

**A CROSS-CULTURAL ANALYSIS OF WOMEN'S SEXUAL HEALTH**

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## **Research Proposal**

The intent of this project stems from a recognition of the international divide among women in terms of reproductive health. While the Democratic Republic of the Congo (DRC) remains a global center of sexual violence and social stigmas surrounding rape victims (Kristof, 2010), women like myself have campus resources like the Cal Poly health center or SAFER program to provide me with adequate information and care. With this recognition of global disparities is a personal interest in the field of medical anthropology and my being an educated and liberated female in the United States, comparing my conditions to others'.

I will be investigating the state of women's accessibility to reproductive health care worldwide and the related treatment of their sexual health and sexuality. I seek to apply a medical anthropological perspective in order to bring to light what these differences and similarities in accessibility and treatment say about international power structures and female empowerment.

This research will be accomplished through a collection and analysis of various scholarly sources and reliable statistics. I hope to first look at a national scale then contextualize, compare, and contrast it on an international scale, focusing on developing regions.

## Annotated Bibliography

**ABC News. (2012). Rush Limbaugh Calls a Woman a 'Slut.' Video. Retrieved from <http://abcnews.go.com/GMA/video/rush-limbaugh-calls-woman-slut-15831822>**

I thought the Rush Limbaugh-Sandra Fluke controversy to be especially pertinent to the issue of women's health because it helped to reveal some of the major attitudes that are prevalent in our nation concerning women's sexual health and sexuality, especially with respect to their ability to gain greater access to birth control and have more say concerning their health and health care.

**ABC News. (2012). Romney 'Missed Opportunity' to Take on Limbaugh. Video. Retrieved from <http://abcnews.go.com/GMA/video/romney-missed-opportunity-limbaugh-15848368>**

I wanted to include information about Romney because he is the GOP candidate. Many of the feelings about insurance coverage of birth control and the issue in general divides people in terms of ideology. I wanted to see the differences in the way President Obama and Mitt Romney not only dealt with the general controversy, but also the way in which they handled Limbaugh's comments and how much of a priority they made the issue compared to other political and social issues.

**Cook, R.W. & Ngwena, C.G. (2006) Women's access to health care: The legal framework. *International Journal of Gynecology and Obstetrics*, 94(3), 216-225.**

Using the UN's MDG's concerning women's access to health care, this article discusses in detail three important legal principles, including evidence-based health care, transparency between providers and patients, and fairness in access, that are important in establishing equality in women's reproductive health care. The authors argue that these principles need to be established to help meet the UN's goals, but that these principles must be a part of our policies and laws to be effective. This article ties into my research in that it discusses some of the social flaws present in obstructing equality in health care and proposes a solution.

**C-Span. (2012). Democrats Hold Hearing on Contraceptives & Women's Health. Retrieved from <http://www.c-span.org/Events/Democrats-Hold-Hearing-on-Contraceptives-amp-Women39s-Health/10737428508/>**

This particular source was helpful in obtaining Sandra Fluke's testimony. Miss Fluke's testimony was very insightful. She is representative of a portion of the female population who desires better access to preventive services. Her words revealed the issues that are keeping women from having these services and how it has affected them.

**Eckholm, Erik. (2012). Poll Finds Wide Support for Birth Control Coverage. *The New York Times*. Retrieved from <http://www.nytimes.com/2012/03/02/us/politics/americans-divided-on-birth-control-coverage-poll-finds.html>**

This poll revealed national perceptions and attitudes concerning insurance coverage of birth control. It showed breakdowns by ideology and age. It helped to show where the differences in opinion lied and why.

**Greenberger, Marcia. (2012). Stop sex discrimination in health plan costs. *CNN*. Retrieved from <http://www.cnn.com/2012/03/20/opinion/greenberger-health-premiums-gender-gap/index.html>**

Greenberger's article gave the basic information needed to show some of the gender-related issues that exist in current health care coverage. The numbers and information she presents shows a shocking, seemingly unnecessary difference between the sexes in terms of insurance costs.

**Jordan, Brigitte. (1993). *Birth in Four Cultures*. Prospect Heights, IL: Waveland Press.**

I was particularly interested in including information concerning the evolution of birth in this country because pregnancy and birth are major, if not the most important, aspect of women's health. I desired to investigate how it has evolved over the past centuries, and why it has taken the turn that it has. My belief, and what this information shows, is that economic and legal benefits have taken priority over women's and children's health in our recent system.

**Kaiser Family Foundation. (2011). Women's Fact Sheet: Women's Health Policy Facts. Retrieved from <http://www.kff.org/womenshealth/upload/6000-091.pdf>**

I used this information to give an overview of the current state of insurance coverage for women in the U.S. Without digging too deep, one can tell there exist disparities not only between the sexes but between women of different status and race. This would support not only my assertion that there exists an issue with access but that it is an issue that exists because of power structures.

**Kellman, Laurie. (2012). GOP Takes turn crafting women anti-abuse bill. *Msnbc*. Retrieved from [http://www.msnbc.msn.com/id/47346308/ns/local\\_news-clarksburg\\_wv/t/gop-takes-turn-crafting-women-anti-abuse-bill/#.T7BC0p9Yv9k](http://www.msnbc.msn.com/id/47346308/ns/local_news-clarksburg_wv/t/gop-takes-turn-crafting-women-anti-abuse-bill/#.T7BC0p9Yv9k)**

This article and example of political controversy is used because it serves to show the existence of maltreatment of the issue of sexual violence in the U.S. This is particularly interesting to compare to the issues of rape and female genital cutting in the developing world because we often believe that it does not exist here.

**Kitzinger, Sheila. (1998). Letter from Europe: The Caesarean Epidemic in Great Britain. *Birth*, 25(1), 56-58.**

Kitzinger's testimony was used in conjunction with other accounts about the medicalization of birth to show how the treatment of birth has taken the power out of the hands of women and put it into those who exist as a part of a network of power structures that do not truly benefit or look out for the needs of women and children, especially by allowing them to participate more fully in the decision-making process.

**Kristof, Nicholas. (2010). Opinion: Congo's Forgotten War. *The New York Times*. Video. Retrieved from <http://www.youtube.com/watch?v=9jaTmyjjYdA&feature=relmfu>**

I found Kristof's account of the sexual violence in the Congo to be extremely pertinent to this paper because it showed not only the prevalence of rape but the treatment of rape victims as well as sexual health care treatment. It shows how power structures like gender disparities and

social norms prevent women from gaining not only the health care services they need to physically recover but the social support as well.

**Lake, Ricki and Abby Epstein. (2011). *The Business of Being Born*. U.S.: Barranca Productions.**

This documentary was especially helpful in providing insight into the issue of the medicalization of pregnancy and birth. It presented a wide array of opinions and accounts from people on both “sides” of the issue. It helped to show, as the other sources did, how birth has been taken out of the hands of those undergoing the process.

**Lippman, Abby. (1999). Choice as a risk to women’s health. *Health, Risk, & Society*, 1(3), 281-291.**

Lippman examines the relationship between biomedicine, healthcare, and the idea of women’s choice. She looks specifically at how we view choice, how it is constrained socially, and some potential risks involved. She argues that to offset these growing and negative trends in health care and concept of choice within the system, women need to become more educated and actively involved in determining their options and ability to make decisions. This ties in specifically to my research concerning female empowerment and its relationship with health care.

**Ojanuga, DN & Gilbert, C. (1992) Women’s access to health-care in developing-countries. *Social Science & Medicine*, 35(4), 613-617.**

This discusses developing nations on a broad scale, looking at how a variety of socio-economic and cultural factors play a role in their limited access to health care, especially compared to men. It argues that this lack of access affects other aspects of their lives and their children’s lives. The authors believe that the only way to improve the accessibility is by them playing a role in improving other factors first, such as their civil rights and status as well as education. These factors are also major divides among men and women in these developing countries. This broad although effective examination of accessibility ties in to my comparison between the U.S., other developed nations, and developing nations and what it reveals about differing power structures. It also shows that the solutions to improving accessibility cannot be applied equally; each area has its individual needs.

