

## Advance Toward Gender Equality and Equity

*Sexual health requires gender equality, equity and respect. Gender-related inequities and disparities of power deter constructive and harmonic human interactions and therefore the attainment of sexual health.\**

### Introduction

**M**illennium Development Goal 3 calls for the promotion of gender equality and women's empowerment. At the time of the Millennium Declaration the primary target advocated for measuring progress for MDG 3 was gender disparities in access to education. The U.N. (2005) Millennium Task Force on Education and Gender Equality expanded the range of progress indicators to include health and nutrition, access to opportunities in the work force, and participation in government.

Furthermore, the Task Force has clearly acknowledged that "Achieving Goal 3 requires guaranteeing women's and girls sexual and reproductive health and rights" (U.N., 2005, p. 53). It has been clearly and unambiguously demonstrated in this technical document and elsewhere that the provision and universal access by girls and women to schooling and sexuality education and clinical services is a necessary prerequisite to achieving the MDGs. However, the dispensation of these services, as crucial as they are, is not sufficient to empower women to exercise the right to gender equality. Genuine equality for girls and women in achieving the right to sexual health will require not just access to education and services; it will require increasing levels of autonomy of sexual expression and equality of power within sexual relationships.

\*This chapter was informed by the WAS Expert Consultation in Oaxaca, Mexico, a thorough review of the literature, and the background paper written by Elizabeth Castillo Vargas and Adriane Little Tuttle (see Appendix IV and V).

Achievement of the human right to sexual health demands the autonomy for girls and women to enter into sexual relationships on their own accord and on an equal footing with their partners.

MDG 3 utilizes the term “gender equality”. Nonetheless, the term equity has been frequently used. In some cases equity and equality are used interchangeably. Equality has been defined as equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society at large (WHO 2001). However, to fully and adequately address the need for girls and women to achieve sexual and reproductive health rights also requires that we recognize that men and women have different experiences and needs with respect to sexuality and sexual health. To achieve sexual health, therefore, all people, but particularly girls and women, require gender equality, equity and respect.

Gender equity is the process of being fair to women and men. To ensure fairness, strategies and measures must often be available to compensate for women’s historical and social disadvantages that prevent women and men from otherwise operating on a level playing field. Equity leads to equality. Gender equality requires equal enjoyment by women and men of socially-valued goods, opportunities, resources and rewards. Where gender inequality exists, it is generally women who are excluded or disadvantaged in relation to decision-making and access to economic and social resources. Therefore a critical aspect of promoting gender equality is the empowerment of women, with a focus on identifying and redressing power imbalances and giving women more autonomy to manage their own lives. Gender equality does not mean that men and women become the same; only that access to opportunities and life changes is neither dependent on, nor constrained by, their sex. Achieving gender equality requires women’s empowerment to ensure that decision-making at private and public levels, and access to resources are no longer weighted in men’s favour, so that both women and men can fully participate as equal partners in productive and reproductive life (UNFPA 2005).

Therefore both gender equality and equity both must form the basis of sexual and reproductive health programming that will meaningfully address sexuality related power imbalances and enable girls and women to achieve full sexual and reproductive health rights.

According to the WHO (2003),

The MDGs explicitly acknowledge that gender – what a given society believes about the appropriate roles and activities of men and women, and the behaviors that result from these beliefs – can have a major impact on development, helping to promote it in some cases while seriously retarding it in others (p. 1).

The need to promote the empowerment of women in the realm of reproductive health was recognized by the International Conference on Population and Development (ICPD) (UN, 1995). Furthermore, gender-based violence and sexual coercion, sex trafficking, female genital mutilation, and forced early marriage have been identified as some of the manifestations of gender inequality that must be addressed in order to achieve the MDGs (UN, 2006).

Many of the most basic gender inequalities that pervade nearly all cultures are deeply rooted in prevailing, entrenched attitudes and norms towards sexual behavior. It has been made clear in the literature on sexual health and global development that increased access for women and girls to sexual and reproductive health is an essential enabling factor in reaching the goal of gender equality (e.g., U.N., 2005; 2006).

Access to services, however, is insufficient. It is necessary to also recognize that the inequitable gender norms and practices enacted in sexual relationships cannot be isolated from gender equality in wider social, economic, and political relations. In other chapters of this declaration and technical document, female genital mutilation, sexual violence against girls and women, the sexual trafficking of girls and women (see Chapter 3), as well as the disproportionate burdens of HIV/AIDS and STIs that are borne by women (see Chapter 6) has been amply demonstrated. These expressions of gender inequality related to sexuality cannot be resolved without purposefully addressing the entrenchment within most cultures of gendered norms which control sexuality and sexual behavior.

