aged 15 and above) living with HIV (Figure 11).

Assessing the prevalence of gender-based violence in the Western Pacific Region is hampered by the varying definitions of genderbased violence, the silence that continues to shroud issues of domestic violence, and the normalization of violence in some areas. - e prevalence rates for domestic physical violence against women ranges between 5.8% and 65% and for sexual abuse between 4% and 50% in countries and areas in the Region. It is likely that these figures underestimate the true extent of the problem. In the Philippines, 10% of women who have had premarital sex did so against their will. One study found that gang rape is a major concern in Cambodia, Papua New Guinea and the Solomon Islands. A survey of male school students in Phnom Penh, Cambodia, concluded that 34% of respondents knew someone who had participated in *bauk* (gang rape). Analysis of a national survey concluded that 4% of women in the Philippines have had non-consensual sex.

Men, particularly young men and boys, may also be vulnerable to sexual abuse. A study in Cambodia concluded that sexual abuse is quite common among male street children. Of the study population, 41% homeless boys aged 15- 19 years reported being raped and 18% reported experiencing incest. An estimated 1% of men in the Philippines have experienced non-consensual sex.

Studies in developing countries have found that women carry a heavy burden of gynaecological problems throughout their reproductive years and into later life. - is burden is partly due to the limited medical care they received during pregnancy, labour and delivery. Women's reproductive health problems in later life include cervical cancer, uterine prolapse, fistulas, bladder problems and breast cancer. In addition, during menopause, women experience a decline in their reproductive hormone levels. As men age, erectile dysfunction can become common as a result in changes in penile blood flow. At the same time, the incidence of prostate cancer tends to increase with age. These conditions can lead to urinary, erectile or libido problems.

Gendered consequences of poor sexual and reproductive health

The social and economic consequences of poor sexual and reproductive health tend to be different for men and women. For example, the social repercussions of infertility, including that arising from abortion-related complications or maternal morbidity, tend to be more severe for women than for men. Infertile women may be discriminated against within their households, and divorced or separated from their families. In some societies, survivors of severe forms of gender-based violence such as rape tend to be blamed and scorned as "fallen women" who have lost their honour and, at times, their virginity. A study from Cambodia found that survivors of rape were perceived as bringing shame to their family and are often forced into prostitution or to marry the perpetrator. Similar trends have been reported in the Philippines. Women are often stigmatized as being reservoirs of STIs and other diseases.

The social and developmental consequences of reproductive health decisions can also be far-reaching. For example, an unintended pregnancy can severely compromise a young girl's health, education and job preparation.