**Pear, Robert. (2012). Gender Gap Persists in Cost of Health Insurance. *The New York Times*. Retrieved from <http://www.nytimes.com/2012/03/19/health/policy/women-still-pay-more-for-health-insurance-data-shows.html? r=1>**

Pear’s article was used in conjunction with others to show the disparities in health care coverage in the U.S. It shows that the reasons we would assume would result in these differences (e.g. women needing maternal health care, etc.) are not what actually affects the costs. This information will be used to further my thesis in showing that these differences exist because of social, political, and economic structures.

**Ross, Ellen and Rayna Rapp. (1981). Sex and Society: A Research Note from Social History and Anthropology. *Comparative Studies in Society and History*, 23(1), 51-72.**

Ross and Rapp’s article provides the information concerning the social context that exists to influence perceptions of sexuality, including sexual health and health care. Most of the

material analyzes historical European culture, but the theory utilized still applies to current global culture.

**Self, Sharmistha & Grabowski, Richard. (2012). Female Autonomy and Health Care in Developing Countries. *Review of Development Economics*, 16(1), 185-198.**

The major argument made is that greater autonomy leads to more influence in determining allocation of resources within a household. Especially in developing countries, female autonomy is already a huge issue in itself. They conduct a study with the hypothesis that increased autonomy leads to a greater likelihood of visiting a medical doctor (as opposed to other traditional sources). They find that mobility and choice of work do in fact play a large role for women but not education, all as measures of autonomy. Education for men, however, does play a role in increasing likelihood revealing some important gender inequalities. This ties into my research concerning differences in power structures and gender inequalities and female empowerment.

**Sherwin, Susan. (1998) *The Politics of Women's Health: Exploring Agency and Autonomy*. Temple University Press: Philadelphia, PA.**

This collaborative effort between American and Canadian women from a range of disciplines but all coming from a feminist perspective examines a number of countries, including developed and developing, looking at data and modern health care systems. Their overall focus is on issues facing women in terms of empowerment in their health care systems and what these differences in empowerment reveal. This ties into my discussion specifically of female empowerment and power structures as related to health.

**Singer, Natasha. (2012). With Support Off as Events Begin, Komen Works to Revive Its Image. *The New York Times*. Retrieved from <http://www.nytimes.com/2012/04/28/us/with-komen-image-hurt-support-for-affiliates-lags.html?pagewanted=all>**

The issue concerning the Komen Foundation and Planned Parenthood was an important example of how women's access to health care is affected by politics and ideology. This is expressed through the fact that Republican politicians wished to restrict financial aid to an organization that provided something (abortions) they did not agree with.

**The New York Times. (2012). Times Topics: Contraception and Insurance Coverage (Religious Exemption Debate). *The New York Times*. Retrieved from [http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health\\_insurance\\_and\\_managed\\_care/health\\_care\\_reform/contraception/index.html](http://topics.nytimes.com/top/news/health/diseasesconditionsandhealthtopics/health_insurance_and_managed_care/health_care_reform/contraception/index.html)**

This collection of articles was an important source of information to give a broad overview of the current state of health care and the controversy over health care reform and funding. It aided in my analysis of the U.S. health care system and the evolving controversy. A number of specific events within this controversy highlight reasons for restricting access to care as well as attitudes toward women's sexual health.

**Torregrosa, Luisita Lopez. (2012). U.S. Culture War With Women at Its Center. *The New York Times*. Retrieved from <http://www.nytimes.com/2012/04/04/us/04iht-letter04.html?pagewanted=all>**

This NYT article explicitly discusses the existence of the current controversy surrounding women's reproductive health. It contains some quotes and events that express current sentiment and opinion on national political, social, and economic priorities.

**Wiley, Andrea S. & Allen, John S. (2009) *Medical Anthropology: A Biocultural Approach*. Oxford University Press: New York.**

Pertinent chapters discuss reproductive health, especially for women, and social inequality in healthcare for both men and women. Based in evolutionary theory, this will tie into my discussion of differences in accessibility and the current conditions of women's health care globally and locally.

**World Health Organization. (2009) *Women and Health: today's evidence tomorrow's agenda*.**

Discusses current issues facing women and the continual failure to meet demands of women over the decades. Using updated information and fact sheets from WHO concerning the conditions of women's health and health care worldwide in conjunction, this reveals the current conditions and implications which will support my claim that there are global problems with women's access to proper health care.

**United Nations. (2010). Goal 5: Improve Maternal Health Fact Sheet. Retrieved from [http:// www.un.org/millenniumgoals/pdf/MDG\\_FS\\_5\\_EN\\_new.pdf](http://www.un.org/millenniumgoals/pdf/MDG_FS_5_EN_new.pdf)**

I thought that using the UN MDG's was a very strong framework for analyzing the global state of female health care. Used in conjunction with the other reports, it gives reliable and insightful statistics that show just how much the world's women are lacking in adequate access to care.

**United Nations. (2011) *The Millennium Development Goals Report 2011*.**

Looking specifically at the millennium goals pertaining to improving women's access to health care internationally, this discusses where the UN stands with its development goal currently. I have used much of this information to show that this is indeed a pertinent issue worldwide.



## **Outline**

### I. Introduction

- A. Thesis: Power structures serve to limit female empowerment and autonomy with respect to their sexual health

### II. Body I - The United States (Regional Conditions and Analysis)

- A. Current state of access to health care
- B. Health care changes and controversy

### III. Body II - Worldwide (Regional Conditions and Analysis)

- A. Current state of access to health care
  - 1. Focus on developing regions

### IV. Conclusion

- A. Regional Comparison and Global Analysis
- B. Looking Ahead to the Future of Women's Health

## **Introduction**

The UN has a Millennium Development Campaign in which they have set a series of goals to help combat poverty by 2015. One of these goals concerns maternal health. One of the two targets of this goal is to reduce the maternal mortality ratio by three quarters. The second concerns achieving universal access to reproductive health. According to the UN statistics, the following issues are present today: 1) more women are receiving antenatal care; 2) inequalities in care during pregnancy are striking; 3) only 1 in 3 rural women in developing regions receives the recommended care during pregnancy; 4) progress has stalled in reducing the number of teenage pregnancies, putting more young mothers at risk; 5) poverty and lack of education perpetuate high adolescent birth rates; 6) progress in expanding the use of contraceptives by women has slowed; 7) use of contraception is lowest among the poorest women and those with no education; and 8) inadequate funding for family planning is a major failure in fulfilling commitments to improving women's reproductive health (United Nations, 2011).

The Democratic Republic of the Congo (DRC), ridden with a past of ethnic conflict and warfare, has come to be known as the rape capital of the world. In a visit to the DRC by New York Times reporter Nicholas Kristof, he learned that numbers of women who are raped in the DRC contract sexually-transmitted diseases (STDs) but because of the social stigmas placed upon rape victims, not only do these women become abandoned by their partners, they also become outcasts in society, unable to receive the necessary treatment for their disease (Kristof, 2010). Young women, in particular, are at risk for being infected due to biological factors, lack of education and services, as well as norms and values that undermine their ability to protect themselves (WHO, 2009). Comparatively, women in the U.S. live in a society that teaches that a rape victim is never at fault. From a young age, females in the U.S. are taught about general

female health and health care options. These days it is relatively easy for a young woman to receive a prescription for birth control. At the Cal Poly health center, not only are you able to receive contraceptives discreetly and cheaply, but they perform a variety of female health-related exams, including STD exams, at virtually no cost.