Several theoretical frameworks emphasize the relationships between gender inequalities and sexuality (Butler, 1990; Weeks, 2003). Scripting theory (Gagnon, 1990) provides a useful framework for studying and analyzing the cultural construction of gender roles and has been used effectively to examine gender inequality in sexual relations (See O’Sullivan, Harrison, Morrell et al, 2006). Modification of inequitable gendered sexual scripts may begin with an affirmation of girls and women’s basic human rights to sexual health and gender equality.

## The Imbalance of Power: Sexual Scripts Enact Gender Inequality

Gender power imbalances can relate to sexual partnerships (number, timing, choice and social status of partners); sexual acts (their nature, frequency, voluntary/involuntary); the sexual meanings given to specific behaviors (male/female gender roles related to sexuality, ideal images of manhood and femininity, beliefs about virginity, etc); sexual drive and enjoyment (how they contribute to sexual identity, gender differences in perceptions of sexual pleasure) (Dixon-Mueller, 1993; Spicehandler, 1997). These imbalances of power are played out in a culturally dominant script for sexual interaction between men and women and in most contexts the script places the control of sexual activity in the hands of men. As Dixon-Mueller (1993) puts it, “Interpersonal sexual scripts are played out in the context of hierarchal social structures in which some people have the power to determine the sexual and reproductive lives of others” (p. 279).

Psychological and social elements of reproductive behavior are shaped to some extent by physiology and psychological determinants. Nevertheless, all gender related behavior, including most prominently, sexual activity, is shaped by cultural traditions and expectations. It is these forces that largely write the script for sexual behavior. In brief, the sexual script is the experiential and behavioral guide that each of us learns from our culture about how to be sexual (Gagnon, 1990). In most societies, gender and sexual conduct are closely linked and the scripts for how men and women are expected to behave sexually are clearly delineated. As Gagnon suggests,

Scripts for sexual encounters from the opening phase to the couple separating are now acknowledged to be entirely gendered, with men conventionally expected to conduct themselves assertively, to make the first move and to lead in the subsequent steps, and to be knowledgeable in the ways of sexual practice...Women are expected to be more passive, more compliant at the beginnings of sexual interactions, and pleased and responsive as such interactions progress (p. 15).

O’Sullivan et al., (2006) caution that while some generalizations are possible concerning the applicability of this script, “...it is important to note that such generalizations need to be understood as being contingent on specific gender paradigms and sociocultural contexts” (p. 100). Given the vast diversity in social and cultural norms across the globe, the basic script for heterosexual sexual activity is remarkably consistent across cultures with respect to the gendered power imbalance it enacts. In playing out this dominant sexual script boys/men and girls/women are often conforming to typically rigid conceptualizations of masculinity and femininity from which it is often very difficult for individuals to make even subtle personal revisions without risking derision,

humiliation, stigmatization, or worse. Wiederman (2005) describes the confining nature of these scripts. For boys and men, the script dictates that they should be goal directed, in control, and assertive in the pursuit of sexual activity and self-pleasure. Girls and women play their complementary role in the script by showing restraint, emphasizing emotional-relational concerns over physical pleasure, but finally ceding control and giving in to male desires.

That females' standards typically represent a barrier each male must overcome fits well with the competitive and achievement-oriented aspects of masculine gender roles. Masculinity calls for being proactive and able to outdo one's opponent, and unfortunately this is a stance many young men take in relation to early sexual relationships. In many cases, male-female differences in sexual roles set up a dynamic of polar extremes; the more he pushes for sex, the more defensive she has to be, and vice-versa. For many couples, it can seem as though he is obsessed with sex and that she is completely indifferent or disinterested (Wiederman, 2005, p. 498).

Not only do these prevailing ideas constrict people's ability to form mutually beneficial relationships, they also place women and girls in a disadvantaged position with regard to sexual and reproductive health. Dixon-Mueller (1993) gives some apt examples:

...cultural definitions of masculinity and femininity influence people's perceptions of the use or nonuse of a contraceptive method – or of such particular methods as condoms or sterilization – as unmanly or unfeminine, quite apart from whether the methods are considered safe or effective. How do people's perceptions of what is masculine or feminine or of the nature of their sexual relationships, or of the meaning of particular sexual acts influence their decisions about contraception or pregnancy termination? In turn, how does contraceptive use or the experience of abortion – that is the separation of the act of intercourse from its reproductive consequences – affect people's perceptions of their own or their partner's masculinity or femininity, of the quality of their relationships, of the meaning of their sexual acts? (279).

