How Gender Affects Safe Motherhood Across the Life Cycle

Time: 1 hour, 30 minutes

Activity Objective:

Recognize gender-related barriers to safe motherhood across the life cycle.

Materials:

Prepared Flipcharts: Instructions for Life Cycle Activity

Continuum of Levels of Caregiving

Six Areas of Gender's Impact on Safe Motherhood

Activity:

1. Explain that now we are going to look specifically at four stages in a woman's/girl's life related to maternal health and gender roles and norms. Divide the participants into four smaller groups. Assign each group one of the following categories:

- Pre-pregnancy
- Pregnancy
- Labor and Delivery
- Postpartum

2. Ask the groups to do the following (display flipchart):

   1. Brainstorm and list on a flipchart the gender norms and roles for both women and men at each stage and the possible impacts they can have on the health outcome for the pregnant girl/woman at that stage.
   2. Choose a presenter.
   3. You will have 20 minutes for this activity.

3. After 20 minutes, call time. Ask each group to briefly report the results of its discussions. Responses for each category should include the following:

Pre-pregnancy:

- Decision whom/when to marry.
- Early age of marriage.
- Girls are denied education in many societies due to their families' need for them to work, lack of school fees, and early marriage. Limited resources for education are often allocated to the boy child.
- Girls and women often do not receive education/information about sexuality, pregnancy, etc.
- Girls and women in many societies lack access to proper nutrition due to their low status, which impacts their overall health and development.
- Women and girls do not always have the power to control when, and with whom, they have sex.

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- Women and girls, and especially young or nonmarried women/girls, do not always have access to contraceptive information, services, or supplies.
- Women often do not have a voice in deciding on family planning matters.
- Couples are discouraged from discussing their desired number of children.
- There is pressure to prove fertility for both women and men.
- Due to the lack of FP use, births are not limited or spaced at least two years apart; this can create complications, especially for young married girls.

Unintended pregnancies are high risk, as they are more likely to end in abortion, and unsafe abortions can result in death.

Pregnancy:

- In some societies, there is pressure to have a boy child.
- The timing of pregnancy often is not in the woman's control.
- In many societies, women's mobility is limited, thereby limiting their ability to seek proper antenatal care.
- In many societies, women are not allowed to make independent decisions to access healthcare or to arrange transportation to antenatal visits.
- In many societies, women and their male partners feel it would be shameful for a woman to be examined by a male provider.
- In many societies, women do not have access to financial resources to pay for antenatal services or for transportation to antenatal visits.
- Men and women alike may not understand the pregnancy and childbirth process, the signs of pregnancy complications, proper nutrition, etc.
- In many societies, women and girls are denied proper nutrition, especially food rich in iron and vitamin A, due to their low status.
- Many women are responsible for strenuous work in the household. Male partners and families may not understand that it jeopardizes her health or the health of the developing fetus.
- Studies show that women experience intimate partner violence (IPV) during pregnancy, and that in some country contexts, women may experience IPV for the first time or at greater levels while pregnant. (Gill, K., R. Pande, and A. Malhotra. 2007. Women Deliver for Development. *Lancet* 370(9595): 1347–1357).
- Communities may not understand the importance of timely access to emergency obstetric care and/or may not prioritize women and their safe motherhood.
- At multiple levels of policy (from national to municipal government and health services to community), women's health and well-being is not prioritized.

Labor and Delivery

- In some cultures, sex selection is practiced and female fetuses are aborted or female infants killed.
- In some cultures, women are expected to go through labor and delivery alone, without help, and/or in dangerous and unhygienic conditions.
- Skilled attendance may not available during labor and delivery, as husbands/male family members/mothers in-law sometimes refuse to allocate funds to pay for their services.

- Transportation may not be arranged due to husband/male family members/mothers-in-law/community not allocating funds for payment.
- The woman and her partner may not know/understand the symptoms of complications and delay seeking help.
- There can be a delay in receiving adequate care at a health facility, if providers do not see women in labor as a priority, or if providers demand payment up front for delivery and complications services.
- In many societies, women and their male partners feel it would be shameful for a woman to be examined by a male provider.
- In hospitals, women are sometimes forced or coerced to labor in positions not of their choice for the convenience of the provider or to meet rigid clinical norms.
- Providers may not explain interventions and the full range of their consequences to women, impinging on their right to informed consent.
- Fathers are sometimes prevented from being present at birth and/or not welcomed into facilities/spaces where birth will occur.

Postpartum:

- Due to gender norms that women do not have a right to knowledge or may not be able to understand information, women are not provided information about postpartum complications. Due to gender norms that pregnancy is not a male concern, men are also not included as a potential partner to be educated about postpartum complications.
- Health systems have not prioritized supervision of women's and child's health status within the first 24 hours after delivery.
- In many societies, women and girls are denied proper nutrition due to their status, especially food strong in iron and vitamin A.
- Women are sometimes expected to return to doing heavy housework, such as gathering water and firewood and taking care of older children soon after delivery.
- Women sometimes cannot make the decision to use contraception for birth spacing or to prevent pregnancy when the desired number of children is reached.
- In many societies, women are discouraged/not allowed to discuss the optimal number of children with their partners.
- In some societies, pressure to have a boy child pushes women to become pregnant too soon after a girl child is born.