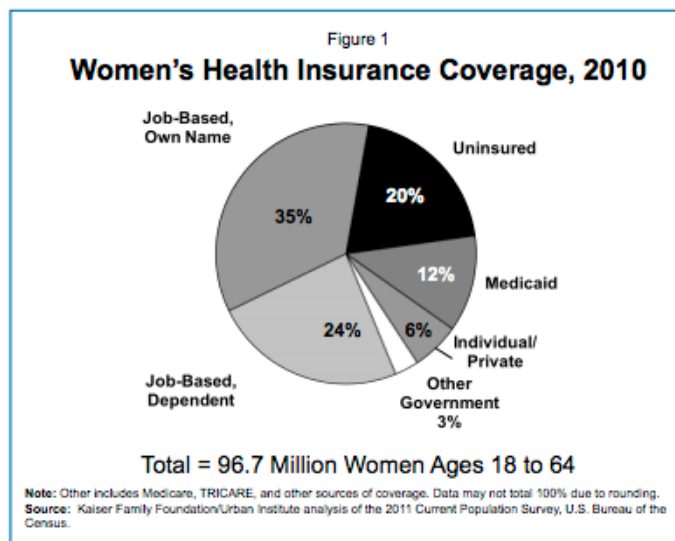
However, the Land of the Free is not without its own issues related to female healthcare. A number of recent national events highlight a major division in American opinion. Firstly, in the race for the GOP candidate for the 2012 presidential elections, questions concerning contraceptive use and government funding for contraception have become hot topics. Meanwhile, the Obama administration has dealt with heavy protest concerning a controversial birth control mandate requiring most religiously-affiliated employers' health plans to cover birth control (The New York Times, 2012). Additionally, a major amount of backlash came in response to an announcement by the Susan G. Komen foundation to cut funding to Planned Parenthood (Singer, 2012). Many conservative and pro-life groups were in favor of the move but those against it argued that it was placing politics above women's health. Even more recently, Rush Limbaugh, a conservative political commentator, used the words "slut" and "prostitute" in reference to Sandra Fluke, a Georgetown University law student and women's rights activist who spoke before Democratic members of the House of Representatives concerning government funding of birth control (ABC News, 2012). Limbaugh's words were met with an outcry to which he eventually made an apology to Miss Fluke on his radio show. Fluke ultimately rejected his seemingly insincere apology, and Limbaugh has since lost support from advertisers during his show's hours. Even in America, concepts of liberties and government role are a major source of debate. Although women like Sandra Fluke live in a country where they have the freedom to

attend a prestigious university, unlike the women of the DRC, the shocking similarity is the maltreatment concerning their reproductive health.

In examining these global similarities and differences in access to reproductive health care and treatment of sexual health and sexuality, I endeavor to reveal the way in which power structures serve to limit female empowerment and autonomy.

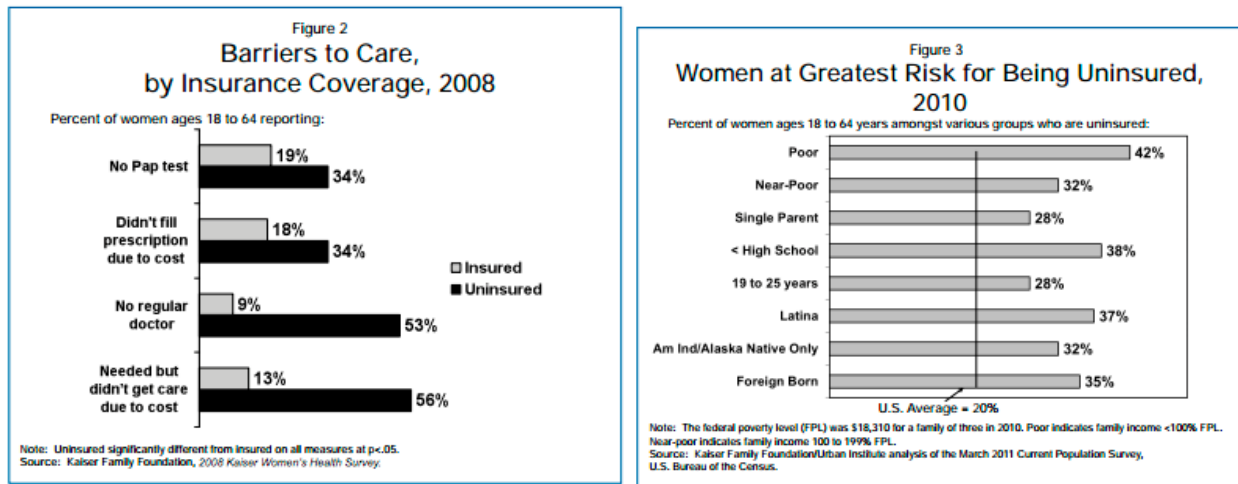
### The United States

According to recent statistics in the United States, most women between the ages of 18 and 64 have healthcare, but because of the various types of private and public forms of health care programs, approximately 1 in 5 women are left uninsured (Kaiser Family Foundation, 2011). As seen in *figure 1* below, the majority of health care coverage for women comes from employer-sponsored insurance. However, women are less likely than men to be insured



independently through their job. Because of this, women are also more likely than men to lose their insurance coverage in the case of becoming widowed, divorced, or if their spouse loses his job or coverage. Of those women who remain uninsured, studies have shown they are also more likely to postpone care and have generally lower health outcomes (fig.2). Those at risk of being

uninsured tend to be younger, lower-income, and ethnic minorities, especially Latin American (fig.3). This would indicate that the disparities in insurance coverage are not only gender-related



but also age-related, racial, social, and economic. This would be consistent with what past research that has suggested “that within wealthy countries there are more often than not inequalities in access to other kinds of resources and other meanings of status differentials that are important to health” (Wiley and Allen, 2009, 341). This gradient in health has been explained as being “a combination of factors related to the lived experience of inequality and the extent to which a country’s public policies elaborate or attenuate social hierarchies” (342). Some of these factors include “1) one’s relative wealth and status; 2) social cohesion and social participation; and 3) sources of social support” (342). Within these social and economic conditions and constraints, we see some disparities among racial and ethnic groups. It is important to realize that these differences are attributed more so to social factors rather than biological factors. This is due to the social construction of race and related constraints, such as discrimination (348-351).

In general, the health care reform debate has already been one of great controversy in the United States. It seems that across the parties, all agree that there are issues of access and affordability but disagree on the way in which to change. In March of 2010, President Obama

and Congress passed the Affordable Care Act (ACA), colloquially known as “Obamacare.” Since that time, there has been a great push, especially by the Republican opposition, to challenge the constitutionality of this health care reform. Set to start in 2014, this new health care law would prohibit gender discrimination in coverage through the elimination of gender rating, the practice of charging women different premiums than men. Currently, the practice of gender rating costs women approximately \$1 billion a year (Greenberger, 2012). As seen above, many women are left uninsured and many do not have independent access. Bearing that in mind, women are much more likely to forgo preventive health care if it is not affordable or too expensive (Greenberger, 2012). Therefore, banning gender rating would assist in increasing the number of insured women by improving affordability. However, according to recent research, two years later, most insurers have done little to even reduce this gender gap (Pear, 2012). According to a report by the National Women’s Law Center, in the states that have not yet banned gender rating, over 90% of the best-selling health plans charge higher premiums to women. Mary Beth Senkewicz, the 2007-2011 deputy insurance commissioner of Florida, believes that if insurance companies began to voluntarily reduce gender rating, come 2014, “they could reduce the impact that will occur...when rates are expected to increase for many men under the age of 55.” However, according to Senkewicz, “This is a business decision. Insurers may not want to raise rates for men because they might lose some customers.” According to some insurers, this practice is continued because women between the ages of 19 and 55 tend to use more health services (i.e. more doctor visits, regular checkups, more prescription drug use, and more chronic illnesses). Yet, at the National Women’s Law Center, they point out the disparities among genders vary greatly between insurers, which calls into question the justification of gender rating. Additionally, one might think the fact that women require maternity care would

result in a need to charge differently. However, in the individual insurance market, maternity care is generally an optional benefit (rider) that requires an additional premium. Under the ACA, insurance plans would require maternity care to be covered as an “essential health” benefit (Pear, 2012). Other “essential benefits” that would be mandated by the ACA would include outpatient and hospitalization care, prescription drugs, rehabilitation, and mental health care (Kaiser Family Foundation). Additionally, it would require new private plans to cover preventive services and vaccines recommended by federally-sponsored committees without co-payments or cost sharing. Such services would include pap tests, mammograms, bone density tests, and the HPV vaccine. The federal Health Resources and Services Administration (HRSA) also approved a provision to the act to include other services such as prescribed contraceptives, breastfeeding supplies (e.g. breast pumps), screenings for evidence of domestic violence, well woman visits, and other types of counseling and screening services. With that being said, now that the ACA is still in the middle of a pending Supreme Court case, many insurers hesitate to act until the issue is fully resolved.