Amaro (1995) points to the various ways in which culturally determined gender roles influence and define the interpersonal relationships in which sexual behaviors occur and the gender inequitable nature of these relationships often places girls and women at much greater risk for negative sexual health outcomes, particularly HIV infection. As an example, Amaro cites Pleck, Sonenstein and Ku's (1993) analysis of large-scale survey data of Black, Latino, and White teenage boys in the United States which found that those who scored higher in traditional masculine ideology were less likely to have sex in

the context of an intimate relationship, more likely to view male-female relationships as adversarial, less likely to use condoms, and less likely to believe that it is a male's responsibility to prevent pregnancy.

Studies that have explored and shown the relationships between gender role stereotypes related to sexuality and relationship power and their implications for sexual health have been conducted in many parts of the world including the United States (Pulerwitz, Amaro, De Jong et al., 2002), Ghana (Ampofo, 2001), South Africa (Varga, 2003), Mexico (Marston, 2004), Nicaragua (Sternberg, 2000), and Thailand (Tangmunkongvorakul, Kane, & Wellings, 2005). For example, Pulerwitz et al. found that young women in the United States who perceived that they had low levels of power in their relationships were much less likely to use condoms than women who experienced high levels of relationship power. In their study of young people's access to health care in Thailand, Tangmunkongvorakul, Kane and Wellings found that young women's access and standard of care related to sexual health was compromised by gender double standards favoring males and that this led the subjects to seek unsafe, clandestine abortions.

In describing gendered expectations for behavior related to sexuality, Ilkaracan and Jolly (2007) illustrate additional examples of the oppressive nature of prevailing gender scripts for both males and females.

...social influences around sexuality affect us all. Gender is one of those influences, i.e., expectations about how women and men, boys and girls, will behave differently from each other (as well as expectations that everyone will be either male or female, and not transgender). Those who conform to these expectations, such as girls who undergo female genital mutilation or have an early marriage, may suffer to fit their sexualities into limited and unequal channels. Boys may pay a price too. For example, in places as diverse as Turkey, Pakistan and Brazil, many boys are taken to brothels by their fathers, brothers or friends at an early age without feeling willing or ready for such an experience, and sometimes finding it traumatizing (p. 4).

Langen's (2005) research in Botswana and South Africa provides a vivid example of how gender power imbalance in sexual interactions curtails women's ability to protect themselves from HIV infection. Langen concluded from her studies that the public health community must come to see sexual health as "the business of men" not just women because simple educational messages such as instructing people to "use a condom" are much less effective if they do not address these gender power imbalances. Without the involvement of men and boys in sexual and reproductive health programming, it will not be possible to genuinely empower women and girls. Men and boys must be educated so that they are fully informed of the consequences of

their sexual behaviors and encouraged to take responsibility for their own sexual health and take equal responsibility for the sexual health of their partners.

## Promoting Gender Equitable Sexuality

It is increasingly recognized that the basic principles of human rights extend to sexual rights (WAS, 1999, WHO, 2004). The issue of gender inequality related to sexuality therefore falls precisely within the realm of human rights (Ilkharacan & Jolly, 2007). These authors point out that resistance and retrenchment in the area of human rights has frequently been based on the argument that cultural traditions, often specific to gender and sexuality, can be held up to legitimately limit basic human rights. They also note that appeals to cultural tradition that have been used to justify discrimination against gays and lesbians have also functioned to curtail the sexual autonomy of women.

However, the notion that cultural tradition ought to limit human rights is waning in many parts of the world and has been challenged by scholars (Mullally, 2006). While respect for cultural tradition remains a justifiable aspiration, progressively larger proportions of the global community are moving towards a recognition of women's right to reproductive and sexual health as evidenced by the ICPD endorsed definition of reproductive health (U.N., 1994) as well as a recognition of the importance of gender equality to global development as evidenced by MDG 3.

In other words, the conditions for meaningful progress in moving towards gender equality in sexuality are increasingly falling into place.

Positive change is possible. An innovative program conducted in Rio de Janeiro, Brazil focused on addressing gender norms among young men as a strategy to reduce HIV risk (Pulerwitz, Baker, Segundo, & Nascimento, 2006). The program combined interactive group education sessions for young men led by adult male facilitators with a community-wide social marketing campaign to promote condom use that emphasized gender-equitable messages. Among the findings of the program's evaluation study was that support for inequitable gender norms among young men at baseline was significantly associated with HIV risk behavior, the program was able to effectively promote gender equitable norms, and therefore lower HIV/STI risk.