4. After each group reports out, ask the following:

- What do you think of the report out?
- Was anything missing?
- Did anything surprise you?

5. After all the groups have reported out, share anything they missed.

6. Observe that gender barriers to safe motherhood are not just at the level of individual women and their partners and their families and communities but also within healthcare institutions and policy decisions/priorities. Note that recent frameworks for considering maternal health have included the idea of a continuum of care not only across the life cycle but across these different levels of caregiving (Kerber, Kate J., Joseph E. de Graft-Johnson, Zulfiqar A. Bhutta, Pius Okong, Ann Starrs, and Joy E. Lawn. 2007.

—Continuum of Care for Maternal, Newborn, and Child Health: From Slogan to Service Delivery.‖ *Lancet* 370(9595): 1358–69).

7. Display a flipchart with a graphic of the continuum of care at places of caregiving.

Appropriate access, referral, and follow-up between levels	Hospitals and health facilities
	Outpatient and outreach services
	Family and community care

From Kerber et al., 2007.

8. Ask the group to re-cap briefly: Based on what participants identified as the key gender barriers in the life cycle, which seem to relate to these different levels of caregiving? Be sure that the following are mentioned:

- Gender-related factors related to the three delays (recognizing need for emergency care, accessing emergency care, and receiving care once at a facility)
- Gender-related factors related to quality of care within the healthcare facility and efficient referrals (e.g., respect for women and their community [often female] caregivers, inclusion of men to provide support for their female partners)
- Gender-related factors to prioritizing resources for adequate, high-quality services and emergency transport by decisionmakers/policymakers at community, municipal, and other government levels.

9. Display the flipchart and explain that the factors affecting women's access to good antenatal care and emergency obstetric care can be categorized under six areas:

1. **Limited access to education**: girls who are denied schooling tend to have poorer health, larger families, and children with a higher risk of death. Women's/girls' low educational levels also lead to early marriage (or early marriage contributes to this limited access).
2. **Limited exposure to information**: men may not see involvement in their partner's health as their concern due to gender norms and roles and, in particular, may be unaware of danger signs and the risks facing mother and child. Women often lack access to information as they are not perceived to be decisionmakers. If women do have knowledge, they may not feel empowered to act on it.
3. **Limited financial resources**: women frequently cannot make independent health decisions or seek services due to lack of access to funds. Communities and local health care services often have not prioritized women and their safe motherhood, and have not sought to ensure available financial resources and transportation in cases of emergency.
4. **Limited mobility**: in some societies, women cannot leave their homes without the permission of the husband/male members of family.

5. **Limited power in decisionmaking:** men and/or mothers in-law often exercise authority over whether and when a woman can seek outside care and whether household resources can be spent on routine or emergency care. Within the community outreach and referral system, female community health workers may not have the respect and authority needed to refer women for emergency care or to have their recommendations acted on with the necessary speed.
6. **Social and cultural norms:** women's pregnancies and safe motherhood are often not prioritized for action by women, their partners, families, communities, and health systems because of the lower status accorded women and the linked assumption that women's death and suffering in pregnancy are a ―natural‖ part of being a woman. Communities and healthcare systems often also assume that pregnancy is a woman's concern and, thus, that men (outside of designated roles as healthcare providers) do not have a role in understanding or supporting healthy pregnancies. Many providers and health systems similarly enact gender norms that discriminate against women, assuming that women's perceptions, preferences, and experiences are not to be listened to or valued; this discrimination may apply to women providers (often female community health workers or midwives), whose knowledge and referrals may be disregarded.

10. Finally, state that as we have seen and discussed, men's roles in many societies as key decisionmakers have an impact on women's health.

- Men need to be involved in community-wide decisions to ensure that resources and systems for medical assistance and transport are in place and available to women who need them.
- Not just the husband/partner, but men in all positions as gatekeepers in a community—community leaders, tribal leaders, religious leaders, policymakers, service providers, and family members—can contribute to saving pregnant and post-delivery women's lives.
- There is strong evidence showing that men are concerned about the health of women and children, and both men and women see potential benefits from an expanded role for men in safe motherhood and reproductive health (RH).
- As men are engaged, it is crucial to enable *constructive* men's engagement so that women's often precarious ability to control their own bodies and decisions is enhanced, rather than unintentionally undermined (Gay J., K. Hardee, N. Judice, K. Agarwal, and K. Fleming. 2003. *What Works: A Policy and Program Guide to the Evidence on Family Planning, Safe Motherhood, and STI/HIV/AIDS Interventions; Module 1: Safe Motherhood.* Washington, DC: POLICY Project).

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