Yet, out of all issues concerning women's health, currently the topic of birth control is one of the most controversial. In January 2012, the Obama administration announced that, as part of the rollout of the ACA, most plans must cover contraceptives for women free of deductibles and co-payments (The New York Times, 2012). As a response, there was a general outcry against the mandate as threatening the rights of religious freedom. Although the mandate does not apply to church institutions, it does apply to affiliated corporations, such as hospitals and universities. Prior to this announcement, 28 states had already created similar legislation requiring religiously affiliated institutions to provide reproductive health care coverage. This new law would help to free up the economic barriers which keep many women from using birth

control currently and will be considered one of the preventive health care services provided by insurance plans. Contraceptives included are not only oral contraceptives but emergency contraceptives such as ella and Plan B, as well as sterilization procedures. The administration rejected the Roman Catholic Church's request from exemption for insurance provided by their affiliated hospitals, colleges, and charities, and instead allowed them until August of 2013 (rather than August of 2012 for most companies) to comply. However, this has made some groups even angrier and ready to fight the new regulation. In recent times, the administration responded to this by providing an "accommodation" to church-affiliated corporations by saying they would not have to provide or pay for the coverage directly but instead have it offered to female employees through their employers' insurance companies so that the religious employers would be removed from the situation. Yet even this has failed to placate religious leaders who feel it still infringes on religious liberties and consciences. The issue has sparked fervor in the presidential debates, especially in the primaries for the G.O.P candidate and upcoming presidential election. A poll from March showed that about 63% of Americans supported the new federal policy requiring private plans to cover birth control free of charge (Eckholm, 2012). Among the individual parties represented, 80% of Democrats voiced approval while 40% of Republicans and 60% of independents supported the policy. The director of the survey, Mollyann Brodie of the Kaiser Foundation, said that disagreements over the mandate actually show more views on the ideas of federal regulation rather than on contraception itself. Forty-three percent of Republican women in the poll believed it was a war on religious freedom (compared to 10% of Democratic women), whereas the Obama administration, many democratic leaders, and women's health advocates call it a Republican war on women. The differences are not only partisan but age-related. There was little difference between the sexes on the issue. In



the Republican party, the poll found that over half of those between the ages of 18 and 49 were in support compared to only 33% of those 50 and over. Yet overall, less than 1% of all people surveyed wanted the issue of women's health and contraceptives to be a main topic of discussion for candidates. Many people believed the issue was "being driven by election-year politics." Nonetheless, still about 25% of women surveyed said the candidates' views on women's reproductive health could be a major factor in influencing their vote. According to a Pew Research Center survey from March 29<sup>th</sup>, the gender gap appeared to be widening between President Obama and Republican presidential candidates (Torregrosa, 2012). Although Mitt Romney is the favored G.O.P candidate, his campaign is struggling to regain female voters. What then does the response of religious employers and the public polls say about the treatment of female sexual health? As Ellen Ross of Ramapo College and Rayna Rapp of the New School for Social Research point out, "The personal is political" (Ross and Rapp, 1981). As we see with the unfolding of the debate, those "intimate details of private existence" such as the accessibility of contraception to women "are actually structured by larger social relations." In this case, these kinds of relations are seen here through "community sociability--peer groups...[and] the involvement of Church regulations on sex...[which] reflect both the autonomy of community groups and the presence of a larger social world." As we see, the lines between approval of this mandate are generally ideological and even generational. While in the past, "properly brought-up Victorian women were taught that they need never be 'bothered' by sexual passions, while their more 'liberated' daughters learned that orgasms were their anatomical destiny." Similarly, in the case of birth control, we see that even the divide among women exists due to age which would remind us of the social context concerning sexuality and sexual health. It reinforces that "family

contexts, religious ideologies, community norms, and political policies” influence what is permissible or impermissible in a given time and place.

We see this principle once more when, over a year ago, conservatives first attempted to cut off federal aid to Planned Parenthood, saying that it was using taxpayer money for abortions (Torregrosa, 2012). This year, the Susan G. Komen Foundation, one of the leading U.S. breast cancer charities, moved to create a policy change that would prevent certain local affiliates from providing funding the Planned Parenthood breast health programs. However, this received a major backlash, to which Komen ultimately changed this decision. This did not occur without some damage done. Since the controversy, attendance and donations have declined by over 25% (Singer, 2012). Komen’s national VP of communications, Leslie Aun, said they are attempting to review their grant-making process and to increase their affiliates’ role, also calling the decision from February one of the “missteps” they will look to avoid from now on. Nonetheless, many affiliates remain doubtful of the national group’s ability to properly represent their views and interests. As with religious institutions, large social organizations like the Komen Foundation “may appear distant and abstract, but they actually influence the intimate experiences people have, defining circumstances under which shifting sexual mores are played out” (Ross and Rapp, 1981). In this particular case, there were ideological disagreements with access to abortion services, and thereby the restriction of aid serves to limit acceptable circumstances. Dr. Abby Lippman also reminds us that it is through this method that larger social institutions serve to make true autonomy impossible for women by limiting the options they have to choose from (Lippman, 1999).

Another incident of backlash came after February 16<sup>th</sup> when the Republican-led House Committee on Oversight and Government Reform heard from a number of witnesses, male

clergymen of different faiths including a Jewish Orthodox rabbi, to speak out against Obama's policy. In response, a female Congress member asked where the women were in a hearing concerning female health to which a male member of Congress said it was about religious liberty and not women or contraceptives (Eckholm, 2012). Sandra Fluke, a third year law student at the Jesuit Georgetown University and former president of the university's club Law Students for Reproductive Justice (LSRJ), was blocked from testifying at this hearing. However, she was able to speak before the House Democratic Steering and Policy Committee the following week to present her case for why the government should provide free contraceptives through the ACA (C-Span, 2012). Fluke made the case that, without coverage, contraception can cost up to \$3,000 at a law school and that 40% of the female Georgetown law students claimed financial distress because of it. Fluke not only discussed the issues for young unmarried women but those for married couples who had to go without because they could not fit it into their budget. She responded to claims that women can instead use non-profit clinics as a means of obtaining birth control with the argument that clinics have not been an adequate resource especially when many legislators are attempting to defund them. She continued by relating a story of a friend with polycystic ovarian syndrome who uses birth control to prevent cysts. Her birth control is covered by Georgetown because it is not meant to prevent pregnancy. However, this is not the case at all religiously-affiliated institutions. Fluke makes the argument that even when these institutions attempt to make amendments that would provide exceptions, they are unsuccessful. She says that "when you let university administrators or other employers rather than women and their doctors dictate whose medical needs are legitimate and whose are not, a woman's health takes a backseat to a bureaucracy focused on policing her body." After a while, her friend with polycystic ovarian syndrome, who is also a lesbian, had to stop taking birth control because she was being hassled

by insurers over the legitimacy of her claim that it wasn't to prevent accidental pregnancy and ultimately ended up in the ER with a cyst the size of a tennis ball that required the removal of her entire ovary, resulting menopausal symptoms, and possible infertility. Many of the students reported similar situations in trying to prove they were not using birth control to prevent pregnancy. Fluke argues, with student testimonies, that policies like Georgetown's sends a message that women's reproductive health is not a priority. She said that media had put the fault on the students because they should have known what to expect when enrolling at a Jesuit school. In conclusion, Fluke reminds the committee that these are voices of Catholic women not looking to wage war against religion or religious institutions but are simply seeking the care they need and deserve. She also concludes that many employers and religious leaders claimed satisfaction with the proposed exemption the Obama administration had put forth and hoped others would feel the same. After the hearing, their initial refusals by the House recording studio to televise the hearing, Democratic aides of Leader Nancy Pelosi said that Republicans on the Committee of House Administration were trying to "silence" the issue, but Republicans denied the charge and argued that it was about following procedures. Shortly after, conservative radio talk show host Rush Limbaugh railed on Sandra Fluke for several days (ABC News, 2012). In one instance, he brings up the hearing, asking, "What does it say about the college co-ed Sandra Fluke? Who goes before congressional committee and essentially says that she must be paid to have sex. What does that make her? It makes her a slut, right? It makes her a prostitute. She wants to be paid to have sex." Additionally, in response to Fluke's comments concerning the price of contraception being up to \$3,000, Limbaugh replied, "She's having so much sex, she can't even afford the contraception. She wants you and me and the taxpayers to pay her to have sex. What does that make us? We're the pimps." On another day, he continued with, "If we're