A similar program conducted with men aged 18-29 in Mumbai, India was successful in encouraging young men to critically discuss gender dynamics and health risks as well as in advancing gender equitable norms related to sexuality (Verma, Pulerwitz, Mahendra, et al., 2006). In their study of the gender dynamics in the primary sexual relationships of rural South African women and men aged 18-24, O'Sullivan et al., (2006) found that the traditional sexual script of male assertiveness and control and female passivity predominated but that some young men and women had begun to internalize more equitable gender norms for sexual relationships. The authors note that there is a lack of new models of sexual relationship behavior and that the voices of men and women

expressing egalitarian norms could be utilized as peer leadership in sexual health promotion programs.

For girls and women accessing health care, particularly when it is reproductive health care, the issues of sexual partnerships, sexual acts, sexual meanings, and sexual drives/enjoyment should be addressed with individuals as part of the services offered. In some cultures, males may hold their physicians in very high regard and, thus, these professionals may be ideally placed to speak with men and boys about gender equitable norms for sexual behavior. For boys and men who may seek out health care less often or not at all, school-based education, media campaigns, and community opinion leaders influential with males (e.g., sports stars) can be utilized to endorse social/cultural norms that promote gender equality in the sexual realm.

## Conclusion: Promoting Change at All Levels of Society

The process of achieving gender equality has been gradual, with progress being uneven across the many different cultures of the world.

There can be no doubt, however, that among the greatest changes in the social fabric of the world community during the twentieth century was a significant trend to question rigid patriarchal social structures and to move towards more gender equitable societies.

In many ways, the strides that many cultures have taken in pursuit of gender equality have been part of a larger process of extending fundamental and basic human rights to oppressed and marginalized communities that have suffered discrimination based upon race, ethnicity, religion, class, gender, sexual orientation, disability, and age. Clearly, the process of attaining basic human rights by all peoples of the world is in its infancy.

And, in many cultures the same may be said with respect to the human right of equality for girls and women. In articulating key priorities for global development, the United Nations has definitively recognized the centrality of gender equality, making it one of the eight MDGs. Furthermore, it must be recognized that many of the MDGs (i.e., reduce child mortality, improve maternal health, combat HIV/AIDS) are tied in various ways to the attainment of girls and women's right to sexual and reproductive health.

These rights, however, cannot be fully realized without basic equality of power within sexual relationships.

Clinical programs related to sexual health can and should address these inequalities. However, such programs, in-of-themselves, cannot bring about the profound social

change required to transform the communal and individual level scripts that shapes all aspects of our sexual behavior.

Leadership in advocating for social change with respect to sexuality and gender equality must permeate all levels of society. Political, religious and cultural opinion leaders should advocate for gender equality in all realms of life including interpersonal relationships and sexuality.

Fathers and mothers must teach their sons and daughters that equality means that girls and women should have equal power in determining and negotiating sexual behavior with their partners and that this equality of power extends to all types of sexual relationships including marital relationships.

Sexuality education programs taught to youth in schools and other settings must be gender sensitive as well as encouraging participants to think about sexuality and relationships from the standpoint of principles of human rights, including gender equality.

Popular entertainment media (music, movies/television, video, internet) is often infused with sexual imagery and the makers of popular media should be encouraged to create representations that model gender equality, not reinforce traditional sexual scripts that perpetuate inequality. In sum, all levels of society must work collectively in order to realize meaningful change in the realm of sexuality and gender equality. Failure to address gender imbalances in sexual relationships will cripple broader efforts to promote sexual health and to achieve MDG 3 in particular but also the Millennium Development Goals in general.

## Necessary Actions

2.1 The discourse of rights as it has been applied to the right of girls and women to quality and sexuality education and services in international agreements and covenants must explicitly include the fundamental right to autonomy and equality within sexual relationships.

2.2 Policy makers and public opinion leaders must speak openly of the fact that a substantial and important component of gender inequality is directly related to power imbalances in sexual relationships.

2.3 Fathers and mothers and families and communities play key roles in contributing to the formation of the gender roles of children. They should be encouraged and assisted in helping their children to develop gender equitable roles. Fathers, in particular, can be instrumental in encouraging their sons to embody gender equitable conceptions of masculinity.

2.4 To effectively reach their stated objectives, sexuality education programs, particularly those aimed at youth, must address the gender-based dynamics within sexual relationships and assist students in developing and implementing gender equitable behavior.

2.5 Media portrayals, whether it is through music or visual representation, frequently model in subtle and blatant forms, sexual scripts for young people. The modeling of gender equitable sexual scripts in popular media has the potential to make a powerful contribution to societal-wide gender equality. The entertainment industry should, therefore, be strongly encouraged by governments and the public at large to become a force for positive change with regard to sexuality and gender.

2.6 Legal and policy change to ensure that women and men have equal access to sexual health care services, regardless of income differentials, without stigma, discrimination or bias by providers and the health services.

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