gonna have to pay for this, then we want something in return, Miss Fluke, and that would be the videos of all this sex posted online so we can see what we're getting for our money." Fluke reported that she was initially stunned but then outraged because "this is historically the kind of language that is used to silence women." Obama openly condemned Limbaugh's comments and fully apologized to Sandra Fluke. However, G.O.P. candidate Mitt Romney simply answered by saying it was not the kind of language he would have used and said little else (ABC News). G.O.P. analyst Matthew Dowd says that Romney, especially during a time where the pressure is on with Obama and issues like the Rush controversy are "taking away time" from the bigger issues like the election and economy, missed the chance to take on Limbaugh to help unify the country and say this is not the kind of political discourse that should be used. Dowd says the reason the Romney most likely did not step up is because he tends to be more risk adverse. Ultimately, many of Limbaugh's sponsors pulled from his show, and in response to the general outcry, Limbaugh attempted to apologize to Sandra Fluke in a way she felt was insincere. Many have simply written Limbaugh's behavior off as typical of his radio character. From the Republican committee's refusal to hear Sandra Fluke to dispute about airing the hearing to Limbaugh's comments, we see attempts to control through silencing. By using either political power or archaically threatening language, we are reminded that communities "are the locus not only of the regulation of sexual partner and practices, but for the transmission of sexual knowledge as well" (Ross and Rapp, 1981). Indeed, knowledge is a powerful tool, and aside from mitigating sexual health, controlling sexual knowledge has a strong impact on education and empowerment to act on that educated knowledge. Ellen Ross and Rayna Rapp (1981) remind us that in the past, this restriction of knowledge negatively affected the health of women:

Many women knew close to nothing about sex or reproduction, even at their first pregnancy. The especially high rates of illegitimacy and infanticide among French and English nineteenth-century servants suggests not only their isolation from country or town working-class communities, but their ignorance about contraception, abortifacients, and abortionists (62).

Additionally, one of the strongest cases of the control of knowledge (to step away from the contraceptive debate momentarily) is that concerning pregnancy and birth, which have become increasingly medicalized in recent years. Twenty-five percent of births occur through caesarean section, which is a much higher rate compared to other developed countries (Wiley and Allen, 2009). C-Section procedures can be beneficial for women who are older or as a way to avoid pain or potential future sexual dysfunction from vaginal delivery. Furthermore, it is often a necessary procedure in certain medical emergencies. Lastly, many women favor it because it allows them to have more control as to when they will deliver. However, the c-section option has become one that is heavily promoted for a number of other reasons aside from safety:

There is an argument for caesareans when a doctor wants to protect himself against being sued by a patient, particularly in cases where there has been a difficult delivery before. There are also financial considerations. With a normal pregnancy and normal delivery, you can't claim yourself off your health insurance policy unless it is a European or American one with higher premiums and less exclusions. But there is an inducement for the patient to opt for a caesarean if the insurance company will pay, because the whole process is then cheaper for the patient (Kitzinger, 1998).

Kitzinger's statement reveals one of the cultural and economic ways in which more medicalized procedures are "encouraged" to women. America's medicalized system surrounding pregnancy

and birth also reveals a lot about the current state of female empowerment and decision making. Most other cultures use traditional midwifery for delivery (Wiley and Allen, 2009). Not all of these midwives have biomedical or professional training, however. The techniques differ greatly though in that there is greater focus on emotional and social support, as well as allowing the woman to actively participate in the labor process. Anthropologist Brigitte Jordan describes an experience with an elderly Mayan midwife named Doña Juana in Yucatan, Mexico. As Jordan describes, “Doña Juana says that every woman must *buscar la forma* (find her own style). For her, the midwife’s function is to assist with whatever method the woman comes to find best (Jordan, 1993). On the other hand, as biomedical practices progressively become the norm worldwide, we see traditional birth attendants and midwives being replaced by medical doctors with “professional degrees, specialized knowledge, intensive and expensive interventionist technologies, and a set of expectations about what constitutes a ‘normal’ or ‘appropriate’ birth” (Wiley and Allen, 2009). In fact, in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries as biomedicine grew, midwifery became outlawed in many U.S. states. At the time, the university systems were still mostly white males, and midwives became associated with images of being elderly, foreign, dirty, and ill-trained. It wasn’t until the 1960’s and 70’s when midwifery had its resurgence that women once again had this option. From this, we can conclude a number of major hindrances to female autonomy. Firstly, we see the way in which political and social forces serve to limit knowledge and options to women. Doctors and bureaucrats essentially profit through the control of knowledge, by telling women they don’t understand what’s best for themselves (Lake and Epstein, 2011). These constraints on knowledge and options benefit the powers-that-be at the expense of women’s autonomy and health.

Finally, Limbaugh's words are not the only kind of degrading discourse that has been used during the general debate over women's health and insurance coverage in the United States. Around the world, "international organizations are marshaling forces to end the abuse of oppression of women and girls...and enact laws to advance gender equality," and here in the U.S. which is "farther" along than many and often tries to stand as the example, "a cadre of conservative Republicans is being accused of waging a concerted campaign to turn the clock back" (Torregrosa, 2012). After the hearing with Sandra Fluke, a financial supporter of former-G.O.P. presidential candidate Rick Santorum, said that "'gals' could prevent pregnancies by putting an aspirin 'between their knees.'" In several states, there have been debates over enacting laws that would require women to undergo an invasive vaginal ultrasound in order to have an abortion. Some are even seeking to make provisions to the Violence Against Women Act of 1994 (VAWA). Recently, the House Judiciary Committee voted 17-15 to renew the act which recently expired (Kellman, 2012). Republicans opposed additional provisions that would protect Native Americans and immigrants and when the senate voted to reauthorize the law, House Republicans began writing their own version of the act. Although there was some bipartisan support, there still remained differences surrounding abused illegal immigrant women. Republicans remain worried that the law can fraudulently be used to gain citizenship or residency. Still, some believe the proposed bill will create a rollback that will fail "to protect [female] victims that are vulnerable, that are too traumatized, too scared to report and who face barriers." As with the control of contraceptive use, the protection of victims of violence is influenced by the "legal systems [which] provide a material background against which sexual relations are played out, whether they affect sexuality directly (e.g., legitimacy clauses, the outlawing of abortion, and sex codes defining prostitution) or at a distance (e.g., welfare and the



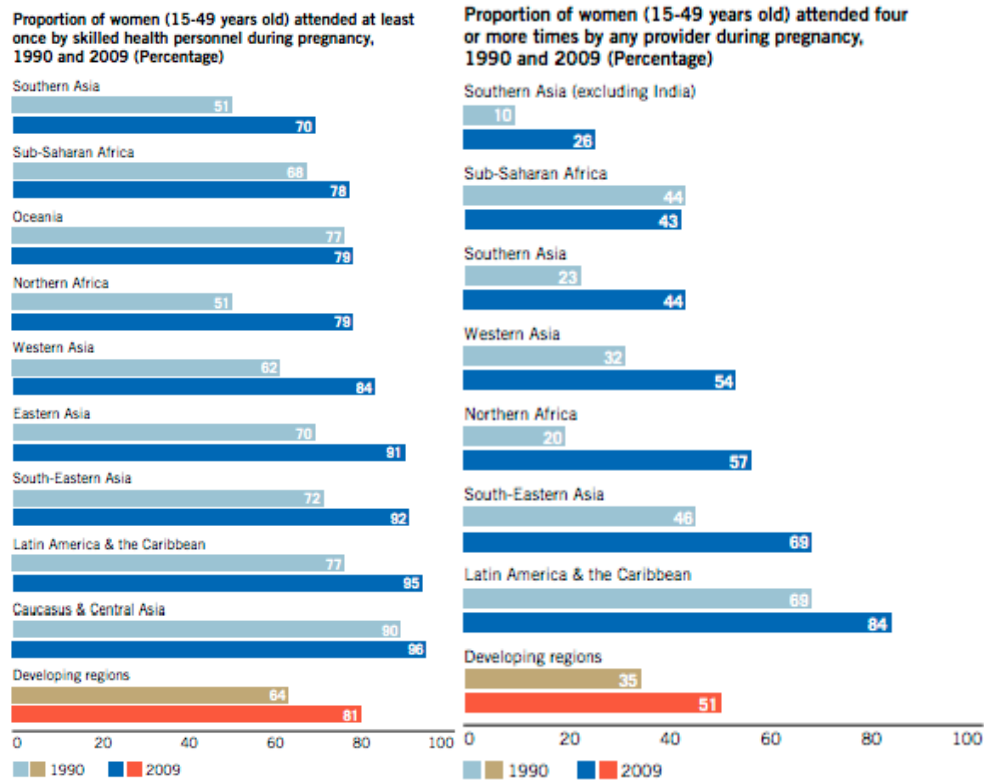
responsibilities of fathers)” (Ross and Rapp, 1981). As Sandra explains to the Democratic committee, these kinds of examples reveal how just how “a woman’s health takes a backseat to bureaucracy” (C-Span, 2012).

### **Worldwide**

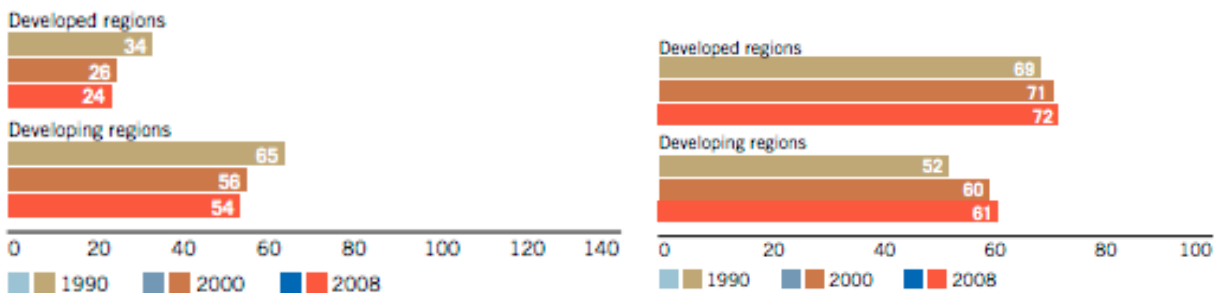
UN and World Health Organization (WHO) reports reveal just how important and prolific the issue women’s health is globally. One cannot discuss women’s health without talking about reproductive health, which ultimately affects the health of coming generations. So then why is it that such great disparities exist and women’s health remains less than a top priority to many when it is the foundation of our continued survival? Some biological and behavioral advantages seem to result in the life expectancy of women to be longer than that of men (WHO, 2009). Yet, the unique conditions of the female life often result in greater health challenges requiring greater attention in care. Discrimination, however, has resulted in an inability to get adequate care. Inequalities are seen not only among the genders but between high and low-income countries as well as within social structures of countries. We have seen in detail some of the current policies and attitudes towards women’s health in the United States. Now, we will take an overall look at some of the conditions of the rest of the world with an overall look and then a focus on developing regions to better contextualize the U.S.’s situation.

Not only does one of the UN MDG’s hope to reduce maternal mortality but also to achieve better universal access to reproductive health care, especially in middle and low-income regions. According to recent UN statistics, more than 350,000 women die annually from complications during pregnancy or childbirth, almost all in the developing world (United Nations, 2010). As a result, more than 1 million children are orphaned and therefore up to 10 times more likely to die at a young age. Although rates of maternal mortality have decreased,

they are not meeting the goal to achieve a three-quarter reduction by 2015, per the UN's MDG. Approximately 80% of these deaths are preventable and occur for such reasons as hemorrhaging, sepsis, unsafe abortion, obstructed labor, and hypertensive diseases of pregnancy. In these cases, women are lacking access to proper health services, equipment, and skilled medical caregivers. Although many more women are now receiving antenatal care, as compared to numbers from 1990, disparities still exist among certain areas, particularly regions such as sub-Saharan Africa, Southern Asia, and Oceania. Those with the greatest risk of maternal mortality are young, adolescent mothers. By 2007, about 62% of married women or those in a civil union had access to a form of contraception, but these increases are now occurring at a slow rate than in the 90's. The UN estimates that by better meeting the needs for effective and safe contraception the number of maternal deaths could be cut by a third. Therefore, increased funding to improve access to contraception is extremely important. However, official development assistance in the past decade has dropped from 8.2% to 3.2%. With respect to providing universal access to reproductive health care, the UN has recently found that more women between the ages of 15 and 49 have at least one skilled birth attendant during pregnancy (refer to lower left figure, United Nations, 2011). Nonetheless, women are still not receiving the recommended frequency of care. The UN recommends a minimum of four antenatal visits, but in developing regions, this number remains low (refer to lower right figure).

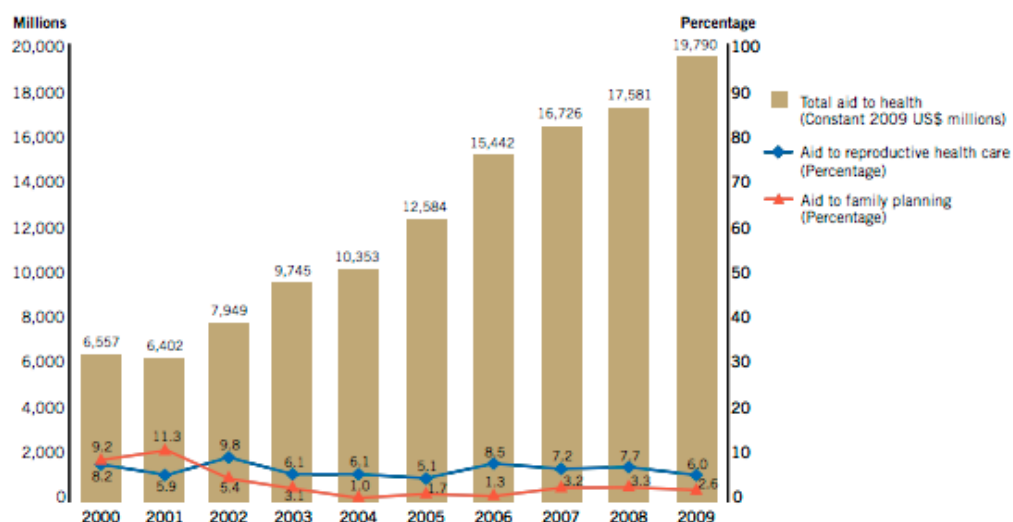


The adolescent period is generally marked by greater health and fertility but also greater risk (WHO, 2009). As stated before, the adolescent birth rate (number of births per 1,000 women ages 15 to 19) decreased between 1990 and 2000 then has slowed in the past decade, with Sub-Saharan Africa changing the least among all regions and still maintaining the highest rate (refer to lower left figure). Although contraceptive use has risen among women aged 15-49 (lower right figure), married or in a union, sustaining these gains will be difficult as the number of women of



reproductive age is also rapidly increasing: 50% since 1990. Therefore, the need to provide better access to services and programs is much more vital to keep pace with the increasing population. Over 120 million worldwide aged 15 to 49, married or in a union, do not have access to family planning services. This number is about 1 in 5 and 1 in 4 of women of childbearing age in Sub-Saharan Africa and the Caribbean. Comparatively, even in regions such as South-Eastern Asia and Northern Africa where it is relatively widespread, the number of women with unmet needs remains at about 1 in 10. According to the UN, efforts to improve access will not only improve maternal and, as a result, child health, but “will contribute to reduced poverty, greater gender equality, and the empowerment of women by improving the chances that these young women will go to school and eventually engage in paid employment.” Despite increasing demand for family planning, funding has declined over the past decade (refer to figure below). Yet, through increasing funding to meet contraceptive needs could result in lower costs of maternal and newborn health care.

Official development assistance to health, total (Constant 2009 US\$ millions) and proportion going to reproductive health care and family planning (Percentage), 2000-2009



In developed countries, female fetuses compared to male fetuses not only have a higher survival rate, but women also tend to live longer (Ojanuga and Gilbert, 1992). On the other hand,

in developing countries, the gap between male and female life expectancy is much smaller and sometimes men live much longer than women. Especially in developing countries where the social structure is still very much patriarchally organized, the health of women suffers relative to men's (Self and Grabowski, 2012). Additionally, female children have higher mortality rates. Many of the advantages that usually accompany longer life expectancy for women are associated with biological factors. Although female infants in developing regions have these same advantages in the beginning, a host of socio-economic factors negatively inhibit this advantage so much so that by adulthood it is gone. As we've seen, women's health is reproductive health and the highest rates of health complications and mortality are reproductively related. Many of the common immediate causes of maternal mortality are caused by or made worse due to other factors like poor communication and transportation which prevent women from giving birth in the appropriate location. Factors such as a lack of sanitation or clean drinking water which normally are major sources of health-related problems further complicate pregnancy and birth. Half of births are attended by a traditional birth attendant (TBAs), many of whom lack the medical skill to handle complications during birth.

Rampant malnutrition in developing regions is also one that worsens the already sensitive nature of pregnancy (Ojanuga and Gilbert, 1992). Iron deficiency resulting in anemia is one of the major micronutrient deficiencies for women and anywhere from 50-60% for pregnant women in particular, which is twenty times higher for non-pregnant women. Despite the importance of proper nutrition during the childbearing age for successful reproductive capacity, men tend to show a higher caloric consumption by nearly 29%. Unfortunately, these inadequate maternal diets result in decreased lactation, which in turn serve as inadequate sources of nutrition for their newborn babies who are already at risk of a lower birth weight from the mother's malnutrition.

On top of this inability to provide the proper amount of nutritious breast milk, extensive research in developing regions has shown a favoring of male children to female. This is exhibited through male infants receiving more for longer periods of time, especially during times of food shortages. This preferential treatment continues beyond childhood, often seen in cases where the male head of the household is served first and the most.

In addition to pregnancy and birth-related problems, women also receive inadequate attention once they enter menopause (Ojanuga and Gilbert, 1992). During this reproductive stage, women are at a higher risk for cervical and breast cancer. However there is absolutely no emphasis on detecting or preventing these risks, such as treating vaginal infections or condom use. Funds instead go to treating advanced cases of cancer rather than detection or prevention measures.

For many females worldwide, there are a number of social constraints resulting from poverty, social and cultural traditions, humanitarian crises, and geographical isolation that can inhibit their ability to gain access to information, education, health care, and economic opportunities (WHO, 2009). In general, most of the poor health conditions women are faced with are preventable, but not only are adequate resources relatively unavailable but women also utilize them less than men. Some of the possible barriers are institutional, economic, cultural, and educational (Ojanuga and Gilbert, 1992). As mentioned before, structural or institutional barriers include lack of skilled doctors or attendants, advanced medical technology, and inadequate communication and transportation. Although these issues of infrastructure affect everyone, women are generally uninvolved in the legislative processes, and as a result, their health care accessibility needs are not considered or met. Even with available resources, there are still often discriminatory practices. For example, a study in South Asia reported that although kwashiorkor

syndrome was 33% higher among girls than boys, boys were admitted at a 13% higher rate. Furthermore, even when there are programs or medical advances introduced to the region, only the affluent, which makes up the minor part of the population, can gain access. With that in mind, we look to the issue of economic barriers. "Women's control and involvement in certain economic sectors are important dimensions of status and greatly influence health care delivery" (Ojanuga and Gilbert, 1992). In most developing regions, women take the traditional place within the home with little economic independence. Furthermore, most often the earnings of head of household remain his; there is no joint bank account or custody. This principle applies to women as well, but they generally make little to no income. In addition to low labor force participation, women earn less than men. Even for the affluent women, household income is generally not controlled by her. Many of the socio-economic restrictions, such as traditional household roles, are often influenced by cultural traditions and practices. The Islamic institution of *purdah*, for instance, generally restricts women from the public, which can hinder a woman's chance of seeking out medical access. Gender roles where the male is more dominant or has more say often requires women to receive consent from their husbands for treatment or use of contraceptives. In general, subordination of women results in women's reproductive health being less of a priority. Instead, it is seen as purely her responsibility and a normal occurrence which doesn't need medical intervention. Lastly, one of the biggest barriers between women and adequate access to health care is education. Factors of education and, as a result, empowerment, seem to be the most influential. More often than not, women simply lack the knowledge of their options. Especially with concern to contraceptive use, understanding how to have strong reproductive health improves a woman's physical health as well as her chance of contributing to society. Although there is some variance, across the board there is a consistent rate of higher

illiteracy of women than men, especially in Islamic regions. Quite often this is due to socio-economic status. Limited resources are granted to men, leaving women with little to no access to opportunities for formal education and, as a result, other opportunities for occupation. The majority of the world's population resides within developing regions. This can make research difficult not only because the lack of adequate resources for thorough research but the sheer size. Nonetheless, the need for improved access are still quite apparent. The many system-based barriers make improved accessibility an issue, but especially culture and empowerment. Without women gaining autonomy and equality in other aspects of their lives like income and equal legal rights, they cannot expect to have the right kind of accessibility to health care. No matter the amount of policies or programs or technological advances implemented, without more empowerment and autonomy, women will be unable to overcome these rigid power structures that combine to inhibit their access.

Yet, although it may seem easy, given that it is in women's hands to demand change, this remains one of the greatest obstacles. The research continually shows that in areas where women have greater autonomy (i.e. the independence or freedom to self-govern, make decisions), there is greater well-being and fertility (Self and Grabowski, 2012). Studies have shown that not only does increased female autonomy lead to increased use of health services for the household as a whole but also to increased use of prenatal care. The concept of autonomy is not always measured the same, but in one study in particular involving data from the regions of Uttar Pradesh and Bihar in India, classifies some measurements of autonomy as the amount of mobility outside of the home (usually determined by whether or not she needs her husband's permission), her ability to work outside of the home (generally agrarian work), and level of education. Some other measures used in determining the level of autonomy for individual



women were whether or not the woman lives with in-laws, whether she has a son, and how long she has been married. The hypothesis in this study was that a woman with greater mobility and a higher level of educational attainment would be able to have a higher paying job and therefore be able to have more say in allocating resources towards health care. Additionally, the study hypothesized that women who were more likely to be autonomous would also be more likely to seek out quality care, such as that provided by a trained professional (as opposed to a TBA or healer). Ultimately, the study revealed that in the rural parts of these communities, mobility and education did indeed play a large role in influencing a woman's ability to make choices about her health care. It also increased the chances that she would seek out professional care. However, working outside of the home in an agrarian job, which is often the case, results in more household dependency and reduces her chances of seeing a skilled doctor. It may be that working in non-agricultural employment would result in the opposite.

Relative to the U.S., the forms of degradation, control, and subordination in developing regions often come in a more blatant and traditional form. Nonetheless, the same power structures exist with the same intent to limit female autonomy, which would ultimately assist in improving female sexual health. For instance, in many regions of the world, especially in Africa, the Middle East, Malaysia and Indonesia, the practice is female genital mutilation (FGM), or female genital cutting (FGC) as it is now more commonly called, is still commonly practiced (WHO, 2009; Wiley, 2009). FGC, which involves partial or full removal of the external female genitalia typically for non-medical reasons, can have some potential health risks. On one end there is a clitoridectomy which is only the removal of the clitoris (Wiley, 2009). At its most extreme is a process called infibulation which involves the removal of the clitoris, labia minora, and most or all of the labia majora; most countries do not practice this particular form. What

remains is then stitched together, to be later removed for sex and birth and often restitched after birth. The extensiveness of forms vary by country. Although the numbers have decreased, about 92.5 million females above the age of 10 years old living in Africa undergo some form of FGC (WHO, 2009). FGC often occurs around the time of menarche as a kind of initiation into womanhood (Wiley, 2009). It's often seen as preparing a young girl for marriage and actually increases her chances by making her genitals appear more feminine. It is also used as a means of increasing fertility, protecting sexual purity, solidifying female identity within a group, or setting the bounds for female sexuality. There is often a great amount of pain, but this pain is often seen as a way of preparing women for the pain experienced during childbirth. There are common perceptions concerning the negative health and sex-related consequences of FGC. Yet, on the contrary, very little data would tell us that this is overwhelmingly so. In fact, the data shows quite a range of results, which may be due to the conditions under which the procedure was performed (e.g. skill of surgeon, instruments, hygiene, form of FGC, etc.). WHO has stated that some possible side effects can include pain, infection, hemorrhaging, cysts, scars, emotional and sexual trauma, and issues with sex, urination, menstruation, pregnancy, and child birth. These effects happen only up to 20% of the time, however, which may not be as often as many might think. There is also variation in the amount of sexual pleasure experienced by women after the procedure; some even claim heightened pleasure. In the U.S., such practices would be unheard of and heavily condemned, but when looking at it through the lens of medical anthropology, we see that it is in fact one of their social customs and not necessarily one of their "pathologies" (Wiley, 2009). While this practice has generally gained an outcry by the Western world, many women view it in a positive and desirable way; they are not all being made to undergo the procedure unwillingly. Instead, what may be the less ethnocentric and more helpful approach would be to

assist in reducing the negative effects that do occur and perhaps propose other approaches and models of womanhood, sexuality, marriage, and social station and membership. Although it is difficult for any Westerner to fathom how such “mutilation” can improve beauty or desirability, across the ocean, our culture has its own cultural practices, such as plastic surgery, aimed at improving beauty, normality, femininity, or sexual desirability. It may be less traditional as it is a much more contemporary practice, but it is equally prolific and substantial. Women are mutilating their noses to be thinner, boobs to be perkier and larger, stomachs to be flatter, lips to be fuller, and skin to be tighter. It may very well be that African and Middle Eastern women who have undergone FGC see American women and equally disapprove of their own attitudes about femininity and sexual expression. That being said, both practices create controversy over the ideas of wellness, beauty, sexual expression, and female health. For those being affected by FGC, what is of most concern “is not only the improvement of children’s and women’s rights and health, but also the empowerment of [these girls and women], to develop their own approaches, setting their own priorities and mitigating risks they face for abandoning the practices” (Wiley, 2009). Here is where the regions converge. Each region’s social context sends a message to women about what is acceptable or available. FGC is arguably degrading in that it perpetuates certain social placements of women and bounds of female sexual expression. In the U.S., women can go from an A-cup to a DD-cup if they so choose, yet have fought for decades over the rights to have an abortion or use contraception. Meanwhile, in both regions, women still lack the access to the knowledge they need and influence in the decision-making process concerning their health.

## **Conclusion**

### *Regional Comparison and Global Analysis*

With the contraception controversy in the U.S., we (the readers) saw examples of archaic and sexually threatening terminology used to degrade and silence women. We also saw legislation (e.g. VAWA) that would place certain public policy above women's health. Furthermore, we saw the ways in which sexuality, sexual health, and female autonomy was affected by social, ideological, political, cultural, and economic contexts. We examined the way in which changing trends and social contexts made certain things permissible or impermissible. Overall, we learned how power structures served to control knowledge and policies that would inhibit women's education and options and therefore their empowerment and ability to make decisions regarding their own health.

Autonomy, simply put, is choice. However, simply "granting" the power of choice upon women and therefore solving the inequalities in the accessibility of adequate health care is not so simple. Many feminist and other critics would define choice as a concept apart from social and political structures (Lippman, 1999). However, to do this is also an issue. It ignores the way in which power structures construct choices, who receives the privileges and who does not due to differences such as class, race, or sexual orientation. It fails to address how access to certain resources is vital to choice and how social justice is therefore necessary to keep secure this freedom of choice. Susan Sherwin introduced an idea of relational autonomy to better reflect the interaction between power structures and choice (Sherwin, 1998). She explains the difference between "autonomy, true self governance, which requires 'the removal of barriers of oppression which structure options in ways that further perpetuate existing patterns of oppressions,' and agency, the authority to make, or to express, choices" (Lippman, 1999). Through this definition, we realize that social, political, and economic power structures give us a set of options from which to use our agency by selecting one but that this selection has been created without our

participation. Some of these major barriers go beyond sexism and racism but also changing social trends that constrain women's options. As Sandra Fluke said before the Democratic committee, bureaucracy and political policies are classifying who has legitimate health needs or not, rather than women and reliable doctors (C-Span, 2012). These kinds of fluctuating trends in perspective serve to "define what circumstances a woman should view as risks to health and outline ways to behave when these risks are present, definitions themselves highly dependent on government policies and practices, women's choices cannot be genuinely free, and making them must be risky" (Lippman, 1999). Yet, at the same time, choice may be risky in the sense that an individual's ability to express it is not isolated; women live interdependently and their health choices intersect others'. Therefore, there needs to be both a concern for protecting autonomy as well as social responsibility to protect the health of all women. However, we cannot always expect that this protection will come at the hands of the government or private sectors. As these powerful organizations have heard the demands of women "for empowerment, for choice, and for gender-based care, research and policy, governments and the private sector are playing on our reasonable fears of paternalism, over-medicalisation and exclusion" (Lippman, 1999). The new strategies being promoted not only do not "protect and promote our health" but "in some instances, women may be worse, not better off" with these new options (Lippman, 1999). In order to ensure these proposals and tactics truly support female autonomy, it is imperative that women actively participate in creating this agenda rather than leaving it in the hands of the social, political, and economic powers that have historically failed to uphold female choice and empowerment. Therefore, the problem is not only making sure women gain better access to health care but to the decision-making process.

*Looking Ahead to the Future of Women's Health*

According to UN reports, there have already been some successful tactics to improve the quality and access of care (United Nations, 2010). For example, in Egypt, the Ministry and Health and Population significantly increased obstetric and neonatal care access, especially to vulnerable parts of the population. This consisted of the construction of maternity homes in rural regions which also helped to increase the number of attended births. In 2003, the UN Population Fund (UNFPA) helped to launch a campaign against stopping obstetric fistulas. It has now expanded to 49 countries throughout Sub-Saharan Africa, South Asia, and the Arab States. The issue itself has been integrated into government policies of over 28 countries. Lastly, in Pakistan, UNFPA mobile clinics were set up and over the course of 2005-2008, had about 850,000 patients. These clinics were able to provide a range of reproductive health services, such as antenatal consultations, deliveries, post-miscarriage complications, and referrals for c-sections. They were able to provide skilled birth attendance for 43% of the women living in that rural areas and 12% higher than the overall average in Pakistan. Additionally, in 2010, a Global Strategy for Women's and Children's health was launched to focus on improving funding, policy, service delivery, as well as arrangements for global reporting, oversight, and accountability on women's and children's health. UNFPA, the UN Children's Fund (UNICEF), the WHO, the World Bank, and the Joint UN Programme on HIV/AIDS (UNAIDS) have come together to start the Health 4+ (H4+) program to lower rates of maternal and newborn mortality through a number of increased care tactics including increasing the number of skilled health workers and improving access to reproductive health services. In 2009, UNICEF, UNFPA, and the African Union Ministers of Health started a campaign to reduce maternal mortality in Africa in twenty African countries. Also in Africa, as well as the Arab states and Latin America, UNFPA and the International Confederation for Midwives has worked to both increase the

number of midwives as well as the quality of their training. Lastly, the UNFPA's Global Programme to Enhance Reproductive Health Commodity Security and WHO's evidence guidance in family planning have worked to improve access to reproductive health supplies in over 70 countries.

The issue of accessibility and adequate care will need to be address in all arenas. As mentioned, with respect to the issue of empowerment and autonomy, women need to be active participants in the agenda-making process rather than simply on the patient side of the process. Dr. Abby Lippman, feminist academic and activist, proposes some solutions:

To ensure that women can define their own options, we need to focus not on how to make women responsible for their health, as we do now, but on how to ensure they can be 'response-able' ...we might insist that companies developing expensive medicines for something that ails us apply some of the drug money (profits) towards addressing a social determinant of women's ill health. And in place of stakeholders setting the policy agenda for women's health and genetic technologies, we might adopt more participatory democratic approaches...and engage in more discursive processes to debate and decide on the choices we want for ourselves and our communities. (Lippman, 1999)

In conclusion, as a society, we need to push for the creation of "positive standards, policies and laws to ensure evidence-based, transparent and fair access to reproductive and sexual services" (Cook and Ngwena, 2006). Along with promoting autonomy for women, we need to promote accountability mechanisms that ensure that providers and patients actively work to decide what is working, who holds the responsibility, and whether or not those responsibilities are being fulfilled.

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